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Wat ek is, is net genade,
Wat ek het, is net geleen.
"Gebed" ~ Koos du Plessis

THE ROLE OF A CLINIC MANAGER IN A PRIMARY HEALTH CARE SETTING

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ABSTRACT

In this study the researcher attempted to determine the current role expectations of a clinic manager in a primary health care setting, to identify factors determining and influencing the role of a clinic manager, to determine what effect the current role expectations had on the management of primary health care services rendered at the clinic, to establish the developmental needs of clinic managers to enable them to adhere to their role expectations, and to identify and recommend measures to support clinic managers in the execution of their managerial role by addressing the identified deficiencies.

The researcher selected a quantitative, exploratory, descriptive and contextual design. Clinic managers of fixed clinics in the Free State province were randomly selected to participate in the study and a questionnaire was utilised as data-collection instrument.

The study found that the clinic manager's role is comprehensive and varies from telephonic booking patients to assessment of the quality of primary health care programmes. A number of non-managerial functions were identified, such as consultation of patients, management of medicine, dispensing of medicine and ordering of stock. It was also found that the respondents were not involved in a number of management functions such as financial and human resource management, and adherence to the implementation of standards.

Factors that negatively influenced the clinic managers' management role included:

- Lack of time due to the large number of patients they had to consult due to the shortage of staff.
- Shortage of staff.
- The execution of non-managerial tasks.

Although it was found that the current role of the clinic manager was confusing as it entailed much more than just clinic management, it is foreseen that the role of the clinic manager could in future be clarified if the recommendations are implemented.

KEYWORDS

Clinic manager; Management; Primary health care; Primary health care clinic; Manager's role; District health systems; Job description; Norms and standards; Role expectations; Systems theory.

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List of abbreviations

AIDS	-	Acquired Immune Deficiency Syndrome
ANC	-	African National Congress
ANOVA	-	One-way analysis of variance
ART	-	Antiretroviral treatment
BAS	-	Basic Accounting System
CBO	-	Community Based Organisation
CEO	-	Chief Executive Officer
CHC	-	Community Health Centre
CHP	-	Centre for Health Policy
CHSRD	-	Centre for Health Systems Research and Development
CHW	-	Community Health Worker
DHIS	-	District Health Information System
DHS	-	District Health System
DISCA	-	District STD Quality of Care Assessment
DOH	-	Department of Health
DOT	-	Directly Observed Treatment
EDL	-	Essential Drug List
EPI	-	Expanded Programme on Immunisation
FP	-	Family Planning
FSDOH	-	Free State Department of Health
HBC	-	Home-based care
HR	-	Human resources
HISP	-	Health Information System Programme
HIV	-	Human Immune Deficiency Virus
IMCI	-	Integrated Management of Childhood Illnesses
INC	-	International Council of Nursing
INP	-	Integrated Nutrition Programme
MCWH	-	Mother, Child and Women's Health
MDS	-	Minimum Data Sheet
NDOH	-	National Department of Health
NGO	-	Non-Governmental Organisation

List of abbreviations

NHS	-	National Health System
NPI	-	Netherlands Pedagogic Institute
OSD	-	Occupational Specific Dispensation
PFMA	-	Public Finance Management Act
PHC	-	Primary Health Care
PMTCT	-	Prevention of Mother-to-Child Transmission
RDP	-	Reconstruction and Development Programme
SA	-	South Africa
SAC	-	Senior Administration Clerk
SANC	-	South African Nursing Council
SPSS	-	Statistical Programme for Social Sciences
STI	-	Sexually Transmitted Infections
TB	-	Tuberculosis
TJHU	-	The Johns Hopkins University
USA	-	United States of America
VCT	-	Voluntary Counseling and Testing
WHO	-	World Health Organization

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CHAPTER 1

Orientation to the study

1.1 INTRODUCTION

According to the policy of the National Health System (NHS) in South Africa (SA), primary health care (PHC) services form the basis of health service delivery in South Africa. These services are rendered by primary health care clinics, which have to implement the primary health care package (DOH 2001b:7).

Primary health care (PHC) is a nurse driven process. The staff establishment of clinics consists of a clinic manager, who is usually a chief professional nurse, professional nurses (including various ranks, for example chief professional nurses, senior professional nurses and professional nurses), auxiliary nurses, clerks and cleaners. No posts for enrolled nurses are available on the staff establishment of PHC services rendered by the Free State Department of Health. The number of nurses of each category varies according to the size of the clinic and the population it serves.

Volunteers support the clinics by rendering home-based care services in the community and are involved in the Directly Observed Treatment (DOTs) to strengthen the Tuberculosis Programme. Lay counsellors support the HIV/AIDS programme by counselling patients before and after testing for HIV/AIDS. However, volunteers are not included in the staff establishment of clinics as they only receive stipends from the non-governmental organisations, which are supporting them financially.

In addition to their management responsibilities, clinic managers also have to perform clinical (eg. consultation of patients) and other tasks in the clinic, and therefore cannot execute their management roles effectively. This is a cause of concern in the clinical field.

1.2 BACKGROUND TO THE PROBLEM

The implementation of the National Health System (NHS) led to drastic changes regarding service delivery in clinics ensuring a solid base for a single, unified health care system (van Rensburg 2004:427). Before 1995 clinics were responsible for child health care (which includes healthy baby clinics and immunisation), family planning services and a limited service for minor ailment treatment, whereas chronic illnesses and geriatric services were delivered through the district surgeon concept. Separate district surgeon clinics attended to patients with chronic diseases. Professional nurses allocated to the district surgeon clinics did home visits to these chronic patients.

In 1994 user fees for children under 6 years and pregnant women were removed and in 1997 all user fees at PHC clinics were abolished, thereby resulting in an increase in the utilisation of PHC services (Wilkinson, Gouws, Sach & Karim 2001:30).

As from 1994, several changes in the service delivery in PHC clinics were implemented, which changed the face of all PHC and district surgeon clinics drastically, including (Human 1999:229):

- Medical services for all patients at PHC clinics were free.
- All patients with chronic diseases had to come to PHC clinics for medication and follow-up treatments instead of visiting the district surgeon, resulting in serious negative implications for the elderly, bedridden and terminal patients.
- Chronic medicine had to be stored in and dispensed from the clinics although their infrastructure was unsuitable for this function as the majority of clinics do not have enough storerooms or pharmacists to dispense medicine. Pharmacists for clinics are also not part of the staff establishment.
- As the “district surgeon” concept and “district surgeon clinics” were phased out, doctors had to visit the PHC clinics on a regular or session basis. Patients, who visited the district surgeon in the past, now had to visit the doctor at the clinic, including applications for social grants, trial awaiters and cases of assault.

Before 1995 most of the clinics did not have the services of a doctor. At that time patients without a medical scheme or who did not have funds to pay for treatment had to be referred to the district surgeon or hospital and private patients to their private general practitioners.

In 1996 the Essential Drug List (EDL) was implemented in PHC clinics and professional nurses were allowed to issue Level 1 and 2 medicines, depending on the grading of the clinic. Level 1 medicine can be prescribed by a professional nurse according to the Standard Treatment Guidelines, Level 2 medicine is available on the EDL, but can only be prescribed by a doctor. The PHC approach requires professional nurses to have comprehensive skills to render these services in PHC clinics. South Africa has various categories of training for professional nurses, regulated by the Nursing Act, 50 of 1978, as amended, now replaced by the Nursing Act, 33 of 2005, resulting in different skill levels (Hlahane, Greeff & du Plessis 2006:83). To enable them to dispense Level 2 medicine, professional nurses in the Free State had to undergo special training on physical assessment for six weeks. Upon successful completion, they were authorised by the District Medical Officer to dispense Level 2 medicine.

Drug management encompassing ordering, storing, packaging and dispensing had to be done at clinic level. This had to be done by professional nurses due to a lack of pharmacists and pharmacist assistants.

In most clinics, staff establishments remained as they were before 1995 while the authorities and clients' expectations increased dramatically. Heunis, van Rensburg and Claassens (2006:42) state that similar to the phasing-in of free health care in the mid-1990's, the primary health care package was "dumped" on PHC managers and staff without the necessary preparation to adapt and commit to the initiative, especially at the lower echelons of service delivery. At the same time, little or nothing was done to relieve the prevailing constraints in human and material resources. In addition, there was a marked increase in the number of patients visiting the clinics (Heunis et al 2006:42).

Wilkinson et al (2001:32) point out that in the 18 months following the removal of user fees for pregnant and lactating women and children younger than 6 years, clear changes were

noticed in attendance patterns at a mobile primary health care service in the rural Hlabisa health district. While there was little or no increase in attendance for preventive services, such as antenatal care and childhood immunisation and growth monitoring, for which coverage was already high, attendance for curative services increased by 77%.

In 1997, fees for all PHC services for all people were withdrawn. As a result, the number of consultations for curative care in the mobile unit in Hlabisa health district almost doubled, while consultations for preventive services decreased (Wilkinson et al 2001:32). Access to curative services was encouraged by the removal of user fees, but subsequent clinic congestion and reduced consultation times may have discouraged some women from attending for antenatal care and bringing their children for growth monitoring and immunisation.

Clinic nurses reported strong pressure to spend less time than before with each patient, and subsequently found their work more frustrating and tiring than it used to be (Wilkinson et al 2001:35). Due to the increase of attendance, patients complained of long waiting times at clinics due to a shortage of staff. In an attempt to accommodate and deal with the influx of patients, clinic managers also had to see patients and consequently had less time for their management functions. This, in turn, resulted in the management in some clinics not being up to standard and a lack of supervision filtering in.

Although job descriptions were available for clinic managers, their role was extended and unclear due to various expectations from authorities, colleagues, and patients. Moreover, local government employed some clinic managers while the Provincial Department of Health employed others. The job descriptions differed, leading to a lack of standardisation of job descriptions and role expectations. Clinic managers were unable to meet all the demands made on them and consequently poor management, frustration and stress set in and in some instances even burnout in the PHC clinics. High absenteeism, low staff morale and many resignations were reported. Professional nurses left for private institutions and/or abroad.

1.3 STATEMENT OF THE PROBLEM

Poor client service and deficient management performance can be attributed to two main reasons, namely insufficient staff and the volume and complexity of PHC programmes. At present, there are insufficient registered nurses available in PHC clinics to perform the required functions due to factors such as:

- Uniformly applied staffing ratios in health facilities and defined national staffing norms for PHC are lacking (Pick, Nevhutalu, Cornwall & Masuku 2001:63; Chabikuli, Blaauw, Gilson & Schneider 2005:107). Consequently, there is a key deficiency in the harmonisation between the expansion of PHC services and the demand for nurses.
- With the implementation of free health care services in clinics, services to be rendered as well as care demands increased. Professional nurses have to examine patients, prescribe and dispense medicine, order medicine from the medical depot, and do drug management. Neither pharmacists nor pharmacy assistants are available in most of the clinics. In some clinics, the clinic manager takes responsibility for drug management, involving ordering and checking stock (including expiry dates), receiving orders from the medical depot, and unpacking boxes in the storeroom while in other clinics these routine tasks are delegated to professional nurses. Professional nurses also have to solve problems in the procurement of equipment, drugs and supplies, which are non-nursing duties (Chabikuli et al 2005:104).
- Inadequate staff establishments exist, which is worsened by having to make provision for sick leave, annual leave, family responsibility leave, formal studies and short training courses for staff members.

Clinic managers do not have time to execute their managerial functions, which results in poor or absent drug control management, auditing of records, personnel development and implementation of the full PHC package in the clinic. Furthermore, Chabikuli et al (2005:109) maintain that managers are inadequately prepared for their role as managers and that the position of facility manager is low in rank and unattractive for qualified nurse managers.

PHC programmes require specific expertise from nursing staff and include:

- Chronic Diseases and Geriatrics
- Home Based Care (HBC)
- Health Information System Programme (HISP)
- Human Immune Deficiency Virus/Acquired Immune Deficiency Syndrome and Sexually Transmitted Infections (HIV/AIDS and STI)
- Mother, Child and Woman's Health (including the Expanded Programme on Immunisation (EPI) and Integrated Management of Childhood Illnesses (IMCI), Family Planning and Antenatal Care)
- Mental Health
- Minor ailment treatments
- Prevention of Mother-to-Child Transmission (PMTCT)
- School Health Services
- Tuberculosis (TB) programmes

These programmes have to be implemented at clinic level and it is the responsibility of the clinic manager to ensure proper implementation. Targets have to be reached according to set indicators and monitoring of achievements and non-achievements should be done. Action plans to address failures should be implemented at clinic level. If the clinic manager does not drive the process, targets will not be achieved.

The problem is thus that due to a dramatic increase in the workload of PHC clinics and the inadequate adjustments of staff establishments, the clinic manager (registered nurse / nurse in charge of the clinic) is now required to significantly contribute to the patient care load with a consequential neglect of her management functions.

1.4 RESEARCH QUESTIONS

In the light of the problem, the researcher formulated the following research questions:

- What are the current role expectations of the clinic manager in a PHC setting?
- What factors determine and influence the role of the clinic manager in a PHC setting?
- What effect does the current role expectations of the clinic manager have on clinic management and services rendered at clinics?
- Are the clinic managers equipped to manage clinics optimally?
- Does the clinic manager have realistic role expectations?

1.5 OBJECTIVES OF THE STUDY

The objectives of the study are to

- Determine the current role expectations of a clinic manager in a PHC setting.
- Identify factors determining and influencing the role of clinic managers in a PHC setting.
- Determine what effect current role expectations of a clinic manager have on the management of services rendered at a PHC clinic.
- Establish developmental needs of clinic managers to enable them to fulfil their role expectations.
- Identify realistic role expectations of a clinic manager in a PHC setting under current circumstances.

1.6 ASSUMPTIONS

An assumption is “something accepted as true without proof” (*Oxford English Dictionary* 2002:44). Assumptions are “embedded in thinking and behaviour and therefore influence the development and implementation of the research process” (Burns & Grove 2001:45).

The following assumption served as point of departure for this study:

> If the workload is fair and feasible, a competent and committed clinic manager will be able to manage a clinic effectively.

1.7 SIGNIFICANCE OF THE STUDY

PHC is the cornerstone of health services in South Africa as this is a patient's first level of contact with a health service (van Rensburg 2004:143). Thousands of South African citizens visit PHC clinics daily and rely and depend on their services. Proper clinic management will contribute to effective service delivery to clients.

PHC is still a new concept in South Africa and little scientific information is available on the role expectations of clinic managers. The study wished to examine the problems experienced at ground level and make recommendations to improve the quality of services rendered by PHC clinics. The findings should assist the national and provincial departments of health in policy making.

Clinic managers do not know exactly what is expected of them or what their job descriptions should contain. Serious staff shortages and insufficient staff establishments oblige them to consult patients as a priority thereby leaving them inadequate time for their management functions. Identifying deficiencies would facilitate the development of guidelines on the role expectations of clinic managers and adjustment of staff establishments in an effort to improve service delivery and enable a fair allocation of work for the clinic manager.

1.8 DEMARCATION OF THE STUDY FIELD

The study was limited to the PHC clinics in the Free State province, South Africa. The target group was clinic managers, namely professional nurses in charge of a clinic regardless of their rank.

The focus was on the role expectations of clinic managers and the daily tasks linked to their role expectations.

1.9 CONCEPTUAL FRAMEWORK

A management model served as conceptual framework for this study. As the study explored the role of the clinic manager in a PHC setting, and specifically a PHC clinic, the concept of PHC and its influence on clinic management could not be separated.

1.9.1 Primary health care (PHC)

PHC was the key element in the South African Government's plan to transform health services in South Africa to ensure the availability of a comprehensive and integrated package of essential PHC services for the entire population and providing a solid foundation for a single unified health system. PHC would be the driving force in promoting equity in health care (Department of Health [DOH] 2001a: 5).

Following consultation over four years with national experts and provincial staff, the PHC package was developed at the request of the National Department of Health by the Centre for Health Policy (CHP) at the University of the Witwatersrand (Johannesburg) and the Centre for Health Systems Research and Development (CHSRD) at the Free State University (DOH 2001b:5). This package was expected to contribute to greater social justice and promote equity in health services. Furthermore, it was hoped that its implementation would reduce the gap between those who had access to an appropriate level of care and those who did not (DOH 2001b:5).

PHC services should address the leading causes of mortality and morbidity in the country, thus these services had to be accessible to the broader community throughout South Africa. Professional nurses in the clinics do referral to the next level of services, where necessary.

The vehicle for the delivery of the PHC package is the District Health System (DHS). The DHS comprises clinics (fixed and mobile), community health centres (CHC) and district hospitals (where access to clinics and CHC is limited). All the provinces indicated the need to link the PHC package more clearly with the district hospital. The non-inclusion of district hospitals as part of the package was seen as an omission. However, the development of

the package for district hospitals clearly indicated the link between the two packages (DOH 2001b:37). PHC services are thus rendered within a DHS by clinics, CHC and district hospitals. Table 1.1 illustrates the distinction between DHS, the PHC package, PHC components and PHC programmes.

Table 1.1 Distinction between DHS, the PHC package, PHC components and PHC programmes

DHS
• Is the vehicle for the delivery of the PHC package in the DHS. • DHS comprises: - clinics - CHC - district hospitals
PHC Package
• Divided in three sections - community services - clinics / mobiles - CHC • Entails a list of **services** and **components** of services rendered at community services, clinics and CHC. • Personal community based **services**, eg ***environmental health***. **Components** of this service are for example, chemical safety and managing disposal of sharps. • Clinics, CHC and district hospitals form the platform for the delivery of the package within the DHS. • Includes preventative and promotive services as well as curative and rehabilitative services.
PHC Components
Components are part of the service that is rendered in the PHC package, for example in fixed clinics the **services** rendered is ***Preventative Health Care*** – under 5. The service **components** of this service are for instance ***immunisation, physical screening*** and ***charting of the Road to Health Chart***.
PHC Programmes
• Deal with the leading causes of mortality, morbidity and disability in South Africa. • Programmes are supposed to be rendered at PHC facilities as part of the PHC package. • Programmes: - Non personal health services ♦ Occupational health ♦ Health promotion ♦ Environmental health - Disease prevention and control ♦ Chronic diseases, geriatrics and disabilities ♦ Oral health ♦ Communicable diseases - Maternal, child and women's health ♦ Women's health and genetics ♦ Antenatal care ♦ Post natal care ♦ Contraception care ♦ Screening for cervical cancer ♦ Termination of pregnancy ♦ Genetics ♦ Child and youth health o IMCI o EPI ♦ Nutrition - HIV/AIDS, STIs, TB ♦ HBC ♦ VCCT ♦ PMTCT - STIs - TB - Health monitoring and evaluation - Mental health and substance abuse - Gender issues ♦ Violence and sexual abuse

1.9.2 PHC package

The PHC package provides a comprehensive and integrated package of essential PHC services, which should be available for the entire population. It includes three different types of services:

- Community services (district management functions, non-personal services and community based personal services)
- Clinics/mobiles
- Community Health Centres (CHC).

Table 1.2 presents a broad description of the levels of services included in the PHC package.

Table 1.2 Levels of services included in the PHC package

<table>
<tr><th colspan="4">PHC PACKAGE</th></tr>
<tr><th colspan="2">Community services (district management functions, non-personal services and community based personal services)</th><th>Clinics / mobiles</th><th>Community Health Centres (CHC)</th></tr>
<tr><td>District Management Functions eg
• ensuring a proper referral system
• ensuring a smooth drug supply across the district
• ensuring and monitoring that activities take place outside facilities eg outreach services by clinics</td><td>Non-personal services eg
• environmental health
• health promotion
• school health services
• services to other institutions

Personal services eg
• home based services</td><td>• Services are defined by the level of skills of the staff</td><td>• Some areas do not have a CHC
• In the short term district hospitals can render the services eg deliveries and casualties</td></tr>
</table>

Table 1.3 outlines the different types of services included in the PHC package.

Table 1.3 Functions of different types of services included in the PHC package

COMMUNITY SERVICES	CLINICS/MOBILES	CHCs
• The district management will have a coordinating function between the various levels of service. • Ensuring proper referral systems from community to clinic, to CHC, to district hospital and beyond. • Ensuring smooth drug supply across the district. • Ensuring and monitoring outreach services by clinics, CHCs, environmental health and other relevant specialists to clinics. • Non-personal services, eg environmental health services, school health services. • Community based personal services eg -Home-based care: crèches, disabled and geriatrics -Workplace: occupational health -School health services -Rehabilitation services	• This is a nurse driven process. • Additional services could be rendered, eg services offered by doctors, therapists and oral health practitioners. • Referrals are done from clinics to Community Health Centres (CHC) or to the district hospital. (In the absence of a CHC in a town, patients can be referred directly to the district hospital).	• A multidisciplinary team provides the services to be structured with the following: -A clinic for the local catch-ments area -A referral system with specialists -A 24 hour unit with maternity and casualty services

The clinic manager is responsible for ensuring that the PHC programmes are implemented in the clinic. This study emphasised the role of clinic managers in administering and monitoring the implementation of the PHC package within their clinics.

Kroon's (1995) management model as adapted by Uys (2005:6) was used as the conceptual framework for this study. Uys (2005:5) integrated Kroon's management model with the systems approach, which emphasises the interdependency between structure, process and output. Figure 1.1 outlines the model.

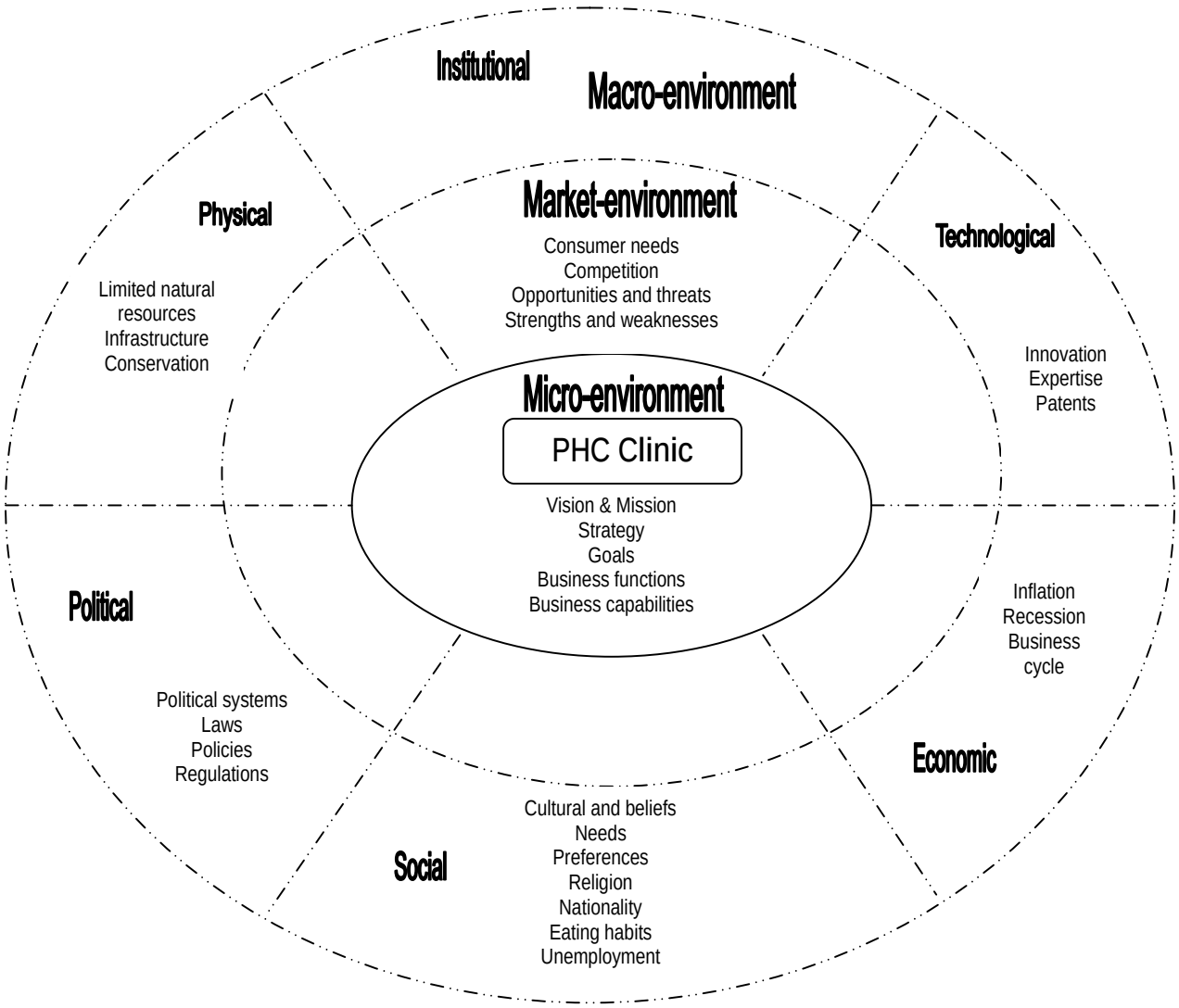

Figure 1.1 The management environment

Source: Uys (2005:6)

1.9.3 Kroon's management model

Kroon's model comprises three main components, namely the macro-, market, and micro-environments (Kruger 1995b:53).

The researcher considered Kroon's management model as adapted by Uys appropriate for this study as it entails the different aspects of the management process. The micro-environment includes the management of input, processes and output, which can be applied to a PHC environment. For the purposes of this study the focus was on the micro-

environment. The micro-environment contains management components, which could be applied to clarify the role of the clinic manager, including planning, organising, leading and control.

The **macro-environment** includes the economic, social, technological, physical and political environments.

The **market or task environment** includes market, competition, opportunities and threats, and strengths and weaknesses.

The **micro-environment** includes business functions (planning, organising, leading and control); business economics management (management approach, basic and additional management tasks, and interest group), and business capabilities.

1.9.4 Systems approach

A systems approach “measures the interrelationship between structures, processes and output within an organisation” (Uys 2005:5). To investigate the role of a clinic manager in a PHC setting, the systems approach was used to indicate the micro-environment’s effect on clinic management.

1.9.5 The four basic management functions

According to Kroon (1995b:8), the four basic management functions are planning, organising, activating (which includes leadership) and controlling. These functions are the most important steps in the management process and are performed consecutively during each activity. To identify to what extent the clinic manager is involved with these functions in managing a PHC clinic, the study investigated these basic management functions (see chapter 2 pages 51 - 85).

The basic management functions will be discussed in depth in Chapter 2.

1.10 RESEARCH METHODOLOGY

According to Mouton (2001:56), research methodology refers to the research process and the kind of tools and procedures to be used. In this study, the researcher followed a quantitative approach, using an exploratory, descriptive and contextual design.

- **Quantitative**

Quantitative research relies on the collection of quantitative data, which has numerical values (Goddard & Melville 2001:52). Data is collected based on precise measurement, like rating scales, and the analysis of quantitative data is usually done by using statistical analysis programmes.

A quantitative approach is used when little is known about a specific topic. As PHC is still a new concept in health care in South Africa, the researcher adopted a quantitative approach because little research has been done on the role of a clinic manager. The researcher wished to identify cause-and-effect relationships so as to make predictions and generalisations on the role expectations of clinic managers. Data was collected by means of questionnaires, and the outcome measured and subjected to statistical analysis (Mardiros 1994:137).

Quantitative researchers assume that there is an objective reality to be observed, claim to be objective in conducting their research, and attempt to avoid human bias (Johnson & Christensen 2000:19). Quantification makes it easier to aggregate, compare and summarise data and opens up the possibility of statistical analysis (Babbie 2001:36).

- **Exploratory**

Exploratory research explores the specific circumstances with regard to the phenomenon being studied in order to develop generalisations about it. Exploration is important in the early phases of research, as researchers have to generate ideas about phenomena before additional research can progress (Johnson & Christensen 2000:14). In the present

researcher's experience, the role of a clinic manager entails much more than just management of a clinic, as he/she has to execute clinical as well as non-managerial tasks. Her perceptions therefore motivated the exploration of the role of a clinic manager.

- **Descriptive**

In descriptive research, a specific phenomenon or situation is studied to see if it gives rise to any general theories, or to see if existing theories are borne out by it. This design may also be used when the phenomenon under study is very complex (Goddard & Melville 2001:9).

In this study, the researcher conducted an in-depth survey of a selected number of PHC clinics in the Free State and then compared the information to see whether any general trends emerge.

- **Contextual**

The *Oxford English Dictionary* (2002:176) defines context as the circumstances that form the setting for an event, statement or idea.

1.11 POPULATION AND SAMPLE

The population consisted of clinic managers in a PHC setting in the Free State, including clinic managers of small fixed clinics in rural areas as well as fixed clinics in bigger towns. Each clinic has a manager in charge, who is a professional nurse. In cases where the fixed clinic has only one professional nurse, he/she will also be responsible for managing the clinic. A second in charge is advisable, but in most clinics this is an internal arrangement, as the current staff establishments do not make provision for such a post.

The study focused on fixed clinics because mobile clinics only have two staff members – the professional nurse and an auxiliary nurse or an auxiliary services officer who is a layperson trained in basic health education. The role of a professional nurse in a mobile clinic differs from that of a clinic manager in a fixed clinic, as they do not have to manage

resources, such as human resources (HR), stock and finances to the extent that their colleagues have to do in a fixed clinic.

A sample “consists of a subset of a population selected to participate in a research study” (Polit & Hungler 1997:468). In this study, the sample referred to clinic managers in the Free State.

In the Free State there are five districts with 223 fixed clinics in total (FSDOH 2007a:6). The researcher obtained a list of all the fixed clinics in the Free State to ensure a proper and unbiased selection of clinics to participate in the study.

A 60% sample of the clinic managers was selected by means of stratified random sampling to ensure an equal distribution of clinic managers for large and small clinics. The rationale was to obtain a reflection of the situation in all fixed clinics and to determine if the situation differed in clinics according to size and utilisation. The aim of stratified random sampling “is to enhance representativeness. It subdivides the population into homogeneous subsets from which an appropriate number of elements can be selected at random” (Polit & Hungler 1997:231).

1.12 DATA COLLECTION

The data was collected by means of a questionnaire. A questionnaire is “a self-report data-collection instrument that each respondent fills in as a means to obtain data for the realisation of the aim of the research” (Johnson & Christensen 2000:127). In this study, the aim was to obtain a true reflection of the role of the clinic manager and how the clinic manager experiences this role.

Social disciplines use questionnaires or interviews as respondents can respond in writing or verbally. Information can be obtained about the research participants’ thoughts, feelings, attitudes, beliefs, values, perceptions and behaviour. By using questionnaires, researchers attempt to measure many different kinds of characteristics (Johnson & Christensen 2000:127).

The researcher considered a questionnaire appropriate as data-collection instrument for this study, as clinic managers could respond to the questions quickly and without hesitation. It is generally assumed that responses obtained from questionnaires are honest, accurate and without deliberate distortion. Another advantage is that respondents can answer the questionnaire at times suitable to them (Goddard & Melville 2001:49).

The information sought involved opinions, judgement, and commitments that could be answered without probing for in-depth answers hence structured and unstructured questions were used. Open-ended or unstructured questions encourage respondents to clarify, explain or justify their responses. Closed questions allow respondents to choose from a selection of alternatives or assign a numerical score or ranking (Goddard & Melville 2001:49). Questionnaires differ from interviews in that they are self-administered. Respondents read the questions on a form and give the answer in writing (Polit & Hungler 1997:256). In this study, the questionnaire included closed ("Yes/No") as well as open-ended (descriptions of emotions, feelings and tasks) questions.

A problem with questionnaires is that of non-returns (Goddard & Melville 2001:48). In order to encourage the return of questionnaires, the researcher enclosed stamped, self-addressed envelopes with the questionnaire as well as guidelines explaining the purpose of the study, the importance of returning the completed questionnaire and the due date for submission.

1.13 DATA ANALYSIS

Data analysis is "the systematic organisation and synthesis of research data as well as the testing of research hypotheses using the data" (Polit & Hungler 1997:455). According to Johnson and Christensen (2000:361), quantitative data is analysed by describing the data values of a variable to construct a frequency distribution. A frequency distribution is a systematic arrangement of data values. Data is rank ordered and the frequencies of each data value are indicated. Data can also be represented by means of graphic representations like bar graphs and line graphs.

The services of a statistician were obtained for the data analysis.

1.14 PRE-TESTING THE INSTRUMENT

A pilot study is a smaller version of a proposed study conducted to refine the methodology (Burns & Grove 2001:49). However, for this study a complete pilot study was not done, pre-testing the instrument was performed. The purpose of pre-testing an instrument is to evaluate the effectiveness of the instrument such as the length, wording and validity (Lackey & Wingate 1998:376).

With the permission of the relevant authorities, the researcher pre-tested the instrument in clinics of the Thabo Mofutsanyana Health District. These clinics were accessible to the researcher as she is stationed in the same health district. The pre-test was cost effective and the researcher is also acquainted with the situation in this health district and the content of the questionnaire could be verified against existing information. The clinic managers participating in the pre-testing could be approached in case of any revision. A group of nine clinic managers similar to the study subjects were tested under conditions similar to those in the actual study. The pre-test helped the researcher to determine the clarity of the items (Johnson & Christensen 2000:139). The selected clinic managers were not involved in the main study.

1.15 ETHICAL CONSIDERATIONS

Ethics is associated with morality and deals with matters of right and wrong. This implies that anyone involved in social scientific research should be aware of agreements shared by researchers and participants about what is proper and improper in the conduct of the research (Babbie 2001:470).

In this study, the following ethical considerations were observed:

- **Permission to conduct the study**

The researcher obtained permission from the Head of the Department of Health of the Free State, the General Manager of District Health Services in the Free State and the District

Managers of the five (5) health districts in the Free State. The final accepted proposal and a copy of the provisional questionnaire accompanied the request for permission.

After permission was obtained from the Head of the Department of Health in the Free State, a letter of introduction was sent to the managers.

- **Voluntary participation**

The researcher explained the purpose and significance of the study to the respondents and informed them that their participation was completely voluntary (Babbie 2001:470).

- **No harm to participants**

The ethical norms of voluntary participation and no harm to respondents are formalised in the concept of informed consent. Participants must base their voluntary participation on a full understanding of possible risks involved (Babbie 2001:471). Accordingly, the respondents were informed that they had the right to withdraw at any time and could refuse to provide information (Polit & Hungler 1997:133).

- **Anonymity**

Anonymity is guaranteed when researchers and others involved in reading or analysing the data cannot identify respondents with any given responses. Anonymity can be maintained during the completion of a questionnaire by not recording the respondents' names on the questionnaire. In this study, the researcher knew that the respondents were from a specific health district, but their names did not appear on the questionnaires.

An interview respondent can for instance never be considered as anonymous since the information is collected from an identifiable respondent (Babbie 2001:472).

- **Confidentiality**

Confidentiality is guaranteed when a researcher is able to identify a given person's responses but promises not to do so publicly (Babbie 2001:472). In this study, the questionnaires were numbered to have some control in terms of completed questionnaires received back by the researcher.

- **The right to self-determination**

Polit and Hungler (1997:133) and Polit and Beck (2004:147) point out that participants have the freedom to control their own activities, including their voluntary participation in research. The right to self-determination includes freedom from coercion, which involves explicit or implicit threats of penalty when failing to participate or excessive rewards from agreeing to participate. The researcher informed the respondents that they were free to participate or refuse to participate.

- **Informed consent**

Informed consent means that participants "have adequate information regarding the research, comprehend the information and have the power of free choice enabling them to consent to or to decline participation in the research voluntarily" (Polit & Hungler 1997:134).

The researcher explained the nature, purpose and significance of the study to the participants and informed them of their rights to voluntary participation, respect, anonymity, confidentiality and no harm.

1.16 LIMITATIONS OF THE STUDY

The researcher is well known in the Thabo Mofutsanyana Health District where the pre-testing of the instrument was done, and she also supervises some of the clinics. Some of the respondents might, therefore, not have been at ease while responding to the questionnaire. In addition, the results of the study cannot be applied to the rest of South Africa, as the situation in other provinces and areas was not researched.

1.17 DEFINITION OF TERMS

For the purposes of this study, the following terms are used as defined below.

- **Clinic**

A clinic is a fixed structure in which PHC services are provided usually by nurses linked to a CHC (DOH 1996:69). Van Rensburg (2004:432) defines a fixed PHC clinic as "a facility of varying size, staffed by nurses and delivering a varying package of PHC services on a daily basis for eight hours a day during the week to its catchment population which is ideally within a radius of five kilometres from the facility. Such a clinic may or may not have doctor services at their disposal. Some clinics are equipped to render maternal and obstetrical services on a 24-hour basis."

- **Clinic manager**

A clinic manager is a professional nurse, senior professional nurse or chief professional nurse in charge of a fixed PHC clinic.

- **Community Health Centre (CHC)**

A CHC is usually a 24-hour health care facility providing an extended variety of services at a clinic (DOH 1996:70). It is a relatively sophisticated facility where a wider spectrum of services is delivered. A CHC operates for 24 hours and seven days a week, provides an emergency response and has a full-time/resident doctor available (van Rensburg 2004:432).

- **District health system (DHS)**

The DHS is the vehicle for providing quality PHC to everyone in a defined geographical area. The DHS is a system of health care, where individuals, communities and all the

health care providers of the district participate together in view of improving their own health. It forms the building blocks of the NHS (FSDOH 1998:3).

- **Health District**

A health district is a geographic area small enough to allow maximal involvement of community participation so that local health needs are met, but also large enough to effect economics of scale (DOH 1996:72).

- **Management**

Kroon (1995a:7) describes management as a process, where people in their capacity as leaders utilise human and other resources effectively to achieve the goals of the organisation.

- **Manager**

According to Kroon (1995b:9), an effective manager

- Is a good leader with a vision who communicates his/her vision to subordinates and utilises his/her power with consideration to achieve the vision.
- Creates a calm work environment, and gives direction and support.
- Works with people and through people, and utilises skills of subordinates to achieve goals.
- Provides opportunities and encouragement to subordinates to reach high achievements.
- Utilises limited sources optimally.

A manager is a person who has been appointed in a leading position. He/she has committed himself/herself to take the lead in the execution of specific tasks by determining how employees under his/her control can be motivated and how to do things correctly (Kroon 1995b:8).

- **National Health Service**

The National Health Service refers to health services provided by a country for all its citizens (DOH 1996:73).

- **National Health System**

The national health system is the organisation of the country's health service, including services provided by central government, the provincial governments, local government, non-governmental organisations (NGO's), community-based organisations (CBO's) and the private sector (DOH 1996:73).

- **Primary health care (PHC) approach**

The PHC approach is the underlying philosophy for the provision of health care services which is based on the Alma Ata Declaration (WHO 1978b), and which encompasses comprehensive care that includes curative, preventive, promotive and rehabilitative care within the context of, amongst others, community participation and inter-sectoral collaboration (DOH 1996:73).

- **PHC package**

This is a comprehensive package of PHC services available at clinics for the entire population of the country. The package includes district hospital services, environmental health services and other preventive, promotive and monitoring services and comprehensive personal ambulatory services, including access to essential medicines for PHC (DOH 1996:9-10).

1.18 OUTLINE OF THE STUDY

Chapter 1 is an orientation to the study and outlines the purpose and significance thereof, the problem statement, research design and methodology, and data collection, and defines key terms used in the study.

Chapter 2 discusses the theoretical framework, which informs the study. For the purpose of this study, Kroon's (1995) management model as adapted by Uys (2005) was used.

Chapter 3 discusses the literature review conducted for the study.

Chapter 4 covers the research design and methodology.

Chapter 5 presents the data analysis and interpretation.

Chapter 6 concludes the study and makes recommendations for practice and further research.

1.19 CONCLUSION

The present study investigated the role of a clinic manager in a PHC setting in the Free State. This chapter discussed the purpose and significance of the study, the research problem and questions, assumptions, demarcation of the study field, research design and methodology, data collection, and ethical considerations, and defined key terms used in the study.

Chapter 2 discusses the conceptual framework of the study.

CHAPTER 2

Conceptual framework

2.1 INTRODUCTION

The conceptual framework for this study was based on Kroon's (1995) management model as adapted by Uys (2005). This chapter explores and elucidates the model with reference to management in general, including the management process, namely planning, organising, leading and controlling. The systems approach will also be discussed to indicate its relationship with Kroon's management model.

Kroon (1995b:3) regards management as one of the most important human activities. It is the basic task of all managers at all levels in all institutions. In the performance of their duties, all managers should apply management principles to create circumstances under which individuals can work together towards achieving goals. Management requires technical, human and conceptual skills. Although technical skills are relatively easily acquired, it is considerably more difficult to acquire human skills. However, the most difficult skills to acquire are conceptual skills.

2.2 KROON'S MANAGEMENT MODEL AS ADAPTED BY UYS

Kroon (1995b:7) describes management as a process whereby leaders utilise human and other resources as efficiently as possible to provide certain services to achieve the goals of the business. General management refers to the task of leading, which takes place at all levels of management (Kroon 1995b:4).

The four basic management functions are planning, organising, activating and controlling (Smit & Cronjè 2002:8). This study uses the term "leading" for "activating". Decision-making, communication, motivation, coordination, delegation and discipline are the six additional management functions. In this study, coordination and delegation were incorporated as part of organisation.

Kroon (1995b:5) lists the following business functions to which the management process applies (see figure 2.1):

- administrative management
- human resource management
- patient care
- purchasing management/support services
- management of public relations/marketing
- financial management.

In order to cover the concept “general management”, these functions are described briefly in section 2.3.4.1.

Uys (2005:5) adapted Kroon’s management model by integrating the management environment with the systems approach, which emphasises the interdependency between structure, process and output. This model was appropriate for this study because it highlights the environment integrated with the systems approach to clinic management with special reference to the micro-environment. Figure 2.1 illustrates the business functions.

1 MACRO-ENVIRONMENT

- Economical environment (interest rate, inflation)
- Social environment (culture, values)
- Technological environment (expertise, innovation)
- Physical environment (facilities, climate, infrastructure)
- Political environment (political system, laws)

2 MARKET- OR TASK ENVIRONMENT

OPPORTUNITIES AND THREATS
STRENGTHS AND WEAKNESSES

- Market (patients, clients, medical practitioners)
- Competition (other clinics, hospitals)

3 MICRO-ENVIRONMENT

3.1 BUSINESS FUNCTIONS

- **Administrative management**
- **Human resource management**
- **Patient care**
- **Purchasing management / Support services**
- **Marketing / Management of public relations**
- **Financial management**

3.2 BUSINESS ECONOMICS MANAGEMENT

3.2.1 Management approach

- **Vision and mission**
- **Core management tasks**
- **Participative management**

3.2.2 Basic management functions

- **Planning**
- **Organising**
- **Leading**
- **Control**

3.2.3 Additional management functions

- **Decision making**
- **Communication**
- **Motivation**
- **Disciplining**

3.2.4 Interest groups

- **Suppliers**
- **Clients**
- **Competitors**
- **General public**
- **Government**

3.3 BUSINESS CAPABILITIES

- **Equipment**
- **Capital**
- **Labour**

3.4 OUTPUT

- **Shares**
- **Profit**
- **Growth**

Figure 2.1 The management environment in perspective

Adapted from Uys (2005:6)

2.3 THE MANAGEMENT ENVIRONMENT IN PERSPECTIVE

The environment plays an important role in management because it can impact on the achievement of the organisation's goals. Figure 2.1 summarises Kroon's model as adapted by Uys (2005:6) and serves as reference to enlighten the theoretical framework.

Management cannot be executed effectively and thoroughly without taking external factors into account (Booyens 2001:3). Kroon's model emphasises the environment's crucial role in management and differentiates between three environments, namely the macro-, market and micro-environments. The micro-environment will be discussed extensively as it is relevant to the management of a PHC clinic. Kruger (1995b:53), Smit and Cronjè (2002:64) and Tappen (2001:9) point out that the *macro-environment* includes all uncontrollable variables and their consequences for management. Strategic decisions must be taken with regard to economic, social, technological, physical, political, institutional and international environments based on the changes in the macro-environment (Kruger 1995b:53; Smit & Cronjè 2002:71). The fast changing environment in which PHC service finds itself requires adaptability in the management approach as well as a thorough environmental awareness.

The *market environment* is known as the immediate environment outside the business/organisation. It lies between the micro- and macro-environments and is also known as the task environment. The market or task environment serves as a buffer between the micro- and macro-environments and is affected by both (Kruger 1995b:53; Smit & Cronjè 2002:67).

The *organisational environment* is referred to as the decision-making or *micro-environment*. This encompasses the strategy, basic functions, management tasks, setting of goals, resource abilities, and expectations of interest groups that must be taken into account. Elements of the micro-environment can be completely controlled by management. The organisation uses input obtained from the environment and delivers output when there is a need in the environment (Kruger 1995b:51; Smit & Cronjè 2002:67).

2.3.1 The macro-environment

In order to understand Kroon's model, the macro-environment, which comprises a variety of components, will be briefly discussed. In Kroon's model as adapted by Uys, the macro-environment comprises the *economic*, *social*, *technological*, *physical* and *political* environment.

Figure 2.2 illustrates the various components of the macro-environment that might affect management.

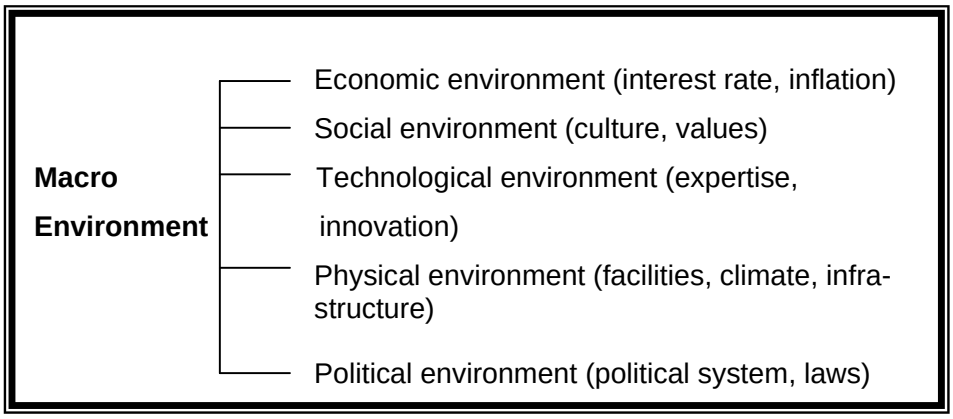

Figure 2.2 The composition of the macro-environment

Source: Uys (2005:6)

Health care is strongly influenced by a country's political, economic, social and cultural realities and health care services are not rendered in isolation (Smit & Cronjè 2002:77). Health care has to respond to the explosion of knowledge, advanced technology and ethical dilemmas in such a way that the quality of health care provision is improved (ICN 2003:11).

The health service delivery system is constantly changing with the aim of improving people's health, which brings new challenges (ICN 2003:12). Taking the variety of environments encompassed in the macro-environment into account, it is evident that the environment has played an important role in the development of the health services in South Africa since 1994.

Looking at the *political environment*, it can be argued that the then newly elected government adopted the NHS, including its principles of free health care, to ensure accessibility to PHC services for all citizens. Kaluzny and Shortell (2000:435) describe the influence of politics on health care in the sense that policy is shaped by political figures and special interest groups, rather than by objectivity towards the services that should be based on the community's needs. These changes also relate to the *social environment*, as health services are now accessible to the poorest of the poor. Due to human rights and the right to confidentiality, the fact that HIV/AIDS is not regarded as a notifiable disease has a negative impact on the successful treatment of this illness, as the prevalence cannot be determined accurately. The political environment is also related to the *economic environment* as PHC currently benefits more from the health budget than in the past (van Rensburg 2004:451).

The *physical environment* plays an important role in the macro-environment. If the physical environment is not conducive to the services that should be rendered, it will influence the achievement of goals. For example, at some of the clinics, there is inadequate space in the waiting rooms so patients have to wait outside the clinic in all weather conditions. The Free State Department of Health (FSDOH) strives for accessibility of clinics, but because of the limited available space in some of the clinics, they fail to be accessible to all.

The value of the *technological environment* should not be underestimated. Most of the clinics in the Free State do not have computers and data capturing has to be done manually. This results in a large amount of paperwork that must be done by the professional nurses. In most of the clinics, the clinic manager has to compile the monthly data sheets from the professional nurses' manual records, which is time consuming. By the end of the month the clinic manager has to collate all the data sheets of the professional nurses and compile one combined data sheet for all the professional nurses. The data includes a variety of information. Due to the extensiveness of the content, the data sheet cannot be discussed in this study (see Annexure A for an example of a data sheet).

2.3.2 The market or task environment

Several factors affect the market or task environment (see figure 2.3).

Figure 2.3 Factors influencing the market or task environment

Source: Uys (2005:6)

According to Kruger (1995b:66) and Smit and Cronjè (2002:70), the market environment with *competition* as the main component, has the consumer as the point of departure. In a PHC setting the patient is seen as the consumer. Opportunities and threats have to be taken into consideration because the focus of the market is to satisfy the patient by rendering quality health services.

The researcher found that patients complained when they were dissatisfied with services at a clinic. A specific complaints procedure was implemented by the Department of Health. Complaints are addressed according to the prescribed procedure to strive to reach patient satisfaction that will contribute to the rendering of quality health care.

The *market environment* also refers to marketing of specific PHC programmes, such as Voluntary Counselling and Testing (VCT), Antiretroviral treatment (ART) and TB. By using marketing strategies, the Department of Health is attempting to enforce the implementation of programmes to tackle the most common illnesses among the South African population. However, it has been found that programmes are implemented and marketed, without realising the actual need and extent thereof. With the implementation of the ART programme, the actual implications were only realised after implementation; for instance, the standards determined were too high and unattainable, and there was a shortage of staff (van Rensburg 2006:51). Consequently there is a need to expand the programme and the role of the professional nurses by enabling them to prescribe treatment of ART

patients. The availability of resources, such as doctors, nurses, social workers and pharmacists, is a challenge to the success of this programme (Steyn, van Rensburg & Engelbrecht 2006:95). The aim of treating HIV/AIDS patients effectively is impossible without the necessary resources.

As this study specifically examines the clinic manager's management role, which is set in the micro-environment, the job description and its applicability to the clinic manager, will first be high-lighted before the micro-environment is discussed.

2.3.3 Job description of a clinic manager

Anglin (2003:43) maintains that nurses can function effectively in a managerial role. Nurse managers are expected to coordinate patient care and supervise nurses in the delivery of quality care.

To ensure that a clinic is managed effectively, clinic managers are guided by their job description. The clinic manager should know precisely what inputs are necessary to perform tasks and what the output of the task entails or whom to report to. Assessment of the output should be done on whether the manager performed well, averagely or poorly, and this is based on the job description (Du Preez 1995:269; Marriner-Tomey 2004:358).

2.3.3.1 Definition of a job description

A job description is a detailed, concise and clear written exposition of the activities, duties and responsibilities of each post in an organisation (de Bruyn 1995:231; Marriner-Tomey 2004:358; du Preez 1995:269; Booyens 1998:220). Booyens (1998:232) is of the opinion that a job description should be individualised and that the major and important elements of a job should be recorded, and not all the tasks assigned to an employee.

In a PHC setting, the job description of a clinic manager in a clinic with the ART programme differs from that of one in a clinic where ART services are not implemented. Chabikuli et al (2005:111) maintain that the lack of clarity on job descriptions is of concern

as this raises questions about the conduct of performance appraisals of clinic managers.

2.3.3.2 Role clarification of a clinic manager

Role clarification is vital to indicate precisely to clinic managers what is expected of them. The FSDOH (2007b:3) clarifies the proposed role of a clinic manager as follows:

- The clinic manager is the person in charge of a facility.
- It is the responsibility of the clinic manager to do the administrative tasks according to the Clinic Supervisory Checklist. The checklist is a tool that guides and reminds the clinic manager of the execution of his/her management tasks.
- He/she is responsible for all the programmes not related to patient care. These include management of the EDL and the District Health Information System.
- Implementation of all PHC programmes in the clinic according to the PHC package.
- Reporting to the clinic supervisor.
- Submission of written monthly reports to the clinic supervisor.
- Responsible for management of HR, equipment, finances and any other administration in the facility.
- Compile monthly reports on all programmes and submits them according to the set dates.
- Implementation of all policies and guidelines in the facility.
- Identify training needs of personnel.
- Provide weekly minutes of meetings/in-service training sessions at the clinic.

Freed and Dawson (2006:44) describe the role of the front line manager, or manager at functional level, which is relevant to the clinic manager, as a non-executive manager who oversees the clinic and reports to the clinic supervisor. The clinic manager supervises the staff of the clinic and is responsible and accountable for achieving the goals of the institution (Freed & Dawson 2006:44). Rendering patient care is not stipulated as part of the clinic manager's role. In other words, what is required of the clinic manager in the real world does not conform to theory, as he/she frequently or continuously needs to consult patients due to staff shortages.

Tembani, van Rooyen and Strümpher (2003:64-66) describe the clinic supervisory system and the role of nurse supervisors as follows:

- Setting goals for the clinic in consultation with the clinic staff and the district management team. The district management team comprises the district manager and his/her management team at district level. The management team comprises managers of the various health services rendered in the particular district. This entails PHC, environmental health, oral health, rehabilitation, nutrition, financial management, human resources, pharmaceutical services, medical services, training of staff, and district hospital management. All these managers report to the District Manager at the district office, who reports to the General Manager of District Health Services at the Provincial Office.
- Assisting clinic staff in meeting those goals.
- Ensuring the clinic is well staffed and equipped.
- Identifying training needs, facilitating training.
- Monitoring the quality of service delivery.

Tembani et al's (2003:66) description of the clinic manager's role is relevant to Kroon's management model, which served as the conceptual framework for this study, linking the different management components. Figure 2.4 depicts the relationship between the role of the clinic manager according to Tembani et al (2003:66) and Kroon's management model.

Role of the clinic manager according to Tembani et al (2003:66)	Relationship to Kroon's model as adapted by Uys (2005:6)
Setting of goals	Planning
Assisting clinic staff to meet goals	Organising and leading
Ensuring the clinic is well staffed and equipped	Planning, organising
Identifying training needs	Planning
Monitoring the quality of services delivered	Leading, control

Figure 2.4 Relationship between Tembani et al's (2003:66) role of the clinic manager and Kroon's management model as adapted by Uys (2005:6)

The clinic manager's role described by the FSDOH (2007b:3) correlates with the management role described by Smit and Cronjè (2002:16) and Grohar-Murray and DiCroce (2003:50). The role is to set goals, implement effective communication channels, such as feedback sessions during meetings, and provide written reports. Knowledge of group dynamics is essential to achieve organisational goals (Grohar-Murray & DiCroce 2003:50).

The role of a clinic manager includes

- Coordinating the day-to-day clinical activities.
- Working with health care providers to establish policies and procedures where changes are needed. In South Africa, this only applies to PHC clinics to compile internal clinic policies and procedures. National policies are determined by the National Department of Health (NDOH) and implemented by the FSDOH and cannot be changed at local level. Towner (1997:40) highlights the importance of policies being used by service providers as policies guide service providers on what should be done while procedures indicate how to execute a task. Procedures supporting the policies should be implemented within the relevant scenarios. PHC forms part of the NHS and the DHS, as the DHS is the vehicle for the rendering of PHC services. Various policies exist in PHC to ensure the standardised implementation of the PHC package. Annexure B serves as a comprehensive summary of policies and acts which apply to PHC.

- Resolving conflicts
- Monitoring room utilisation and maintaining patient flow.
- Managing issues relating to billing or charge capture. According to South African policy, health services are free of charge at PHC clinics, thus clinic managers will be excluded from this task.
- Intervention on issues relating to patient complaints, health care providers' concerns, operational issues and taking measures to correct situations.
- Preparing and maintaining clinic statistics and reports.
- Monitoring clinic compliance with quality assurance guidelines.
- Ensuring that clinic equipment is maintained.
- Monitoring of monthly expenditure statements for budgets.

Little has been written about the job description of a clinic manager. The researcher found no clear distinction in the literature reviewed between the concepts "clinic manager" and "clinic supervisor". In this study, the job description of the clinic supervisor was adjusted to the job description of a clinic manager. However, this job description does not indicate any clinical services to be rendered by the clinic manager or that the clinic manager should be a professional nurse.

In Baltimore, USA, The Johns Hopkins University (TJHU 2004:1) lists the following essential components in a clinic manager's job description: scope of responsibility; decision-making; authority; communication, and educational level.

- ***Scope of responsibility*.** The clinic manager's responsibility includes knowledge of formal and informal departmental goals, standards, policies and procedures.

- ***Decision-making*.** The clinic manager exercises judgement and assumes responsibility for decisions and consequences having an impact on people, costs and/or quality of service within the functional area.

- ***Authority*.** The clinic manager oversees two or more full-time employees and conducts performance appraisals. In the USA, clinic managers have authority to appoint, dismiss

and discipline their subordinates (TJHU 2004:2). In South Africa, clinic managers do not have the authority to appoint or dismiss staff. As clinic managers they are only allowed to recommend appointment or dismissal of staff.

- ***Communication*.** The clinic manager requires tact and persuasion in all verbal and written communication actions. Sound communication and listening skills are crucial in the management of nurses and other clinic staff.

- ***Educational level*.** A high school diploma is a requirement for a clinic manager, but a Bachelor's degree or equivalent work experience is preferred. In the USA (TJHU 2004:2), being a clinic manager does not require a person to be a registered nurse. In South Africa, registration with the South African Nursing Council (SANC) as professional nurse is a requirement.

- ***Physical requirements of incumbent*.** The physical requirements of the clinic manager should be within the normal range; for example, the ability to see within normal parameters, to hear within normal range, and to stand, walk or sit for an extended period of time. Physical requirements and previous experience are also included in the job description. However, this pertains to the job specifications; in other words, the capabilities that a person should have to do the job.

A comparison of the USA and SA job descriptions indicates many similarities as well as certain differences. Corresponding tasks include submission of reports; ensuring maintenance of equipment; financial and budget control; knowledge and implementation of policies, guidelines and procedures; management of quality, and ensuring achievement of goals. The rendering of patient care is not indicated at all.

The literature review indicated that a clinic manager's job description is extensive. Lehmann and Sanders (2002:125) point out, however, that a mismatch often exists between the job description and the actual roles performed. Most clinic managers find themselves occupied with other activities such as rendering of clinical services and attendance at unscheduled meetings, workshops and training sessions, rather than performing their management roles.

2.3.4 The micro-environment

The internal environment encompasses the mission, strategy, objectives, business functions, business abilities and factors that are controlled by management (Kruger 1995b:67; Smit & Cronjè 2002:67).

The micro-environment which has a strong influence on the management of a PHC clinic, will be discussed extensively. For the purpose of this study, the conceptual framework, its application to the PHC setting and the clinic manager's role are integrated in the discussion of the micro-environment (see figure 2.1).

2.3.4.1 Business functions

The business functions are processes to which the management process is applied. The following six business functions are evident in all health care institutions:

- administrative management
- human resources management
- patient care
- purchasing management/support services
- marketing
- financial management

Figure 2.5 indicates the business functions applied in a PHC setting.

Figure 2.5 Business functions

Source: Uys (2005:6)

- ***Administrative management***

Administrative management includes, among other things, the processes of provisioning of stock and equipment to the clinics. A specific procedure has to be followed to purchase equipment. Should the provisioning section function improperly, needed stock and equipment cannot be provided which, in turn, will limit service rendering.

Office administration covers a wide range of activities, such as organising administrative work, supervision and control, document duplication, filing and indexing, sorting of incoming and outgoing mail and management of information by a computerised management information system. The availability of information plays a major role in the management process. Accordingly, without an effective administrative or information function, effective management of the institution is impossible (Kroon 1995b:5). Should the clinic be overcrowded with patients, the information on the number of patient visits to the clinic can be used to identify the need for a new clinic.

- ***Human resource management***

The workforce is recognised as an important organisational asset in contributing to performance at an individual, team or organisational level (Parker 2006:418). The overall performance of a team is a management responsibility. As the clinic manager is

responsible for the management of the team of employees allocated to the clinic, the team's performance is regarded as his/her responsibility.

To enable an institution to render a service, human resource (manpower) needs should be determined. Recruitment, selection, placement, induction and orientation, as well as formulation of personnel policy, and training and development of existing personnel are included in human resource management. Other human resource-related tasks include handling transfers, promotions, remuneration, demotions, resignations and dismissal of employees (Kroon 1995b:5). Kruger (1995b:67) stresses that the human resource department should keep abreast of the organisation's human resource requirements through human resource planning.

Staff shortages, especially in terms of nurses in PHC clinics, have long been a burning concern. There is a serious shortage of nurses who are competent in consulting, diagnosing and treating patients (Strachan 1999:8). Netshandama, Nemathaga and Shai-Makoho (2005:64) found that in some clinics in the Limpopo Province, the staff establishments of PHC nurses remained unchanged despite the introduction of free health care services years ago.

Another important factor in ensuring quality services is the availability of well-trained staff. Prior training of staff in PHC programmes is essential to equip professional nurses to competently render effective service. For example, training in the TB, HIV/AIDS, PMTCT, EPI, Family Planning, Mental Health and IMCI programmes is needed to equip the PHC nurse. At the same time, however, the variety and number of training sessions, which are presented regularly, result in a continuous shortage of staff due to absenteeism for the duration of the training. This intermittent absenteeism reflects a deficiency in the human resource structure standard, as the availability of personnel in the organisation relates to business capabilities.

This raises the question of whether it is really possible to render quality services with a serious staff shortage. Some human resource procedures also do not contribute to effective service rendering. For example, when a vacant post has to be filled, a specific procedure has to be followed before an appointment is approved. In the FSDOH, the Head of the Department has to approve the appointment of a general worker, which is the lowest

staff rank. Delegating the signing of appointments could fast track the process. Ultimately, due to the red tape, it might take months to fill a post thereby resulting in negative consequences for the staff and service rendering.

- ***Patient care***

Policies, guidelines and procedure manuals guide patient care. Patient care is rendered according to them, which serves as a means to ensure that patient care is rendered according to specific standards.

- ***Purchasing management/Support services***

The main activities related to *purchasing management* are obtaining the required resources, searching for possible sources of supply, negotiating with and choosing suitable suppliers, placing orders, receiving and inspecting purchased items as well as warehousing and control (Kroon 1995b:5). Obtaining required resources is a challenge in some districts as the infrastructure is not conducive to effective service rendering. Electricity breakdowns (power outages), which occur frequently, last for long periods, causing a delay in the processing of orders. The effect is that clinics have to continue to render services without sufficient stationery and cleaning material. A lack of cleaning material has a negative impact on proper infection control when orders are not processed via the electricity-dependent computerised system at the district office.

Kruger (1995b:68) maintains that the purchasing function should be associated with the requirements of the production function to ensure that the correct amount and quality of material and equipment are maintained. Netshandama et al (2005:64) found that shortages not only of staff, but also of medication, equipment and supplies were among the greatest concerns of PHC nurses in clinics in the Limpopo Province.

It happens in clinics in the Free State that specific medicine is out of stock due to problems at the medical depot in Bloemfontein. The medical depot may be awaiting deliveries from the suppliers, or the contract for specific medicine with the supplier has expired. The new contractor might not yet be appointed, thereby causing a long delay in the availability of medicine.

In a PHC setting, support services cover services like rehabilitation, which includes physiotherapy, radiology, occupational therapy, speech therapy, audiology and oral health. For patient access to these services, the professional nurse should follow the prescribed referral procedure to book the patient for the required service. Feedback to the professional nurse is expected from the particular service to ensure continuity in treatment. The availability of these services contributes to the achievement of the goals of the Department. Should these services be lacking, comprehensive care cannot be rendered.

- ***Marketing management/management of public relations***

The availability and promotion of health services marketing influences the extent of their utilisation. Corporate services in the FSDOH market the services rendered by the Department, particularly PHC services at the clinics.

It has been found that patients, who have medical aids, also visit the clinics to receive their chronic medicine either to save on their medical expenses or because the medical aid is exhausted. Most of the time these patients complain about the service because they are not willing to wait in the queue for consultations or medicine. The system has to be explained in the clinic and in the media to inform the community about the procedures to follow. The clinic managers find this behaviour another burden, as they have to deal with these complaints.

When services are marketed during community meetings, people/members of the community are informed about the functioning of the clinics. When necessary, this is also done on a daily basis according to the situation in the clinic, such as staff shortages due to unexpected sick leave of staff. The marketing function is based on the transfer of ownership of the goods and services of the business to the consumer and in so doing earning an income (Kroon 1995b:6).

PHC services in South Africa are free of charge and consequently do not generate any income for the Department of Health. PHC services are marketed by means of the media and road shows to inform the people about the available services. Community meetings

also contribute to marketing as information on services is conveyed to the community and complaints of the community addressed.

Public relations are supplementary to the marketing function and involve purposeful, planned, ongoing liaison between the institution and its interest groups with the aim of creating, maintaining and improving mutual goodwill. A positive attitude towards the institution throughout the broad community can contribute to the achievement of its goals (Kroon 1995b:6). Should complaints on service rendering be received from the community, the complaints should be addressed as soon as possible to ensure patient satisfaction.

- ***Financial management***

Financial management refers to all the processes involved in an institution's expenditure. Should it be necessary to purchase equipment or attend a course, the expenditure should be submitted to the institution's Expenditure Control Committee. The aim is to manage the budget properly, to prevent unnecessary expenditure, and to stay within the legal framework of the Department of Health.

To understand the reasons for the availability of *capital*, it is necessary to discuss the importance of *finances* in the management environment.

Capital is a determining factor in terms of the abilities of a business/organisation to render effective service (Kruger 1995b:67). Uys (2005:24) emphasises that no organisation can exist without the necessary funds and their optimal management. The Free State Province doubled its expenditure on PHC from R91.00 per patient to R221.00 in 2000. This increased expenditure contributed to improved TB cure rates, a drop in the number of STIs, a drop in the stillbirth and perinatal mortality rates, and a well-functioning immunisation programme (Belot 2007:2).

The *budget* is an important aspect of capital and should be managed by managers on all levels of management. Since those rendering the service are usually more aware of the circumstances and conditions prevailing in the day-to-day operations of an organisation, the current trend is to decentralise the budget process down to the point of service delivery (Booyens 1998:169).

In the DHS, a budget is allocated to a specific district, which is divided into a budget for the different PHC programmes and local areas. The budget for all local areas is not divided into a separate budget for each specific clinic (see Annexure C for the composition of a standardised budget for a local area in a health district). The researcher has found in practice that a verbal need was expressed by clinic managers in Dihlabeng Local Area to have a budget per clinic available, as clinic managers would then be better able to manage and control the finances of their clinics. The reason was that clinic managers wished to have insight into the finances of their clinics.

The only solution to provide clinic managers with figures is to divide the budget as allocated per local area into the number of clinics. This is not an easy task as clinics differ in size, which influences the allocation of staff, number of patients visiting the clinic, medicine orders, maintenance and usage of stationery and cleaning material as well as invoices received for municipal services. It would therefore be very difficult to provide every clinic with a correct budget allocation.

Financial management influences the efficiency of clinic management, but the researcher found that in the PHC setting clinic managers do not engage actively in financial management of their clinics. In some instances they are not acquainted with the budget of their local area. Clinic managers are also not involved in or allowed to request shifting of funds between budgets as that is the local area manager's responsibility. However, funds can only be shifted between budgets to ensure effective utilisation of funds according to the identified health needs (Tofts 2006:409). In the districts, the Assistant Manager: Finances is the person solely responsible for the shifting of funds.

The fact that the majority of the population continues to be without health insurance coverage and that health care expenditure consumes a significant portion of the gross national budget has an effect on financial management (Kaluzny & Shortell 2000:438). Kaluzny and Shortell (2000:440) also point out that besides South Africa, the United States of America is the only other industrialised country that does not guarantee financial access to health care for all citizens.

2.3.4.2 Business economics management

According to Kroon's model, business economics management has four sub-sections (refer to figure 2.1) namely

- the management approach
- the management process (basic management functions)
- additional management functions
- interest groups.

- ***Management approach***

The management approach has a direct effect on output. The management approach has three dimensions, namely the vision and mission, core management tasks, and participative management (see figure 2.6).

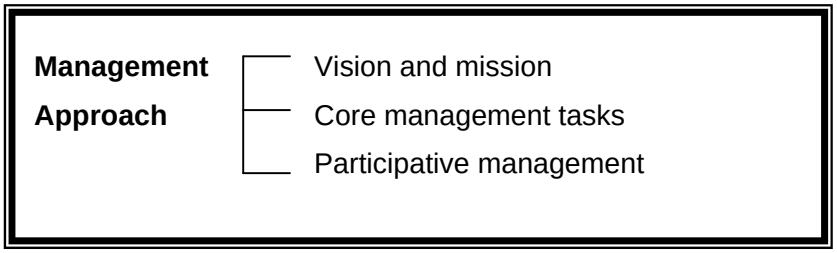

Figure 2.6 Dimensions of the management approach

Source: Uys (2005:6)

According to Uys (2005:36) and Smit and Cronjè (2002:22), management can be regarded as an art because many management skills cannot be learnt from a textbook or classroom. An effective manager has to have a definite vision, knowledge of the theory of management, and good communication skills (Smit & Cronjè 2002:17; Glasser 1989:202). However, this does not guarantee effective management, as managers have to rely in some cases on their intuition and judgement (Uys 2005:36). The guiding dimensions of the

management approach are *vision and mission, core management tasks* and *participative management* (Uys 2005:36).

- ***Vision and mission***

An outstanding characteristic of successful leaders, entrepreneurs and top managers is often the fact of being a visionary. Vision includes far-sightedness about where the organisation should go and how to get there (Kroon 1995b:142; Uys 2005:37; Koch & Minnaar 2001:66; Marriner-Tomey 2004:215).

The *vision* of the FSDOH (2002:2) is "a healthy and self-reliant Free State community".

The *mission* describes the purpose of the existence of the organisation and should include the product range of services, the market, and the image of the organisation (Kroon 1995b:142; Uys 2005:37; Koch & Minnaar 2001:67; Marriner-Tomey 2004:216; Swansburg 2002:81).

To achieve its vision, the *mission* of the FSDOH (2002:2) is to:

- Provide quality, comprehensive health care services to the Free State community.
- Utilise health care resources optimally to provide a caring and compassionate service.
- Empower and develop all personnel to the best of their potential.

Every PHC clinic should have its own vision and mission that supports the global vision and mission of the DOH. If a clinic has a self-developed vision and mission, staff can contribute to it by being committed to achieving the set goals.

- ***Core management tasks***

The *core management* tasks entail several facilitating aspects, which all managers need to use in their daily management of their units or institutions. Most managers execute a number of tasks and fulfil a variety of roles and these aspects or characteristics enable

goal achievement (Kroon 1995b:14, 16; Uys 2005:36; Smit & Cronjè 2002:15; Grohar-Murray & DiCroce 2003:50,155, 292; Huber 2000:124):

- Managers work *with and through other people* to achieve the goals of the institution. These people include all levels of management, workers and people outside the business, such as clients, suppliers and union representatives.
- Managers serve as *channels for communication* in the organisation, for example, during planning when goals are set, when tasks are delegated and during control when feedback reports are received.
- Managers should *balance competing goals* and set priorities. By performing the most important tasks first, time is managed effectively.
- Managers should act as *mediators*. Should conflict exist due to a difference of opinion or personally, the manager should be able to handle the conflict.

As the managerial role is extensive and often difficult, managers can apply a number of *principles* to support their role. According to Middaugh (2006:382), to facilitate managerial success, managers should incorporate the following principles in the daily activities: *present, win, involvement* and *return on investment*

Present: A manager should “be present in an appointed place, arise and come into being” (Middaugh 2006:382). In the case of a clinic, then, this means that the clinic manager has to take responsibility for and manage the clinic effectively by applying management principles. In order to do so, the clinic manager has to be equipped for this.

Win: A manager should gain the support of the personnel, persuade staff to achieve goals and contribute to the obtainment of an award. A manager who nominates a staff member for an award is supporting hardworking staff to gain acknowledgement for all their efforts. A manager should be open-minded to identify hardworking staff and support them by nominating them for awards.

Involvement: A manager should motivate staff to participate in an event or ongoing process. Managers’ involvement is not only about giving of their time, but also contributing their input and energy.

Return on investment: This includes the percentage income from the investment or profit from an investment as a percentage of the amount invested. In a PHC clinic, this could be linked to the achievement of set objectives for the clinic. Managers should concentrate on building relationships with their staff. By taking time to make contact with subordinates, managers send the message that they really care for them (Minnaar 2001:22). Managers should not sit behind their desks all the time, but should be out in the operating areas of the institution to make interpersonal contact.

Middaugh (2006:382) emphasises that managers have to make frequent interpersonal contact in order to

- *Obtain information and make timely decisions.* Managers should be in the field to see things first hand and to act quickly when necessary.
- *Understand what people think and feel.* Personal contact will enable the manager to know how others feel.
- *Keep people informed.* Keep employees abreast of changes and plans.
- *Obtain feedback.* Giving and receiving praise and constructive criticism contribute to personal growth and comfort.
- *Inspire and innovate.* Visible managers can remind their staff that they are striving for quality and safe care.

Middaugh (2006:383) states further that when managers are present and involved, they can contribute to effective management by setting examples for the staff.

In Minnaar's (2001:22) study on the availability of nurse managers to assist nurses in the nursing situation in selected hospitals in KwaZulu Natal, the nurse managers indicated the importance of supporting staff should the need arise. Minnaar (2001:23) maintains that role modelling by the manager plays a significant role as it contributes to the growth and development of staff. Caring defines the nurse manager's behaviour and attitude in a more relational and growth-orientated way. Duties do not change in caring management, but the manner in which people go about executing them, does. The use of power changes to empowerment and growth and development, which is a constant challenge for nurse

managers (Minnaar 2001:23). The upgrading of management knowledge and the implementation of caring principles in nursing management is crucial to equip nursing managers to survive in demanding management circumstances (Minnaar 2001:26).

- ***Participative management***

Participative management is a process whereby employees play a vital role in planning, decision-making and changes in the organisation (Kroon 1995b:13; Uys 2005:36; Booyens 1998:134).

Involving employees in these processes may lead to the setting of objectives with greater acceptance and commitment to accomplish the objectives (Kroon 1995b:13). Participation in management functions produces satisfaction in subordinates and staff retention (Grohar-Murray & DiCroce 2003:152). Participative management will ultimately result in innovation and an increase in productivity (Jooste 2001a:158). Goals will be reached because of the higher levels of production and motivation amongst staff (Uys 2005:37; Kroon 1995b:12).

2.4 THE MANAGEMENT PROCESS

According to Kroon's model (Uys 2005:6) and basic management functions include planning, organisation, leading and control.

Smit & Cronjè (2002:8) maintain that the management process basically comprises planning, organisation, leading and control. In addition, the four management functions of decision-making, communication, motivation and disciplining are the means by which the organisational goals can be achieved. Without proper planning, organising, leading and control, the goals will not be achieved. A well-planned, organised, managed and controlled service could nevertheless still fail due to factors like poor communication and lack of staff motivation.

Figure 2.7 illustrates the management process and indicates the interrelationship between the basic and additional management functions. Although Kroon's model indicates coordination and delegation as additional management tasks, in this study they were

considered part of organisation. Consequently, for the purposes of this study, there were only four additional management functions.

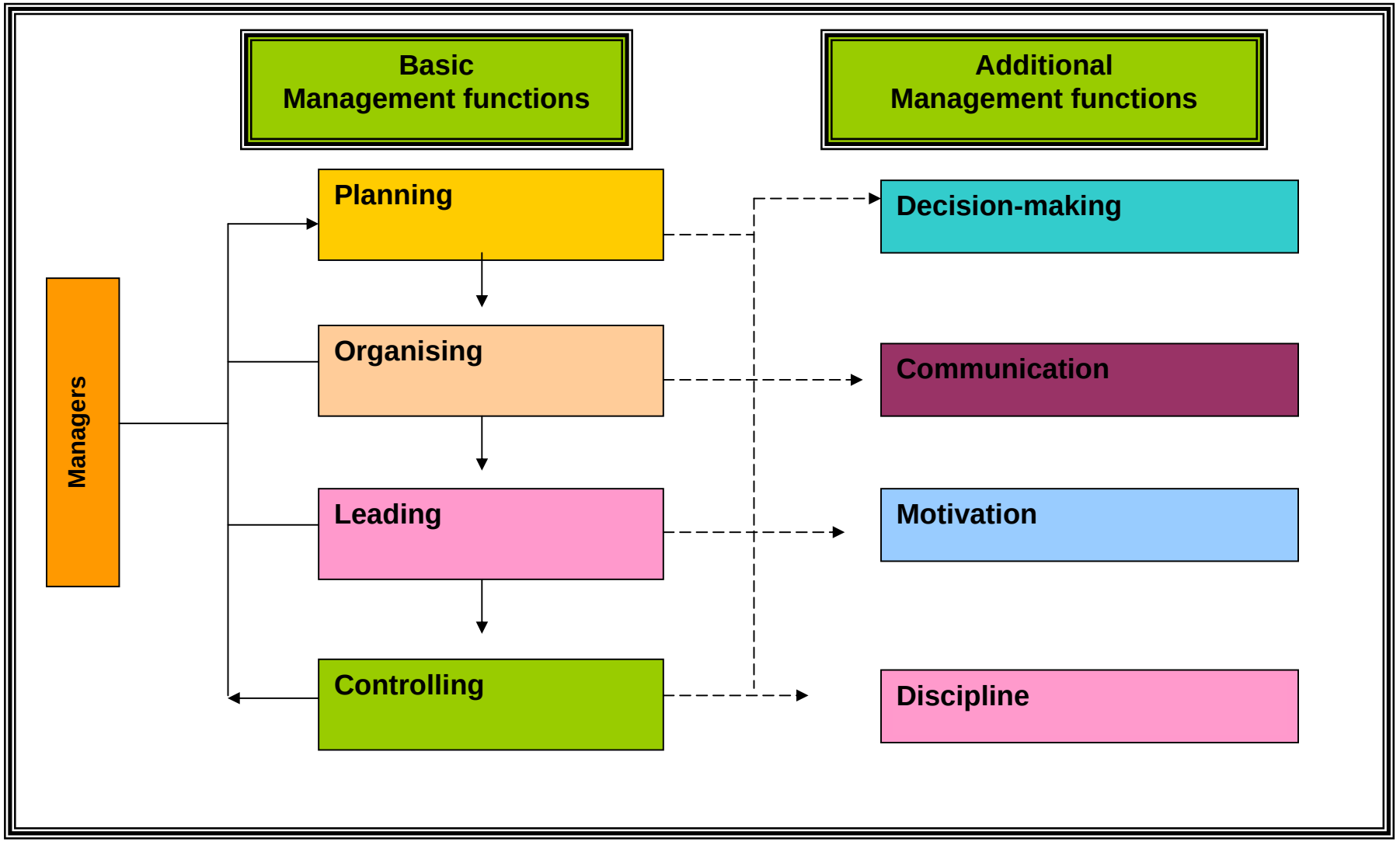

Figure 2.7 Interrelationship between basic and additional management functions

Source: Uys (2005:38)

2.4.1 Planning

The first phase of planning is a conscious deliberation and visualisation of what the institution should achieve within a particular time (Kroon 1995b:9; Grohar-Murray & DiCroce 2003:155). This phase comprises formulating goals and objectives in every area where performance or results are expected (Huber 2000:82). According to Du Toit (1998:55) and Huber (2000:82), involvement in planning is one of the duties of registered nurses. Moreover, the registered nurse should be involved in the establishment and maintenance of an environment that addresses patients' physical and mental health needs.

The second phase of planning is the drafting of a realistic and feasible plan, which identifies the resources that will be required and activities to be executed to reach the stated objectives and goals (Kroon 1995b:10; Grohar-Murray & DiCroce 2003:156; Huber 2000:82).

2.4.1.1 Planning as a concept

Planning is the first of the four basic management functions. The management level determines the types of goals, objectives and plans that should be developed (Kroon & van Zyl 1995:111; Huber 2000:82). Middle and first-line managers are responsible for tactical and operational planning, while top management is mainly concerned with strategic planning and the strategic plan (Kroon & van Zyl 1995:112). Strategic planning is costly and the commitment of top management is essential to achieve success (du Preez 1998:4; Uys 2005:39). It entails consideration of the organisation's vision and mission as well as strategies, policies, goals and objectives (Uys 2005:39; Steven 1995:70).

The clinic manager has to plan the activities that should take place in a clinic. When planning, the clinic manager should consider the DOH's goals and objectives. These goals and objectives should guide all the activities that should take place in the clinic.

Kroon and van Zyl (1995:112) and Uys (2005:40) point out the following deductions about planning:

- Planning is a *thought* process as well as an action process. During the thought process managers deliberate on what should be done. The implementation phase of planning is reflected in the action phase while organising and leading take the process further.
- Planning is *future* directed as management attempts to take decisions that will contribute to the achievement of objectives in the future.
- Goals and objectives are formulated during planning and results that should be achieved within a specific time span should be clearly indicated.
- Planning identifies and clarifies the activities that should take place to achieve the objectives as well as resources needed to carry out these activities.
- Planning promotes effective utilisation of resources.
- Decision-making is an important part of the planning process and involves identifying and implementing the most suitable alternatives.

Business planning is the process by which service heads and unit managers plan how to best utilise the available resources to meet the strategic plan (Tofts 2006:400). In a health care context, the two main categories of resources that the business plan has to consider are human resources and finances.

2.4.1.2 Importance of planning

Managers should plan for the following reasons (Kroon & van Zyl 1995:113; Uys 2005:42; Grohar-Murray & DiCroce 2003:156):

- Problems can be anticipated, managers can be proactive and uncertainty can be reduced.
- Attention is focused on the institution’s goals and objectives.
- Performance improves as planned activities can be performed in a structured way.
- Planning elicits commitment and provides motivation.
- Managers are obliged to find methods to achieve the stated objectives.
- Planning facilitates control as results are compared with the stated objectives.
- Planning ensures coordination.

- Input and output are planned as a whole, duplication can be eliminated and synergy achieved.

The clinic manager should plan the implementation of all the programmes in the clinic. This will entail the management of human resources, such as management of leave, planning of daily work programmes, among other things (du Preez 1998:21).

With the implementation of the provision of chronic medicine at PHC clinics, the clinics found that this provisioning had to be implemented with immediate effect. Although it served the purpose of focusing on the DOH goals and objectives, there was no time to plan the implementation thoroughly. Consequently, staff moral was low due to the additional workload and lack of infrastructure in the clinics. Some of the clinics did not have either a proper storeroom or a big enough waiting area to accommodate the additional patients. Not only did the patient load increase, but also professional nurses had to manage all the medicine, including ordering, dispensing and stock control.

2.4.1.3 The role of the past, present and future in the planning process

Planning cannot ignore change and by means of planning, management tries to be pro-active. Planning should be a feasible process and regular revision of plans is necessary to prevent planning from becoming static (Kroon & van Zyl 1995:114).

In the health sector changes are constantly taking place. To keep track of all the changes, planning has to take place as the need arises (du Preez 1998:4). Prior to the implementation of the antiretroviral treatment (ART) programme, planning had to be done on a strategic as well as implementation level to estimate the sustainability of the programme.

2.4.1.4 Planning and management levels

Irrespective of the management level, managers have a particular responsibility to plan. The nature and extent of planning done at different levels, the time devoted to planning, its complexity and the time period for which it is done differ from management level to

management level (Kroon & van Zyl 1995:115). Figure 2.8 depicts planning at the different management levels.

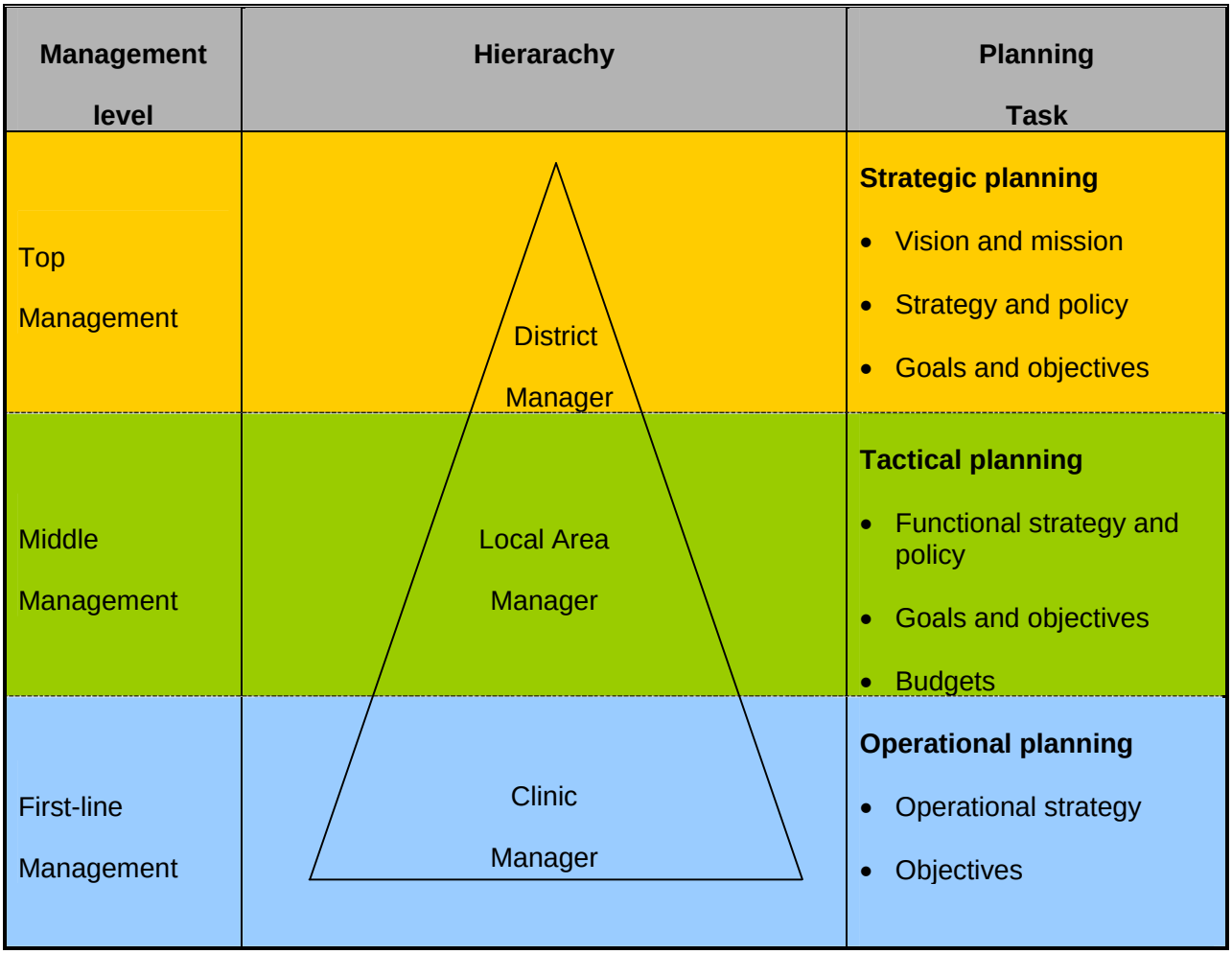

Figure 2.8 Planning and the management levels

Source: Kroon and van Zyl (1995:115)

Top management does strategic planning, as it is responsible for the formulation of the organisation's vision and mission, strategy and goals. Strategic planning directs action towards the achievement of the objectives and the results are seen in the long term. Strategic planning serves as a guideline for the planning that should be done by middle and first-line managers closer to the functional level (Kroon & van Zyl 1995:115).

A strategic plan is necessary in an organisation because of changes taking place in the external environment and the complexity is increased by the effect of uncontrollable

variables, such as the economic, political, social and technological environment (Kroon & van Zyl 1995:117). The political environment played a crucial role in the implementation of the concept of PHC in South Africa. The governing political party, the African National Congress, implemented the NHS where the main vehicle for service delivery was PHC (FSDOH 1998:3).

Middle management plans for activities of the various functional areas. Middle management must draw up tactical plans that will lead to the achievement of the objectives and goals in the institution, based on the strategic plans (Uys 2005:40). In the PHC setting, the compilation and review of the annual district health plan serves as an example of middle management planning.

First-line management is responsible for the planning of operational plans. This is done within the framework provided by middle management. Operational planning is less complicated, less comprehensive and less uncertain than tactical or strategic planning (Kroon & van Zyl 1995:116). In a PHC clinic, operational planning will take place for the implementation of PHC services, how challenges at grass root levels can be tackled, how available resources can be utilised effectively and how objectives can be reached.

The clinic manager uses the daily work programme, for example, to plan the rendering of services and to ensure that all the services are provided. The drafting and availability of an annual leave plan ensures that ample staff will be available for service rendering throughout the year. It is evident that the basic management functions are related to one another. The availability of a work programme and an annual leave plan relates to planning, organisation and control. None of these business functions can be isolated from one another as all the business functions, namely planning, organising, leading and controlling, are included in the management of a service or institution.

The different management levels support one another and are interdependent and coordination between top, middle and first-line management is essential (Kroon & van Zyl 1995:116). Ultimately, the contributions of all management levels contribute to the achievement of the goals of the organisation (i.e., the FSDOH in a PHC setting).

2.4.1.5 The planning process

Table 2.1 summarises the steps in the planning process.

Table 2.1 Steps in the planning process

STEP	CONTENT
1. Strategic inputs and situation analysis.	1. Coordination between the strategic plan, tactical plan and operational plan is important. 2. Coordination between the plans should be ensured to implement the strategy.
2. The formulation of goals and objectives.	1. Goals and objectives entail the results that should be achieved over the long- and short term. 2. Standards should be set to ensure that objectives are achieved.
3. Alternatives and the choice of the best alternative.	1. Analysing the information of a situational analysis makes it possible to implement the most suitable alternative.
4. Programming, scheduling and budgeting.	1. Programming is a step-by-step exposition of the activities in order to achieve the objectives. 2. Scheduling is the allocation of time for the different activities. 3. Budgeting: the budget gives expression to the plan. The real cost of the plan can be compared with the budget.
5. Implementation of the plan	1. Putting into operation the final plan. 2. Allocating activities to people. 3. Activating comes into operation.
6. Evaluation and control of the plan	1. Actual performance is determined and compared with the planned performance.

Source: Kroon and van Zyl (1995:121)

A situational analysis should be part of the planning process (Koch & Minnaar 2001:71; Kroon & van Zyl 1995:121). This includes several aspects, such as the role of the service in the past, the staffing complement, consumers utilising the service, political reasoning, focusing on primary health care with emphasis on affordability, equity and accessibility, staff morale, staff productivity, and financial constraints.

The advantages and disadvantages of a strategy should be weighed against each other to determine which would be the most beneficial (Koch & Minnaar 2001:71; Kroon & van Zyl 1995:121). Koch and Minnaar (2001:71) and Kroon and van Zyl (1995:121) emphasise that programming, scheduling and budgeting play an important role in planning.

2.4.2 Organising

Kroon's model refers to coordination and delegation as additional management tasks (Kroon 1995b:12). However, organising includes coordination and delegation.

After completing the planning phase, it is essential to utilise the available resources and staff to achieve the institution's goals. Continuous organising does this. Organising is part of the management process and deals with organising tasks, responsibilities and authority of persons and resources enabling people to work effectively towards the vision, mission and goals (Uys 2005:45; Huber 2000:83; Smit & Cronjè 2002:190).

2.4.2.1 The process of organising

Organising deals with the grouping of activities to maintain functional divisions and subdivisions in order to achieve the organisational goals (Smit & Cronjè 2002:193). Examples of this are the creation of posts within these divisions as well as determination of duties, authority and responsibility. An organisational structure is established which provides a structural framework (organogram) of the organisation's activities, its main and subdivisions, lines of authority, channels of responsibility as well as communication and different management levels (Kroon 1995b:10; Smit & Cronjè 2002:190).

Managers are usually responsible for designing and changing organisational structures. These activities are related to the implementation of national policies, protocols and guidelines. Should changes take place in health care, managers have to think beyond the hierarchical structures of traditional organisations. How managers manage change will ultimately determine the difference between success and failure in an organisation (Brooks 2006:263; Smit & Cronjè 2002:216).

The traditional shape of organisations reflects Taylorism or a scientific management approach of the nineteenth century. Traditional organisations adopted a strategy of centralised control through vertical hierarchies and functional departments. Communication usually flows up and down the hierarchical structures as opposed to across or around the organisation (Brooks 2006:263).

A manager's basic function is to direct the efforts of an organisation to achieve the organisation's goals as well as the maintenance of the organisation's feasibility (Kroon 1995b:9). The managerial role is not housed within the person of a single individual. The role represents a number of people whose activities should be integrated to result in a full understanding of the manager's role (Kroon, 1995b:9; Mintzberg, Guinn & Ghoshal 1998:37).

With the implementation of the NHS, the organisation of health services in South Africa reformed. This is evident in the implementation of the DHS, which resulted in the decentralisation of authority in health services. Health services are now managed by a district manager per health district and no longer on a provincial level as before (FSDOH 1998:23).

2.4.2.2 Principles of organising

The following important principles of organising need to be taken into account: *chain/unity of command*, *span of control, requisite authority, continuing responsibility, organisational centrality, management by exception, delegation* and *coordination* (Booyens 1998:185).

- ***Coordination***

Van Niekerk (1995:197) describes coordination as the process whereby management organises the work to be performed by individuals and sections, thus obtaining good cooperation in order to achieve the objectives of the organisation in the most efficient way.

Coordination with regard to all the management functions, which include planning, organising, leading and control, should be emphasised. The performance of tasks in the organisation should be well coordinated to ensure the achievement of the organisational

goals (Kroon 1995b:12; Huber 2000:82). The manager directs personnel to execute the desired actions to achieve the goals. Often priorities are set to ensure that the main aspects get priority attention.

In a PHC setting, programme coordinators are appointed in the district to coordinate the different programmes, for example TB, EPI, IMCI, Mental Health, Mother, Child and Women's Health (MCWH) and HIV/AIDS. These programme coordinators have to guide the personnel on legal matters, policies, guidelines, protocols and training. Their support is vital to ensure performance and the achievement of targets.

It is evident from practical experience that the clinic manager must apply the following elements of management to enhance coordination:

- Involve staff in planning and formulation of objectives for the clinic, taking into consideration the objectives of the national and provincial DOH.

- Hold regular discussions and meetings with clinic staff.

- Develop a convivial workplace that boosts morale and increases willingness to cooperate with others. Team building sessions can be arranged to contribute to a positive workplace culture.

- Give feedback to the staff on new developments, policies, decisions and challenges as the dissemination of information can enhance coordination. Should internal politics and conflict be present in the workplace, manage these situations in a meaningful way to lessen or eliminate stressful events or circumstances.

- ***Chain of command***

The chain of command is known as the chain of reporting, ranging from the ultimate authority at the top to the worker with the least authority at the bottom. Usually communication flows in a downward direction (Booyens 1998:186; Smit & Cronjè 2002:194). Grohar-Murray and DiCroce (2003:126) describe the chain of command as the *unity of command*. Unity of command is the process whereby an employee should only receive orders from one supervisor (Booyens 1998:186; Smit & Cronjè 2002:194; Marriner-

Tomey 2004:284). This principle is not always applicable in a PHC clinic, as the clinic manager receives orders not only from the clinic supervisor, but also from doctors, pharmacists, rehabilitation staff, and programme coordinators. Dual command, where duties overlap, confuses workers and should be avoided in the workplace (Grohar-Murray & DiCroce 2003:126). The chain of command in PHC services in the DHS originates from the district manager who holds the highest authority to the general worker with the least authority.

- ***Span of control***

The span of control implies that managers should only be in charge of groups that they can supervise effectively. Effective management refers to numbers, functions and geography. To manage effectively, it is essential that clinic managers be able to have proper control over the number of subordinates under their span of control. Clinic managers should manage the clinics to which they are allocated and where they are physically present. It is impossible to manage a clinic effectively if the clinic manager is absent, as the successful operation of a PHC clinic depends to a great extent on his/her management capabilities (Booyens 1998:186; Smit & Cronjè 2002:194; Grohar-Murray & DiCroce 2003:127).

In a PHC setting, some clinic managers are situated several kilometres away from their supervisors because of the distance between the towns where supervisors are located and where the clinics are situated. For example, in the Dihlabeng Local Area, the distance between the clinic supervisor and the clinic manager is 100 kilometres. This is the result of a political decision on the boundaries of local municipalities. The distance has a negative effect on proper clinic management due to factors like a lack of transport, which results in the clinic manager not being able to attend clinic manager meetings and in-service training sessions.

- ***Requisite authority***

When an employee is assigned the responsibility of performing a certain task, the necessary authority to obtain and use the resources for the accomplishment of the task must be granted to him/her (Booyens 1998:186; Grohar-Murray & DiCroce 2003:127; Smit

& Cronjè 2002:196). When a clinic manager goes on leave, he/she has to appoint an acting clinic manager in writing, emphasising that the acting person will function within the delegations of the clinic manager. Should this be omitted, the clinic will be disorganised due to a lack of proper management, responsibility and accountability.

- ***Continuing responsibility***

A manager, who delegates responsibility for the performance of a task to a specific employee or employees, should not be absolved from taking final accountability for the successful completion of the task. This emphasises the fact that the clinic manager remains responsible for the entire clinic, although he/she delegated some tasks to his/her subordinates (Booyens 1998:187). Although managers can delegate responsibility and authority, accountability can never be delegated (Smit & Cronjè 2002:196).

- ***Organisational centrality***

The more people a manager interacts with directly, the more information he/she gains. Through gaining a lot of information, the manager becomes more powerful (Booyens 1998:187). Therefore it is essential for a clinic manager to continuously gain knowledge on PHC matters as well as on relevant matters, such as management, general health matters, and networking. A manager in a PHC setting who networks with other stakeholders, like NGOs, CBOs, politicians and other government departments, has more power due to the increased information and knowledge and his/her association with them.

- ***Management by exception***

Booyens (1998:187) found that not all organisations apply or follow this principle. Management by exception requires employees to report only exceptions or departures from the normal routine functioning to higher authority. Unusual or exceptional cases are only referred to top management when these cases cannot be controlled by local organisational mechanisms (Booyens 1998:187).

The researcher has confirmed that in the FSDOH, all exceptional cases in a district should be referred to a committee of managers known as the District Adverse Event Committee. This committee handles exceptional cases pertaining to patient care at monthly meetings. Should there be an urgent case, a special meeting is called to deal with the issue. If a case needs further investigation, it is referred to the Provincial Adverse Event Committee for attention, which consists of representatives of the different health institutions in the Free State. These members are representatives of the academic health complexes, regional hospitals and the health districts, comprising the district hospitals and PHC clinics.

To apply the principle of organising in the clinic, clinic managers should organise the following activities in their clinics:

- Group activities, for example health education for a group of patients, immunisation campaigns, staff meetings or ordering of supplies.
- Prioritisation and delegation of tasks to subordinates to render patient care.
- Coordination with multidisciplinary team members, such as doctors, pharmacists, social workers, NGO's, CBO's, traditional healers and various representatives of the community in order to achieve objectives. Failed organisation results in an ineffective health service.

- ***Delegation***

Delegation is the process of delegating authority and responsibility to lower levels of management (du Preez 1995:265). Delegation is the allocation of duties, authority and responsibilities to subordinates for the purpose of easing the manager's task and providing learning experiences for subordinates (Uys 2005:50; Kroon 1995b:12).

A manager cannot cope personally with all the responsibilities therefore some tasks have to be delegated to lower management levels and workers to reduce the burden (Kroon 1995b:12; Anders & Hawking 2004:322). The clinic manager delegates certain tasks to his/her subordinates because he/she cannot attend to all the expected tasks. These tasks might include the coordination of specific PHC programmes in the clinic. If clinic managers are of the opinion that they will not be able to coordinate all the programmes themselves,

compile monthly data, and control medicine, they might delegate these tasks to subordinates.

By delegating authority to personnel, they are given the opportunity for training and development. Delegation of tasks can significantly affect employees' attitude and morale, as they perceive that they are trusted with authority and responsibility. This, in turn, results in a positive attitude towards supervisors and improved morale (du Preez 1995:266).

Roos and Booyens (1998:297-298) list the following reasons for failing to delegate tasks:

- lack of confidence in subordinates
- fear of losing control over highly valued activities
- fear that a talented subordinate might perform the job better.

2.4.3 Leading

Booyens (1998:419) states that leaders are necessary to see that the *correct* things may be done correctly, while managers are there to see that things are done correctly. Leading as a basic management function should therefore play a significant role in the successful management of a clinic.

2.4.3.1 Definition of leading

Kroon (1995b:10) describes leading as "the process of influencing people to such an extent that they will excitedly contribute to work activities in order to achieve the goals of the institution". D'Aunno, Fottler and O'Connor (2000:65) maintain that it is the primary task of management to motivate people to perform at high levels to achieve organisational objectives. Leadership is crucial to the nursing profession because of tumultuous changes in health care and the demand on nurses to improve care delivery (Donnelly 2003:22).

The clinic manager has to provide leadership and direction in

- the implementation of the PHC package in the clinic
- the achievement of set indicators for various PHC programmes
- giving support to the clinic staff on various issues, such as personal problems and guidance on the implementation of policies and guidelines.

Leadership includes activating, motivating and communicating, and is a difficult and demanding task because people have to be activated in groups or individually. The manager is challenged by creating conditions that will allow individuals to achieve their personal goals and those of the organisation at the same time (Kroon 1995b:10).

D'Aunno et al (2000:65) point out that the type of workers health services managers have to motivate range from highly educated and professional workers, like doctors and nurses, to minimum wage workers. In a PHC clinic, the minimum wage workers are usually the general workers in the clinic. Professional nurses are academically highly qualified while some continually improve their academic qualifications by registering for post- basic degrees or diplomas.

There is no consensus on the concept "activating". Kroon (1995b:10) includes leadership and motivation in "activating". Sellgren, Ekvall and Tomson (2006:349) and Booyens (1998:417), however, describe leadership as a separate management function.

In this study activating and leadership were used synonymously, with "leading" also referring to "activating". Sellgren et al (2006:348) hold that leadership ability is crucial in influencing a group to adhere to the vision and mission and to achieve the organisational goals. Nursing management is thus both a challenging and difficult task. When the clinic manager applies the concept of leading in a PHC setting, it includes supervision and direction and enhances growth and development of personnel.

2.4.3.2 Supervision

In this study, supervision was considered a sub-section of leading (activating).

Kron and Gray (1987:156) describe supervision as a tool of management leadership. For many years the traditional autocratic form of supervision was practised in nursing, but the emphasis now is on supporting the individual to improve on performance (Kron & Gray 1987:156). Supervision is part of the management process and the clinic manager has to display effective supervisory skills and tasks in the clinic to ensure the rendering of quality services.

Reagon, Irlam and Levin (2004:46) contend that regular supervision is essential to improve and maintain the quality of services delivered. They indicate that more supervisory visits should be done, without stipulating a definite number of visits advisable.

Supervisory visits done by a clinic supervisor can support the clinic manager in her management role. The clinic supervisor can guide the clinic manager on management functions as well as the implementation of the PHC programmes in the clinic. Supervision includes guidance and support. Should any imperfections be identified, the clinic manager has the opportunity to correct it. Supervision offers an excellent opportunity to give feedback to employees. With supervision, the clinic manager has the opportunity to give direction to the staff with regard to various aspects, for example human resources management, financial management, labour relations. Supervision enhances personnel growth and development as the employer is exposed to training and feedback on performance.

Supervision is now considered to be guiding, teaching and supporting subordinates to develop new skills and an understanding of their jobs (Kron & Gray 1987:186). Ross and MacKenzie (1996:144) concur, describing the main purpose of supervision as “to improve the quality of patient care by developing skills and by monitoring and improvement of staff performance”. According to Lehmann and Makhanya (2005:140) and Lehmann and Sanders (2002:125), sufficient support to subordinates through supervision will improve work satisfaction and the ability to function productively. Furthermore, leadership

development should be given priority on the national and provincial capacity development agenda of managers. This should also be made applicable to the development of clinic managers, as they are responsible for the management of PHC clinics, which serve the community.

Dick and Pekeur (1995:4) are of the opinion that a clinic may be regarded as a small organisation and suggest that a model developed by the Netherlands Pedagogic Institute (NPI) be applied to study the management of a clinic. A PHC clinic complies with this model as the four essential components are interrelated in the clinic environment. This model describes an organisation as a complex system consisting of four essential components, which fit in well with the basic management process.

- Mission – politics, values and the objectives of the organisation.
- Resources - equipment, manpower, buildings.
- Procedures – work processes that should take place in an organisation. In the systems approach, specific directives to achieve the expected results in the end will guide the performance of a specific procedure.
- Relations – co-operation and the manner in which people work together.

Kroon's management model as adapted by Uys (2005:6) and Dick and Pekeur's model (1995:4) have corresponding components. In practice, the concept of management also applies to the four components mentioned, as the manager is responsible for the availability and utilisation of resources, execution of work processes, co-operation with team members and reaching of goals. It is evident from practical experience that supervision of subordinates can enhance the effective use of resources and execution of procedures that contribute to the attainment of the DOH's goals.

Supervision is now considered a means to teach, support, guide, correct and encourage people in order to develop new skills and create an understanding of their jobs.

2.4.3.3 Management structure of a PHC clinic

The management structure of PHC clinics consists of clinic managers, clinic supervisors and local area managers. Figure 2.9 illustrates the different levels of the clinic manager, clinic supervisor and local area manager in the PHC clinics of a local area. The different levels of clinic management are not all situated at the clinic, but the clinic supervisor and local area manager are part of the broader context within which the clinic functions.

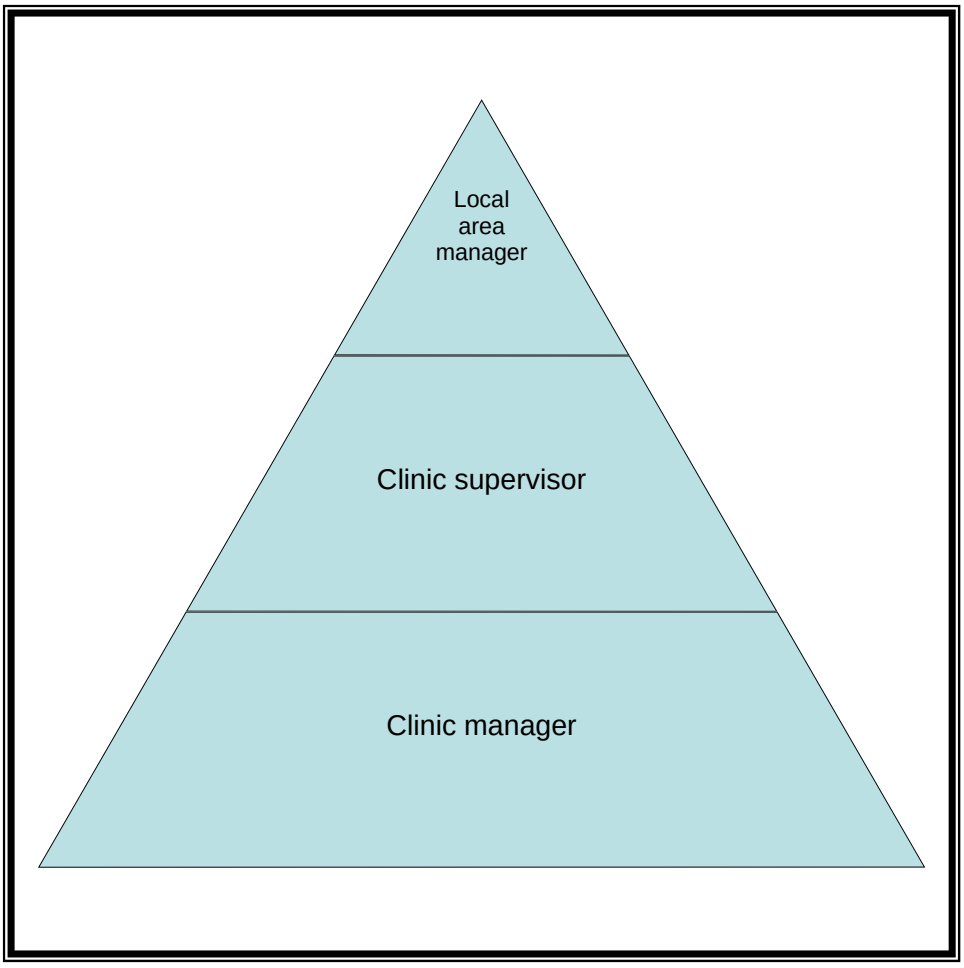

Figure 2.9 Levels of the management structure of a PHC clinic

- **Clinic Manager**

Tembani et al (2003:64) refer to the registered nurse in charge of a clinic as a "clinic manager" as well as "clinic supervisor", which is confusing considering the three levels of authority mentioned above.

In the Free State, the person in charge of a clinic is referred to as a "clinic manager" and in this study the focus was on the registered nurse in charge of a fixed clinic. The clinic manager is allocated to a particular clinic to ensure proper management of the clinic. The clinic manager is not appointed as such, as the present staff establishment does not make provision for a "clinic manager" post. The clinic manager might even earn a lower salary than some of her colleagues. Some chief professional nurses in the clinic, who are not clinic managers, might be on a higher scale due to the rank promotion system implemented in the past. Officials were promoted to higher ranks because of their years of service and not because of their competencies.

- **Clinic supervisor**

The second level of supervision is the clinic supervisor. Clinic supervisors supervise five to six clinics according to the prescriptions of the *Clinic Supervisory Manual* (FSDOH 2007b:[sp]). The post of clinic supervisor is not on the staff establishment, but due to the implementation of the manual, service providers ("renderers") in clinics with the rank of chief professional nurse were withdrawn from clinical services to supervise clinics. This contributed to the staff shortage in clinics because less professional nurses are available to attend to patients. The clinic supervisor is also a professional nurse with the rank of chief professional nurse or nursing service manager who is responsible for management of a number of clinics, which includes the supervision of the PHC programmes rendered by these clinics. The supervisory functions of the clinic manager and clinic supervisor are complementary, then, with the clinic supervisor being in a supportive role to the nurse in charge of the clinic by updating him/her on changes and developments in policies and practices. The clinic supervisor also supports the clinic manager with problem solving, facilitates the acquisition of the necessary skills and provides him/her with a written report after every supervisory visit. This feedback report highlights issues that need to be rectified

as well as the performance of the clinic staff (Tembani et al 2003:64).

- ***Local area manager***

Practical experience has confirmed that in the Free State the *local area manager* is responsible for the management of all PHC services allocated to him/her according to the boundaries of a specific local municipality. The local area manager is appointed on a higher level than the clinic supervisor and clinic manager (refer to figure 2.9 on page 70).

- ***Programme coordinators at the district level***

The programme coordinators are based at the district office. They do not form part of the management structure of a PHC clinic. They support and monitor the implementation of the specific programmes, such as mental health, MCWH and IMCI in a district. These coordinators monitor the specific programmes when visiting a clinic occasionally. For the purpose of fluent communication, these visits should be arranged by the district coordinator in the district office who informs the local area manager responsible for the management of the local area about the planned visit. The local area manager informs the clinic supervisor of the intended visit, who will inform the clinic manager.

The organogram (Annexure D) illustrates the staff establishment of a fixed PHC clinic in one of the local areas in Thabo Mofutsanyana district. It is a standardised organogram for a PHC clinic in the Free State. It should be noted that there is no provision for the term “clinic manager”, but in general the person in charge of a clinic is known in the Free State as a “clinic manager”. The organogram of Bohlokong Clinic indicates the professional nurse in-charge of a clinic only as “Chief Professional Nurse” and serves as an example of a staff establishment of Dihlabeng Local Area in Thabo Mofutsanyana health district.

2.4.3.4 Leadership styles

Leadership styles can influence the management of a PHC either positively or negatively, depending on the leadership style preferred by the clinic manager.

According to Sellgren et al (2006:348), the leadership style of a manager can be important for subordinates' acceptance of change and to motivate them to achieve high quality care. In early studies leadership style was described as consisting of two broad and independent behaviour dimensions: *production-/task-orientated* and *employee and relations focused*.

The most common leadership styles are autocratic; democratic/participative; laissez faire; bureaucratic; situational; transformational, transactional and change-orientated.

- ***Autocratic***

The main characteristic of this leadership style is the giving of orders. The leader usually makes decisions alone. This leadership style is suitable for crisis situations, when the focus is on getting the job done, or when it is difficult to share decision-making.

In normal day-to-day activities this leadership style leads to a dependent, aggressive, submissive group of subordinates who are unproductive in the absence of the leader, who has a tendency of high absenteeism (Booyens 1998:423).

- ***Democratic or participative***

This style is appropriate for groups of people who will work together for extended periods. Everybody shares implementation of decisions and responsibility for effective work performance.

Group members exhibit a high morale; are not totally dependent on the leader, and are willing to take risks. Democratic leaders offer information and do not issue commands, stimulating questions are asked, their criticism is constructive and group members are trusted to be committed to accomplish goals that have been set (Booyens 1998:424).

- ***Laissez faire***

Booyens (1998:424) states that the laissez-faire or ‘free-reign’ leader is inactive, passive and non-directive. A person who has a need for approval and is afraid to offend subordinates practises this leadership style. This type of leader is permissive, has no established goals or policies. He/she offers very little to the group because few commands, suggestions or criticisms are given. Members of the laissez-faire group act independently of each other and often work against each other because of lack of cooperation and coordination. This results in high frustration.

When the members of a group are highly motivated, self-directed and able to coordinate activities among themselves, they have the freedom they need to be creative and productive under the laissez-faire leadership style.

- ***Bureaucratic***

Booyens (1998:425) states that in this type of leadership an insecure leader finds security in following established policies. Power is exercised by commanding subordinates to follow relatively inflexible rules. This leader tends to communicate with subordinates on an impersonal level, as interpersonal communication is not the leader’s strong point. As the leader avoids making decisions without having standards or norms to guide him/her, this insecurity may result in the presence of a high level of frustration in the group members.

- ***Situational***

In situational leadership, the situation is the main determinant that affects the leader’s style of leadership (Booyens 1998:425). The task at hand and the subordinates’ ability and willingness to accept and perform the task will determine the amount of directing required from the leader. A leader should assess the following factors in a situation in order to decide on the appropriate leadership style:

- individual differences
- group structure
- values
- attitudes
- leader's and followers' needs and expectations
- the degree of interpersonal contact possible
- the organisational structure, culture and climate
- the organisation's policies and procedures
- existing communication patterns among group members.

- ***Change-orientated***

Today change is the natural state in the public and private sector and leadership is focused more on renewal and change and less on stable efficiency (Sellgren et al 2006:349).

Sellgren et al (2006:349) describe a new leadership style, called *change-oriented leadership behaviour* that focuses on change within institutions. This leadership was not needed before the middle of the 1980's, and is seen as a combination of the three dimensions of leadership, namely production, employee (relation)-oriented and change-oriented. Figure 2.10 illustrates the representative behaviours for the three leadership dimensions.

- **Production (task)-oriented leadership**
  - Plans carefully
  - Gives clear instructions
  - Is very exact about plans being followed
  - Defines and explains the work requirements
- **Employee (relation)-oriented leadership**
  - Shows regards for the subordinates as individuals
  - Is considerate
  - Is just in treating subordinates
  - Relies on subordinates
  - Allows subordinates to decide
- **Change-oriented leadership**
  - Offers ideas about new ways of doing things
  - Pushes for growth
  - Initiates new projects
  - Gives thoughts about the future
  - Likes to discuss new ideas

Figure 2.10 Dimensions of change-orientated leadership behaviour

Source: Sellgren et al (2006:349)

Each of the three leadership dimensions of the change-oriented leadership style will positively contribute to the management and outputs of clinics. Clearly then, clinic managers can apply any of a number of leadership styles depending on their personality or requirements of the situation.

- ***Distinction between transformational and transactional leadership***

The classical production-/task-oriented and employee-/relation-oriented leadership styles have been transposed into new dimensions called *transactional versus transformational leadership styles* (Sellgren et al 2006:349).

Booyens (1998:436) describes *transformational leadership* as future-oriented and concerned with change and the empowerment of others. According to Huber (2000:65), transformational leadership is a process that motivates subordinates by appealing to higher ideals and moral values. It can also be seen as a combination of the employee-relation-oriented and the change-oriented leadership styles. A transformational leader stimulates and empowers the staff in creative thinking and gives freedom for innovation and individual growth. Components such as inspirational motivation, idealised influence, intellectual stimulation and individualised consideration are highly valued in transformational leadership (Tappen 2001:44; Smit & Cronjè 2002:293; Booyens 1998:436; Sellgren et al 2006:349).

A *transactional leader* is focused on structure, role expectations and the criterion that every extra effort has to be rewarded, as nothing will be gained from anybody if they are not rewarded (Sellgren et al 2006:349; Huber 2000:65; Booyens 1998:436) (see figure 2.11).

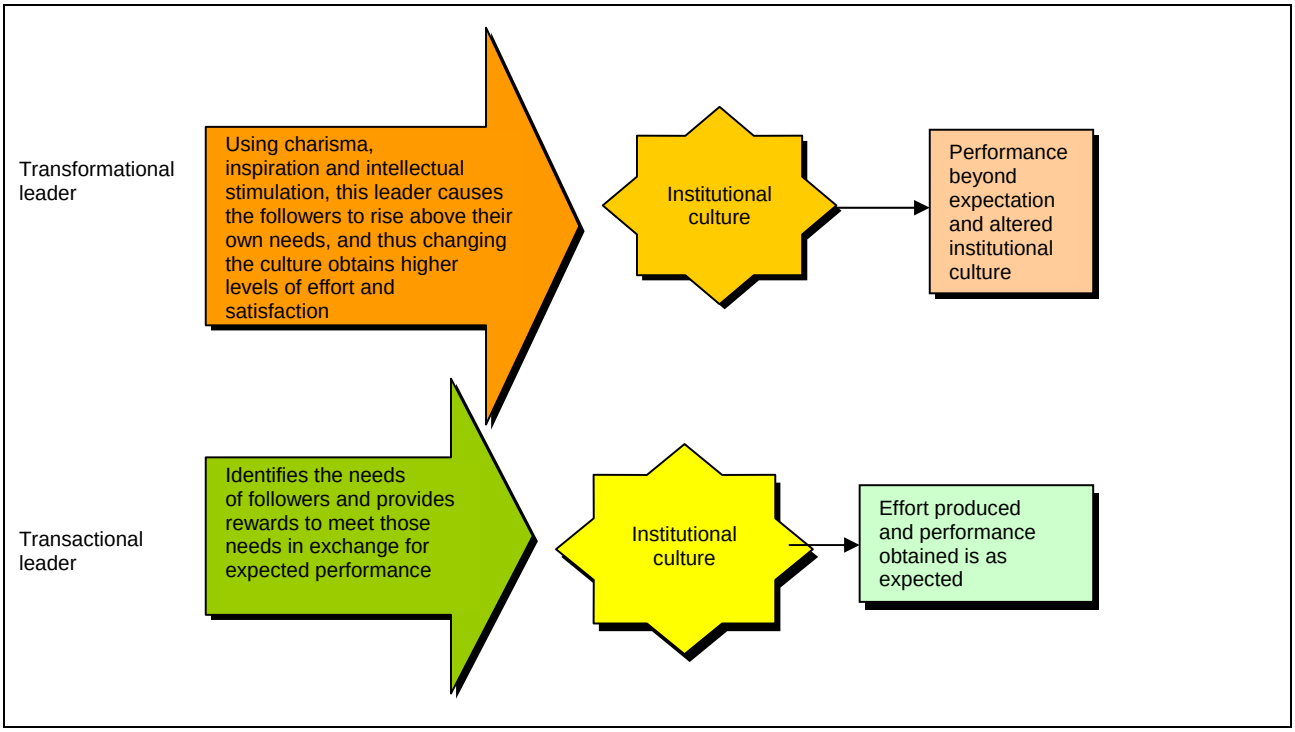

Figure 2.11 Transactional and transformational leadership

Source: Huber (2000:65)

According to Booyens (1998:437) and Smit and Cronjè (2002:293), the leaders of the future (transformational leaders) will have the following characteristics in common:

- a broad education
- boundless curiosity and enthusiasm
- belief in people and teamwork
- willingness to take risks
- devotion to long-term growth rather than short-term profits
- commitment to excellence
- readiness to face challenges
- vision

The distinction between *transformational* and *transactional* leadership is that transactional leadership attempts to preserve and work within the constraints of the status quo of the institution, while transformational leadership seeks to change and replace it (Pointer & Sanchez 2000:118; Booyens 1998:436).

Following the explanation of the leadership styles, transformational leadership could be seen as the most suitable leadership style applied in a PHC setting, as leaders have to adjust to continuous change, show creativity and innovation. PHC is still a fairly new concept in South Africa and adjustments will have to take place because of an ever-changing environment. The successful implementation of these changes will be a challenge for clinic managers.

2.4.3.5 Characteristics of effective nursing leaders

According to Sellgren et al (2006:349), the five characteristics of an effective nurse leader are highlighting, respecting, influencing, creativity and supporting, whereas the competencies of a nurse manager include analytical thinking, knowledge in management and visioning (Sellgren et al 2006:350; van den Berg 2004:1; Blais, Hayes, Kozier & Erb 2006:173). Van den Berg (2004:2) is of the opinion that a nurse manager should exercise alternative thinking by thinking differently than in the past. The repertoire of an effective

leader includes the why, when, where, how, who and what. Alternative thinking leaders thrive on being life-long learners.

Van den Berg (2004:1) states that value-led leadership and role modelling has an important role to play in leadership. Values originate from the mission and vision of the Reconstruction and Development Programme (RDP), the Constitution of South Africa as well as the National and Provincial Departments of Health. Van den Berg (2004:1) states that only nurse managers who are value-led leaders can really be effective leaders.

Effective leaders should be true to themselves, love themselves and respect themselves. At the same time they develop continuously because they learn from their colleagues and followers. They earn respect as they take the lead to achieve the set vision and mission. An effective leader should have respect for the right to health and health care, life, human dignity, privacy, freedom of religion, belief and opinion, culture and language and social security (van den Berg 2004:1).

The final management function is control.

2.4.4 Control

When applying control measures, the clinic manager aspires for quality PHC services and optimal staff utilisation. The purpose of control is to measure the quality of output gained by giving a lot of input, for example finances and manpower.

Crous (1995:443), Huber (2000:82) and Smit and Cronjè (2002:390) describe control as a systematic approach through which managers can compare real performance with plans, standards and objectives and take corrective action if deviations occur.

For effective management of a clinic, control has to be exercised. Examples of control are evaluating the performance of staff, assessing success rates with the implementation of the PHC programmes, and adherence to financial policies and legal prescriptions.

2.4.4.1 Importance and principles of control

According to Kroon's model (Crous 1995:444; Uys 2005:47) the principle aim of control is to ensure that activities are undertaken to ensure the achievement of objectives.

The purpose of control is to

- prevent crises
- lead to standardised actions to increase efficiency
- prevent malpractices, theft and waste
- control subordinates to whom tasks are delegated effectively
- do performance appraisal of staff
- standardise quality
- prevent that environmental change results in activities not being carried out according to plans.

2.4.4.2 Different types of control

Crous (1995:444) maintains that control can be executed before the activity commences, during the activity, after completion of the activity or during all three stages. These different stages are known as *pre-control, steering control* and *post- control.*

Pre-control aims at anticipating problems and takes place before the activity or project gets under way. Control should thus be implemented even before performance takes place. Management should address the formulation of policies and procedures, standards, criteria and rules; personnel should have the relevant qualifications and should be able to do the work (Crous 1995:444; Smit & Cronjè 2002:407).

This raises the question whether pre-control was done by the FSDOH before the implementation of free health services and chronic medicine provision at PHC clinics. It is evident from practical experience that nurses were not trained on screening and management of the EDL medicine and the waiting areas in clinics could not accommodate the additional patient load. Notwithstanding this, clinic and local area managers had to

implement the policy despite the lack of infrastructure. There was not enough time available for proper planning, as the service had to be implemented with immediate effect as instructed by the Department of Health.

Steering control takes place primarily at the level of the clinic manager and while the work is being done. Problems are corrected on the spot before they have far reaching consequences. No activities should progress to the next step before the current step has been satisfactorily completed (Crous 1995:445).

For example, with the implementation of the anti-retroviral programme at clinics, patients had to be transported with the commuter service of the Department of Health to assessment and treatment sites. It was noted that the commuter services arrived very late to transport patients home. As the clinics close down at 16h00, the clinic staff did not feel comfortable leaving the patients unattended at the clinic gates. The clinic manager discussed this situation with the manager of the commuter service and a solution was found before it had detrimental consequences.

Post-control concentrates on completed achievements and results. A disadvantage is that damage is already done by the time the manager receives sufficient information concerning the problem or deviation. This type of control can be done in cases of budget control and sales figures. Smit and Cronjè (2002:410) are of the opinion that post-control can be utilised for performance management. Output plays a major role to guide service providers on the outcome of their services, thus output can be regarded as achievements reached or the consequences due to the input. In a PHC setting, output might be a healthy community, well-equipped staff due to relevant training or a quality service that is rendered due to quality management training. The advantages are that managers can obtain an indication of the effectiveness of a total planning action as well as feedback on the performance of employees (Crous 1995:449; Hellriegel, Jackson, Slocum, Staude, Amos, Klopper, Louw & Oosthuizen 2004:409).

2.4.4.3 Characteristics of effective control

An effective control system has the following characteristics (Crous 1995:449; Uys 2005:48; Smit & Cronjè 2002:411; Hellriegel et al 2004:413):

- The control system should lead to *accurate, reliable and valid information*. If an evaluation tool is utilised to evaluate the progress made on the implementation of a programme, like antenatal care, it is important that the assessor as well as the clinic staff are convinced that the information obtained is accurate, reliable and valid.

- Control should be *economical.* In a PHC setting, it is important that control be economical because of the variety of PHC services rendered in a clinic. Should the assessment tool to assess the quality of PHC services generate cost, it would not be conducive to sound financial management.

- Planning and control should be *integrated*. Control is ineffective when control systems are not integrated with the planning process. Standards should be related to the set objectives to ensure proper control. The planning and implementation of the PHC package are integrated with the control measures in place to measure the efficiency of services rendered. Indicators utilised in PHC clinics are specific control measures to evaluate the outcome of specific PHC programmes.

- Control should be *flexible* to allow for environmental change in a PHC setting. Due to the prevalence of different kinds of illnesses, adjustments have to be made because of the continuous changing health needs.

- *Timeliness* implies that information should be gathered, processed and evaluated timeously to ensure that correct interventions will take place. For example, in a PHC setting the prevalence of multi-drug-resistant TB should be investigated immediately to prevent an outbreak of the disease.

- Since managers cannot control everything, emphasis should be on the *exception* and control should be focused on strategic control measures.

Corrective action should also be taken after deviations have been exposed. When a performance appraisal is done on a subordinate and deviations identified, availing of specific remedial action plans can rectify the deviations (Kroon 1995b:169).

2.4.4.4 Tools contributing to control

Table 2.2 developed by the researcher illustrates the tools managers can use to contribute to exercising control.

Table 2.2 Tools for exercising control

TOOLS	PURPOSE
❖ **Performance appraisal and productivity**	• To evaluate productivity of staff • To rectify deficiencies • To enhance productivity • To give incentives to those who qualify (Troskie 1998:551)
❖ **Risk management**	• To identify and correct shortcomings in the care of patients • To protect the assets of a health care setting • To have control over injuries • To be as effective and economical as possible (Koch 1998:583)
❖ **Quality improvement**	• To ensure professional accountability (Muller 1998a:599) • Funders of health care wants proof that quality care is delivered (Muller 1998a:599) • Quality services can serve as a marketing principle to market services rendered by an organisation (Muller 1998a:600)

Troskie (1998:551) describes performance appraisal as a systematic approach evaluating an employee's strengths and developmental needs. Job and training requirements are norms that could be used to evaluate job performance of nurses. The DOH determines

specific norms and standards for the rendering of PHC services. The DOH expects service providers to adhere to these norms and standards to ensure the rendering of quality health services to the community (DOH 2001a:5).

To exercise control, the clinic manager has to have standards and criteria available to assess the quality of services rendered.

Standards currently available, are the DOH assessment tools developed for the monitoring of PHC programmes, which are aimed at enhancing the quality of services rendered at clinics. These tools include *A comprehensive primary health care service package for South Africa* (DOH 2001b) and *The primary health care package for South Africa - a set of norms and standards* (DOH 2001a), which can be used in the clinic to control the implementation of the PHC programmes. The *Handbook for Clinic/CHC Managers* (DOH 2000) has checklists against which the clinic manager can check what should be done in a clinic, such as checking an inventory every three months, drug management, record keeping and management of data. The clinic manager should do assessments and reviews of clinic activities at pre-determined times/intervals. This includes performance appraisals of staff, auditing of patient records and completion of tools to assess the quality of services rendered in the clinic. Assessment tools are available for PHC programmes such as IMCI, EPI, STI, mental health, chronics and geriatrics, TB, antenatal care, drug management and District Health Information System (DHIS). When reviewing the outcomes of the tools, action plans have to be put in place to improve deficiencies. Re-assessments should be done after the implementation of the action plans in order to evaluate progress and improvement achieved.

The clinic manager can apply the following means of measurement:

- ***Data gathering***. Every professional nurse keeps a monthly datasheet to capture all the patients who consulted him/her during the month. This serves the purpose of assessing productivity per professional nurse and to obtain a true reflection of the quality of care rendered (Muller 1998a:613).

- ***Statistics***. Statistics serve to identify the attendance of patients at a clinic and can reflect whether attendance is good or bad. Depending on the outcome, the clinic staff, guided by the clinic manager, should make plans to put remedial action in place. Data gathering is also a form of statistics.

The management process cannot be regarded as an entity on its own. The management process is interdependent on all the other elements and functions in the micro-environment as they influence one another, including business functions, business economics and business capabilities.

2.5 THE ADDITIONAL MANAGEMENT FUNCTIONS

According to Kroon (1995b:9) the basic management functions include planning, organising, activating and controlling.

Decision making, communication, motivation and disciplining, are additional management functions that supplement the basic management functions and contribute to the achievement of organisational goals (Uys 2005:48; Kroon 1995b:11).

The additional and basic management functions support each other in the management process. Depending on the needs of a particular situation, the clinic manager can apply the additional management functions in correlation with any of the four basic management functions.

- ***Decision making***

Kroon (1995b:11) and Huber (2000:378) consider decision making as the most important of the additional management functions as it might result in either the success or failure of a business. The decision maker should carefully consider the consequences of each alternative before taking a decision (Marriner-Tomey 2004:58). Grohar-Murray and DiCroce (2003:82) emphasise that the clinic manager should exercise judgement, participate in decision making and assume responsibility for decisions that have an impact on people, costs and/or quality of service. Booyens (1998:503) is of the opinion that nurse managers should demonstrate problem-solving skills in all situations that change frequently and

rapidly. The nurse manager's decision should be appropriate and rational; move the organisation in the right direction and meet the set objectives.

According to Booyens (1998:506), when decisions have to be made, managers should consider the steps in the decision-making process, namely

- recognising the problem
- gathering relevant information
- developing and evaluating alternative solutions
- selecting a solution
- post-decision activities/implementing the decision

During a strike action, the clinic manager has to decide whether he/she will participate in the strike action or not. For ethical reasons, his/her own values and convictions, the clinic manager can decide to go to work despite the strike action.

Since PHC is a nurse-driven process, PHC nurses are confronted with situations where prompt decisions have to be made. The clinic manager is expected to function independently as clinic manager, as the direct supervisor might not be physically present in the clinic. Striving to achieve the set organisational objectives, should guide the clinic manager in his/her decision-making role.

- ***Communication***

According to Kroon (1995b:11), communication plays a major role in all management functions as it provides the information necessary for successful work performance. Communication by the clinic manager requires tact and persuasion in all verbal and written communication efforts. The application of skilful communication is fundamental to successful leadership (Grohar-Murray & DiCroce 2003:53).

Supportive communication contributes to a situation where employees feel free to contribute by asking questions and to give solutions to problems (Booyens 1998:268). Clinic managers who implement supportive communication contribute to the success of teamwork and the implementation of quality care, as subordinates feel that managers value

their opinions. Staff relationships, attitude, morale, motivation and performance are determined by the way in which communication takes place (Kroon 1995b:11; Uys 2005:49).

- ***Motivation***

Kroon (1995b:12) describes motivation as coming from within a person, but a manager should attempt to foster and encourage employees' willingness to strive to do their best. Jooste (1998:451) points out that motivation is influenced by the manager's personal characteristics and the various conditions existing in an organisation. According to Uys (2005:50), managers should know their staff so well that they are aware of what could serve as motivating factors for different individuals.

In a PHC clinic, this can be illustrated by a situation where an employee strives to obtain an award for excellence and walks the extra mile to achieve it. At the same time, a colleague in the same situation is not motivated to obtain an award and only performs the tasks expected of him /her according to his/her job description.

- ***Discipline***

Bezuidenhout (1998:676) defines discipline as an action taken by management against an individual or a group who failed to conform to the rules established by management. Discipline must be applied with tact and fairness. Disciplining should take place privately, consistently and irrespective of position. The aim of disciplinary action is to shape a subordinate's behaviour to ensure order and the achievement of the set goals (Kroon 1995b:13).

The four additional management functions play a vital role in clinic management. If utilised effectively, they can contribute to the achievement of the organisational goals.

Figure 2.12 illustrates that the micro-environment, consisting of the elements indicated, and the clinic manager is interdependent of each other. For example, due to a lack of funds (business capabilities), the clinic manager has to plan (use the management process) how to keep staff motivated and has to delegate tasks (management process) to achieve the goals of the clinic.

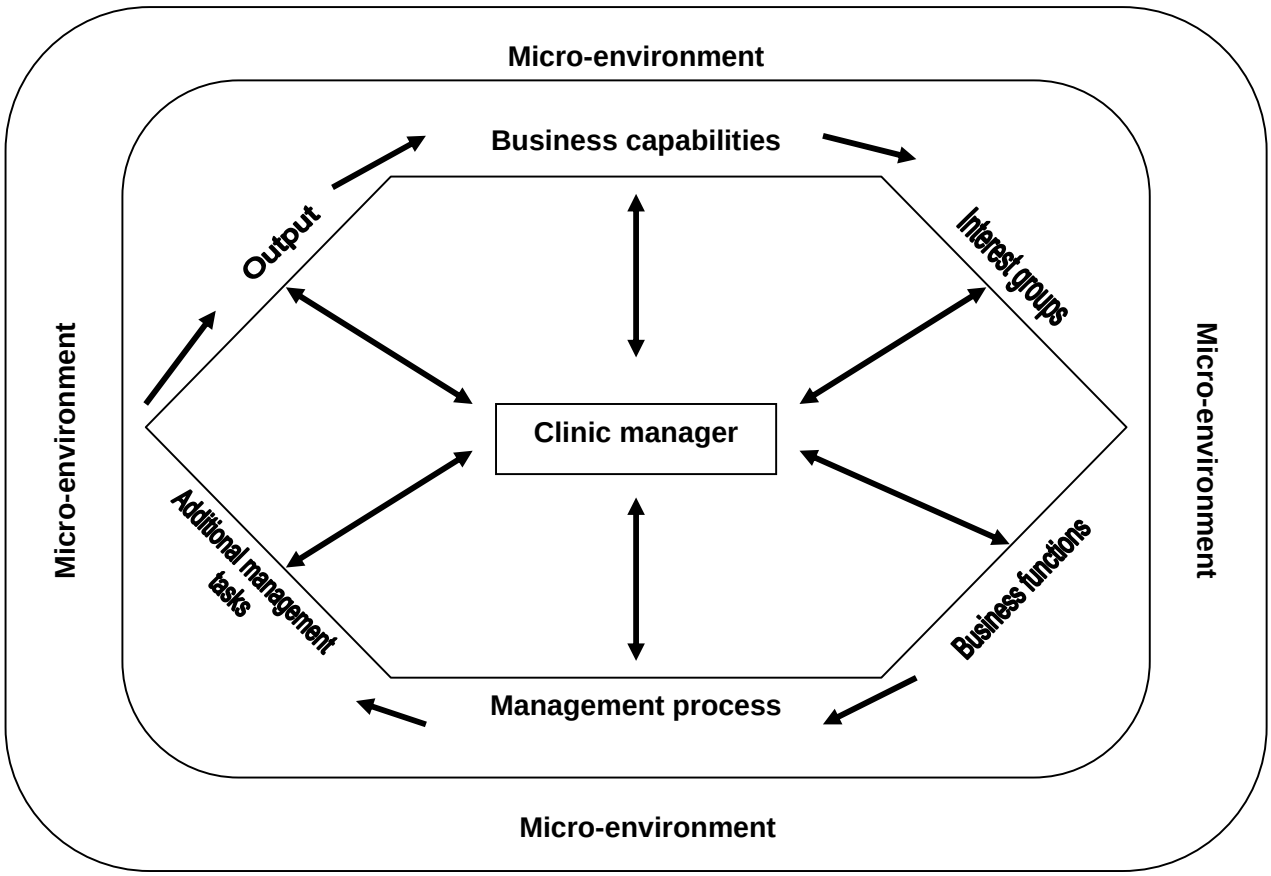

Figure 2.12 The interdependency of the clinic manager and the micro-environment.

2.6 INTEREST GROUPS

Interest groups comprise *clients, suppliers, competition, the general public, authorities* and *employees* (Kroon 1995:52; Uys 2005:9; Smit & Cronjè 2002:321). They are also part of the structure in view of the systems approach. Interest groups can play a significant role in a PHC setting. A clinic committee member who is part of the community (clients) can contribute positively or negatively to the effective functioning of a clinic. The same principle applies to employees. Their attitude, commitment and motivation will determine the success rate of a clinic.

2.7 BUSINESS CAPABILITIES

In Kroon's model, the business capabilities comprise equipment, capital and labour (Uys 2005:6). The business capabilities will now be discussed and applied to a PHC setting.

- **Equipment**

It is the responsibility of the clinic manager to manage the equipment of the clinic. To be able to render quality services, a PHC clinic should have all the essential equipment available listed by the DOH (see table 2.3).

Table 2.3 Essential equipment list

Consulting Room	Procedure Room	Staff Room	Dispensary	Utility / Dirty Store	Instruments
- Examination couch - Obstetric bed - Haemoglobin metre - Examination light - Baumanometers (wall, desk, mobile) - Kickabout - Kickabout bucket - Diagnostic sets (portable and wall) - Doptone - Scale with height measure - Baby scale - Small dressing trolley	- Haemoglobin metre - Examination light - Kickabout - Kickabout bucket - Eye chart - Diagnostic sets (wall and portable) - Baumanometer (mobile, desk and wall)	- Vaccine refrigerator	- Graduated measuring jug - Gram scale - Counting tray	- Needle incinerator - General incinerator - Bedpan - Urinals - Soiled linen receiver - Autoclave - Sputum mug	- Stitch scissors - Mayo scissors - Episiotomy scissors - Needle holder - Tissue forceps - Patient trolley with mattress - Stethoscope - Emergency trolley

Source: DOH (2000:20)

The researcher has found in practice that the following aspects are important in the management of equipment:

- Equipment on inventory should be maintained, serviced and sent for repairs when out of order. A maintenance plan of all equipment in the clinic should be in place and adhered to.
- Services that cannot be rendered due to a lack of specific equipment should be noted. This information should be submitted to the clinic supervisor, who is the clinic manager's supervisor. The equipment needs should be indicated on the budget of the next financial year.

- **Capital**

Consumers of health services are beginning to state clearly the kind and quality of health care delivery they expect from health professionals and health care organisations. Health care funders want proof of the quality of services rendered (Muller 1998a:599). In a PHC setting, the South African taxpayers fund the health care service since their money funds the government sector.

In order to render a PHC service, funds are allocated on a yearly basis to the FSDOH who allocates specific amounts to each district's budget, which includes the budgets of each local area in the district. It is evident from practical experience that the district office manages the local area budget. Consequently, neither the local area manager nor the clinic manager has information available on the expenditure of the local area's budget unless an expenditure report is forwarded to the local area manager.

Clinics are not regarded as cost centres therefore the clinic manager is not informed about financial matters. This results in frustration for both the clinic manager and local area manager and is considered a serious deficiency as financial management is regarded as an important business function. To render an effective service, it is crucial to have financial resources available. The researcher has confirmed that the consequences of a lack of finances could result in essential equipment not being purchased, no vacant or critical

posts being filled, and stringency measures being put in place. All these would have a negative impact on clinic services.

According to the DOH (2000:13), the following matters are considered important with regard to finances:

- Is the budget for main categories known for the year?
- Is the budget known for
  - drugs
  - stationery
  - cleaning materials
  - telephone and other communication?
- Are annual personnel costs known?
- Are expenditure reports analysed by the clinic?

- **Labour**

The availability of a sufficient labour force in a PHC setting plays a vital role in the rendering of quality services in a clinic. To equip the clinic manager for her management role, it is essential for the clinic manager to be acquainted with the staff establishment of the clinic. This staff establishment should be displayed for all to see. The clinic manager can use this staff establishment to indicate the need for more staff to district management.

The researcher has found that the professional nurses' workload will be affected by the availability of staff. For example, in a clinic with a daily average of two hundred patient visits, if four professional nurses are on duty, the workload per professional nurse will be 50 patients per nurse per day. It should be noted that this is a crude workload because the real contribution per nurse may vary.

2.8 THE SYSTEMS APPROACH

According to Huber (2000:16), the general systems theory forms the theoretical framework for understanding the health care system. A PHC clinic functions as a system with a set of interacting elements that work together to accomplish specific goals. These elements contributing to the accomplishment of specific goals are contained in the macro-, meso- and micro-environment (Kruger 1995b:52).

Definition of the systems approach

Gillies (1989:71) define the systems approach as an important tool in the planning and control functions of management. A system can be defined as a set of objects in interaction to achieve a specific goal (Gillies 1989:71; Huber 2000:16). A system is an ongoing process comprising of interrelated sub-systems, each of which has its own objective that contributes positively toward goals of the larger system (Gillies 1989:71; Smit & Cronjè 2002:61; Brooks 1995:145).

According to Roos (2001:123) the systems approach strives to attend to challenges by looking at the interrelationships between the system's input, throughput, output and the environment, as indicated in figure 2.13.

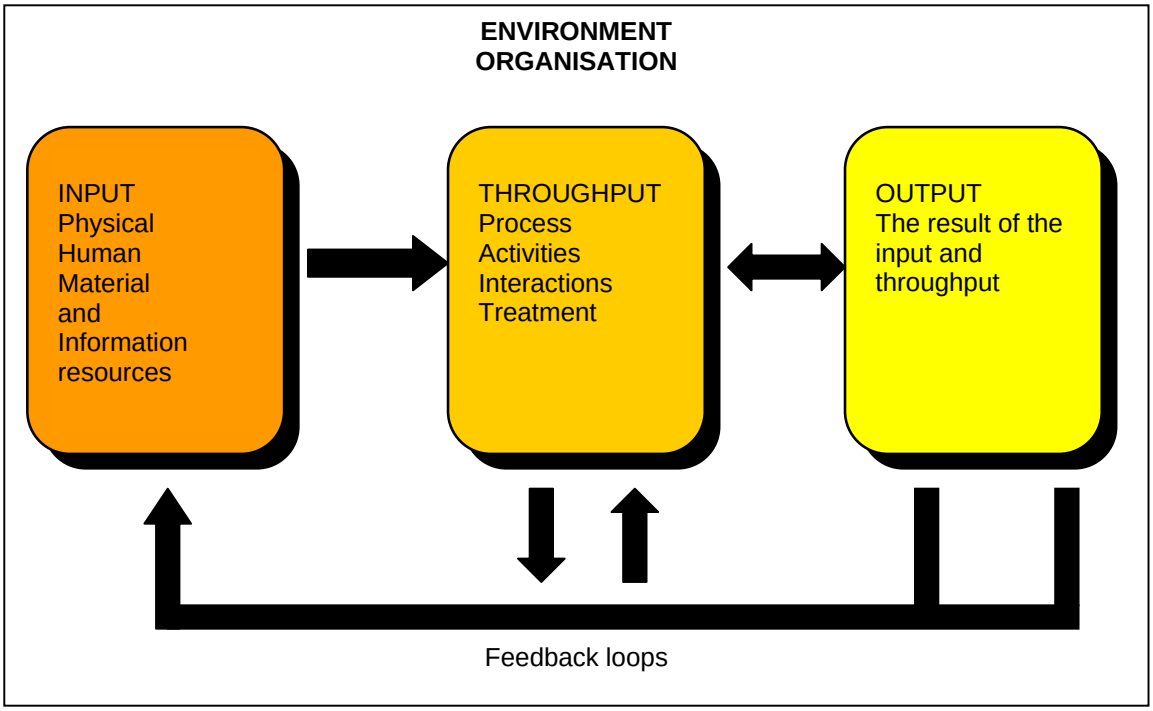

Figure 2.13 The systems approach

Source: Roos (2001:123)

The *input* comprises the physical, human, material, financial and informational resources (Roos 2001:123). In a PHC clinic environment, the input contains the number and type of human resources, clinic buildings, equipment, supplies, funds and the number of patients visiting the clinic.

The *throughput* is the process by means of which the system converts the input with energy into action, which is evident in the service provided (Roos 2001:124). For example, the national campaigns held nationally to wipe out communicable diseases like TB, polio and measles.

The *output* is the product, which is the result of the input and throughput activities (Roos 2001:124). The immunisation coverage reached during a campaign will indicate the success achieved during such a campaign.

2.8.1 Significance of the systems approach to the nurse manager

A nurse manager has to work within, among, and on a variety of systems of all kinds (Gillies 1989:73). This can also be applied to the clinic manager in a PHC clinic. The DOH, which is the employer, is regarded a structural system and the PHC clinic of which the clinic manager is a member is a functional system. The management of the clinic, which is a job responsibility, is a power system. At the same time, the work group that the clinic manager is leading is regarded as a social system.

The clinic manager of a PHC clinic is thus included in a diversity of systems, which are all goal directed. Inputs for each system are intended to achieve specific objectives. The systems approach has advantages for the PHC nurse as it encourages nurses to view patients as members of families, groups and the community (Huber 2000:16).

2.8.2 Standards

The systems approach measures the interrelationship between the *structures*, *processes* and *output* in an organisation and this measurement is based on three types of standards, namely structure, process and output standards (Uys 2005:5).

2.8.2.1 Structure standard

The DOH (2001a) document, *The primary health care package for South Africa - a set of norms and standards* is a *structure standard* describing the norms and standards that should to be made available in the package of PHC services. This document also acts as guidance for provincial and district health authorities to provide these services.

A structure standard refers to the composition of an institution. It entails the vision and mission, facilities, human and material resources and the organisational framework (Uys 2004:18; Uys 2005:7). A health care service needs structural input to be able to function and the structure continually interacts with the macro-, market and micro-environment (Uys 2004:11; Uys 2005:7). Structure standards are thus related to the availability of resources needed to render health services to the community (Uys 2005:7).

The structure standards include guidelines for the management of services that should be rendered to achieve the organisational goals. An example of a structure standard in a PHC

setting is that a clinic should render services for a minimum of eight hours a day (DOH 2001a:12).

The primary health care package for South Africa - a set of norms and standards (DOH 2001a) is an example of a structure standard. This document outlines all the services that should be rendered by a PHC clinic and serves as a guideline and standard for service rendering (see chapter 3 pages 133 – 146 for discussion).

2.8.2.2 Process standard

A process standard refers to actions or tasks that should be performed by staff to obtain the desired results in the form of output (Uys 2004:18, Uys 2005:7; Booyens 1998:310). If services are delivered ineffectively, the service will be of poor quality and the set objectives will not be achieved.

A comprehensive primary health care service package for South Africa (DOH 2001b) serves as a *process standard* as it describes *how* services should be rendered to patients. In other words, it guides the service provider as to what is expected in order to achieve the DOH goals.

2.8.2.3 Output standard

Output standards refer to the results obtained after specific actions have been taken. The output obtained should be assessed to determine the quality of services rendered and whether the goals of the institution have been met (Uys 2005:10).

2.9 INTERDEPENDENCY BETWEEN KROON'S MANAGEMENT MODEL AND THE SYSTEMS APPROACH

Uys (2005:9) integrates Kroon's management model with the systems approach and describes specifically the interrelationship and interdependency of the micro-environment and the systems approach (see figure 2.14). Table 2.4 illustrates how the systems approach relates to the micro-environment.

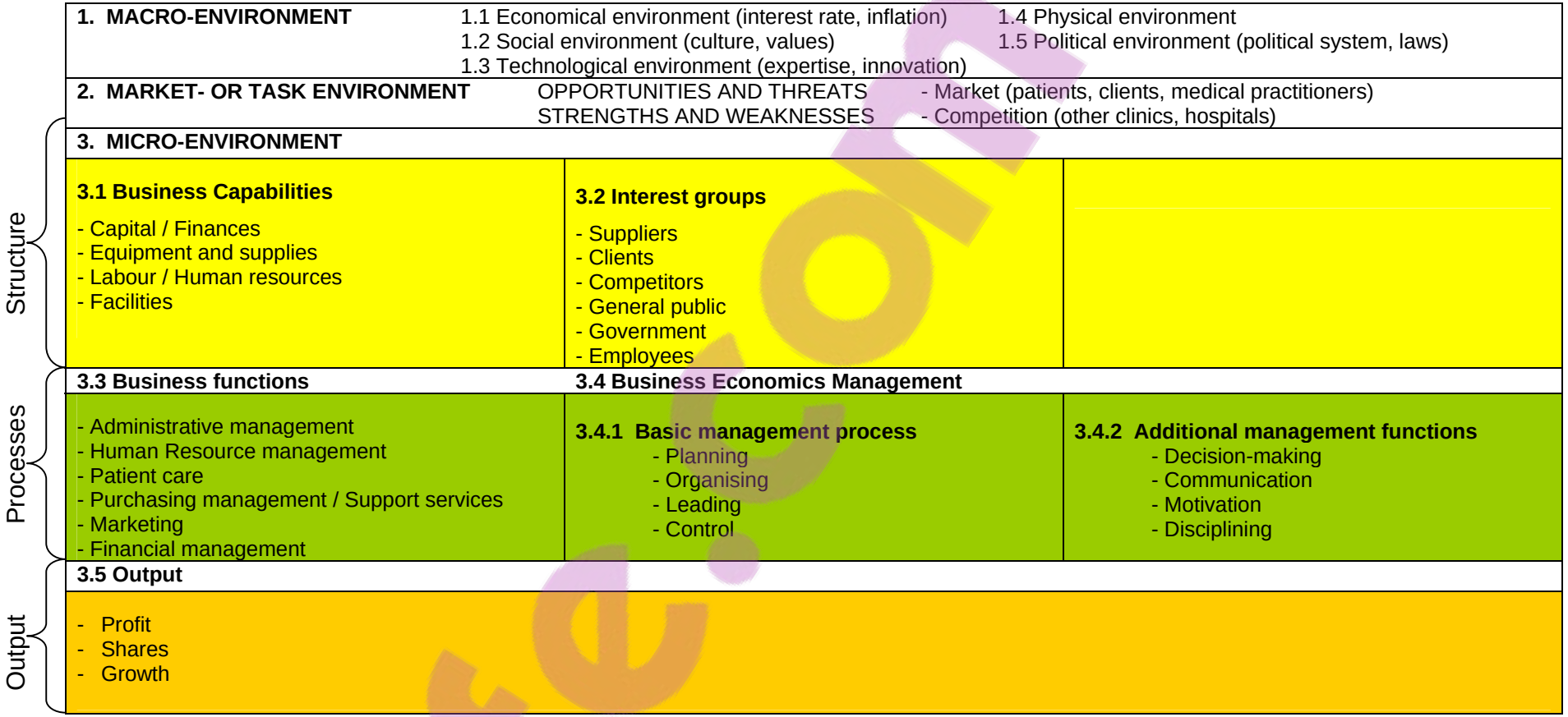

Figure 2.14 The interdependency between structure, process and output within the micro-management process

Source: Uys (2005:9)

Table 2.4 The systems approach related to the micro-environment

1. STRUCTURE	2. PROCESSES	3. OUTPUT
1.1 Business capabilities • Capital (Funds) • Equipment • Labour	**2.1 Business functions** • Administrative management • Human resource management • Patient care • Support services/procurement • Financial management	**3.1 Profit** **3.2 Growth** **3.3 Quality patient/client care** **3.4 Healthy population**
1.2 Interest groups • Clients • General public • Authorities • Employees	**2.2 Business economics management process** **2.3 Basic management process** • Planning • Organising • Leading • Control	
1.3 Management approach • Vision and mission • Core management tasks • Participative management	**2.4 Additional managerial tasks** • Decision making • Communication • Motivation • Disciplining • Training	

Source: Uys (2005:9)

The *structure* relates to business capabilities, interest groups and management approach; *processes* relate to business functions, the basic management process and the additional managerial tasks while *output* refers to profit, growth, quality patient care and healthy populations.

Gillies (1989:74) and Smit and Cronjè (2002:62) emphasise the interdependency of the system and its environment. The ability of the clinic manager to decrease negative and increase positive effects of the system will depend on the permeability of system boundaries to penetration by environmental influences. For example, if sufficient funds are not available on the budget to purchase equipment, a request can be made to shift funds from another component in the allocated budget to avail funds.

According to Kruger (1995b:51), a business/organisation can be regarded as a creation of its environment as its assets, income, problems, opportunities and continued survival depend to a great extent on the environment. Management continuously has to adjust in the organisation as a result of many changes taking place due to instability in the environment (Smit & Cronjè 2002:63). So, for instance, unplanned sick leave creates a staff shortage necessitating the clinic manage to re-allocate tasks to the available staff members to ensure that gaps caused by the absence of the professional nurse are covered.

2.9.1 Business capabilities as structural input

The structure in a PHC clinic is not always conducive to the achievement of goals. In this study, *capital/finances, equipment, labour/HR and facilities* were regarded as the structural components of any institution or service.

According Kroon's (1995b:67) model, business capabilities comprise capital, equipment and labour. In the PHC setting, a clinic, which renders a comprehensive PHC service, serves as the structure of the organisation. As a health institution, the PHC clinic consists of nurses, doctors, clerks, cleaners and support groups like home-based carers and DOT supporters.

- **Capital/Finances**

The *availability of capital* will influence the quality of services rendered at a clinic. The consequences of capital not being available include that staff cannot be appointed and that the necessary equipment for effective service will not be available due to a lack of funds to purchase it.

- **Equipment and supplies**

The unavailability of equipment results in frustration for staff and patients being deprived of certain services due to a lack of resources. Should there be no Baumanometers or stethoscopes in the clinic, a complete physical assessment of the patient cannot be performed. These result in ineffective service, as the monitoring of blood pressure is a basic procedure performed in PHC.

- **Labour/Human resources**

A lack of HR could have serious consequences for patients. For example, staff shortages can cause patient dissatisfaction because of long waiting times at clinics. Some dissatisfied patients might complain to the press and the general public could get a totally negative impression of the clinics. Moreover, staff shortages result in burnout, frustration and even resignations, as the staff cannot cope with the workload.

- **Facilities**

The availability and structure of facilities as business capabilities are related to the structure standards of the systems approach. Should a PHC have no fully equipped maternity section, the clinic can still do emergency deliveries provided the basic equipment is available. Clinic managers and their staff have to improvise to act in an emergency situation.

2.9.2 Interest groups

Interest groups play an important role in the micro-environment (see section 2.6).

2.9.3 Business functions

Business functions play a significant role in the micro-environment (see section 2.3.4.1). With reference to the systems approach, business functions relate to the components that need to be managed.

2.9.4 Interdependency of processes, business functions, the management process and additional management functions

According to Uys (2005:9), business functions, the basic management process and additional management functions are related to the processes of the systems approach. A process deals with *how* the service is rendered (Uys 2004:18; Mullller 1993:601). The referral system in PHC is regarded as a process standard as it prescribes the exact procedure that should be followed when referring a patient from a PHC clinic to a higher level of care. The implementation of an effective referral system is essential to ensure that the utilisation of health services complies with NHS policy.

The processes to achieve goals are interrelated with the business functions such as administrative management, human resources management, patient care, and support services including provisioning. Within a system, such as the DHS, which includes the PHC clinics, specific processes have to take place before any output can be achieved (Sambo, Chatora & Goosen 2003:14).

2.10 OUTPUT

Van Niekerk (1995:207); Uys (2005:9) and Hellriegel et al (2004:58) refer to output as profit, shares and growth. Unlike a private institution, a PHC clinic is a subsystem of the DOH and is consequently not focused on profit, shares and growth. However, the DOH expects output to be evident in good results for patients, taking into consideration the expenditure incurred to support the achievement of goals.

The DOH established indicators to evaluate the output. The performance of the programmes can be assessed against the set of indicators as established nationally, provincially and locally. To illustrate this, graphs indicate the achievements of a local area in the Thabo Mofutsanyana district with reference to specific targets that should have been achieved (see Annexures E, F and G). The researcher has confirmed that in cases where targets were not achieved, the clinic staff had to do planning to put actions into place for improvement. Output serves as an important tool to support the clinic manager in managing the PHC programmes in the clinic.

From the discussion, it is evident that the components of both Kroon's model as adapted by Uys (2005:6) and the systems approach are interdependent. If the structure component is inadequate, it will influence service delivery in the process component. If the outcome component is unsatisfactory, more work has to be done to achieve the objectives. Thus the outcome component influences the process and input components (Uys 2004:18). According to Uys (2005:9), these components interrelate with the components of the micro-environment described by Kroon, namely business functions, business economics management, business capabilities, and output.

2.11 CONCLUSION

This chapter discussed Kroon's (1995b:67) management model as adapted by Uys (2005:6), which formed the conceptual framework of the study. The management process comprises planning, organising, leading and controlling as well as the additional management functions of decision-making, communication, motivation, coordination and discipline. The interrelationship between the systems approach and Kroon's (1995) management model as adapted by Uys (2005:6) was also discussed.

Chapter 3 covers the literature review undertaken for the study.

CHAPTER 3

Literature review

3.1. INTRODUCTION

A literature review is a study providing an overview of scholarship in a certain discipline through an analysis of trends and debates (Mouton 2001:179). The purpose of the literature study was to explore literature related to the topic under study.

The literature review covered the following:

- The current role expectations of a clinic manager in a PHC setting
- Factors determining and influencing the role of clinic managers in a PHC setting
- The effect of current role expectations of a clinic manager on the management of services rendered at a PHC clinic
- Developmental needs of clinic managers to enable them to fulfil their role expectations
- Guidelines for realistic role expectations of a clinic manager in a PHC setting under prevailing circumstances.

Figure 3.1 presents a summary of the aspects explored in the literature review.

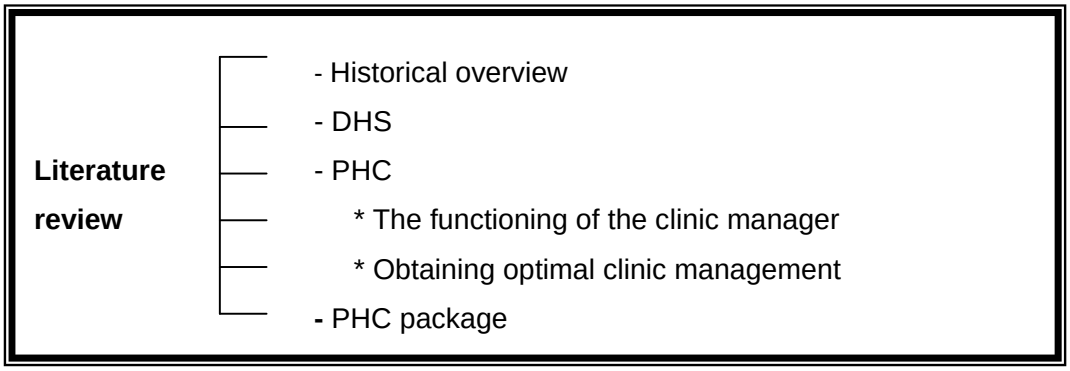

Figure 3.1 Summary of the literature review

In the literature review, the researcher examined the history of the development of a DHS in South Africa and what the DHS entails, the structure of the DHS, the concept of PHC,

and the PHC package. With regard to PHC, the literature review also included the management structure of a PHC clinic, problems and challenges in the management structures of PHC clinics and guidelines to address the problems, especially the two parts of the PHC package, namely *The primary health care package for South Africa - a set of norms and standards* (DOH 2001a) and *A comprehensive primary health care service package for South Africa* (DOH 2001b).

3.2. HISTORICAL OVERVIEW

To understand a comprehensive PHC service in South Africa, it is necessary to briefly trace the development of the DHS in South Africa. In the 1990s, South Africa was one of the few countries in the world where an entire transformation of the health system began and the delivery of health care was changed according to the principles of the PHC approach (DOH 1995; 2001d:1; Mashazi 2002:7).

In his address at the National Health Summit in 2001, President Thabo Mbeki (Reaching out 2002:26) stated that in 1994 Government had set out a path intended to lead to fundamental change in South Africa's model of health care delivery. Government had committed itself to build a unified health system. This unified health system would:

- Strive for organisational coherence
- Unify in its expression of humanity and its proud contrast to racism of the past
- Unify in its ability to bring public and private health sectors within a common framework of social and professional values and objectives.

Following the first democratic election in South Africa in 1994, PHC was introduced as the founding philosophy of the health system. President Thabo Mbeki (Reaching out 2002:26) acknowledged that it would be an uphill struggle to establish the primacy of PHC, but the purpose of the struggle was to improve the health status of the people and this is inseparable from the struggle against underdevelopment and poverty.

According to Mbeki (Reaching out 2002:26), this was a radical move to assert that PHC would become the bedrock of the health system of South Africa, particularly considering from where South Africa had come:

- The recent heritage was one of racial inequality and economic exclusion through pass laws and this was the antithesis of development.
- Institutions of government and social mobilisation had little relationship with one another and were usually antagonistic towards one another.
- The public health service was split on racial lines and resources were concentrated on curative services rendered at academic hospitals.

Mbeki (Reaching out 2002:26) pointed out that the concentration of resources on curative services was a far cry from the health promotion, preventive programmes and early intervention demanded by PHC. The National District Health System Committee was formed in 1994 with the goal of moving away from curative-based services to a system based on PHC (Hall, Ford-Ngomane & Barron 2005:45; DOH 2001d:2). After the 1994 elections, the ANC committed itself to the promotion of health through the processes of prevention and education, which form the pillars of PHC (Gilson 1999:11).

The new Government elected in 1994 intended to follow the PHC approach for the delivery of health services in the new South Africa (Benatar & van Rensburg 1995:17; Peltzer 2001:46). The Alma Ata Declaration (WHO 1978b) emphasises that essential health care is based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination (Gilson 1999:11; Mchunu & Gwele 2005:30; Mashego & Peltzer 2005:20; Benatar & van Rensburg 1995:20; Mashazi 2002:13).

3.3 DISTRICT HEALTH SYSTEM (DHS)

The DHS will be discussed under the following headings:

- Definition and clarification of the DHS
- Characteristics of the DHS
- Reasons for developing a DHS
- Aims of restructuring the health sector
- Principles of DHS
- Effects of implementing the DHS.

3.3.1 Definition and clarification of the District Health System (DHS)

The District Health System (DHS) is the vehicle for providing quality primary health care to a defined geographical area. The DHS was promoted as the unit within which the implementation of PHC by health and health-related sectors and communities could be organised and coordinated (Sanders 2003:51). The DHS forms the building blocks of the national health system (NHS) in South Africa (Nicholson 2001:28; DOH 2001c:5).

According to Roemer (1997:1539), an NHS is “the complex of activities in a nation that result in the provision of health services to the population. The aim of these services is to promote the health status of the population, prevent disease, provide medical diagnosis and treatment, and to rehabilitate individuals to maximum functioning. A national health system is not regarded as a summation of activities that produce health.” A population’s health status is influenced by factors in the physical and social environment (Roemer 1997:1539; van Rensburg 2004:413). Kruger (1995b:52) emphasises the influence of the environment on an organisation.

According to Roemer (1997:1539), the national health system can be described according to the functions of its main components. At the conceptual centre of the system is the *organisation of programmes*. Feeding into the central component is a complex of activities enabling production and service delivery such as personnel, facilities, knowledge and

commodities (Roemer 1997:1540). Many types of *health services* provided to people emanate from these activities. Two others support these three components: *economic support* and *management*. Figure 3.2 illustrates the NHS. In the centre of the NHS is the organisation, for example the Department of Health. The health needs of the community have an effect on the organisation in the sense that the organisation in the end will have to have health results. In order to achieve health results, the organisation has to be supported by resources, management, economic support and service delivery.

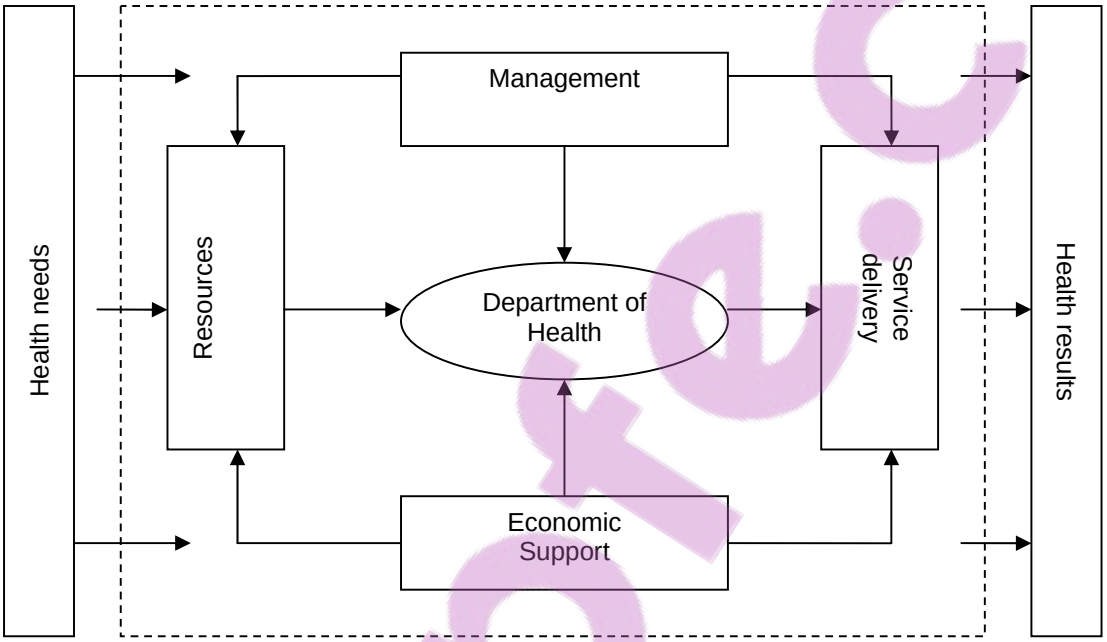

Figure 3.2 Model of a national health system indicating its components and their relationships to health status

Source: Roemer (1997:1539)

In serving as a vehicle for delivering the health services anticipated by the NHS, the DHS provides the means for enabling the provision of health care at community level. The DHS comprises the following (FSDOH 1998:44):

- Goals to meet the basic health needs of the community
- A range of PHC services, including the district hospitals
- Support systems such as patient transport and laboratories
- Referral system between various levels of facilities
- Staff.

3.3.2 Characteristics of the DHS

The DHS is characterised by the following (DOH 2001d:4):

- It contains a number of geographical sub-divisions, called “health districts”; each with a clearly defined catchment population
- Clear guidelines exist to demarcate the health districts, including
  - each to include a level 1 hospital
  - population not to exceed 500,000
  - the furthest clinic to be reached in approximately 3 hours from the district office
  - being of a reasonable size to ensure effective management
  - each health district to have a decentralised health management team.

The health management team consists of members from the following disciplines:

- The chief executive officers (CEOs) of the district hospitals
- Financial management
- Human resources management
- Supply chain management
- Clinical services comprising of:
  - Public health (District Medical Officer for Health)
  - Pharmaceutical services
  - Rehabilitation services
  - Nutrition
  - Radiography
  - Oral health
- Community development
- Primary health care, including all programmes and supported by the PHC manager of the district and the district coordinators for specific programmes:
  - TB
  - STIs
  - MCWH
  - Mental health

- A local area manager to manage a local area in the district. The number of local area managers depends on the size of a local area and the number of local areas per district.
- The district manager is the leader of the management team and is allowed to delegate tasks and responsibilities to the members according to specific delegations vested in him.

This team meets on a monthly basis or more frequently, should the need arise. Every discipline has a designated manager who is responsible for the management of that discipline. This manager is accountable to the district manager. Service rendering in the district is rendered according to the stipulations of the DHS emphasising the principles of PHC.

Hall, Haynes and McCoy (2002:1) and the DOH (2001d:5) point out that the health management team would be responsible for:

- delivery of a comprehensive and integrated package of health care to the population
- planning, managing, implementing and monitoring health care delivery that is appropriate for the population
- ensuring equitable and cost effective use of resources
- establishing a proper referral system between the DHS and relevant services outside the health district.

3.3.3 Reasons for developing a DHS

The rationale for adopting the DHS was included in the ANC's Health Plan and the Reconstruction and Development Programme (DOH 2001d:6; Benatar & van Rensburg 1995:17). The health sector reform was driven by the desire to rectify the structural distortions and inequities, which characterised the health sphere in the previous dispensation. Total absence of a unitary system existed due to manifold fragmentation of the health system along structural, functional, racial, geographical, socio-economic and racial lines and in terms of authority. Major inequities and disparities in the provision of health existed under the apartheid system favouring a White, urban, wealthy and medically

insured clientele. Underprivileged and previously disadvantaged citizens could not benefit like the medically insured clientele. They often had to be accommodated by the public sector, which was particularly underserved and underprovided in the rural areas and homelands due to shortages of staff and other resources. The implementation of the equity principle addressed this deficiency (van Rensburg 1999:3; DOH 2001c:5).

The World Health Organization (WHO) and the ANC national health plan promote the DHS as a vehicle for delivering health care, more especially PHC (Swartz & MacGregor 2002:158; Strasser, London & Kortenbout 2005:134; Mchunu & Gwele 2005:158). The development of a district-based health care system in South Africa is part of the broader policy development in the health sector towards a NHS (FSDOH 1998:3; Swartz & MacGregor 2002:158). According to Nicholson (2001:24), Swartz and MacGregor (2002:157), Mabaso (2006:22) and Mashazi (2002:13), the apartheid system was one of the most unequal, fragmented and inefficient health systems in the world. Health services were duplicated on a racial basis and fourteen different health departments administered health, including ten Bantu (Black) tribe health departments, three own affairs' health departments for the White, Coloured and Indian populations, and one general affairs department. There were provincial health departments in the four respective provinces and 382 local authorities, which were also responsible for the rendering of some health services.

According to Petersen and Swartz (2002:1010), Nicholson (2001:25) and Mabaso (2006:22), the previous government adopted a medicalised approach to health, which emphasised *curing* rather than *preventing* disease. This approach was focused on hospital-based medicine and the use of advanced technology (Benatar & van Rensburg 1995:18). Sanders (2003:50) maintains that the dominance of hospital-based health care and the lack of training of health professionals in PHC matters were significant impediments to the successful implementation of PHC (Sanders 2003:53). Services were fragmented to such an extent that services that supported the prevention of disease, for example immunisations, were separated from services that treated diseases (Sibaya & Muller 2000:6).

After 1994 major strides were taken to meet the challenge to overcome the problems inherited from the apartheid system.

3.3.4 Aims of restructuring the health sector

Various reasons contributed to the restructuring of the health sector. Nicholson (2001:25) and Swartz and MacGregor (2002:158) describe the aims of restructuring as to:

- Unify the fragmented health services at all levels into a comprehensive and integrated national health system. A DHS was seen as the most suitable way to achieve this.
- Reduce inequalities in health service delivery.
- Prepare partners, including the private sector, NGOs and communities, in support of an integrated NHS.

These aims were incorporated into the principles supporting the DHS.

3.3.5 Principles of the DHS

The first South African democratic government announced in 1994 that it intended to develop a district health system (DHS) as the main vehicle for the delivery of comprehensive PHC services (Mabaso 2006:23). The rationale for the DHS was to eliminate fragmentation and to create an integrated service (Swartz & MacGregor 2002:155). This was substantiated by the principles underpinning the DHS (Owen 1995:4; FSDOH 1998:8; van Rensburg 2004:413; Mashazi 2002:2):

- Overcoming fragmentation
- Equity in resource allocation
- Comprehensive and integrated services
- Effective services
- Efficient services
- Good quality services
- Easy and appropriate access to services

- Accountability to the local community
- Community participation
- Decentralisation of authority and responsibility
- A developmental and inter-sectoral approach
- Sustainable services.

The application of these principles was evidence of the strategy for implementing PHC services in South Africa. Dennill, King and Swanepoel (1999:67) and Nicholson (2001:26) point out that the implementation of PHC services is based on the following:

- *Equity*: All people should have equal access to basic health care. There should be no subgroup variability and discrepancy in care.
- *Accessibility*: Services should be within the reach of all people. This includes geographical, financial and functional accessibility.
- *Affordability*: No person should be denied health care because of an inability to pay.
- *Availability*: Sufficient and appropriate services should be available to meet the particular health needs of each community.
- *Effectiveness*: Services should be justifiable with regard to cost. Services provided should do what they were intended to do for the specific community.
- *Efficiency*: Attained results should be proportionate to the input, expenditure, resources and time utilised.

Tanser (2006:846) contends that PHC should be accessible to all communities in developing countries. Poor access may result in adverse pregnancy outcomes, infantile mortality, decreased vaccination coverage and decreased contraceptive usage.

To ensure equity in the provision of PHC services, the National Department of Health developed *a standard package of services*, which should be available throughout the country. This package comprises two documents: *The primary health care package for South Africa – a set of norms and standards* and *A comprehensive primary health care service package for South Africa* (see section 3.5). These documents stipulate the

community health programmes and services that should be rendered in all clinics and community health centres (CHCs) (DOH 2001a:5).

3.3.6 Effects of implementing the DHS

The ANC government embarked on transformation with the *Reconstruction and Development Programme* and the *National Health Plan* serving as a framework for improving the health of the nation (Allen, Makubalo, Shisana & Mbobo 2000: 1186). The ANC took up the challenge of establishing the district-based PHC system for South Africa (Hall et al 2002:6; van Rensburg 2004:420).

3.3.6.1 Positive effects

The implementation of a NHS, based on PHC principles and delivered by means of the DHS approach, faced considerable challenges. In reviewing the key issues to facilitate the introduction of PHC, adaptations had to be made. For example, legislation was needed to implement the required changes. The South African Nursing Council (SANC) realised that the previous Nursing Act (50 of 1978, as amended) was inadequate to meet the challenges faced by the nursing profession who participated in the implementation of health policies after 1994. Subsequently, the SANC reviewed both legislation and policy ensuring protection of the public and the provision of nursing care as expected by the public (Pillay, Marawa & Proudlock 2002:9).

The institution of free health care for PHC services removed the barrier of inaffordability of health care, making it more accessible to thousands of people who would have avoided seeking help from health service providers in the past because of a lack of funds. This resulted in a socialisation of health care, which stood in sharp contrast to the policy of the previous government where the strengthening and expansion of the private sector was one of the mainstays of the health policy (Benatar & van Rensburg 1995:20).

The inauguration of the DHS as the basis for the South African health care system meant the regionalisation of services, dividing the nine provinces into smaller administrative and

service units. This resulted in 50 health regions and about 170 health districts. Authority and decision-making were devolved to regional and district offices enabling decentralisation of authority. Management autonomy at the level of the health facility was maximised and district health authorities had greater responsibility for the determination of priorities and the allocation of funds in their areas of jurisdiction (van Rensburg 1999:5). The unification of the previously fragmented health system by means of integrated services and facilities was consolidated under a single national ministry of health, responsible for overseeing, supporting and coordinating the entire health system of South Africa (van Rensburg 1999:6; van Rensburg 2004:6; DOH 1995:8).

Training of health personnel was adjusted since training was previously based on a hospital and curative model. Strasser et al (2005:134) point out that under apartheid the emphasis was on tertiary care. To prepare nurses for PHC, basic education, practice settings, tutor qualifications and cultural expectations had to be revamped. Training of health personnel is less focused on hospitals and high-tech solutions and more practice-oriented, thus producing staff who are more efficient and effective in delivering care in PHC settings, as well as in remote rural areas (van Rensburg 1999:12; Benatar & van Rensburg 1995:19).

3.3.6.2 Negative effects

The implementation of the DHS also had negative consequences for the health services in South Africa. Strasser ([Sa]:3), Minnaar (2001:19) and Heunis et al (2006:37) maintain that nurses are the backbone of PHC services. Ross and MacKenzie (1996:150) emphasise that nurses are the first point of contact for the patient.

The nurse practitioner is the most available frontline provider of health care within the DHS. Regardless of the availability and maldistribution of doctors and pharmacists in many areas, the professional nurse has an ethical obligation to act in the best interest of the patient. This has led to professional nurses at times having to act beyond the traditional scope of their practice and the problem of grey area practice coming into being especially

in the underserved areas like the remote rural areas where there is a shortage of doctors and pharmacists (Muller 1998b:4; Ross & MacKenzie 1996:151).

The transformation process had serious consequences for health services and service providers. For example, Muller (1998b:6) points out that free maternal and childcare as well as free PHC services resulted in services being flooded by patients, rendering them unable to cope with the increased demands. However, Dedicoat, Grimwade, Newton and Gilles (2003:777) indicate that the impact of free medical services on attendance at PHC clinics is unknown. According to Ehlers (2000:76), the opening of more than 200 new clinics and the delivery of 53 new mobile clinics resulted in 125,000 more patients visiting the health services. Nurses managing health care clinics should bring such statistics to politicians' notice and request additional staff and resources (Ehlers 2000:76).

The large influx of patients to health care facilities placed an extreme burden on health care staff of all the provinces. Mashego (1999:12) stressed the situation, stating, "We don't have enough staff and doctors and nurses feel overworked". Dlodlo (2007a:1; 2007b:17) reports that nurses suffer from burnout due to the extensive workload.

The implementation of the DHS affects not only the CHC, but also PHC clinics as they render services in the absence of a CHC. According to Haque (2002:14), the developing DHS has had the following effects:

- The patients of previous vertical programmes like school health, oral health, reproductive health, geriatrics, midwifery and obstetric health now attend clinics and CHCs.
- The phasing out of the district surgeon concept delegated more responsibilities and services to clinics, resulting in more patients flocking to clinics.
- Waiting times for appointments with doctors at secondary and tertiary level health care institutions were prolonged. This resulted in more visits from patients awaiting referral and an increase in patient backlog in PHC facilities.
- Free PHC services also resulted in more patient visits to PHC facilities.

Haque (2002:14) points out that, at the Tafelsig CHC, the staff found it extremely difficult to maintain a standard of preventative care after the introduction of curative services for all. In the past, selective preventative services, for example family planning, developmental screening for neonates, immunisation of children under five and treatment of communicable diseases such as TB and STI, were provided as a vertical programme. The implementation of curative services at PHC clinics resulted in an unlimited and growing demand of the community for curative services. The increasing curative care demands made it difficult for staff to maintain a high standard of preventive care as the need for curative services tended to dominate the preventative needs of the community.

3.3.6.3 Evaluation of the DHS

Sambo et al (2003:5) found that health systems in Africa were undergoing considerable changes like the decentralisation of health services. To support them in the implementation of reforms at district level, Sambo et al (2003:3) developed a document *Tools for assessing the operationality of district health systems* for use by district management teams as a basis for improving the operationality of the DHS. These tools include suggestions to ensure optimal assessment of district health services rendered in a specific district. This raises the question whether this valuable document is effectively applied in the Free State, as the information was quite new to the researcher until the literature review.

Considering all these effects, the transformation of the health sector has indeed made a significant difference (van Rensburg 1999:12). Health reform in South Africa can be said to have vast potential and to have opened numerous new avenues for better, easily accessible and more equitable health care services. Despite these positive outcomes, however, the reforms have not been altogether fundamental and beneficial. The overhasty pace and political thrust of the transition has, in many respects, introduced unintended negative results detrimental to the effectiveness and efficiency of the system, as well as to the quality and user-friendliness.

3.4 PRIMARY HEALTH CARE (PHC)

The ANC government took up the challenge of establishing the district-based PHC system for South Africa. PHC and the DHS formed the cornerstone of health transformation in the country. The transformation was guided by two policy documents, the *Reconciliation and Development Plan* and the *National Health Plan for South Africa* (van Rensburg 2004:420; Mchunu & Gwele 2005:30). PHC encompasses accessibility, community participation and cost effectiveness. It brings health care as close as possible to people, as it is the first level of contact with health services (Dennill et al 1999:2; van Rensburg 2004:413).

3.4.1 Definition of PHC

The Alma-Ata Declaration (WHO 1978a:428) defines PHC as "essential care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination. It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with the national health system, bringing health care as close as possible to where people live and work, and constitutes the first element of a continuing health care process". This definition is supported by Dennill et al (1999:2), Sokhela (1999:229), Sibaya & Muller (2000:7) and Ehlers (2000:75). Smith (2006:118) and Louwagie, Bachmann and Reid (2002:32) emphasise that effective primary health care is the point of first contact for all new health needs. Petersen and Swartz (2002:1008) maintain that PHC providers are the first, and sometimes the only, health care personnel to come into contact with patients who are HIV positive.

3.4.2 Basic components of PHC

The following eight basic components of PHC are listed under Section VII of the Alma-Ata Declaration (WHO 1978a:428) and illustrate the different services that should be provided in PHC clinics (Dennill et al 1999:3; Taket 2001:30):

- Education about prevailing health problems and methods of preventing and controlling them.
- The promotion of food supply and nutrition.
- An adequate supply of safe water and sanitation.
- Maternal and child health care, including family planning and care of high-risk groups.
- Immunisation against major infectious/communicable diseases.
- Prevention and control of locally endemic diseases.
- Appropriate treatment of common diseases and injuries.
- The provision of essential drugs.

3.4.3 PHC as a concept

PHC is *not* primary care, primary medical care nor primary curative care. Primary medical or curative care is the assessment (history taking and physical assessment) as well as specific care or treatment of a patient. Primary medical care is only one aspect of primary health care (Dennill et al 1999:3; van Rensburg 2004:414).

Although PHC services are the point of entry into the health care system, PHC is *not* only first contact care. If the need arises, PHC may lead to more advanced levels of care in sophisticated care facilities like Level 2 or Level 3 hospitals. Hall et al (2005:46) argue that the PHC approach is more than the provision of primary level services. A seamless referral system from the community to the most sophistically health care facility is available in the delivery of district health services.

PHC is *not* only health services for all; it entails much more than health facilities and health personnel (Strasser et al 2005:138). PHC includes community development and requires a

multi-disciplinary approach. The multi-disciplinary approach entails involvement of pharmacists, doctors, physiotherapists, speech therapists, occupational therapists, social workers, dieticians, dentists, radiographers and environmental health officers.

The community is involved by participating in governance structures like clinic committees and members are trained in their roles and functions in the clinic environment. The community knows what their health needs are and needs to be involved in health matters to improve their health status (Mchunu & Gwele 2005:35). Community development is also strengthened by informing communities about various illnesses and the prevention thereof by giving information via the media (radio and television) and during health education sessions in the clinic's waiting area or on a one-to-one basis in a consulting room.

PHC is *not* cheap, simple nor second-class care (DOH 2000:3; van Rensburg 2004:414). It is a misconception that only hospital or high technology care is first-class medicine and any other form of health care is second-class. Comprehensive PHC implies interventions firmly based on scientific research. The coordination, planning and implementation of the PHC approach are complex, as this approach and the DHS model apply to the whole of the health system and all levels of health care delivery (van Rensburg 2004:414).

PHC is the product of the community it serves as it is based on the needs identified by the community. PHC is thus a broad concept, which is a combination of task-orientated basic health care services and the process of community development (Dennill et al 1999:4). Smith (2006:118) states that effective primary care provides comprehensive care for all needs common in the population.

For the successful implementation of PHC, Dennill et al (1999:6) indicate that a strategy should be determined and political commitment to PHC by the reigning government is a necessity. The ANC as the governing political party supports the PHC concept, as the concept of PHC arises from the NHS, which was approved by government. However, for PHC to be fully functional requires the ruling political party to avail the necessary resources to ensure rendering of quality services.

In order to cater for the health needs of the broader South African population, a shift in the emphasis of health care was necessary. Instead of curative hospital-based care, the emphasis was on community-based PHC. However, Petersen (1999:908) maintains that primary level care, provided by PHC nurses, remained pre-dominantly biomedical in orientation, as they had to function as “mini doctors” in rural areas.

3.4.4 The functioning of a clinic manager

The DHS was established to enable the provision of PHC. Nevertheless, the absence of the necessary adjustments in the number of suitably qualified health care personnel and sufficient resources means that not all clinics achieve the aims of the DHS and PHC.

Tembani et al (2003:67) identify the following reasons for the deficiencies in clinic management:

- clinic managers’ workload
- insufficient management training
- lack of resources
- lack of autonomy
- stress on human resources
- attitudes of colleagues.

3.4.5 Clinic managers’ workload

The role of a clinic manager should be mainly management in nature. However, besides their managerial role, clinic managers are expected to perform nursing duties such as assessing patients, prescribing medication, dressing wounds, and counselling, due to insufficient staff numbers.

Tembani et al (2003:66) found that the inability of clinic managers to perform managerial functions emanated from their role confusion. This raises the question whether it was actually confusion or whether they just had too much to do when clients come first.

Dedicoat et al (2003:778) found that the 1991 and 2001 patient records at the Inhlwati Clinic in the Hlabisa district, KwaZulu-Natal showed that staffing levels at the clinic did not change and no other health care facilities had been opened or closed within 30 kilometres. In 1991, there were 836 patient consultations and 1 546 in 2001. Due to the increase in patients, the management responsibilities had also increased. However, in a national survey in 2000, Viljoen, Heunis, Janse van Rensburg, van Rensburg, Engelbrecht, Fourie, Steyn and Matebesi (2000:44) found no noticeable difference in the workload of nurses in the Free State over a period of three years (see figure 3.3). In 1997, nurses in fixed clinics consulted 424 patients per month, but in 2000 the number decreased slightly to 418 patients per month. As the survey was done nationally, nurses referred to in figure 3.3 include professional and enrolled nursing auxiliaries. In 2000, professional nurses only consulted 6 patients less compared to 1997 (Viljoen et al 2000:44). Thus there was no congruence between Dedicoat et al's (2003) and Viljoen et al's (2000) studies regarding the actual increase in patient visits at clinics.

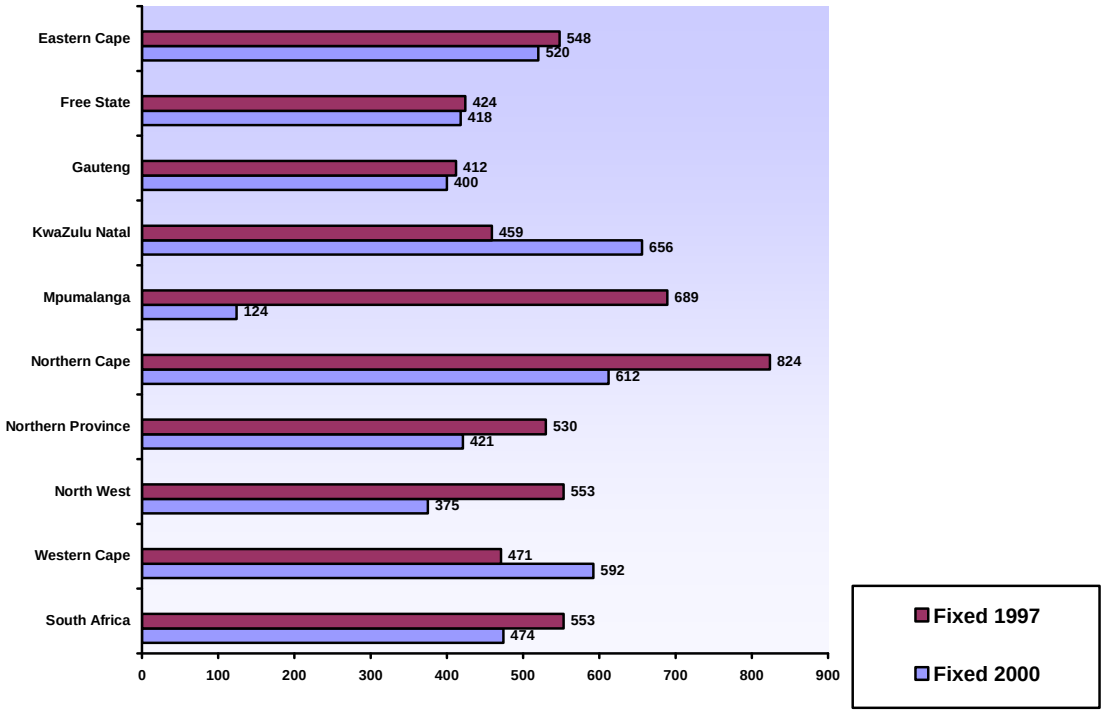

Figure 3.3 Average number of patients attended to per professional nurse in the Free State in fixed clinics, 1997 and 2000

Source: Viljoen et al (2000:45)

In their study of the clinic supervisory system, Tembani et al (2003:67) found that the clinic manager's time was devoted to direct patient care rather than to the expected management functions. Managerial duties were often neglected and the management function was the least performed function by clinic managers. Clinic managers have the same experience at present in PHC clinics. Tembani et al (2003:66) note that inadequate preparation for the supervisory role, a lack of resources and a lack of autonomy contribute to the problem.

The present researcher compared the workload of two clinic managers in the Thabo Mofutsanyana health district early in 2007 for the purpose of establishing an average patient load per clinic manager (see table 3.1).

Table 3.1 Workload of two clinic managers in the Thabo Mofutsanyana District, 2007

CLINIC A	Patients seen by clinic manager	Consulting days	Average daily patient load of clinic manager	Comments
January 2007	271	13 days	20	Manager on leave from 15–26/01/07. Manager was on duty only for 13 days.
February 2007	388	17 days	23	
CLINIC B				
January 2007	924	15 days	61	Administrative tasks and attendance of meeting 5 days
February 2007	820	11 days	74	Administrative tasks and attendance of meetings 6 days

A comparison of the workload of the two clinic managers indicated a large discrepancy in their workloads. In clinic A, the clinic manager saw an average of 22 patients per day, whereas in clinic B, the clinic manager saw an average of 68 patients per day. The two clinics rendered services to approximately the same number of patients per month.

However, the vast difference in the number of patients cared for by the clinic manager could be ascribed to the severe staff shortage in clinic B.

The clinic manager of clinic B was thus forced to see more patients, as patient care is a priority. Comparing the general management of the clinic, the management of clinic A is far better off than that of clinic B. Accordingly, during supervisory visits, the outcome of the assessment tools, the Red Flag and Regular Review, clinic A's overall performance was much better than clinic B's. This could be attributed to the fact that the clinic manager of clinic A did not consult the same number of patients. The researcher has confirmed that taking the number of workdays into consideration, the clinic manager of clinic B worked fewer days than the clinic manager of clinic A, but the clinic manager of clinic B consulted considerably more patients.

A professional nurse working at a PHC clinic in the Northern Cape described the workload of professional nurses in clinics (Thom 2005:117) as follows: "It sometimes gets to me when I realise that the following day will simply be a repeat and the next group of patients will be waiting for me. Nothing can be postponed. You have to just keep going." According to the nurse (Thom 2005:116), "There are so many people (in the public sector) who need us. We are very short staffed and there are so many patients, the need is great." Van Rensburg (1999:46) found the main constraints for most public facility and programme managers were staff shortage and a lack of management support. In a study in Region B of the Free State, De Wet, Ackermann and Crichton (2002:12) recommend investigating or re-investigating the patient load clinics have to carry, to enable the PHC worker to give each client the attention they need.

One of the consequences of unmanageable workloads is stress. Stress manifests itself in low morale, and rapid staff turnover with detrimental effects on service delivery (Ijumba 2002:187; Zondi 2003:7; Mabaso 2006:38). Van Wyk (2007:7) is of the opinion that stressful work conditions might contribute to poor mental health and nursing is most stressful in times of staff shortages. Too long working hours and unrealistic expectations contribute to high stress levels.

The literature review stressed that staff shortages in clinics contributed to a work overload that adversely affected the proper rendering of services to communities and affected the health and well being of health care personnel.

3.4.6 Inadequate management training

Tembani et al (2003:67) maintain that clinic managers are inadequately prepared for their managerial role. The supervisory role was emphasised, but management consists of much more than supervision. No orientation was given on what and how to supervise. There was a need for formal training to function effectively in their management roles. Ijumba (2002:190) points out that many clinic managers have no formal training in leadership and management. They work in isolated areas and are confronted with the reality of organising work and managing staff in the most difficult circumstances with for example, poor infrastructure and facilities, and a lack of proper material and human resources.

In a study of general provincial and private hospitals in KwaZulu-Natal, Minnaar (2001:20) found that nurses were taught to be nurturers and carers, but were not trained to be managers. According to Heunis et al (2006:42), most deficiencies and weaknesses in the implementation of PHC services pertain to those requirements with which most of the facilities did not comply. Services have to be implemented at a PHC level, but when there is a lack of proper management, services will not be delivered to reach the set objectives.

These deficiencies include:

- management
- client-held records
- protocols
- availability of stationery
- drugs
- supplies
- proper stock control.

According to Kroon's (1995) model, these requirements are part and parcel of the business capabilities and basic management process in the micro-environment which play an important role in effective and efficient service delivery. Rispel (1995:234) states that one of the greatest challenges in nursing is the development of supportive management styles that involve rank and file members in decision-making. All categories of personnel should be valued and practices should be encouraged that make best use of the skills and capacities of the personnel involved.

Strasser (1998:2) warns about the danger of assuming that management skills are innate and managers automatically dispose of managerial expertise. Inadequate training relating to role expectations of clinic managers is one of the factors resulting in them failing to perform their management function optimally.

3.4.7 Lack of resources

Inadequate resources especially personnel, transport, time, equipment and infrastructure resources, such as inefficient clinic buildings, lack of computers and lack of a proper communication system, prevent efficient performance of the management function (Ijumba 2002:194). In view of shortages of staff, clinic managers could not perform their managerial duties due to time constraints. For example, according to one professional nurse (Tembani et al 2003:67), "Checking the work performance of your subordinates, identifying their strengths and weaknesses, the knowledge and skills that they have, the knowledge and skills that they lack, you don't have time to do it."

The requirement for nurses to have increasingly complex clinical skills, such as the assessment of patients, prescribing and dispensing of medicine and termination of pregnancies, their widened scope of practice and the management of a number of new programmes contribute to the shortage of nursing staff. Some management functions such as financial accountability, budgeting and planning, were decentralised, while the high turnover of staff resulted in more demands on the remaining staff (Hall et al 2005:55). Lehmann and Makhanya (2005:137) point out that the responsibilities and workload of nurses increased dramatically, demanding a wide range of new skills from frontline providers, planners and managers. Within a short space of time health care employees and

the health system had to adapt to a completely new disease profile. The impact of the devastating effect of HIV/AIDS on the health system was that all other existing diseases were overshadowed by one crushing fatal disease.

Shortage of stock, equipment and infrastructure resources ranging from medical supplies and surgical stock to equipment, telephones and radiophones contribute to inefficiency. All these factors interfere with effective clinic management (Tembani et al 2003:67). Insufficient attention is also given to the implication of health sector reforms on human resources (Hall et al 2005:54). Staff shortages are of serious concern. Sanders (2003:57) stresses that a prerequisite for PHC services is that sufficient numbers of staff should be available.

In a comparison of the clinical competencies of nurses at local authority clinics of Bloemfontein who had done the one-year Advanced Diploma in Health Assessment, Diagnosis and Treatment, Louwagie et al (2002:34) found that “untrained” nurses (who did not do the course) scored significantly better for diabetic symptoms and clinical examination than the “trained” nurses. The results highlighted a lack of knowledge, bad habits, low commitment, shortage of equipment and the absence of standardised formats (for diabetes) as the main reasons for poor performance.

3.4.8 Lack of autonomy

Although clinic managers were given the responsibility of being in charge of clinics, they could not make independent decisions as they were expected to consult their supervisors or nursing service manager even for issues they perceived as trivial, such as rotation of professional nurses in the clinic from one PHC programme to another (Tembani et al 2003:67). In other words, they are known as “clinic managers”, but the authority to lead and control is not given to them. Thus, clinic managers do not fully participate in the management process.

3.4.9 Stress and human resources

Tembani et al (2003:67) and Uys (2004:31) indicate that the challenging and complex nature of the clinic manager's role causes them stress. A heavy workload and limited resources were noted as the main stressors. Uys (2004:3) asserts that effective support provided by supervisors has the potential to reduce illness, absenteeism and cost. In busy clinics, some professional nurses have a tendency of regular absenteeism. When a clinic is already experiencing a serious staff shortage, the absenteeism worsens the situation. In order to overcome the staff shortage, the services of a professional nurse from a nursing agency are used to fill the gap. As it is expensive to use professional nurses from agencies, expenditure increases.

Kraus (1999:12) emphasises the heavy workload in clinics in view of inappropriate human resource planning. PHC services were implemented without any enlargement of staff establishments. Kraus (1999:12) indicated that the staffing levels in district services were roughly half to a third of the recommended levels. In this study, the researcher found no newly recommended levels. The NDOH is not aware of any national norms nor does it have specific sources available for international norms (van den Bergh 2007:[sp]). Almost 60% of the health professionals in South Africa are nurses and midwives. The registered nurses to the population ratio is 1:233, which compares favourably with the recommended 1:500 of the WHO (Muller 1998b:4).

Kraus (1999:12) emphasises realistic staffing norms for health services by government, labour and professional councils, such as the SANC. The provincial DOH should have developed strategies to right-size staff establishments since the implementation of PHC as the basis of health care provision. These amended staff establishments should have been aggressively pursued at institutional, district, regional and provincial level with specific time frames (Kraus 1999:12). The vacancy rate for professional nurses in all categories of health services in the Free State is 28.3%; in other words, 0,31 professional nurses are in a post per 1000 people (FSDOH 2005:23). The fact that vacant posts could not be filled due to financial constraints contributes to the high vacancy rate. In addition, filling a vacant post is a time-consuming process. All the red tape of obtaining different people's signatures for approval of an appointment is a major reason for vacancies not being filled.

In a national survey of PHCs, Viljoen et al (2000:44) found no consensus among health managers on a realistic number of patients that could be consulted by an average professional nurse per day in a fixed clinic and CHC. Their answers varied from 20 to 35 patients per day. The survey did not indicate to whom “health managers” referred specifically. According to Lehmann and Sanders (2002:123), Kraus developed staffing norms for district personnel in various South African provinces. The researcher could however not trace these norms during the literature review.

The present situation raises the question whether staff establishments in the Thabo Mofutsanyana District are adequate. The workload of professional nurses in the Dihlabeng Local Area is the highest in the District – not because of vacancies in their staff establishment, but because professional nurses are taken from the clinical service to perform coordinator and supervisory functions at local area level (see Annexure H). No posts are allocated for co-ordinators on the staff establishment of a specific local area.

Clinic managers find the allocation of clinic staff to a clinic for a specific period and then relocating them to another clinic stressful. This practice is very demanding on clinic managers, as they have to keep on orientating new staff members to the clinic (Tembani et al 2003:68). Clinic managers in the Thabo Mofutsanyana Health District had the same experience, as the services of private agency nurses were used in PHC clinics to relieve staff shortages. Often these professional nurses had no experience of a PHC clinic. They had to be orientated and when they knew how the clinic operated, they had to leave due to factors like moonlighting while they were on vacational leave.

3.4.10 Attitudes of colleagues

In their study, Tembani et al (2003:65) found that the attitude of colleagues, local area managers, clinic supervisors and subordinates often induced stress in clinic managers. Clinic managers found it difficult to maintain discipline amongst subordinates and indicated that they could not obtain sufficient support from their clinic supervisors in dealing with subordinates with negative attitudes and behaviours. With reference to supervision, some

clinic managers alleged that supervision was like a policing or faultfinding exercise by the clinic supervisor.

All these problems and challenges experienced by the clinic managers were labour-related issues. This emphasises that when organisations, in this case PHC clinics, do not have adequate and effective human resources available, their management will not be efficient and consequently objectives cannot be reached. Adequate business capabilities are crucial to ensure that quality services can be rendered to the community.

3.4.11 Obtaining optimal clinic management

Regarding optimal clinic management, Tembani et al (2003:70) contend that first-level clinic managers should be relieved of clinical duties to enable them to plan, organise, monitor, evaluate and oversee activities in their clinics. The purpose of these managerial tasks is to achieve optimal performance and to equip the clinic manager with managerial experience and skills.

The DOH (2000:3) issued the *Handbook for Clinic/CHC Managers* to guide clinic supervisors and local area managers in clinic management. Tembani et al (2003:68) identify guidelines and activities to prepare, equip and support clinic managers to optimise clinic management.

3.4.12 Line management support

Strasser (1998:3) and Truman (1989:382) recommend supervisory visits by clinic supervisors to provide support to clinic managers. The DOH (2000:14) stipulates that clinic visits should be scheduled, objectives for each visit determined, a checklist used, records kept and timely feedback provided to the clinic manager. Zondi (2003:13) found that a lack of supervisory support was positively linked to burnout amongst nurses.

In the researcher's experience, local area managers, clinic supervisors and clinic managers find monthly meetings with clinic managers valuable to share problems. Planning can be done jointly and the best solutions sought for identified problems.

Progress in the implementation of the various PHC programmes is also discussed and where necessary, action plans to improve services discussed for implementation. Standard items on the agenda are the availability of resources, including adequate staff, sufficient equipment, and supplies and facilities.

Tembani et al (2003:69) emphasise that the availability of supervisory tools and resources contributes to the effectiveness of clinic management. The tools include supervisory checklists, a handbook for clinic managers outlining clinic functions and policies, performance appraisal tools, treatment guidelines and protocols.
These tools cover the four management processes of planning, organising, leading and control. For example, if no transport for the professional nurse in the clinic was available to render school health services, what did the clinic manager do to plan to organise transport? How did he/she support the professional nurse and how did he/she control whether a car was available or not?

The clinic supervisor should complete the supervisory tools monthly. A copy of the tool should be left with the clinic manager to do remedial action on identified deficiencies.

3.4.13 Community involvement and support

The importance of the supportive value of community participation, like the establishment of clinic committees, to participate in health matters such as community development and handling of patient complaints, should be emphasised. Not only would community participation contribute to ease the clinic manager's task, but clinic committees could support the clinic manager with problem solving (Tembani et al 2003:68). The WHO (1978) identifies community involvement as one of the principles of PHC (Mchunu & Gwele 2005:31). The clinic manager's checklist also indicates community involvement as one of the major areas that needs to be utilised and managed in a clinic (DOH 2000:4).

3.4.14 Availability of clear job descriptions

The fact that there is no position entitled "clinic manager" on the staff establishment of PHC clinics in the Free State results in a major problem with regard to proper clinic

management. It can be assumed that if there is no such position, it also does not have a proper job description. On the staff establishment, the professional nurse in charge of the clinic is identified as a “Chief professional nurse” (see chapter 2 pages 34 – 39 for extensive discussion of the job description of a clinic manager). It should be noted, however, that clinic managers’ job descriptions should be clear to be useful. Strasser (1998:23) emphasises that one of the difficulties experienced by clinic managers is the lack of a clear job description. It is important that the job description indicate the managerial duties of the clinic manager as well as the lines of communication and authority so that management of the clinic will be of a high standard to ensure the achievement of the set goals. To support clinic managers with their management function, it is important that all staff members should have relevant job descriptions of their positions, which relate to the mission and vision of the facility, the district and the province (DOH 2000:11).

3.4.15 Clear selection criteria

Selection criteria should be available for the position of clinic manager (chief professional nurse). Criteria for appointment should include relevant experience, for instance, 3 years of service in a PHC clinic, qualifications such as registered nurse, midwife, psychiatry, community health and nursing management, knowledge, and personal attributes such as leadership, good interpersonal relations, communication skills and being able to work under stress. Fowler (1995:36) holds that the successful completion of a relevant formally recognised course, such as a Diploma in Nursing Management, would contribute greatly to the management knowledge and skills of a person to be responsible for the management of a clinic. In the researcher’s view, this is debatable, as knowledge obtained is no guarantee of successful management, although such a qualification would provide the necessary theoretical foundation. At the same time, practical experience has shown that well trained people do not always apply their knowledge in the work situation.

3.4.16 Implementation of an orientation programme

In a PHC setting, the new clinic manager should be orientated by the clinic supervisor who is the direct supervisor. According to Tembani et al (2003:69), an orientation programme for clinic managers should cover the job requirements and job expectations of daily, weekly

and monthly duties, the physical layout of the clinic, and communication channels and structures. It is essential to formally introduce the newly appointed clinic manager to the clinic staff, clinic committee and community members in order to make the new manager feel more at ease and facilitate his/her functioning. The orientation programme is a planned, purposeful method, whereby employees are prepared for their work situation (Jooste 2001b:171; Hellriegel et al 2004:244).

3.4.17 Delegation of responsibility and authority

Tembani et al (2003:69) emphasise that delegation of responsibility and authority by the clinic supervisor and local area manager to clinic managers will assist in removing over-reliance on clinic supervisors and local area managers who in most cases visit the clinic once a month or seldom due to transport problems. The proper transfer of authority from a person vacating a post to the new registered nurse who will take over charge of the clinic should be in place (Tembani et al 2003:69). Roos (2001:133) maintains that when subordinates respect the manager and orders are fair, no problems will be experienced to implement these orders.

3.4.18 Preparation for a management role

In order to prepare a professional nurse for the position of clinic manager, a prospective clinic manager can act as an understudy to an experienced clinic manager for a fixed period in order to learn the realities of the job and build confidence (Hellriegel et al 2004:245). Clinic managers should at least have management skills, knowledge of PHC activities and programmes, health promotion, good interpersonal skills as well as the ability to manage and mentor their staff (Strasser 1998:2; Freed & Dawson 2006:45).

3.4.19 Review of training needs of clinic managers

The importance of in-service training for managers cannot be overemphasised. Tembani et al (2003:70) recommend training in the following:

- Resource planning and management, including financial planning and human resources planning and development
- Time management
- Stress management
- Labour relations
- Identification and utilisation of support systems.

Clinic managers are thus required to keep abreast of the rapid changes in health care through periodic training and updates (Tembani et al 2003:70).

3.5 THE PHC PACKAGE

The Department of Health launched two documents in 2001 to support the concept of PHC in South Africa. These documents are:

- *The Primary Health Care Package for South Africa – a set of norms and standards*.
- *A Comprehensive Primary Health Care Service Package for South Africa.*

These two documents are concise and comprehensive and will only be briefly introduced. Due to their extensiveness, it was not feasible to attach the two documents. For referral purposes, the documents can be obtained from the Department of Health at telephone number (012) 312-0055. Figure 3.4 summarises and illustrates the PHC programmes in South Africa.

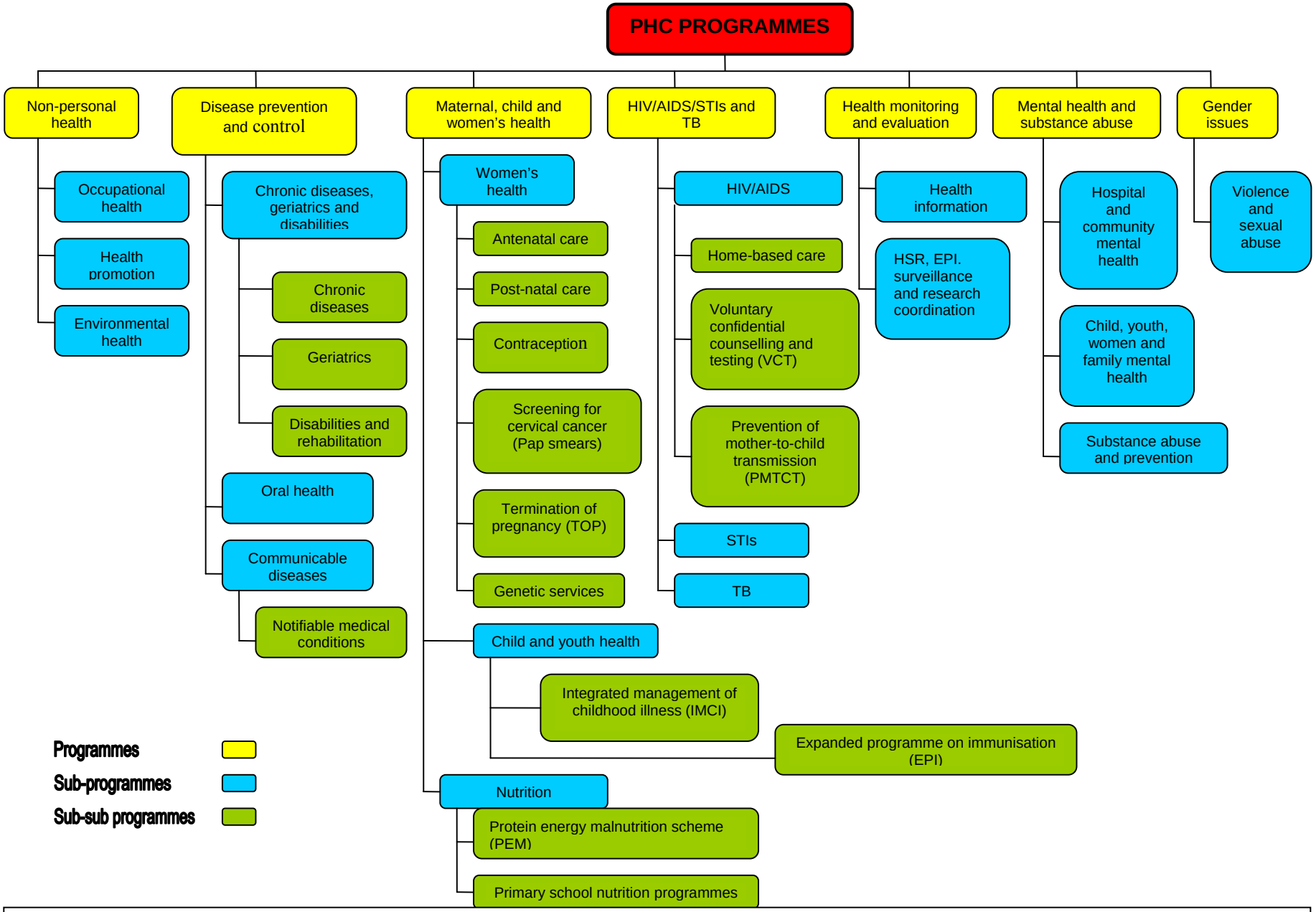

Figure 3.4 PHC programmes and clusters of programmes incorporated in the Comprehensive Primary Health Care Service Package for South Africa
Source: van Rensburg (2004:423)

Figure 3.4 illustrates the main PHC programmes as well as the various sub-programmes supposed to be rendered at PHC facilities. The PHC programmes are included in *The Primary Health Care Package for South Africa - a set of norms and standards* as well as in *A Comprehensive Primary Health Care Service Package for South Africa*.

Figure 3.5 illustrates the two sections of *The Primary Health Care Package for South Africa - a set of norms and standards*.

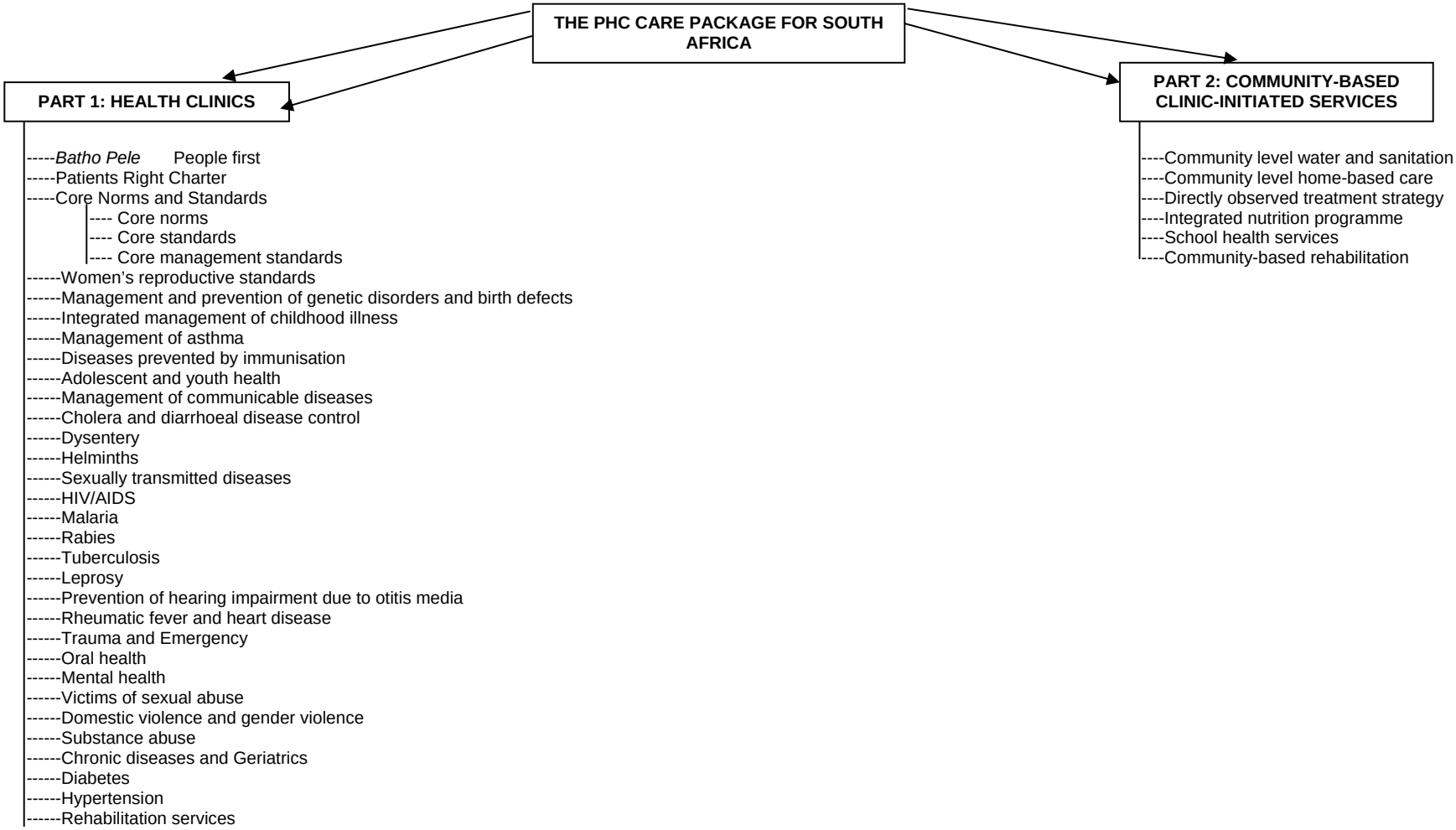

Figure 3.5 The composition of The Primary Health Care Package for South Africa – a set of norms and standards

3.5.1 Distinction between *The Primary Health Care Package for South Africa - a set of norms and standards* and *A Comprehensive Primary Health Care Service Package for South Africa*

In order to understand the contents of these two documents, it is necessary to discuss the differences between them.

3.5.1.1 The Primary Health Care Package for South Africa - a set of norms and standards

This document defines parameters for service delivery and describes the norms and standards required for quality service. It highlights the scope of the tasks of health providers in clinics and the range of skills required of them. It also lists detailed components of services for each section.

- **Definition**

The *PHC Health Care Package for South Africa - a set of norms and standards* serves as an integrated package of essential PHC services available to the entire population of South Africa. This document provides the solid foundation of a single, unified health system promoting quality health care and makes it possible for the people of South Africa to take cognisance of what quality of PHC services they can expect (DOH 2001a:5).

The goal of the document is to establish national norms and standards as a move towards equity in the provision of PHC services. The purpose is to reduce the gap between those who do and those who do not have access to an appropriate level of care. The implementation of this package envisaged that services should be available, affordable and accessible to the entire population.

- **Norms and standards**

Norms and standards are related to quality management. As the Department of Health strives towards quality services for all, norms and standards play a vital role in the

rendering of PHC services (Heunis et al 2006:38). The Minister of Health, Dr ME Tshabalala-Msimang refers to equity and access of health care as the fundamental principles underpinning the transformation of health services in South Africa (DOH 2001a:2).

The *Primary Health Care Package for South Africa - a set of norms and standards* contains the norms and standards pertaining to health services that should be available at PHC clinics. The document consists of two parts. Part 1 consists of norms and standards for health care clinics pertaining to principles of service delivery and specific discipline- or disease-related services that should be rendered at PHC clinics, while Part 2 consists of norms and standards for community-based clinic-initiated services in view of their quality. These services include community water and sanitation, community home-based care, DOTs, and the integrated nutrition programme (INP), school health services and community-based rehabilitation. Although clinics per se are not responsible for water and sanitation, these services are regarded as PHC services executed by environmental health practitioners.

- **Definition of norms and standards**

The Primary Health Care Package for South Africa - a set of norms and standards (DOH 2001a:7) defines norms and standards as:

- A **norm** is a statistical normative rate of provision or measurable target outcome over a specific period of time.
- A **standard** is a statement about a desired and acceptable level of care.

The various components of comprehensive PHC services are described in *A Comprehensive Primary Health Care service package for South Africa*. Norms and standards for each component are described in *The Primary Health Care Package for South Africa - a set of norms and standards*. These norms and standards are derived from existing national policy documents and other authoritative sources, such as the WHO and research done in this country.

When interpreting these norms and standards, two important issues need to be taken into account in a local setting, namely

- Role of national and provincial health authorities
- Staff competency (DOH 2001a:7).

The set of norms and standards is about **what** services at **what** standards are required. It does not specify clearly **how** the services should be provided, but it serves as a guideline. It is for provinces and local government to decide in the light of local circumstances how these services should be rendered to the community. Provincial and local government had to sharpen up these standards with verifiable time-limited measures based on existing performance by service providers and anticipated improvements (DOH 2001a:7). Many standards are related to staff competency. It is the responsibility of the clinic manager to rectify any deficits identified in themselves and their staff during service rendering, by providing and attendance of appropriate training.

To provide the same services in different environments, different kinds of facilities would be required, such as the use of mobile clinics in remote rural areas compared to polyclinics in high-density urban areas. Because of these differences, the documents could not offer national standards on facilities and staffing.

- **Development of the PHC package**

The Centre for Health Policy of the University of the Witwatersrand and the CHSRD of the Free State University developed the document, *The Primary Health Care Package for South Africa - a set of norms and standards,* at the request of the National Department of Health.

Literature reflected the priority programmes, which needed to be protected, as follows (DOH 2001b:7):

- Child health, in particular infectious diseases
- STDs and AIDS
- TB
- Reproductive health: ante-natal, family planning and maternity
- Mental health
- Chronic diseases (hypertension, diabetes, asthma)
- Trauma and injuries
- Disabilities.

The initiative to create a package of PHC services was taken at national level, but the development of the initial version of the package was built on work carried out in some provinces (DOH 2001b:8). Suggestions and comments received from the provinces involved were integrated to create the package for implementation in PHC clinics. The package was developed using a service-based rather than a programme-based approach. The aim was to define services per level of facility in order to ensure maximising integration of services as stipulated by the National Health Plan (DOH 2001b: 8).

As experts, the Centre of Health Policy relied on consultations while the Gauteng Health Department was involved in lengthy consultation with provincial and local authority officials (DOH 2001b:8). Consultation workshops were held in eight (8) provinces and comments, suggestions and recommendations from these workshops were integrated in the final document (DOH 2001a:9). Consultation at grass root levels took place in Gauteng and the Free State with health service managers, frontline providers working in mobile clinics, clinics and community health centres. Urban, peri-urban and rural areas were covered and clinics of local authorities and provincial services were contacted. Due to resource limitations, it was envisaged that the package would be phased in over time (DOH 2001b:7).

The Minister of Health, Dr ME Tshabalala-Msimang appealed to healthcare workers to assess the performance of clinics against the standards described in the document *The Primary Health Care Package for South Africa - a set of norms and standards* and to develop plans to address the shortfalls (DOH 2001a:2). These norms and standards were

derived from existing national policy documents and other authoritative sources such as the WHO and research done in South Africa. Attempts were made to ensure that the standards in the document are practical, essential and comprehensive, and describe the range of services that should be available in clinics to all citizens.

3.5.1.2 A Comprehensive Primary Health Care Service Package for South Africa

This document explains the comprehensive services that will contribute to social justice and promote equity by reducing the gap between those who have access to an appropriate level of care and those who do not (DOH 2001b:7). The document outlines all protocols regarding service delivery, including the category of patients who will be visiting the clinic, the frequency of visits and which actions should be performed during the visit. This is related to the systems approach and specifically to the processes that should take place to achieve the set goals.

The document, *A Comprehensive PHC Service Package for South Africa* (DOH 2001b) firstly entails a standardised comprehensive 'basket' of services to be delivered at PHC level that may include preventive and promotive as well as basic curative and rehabilitative services. In South Africa, PHC delivery was formerly strongly based on a vertical approach but due to the implementation of the PHC approach, the principles of a comprehensive service package envisage an organisation of services that allows for a one-stop approach. The PHC package provides guidance on which services should be available at different levels of care (van Rensburg 2004:422; Heunis et al 2006:39).

The National Department of Health (NDOH) as well as the provincial Departments of Health, health workers and communities can apply the *Comprehensive Primary Health Care Package* for the following purposes:

- Negotiating budgets for PHC
- Planning for moving towards comprehensive services
- Planning for the integration of non-personal services
- Monitoring the move towards comprehensive PHC services away from a curative-based health service

- Assisting health workers to identify the scope of services to be delivered
- Assisting communities regarding health services that can be expected.

The *Comprehensive Primary Health Care Package for South Africa* comprises three different types of services:

- District/community-based services
- Fixed clinics
- CHCs.

Figure 3.6 illustrates the levels of services rendered in the *Comprehensive PHC service package for South Africa.*

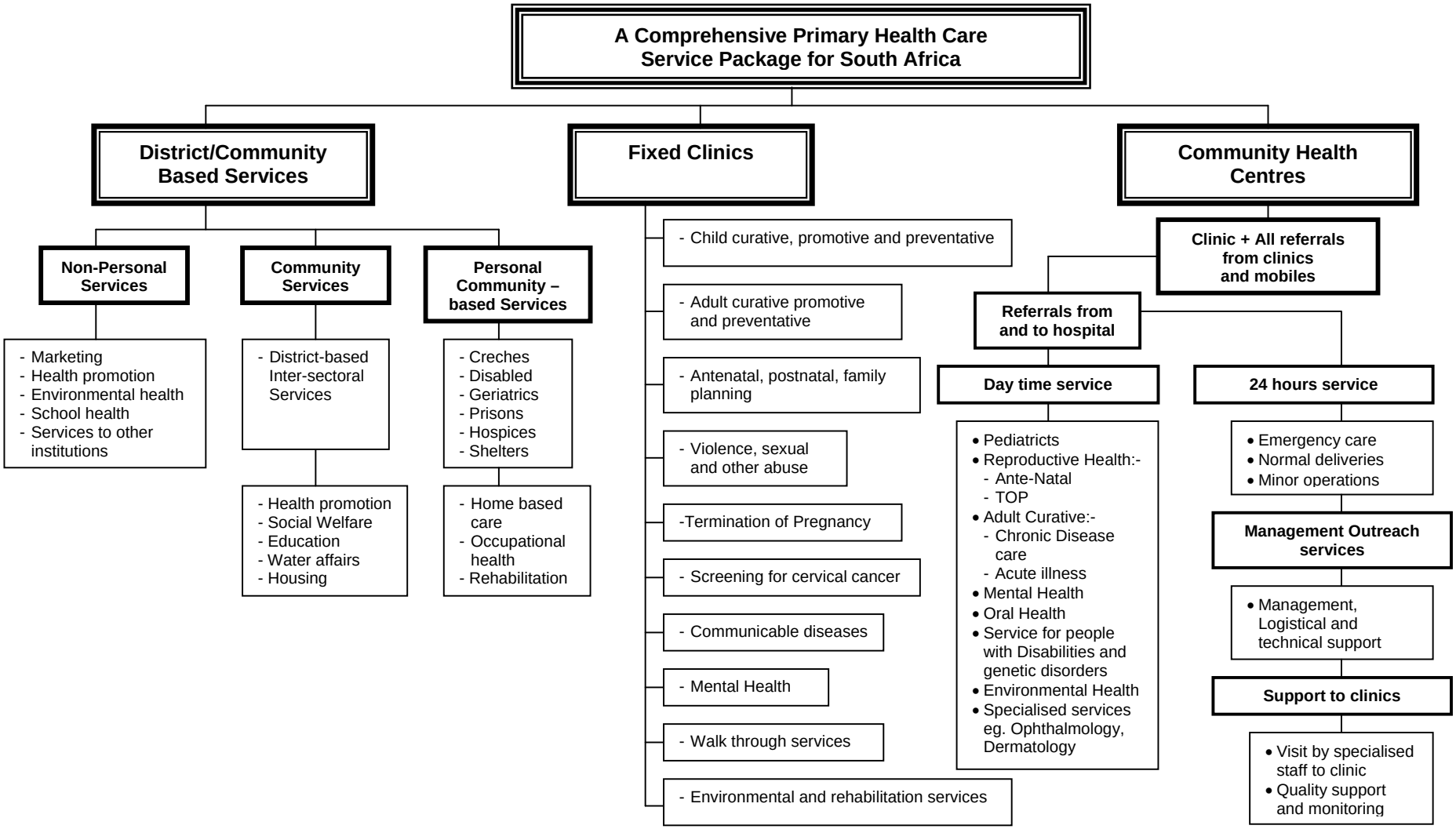

Figure 3.6 A diagrammatic illustration of the compilation of the Comprehensive Primary Health Care Package of South Africa

Source: DOH (2001b:11)

The *Comprehensive Primary Health Care Service Package for South Africa*

The *Comprehensive Primary Health Care Package Service Package for South Africa* (DOH 2001b) covers the district- or community-based services, fixed clinics, and CHCs.

- **District/community-based services**

  - *Non-personal services*

These services include environmental health services, health and school health services. Clinic staff renders school health to children at the schools.

  - *Community services*

In the pursuit of equity, it is essential that these services, such as health promotion, social welfare, education, water affairs and housing, be planned at a district level.

  - *Personal community-based services*

Health services are rendered according to needs, groups and organisations in the community, for example crèches, disabled people, prisons, hospices and shelters.

- **Fixed clinics**

A professional nurse renders these services. Services at clinics are defined by the level of skills of the staff and not by the size of the clinic. This implies that even small clinics in a remote rural area can render specialised services. For example, an advanced midwife can conduct complicated deliveries successfully based on her skills.

A clinic is a facility of varying size, staffed by nurses that delivers a variety of services stipulated in the *Comprehensive Primary Health Care Package of South Africa* (DOH 2001b:9), for eight hours a day during the week to its catchment population. The catchment area should ideally be within a radius of 5 kilometres from the clinic. Such clinics may or may not have the services of a doctor. Some clinics are equipped to render maternal and obstetrical services on a 24-hour basis (van Rensburg 2004:432).

Additional services rendered at clinics could be visits by doctors, staff of the rehabilitation programme, ophthalmologists and oral health. The *Comprehensive Primary Health Care Package for South Africa* emphasises the importance of the availability of these services in very remote rural areas where community health centres/hospitals may be non-existent or very distant (DOH 2001b:9).

Various services are rendered from a fixed clinic, for example child health care with the aim on curative, promotive and preventative services. Figure 3.6 illustrates the variety of programmes implemented in a PHC setting.

- **Community health centres**

Some areas do not have CHCs at their disposal. The proposed organisation of a CHC suggests that a CHC be structured with three components:

- A clinic for the local catchments area
- A referral section with specialists
- A 24-hour unit with maternity and casualty services.

The CHC referral or outreach section should visit the clinics in its local area to hold clinical sessions to offer training, execute audits and to support staff. These visits would decrease the number of referrals to secondary services and will increase the quality of care at local level. Local hospitals could take over this function where CHCs do not exist (DOH 2001b:10). Clinics are thus subordinate to CHCs as for example, the services of a full-time medical doctor, advanced midwives, social worker, and dietician should be available.

- **Referral mechanism**

To avoid overloading of CHCs by seeing the CHC as a centre for excellence, it was suggested that patients visiting the referral section in the CHC, would also obtain a referral letter from the clinic. Those patients visiting the referral section of the CHC directly will have to go to the clinic section of the CHC, where the need for referral will have to be assessed (DOH 2001b:10).

Referral down from the CHC to the clinic should be accompanied by a letter indicating the diagnosis of the patient and the way forward with the patient. Serious cases will be referred directly from the clinic to the hospital without referral to the CHC.

It will now be necessary to look at the value these documents hold for the clinic manager.

3.5.2 Value of *The PHC package for South Africa - a set of norms and standards* and *A comprehensive PHC service package for South Africa* for the clinic manager

The question can be posed whether the abovementioned documents contribute to the management task of a clinic manager. These two documents support the clinic manager on the following as illustrated in Table 3.2.

Table 3.2 Support to clinic managers by *The PHC Package for South Africa – a set of norms and standards* and *A comprehensive PHC service package for South Africa*

The PHC Package for South Africa – a set of norms and standards	*A Comprehensive Primary Health Care Service Package*
• A set of norms and standards is available on service rendering, explaining clearly to the clinic manager what should be adhered to when rendering services. • The set of norms and standards support clinic managers with supervision, to enable them to assess the services according to the norms and standards.	• Support with identified requirements in terms of - Staffing - Infrastructure - Equipment - Financial resources - Negotiating an appropriate budget

3.6 CONCLUSION

This chapter discussed the literature review conducted for the study with regard to the objectives of the study. The following was discussed:

- The historical overview
- The development of a DHS

- PHC
- The functioning of the clinic manager
- Obtaining optimal clinic management
- The PHC Package.

Chapter 4 covers the research design and methodology.

CHAPTER 4

Research design and methodology

4.1 INTRODUCTION

This chapter describes the research design and methodology used for the study, including the population, data-collection instrument, data collection and analysis, and ethical considerations. According to Polit and Beck (2006:504), the steps, procedures and strategies for gathering and analysing data in a research investigation are the methods of research.

4.2 RESEARCH DESIGN

The research design is a plan or blueprint of how the research will be conducted (Mouton 2001:55; Polit & Beck 2006:55). The research design focuses on the end product and the logic of research methodology (Mouton 2001:56; Uys 2004:41). For this study, the researcher selected a quantitative, exploratory, descriptive and contextual design.

4.2.1 Quantitative

Quantitative research is conducted within the context of previous knowledge. A literature review is conducted before any data are collected, as a quantitative researcher strives to understand what is already known about the topic (Polit & Beck 2006:55).

Quantitative research relies primarily on the collection of quantitative (numerical) data (Johnson & Christensen 2000:17; Polit & Beck 2006:36). Johnson and Christensen (2000:19) point out that quantitative researchers operate under the assumption of objectivity and claim to be objective when they do their research. Quantitative researchers reduce measurements to numbers, by using rating scales to measure attitude. A five-point Likert scale, with the response alternatives of (1) Strongly disagree, (2) Disagree, (3) Neutral, (4) Agree, and (5) Strongly agree, serves as an example. At the end the researcher calculates and reports an average for the group of respondents (Johnson &

Christensen 2000:20). The questionnaire used as data-collection instrument contains questions based on the principal of a point scale.

This study was quantitative as the aim was to identify the different factors influencing the role of a clinic manager in a PHC setting. The factors or variables included non-nursing tasks, workload of professional nurses, and absenteeism. The numerical data was used to substantiate the factors affecting effective clinic management in PHC clinics in the Free State.

4.2.2 Exploratory

Exploratory research explores the dimensions of a phenomenon or develops or refines a hypothesis about relationships between phenomena (Polit & Beck 2006:5).

This study was exploratory, as it would provide new knowledge on a perceived problem. The study was expected to provide new knowledge regarding factors that influence a clinic manager's role in a PHC setting.

4.2.3 Descriptive

According to Johnson and Christensen (2000:302), the purpose of descriptive research is to provide an accurate description of the situation. Polit and Beck (2006:498) describe the main objective of descriptive research as the accurate portrayal of the characteristics of persons, situations, or groups, and/or the frequency with which certain phenomena occur. This study was descriptive as it was aimed at the role of a clinic manager in a PHC setting. The findings would provide clinic managers' perceptions and experience of their roles and describe the existing situation of clinic managers.

4.2.4 Contextual

The study was conducted in a PHC setting in a specific geographical area, namely the Free State province. South Africa consists of nine provinces, each with a number of districts, consisting of local municipalities. These local municipalities are also known as

local areas. In the Free State, there are five districts: Motheo, Lejweleputswa, Fezile Dabi, Thabo Mofutsanyana, and Xhariep.

Each district comprises a number of local municipalities. Figure 4.1 indicates the districts and the number of fixed clinics in each district. For example, *Thabo Mofutsanyana* district comprises the following local municipalities: Setsoto, Dihlabeng, Nketoana, Phumelela and Maluti-a-Phofung. *Fezile Dabi* district comprises Moqhaka, Nqwathe, Metsimaholo and Mafube. *Lejweleputswa* district comprises Masilonyana, Tokologo, Tswelepele, Matjhabeng and Nala. *Xhariep* district comprises Letsemeng, Kopanong and Mohokare. *Motheo* district comprises Naledi, Mangaung and Mantsopo. The borders of the districts and their local municipalities were determined politically. This study focused on the five districts of the Free State Province with their various local municipalities and 223 fixed clinics (see table 4.1).

Table 4.1 Number of fixed clinics per district in the Free State

Districts	Thabo Mofutsanyana	Fezile Dabi	Lejwele-putswa	Xhariep	Motheo	Total
Clinics	65	33	45	17	63	**223**

Table 4.2 indicates the population per district (FSDOH 2007a:7).

Table 4.2 Population per district in the Free State

District	Population
Thabo Mofutsanyana	738,328
Fezile Dabi	487,971
Lejweleputswa	762,858
Xhariep	132,070
Motheo	736,292
TOTAL	**2 857,519**

Source: DOH (2007a:7)

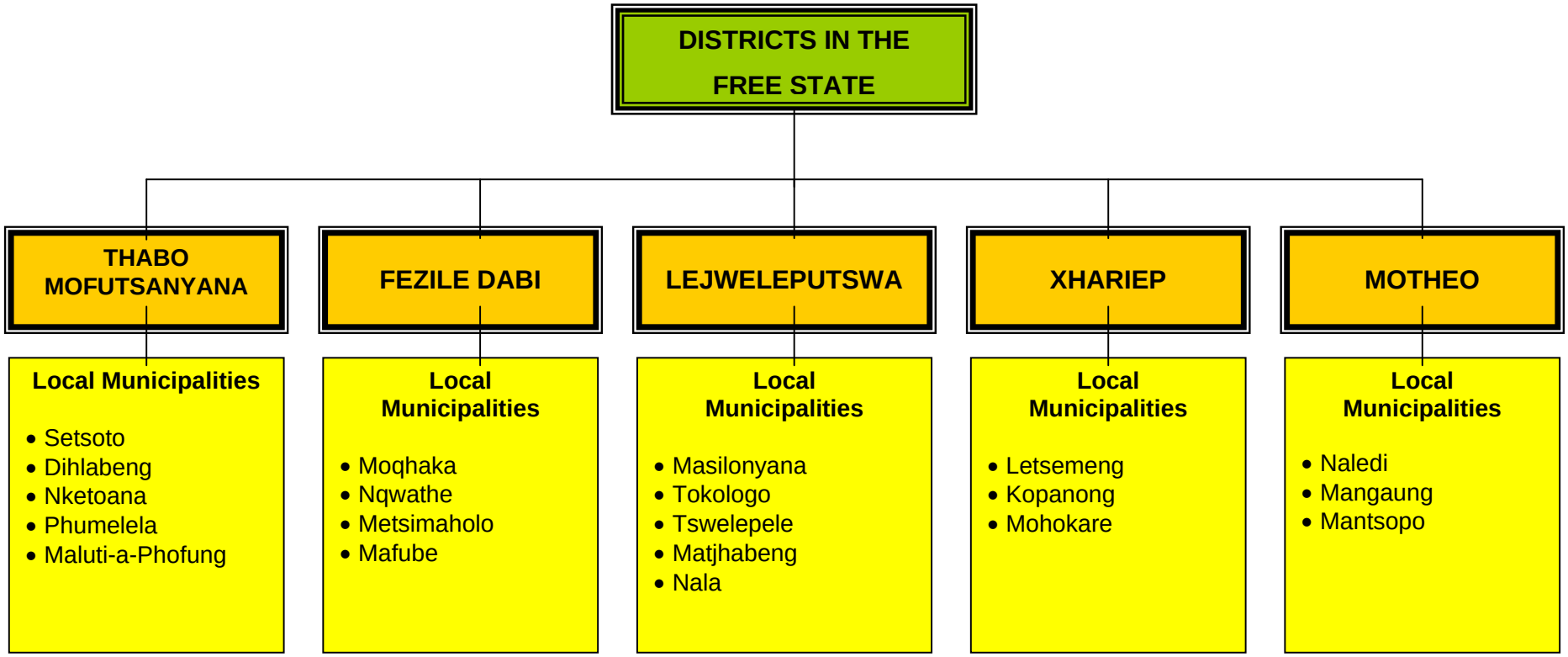

Figure 4.1 Composition of the districts in the Free State

4.3 POPULATION

The population includes all the elements (individuals, objects or substances) that meet certain criteria for inclusion in a given universe (Burns & Grove 2001:47; Polit & Beck 2006:56). For the purposes of this study, the population referred to clinic managers, the persons in charge of a clinic, whose responsibility it was to manage a specific fixed PHC clinic within the context of the Free State Province. There were 223 clinics thus providing a total population of 223 for this study.

Only clinic managers of fixed clinics were selected because of the difference in managerial functions between mobile and fixed clinics, such as the span of control, which includes human resources management. The inclusion criteria stipulated that a professional nurse in charge of a fixed clinic, irrespective of the size of the clinic, be included in the study.

4.3.1 Sampling

Burns and Grove (2001:365) describe *sampling* as the selection of a group of people, events, behaviours or other elements with which to conduct a study. Polit and Beck (2006:508) refer to sampling as "the process of selecting a portion of the population to represent the entire population".

4.3.2 Sampling method

For the purposes of this study, stratified random sampling was used.

- **Random sampling**. Polit and Beck (2006:508) define random sampling as the selection of a sample such that each member of a population has an equal probability of being included.

- **Stratified random sampling**. Polit and Beck (2006:511) describe stratified random sampling as the random selection of study participants from two or more strata of the population independently.

The aim of stratified sampling is to enhance representativeness (Babbie 1998:218). In stratified sampling, the researcher divides the population into sub-populations. All the fixed clinics in the Free State Province were divided into sub-populations according to the size of the staff establishment of the clinics. The staff establishment includes all categories of staff, for example professional nurses, auxiliary nurses, clerks and cleaners. After dividing the population into sub-populations, a random sample was selected from each sub-population (Neuman 1997:212). For stratified random sampling, the most common procedure is to group together those elements that belong to a sub-population and to select randomly the desired number of elements (Polit & Hungler 1997:231).

To obtain representativeness, out of the total of 223 fixed clinics in the Free State, 60% were selected by stratified random selection. Stratification divided the smaller and larger clinics into the following categories:

- small clinics (0 - 5 staff members)
- medium clinics (6 - 10 staff members)
- large clinics (11 - 20+ staff members)

A total of 135 clinic managers were therefore involved in the study, representing the sizes of the clinics as follows (table 4.3):

Table 4.3 Strata into which the clinics were divided

Clinic staff establishment size	Number of clinics
0 – 5	45
6 – 10	45
11 – 20+	45
TOTAL	**135**

4.3.3 Inclusion criteria

Only clinic managers and acting clinic managers were included in the study. The reason was to ensure that professional nurses who ought to be knowledgeable about the management of PHC clinics completed the questionnaire. However, no limit was put on the period of being in the position of clinic manager.

4.4 DATA-COLLECTION INSTRUMENT

To collect data in a structured manner, a researcher has to develop a data-collection instrument if an existing one, which answers the research questions, is not available (Uys 2004:46). According to Polit and Beck (2006:294), structured quantitative approaches to collect data are appropriate when researchers know in advance exactly what they need to know. Therefore, researchers can frame appropriate questions to obtain the needed information.

A formal, written document to collect data is known as an *instrument*. The instrument is a *questionnaire* when respondents complete the instrument themselves in writing (Polit & Beck 2006:508). Babbie (2001:239) describes a questionnaire as “an instrument specifically designed to elicit information that will be useful for analysis”.

4.4.1 The questionnaire as data-collection instrument

For this study, a questionnaire was selected as data-collection instrument because the population was dispersed over the whole Free State. It was more convenient and cost effective to distribute a questionnaire, which would be returned to the researcher by mail, than, say, personal interviews, which would entail travelling long distances and be time-consuming and very costly.

4.4.1.1 Advantages of a questionnaire

Using a questionnaire for data collection had several advantages. The respondents could complete them at a time that suited them. They were anonymous so the respondents did

not feel that their responses would disadvantage their position in the work environment. The questions were mostly structured and consistent, but open-ended questions were included to enable the respondents to expand on certain items. The absence of an interviewer ensured that the respondents reacted to the questions themselves rather than to the interviewer (Polit, Beck & Hungler 2001: 269). The respondents had more time to weigh the issues carefully before responding (McKenna, Hasson & Keeney 2006: 267).

4.4.1.2 Disadvantages of the questionnaire

The clinics in the Free State Province were included in the study by means of stratified random selection; therefore the study population was spread over a vast geographical area. This resulted in delays in receiving the completed questionnaires in time. All the questionnaires were first sent to a central post office in Bloemfontein, before being delivered to the researcher's postal address. The date for submission was extended by two weeks to cover the late return.

Some respondents were reluctant to complete the questionnaires and the researcher had to make several follow-up telephone calls to local area managers who had assisted with the distribution of the questionnaires in their specific local areas. Some questionnaires were received after the calls.

4.4.2 Development of the data-collection instrument

The questionnaire (see Annexure I) was constructed as follows:

- A covering page with instructions to the clinic manager of the selected clinic
- Section A: Biographical information (questions 1-8)
- Section B: Planning functions (questions 9-17)
- Section C: Organising functions (questions 18-47)
- Section D: Leading functions (questions 48-64)
- Section E: Controlling functions (questions 65-77).

The items were coded to ensure that the responses could be captured by a computer. Structured questions were developed with a varying number of response alternatives from which the respondents had to choose the most appropriate ones according to their personal view or experience.

4.4.3 Validity and reliability

It is essential for a data-collection instrument to comply with the requirements of validity and reliability.

4.4.3.1 Validity

Validity refers to the potential of the instrument to measure what it is intended to measure (Polit & Beck 2006:512). The literature review and the researcher's practical experience served as the basis for content validity. The instrument was submitted to two clinic supervisors, who were formerly clinic managers, for comment. Both supervisors interpreted the questions the same.

The sample of PHC clinics was homogenous as they all delivered PHC services to the community. To ensure representativeness during sample selection, the clinics were divided into strata according to the number of staff on the staff establishment (see table 4.3).

Four types of validity exist, eg. face validity, content validity, criterion-related validity and construct validity. For the purposes of this study face and content validity were observed.

- **Face validity** refers to whether the instrument appears to measure the appropriate construct (Polit & Beck 2006:328). Face validity was applicable to this study as the clinic managers' input indicated that the questionnaire measured what it was intended to measure. Face validity was ensured by submission of the instrument to the promoters, statistician and clinic managers.

- **Content validity** refers to the degree to which the items in an instrument adequately represent the universe of content of the concept being measured (Polit & Beck

2006:497). The important question is: how representative are the questions of all the questions that might be asked on this topic? In this study, the focus was the role of the clinic manager and the management process, both these components were extensively covered in the literature review, and served as the basis of the questionnaire.

- **Criterion-related validity** refers to the establishment of a relationship between scores on an instrument and an external criterion. It considers the extent to which items in a questionnaire measure the real-world conditions or events they are intended to measure. This type of validity can be assessed by comparing questionnaire responses (Murphy-Black 2006:375).

- **Construct validity** is described as the degree to which an instrument measures the construct under investigation (Polit & Beck 2004:714).

4.4.3.2 Reliability

Polit and Beck (2006:508) define reliability as "the degree of consistency with which an instrument measures the attribute it is designed to measure". The aim of the pre-test is also to test reliability. A pre-test of the instrument found that the questions were clear and no changes were necessary. During the data analysis the Cronbach alpha measured scientific reliability (Polit & Beck 2004:715).

4.4.4 Pre-testing of the instrument

According to Polit and Beck (2006:296), a pre-test is a trial run to determine whether the instrument is useful in generating desired information. Researchers pre-test their data-collection instruments to assess their adequacy (Polit & Beck 2006:56).

The researcher pre-tested the instrument with nine clinic managers before it was distributed to the selected sample. The clinic managers involved in the pre-test did not participate in the main study. A letter was submitted to the clinic managers selected for the pre-test to request their support (see Annexure J). The pre-test wished to determine the

time required to complete the questionnaire, to eliminate ineffective questions, and to add any relevant questions that might have been omitted.

It was found that it took an average of forty-five minutes to complete the questionnaire, but the respondents involved in the pre-test were of the opinion that it was due to the extensiveness of the questions. Nobody felt that questions should be omitted to shorten the instrument. No corrections had to be made to the contents of the questionnaire. All the clinic managers involved in the pre-testing found that the questionnaire was applicable to their circumstances, roles and functions in the clinic.

4.5 DATA COLLECTION

Data collection refers to gathering information to address a research problem (Polit & Beck 2006:498).

The questionnaire was accompanied by:

- A letter from the researcher requesting the clinic manager to complete the questionnaire (see Annexure K).
- Letter of approval from the Head of Health of the Free State Department of Health to conduct research in PHC clinics in the Free State (Annexure M).

The local area managers were requested to distribute the questionnaires to the clinic managers of the clinics they were responsible for. The district managers and local area managers were requested to commit their support to the study in order to ensure a high response rate from clinic managers.

Self-addressed envelopes were included with the questionnaires to ensure their return to the researcher on completion. Questionnaires did not have to be returned via the supervisor as the respondents were requested to mail it on completion.

The questionnaires were numbered in the right-hand top corner according to the size of the staff establishment to enable the researcher to control the stratified random selection. No

name of any clinic was visible on the questionnaires. This contributed to the principle of anonymity.

The contents of the questionnaire were extensive, but the reason was explained in the letter of introduction and during the presentation to prevent respondents' possible negative attitude towards the questionnaire. The questionnaire was comprehensive to ensure that no relevant factors affecting the clinic managers' tasks and roles were omitted. Since clinic managers are already overloaded, the researcher emphasised the importance of their knowledge and valuable contribution to the research.

4.6 PERMISSION TO CONDUCT THE STUDY

Before commencing the study, the researcher requested permission from the Head of Health of the Free State Department of Health in writing to conduct the study in the PHC clinics of the Free State (see Annexure L). The research proposal and the provisional data-collection instrument accompanied this request.

Upon approval by the Head of Health of the Free State Department of Health (see Annexure M), a letter was submitted to the General Manager of District Health Services in the Free State to present the proposed study at an extended provincial DHS meeting (see Annexure N). All the district managers and local area managers of the Free State are represented at such meetings. Permission was granted and the general manager wrote a letter to the district managers and local area managers to support the researcher (see Annexure O).

The researcher requested the district and local area managers' cooperation with the study and the distribution of the questionnaires. All the district managers and local area managers responded positively and were willing to distribute the questionnaires.

4.7 DATA ANALYSIS

According to Polit and Beck (2006:57), quantitative data is analysed by means of statistical analysis. To prepare for data analysis, data should be processed and managed in an

orderly fashion. Researchers prepare for analysis by coding, which is the process of translating data into numeric form. Another preliminary step involves the transferring of data from written forms to computer forms, which enhances the process of data analysis. Descriptive statistics, containing frequencies and percentages, were applied in the data analysis.

Descriptive statistics are usually calculated using a computer (Burns & Grove 1993:478). Descriptive statistics include *mean, median* and *standard deviation*. *Mean* is the "average" score and the *standard deviation* is the "average" difference (deviation) score (Burns & Grove 1993:478). Nieswiadomy (2002:244) defines descriptive as those statistics that organise and summarise numerical data gathered from populations and samples. Descriptive statistics allow researchers to examine the characteristics, behaviours and experiences of study participants (Nieswiadomy 2002:245). In this study, *inferential statistics* were used for the correlations. Inferential statistics are concerned with populations and assist researchers to determine whether the difference found between two groups is a real difference or only a chance difference that occurred because an unrepresentative sample was chosen from the population. Inferential statistics are used to determine that the likelihood that the sample chosen for a study is representative of the population (Nieswiadomy 2002:244).

A professional statistician analysed the data, using the Statistical Programme for Social Science (SPSS) version 14.0.

4.8 ETHICAL CONSIDERATIONS

Ethics imply that anyone involved in social scientific research should be aware of agreements shared by researchers and participants in the conduct of the research in order to protect participants against danger, harm, physical and mental discomfort and exploitation (Babbie 2001:470).

In this study, the following ethical considerations applied:

- **Voluntary participation**

Voluntary participation implies that respondents are freely willing to participate in the research. In this study, the participants were asked to participate by means of an introductory letter attached to the questionnaire.

- **No harm to participants**

According to Polit and Beck (2006:87), respondents should not be subjected to unnecessary risks of harm or discomfort. Their participation must be essential to achieving scientific and socially important aims that could not otherwise be realised. In research, *harm* and *discomfort* can be physical, emotional, social or financial.

In this study respondents were not confronted with situations where participation could result in injury, death or undue distress.

- **Anonymity**

Johnson and Christensen (2000:83) state that anonymity means that the researcher does not know the identity of respondents. According to Mouton (2001:243), respondents have a right to remain anonymous, which should be respected.

To ensure anonymity, no names were recorded on the questionnaires. In the pre-test, the researcher knew that the respondents were from a specific district, but no names were indicated on the questionnaires either.

- **Confidentiality**

Confidentiality is a pledge made to respondents that any information they provide will not be publicly reported or made accessible to parties not involved in the research (Polit & Beck 2006:95). Johnson and Christensen (2000:83) add that confidentiality means that the

respondent's identity, although known to the research group, is not revealed to anyone other than the researcher and his or her staff.

It is essential for research that confidentiality be maintained throughout the research process (Polit & Beck 2006:91). In this study, the questionnaires were numbered at the top, but the respondents' responses could not be linked to their identities.

- **Right to self-determination**

Respondents have the right to decide whether they want to continue with the research. They can inform the researcher at any time that they are not willing to participate any longer with the research (Polit & Beck 2006:88; Polit & Beck 2006:510; Johnson & Christensen 2000:81). No respondent was forced to complete the questionnaire, although the researcher did follow-ups telephonically and electronically to the respective local area managers who distributed the questionnaires to remind the respondents about the submission of the questionnaire.

- **Informed consent**

Respondents should have adequate information regarding the research to enable them to consent or decline participation (Polit & Hungler 1997:134; Polit & Beck 2006:93; Johnson & Christensen 2000:75). Polit and Beck (2006:93) point out that researchers seldom obtain written informed consent when the primary means of data collection is through self-administered questionnaires. Generally, *implied consent* is assumed. The assumption is that the return of the completed questionnaire reflects the respondent's voluntary consent to participate.

When discussing the study with the district managers and local area managers of the Free State, the researcher informed them of the purpose of the study; type of data that would be collected; sampling process; data-collection procedures, and potential benefits for the respondents and the health service, and promised confidentiality and respect for privacy.

4.9 CONCLUSION

This chapter described the research design and methodology, including the population, sampling and sample, data-collection instrument, data collection and analysis, validity and reliability, and ethical considerations.

Chapter 5 discusses the data analysis and interpretation.

CHAPTER 5

Data analysis and interpretation

5.1 INTRODUCTION

This chapter discusses the data analysis and interpretation.

The objectives of the study were to

- Determine the current role expectations of a clinic manager in a PHC setting.
- Identify factors determining and influencing the role of clinic managers in a PHC setting.
- Determine what effect current role expectations of a clinic manager have on the management of services rendered at a PHC clinic.
- Establish developmental needs of clinic managers to enable them to fulfil their role expectations.
- Identify realistic role expectations of a clinic manager in a PHC setting under current circumstances.

In view of the difficulties experienced by clinic managers in the clinical field, this study aimed to determine what their role should be, and what deterred them from being effective managers.

The data is presented according to the management process, which served to structure the questionnaire in this study.

5.2 RESPONSE RATE

The response rate is the rate of participation in a study, calculated by dividing the number of persons participating by the number of people sampled (Polit et al 2001:480; Polit & Hungler 1995:652; Polit & Beck 2006:509).

In this study, 135 questionnaires were distributed to selected clinic managers and a total of 97 questionnaires were returned. The response rate was thus 72.0%. According to Murphy-Black (2006:378), research studies that use a representative sample are dependent on a good response rate as a low response rate can have a significant impact on the usefulness of the findings.

It was noted that not all the respondents answered all the questions; therefore, the frequencies indicated in the tables and figures are often less than the total number of respondents. If all the respondents answered a question, the total number of the sample, namely 97, was indicated. In other cases, the actual figure was indicated as the n value and missing values were noted.

The generally accepted level of response to be aimed for is 80.0%, but Murphy-Black (2006:378) points out that this can vary considerably in published research. Nieswiadomy (2002:218) states that one serious disadvantage of questionnaires is the low return rate that frequently occurs – even a 25 to 30% return rate can be expected with mailed questionnaires. The response rate of 72.0% for this study was consequently considered good. The researcher concluded that the respondents' attitude was generally cooperative and supportive, considering that the questionnaire was extensive, covering seventy-seven (77) questions.

5.3 DATA ANALYSIS

The analysis and interpretation of the data resulted in the findings and recommendations of the study.

According to Wood and Ross-Kerr (2006:243), the goal of data analysis is to provide answers to the research question. The plan for data analysis comes from the question, the design, the method of data collection, and the level of measurement of the data (Wood & Ross-Kerr 2006:243).

Data analysis is the systematic organisation and synthesis of research data (Polit & Beck 2006:498; Polit et al 2001:460). Burns and Grove (1993:766) state that the process of data analysis is conducted to reduce, organise and give meaning to data.

5.3.1 Analysis program

A statistician analysed the data using the SPSS version 14.0. The statistician calculated frequencies for the responses to individual questions. These frequencies were counts of how many respondents selected a particular response (Wood & Ross-Kerr 2006:248). The alternatives *strongly agree, agree, disagree* and *strongly disagree* were provided to enable the respondents to respond to a specific statement according to their personal views. For purposes of analysis and discussion, the positive responses, namely *agree* and *strongly agree*, were grouped together, and *disagree* and *strongly disagree* were likewise grouped. The same applied to “important” alternatives. Reference was made to respondents who “agreed” and those who “disagreed”. In this study, the percentages were rounded off to full percentages, thus everything above point 5 (0.5) became a whole and less than 0.5 was discarded. Due to rounding off, the percentage did not always compute to 100% but in some cases to 99 or 101%. Pie diagrams and bar charts were used to illustrate these frequencies.

5.3.2 Descriptive statistics

Descriptive statistics are the various methods of summarising numerical data for descriptive purposes (Wood & Ross-Kerr 2006:249; Polit & Beck 2006:498; Polit et al 2001:460; Nieswiadomy 2002:359). According to Freeman and Walters (2006:440), categorical data may be displayed using either a bar chart or a pie diagram. The questions in the questionnaire consisted of categorical responses. These responses led to categorical variables, which facilitated the utilisation of pie diagrams and bar charts to illustrate the categorical data.

5.3.3 Inferential statistics

Nieswiadomy (2002:361) and Brockopp and Hastings-Tolsma (2003:298) describe the goal of inferential statistics as to determine as precisely as possible the probability of an occurrence. When working with inferential statistics, data is analysed to establish the likelihood that differences in the target group under study are the result of chance as opposed to manipulation of variables (Brockopp & Hastings-Tolsma 2003:298). Polit et al (2001:463) and Wood and Ross-Kerr (2006:243) refer to inferential statistics as statistics that permit inferences on whether relationships observed in a sample are likely to occur in a population.

5.3.4 One-way analysis of variance (ANOVA)

ANOVA is a parametric inferential statistical test that enables researchers to compare two or more group means (Brockopp & Hastings-Tolsma 2003:310; Nieswiadomy 2002:355; Wood & Ross-Kerr 2006:261). However, Polit and Beck (2006:495) and Polit et al (2001:457) describe ANOVA as a statistical procedure for testing mean differences among *three* or more groups by comparing variability between groups. Polit and Beck (2006:503) describe *mean* as a descriptive statistic that is a measure of central tendency, computed by summing all the scores and dividing by the number of subjects. If a significant difference was detected, the researcher used the mean to establish the performance of the various groups (see section 5.4 for discussion of the application of ANOVA).

5.3.5 Bonferroni or multiple comparison procedures

Multiple comparison procedures (statistical tests) normally applied after an ANOVA indicate statistically significant group differences that compare different pairs of groups (also referred to as *post hoc* tests) (Polit & Beck 2006:504; Polit et al 2001:465; Burns & Grove 1993:515).

Bonferroni's procedure, which checks for or controls the escalation of significance, can be used if various t-tests have to be performed on different aspects of the same data. The t-test is one of the most common parametric analyses used to test for significant differences

between statistical measures of two samples (Burns & Grove 1993:507). Significant differences in the means encountered are discussed under the specific items.

5.3.6 Reliability

Reliability measures show how consistent the respondents were in answering a group of related questions. Before calculating an average for each respondent, one should ascertain that the responses were reliable.

The Cronbach alpha (coefficient alpha) is a widely used reliability index that estimates the internal consistency or homogeneity of a measure composed of several sub-parts (Polit & Beck 2006:498; Wood & Ross-Kerr 2006:212; Polit et al 2001:460). Ideally, a Cronbach alpha of 0.8 and larger is acceptable, as a measure of 1.0 signifies perfect reliability. These reliabilities are done mainly on questions measuring attitudes and beliefs.

Table 5.1 presents a summary of the reliability of 23 questions analysed to assess reliability.

Table 5.1 Reliability measures of questions in terms of Cronbach alpha (n=97)

Question	Item description	Cronbach alpha	n of items
9.1 – 9.11	Staff involvement in developing goals and objectives	0.958	11
10.1 – 10.12	Involvement of clinic manager in planning	0.954	12
11.1 – 11.6	Conversant with budget allocation of clinic	0.937	6
13.1 – 13.6	Received written feedback reports with regard to expenditure of clinic budget	0.851	6
14.1 – 14.3	Informing subordinates on clinic matters	0.710	3
16.1 – 16.5	Importance of obtaining data from the Minimum Data Sheet	0.873	5
17.1 – 17.6	Aspects resulting in negative rendering of PHC services	0.570	6
18.1 – 18.5	Agreement on functions of the clinic manager	0.799	5
19.1 – 19.5	Factors hindering the organisation function	0.838	5
20.1 – 20.4	Training provided on various aspects	0.888	4
23.1 – 23.5	Reasons for the non-rendering of PHC services in a clinic	0.727	5
49.1 – 49.5	Characteristics of communication	0.760	5
51.1 – 51.5	Extent of building credibility with staff	0.907	5
55.1 – 55.4	Reasons for totally unimportant and unimportant referring to conversancy with the disciplinary procedure, grievance procedure and relevant Acts	0.780	4
57.1 – 57.7	Mechanisms used to influence staff	0.678	7
59.1 – 59.10	Extent of experience of a need for development	0.894	10
61.1 – 61.4	Reasons for answering “no” to question 60	0.735	4
62.1 – 62.5	Factors influencing the role of a clinic manager negatively	0.680	5
64.1 – 64.9	Reasons for not regarding the management of clinic data as important	0.647	9
65.1 – 65.6	Extent of satisfaction with support received from supervisor	0.869	6
69.1 – 69.4	Important factors when managing leave arrangements	0.856	4
75.1 – 75.4	Importance of control of resources in the clinic	0.889	4
77.1 – 77.6	Reasons for not monitoring and controlling clinic expenditure	0.707	6

Of the twenty-three questions, 4 measured a reliability of more than 0.9, 8 reached 0.8 or more, and 7 were pegged above 0.7, indicating that most of the questions (19 out of 23)

ranged between fairly high to high reliability. Thus, the questionnaire was considered highly reliable.

5.4 DATA PRESENTATION

For the purpose of data analysis, it was found useful to plot and interpret the data. This indicated extreme outliers together with any interesting patterns. Information could be displayed pictorially when reporting results and summarising data (Freeman & Walters 2006:440).

The data is presented according to the five sections of the data-collection instrument:

- Section A: Biographical information (Questions 1 – 8)
- Section B: Planning function (Questions 9 – 17)
- Section C: Organising function (Questions 18 – 47)
- Section D: Leading function (Questions 48 – 64)
- Section E: Control function (Questions 65 – 77)

5.4.1 Section A: Biographical information

The aim of including biographical information was to identify the respondents' gender, rank, age and qualifications. This section also included the respondents' duration of being a clinic manager and the average number of patients consulted per day.

The individual questions are illustrated by means of graphs, tables and pie charts, and discussed according to the responses.

5.4.1.1 Respondents' gender

The respondents' gender was important, as it would indicate whether mostly females or males held the rank of clinic manager (see figure 5.1).

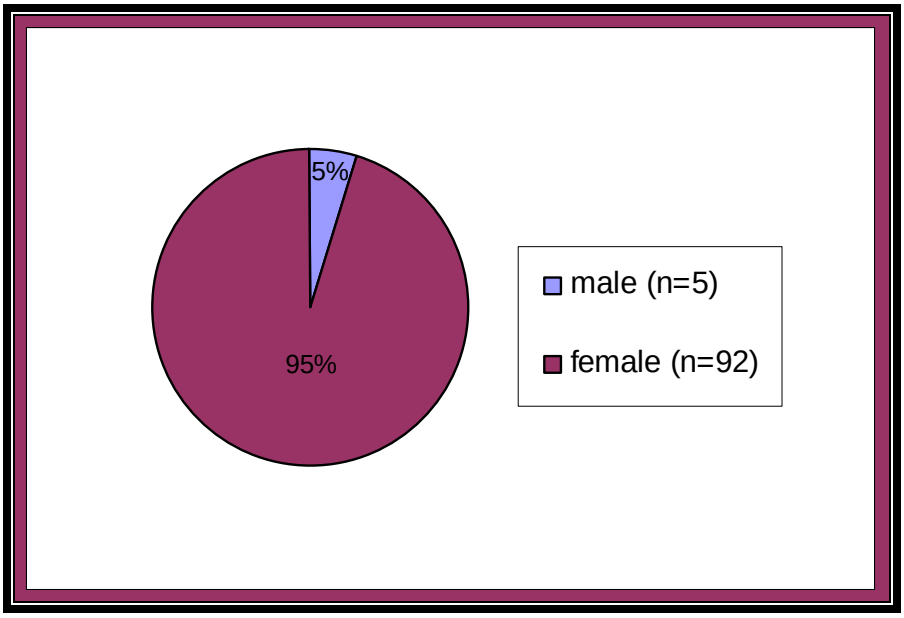

Figure 5.1 Respondents' gender (n=97)

Figure 5.1 indicates that of the respondents, the majority (92; 95.0%) were females compared to males (5; 5.0%). According to the South African Nursing Council (2006), only 5 959 (6.0%) registered nurses are male in comparison with 95 336 (94.0%) female registered nurses. This is in line with the national composition of the nursing profession. In the Free State, 2 696 (11.0%) professional nurses' posts are filled by males in comparison with 21 920 (89.0%) posts filled by females (*Cognos Power Play Web Explorer*, 2007). The high percentage of male professional nurses in the Free State could be due to the number working as occupational health nurses at the Goldfields mines in the Welkom-Virginia area, while fewer seek employment in PHC services and clinics.

5.4.1.2 Respondents' current rank

The respondents' current ranks included professional nurse, senior professional nurse and chief professional nurse (see figure 5.2).

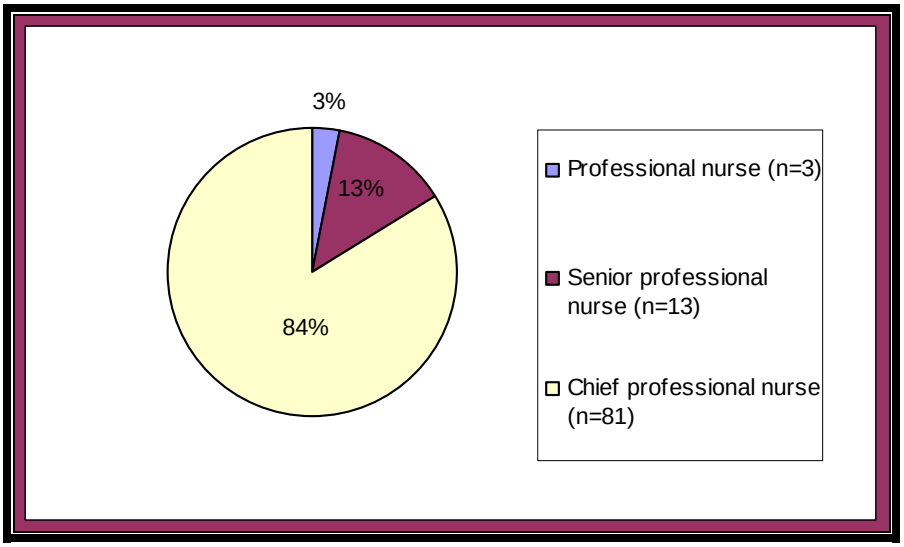

Figure 5.2 Respondents' current rank (n=97)

Figure 5.2 indicates that of the respondents, the majority (81; 84.0%) occupied the rank of chief professional nurse. It was therefore assumed that the respondents (clinic managers) had substantial experience as professional nurses, as the chief professional nurse position is the highest of the three noted levels and can normally not be attained as a newly qualified professional nurse.

5.4.1.3 Respondents' number of years as clinic managers

Booyens (1998:445) maintains that true understanding comes from reflecting on experience. Therefore it was necessary to establish the respondents' number of years' experience as clinic managers (see figure 5.3).

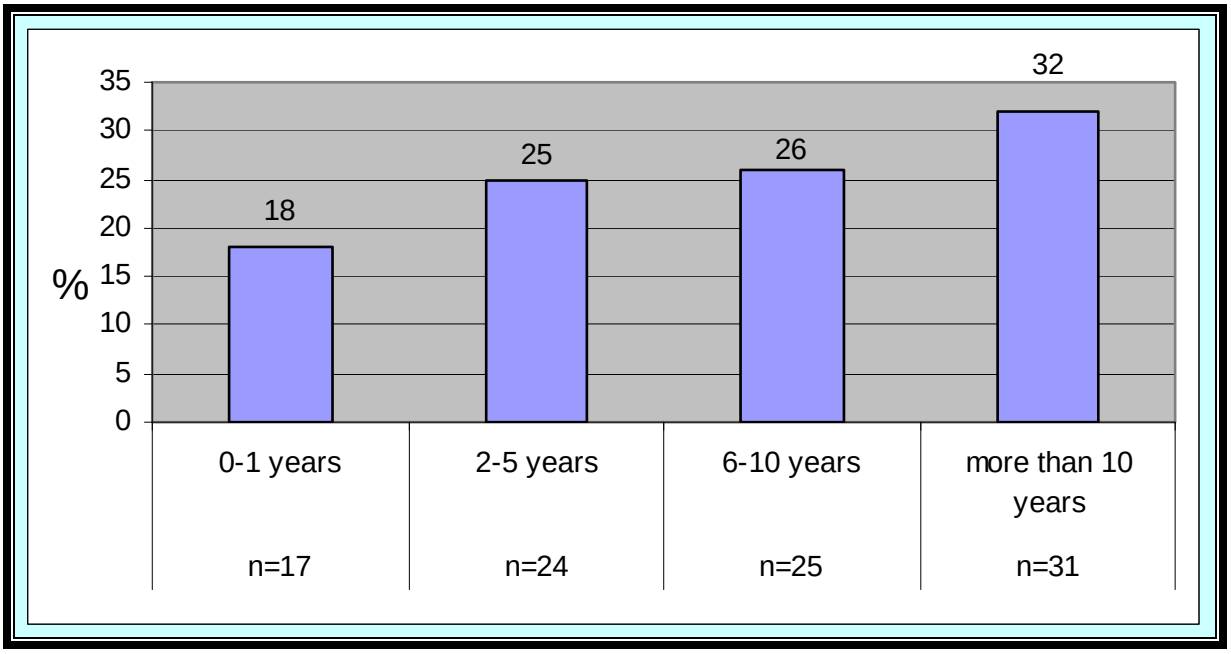

Figure 5.3 Respondents' number of years as clinic managers (n=97)

Of the respondents, 31 (32.0%) indicated that they had held the position of clinic manager for more than ten years (see table 5.3). Their years of experience as clinic managers correlated with their rank in figure 5.2. It was evident that more than half of the respondents (56; 58.0%) had six or more years' experience as clinic managers, from which it was deduced that they were well versed in their role and responsibilities, and might also have had different opportunities for training and development.

5.4.1.4 Respondents' experience as professional nurse in a PHC clinic

After noting the number of years of being a clinic manager, the study wished to determine the respondents' years' experience as professional nurses in a PHC setting (see figure 5.4).

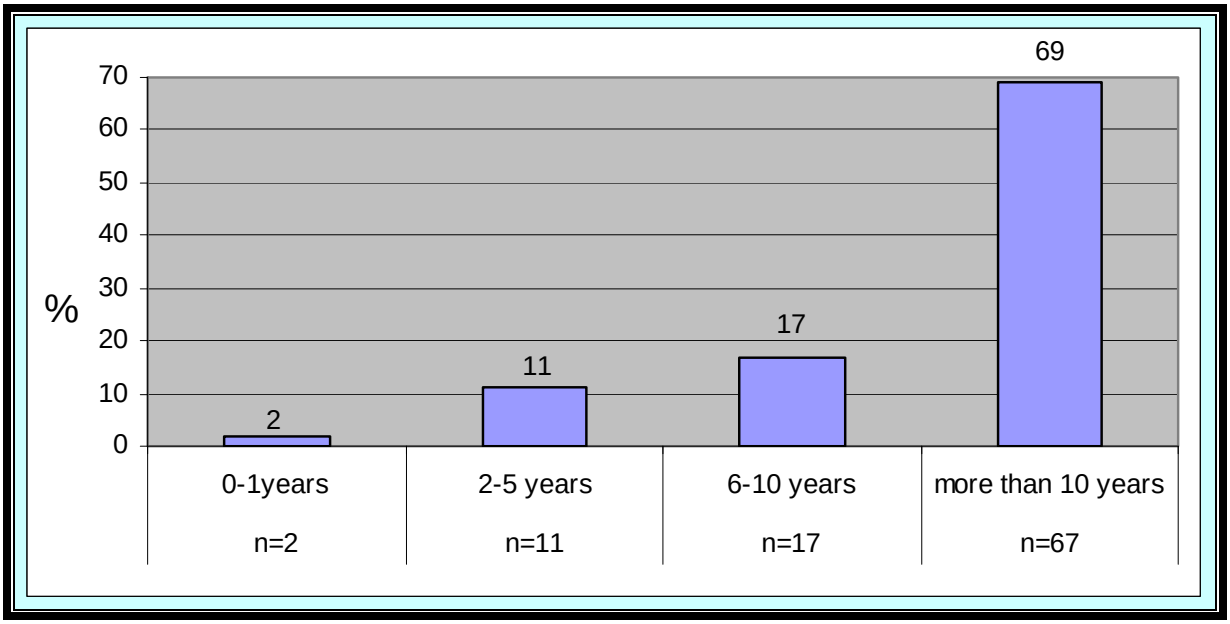

Figure 5.4 Respondents' experience as professional nurses in a PHC clinic (n=97)

The respondents' extensive experience as professional nurses in a PHC clinic correlated with their ranks in figure 5.2. Of the respondents, 67 (69.0%) had worked for more than ten years as professional nurses in a PHC clinic. It was therefore assumed that, because of their years of experience, the respondents should be well acquainted with the functioning of a PHC clinic. However, years of experience do not necessarily guarantee efficiency of services.

5.4.1.5 Respondents' ages

To determine whether age played a role in clinic management, the respondents were asked to indicate their age (see figure 5.5).

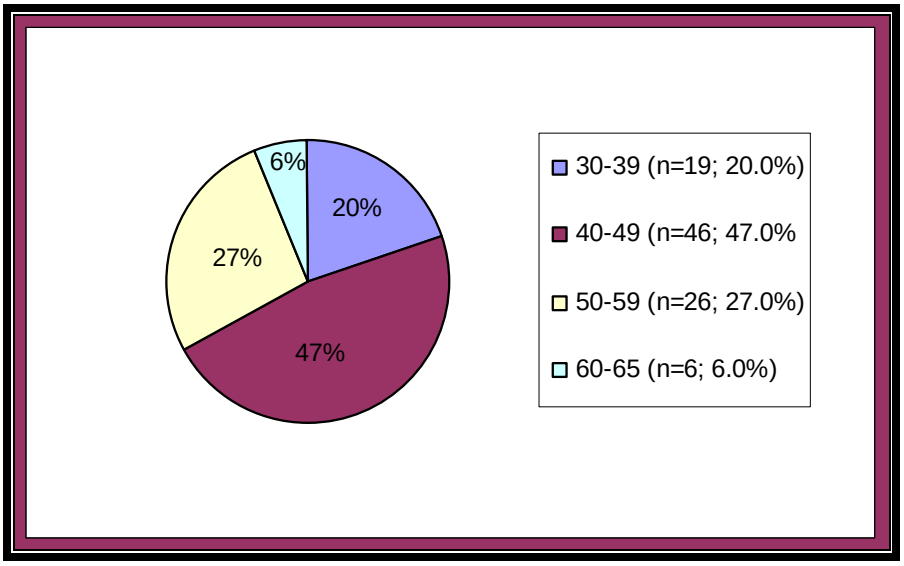

Figure 5.5 Respondents' ages (n=97)

Figure 5.5 indicates that of the respondents, 46 (47.0%) were 40 to 49 years old and 26 (27.0%) were 50 to 59 years old. This correlated with their ranks in figure 5.2 and their years of experience in a PHC clinic in figure 5.4. In addition, 19 (20.0%) were 30 to 39 years old and 6 (6.0%) were 60 to 65 years old. From figure 5.5, it is evident that more than a quarter of the clinic managers would be leaving the services within the next six to fifteen years, taking into consideration that the age for retirement in the civil service is 65 years.

5.4.1.6 Respondents' academic qualifications

In order to determine the respondents' educational level, their academic qualifications were noted (see figure 5.6).

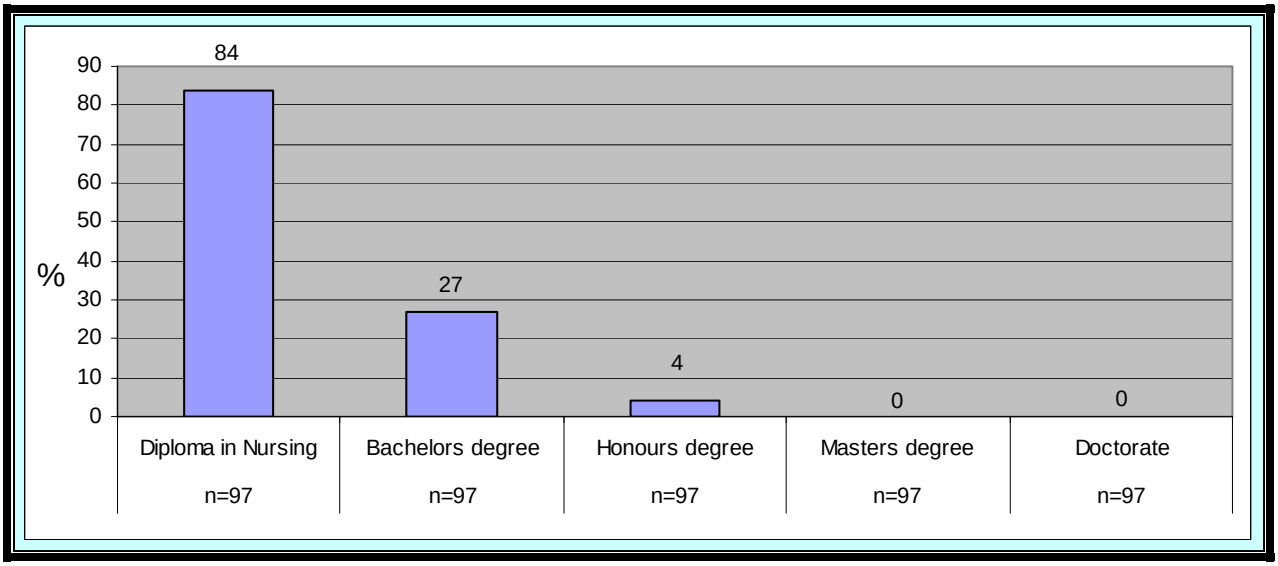

Figure 5.6 Respondents' academic qualifications (n=97)

Figure 5.6 indicates that of the respondents, 81 (84.0%) held a Diploma in Nursing; 26 (27.0%) held a Bachelor's degree, and 4 (4.0%) held an Honours degree. None of the respondents held a master's or a doctoral degree.

5.4.1.7 Respondents' professional qualifications

Pick et al (2001:iv) contend that while the PHC approach is undertaken to address the health care needs of South Africans, there are limitations within and across the PHC scope of practice and profession. The respondents' professional qualifications were analysed to determine their legal scope of practice, considering their knowledge and the skills needed to render an effective service (see figure 5.7).

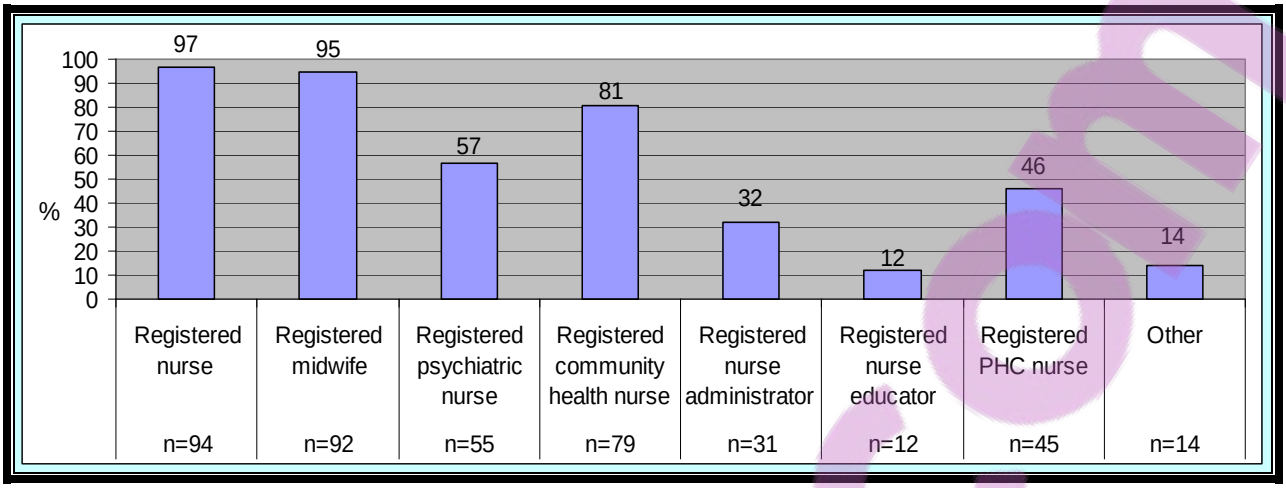

Figure 5.7 Respondents' professional qualifications (n=97)

Figure 5.7 indicates that of the respondents, 94 (97.0%) indicated that they were registered nurses. This might indicate an error on the part of the respondents, as a clinic manager is required to be a registered nurse. The anticipated answer in this case would be 97 (100%), as this is the core qualification a clinic manager should have. Of the respondents, 92 (95.0%) were registered midwives; 79 (81.0%) had a qualification in community health nursing; 55 (57.0%) in psychiatry, and 45 (46.0%) were registered PHC nurses, which were all important qualifications for clinic managers to have.

Of the respondents, 79 (81.0%) were registered community health nurses, which is an advantage for a clinic manager in a PHC setting, as it includes the fundamental principles of the health status of a community. Of the respondents, 55 (57.0%) were registered psychiatric nurses, which would seem to indicate that psychiatric nursing was not considered an essential or popular qualification.

It was of concern that of the respondents, only 31 (32.0%) were registered nurse administrators. This indicated that only one third of the respondents held this qualification, which is imperative for effective clinic management in order to apply sound management principles.

The data indicated that of the respondents, 12 (12.0%) were registered nurse educators and 45 (46.0%) were registered PHC nurses who had completed the one-year post-basic course. This serves as an advantage for the efficiency of the service as at least one

professional nurse in the clinic (the clinic manager) was knowledgeable about PHC matters. However, professional nurses with years of experience in a PHC clinic, in-service training and orientation are also skilled to render a PHC service. Having the PHC qualification is an advantage as it broadens the knowledge of the professional nurse. Professional nurses working in a clinic without this qualification can consult the clinic manager for guidance on diagnosis or treatment of a patient should the need arise. This emphasises a clinic manager's leading function.

5.4.1.8 Respondents' average number of patients consulted per day

The heavy workload of clinic staff has been a longstanding problem resulting in clinic managers having to consult patients in an effort to lessen the workload of the clinic staff.

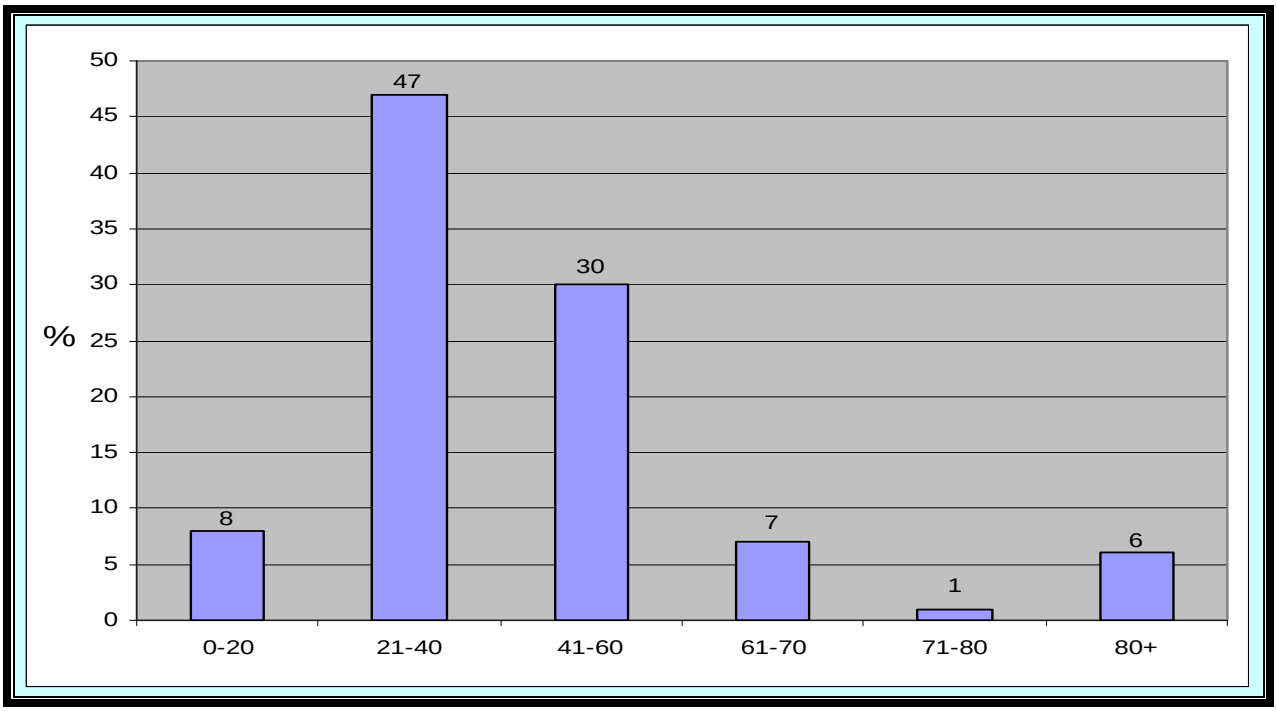

Figure 5.8 Respondents' average patient consultations per day (n=96)

Figure 5.8 indicates that of the respondents, 45 (47.0%) consulted between 21 and 40 patients per day. Lehman and Sanders (2002:123) found that between 20 and 35 patient consultations per day per professional nurse seems to be a manageable norm.

From figure 5.8 it is evident that of the respondents, 96 (100%) consulted patients daily; 81 (84.0%) consulted 21 to 70 patients per day, and 6 (6.0%) consulted more than 80 patients per day. This would raise the question of the quality of the consultations and patient outcomes, as it boils down to 6 minutes per patient per professional nurse. If clinic managers have to consult patients far exceeding the workload norm of 35 patients per day per professional nurse, to what extent will the clinic manager be able to cope with the management responsibilities of a clinic as patient care is a priority? It was noted that one respondent did not answer this question.

5.4.2 Section B: Planning function

Planning is the basic management function that encompasses the purposeful consideration and visualisation of what the organisation should achieve within a particular time span in order to be successful (Kroon & van Zyl 1995:111; Hellriegel, Jackson, Slocum, Staude, Amos, Klopper, Louw & Oosthuizen 2001:10). The four basic management functions are planning, organisation, leading and control.

5.4.2.1 Involvement of staff in developing goals and objectives for programmes

According to Kroon and van Zyl (1995:123), Smit, Cronjè, Brevis and Vrba (2007:134), Zerwekh and Claborn (2006:300) and Pettinger (2007:602), a clear description of the goals and objectives for every business function and project is a critical step in the planning process. Goding (2005:118) states that clinical staff's abilities to implement new strategies are crucial. Utilising the skills and experience of staff in the planning process will promote ownership of the plan and the achievement of goals.

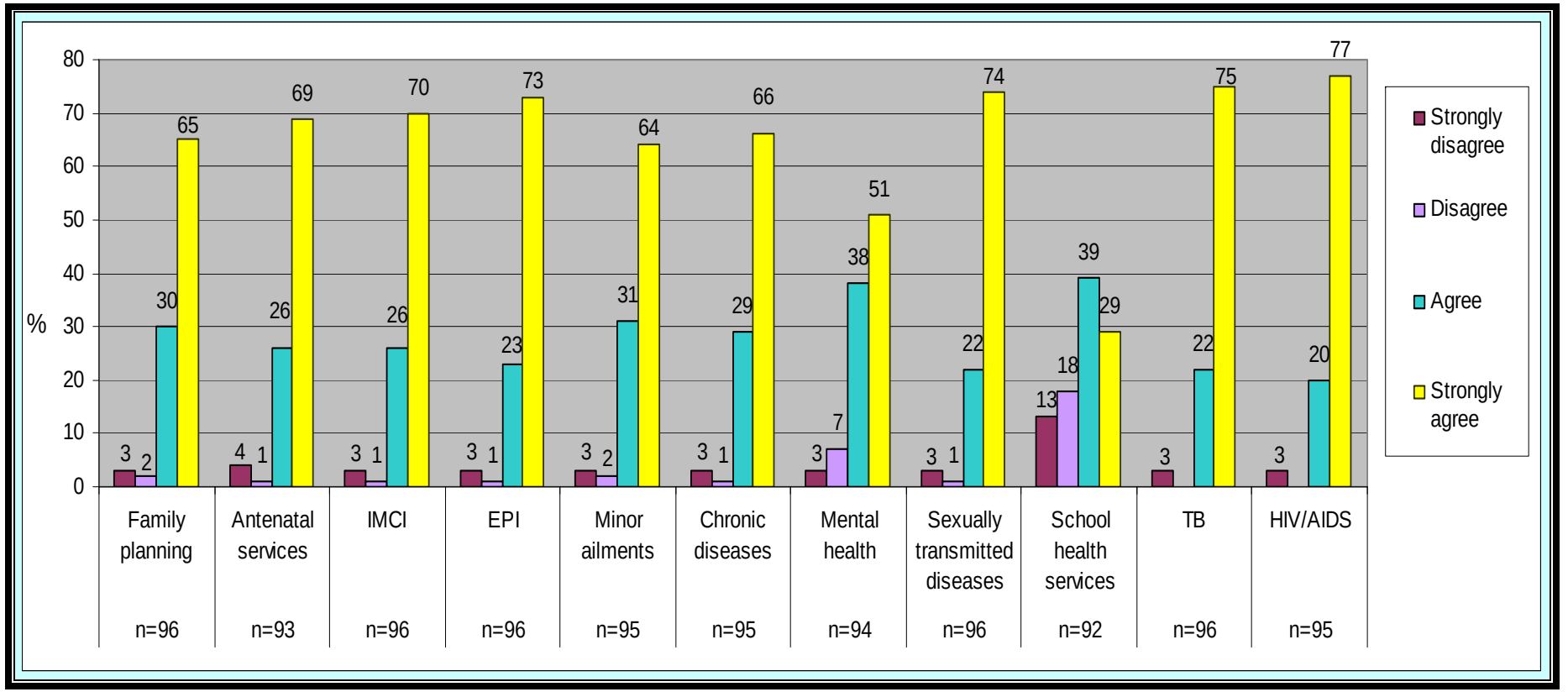

Figure 5.9 Involvement of staff in developing goals and objectives for programmes (n=96)

According to figure 5.9, most of the respondents indicated that they strongly agreed with the statement that they involved their staff in developing goals and objectives. The programme that obtained the highest score was the HIV/AIDS programme (73; 77.0%). This could be due to the fact that HIV/AIDS is a national priority programme because of its epidemic effects on South Africa and PHC services focus on this programme.

The programme with a very low score where respondents strongly agreed on involvement was the mental health programme with a score of 48 (51.0%). This correlates with figure 5.7, which indicated that only 55 (57.0%) of the respondents were registered psychiatric nurses. Due to a lack of knowledge they might not feel at ease setting goals and objectives for this programme. This can also be ascribed to the fact that nurses do not value this programme to the same extent as other PHC programmes.

School health services obtained the lowest score (27; 29.0%) for involving staff in developing goals for programmes. This might be due to the fact that the posts assigned for the rendering of school health are utilised for the delivery of services in the clinic in an effort to address the staff shortage. In an effort to render school health services, the clinic staff render school health services in the Thabo Mofutsanyana district. This contributes to staff shortages in the clinic as some of the clinic staff are withdrawn to attend to school health services. The shortage is thus not addressed at all.

5.4.2.2 Respondents' involvement in planning-related activities

According to Booyens (1998:657), nurse managers are concerned with everyday planning. The availability of accurate information enhances their decision-making abilities and assists them in their general managerial and planning function.

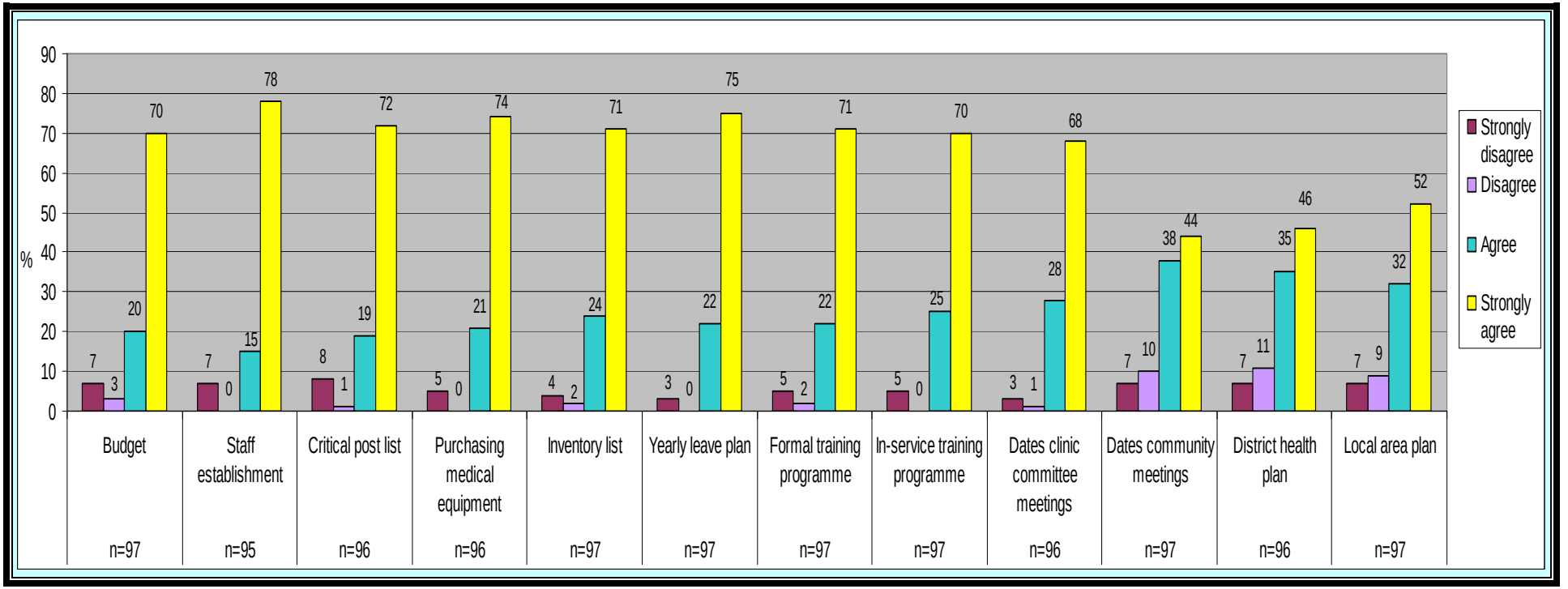

Figure 5.10 Respondents' involvement in planning-related activities (n=97)

From figure 5.10 it is clear that most of the respondents strongly agreed that the clinic manager should be involved with all the activities mentioned.

- **Involvement of clinic managers in the budget**

Of the respondents, 87 (90.0%) indicated that they *agreed* that clinic managers should be involved in the budget and 10 (10.0%) *disagreed*. It is of concern that 10.0% of the respondents indicated that clinic managers should not be involved in financial control. Booyens (1998:177) emphasises that the ongoing monitoring of expenditure is generally assigned to the manager of a cost centre. Booyens (1998:159), Muller, Bezuidenhout and Jooste (2006:425), Huber (2006:778), and Zerwekh and Claborn (2006:372) point out that budgeting and control systems should be devolved to the patient level and as a consequence, nurse managers require knowledge on budgeting to meet these challenges.

- **Involvement of clinic managers in the staff establishment**

Of the respondents, 88 (93.0%) indicated that the clinic manager should be involved in the staff establishment of a clinic. Staffing is based on the ratio of health workers to the population in the categories of health visitor, professional nurse, nursing auxiliary, doctor and dentist (du Preez 1998:37; Muller et al 2006:311). According to Yoder-Wise (2007:270), nurse managers have opportunities to influence the use of staffing resources in the unit. Nurse managers are accountable for projecting the staffing needs of a unit each year as well as using the approved personnel budget to prepare a balanced staffing plan for the unit (Yoder-Wise 2007:270).

- **Involvement of clinic managers in the critical post list**

A critical post list contains a vacant post that is identified as an urgent need in an organisation. No funds are available for this post and this post was never filled previously. The need is submitted on the critical post list to the Head of Health of the FSDOH for approval to fill the post.

With regard to the involvement in the critical post list, the majority of the respondents (87; 91.0%) *agreed* that clinic managers should be involved in the drawing up of a critical post list. This would ensure that a needs list would have to be compiled annually by the clinic manager in collaboration with the local area manager to indicate the number of staff needed to render a quality service to the community. This should be submitted to the District Manager who would submit it to the Provincial Department of Health, in other words, the Head of Health. After submission of the list, funds should be made available on the budget to fill the critical list otherwise it will serve no purpose.

- **Involvement in purchasing of medical equipment**

With reference to the involvement of clinic managers in purchasing of medical equipment, the majority of the respondents (91; 95.0%) *agreed* that it was essential for clinic managers to be involved in drawing up the list for purchasing of medical equipment. Du Toit (1998:55) maintains that nurses should become involved in planning procedures to ensure a clinical environment for the patient. The physical and mental health of the patient is promoted due to the availability of medical equipment for effective service rendering. Smit et al (2007:14-15) state that the planning function entails the acquisition of all products and materials, including equipment. The person responsible for purchasing should be in contact with suppliers, be aware of new products and their quality, and know the prices at which goods can be bought. Often a product of poor quality is bought. This results in equipment which becomes defective within a short time.

- **Involvement in the inventory**

Of the respondents, 91 (94.0%) agreed that they should be involved in control measures of the inventory of their clinics. The researcher is of the opinion that this question on the inventory would have been better suited under Section D relating to Control, as the checking of an inventory is part of asset control. However, Crous (1995:444) and Hellriegel et al (2001:407) maintain that planning and controlling are very closely related. Control is exercised to ensure that objectives are reached, thus bringing it in line with planning as first management function (Crous 1995:444).

- **Involvement of clinic managers in compiling the annual leave plan**

Of the respondents, 94 (97.0%) indicated that the clinic manager should be involved in compiling the yearly leave plan. The fair management of leave is important to ensure that sufficient staff is available in the clinic for service rendering and to ensure staff requests in terms of leave are justly treated.

- **Involvement of clinic managers in planning of formal training and in-service training programmes**

Of the respondents, 90 (93.0%) and 92 (95.0%), respectively, confirmed that it was important for the clinic manager to be involved in formal training and in-service training programmes. Booyens (1998:381), Yoder-Wise (2007:295) and Pettinger (2002:419) emphasise that for an organisation to be successful, it is essential for management to introduce, manage and evaluate programmes with the aim of developing personnel, their skills, attitudes, personal growth and fulfilment.

- **Involvement of clinic managers in planning of clinic committee and community meetings**

Due to the importance of community involvement, the greater majority of the respondents (92; 96.0%) agreed that clinic managers should be involved when dates for clinic committee meetings are determined. This indicated that the respondents considered the clinic committee meetings important, as clinic committees are the informal governance structure of clinics (FSDOH 1998:18). Of the respondents, 80 (82.0%) indicated that clinic managers should be involved when dates for community meetings were set. Clinic committee meetings and community meetings play an important role in community participation with the aim of improving the quality of health services (Reagon et al 2004:46; FSDOH 1998:18).

- **Involvement of clinic managers in the District Health Plan**

Of the respondents, 78 (81.0%) indicated that it was important for them to be involved in compiling the District Health Plan for the district. The 18 (19.0%) respondents who disagreed possibly did not realise that the District Health Plan is the foundation of the local area plan. Ramduny, McCoy and Boulle (1998:5) contend that a district health plan with clear aims and objectives is an important requirement to address the health problems of a district.

- **Involvement of the clinic manager in the local area plan**

The local area plan contains the actions directed at the achievement of the objectives stipulated in the District Health Plan. With regard to involvement of the clinic manager in developing the local area plan, 81 (84.0%) of the respondents indicated that they should be involved. This could be ascribed to the fact that clinic managers rather take ownership for their own local area than for the whole district. According to Ramduny et al (1998:5), effective communication between health workers at all levels should be in place to support the district's health problems.

5.4.2.3 Conversant with budget allocation

Booyens (1998:169), Huber (2006:782), Zerwekh and Claborn (2006:367), and Hellriegel et al (2001:417) state that the current trend in budgeting is to decentralise the budget process down to the point of service since those rendering the service are more aware of specific circumstances and conditions prevailing in the day-to-day operations of the organisation.

Table 5.2 indicates the respondents' knowledge of clinic budget allocations.

Table 5.2 Respondents' knowledge of clinic budget allocations (n=97)

	Strongly disagree	Disagree	Agree	Strongly agree	n	Total
Human Resources	46 (48.0%)	24 (25.0%)	17 (18.0%)	8 (8.0%)	95	99%
Medicine	33 (35.0%)	17 (18.0%)	22 (23.0%)	22 (23.0%)	94	99%
Medical consum-ables	32 (34.0%)	19 (20.0%)	23 (24.0%)	20 (21.0%)	94	99%
Cleaning material	35 (37.0%)	21 (22.0%)	19 (20.0%)	20 (21.0%)	95	100%
Stationery	36 (38.0%)	19 (20.0%)	20 (21.0%)	20 (21.0%)	95	100%
Maintenance	43 (45.0%)	20 (21.0%)	16 (17.0%)	16 (17.0%)	95	100%

From table 5.2 it is clear that most of the respondents indicated that they were not conversant with the budget allocation for human resources (70; 73.0%), maintenance (63; 66.0%), cleaning material (56; 59.0%), stationery (55; 58.0%), medical consumables (51; 54.0%) and medicine (50; 53.0%). Given the high percentage of respondents who either strongly disagreed or disagreed, it was assumed that the majority of the respondents did not have sufficient knowledge of the clinic budget. More than fifty percent of the respondents were not at all conversant with financial matters pertaining to human resources and clinic maintenance.

5.4.2.4 Availability of written feedback on budget expenditure

According to Booyens (1998:177), Muller et al (2006:424) and Lussier (2006:505), the budget holder's responsibility is to monitor expenditure against the budget, analyse sources of variance, and take the required action in response to the variation. This can only be done when quality feedback and financial reports are available to the clinic manager. Table 5.3 indicates the availability of written feedback on budget expenditure.

Table 5.3 Availability of written feedback on budget expenditure (n=97)

	Never	Sometimes	Most of the time	Always	n	Total
Medicine	36 (38.0%)	21 (22.0%)	15 (16.0%)	24 (25.0%)	96	101%
Medical consumables	37 (39.0%)	21 (22.0%)	16 (17.0%)	21 (22.0%)	95	100%
Printing and stationery	57 (59.0%)	17 (18.0%)	11 (11.0%)	11 (11.0%)	96	99%
Cleaning material	64 (66.0%)	13 (13.0%)	8 (8.0%)	12 (12.0%)	97	99%
Staff expenditure	76 (78.0%)	11 (11.0%)	4 (4.0%)	6 (6.0%)	97	99%
Official transport	84 (87.0%)	8 (8.0%)	4 (4.0%)	1 (1.0%)	97	100%

From table 5.3 it is clear that most of the respondents indicated that they “never” received written feedback on budget expenditure related to

- Official transport (84; 87.0%)
- Staff expenditure (76; 78.0%)
- Cleaning material (64; 66.0%)
- Printing and stationery (57; 59.0%)

A large number of respondents also indicated that they never received written feedback on medical consumables (37; 39.0%) and medicine (36; 38.0%).

Lack of feedback on budgetary expenditure leads to a lack of insight into budgetary matters. This can be ascribed to the fact that most of the clinics do not operate as separate independent cost centres. The budget of the local area is a general budget, which includes all the clinics located in the specific local area, and it would be impossible for individual clinic managers to identify their expenditure.

5.4.2.5 Respondents’ patient consultations

As clinic managers often have to render a clinical function in the clinic due to staff shortages, it was necessary to determine the level to which the respondents had to consult patients (see figure 5.11).

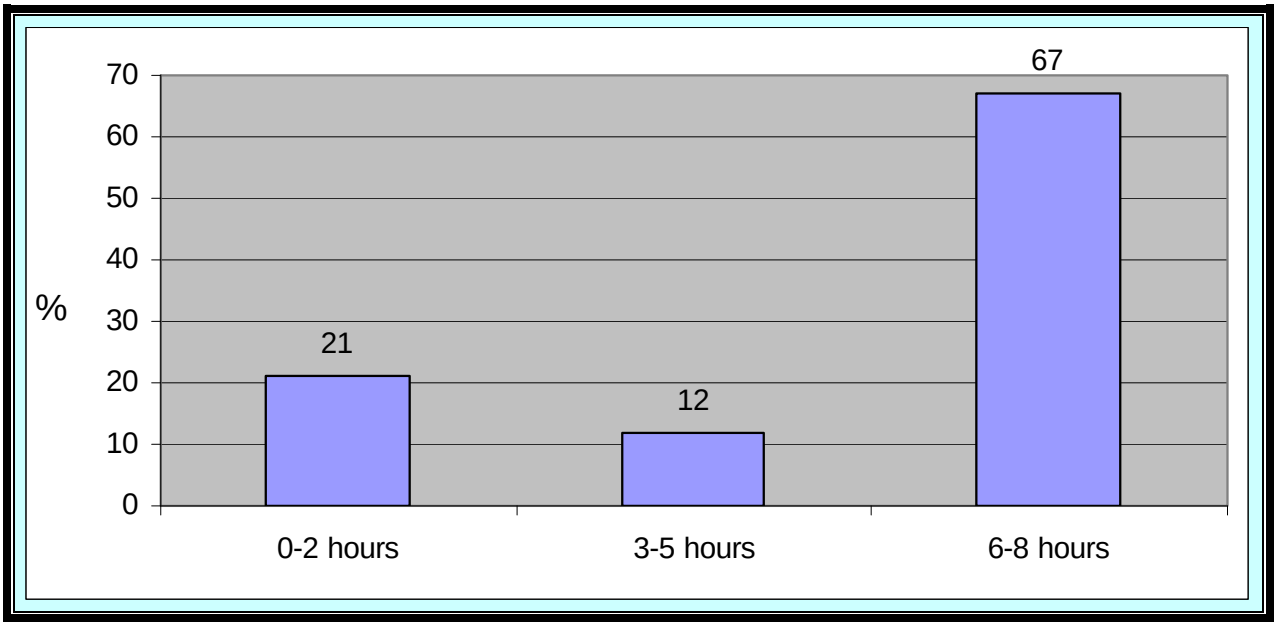

Figure 5.11 Respondents' time spent daily in consulting patients (n=95)

Figure 5.11 indicates that of the respondents, 64 (67.0%) spent an average of six to eight hours per day consulting patients; 20 (21.0%) spent between zero and two hours per day, while 11 (12.0%) spent between three and five hours per day. It is of concern that 64 (67.0%) of the respondents consulted patients for six to eight hours per day leaving little, if any, time for the performance of their management functions. Clinic managers' effective management could be questioned in a situation where they were mainly rendering clinical services in consulting high number of patients on a daily basis. Thom (2005:116) found that in South Africa, some professional nurses see a minimum of sixty patients per day. In such circumstances, the clinic manager has to consult patients otherwise the professional nurses in the clinic will not be able to consult all the patients awaiting a service.

5.4.2.6 Informing subordinates on matters concerning finances, human resources and management meetings

Booyens (1998:275) and Smit et al (2007:366-367) emphasise that sufficient feedback to employees from the manager is of the utmost importance to improve productivity and performance. This supports the individual in planning and setting goals and targets that should be met at a specific time.

Effective communication is a fundamental element of nursing and is regarded as integral to the provision of quality patient care (McGilton, Irwin-Robinson, Boscart & Spanjevic 2006:35). McConnell (2005:291) maintains that an effective leader cares that employees know and understand what affects their tasks and the organisation's plans.

Table 5.4 Informing subordinates on matters concerning finances, human resources and management meetings (n=97)

	Never	Sometimes	Most of the time	Always	n	Total
Financial matters	32 (34.0%)	23 (24.0%)	20 (21.0%)	20 (21.0%)	95	100%
Human resources	12 (12.0%)	15 (16.0%)	30 (31.0%)	40 (41.0)	97	100%
Management meetings	4 (4.0%)	4 (4.0%)	16 (17.0%)	73 (74.0%)	97	99%

Table 5.4 indicates that of the respondents, 89 (91.0%) gave feedback to their subordinates on matters discussed at management meetings, as they attended these meetings, and 70 (72.0%) gave feedback on human resources. This response can be ascribed to the fact that clinic managers are not directly involved with human resource matters in general. They are mostly involved with human resource matters pertaining to their clinic, including management of leave and absenteeism. Most of the other human resource matters were attended to at the central district office.

The number of respondents (55; 58.0%) who did not give feedback on financial matters corresponded with table 5.3, which indicated that they themselves never received written feedback on budget-related expenditure.

5.4.2.7 Involvement of clinic staff in the planning process

First-line management is responsible for operational planning (Kroon & van Zyl 1995:112). In this instance, first-line management referred to the clinic manager who is also an operational manager. According to du Preez (1998:7) and Hellriegel et al (2001:12), operational managers and supervisors are responsible for managing and planning with

their own personnel. Objectives must be set with the personnel and responsibility should be delegated to them.

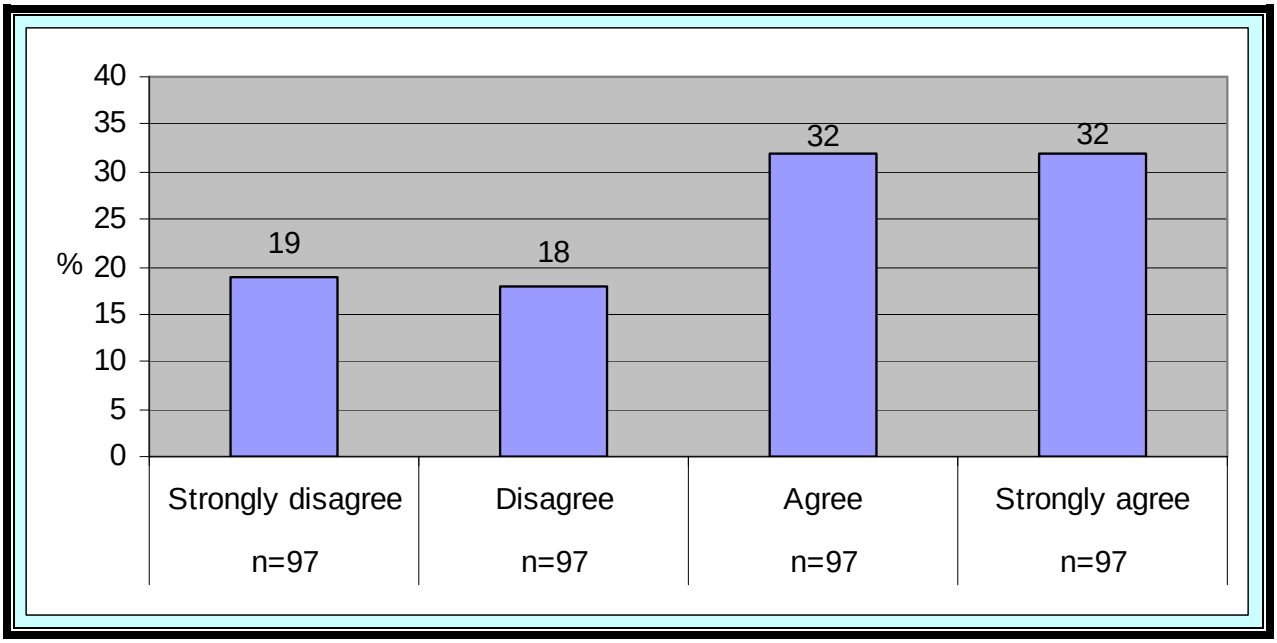

Figure 5.12 Involvement of clinic staff in the planning process (n=97)

From figure 5.12 it is clear that 62 (64.0%) of the respondents either agreed or strongly agreed that the staff were included in the planning process. However, it was not clear whether this response was reliable, as the respondents were required to respond on behalf of their clinic staff. Huber (2006:39) states that the nurse is engaged in constant mental planning when deciding what specific things are to be accomplished for the patients.

5.4.2.8 Information sessions on management a waste of time

The availability of information plays an important role in the planning of PHC services.

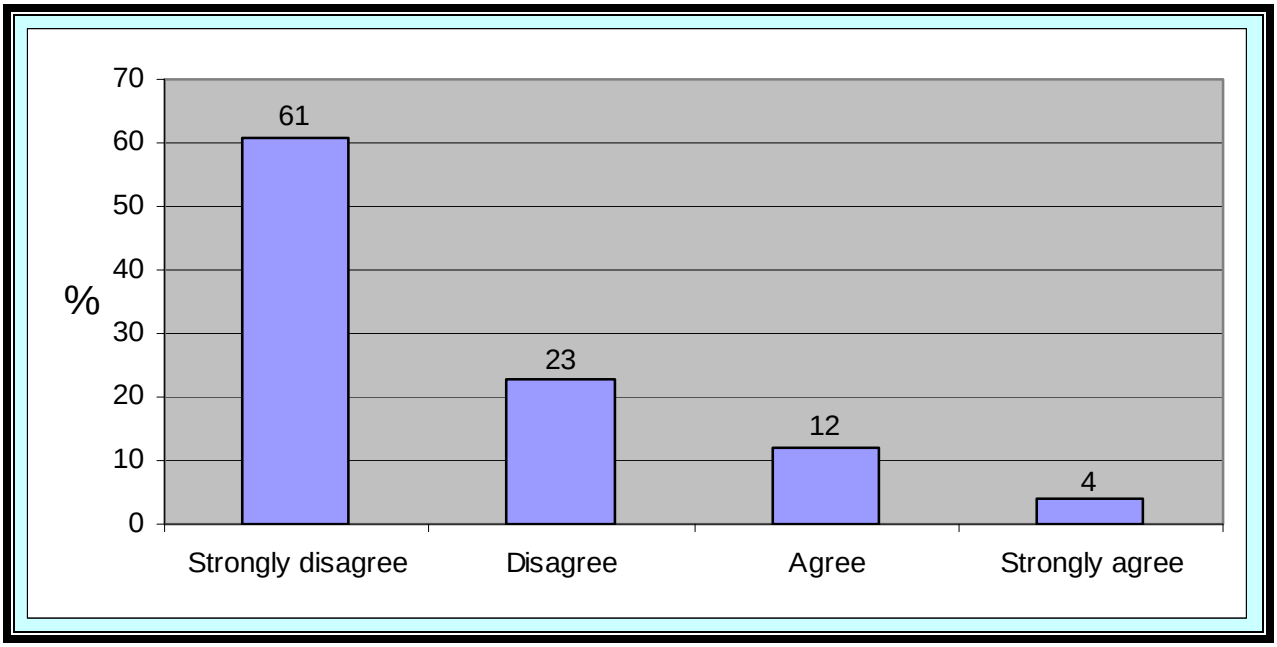

Figure 5.13 Information sessions pertaining to clinic management considered a waste of time (n=97)

Of the respondents, 81 (84.0%) did not agree that information sessions on clinic management were a waste of time (see table 5.13). The respondents clearly realised the need for and value of information and guidance in their quest for good clinic management. This information could contribute to the quality of management of a PHC clinic, as staff would be informed about challenges, new policies, projects and changes in the Department of Health.

5.4.2.9 Feeling at ease due to the availability of sufficient information about clinic

The respondents were asked to indicate the availability of sufficient information in the clinics (see figure 5.14).

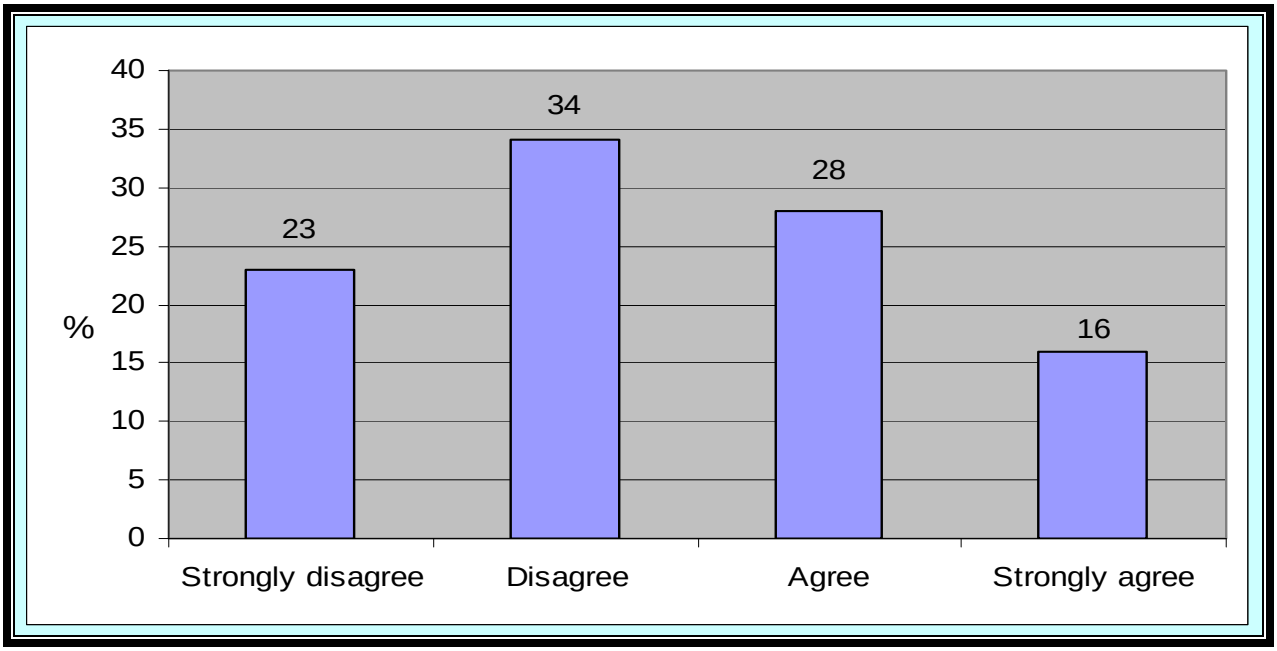

Figure 5.14 Feel at ease because sufficient information about clinic matters is available (n=97)

According to figure 5.14, of the respondents, 55 (57.0%) did not agree that they felt at ease, as sufficient information about clinics was not available, while 42 (43.0%) *agreed* that they felt at ease as they received sufficient relevant information. It was not clear whether the respondents perceived "sufficient information" in the same way. The 55 (57.0%) respondents who disagreed felt that they lacked information about their clinics and therefore did not feel comfortable, as effective management requires relevant information. The reason might be that clinic managers did not get regular feedback on financial matters, human resources issues and challenges.

5.4.2.10 Importance of data from the Minimum Data Sheet (MDS)

The FSDOH regards the Minimum Data Sheet (MDS) as an important tool in the management process. This tool can be utilised in the planning process (see figure 5.15).

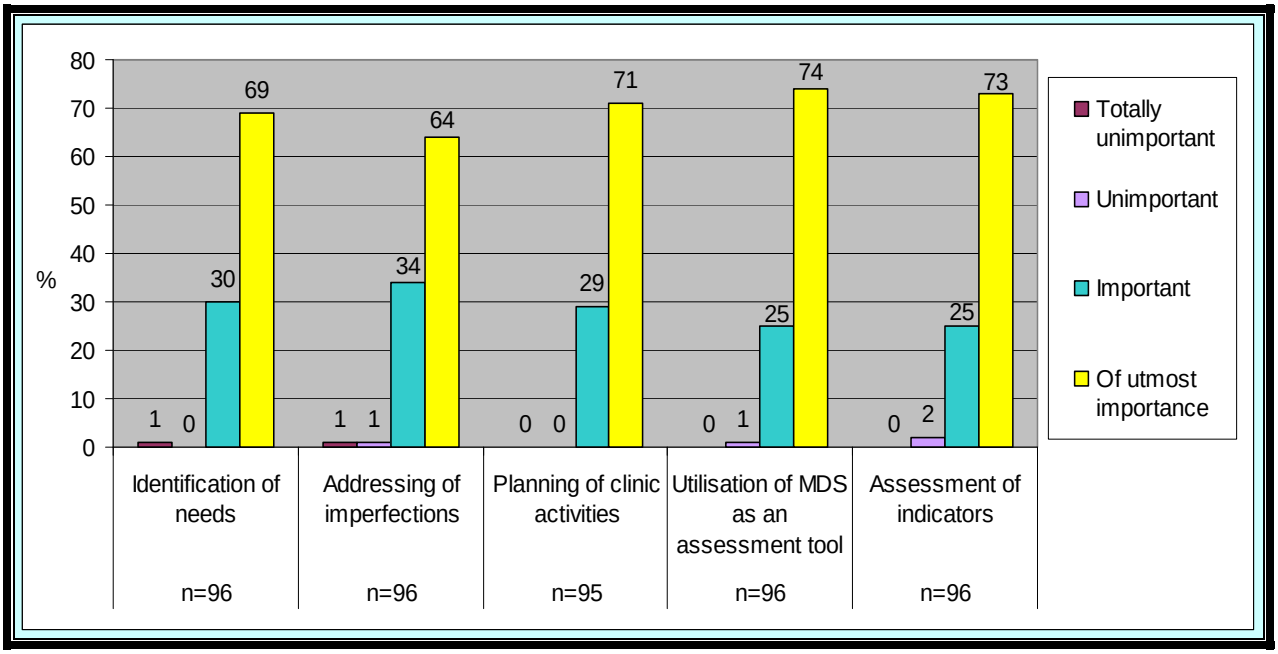

Figure 5.15 Importance of data from the MDS (n=96)

- **Identification of needs**

Figure 5.15 indicates that of the respondents, 66 (69.0%) indicated that the MDS supported them with the identification of needs pertaining to service delivery in the clinics. The nurse-patient workload can be calculated from the MDS and if the workload exceeds the norm of 25 patients per day per professional nurse, this information can be used to adjust the staff establishment of the clinic.

Nel, van Dyk, Haasbroek, Schultz, Sono and Werner (2004:525) and Yoder-Wise (2007:49) maintain that strategic planning and management should include strategic human resources planning in order to ensure a comprehensive planning process encompassing all the organisation's resources.

- **Addressing imperfections pertaining to service delivery in the clinic**

Most of the respondents (94; 98.0%) indicated that the information obtained from the MDS supported them in addressing imperfections pertaining to service delivery in the clinic (see figure 5.15). For example, the data might indicate that only a few persons who are contacts

of sexually transmitted infections (STIs) return to the clinic for treatment. According to Kroon and van Zyl (1995:127) and Huber (2006:41), the activities of an organisation should be directed at improving the utilisation of resources and if it is not up to standard, taking some action to reach effective outcomes.

- **Planning of clinic activities to enhance service delivery**

All the respondents (95; 100%) indicated that the data obtained from the MDS was required to plan clinic activities in view of service delivery (see figure 5.15). If, for example, the data indicates that only a few STI contacts visit the clinic, a plan of action should be drawn up to improve on the attendance of contacts to visit the clinic. The plan might include health education sessions on STIs in the waiting area of the clinic to emphasise the importance of treatment of STI contacts. According to du Toit (1998:59) and Huber (2006:41), the aim of planning is to make the most effective choices in selecting interventions to address shortfalls.

- **Utilising the MDS as a tool indicating conditions in the clinic**

The majority of the respondents (95; 99.0%) reported that the MDS is an important tool as it indicates the conditions in the clinic, which can ensure that quality services are rendered (see figure 5.15). Kroon and van Zyl (1995:111) emphasise that within the framework of a changing and dynamic external environment, management, including the clinic manager, must indicate in which direction an organisation should go.

- **Assessment of indicators to determine whether programme goals are reached**

Of the respondents, 94 (98.0%) indicated that the MDS can be used as a tool to assess indicators to determine whether goals are reached (see figure 5.15). During planning, management must consider the goals and objectives that should be achieved and the resources needed to achieve these objectives and goals (Kroon & van Zyl 1995:111; Smit et al 2007:188).

5.4.2.11 Aspects resulting in negative PHC service rendering in the clinic

Figure 5.16 illustrates some factors that could negatively impact on rendering PHC services.

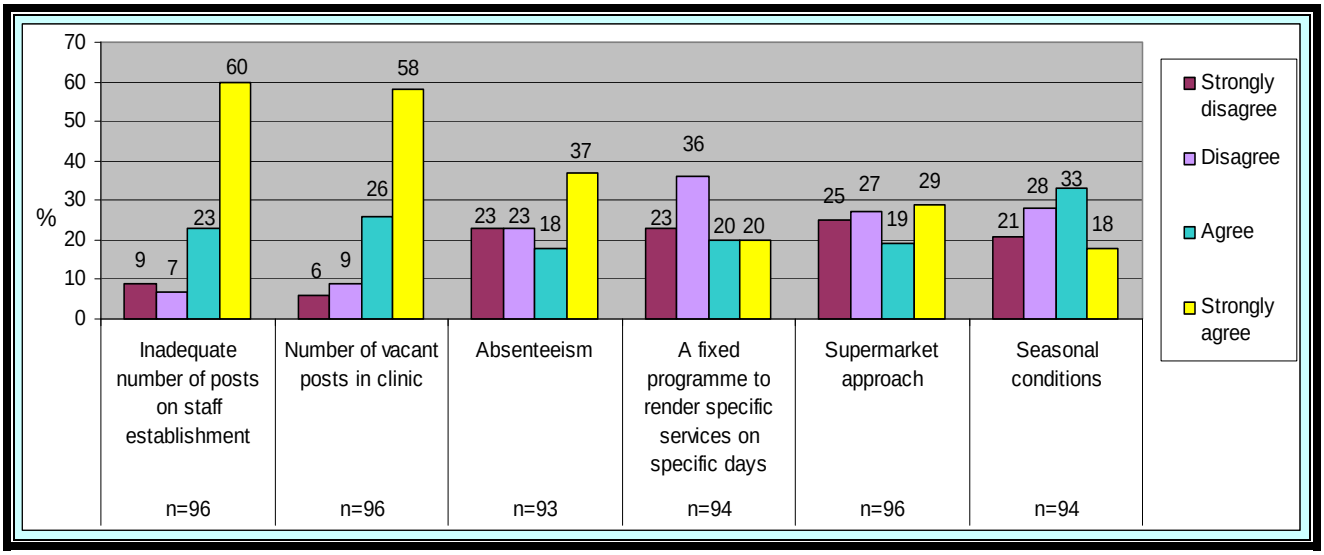

Figure 5.16 Factors that impact negatively on PHC service rendering (n=96)

- **Available posts**

Of the respondents, 80 (83.0%) *agreed* that an inadequate number of available posts contributed to the negative rendering of services (see figure 5.16). Booyens (1998:309) maintains that nurse managers should be responsible for determining the staffing requirements of nursing personnel in their institutions. However, this does not happen in the real situation, as staff establishments are determined at provincial level without clinic managers' involvement.

Huber (2006:714) states that registered nurses can be considered a scarce human resource. Staffing becomes contentious when available resources, especially finances, are limited and consequently the number of posts is restricted.

- **Vacancies**

Most of the respondents (81; 84.0%) *agreed* that the number of vacant posts in the clinic negatively influenced the rendering of services (see figure 5.16). Booyens (1998:372) and Arnold (2005:133) state that if a high vacancy rate exists, the quality of care will decrease. If nurse managers are concerned about the quality of care, they should see to it that the number of patients is limited to a manageable level. However, this is not feasible as all members of the public have the right to get access to a health service. The increased workload due to vacancies causes low morale in the remaining staff, a lowered level of staff performance and a rise in medico-legal risks (Booyens 1998:372). Huber (2006:592) is of the opinion that nurses with the highest nurse-to-patient ratio were more likely to suffer burnout, emotional exhaustion and job dissatisfaction.

- **Absenteeism**

Of the respondents, 51 (55.0%) indicated that absenteeism had a negative influence on service rendering (see figure 5.16). Roos (1998:361) states that absenteeism leads to low staff morale due to overtime work, caused by working with fewer staff than required, and the quality of patient care may be seriously affected. Muller et al (2006:318) point out that absenteeism disrupts the workflow, resulting in a decline of output.

- **Schedule of rendering services**

In order to determine the factors influencing service rendering negatively, it was necessary to determine the influence of (a) rendering specific services on specific days and (b) the effect of the supermarket approach (availability of all PHC services at a clinic every day).

Of the respondents, 56 (60.0%) *disagreed* that rendering specific services on specific days influenced service delivery negatively. With regard to the supermarket approach, 46 (48.0%) of the respondents *agreed* that the supermarket approach contributed to the negative rendering of services. It was thus clear that the respondents preferred set days for specific services to be rendered as a means of enhancing service delivery in their clinics as apposed to the supermarket approach.

- **Seasonal conditions**

With regard to the effect of illnesses related to seasonal conditions on service delivery, two issues are relevant here, namely migrant workers and cultural initiation periods.

Some of the Eastern Free State towns are situated next to the Lesotho border. Depending on agricultural factors, the situation occurs where a large number of Lesotho citizens come to the farms during the harvest season for the purpose of employment. They remain on the farms for a period of two to three months, depending on the harvest. If they become ill, they make use of the mobile clinics, which visit the farms monthly. In between, when the mobile clinic does not visit the farm, many of these workers attend the fixed clinics in town resulting in an overload of patients in the clinic.

Cultural beliefs and habits also play a significant role in the patient load at fixed clinics. The initiation schools in November have an impact on the utilisation rate of the clinics, as many initiates visit the clinics beforehand for a physical examination because a physical examination is required before an initiate is accepted.

The respondents were almost equally divided on the effect of seasonal issues on their service delivery: 48 (51.0%) agreed that seasonal issues had an impact and 46 (49.0%) disagreed that this was so.

Significant differences ($f = 5.0$; $p = 0.025$) were found in the mean scores of item 17. The chief professional nurses had a lower mean score (agreed less frequently with the statements) than the other categories of respondents. Of the respondents, more professional and senior professional nurses agreed that the listed elements adversely affected the delivery of PHC services (see figure 5.16). The professional and senior professional nurses possibly experienced the pressure of clinic management when they needed to act as managers due to the fact that they were not as skilled as the chief professional nurses who gained experience over time.

5.4.3 Section C: Organising function

The vision, mission, goals and strategy of the organisation are the point of departure in organising (Smit et al 2007:189). De Bruyn (1995:221) and Hellriegel et al (2001:11) define organising as the management function that deals with the assignment of duties, responsibilities and authority to people and departments. De Bruyn (1995:221) also states that organising cannot be done once off only at the initial establishment of the business, but is an ongoing process, requiring continuous interaction.

5.4.3.1 Functions of the clinic manager

Figure 5.17 depicts the respondents' perceptions of the five listed functions of a clinic manager.

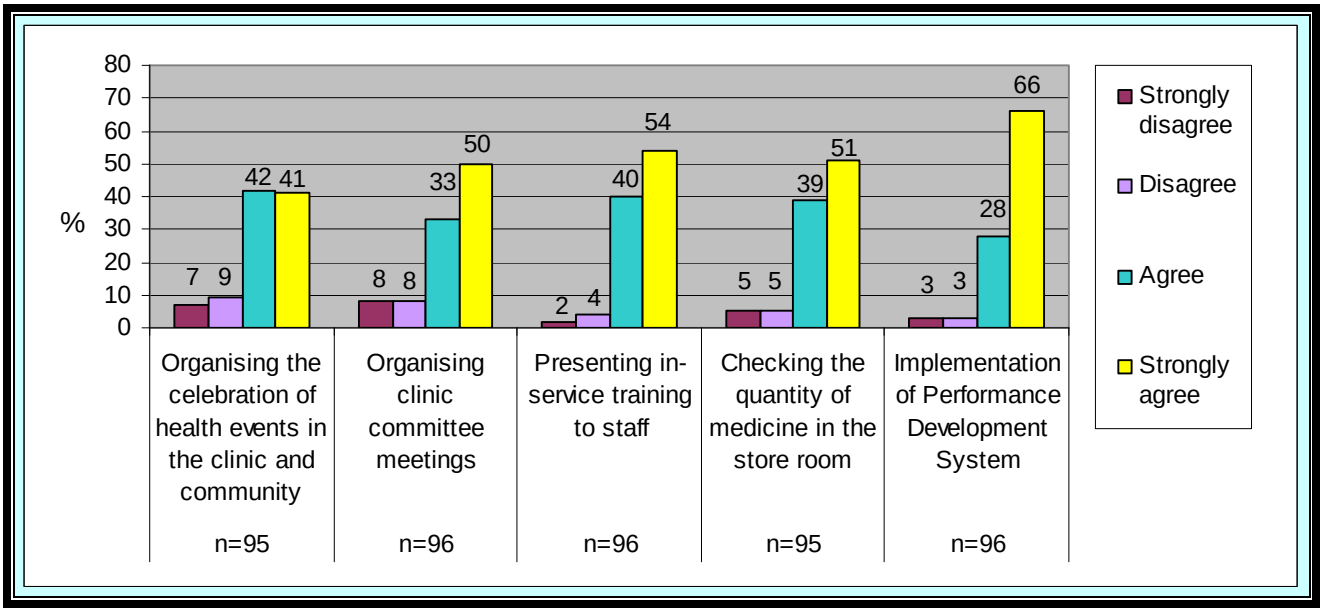

Figure 5.17 Functions of the clinic manager (n=96)

- **Organising health events in the clinic and community**

Figure 5.17 indicates that of the respondents, 16 (17.0%) *disagreed* that clinic managers should be involved in the celebration of health events in the community, while 79 (83.0%) were of the opinion that clinic managers should be involved in organising the celebration of

health events in the clinic and community. Hall et al (2002:14) emphasise that clinic managers should be involved in community matters.

- **Organising clinic committee meetings**

Of the respondents, 80 (83.0%) *agreed* that clinic managers should organise clinic committee meetings (see figure 5.17).

- **Presenting in-service training**

Figure 5.17 indicates that 90 (94.0%) of the respondents confirmed that one of the functions of a clinic manager is to present in-service training to staff. Booyens (1998:384) defines in-service training as training employees on the job. Jobs in the health care service are never static and are subject to rapid change; therefore there is a need for continuous in-service training of health care workers.

- **Checking the quantity of medicine in the store room**

Of the respondents, 85 (90.0%) indicated that one of the clinic manager's functions is to check the quantity of medicine in the storeroom (see figure 5.17). Although pharmacist assistants might be available in some clinics, the clinic manager is still accountable and responsible for the clinic in totality (Koch 1998:582).

- **Implementing the performance development system**

Performance management improves the performance of individuals and the organisation as a whole, and comprises developing both personnel and the organisation (du Preez 1998:15; Lussier 2006:279). Smit et al (2007:321) contend that performance evaluation and reward allocation can either encourage or discourage performance. Muller et al (2006:337) point out that the direct supervisor must be responsible for doing the appraisals of subordinates.

Of the respondents, 90 (94.0%) indicated that the implementation of the Performance and Development System for personnel was a function of the clinic manager (see figure 5.17).

5.4.3.2 Factors hindering the organising function

Figure 5.18 indicates factors hindering a clinic manager's organising function. These include consulting too many patients, too many meetings to attend, staff shortages, having to do too many tasks, and attending to too many issues.

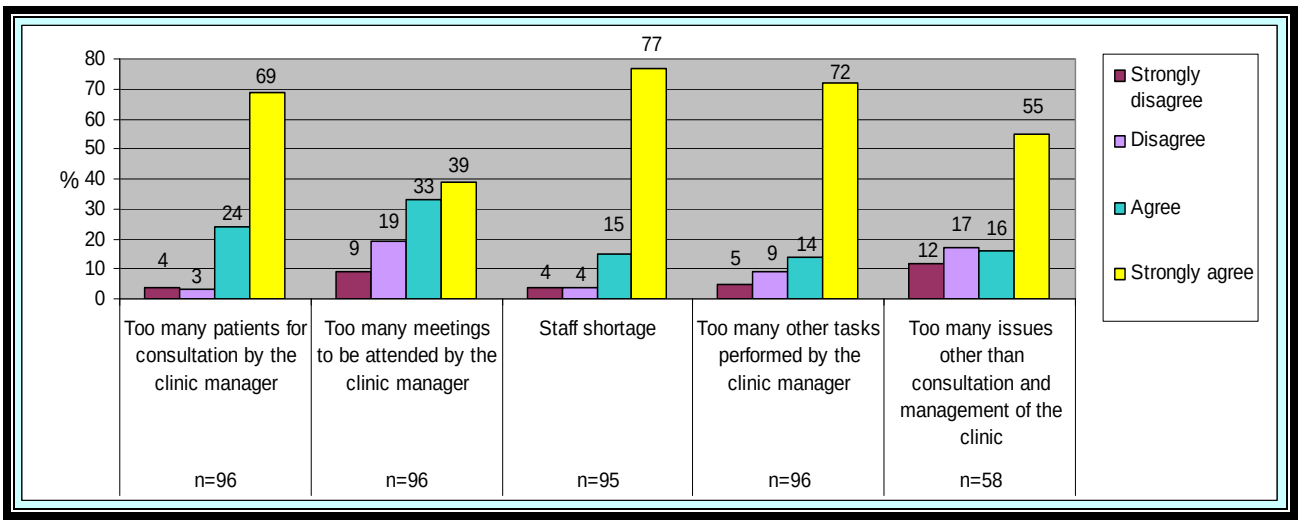

Figure 5.18 Factors hindering the organising function of a clinic manager (n=97)

- **Consultation of too many patients**

Of the respondents, 89 (93.0%) indicated that having too many patients to consult hindered their organising function.

- **Too many meetings**

Of the respondents, 69 (72.0%) *agreed* that being required to attend too many meetings hindered their organising function. Hart and Booyens (1998:256) point out that it is very easy for members of a meeting to use their time unproductively. A meeting may be unproductive because there is no real need for it. This might be due to an incompatible mix of members or a leader who lacks appropriate leadership skills. If members have a heavy

workload and find it difficult to participate in a meeting, it is unrealistic to expect good results from the meeting (Hart & Booyens 1998:256).

- **Staff shortages**

Of the respondents, 87 (92.0%) *agreed* that staff shortages hindered them in their organising function. Chabikuli et al (2005:104) emphasise that the shortage of nurses impacts negatively on PHC delivery and that the success of PHC reform policies depends on the extent to which shortages of staff in South Africa are addressed.

- **Performing too many tasks**

Of the respondents, 82 (85.0%) *agreed* that the clinic manager performs too many tasks, which has a negative effect on their organising function. These tasks include ordering, unpacking and dispensing of medicine, registering of patients, and telephonic bookings for patients.

- **Too many issues**

Forty-one (71.0%) of the respondents *agreed* that too many issues other than consultation of patients and clinic management require the attention of clinic managers, such as dispensing of medicine and transportation of staff due to a lack of drivers.

A comparison was made between the respondents with 0 to 5 years' experience and those with 6 and more years' experience. The ANOVA indicated a significant difference in the means of the two groups' years of experience ($f = 4.474$; $p = 0.039$). The group with 6 and more years' experience had a higher average score. This would seem to indicate that the respondents with more years of experience as a clinic manager in a PHC clinic are aware that other activities are jeopardising their organising function.

5.4.3.3 Specific aspects of respondents' training

The respondents were asked to indicate training in specific aspects that they had attended (see figure 5.19).

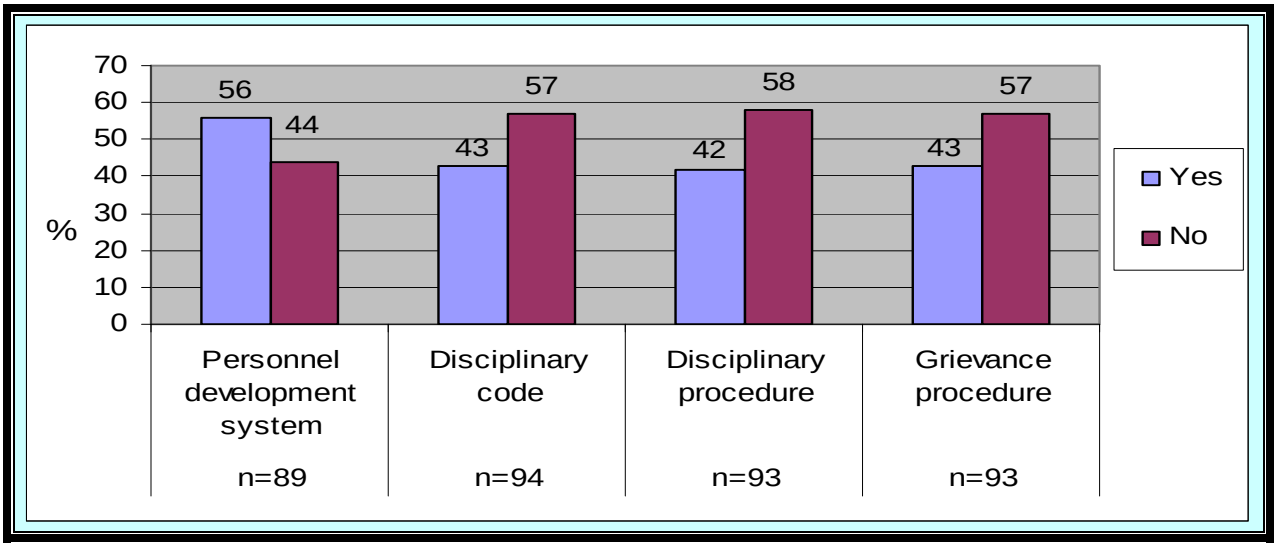

Figure 5.19 Respondents' training in specific aspects (n=94)

Figure 5.19 indicates that the respondents' training included the following aspects:

- **Personnel development system**

Of the respondents, 50 (56.0%) had received training in the personnel development system.

- **Disciplinary code and procedure**

Of the respondents, 40 (43.0%) had received training in the disciplinary code and 39 (42.0%) in the disciplinary procedure.

- **Grievance procedure**

Forty (43.0%) of the respondents had been trained in the grievance procedure.

These findings raised the question of how effectively these procedures could be implemented if such a small proportion of the respondents had been trained in these aspects.

Figure 5.19 indicates a significant difference in all aspects of training attended ($f = 7.0$; $p = 0.009$) by groups with different years' experience. The respondents with 0 to 5 years' experience had a higher mean score than those with 6 and more years' experience, indicating that they had received more training in the specified aspects than their seniors. This would seem to indicate that these particular aspects have received more attention in the past few years, which is promising.

With respect to training, a significant difference ($p = 0.048$) was found in the means of the different age groups. The respondents aged between 30 and 39 had the lowest average score, which indicated that they had not attended the training specified in the question. This finding indicated a definite need for training in these aspects for this age group, as well as for all clinic managers in future.

The Bonferroni test indicated that the mean of the respondents in the 30-39 years age group differed significantly from that of the 40-49 years age group (0.2; 0.50) in terms of training attended. This indicated that the younger respondents (30-39 years) had not attended training in aspects related to responsibilities of clinic managers. Training in these aspects is essential for effective clinic management.

With regard to training, there was a significant difference ($f = 4.0$; $p = 0.041$) between the means of the professional and senior professional nurses compared to the chief professional nurses. The chief professional nurses had a lower mean score than the professional and senior professional nurses. This might be due to the fact that they had longer experience and thus did not consider the training important.

It was noted that some respondents did not answer the question. The reason for this was unknown.

5.4.3.4 Ordering of medicine and medical consumables

The availability of medicine and medical consumables in the clinic is the responsibility of the clinic manager (see figure 5.20).

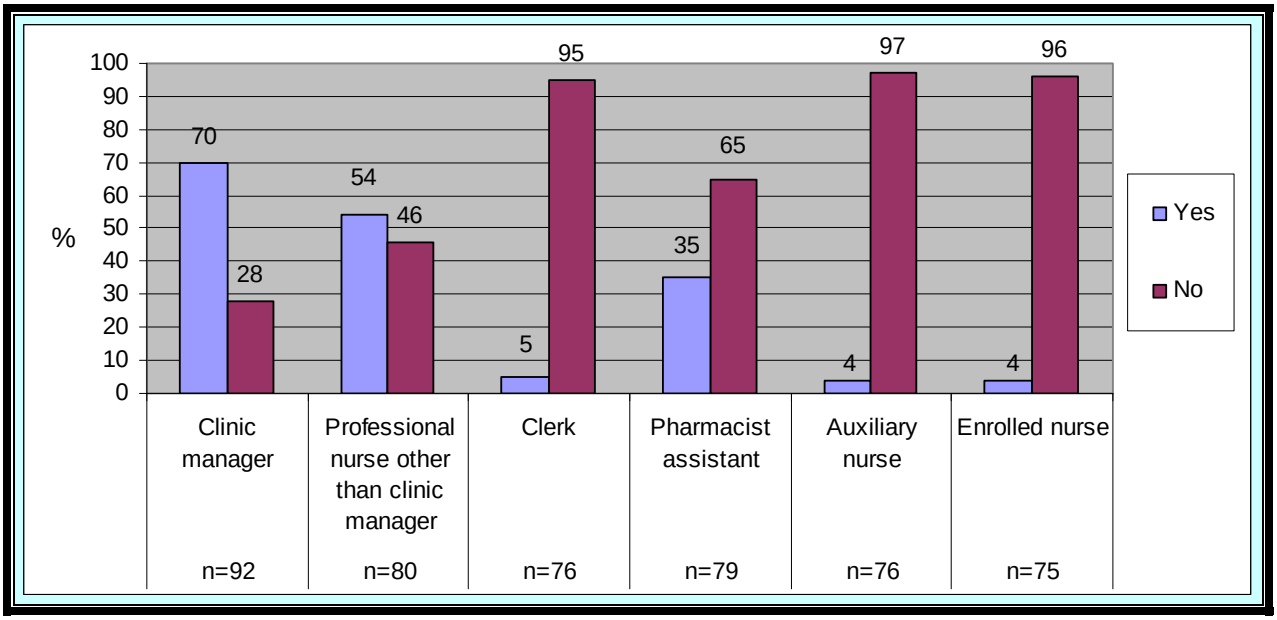

Figure 5.20 Ordering of medicine and medical consumables (n=92)

Of the respondents, 64 (70.0%) indicated that the clinic managers still mainly ordered medicine and medical consumables; 43 (54.0%) indicated the other professional nurses, and 28 (35.0%) indicated that pharmacist assistants took care of the ordering. The reason for clinic managers and professional nurses ordering medicine could be ascribed to the fact that there was still a shortage of trained pharmacist assistants and that vacant pharmacist posts on the staff establishment were not filled or funded.

5.4.3.5 PHC services rendered at clinics

The respondents were required to indicate which PHC services were rendered in their clinics (see figure 5.21).

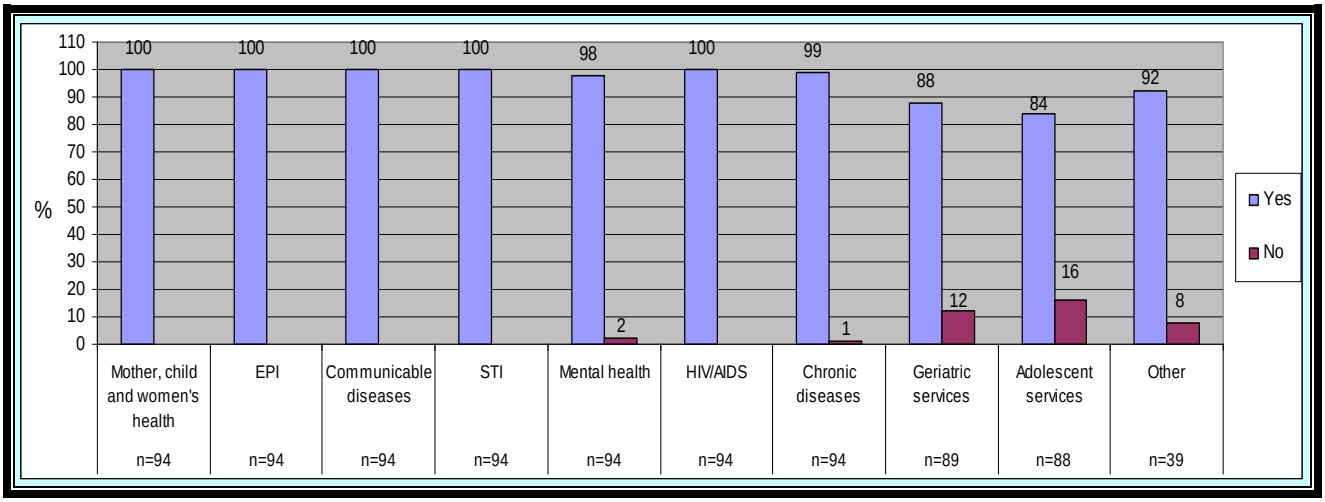

Figure 5.21 PHC programmes rendered at clinics (n=94)

Figure 5.21 indicates that most of the respondents reported the following services at their PHC clinics:

- Mother, child and women's health (94; 100.0%)
- EPI (94; 100.0%)
- Communicable diseases (94; 100.0%)
- STI (94; 100.0%)
- HIV/AIDS (94; 100.0%)
- Chronic diseases (93; 99.0%)
- Mental health (92; 98.0%)
- Geriatric services (78; 88.0%)
- Adolescent services (74; 84.0%)
- Other (36; 92.0%).

Three respondents did not answer the question on mother, child and women's health, EPI, communicable diseases, STI's, mental health and HIV/AIDS. It was of concern that of the respondents, only 78 (88.0%) indicated that they rendered geriatric services and 74 (84.0%) indicated that they rendered adolescent services. Geriatric patients and adolescents will inevitably be present in every clinic's catchment area. It was not clear why geriatric (78; 88.0%) and adolescent (74; 84.0%) services were not offered in all the clinics.

In terms of the PHC package, it is not compulsory to have all the services available at a clinic should there be more than one clinic in a town. Some of the services might be available at one clinic, whilst the others are available at another clinic as long as the full package is available per town.

5.4.3.6 Reasons for not rendering certain PHC services in clinics

The respondents were asked to identify the reasons for not rendering some PHC services in their clinics (see figure 5.22).

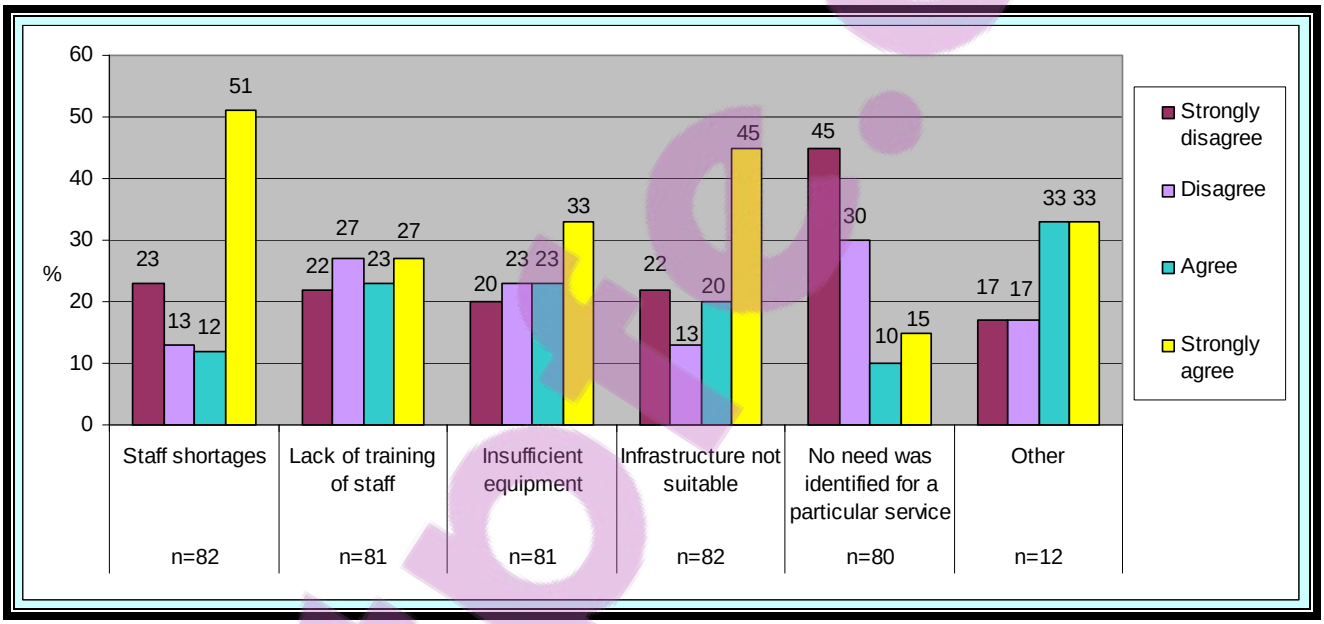

Figure 5.22 Reasons for not rendering some PHC services in clinics (n=82)

- **Staff shortages**

Of the respondents, 52 (63.0%) indicated *staff shortages* as the reason for not rendering some services at the PHC clinics. The reasons might be that all services cannot be expanded without the availability of adequately trained human resources, and the availability of health care personnel in the rural areas is limited. In most non-urban areas there are typically shortages of most categories of health workers and this has to be taken into account in the planning of services (du Toit 1998:117; Arnold 2005:133).

- **Staff not trained to render a specific service**

Of the respondents, 41 (51.0%) *agreed* and 40 (49.0%) *disagreed* that training for the specific services was a contributing factor for not providing some of the services at the clinics. Sixteen respondents did not answer the question. Booyens (1998:381) states that the quality of patient care rendered by staff can be related to their knowledge and skills. Nel et al (2004:393) and Arnold (2005:136) found consensus amongst the forward-looking countries and organisations that the quality of human resources determine a country's prosperity. Governments and employers recognise the important role a skilled and knowledgeable work force can play in securing competitive advantage in international markets.

- **Insufficient equipment available in the clinic**

Equipment is one of the resources used in management (Kroon 1995:8). A combination of equipment with other resources, namely human resources, money and markets, makes it possible to deliver certain products or services that fulfil a specific need in the process to achieve the company's stated objectives and goals (Kroon 1995:8, Nel et al 2004:63). Of the respondents, 46 (57.0%) *agreed* that insufficient equipment was available in their clinics.

- **Infrastructure of clinic not suitable to render specific services**

Of the respondents, 53 (65.0%) *agreed* that the infrastructure of their clinic was not suitable to render specific services.

- **No need identified for a particular service in the community**

Of the respondents, 60 (75.0%) *disagreed* that no need was identified for a particular service. In practice, a need for a service was identified, but some of the other given reasons might be the inhibiting factor.

A significant difference (f = 6.0; p = 0.014) was identified for reasons not to render some services in the clinic. The respondents with 0 to 5 years' experience had higher mean scores than those with 6 years and more experience. This might be due to the fact that the 0 to 5 years group were still acquainted with the demands to which a service had to adhere at grass roots level, while some with 6 and more years' experience might not have known about this. Some of the respondents did not render full-time clinical service in the clinic as they had to attend to the management of the clinic.

5.4.3.7 Responsibility for the implementation of the PHC package in clinics

The respondents were asked who was responsible for the implementation of the PHC package in clinics (see figure 5.23).

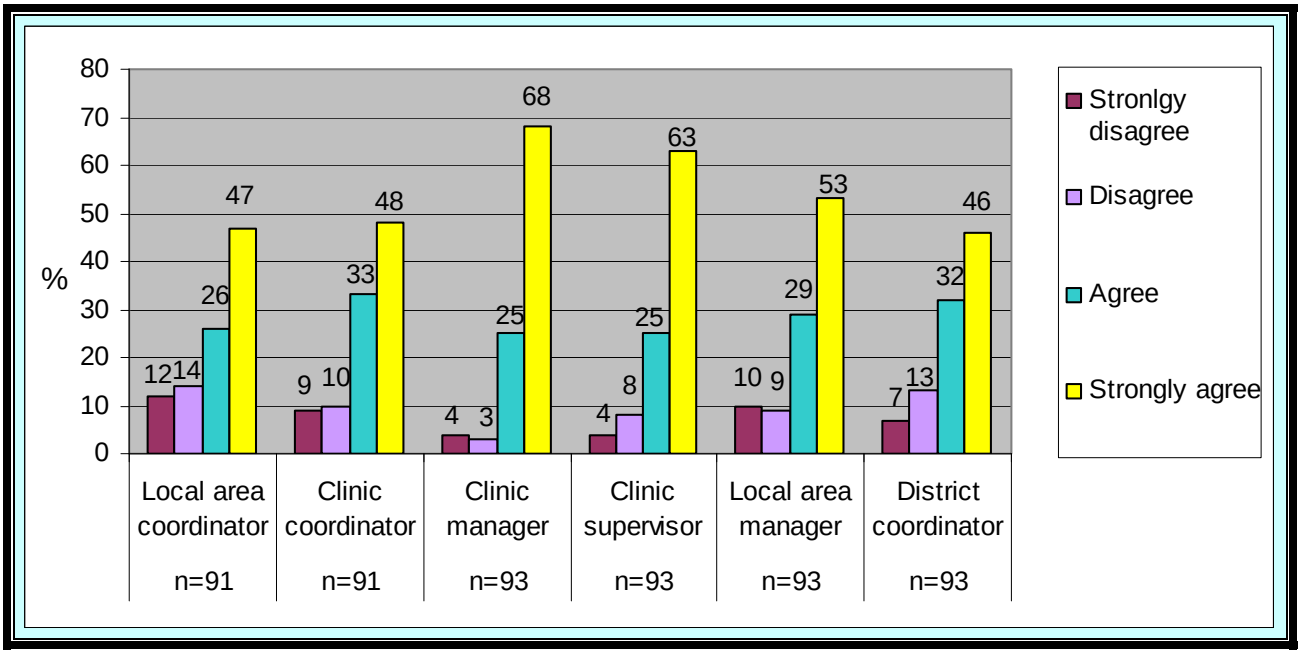

Figure 5.23 Responsibility for implementation of the PHC package in clinics (n=93)

Figure 5.23 indicates that most of the respondents *agreed* that all the role players, in the following sequence should be involved in the implementation of the PHC package in clinics: clinic manager (86; 92.0%), clinic supervisor (82; 88.0%), local area manager (76; 82.0%), clinic coordinator (74; 81.0%), district coordinator (73; 78.0%) and the local area coordinator (67; 74.0%). It is the responsibility of all stakeholders involved with district

health services to ensure the implementation of the PHC package in all clinics (Hall et al 2002:1).

5.4.3.8 Average time spent per day by the clinic manager on organising the different programmes in the clinic

The respondents were asked to indicate the average time they spent per day organising the PHC programmes in the clinic (see figure 5.24).

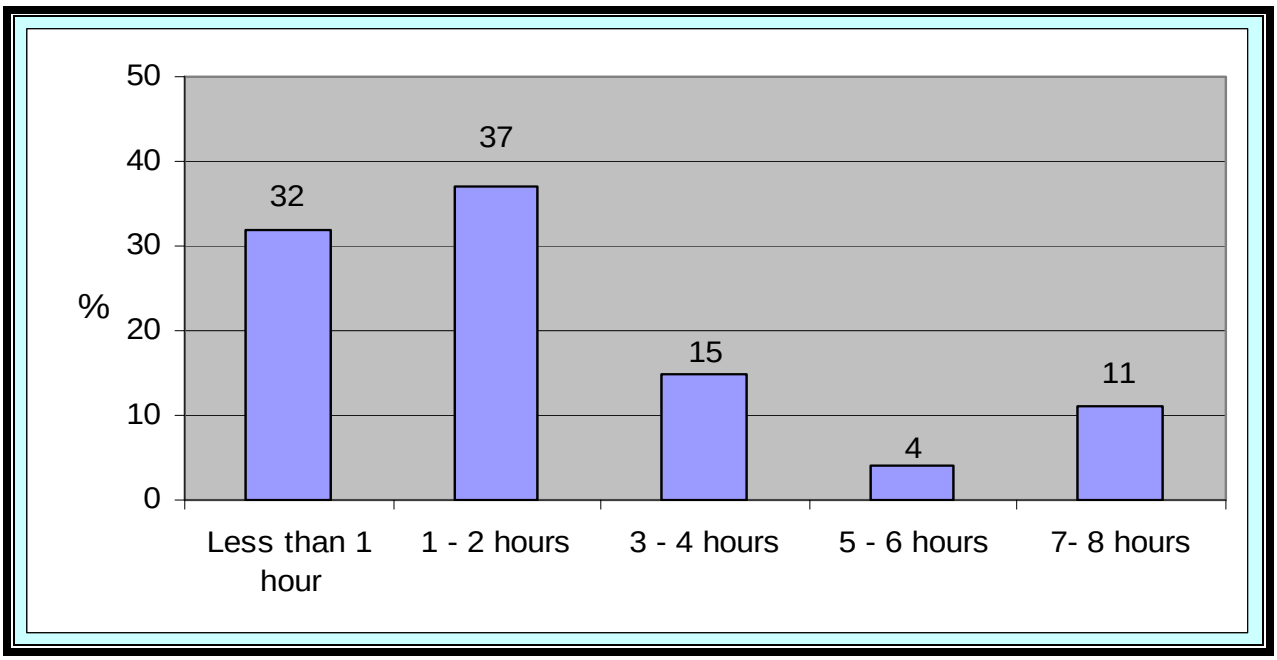

Figure 5.24 Average time spent per day by clinic manager on organising the different programmes in the clinic (n=97)

According to figure 5.24, of the respondents 36 (37.0%) spent 1 to 2 hours per day organising the different PHC programmes. This raises the question whether that is sufficient to organise and implement the various PHC programmes to achieve the targets. Furthermore, 31 (32.0%) of the respondents spent less than an hour on organising programmes. Factors contributing to this situation might be staff shortages that force clinic managers to perform clinical services and other tasks that need their attention, for example, training staff or attending meetings, resulting in neglect of organising the PHC programmes.

5.4.3.9 Frequency of clinic managers' absence from the clinic due to meetings, training sessions and workshops

At times clinic managers are absent from the clinics due to meetings or training (see figure 5.25).

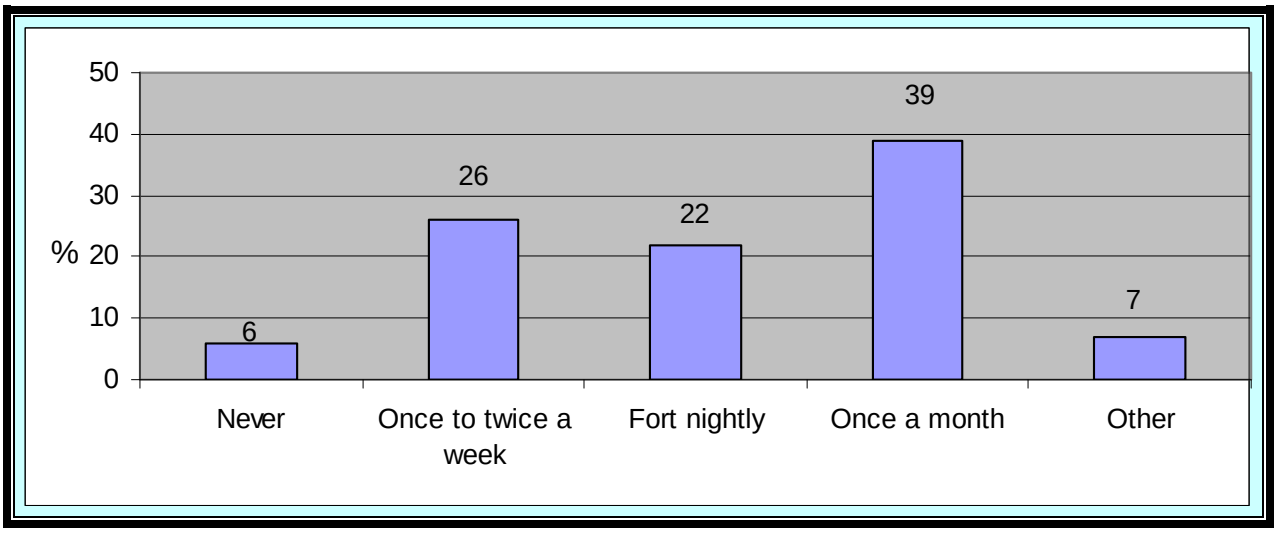

Figure 5.25 Frequency of clinic managers' absence from the clinic due to meetings, training sessions and workshops (n=89)

Figure 5.25 illustrates that of the respondents, 35 (39.0%) indicated that they were absent once a month from the clinic due to meetings, training and workshops; 23 (26.0%) were absent once to twice a week; 20 (22.0%) were absent fortnightly, and 5 (6.0%) were never absent due to meetings, training sessions and workshops. This was interpreted as not attending any meetings, training or workshops. This, in turn, raised concern about these respondents' development, as they were never exposed to any developmental opportunities. De Villiers (1995:315) states that in a rapidly changing environment the training and development of employees becomes a specialised field and training should be focused on the individual needs of employees in order to release their potential within a long-term perspective.

5.4.3.10 Frequency of respondents' consultation or coordination with other stakeholders

Van Niekerk (1995:199) and Pettinger (2007:426) emphasise that coordination encompasses all management functions including planning, organising, leading and control. Coordination can be converted to control, which results in corrective action. Corrective action promotes coordination. Coordination is thus viewed as an integrating part of management (van Niekerk 1995:199). The respondents were asked to indicate the extent of their consultation or coordination with other stakeholders (see table 5.5).

Table 5.5 Consultation or coordination with other stakeholders (n=95)

Stakeholder	Never		Weekly		Monthly		Quarterly		n	Total
	n	%	n	%	n	%	n	%		
Non-governmental organisations	35	40.0	8	9.0	28	32.0	17	19.0	88	100%
District hospital staff	45	48.0	10	11.0	24	26.0	14	15.0	93	100%
Community development officers	33	37.0	3	3.0	32	36.0	21	24.0	89	100%
Regional hospital staff	63	68.0	6	7.0	13	14.0	10	11.0	92	100%
Dietician	19	20.0	19	20.0	53	56.0	4	4.0	95	100%
Social worker	39	45.0	21	24.0	20	23.0	7	8.0	87	100%
Doctor visiting the clinic	18	20.0	64	70.0	7	8.0	2	2.0	91	100%
Rehabilitation staff	25	27.0	24	26.0	43	46.0	2	2.0	94	101%
DOT supporters	9	10.0	79	84.0	4	4.0	2	2.0	94	100%
Home-based carers	9	10.0	77	82.0	7	7.0	1	1.0	94	100%

According to table 5.5, most of the respondents (63; 68.0%) never consulted with regional hospital staff. However, 79 (84.0%) of the respondents consulted weekly with DOT supporters and 77 (82.0%) consulted with home-based carers. The reason for the latter two high percentages is that these carers have to report at least weekly to their clinics on

their patients' condition. Of the respondents, 53 (56.0%) consulted with the dietician and 43 (46.0%) consulted with the rehabilitation staff mainly on a monthly basis.

In addition, 39 (45.0%) of the respondents never consulted with the social worker. This could be ascribed to the fact that vacancies for social workers are often not filled. Many qualified social workers lose interest in applying for a post in the government sector because of the long waiting times between the advertisement of posts and finalisation of appointments. Moreover, many qualified people do not want to work in the rural areas.

5.4.3.11 Respondents' performance of non-managerial tasks in the clinic

The respondents were asked to indicate whether they were required to perform non-managerial tasks in their clinics (see figure 5.26).

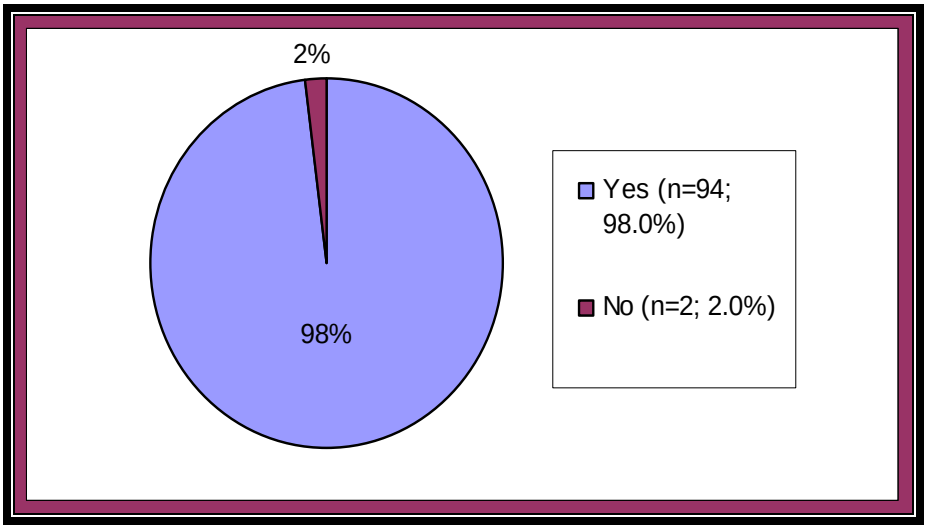

Figure 5.26 Respondents' performance of non-managerial tasks in the clinic (n=96)

According to figure 5.26, 94 (98.0%) of the respondents performed non-managerial tasks in the clinic. Table 5.6 lists the specific non-managerial tasks.

5.4.3.12 Respondents' non-managerial tasks impacting on management performance

The respondents were asked to indicate non-managerial tasks that could be performed by clerks, pharmacists or pharmacist assistants, and transport officers, which affect their management performance (see table 5.6).

Table 5.6 Respondents' non-managerial tasks that affect management performance (n=94)

Task	Yes		No		n	Total
	n	%	n	%		
Registering patients at reception	49	52.0	45	48.0	94	100%
Unpacking medicine	71	76.0	23	24.0	94	100%
Dispensing medicine	81	86.0	13	14.0	94	100%
Booking patients telephonically for appointments at a second level of referral	75	80.0	19	20.0	94	100%
Booking patients telephonically for commuter transport	58	62.0	36	38.0	94	100%
Booking patients telephonically for rehabilitation services	53	56.0	41	44.0	94	100%
Ordering of medicine	66	70.0	28	30.0	94	100%
Transporting subordinates to meetings, training sessions and workshops even if there is no need for the clinic managers to attend	24	26.0	70	74.0	94	100%
Other	7	7.0	87	93.0	94	100%

Of the respondents, 81 (86.0%) dispensed medicine, 66 (70.0%) ordered medicine, and 71 (76.0%) unpacked medicine. This could be related to the non-availability of trained pharmacist assistants in clinics.

With regard to transporting subordinates to meetings, training sessions and workshops even when clinic managers were not required to attend, 70 (74.0%) of the respondents did not take over the role of a transport officer, but 24 (26.0%) did, thereby removing them from

their management responsibilities. This could be attributed to the fact that there are no posts available for a driver on a number of staff establishments of clinics.

Of the respondents, 53 (56.0%) booked patients telephonically for rehabilitation services; 58 (62.0%) booked patients telephonically for commuter transport, and 75 (80.0%) booked patients telephonically for appointments at a second level of referral.

5.4.3.13 Availability of a job description for the clinic manager

The respondents were asked to indicate the availability of a job description for a clinic manager (see figure 5.27).

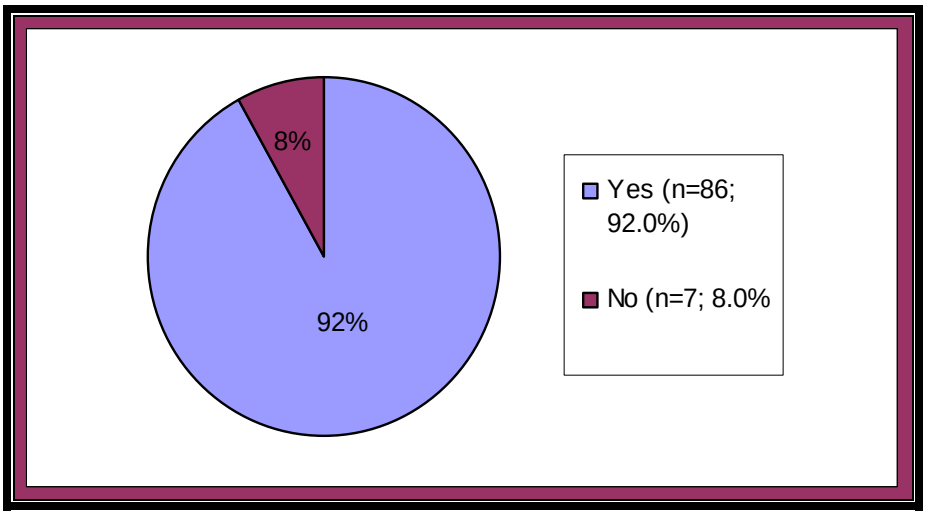

Figure 5.27 Availability of a job description for the clinic manager (n=93)

Of the respondents, 86 (92.0%) did have a job description, but 7 (8.0%) did not.

- **Job description clearly indicates the role of a clinic manager**

The respondents were asked to indicate whether the job description clearly indicated the role of a clinic manager in a PHC setting (see figure 5.28).

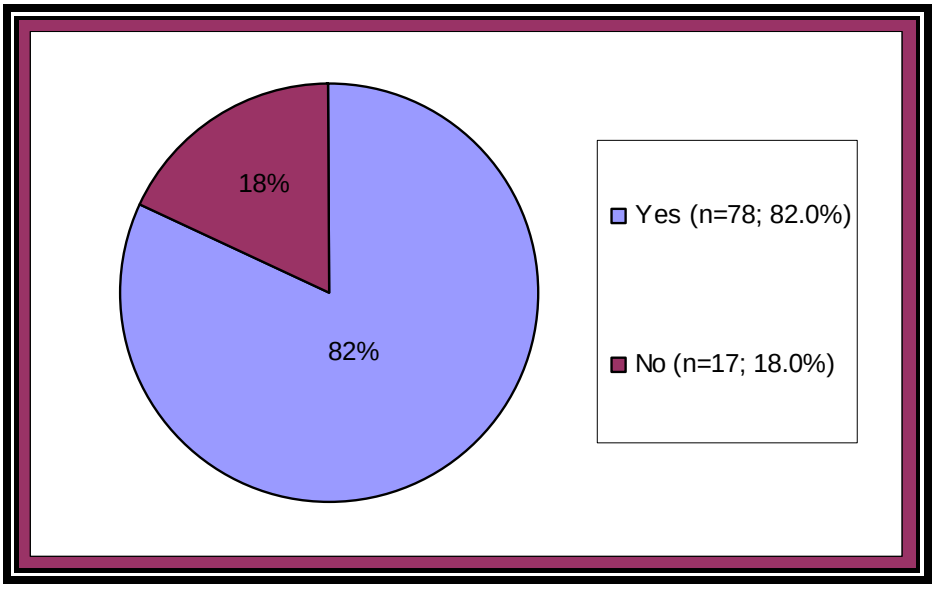

Figure 5.28 Clarity on the job description of a clinic manager (n=95)

Of the respondents, 78 (82.0%) indicated that their job descriptions clearly outlined their role as clinic manager (see figure 5.28). It was of concern, however, that 17 (18.0%) of the respondents indicated that their job description was not clear. This raised the question to what extent a clinic could be managed effectively if the manager did not know what was expected. Tembani et al (2003:67) found that clinic managers experienced role confusion. The management function was not always reflected in the job description and the managers felt that their management functions were neglected.

- **Respondents' ability to adhere to the job description**

The respondents were asked to indicate their ability to adhere to the job description (see figure 5.29).

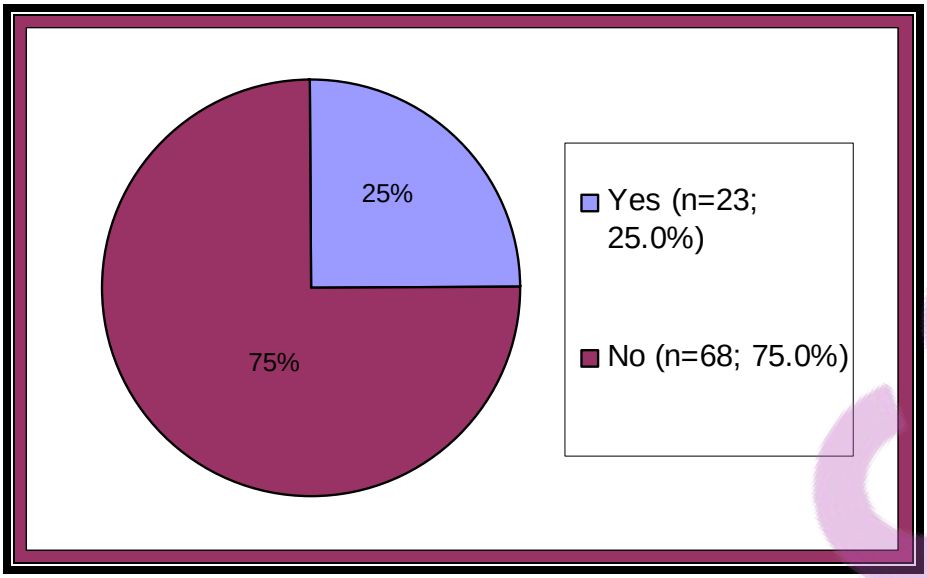

Figure 5.29 Ability to adhere to the job description (n=91)

Figure 5.29 indicates that most of the respondents (68; 75.0%) were unable to adhere to their job descriptions.

- **Reasons for not adhering to the job description**

Several factors can influence adherence to a job description. The respondents were asked to indicate why they were unable to adhere to their job descriptions (see figure 5.30).

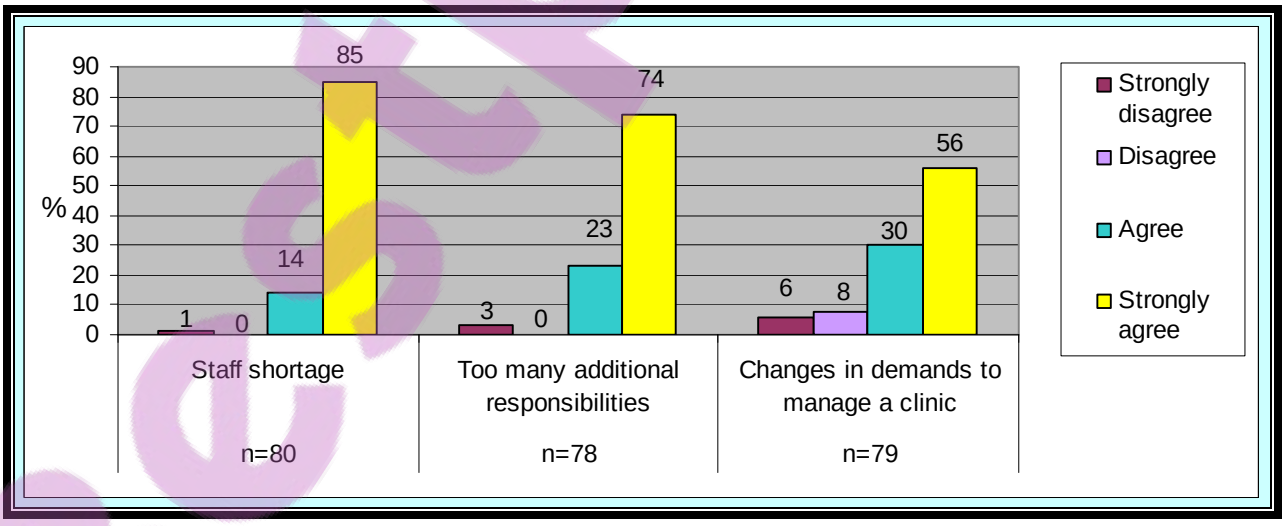

Figure 5.30 Reasons for not adhering to the job description (n=80)

- *Staff shortages*

Figure 5.30 indicates that almost all the respondents (79; 99.0%) *agreed* that staff shortages prevented them from adhering to their job description. Tembani et al (2003:67) point out that inadequate resources, especially personnel, force nurses in charge of clinics to devote most of their time to direct patient care duties and consequently pay less attention to supervisory duties. This will inevitably result in poor management of the clinic and operating results are likely to be below objectives (Arnold 2005:134).

- *Too many additional responsibilities*

Of the respondents, 76 (97.0%) *agreed* that too many additional responsibilities negatively affected their management responsibilities. According to Tembani et al (2003:67), various additional responsibilities, like acquiring and controlling medicines, ordering equipment, organising training for health workers and clinic committees, assisting in establishing and implementing community health projects, assisting with training of student nurses allocated to clinics and liaising with professionals in other disciplines to promote the health status of community members, negatively impact on management.

- *Demands to manage a clinic*

Of the respondents, 68 (86.0%) *agreed* that the demands from above, for example from the Provincial Department of Health and/or the NDOH, changed too often (see figure 5.30). Tembani et al (2003:67) emphasised that among the factors influencing supervisors' tasks and responsibilities were the changing demands made on them. Consequently, clinic managers felt an inability to perform their supervisory roles efficiently and effectively. Clinic managers experience stress as a result of being in charge of clinics and the need to be supported.

5.4.3.14 Effects of provision of expanded/changed health care

The respondents were asked to indicate the effect of the expanded/changed health care provisioning since 1996 on the staff establishment of the clinic in terms of whether the clinic:

		Yes	No
33.1	Was assessed in terms of efficiency		
33.2	Was expanded due to the assessment		
33.3	Was decreased due to the assessment		
33.4	Remained unchanged due to the assessment		

Figure 5.31 illustrates the respondents' replies to the question.

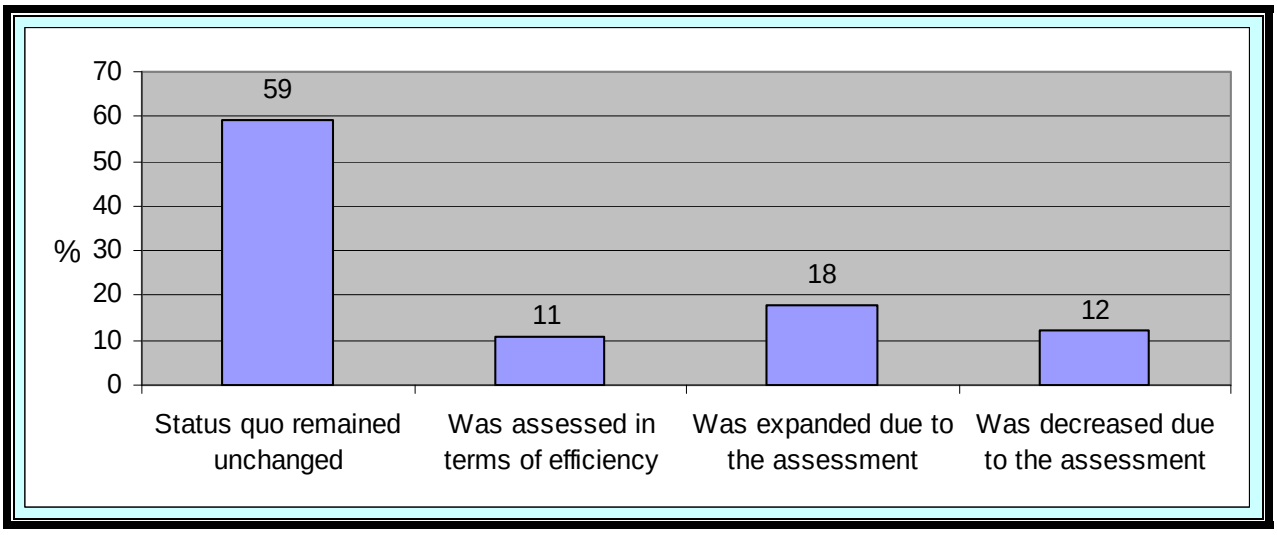

Figure 5.31 Effect of the expanded/changed health care provisions on the staff establishment of the clinic (n=90)

Of the respondents, 53 (59.0%) indicated that the status quo had remained unchanged in their staff establishment even though their workload had increased. According to the data, only 10 (11.0%) of the clinics were assessed for efficiency. Sixteen (18.0%) of the clinics' staff establishments were expanded while eleven (12.0%) were decreased after assessment.

This was identified as erroneous data. According to the data, only 11.0% of the clinics were assessed. However, 18.0% were expanded due to the assessment and 12.0% of the clinics' staff establishment was decreased. Therefore, not only 11.0% of the clinics could have been assessed as the calculations show that adjustment took place in 30.0% (18.0% + 12.0%) of the clinics.

De Villiers (1995:304) states that in the past staffing was often unplanned with detrimental results, but businesses (organisations) presently tend to emphasise scientific human resource planning as an important facet of the staffing process. De Villiers (1995:308) stresses that should the demand for staff be greater than the internal supply, efforts should be made to obtain additional staff from outside. Taking into consideration the mission, strategy and goals of the Free State Department of Health, suitable personnel should be provided to render efficient and effective health services to the community (de Villiers 1995:322).

Du Preez (1998:25) acknowledges that the management of rapid and radical change is a challenge to managers in the overstressed health service. Muller et al (2006:109) maintain that healthcare managers need to have knowledge, skills, attitudes and values to adequately manage change. According to Pick et al (2001:111), a major problem with the implementation of the PHC package was the lack of proper provisioning of personnel to deliver the package. Smit et al (2007:214) confirm that most of the change is new and managers do not necessarily have any guidelines on how to deal with the situation.

5.4.3.15 Hours of service delivery at comprehensive integrated PHC services

All clinics should be accessible for clients and the number of hours a clinic provides a comprehensive integrated PHC service contributes to the accessibility of clinics. The respondents were asked to indicate the hours of service delivery at their clinics (see figure 5.32).

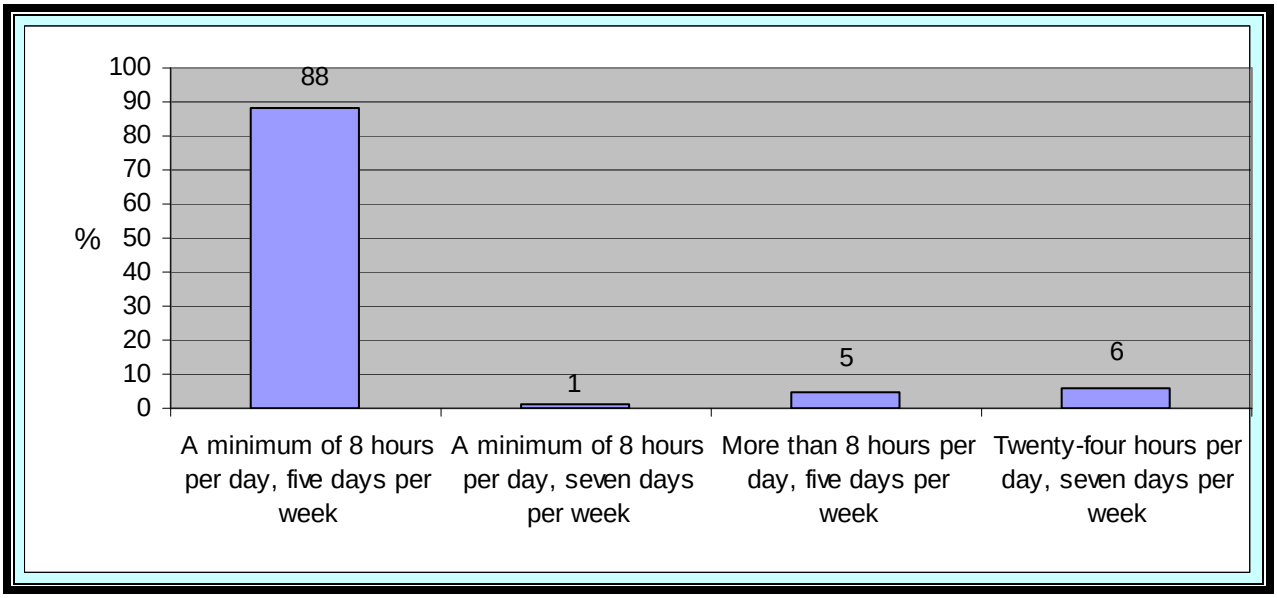

Figure 5.32 Hours of service delivery at comprehensive integrated PHC services (n=97)

According to figure 5.32, the majority of the respondents (85; 88.0%) indicated that a service was provided for 8 hours a day for five days a week in their clinics. This is in line with the core norms and standards for health clinics (DOH 2001a:12). However, in an effort to make PHC services more accessible to the community and to adhere to the referral system of the Department of Health, efforts are made to increase the number of hours for service rendering at PHC clinics. Due to financial constraints and staff shortages, this is only implemented in a few clinics. Of the respondents, 6 (6.0%) indicated that they rendered a 24-hour service; 5 (5.0%) rendered a service of more than 8 hours per day for five days a week, and 1 (1.0%) indicated a service with a minimum of 8 hours per day for seven days a week. Since most of the clinics (85; 88.0%) rendered a service of only 8 hours per day, the district hospitals were overloaded after hours with patients in need of a health service. Most of these cases arriving at the hospital were not emergencies as they could be attended to in a clinic the following day.

5.4.3.16 Availability of one formally PHC- trained professional nurse per clinic

To contribute to the quality of PHC services rendered in a PHC clinic, the ideal would be to have all professional nurses working in a PHC clinic, PHC-trained. The respondents were

asked to indicate the availability of at least one professional nurse per clinic with a PHC qualification (see figure 5.33).

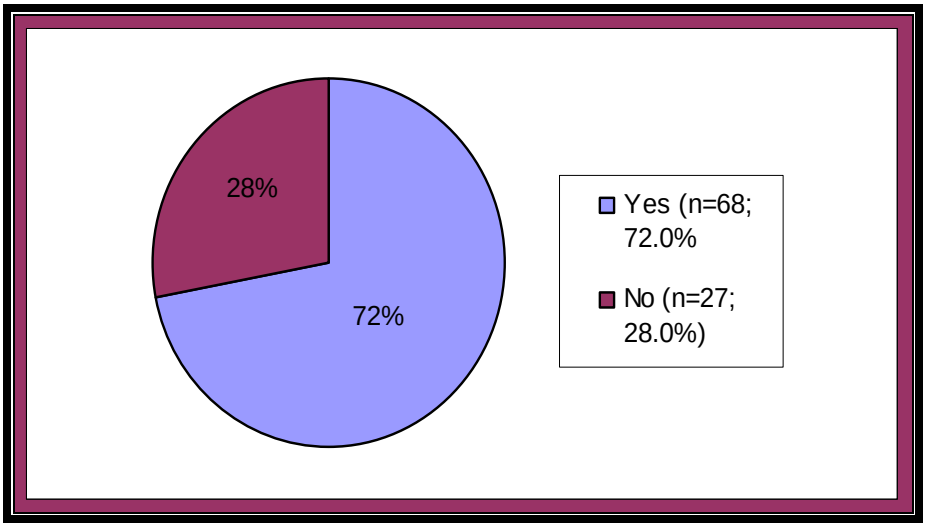

Figure 5.33 Availability of one formally PHC-trained professional nurse per clinic (n=95)

According to figure 5.33, 68 (72.0%) of the respondents indicated that the clinics had at least one professional nurse with a recognised formal PHC qualification. The 27 (28.0%) respondents who did not have a nurse with a PHC qualification in their clinics gave no reasons for the situation. Due to the fact that PHC is a nurse-driven process and PHC nurses should be skilled in assessment, diagnosing and treatment of illnesses, it was encouraging that almost 75.0% of the clinics had a PHC trained professional nurse.

5.4.3.17 Facilitation of programmes, management of PHC clinics, rendering of patient care

The respondents were asked to indicate what they considered the function of the clinic manager with respect to the following three alternatives: facilitation of PHC programmes in the clinic; managing PHC clinics without direct involvement in patient care, and rendering of patient care simultaneously with clinic management (see figure 5.34).

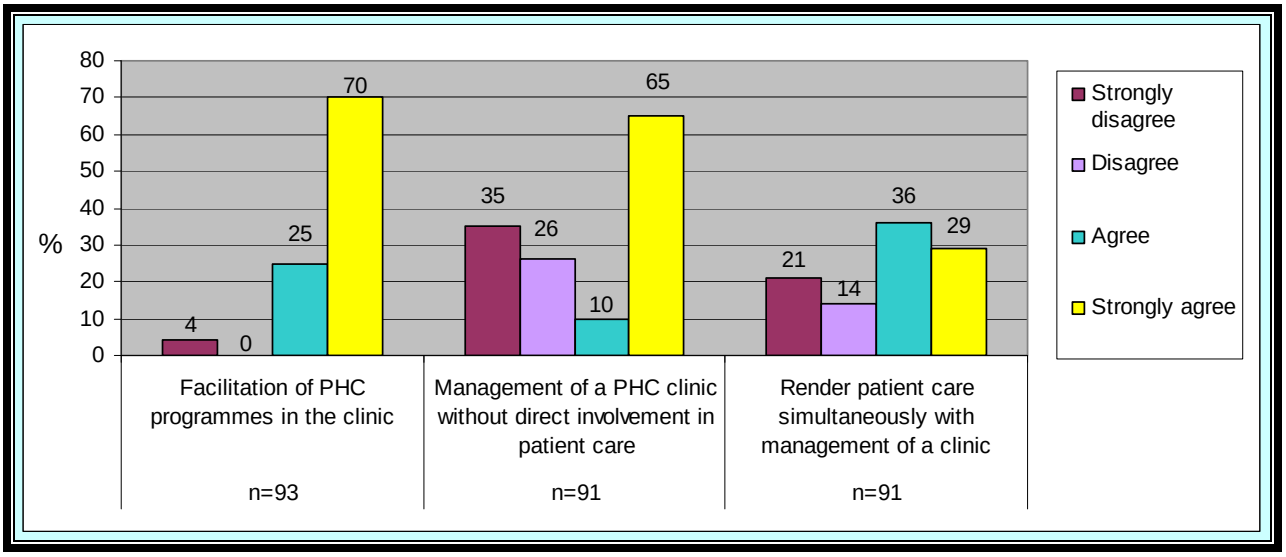

Figure 5.34 Facilitation of programmes, management of PHC clinics, rendering of patient care (n=93)

According to figure 5.34, only 4 (4.0%) of the respondents *disagreed* that it was the clinic manager's function to facilitate PHC programmes in the clinic, while 89 (96.0%) *agreed* that facilitation of PHC programmes was a function of the clinic manager. With regard to patient care, 32 (35.0%) of the respondents *disagreed* that patient care should be rendered simultaneously with clinic management, while 59 (65.0%) *agreed* that they rendered patient care simultaneously with their management function Tembani et al (2003:67) found that clinic managers had to execute nursing duties like assessing patients, prescribing medication, dressing wounds and counselling. These duties were all added to clinic managers' responsibilities.

5.4.3.18 Activities of a clinic manager

The respondents were asked to rate specific managerial activities in their clinics (see figure 5.35).

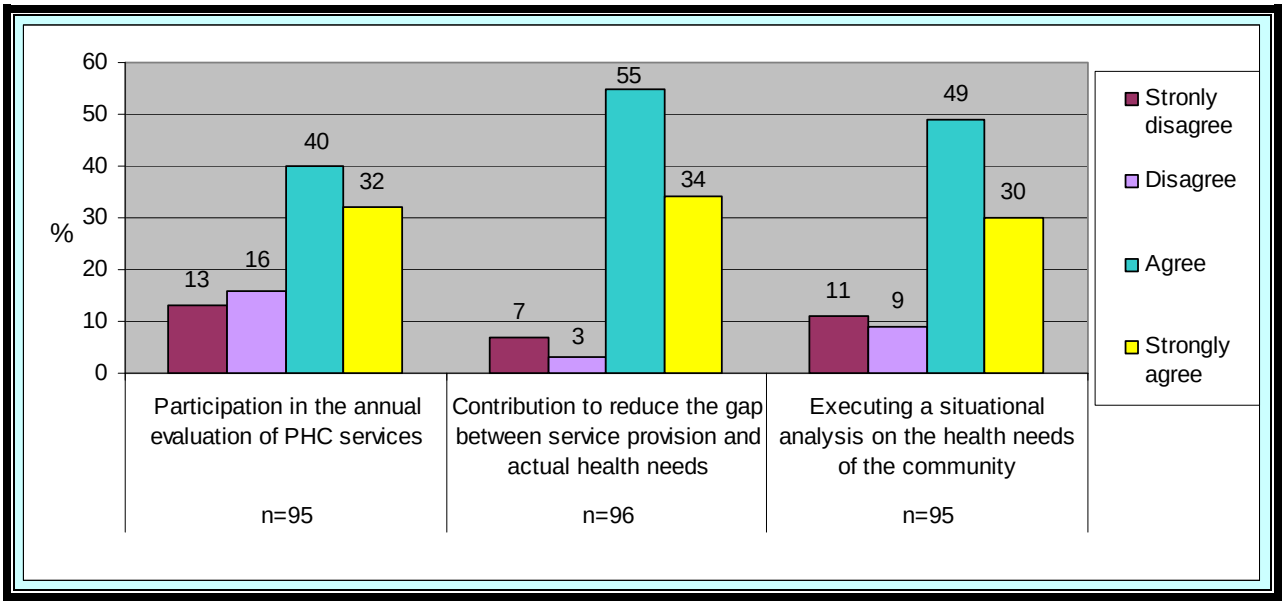

Figure 5.35 Activities of a clinic manager (n=96)

Regular evaluation of any health service is necessary to measure its efficiency and effectivity.

According to figure 5.35, 68 (72.0%) of the respondents *agreed* with *participation in the annual evaluation of PHC service* while 27 (29.0%) *disagreed* that they participated in the annual evaluation of PHC services. This evaluation assesses the correct utilisation of the abilities and skills of personnel, the effective coordination of support services, and the skilful utilisation of resources to ensure that the organisation of the clinic is such that the philosophy and mission of the service can be realised (Booysen 1998:185).

Of the respondents, 86 (89.0%) confirmed that they had a responsibility to *reduce the gap between service provision and actual health needs*. This is in line with the PHC package (DOH 2001b:7).

Of the respondents, 76 (79.0%) did a *situational analysis* on the health needs of the community. According to Kroon and van Zyl (1995:122), a situational analysis comprises an analysis of the internal infrastructure, skills and resources. Based on the information obtained from the analysis, different possibilities can be considered through which the goals of the organisation may be achieved.

5.4.3.19 Availability of printed material in the clinic stipulated by the PHC standards

The following documentation, contained in the PHC standards, should be available in each clinic:

- Educational material
- An EDL manual in every consulting room
- A mini library
- Appropriate national and provincial health circulars
- Appropriate policies
- Copies of the Patients' Right Charter
- Supplies of health education material in local languages.

The respondents were asked to rate the importance of the availability of items in the clinic (see table 5.7).

Table 5.7 Respondents' rating of importance of the availability of printed material in the clinic as stipulated by the PHC standards (n=96)

Item	Strongly agree		Agree		Disagree		Strongly disagree		n	Total
	n	%	n	%	n	%	n	%		
Educational material	76	80.0	15	16.0	1	1.0	3	3.0	95	100%
An EDL manual in every consulting room	86	91.0	8	8.0	0	0	1	1.0	95	100%
A mini library	29	31.0	40	42.0	14	15.0	12	13.0	95	101%
Appropriate national and provincial health circulars	81	85.0	11	12.0	2	2.0	1	1.0	95	100%
Appropriate policies	80	86.0	12	13.0	1	1.0	0	0	93	100%
Copies of the Patients' Right Charter	84	88.0	10	10.0	1	1.0	1	1.0	96	100%
Supplies of health education material in local languages	82	85.0	11	11.0	1	1.0	2	2.0	96	99%

Most of the respondents indicated that they *agreed* with the importance of the availability of the following items in the clinic as would be expected, as it is a requirement of the PHC standards:

- An EDL manual in every consulting room (94; 99.0%)
- Appropriate policies (92; 99.0%)
- Copies of the Patients' Rights Charter (94; 98.0%)
- Supplies of health education material in local languages (93; 97.0%)
- Educational material (91; 96.0%)
- Appropriate national and provincial health circulars (92; 97.0%)
- Mini library (69; 73.0%).

Although most of the respondents indicated that it was important to have these different documents available in their clinics, in reality there is a serious shortage of educational material and references, appropriate national and provincial health circulars, policies and supplies of health education material in local languages, which indicates a lack of support from the authorities. Thus the phrasing of the question did not focus on the availability of these documents.

5.4.3.20 Availability of equipment/facilities in the clinic

It is imperative to have the essential equipment and facilities at hand if optimal service delivery is to be achieved. Accordingly, the respondents were asked to indicate the availability of equipment/facilities in the clinics (see table 5.8).

Table 5.8 Availability of equipment/facilities in the clinic (n=96)

Equipment/facilities	Never		Sometimes		Most of the time		Always		n	Total
	n	%	n	%	n	%	n	%		
Diagnostic sets	1	1.0	6	6.0	15	16.0	74	77.0	96	100%
Blood pressure apparatus	1	1.0	6	6.0	20	21.0	69	72.0	96	100%
Adult scales	0	0	2	2.0	11	11.0	83	86.0	96	99%
Infant scales	0	0	0	0	8	8.0	88	92.0	96	100%
Stethoscopes	0	0	0	0	14	15.0	82	85.0	96	100%
Telephone	4	4.0	4	4.0	15	16.0	73	76.0	96	100%
Refrigeration facilities	1	1.0	0	0	12	13.0	82	86.0	95	100%
Internet	86	90.0	3	3.0	2	2.0	5	5.0	96	100%
Transport facilities	37	39.0	24	25.0	21	22.0	14	15.0	96	101%
Condom dispensers	11	12.0	1	1.0	7	7.0	75	80.0	94	100%
A sharps disposal system	0	0	5	5.0	7	7.0	83	87.0	95	99%
Equipment and containers for taking blood and other samples	0	0	3	3.0	11	12.0	81	85.0	95	100%

According to table 5.8, the respondents indicated that the following equipment/facilities were *always* available in the clinic:

- Diagnostic sets (74; 77.0%) and most of the time (15; 16.0%)
- Blood pressure apparatus (69; 72.0%) and most of the time (20; 21.0%)
- Adult scales (83; 86.0%) and most of the time (11; 11.0%)
- Infant scales (88; 92.0%) and most of the time (8; 8.0%)
- Stethoscopes (82; 85.0%) and most of the time (14; 15.0%)
- Telephone (73; 76.0%) and most of the time (15; 16.0%)
- Refrigeration facilities (82; 86.0%) and most of the time (12; 13.0%)
- Condom dispensers (75; 80.0%) and most of the time (7; 7.0%)
- A sharps disposal system (83; 87.0%) and most of the time (7; 7.0%)

- Equipment and containers for taking blood and other samples (81; 85.0%) and most of the time (11; 12.0%).

As these are basic equipment needs, it was of concern that the abovementioned equipment was not always available at all times. This might be due to contingency measures, which are implemented by the Provincial Department of Health when funds are not available due to over expenditure. The approach of the Provincial Department of Health is to stop all purchases, resulting in clinics not having the necessary equipment to render services.

It was of grave concern that a small minority of the respondents indicated that the following equipment/facilities were *never* available in their clinic, as most of these items are crucial to service delivery:

- Internet (86; 90.0%)
- Transport facilities (37; 39.0%)
- Condom dispensers (11; 12.0%)
- Telephones (4; 4.0%)
- Diagnostic sets (1; 1.0%)
- Blood pressure apparatus (1; 1.0%)
- Refrigerator facilities (1; 1.0%).

The equipment/facilities mentioned are **basic needs** to render a PHC service to the community. This raises the question whether any kind of quality service can be rendered without basic equipment, such as a diagnostic set and a blood pressure apparatus.

5.4.3.21 Availability of a suitable infrastructure in clinics

A suitable infrastructure is essential for the delivery of any form of health care. The respondents had to indicate the availability of the structures listed in table 5.9 in their clinics.

Table 5.9 Availability of a suitable infrastructure in clinics (n=96)

Infrastructure	Yes		No		n	Total
	n	%	n	%		
Functional sluice room	54	56.0	42	44.0	96	100%
Adequate number of consulting rooms without basins	14	15.0	78	85.0	92	100%
Adequate number of consulting rooms with basins	75	80.0	19	20.0	94	100%
Availability of reliable electricity supply	77	80.0	19	20.0	96	100%
Running cold water	91	95.0	5	5.0	96	100%
Running warm water	60	64.0	34	36.0	94	100%
Sufficient availability of consulting rooms	52	55.0	42	45.0	94	100%
Pharmacy	64	67.0	32	33.0	96	99%
Store room space	65	68.0	31	32.0	96	100%

From table 5.9 it is evident that deficiencies existed in most of the clinics with regard to the most basic infrastructure requirements. This was a serious slant on the authorities for not enabling and ensuring that the minimum infrastructure components are available in all of the clinics.

The respondents indicated that the following suitable infrastructure was available:

- Running cold water (91; 95.0%)
- Availability of a reliable electricity supply (77; 80.0%)
- Adequate number of consulting rooms with basins (75; 80.0%)
- Storeroom space (65; 68.0%)
- Pharmacy (64; 67.0%)
- Running warm water (60; 64.0%)
- A functional sluice room (54; 56.0%)
- Sufficient availability of consulting rooms (52; 55.0%)
- Adequate number of consulting rooms without basins (14; 15.0%).

5.4.3.22 Availability of proper mechanisms pertaining to the EDL, medicine and supplies

For the EDL to be applied effectively, certain mechanisms need to be functional in terms of medicines and supplies (refer to table 5.10).

Table 5.10 Availability of proper mechanisms pertaining to the EDL, medicine and supplies (n=96)

Mechanism	Yes		No		n	Total
	n	%	n	%		
Mechanism for the ordering of supplies	92	96.0	4	4.0	96	100%
Mechanism for maintaining supplies	90	94.0	6	6.0	96	100%
Mechanism for control of supplies	89	94.0	6	6.0	95	100%

Most of the respondents indicated that they had the following mechanisms in place:

- for ordering supplies (92; 96.0%)
- for maintaining supplies (90; 94.0%)
- for control of supplies (89; 94.0%).

There was room for improvement, however, as approximately 4 to 6% of the respondents did not have the necessary processes in place, and medicine and supplies form an integral part of service delivery.

5.4.3.23 Utilisation of prescribed standards, treatment guidelines and protocols in patient care

Standards, treatment guidelines and protocols are used in clinics to ensure uniformity and standardisation of care. The respondents were asked to indicate the degree of adherence to prescribed standards and utilisation of treatment guidelines and protocols (see figure 5.36).

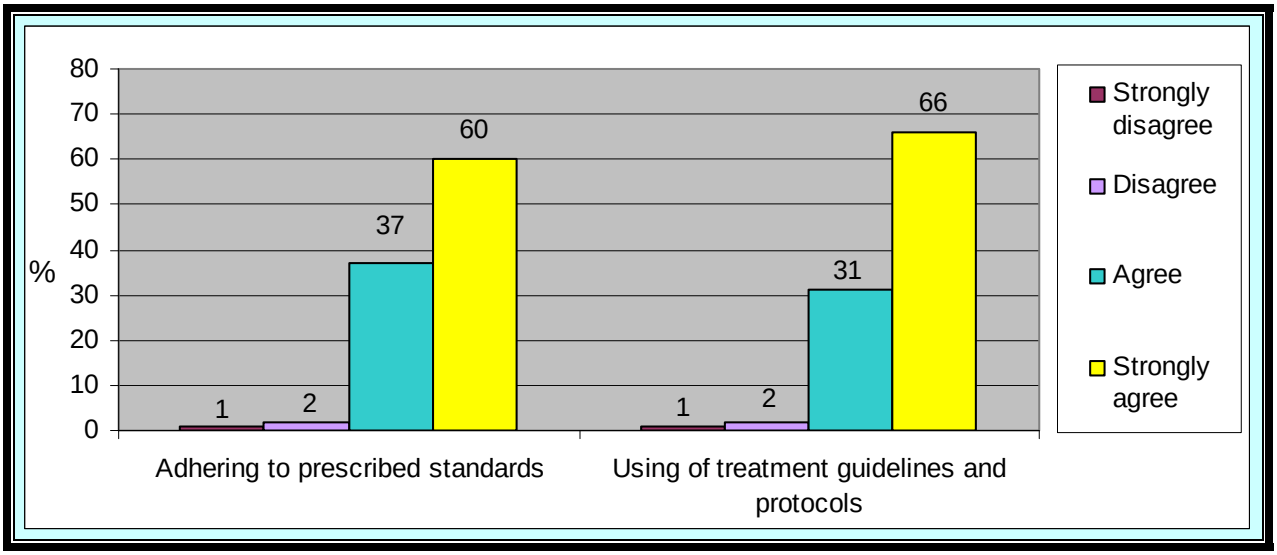

Figure 5.36 Provision of care to patients by adhering to prescribed standards (n=95)

According to figure 5.36, the majority (92; 97.0%) of the respondents indicated that the prescribed standards and treatment guidelines and protocols were observed in the provision of care. According to Muller (1998a:606), standards clearly and objectively define the way in which clinical services should be rendered and managed. A standard is a written description of the desire and level of performance and serves as a basis for comparison (Muller 1998a:606; Muller et al 2006:537; Lussier 2006:493). The document, *The primary health care package for South Africa – a set of norms and standards* serves as a reference of standards available in a PHC setting (DOH 2001a). In PHC services various protocols are available, such as for the treatment of STI, the treatment of suspected rabies cases, and the termination of pregnancy.

5.4.3.24 Provision of patient education in the clinic

Marketing campaigns for various target groups, using mass media and peer education, can play an important role in the prevention of various conditions (Sonko, McCoy, Gosa, Hamelmann, Chabikuli, Moys, Ramkissoon & Hlazo 2002: 266).

The respondents were asked to indicate different means of patient education provided in their clinics (see table 5.11).

Table 5.11 Provision of patient education in the clinic (n=95)

Patient education	Yes		No		n	Total
	n	%	n	%		
Recognised service providers on identified health problems occurring in the community	78	83.0	16	17.0	94	100%
Displaying and availing health information material in the clinic	90	95.0	5	5.0	95	100%
Clinic staff providing health education sessions	86	91.0	8	9.0	94	100%
Utilisation of television programmes	30	33.0	62	67.0	92	100%

Of the respondents, 62 (67.0%) indicated that television programmes were not utilised in providing health education in their clinics. These clinics possibly did not have access to a television set or no material was available for utilisation.

Most of the respondents indicated that patient education was provided by

- Displaying and availing health information material in the clinic (90; 95.0%)
- Clinic staff providing health education sessions (86; 91.0%)
- Recognised service providers on identified health problems, such as in the community (78; 83.0%).

It was thus deduced that patient education was provided in most of the clinics although ideally it should be available in all clinics.

5.4.3.25 Barriers preventing patient education in the clinic

The respondents were asked to indicate barriers to the provision of patient education in their clinics (see table 5.12).

Table 5.12 Barriers to patient education (n=80)

Barrier	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
Lack of time to give patient education because of heavy workload	11	14.0	16	21.0	24	31.0	27	35.0	78	101%
Health information material not available at clinic	20	25.0	28	35.0	20	25.0	12	15.0	80	100%
Health information material not available at Provincial Department of Health	21	28.0	31	41.0	14	18.0	9	12.0	75	99%

According to the respondents, the main reason for not providing patient education was *a lack of time*. Of the respondents, 51 (66.0%) indicated that a lack of time was a barrier to patient education; 48 (60.0%) indicated that health information material was available at the clinic, while 32 (40.0%) indicated that it was not available. Finally, 23 (31.0%) indicated that health information material was not available at the Provincial Department of Health.

5.4.3.26 Equipping the clinic manager by orientation to specific aspects

In order to be familiar and knowledgeable about a new work environment, a good orientation programme is essential. The respondents were asked to indicate the aspects covered in their orientation programme for clinic managers (see table 5.13).

Table 5.13 Specific aspects in an effective orientation programme for the clinic manager (n=95)

Aspect	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
Job description	17	18.0	7	7.0	32	34.0	38	40.0	94	99%
Policies relevant to the clinic	9	9.0	8	8.0	40	42.0	38	40.0	95	99%
Acts relevant to the clinic	8	8.0	13	14.0	36	38.0	38	40.0	95	100%
Organogram of the district	11	12.0	21	23.0	34	37.0	27	29.0	93	101%
Organogram of the local area	12	13.0	18	19.0	35	37.0	30	32.0	95	101%
Organogram of the clinic	6	6.0	7	7.0	41	43.0	41	43.0	95	99%
Work procedures in the clinic	6	6.0	14	15.0	39	41.0	35	37.0	94	99%
Lines of communication and authority	7	7.0	6	6.0	43	46.0	38	40.0	94	99%
Support systems for the clinic manager	14	15.0	19	20.0	34	36.0	28	29.0	95	100%

Most of the respondents indicated that the orientation provided by their supervisors equipped them with the following:

- Organogram of the clinic (82; 86.0%)
- Lines of communication and authority (81; 86.0%)
- Policies relevant to the clinic (78; 82.0%)
- Work procedures in the clinic (74; 79.0%)
- Acts relevant to the clinic (74; 78.0%)
- Job description (70; 74.0%)
- Organogram of the local area (65; 68.0%)
- Organogram of the district (61; 66.0%)
- Support systems for the clinic manager (62; 65.0%).

The fact that 24 (26.0%) of the respondents indicated not being orientated on their job description was of concern. Tembani et al (2003:67) noted that nurse managers felt that they were not adequately prepared for the management role as no orientation on clinic management was provided to them.

5.4.3.27 Equipping the clinic manager for the managerial role

The respondents were asked to indicate whether the orientation programme contributed to equipping the clinic manager for the management role (see table 5.14).

Table 5.14 Equipping the clinic manager with knowledge on the management role (n=95)

Aspect	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
Preparation to manage a clinic	14	15.0	22	23.0	32	34.0	27	28.0	95	100%
Role expectations during management tasks	13	14.0	24	25.0	36	38.0	22	23.0	95	100%

This question covered the same content as the previous question and they could thus have been combined. Question 45 and the two questions could have been combined.

According to table 5.14, of the respondents, 59 (62.0%) *agreed* that the orientation programme prepared them to manage a clinic, and 58 (61.0%) *agreed* that it prepared them for the role expectations of a clinic manager. Booyens (1998:382) emphasises that orientation is the personalised training of the individual employee to ensure that he/she becomes acquainted with the requirements of the job itself. If approached systematically, the adaptation process for the new nurse manager will lessen errors and will ease the controlling function of the direct supervisor (Booyens 1998:384; de Villiers 1995:315).

5.4.3.28 Means to address under-achievement in PHC programmes

The respondents were required to rate three aspects as a means to address under-achievement in PHC programmes (see table 5.15).

Table 5.15 Means for addressing under-achievement in PHC programmes (n=94)

Means	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
Nursing team draws up action plans	5	5.0	7	7.0	46	49.0	36	38.0	94	99%
Nursing team evaluates outcomes of action plans on a monthly basis	6	6.0	13	14.0	44	47.0	31	33.0	94	100%
Having meetings with the nursing team to find reasons for poor performance and to find solutions	4	4.0	6	6.0	45	48.0	39	41.0	94	99%

Of the respondents, 82 (87.0%) indicated that the nursing team drew up action plans to *address under-achievement* in PHC programmes; 75 (80.0%) *agreed* that *evaluation of the outcome of action plans on a monthly basis* took place to address under-achievement, and 84 (89.0%) agreed that holding meetings with the nursing team to find reasons for poor performance was a means to find solutions for poor performance.

5.4.4 Section D: Leading function

According to Booyens (1998:417), Kruger (1995c:354), Muller et al (2006:31) and Yoder-Wise (2007:28), leadership requires a leader and a group of followers who are influenced by the leader. The leader's influence is directed at the achievement of work performance or some common goal (Huber 2006:6; Yoder-Wise 2007:31). Leadership requires a relationship between the people who are to be led and the person who leads them. Leadership is a dynamic and interactive process in which the leader, the followers and the

situation influence each other (Booyens 1998:418; Huber 2006:6; Yoder-Wise 2007:31). In a PHC clinic setting, the leader is the clinic manager, the followers are the clinic staff, and the situation is the PHC clinic environment.

5.4.4.1 Involvement of staff in the development of statements, policies and manuals

Involvement of the staff can be linked to the principle of participative management whereby employees play a direct role in planning and decision-making and through the implementation of participative management employees are empowered to be creative and innovative (Kroon 1995b:13; Booyens 1998:134; Lussier 2006:23). Muller et al (2006:64) point out that decentralisation facilitates the empowerment of employees by giving them the right to make decisions with regard to the allocation of resources, policies and procedures.

Table 5.16 Importance of involving staff in the development of statements, policies and manuals (n=96)

Area for development	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
A mission statement	1	1.0	2	2.0	24	25.0	69	72.0	96	100%
A vision statement	1	1.0	2	2.0	23	24.0	70	73.0	96	100%
A code of conduct	1	1.0	0	0	28	29.0	66	69.0	95	100%
Internal policies	1	1.0	0	0	24	25.0	71	74.0	96	100%
A procedure manual	1	1.0	0	0	27	29.0	66	70.0	94	100%

According to table 5.16, the majority of the respondents (93; 97.0%) *agreed* on the involvement of staff in the development of

- internal policies (95; 99.0%)
- a code of conduct (94; 98.0%)
- a procedure manual (93; 99.0%)

- a mission statement (93; 97.0%)
- a vision statement (93; 97.0%).

This was encouraging because most of the respondents appeared to regard involvement of their staff in the development of guiding documents as important. Involving staff in the development of these statements and documentation leads to a sense of ownership by all.

5.4.4.2 Characteristics of communication

The respondents were asked to rate certain characteristics of their communication with their staff (see table 5.17). Grover (2005:179) and Yoder-Wise (2007:19) state that trust is one of the most critical concepts of effective communication and a key component of a team. Effective communication is related to the degree of trust existing between individuals. Üstün (2006:421) maintains that communication skills are one of the fundamental elements in the daily performance of a nurse. Communication is a powerful tool and nursing skill necessary for reaching positive health goals.

Table 5.17 Characteristics of communication (n=95)

Area of involvement	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
Truly listening to them	1	1.0	0	0	40	43.0	53	56.0	94	100%
Interpretation of body language	1	1.0	4	4.0	48	51.0	42	44.0	95	100%
Being sympathetic	3	3.0	17	18.0	42	46.0	30	33.0	92	100%
Being empathetic	4	4.0	5	5.0	50	54.0	34	37.0	93	100%
Attending to staff problems	1	1.0	2	2.0	40	42.0	52	55.0	95	100%

Most of the respondents *agreed* that their communication with their staff was characterised by the following:

- Truly listening to staff (93; 99.0%)
- Attending to staff problems (92; 97.0%)
- Interpretation of body language (90; 95.0%)
- Being empathetic (84; 91.0%)
- Being sympathetic (72; 79.0%).

A significant difference (f = 10.0; p = 0.003) was noted between the means of the respondents with regard to their years of experience as clinic managers. The respondents with the 6 years and more experience had a higher score in communication skills. The reason might be that due to their years of experience, they are more skilled in communication than the respondents with 0 to 5 years' experience, and also realise the value of effective communication.

With regard to communication, a significant difference (f = 3; p = 0.045) was identified between the respondents' age groups. The respondents aged between 30 and 35 obtained the lowest scores, which indicated that the younger group lacked skills for effective communication and involvement with the staff. It was deduced that most of the respondents' communication was supportive and attentive. Employees could thus feel free to ask questions without fear of retribution (Booyens 1998:268). Good communication in an organisation contributes to achieving the organisation's objectives (Smith 1995:373).

5.4.4.3 Engendering trust in subordinates

The respondents were asked to rate factors that engendered trust in subordinates (see table 5.18). Bally (2007:147) states that for role modelling to be effective registered nurses/managers should establish credibility in the work setting and develop trust among staff members. Feedback is enhanced at all levels by open communication channels, which relate to trust.

Reynolds, Bailey, Seden and Dimmock (2003:33) point out that trust underlies healthcare service provision because staff and patients have to trust managers to have their best interest at heart. Langone (2007:45) maintains that because of the high level of trust,

honesty and ethical standards associated with nursing, nurses have to conduct themselves in a manner that warrants public trust.

Table 5.18 Factors engendering trust in subordinates (n=96)

Factor	Totally unimportant		Unimportant		Important		Of the utmost importance		n	Total
	n	%	n	%	n	%	n	%		
Being honest and open about organisational problems	0	0	1	1.0	29	31.0	65	68.0	95	100%
Sharing information that is in the interest of the employees	1	1.0	2	2.0	24	25.0	69	72.0	96	100%
Not divulging personal secrets and harmful information	2	2.0	0	0	23	24.0	69	73.0	94	99%

Table 5.18 illustrates that the majority of the respondents indicated that the following factors were important to engender trust in subordinates:

- Being honest and open about organisational problems (94; 99.0%)
- Not divulging personal secrets and harmful information (92; 97.0%)
- Sharing information that is in the interest of the employees (93; 97.0%).

These factors contribute to engendering trust in subordinates (Kroon 1995b:14). According to Booyens (1998:440) and Huber (2006:13), trust is not an inherent part of a leader's position, as trust must be earned and carefully nurtured over time.

5.4.4.4 Building credibility with staff

The respondents were asked to indicate aspects that contribute to the building of credibility. Should clinic managers have no credibility, trust in them will be absent, which might lead to de-motivation and reluctance of staff to achieve goals.

Table 5.19 Aspects contributing to the building of credibility (n=96)

Aspects	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
Exhibit knowledge pertaining to primary health care	1	1.0	0	0	33	35.0	59	63.0	93	99%
Encourage open discussion with staff on challenges	1	1.0	0	0	27	28.0	68	71.0	96	100%
Admit mistakes made by clinic managers	4	4.0	0	0	34	35.0	58	60.0	96	99%
Ensure that goals are achievable	1	1.0	0	0	39	41.0	56	58.0	96	100%
Carefully plan actions to achieve goals	1	1.0	0	0	38	40.0	57	59.0	96	100%

According to table 5.19, the majority of the respondents *agreed* that the following factors contributed to building credibility:

- Encourage open discussions with staff on challenges (95; 99.0%)
- Ensure that goals are achievable (95; 99.0%)
- Carefully plan actions to achieve goals (95; 99.0%)
- Exhibit knowledge pertaining to PHC (92; 98.0%)
- Admit mistakes made by the clinic manager (92; 95.0%).

In regard to building credibility with the staff, the respondents with 6 years and more experience had higher average scores with a significant difference ($f = 5$; $p = 0.035$) than those with 0 to 5 years' experience. Due to the extended years of experience of this group, their skills and actions to build credibility amongst staff appeared to improve over the years.

According to Booyens (1998:440), building credibility takes patience, consistency, dependability and unending attention over a long period.

5.4.4.5 Strategies to accomplish effective change

Hellriegel et al (2004:375) state that any organisational change effort can cause unanticipated problems, including diversity interventions. For example, affirmative action/programmes may cause a stigma for individuals or groups targeted with this benefit. Change may evoke emotional reaction and is often associated with feelings of loss, grief, pain and resistance (Blais et al 2006: 258). The respondents were asked to indicate strategies that accomplished effective change in the clinic (see table 5.20).

Table 5.20 Strategies to accomplish effective change in the clinic (n=96)

Strategies	Yes		No		n	Total
	n	%	n	%		
Create an environment in which people feel at ease to talk freely, challenge one another, and explore issues	93	98.0	2	2.0	95	100%
Share information widely among employees to ensure awareness of challenges facing the staff	95	99.0	1	1.0	96	100%
Discuss the future with employees in order to create excitement, increase motivation and stimulate teamwork	88	93.0	7	7.0	95	100%

Table 5.20 indicates that the majority of the respondents applied the following strategies to accomplish effective change in the clinic:

- Share information widely among employees to ensure awareness of challenges facing the staff (95; 99.0%)
- Create an environment in which people feel at ease to talk freely, challenge one another, and explore issues (93; 98.0%)
- Discuss the future with employees in order to create excitement, increase motivation and stimulate teamwork (88; 93.0%).

Booyens (1998:498) states that traditionally the nurse has not been trained to fulfil a leadership role or to act as a change agent. If nurses are not ready to act as change

agents, they risk change being imposed on them from outside the profession. Yoder-Wise (2007:335) maintains that staff who share the creation of change that affects them directly, are more receptive to change.

Respondents who responded with a “no” to the previous question were asked to indicate whether they agreed or disagreed with the following statements (see table 5.21).

Table 5.21 Negative issues pertaining to change (n=48)

Statement	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
I have limited knowledge of information pertaining to the future of health services	12	26.0	19	40.0	11	23.0	5	11.0	47	100%
My subordinates view change as negative and dubious	11	23.0	24	50.0	9	19.0	4	8.0	48	100%
I find it difficult to manage change	17	36.0	23	49.0	4	9.0	3	6.0	47	100%

Of the respondents, 16 (34.0%) had limited knowledge of information pertaining to the future of health services; 13 (27.0%) indicated that their subordinates viewed change as negative and dubious, and 7 (15.0%) found change difficult to manage (see table 5.21).

It was noted that only 10.0% of the respondents responded negatively to this question (n = 96) (see table 5.20). However, in Table 5.21 n = 48, it could be assumed that the respondents misinterpreted this question.

5.4.4.6 Conversant with the disciplinary code, grievance procedure and relevant acts

The respondents were asked to indicate to what extent they valued the importance of clinic staff being conversant with the disciplinary code, grievance procedure and relevant Acts (legislation) (see table 5.22).

Table 5.22 Importance of clinic staff being conversant with the disciplinary code, grievance procedure and relevant Acts (n=96)

Codes, procedures, acts	Totally unimportant		Unimportant		Important		Of utmost importance		n	Total
	n	%	n	%	n	%	n	%		
Disciplinary code	0	0	0	0	33	34.0	63	66.0	96	100%
Grievance procedure	0	0	0	0	33	34.0	63	66.0	96	100%
Relevant Acts	0	0	3	3.0	28	29.0	65	68.0	96	100%

Most of the respondents indicated that the statements were *important*. The respondents responded to the importance of the individual statements as follows:

- Disciplinary code (96; 100.0%)
- Grievance procedure (96; 100.0%)
- Relevant acts (93; 97.0%).

It was encouraging to note that most of the respondents ensured that their staff was well informed about the disciplinary code, grievance procedure and relevant acts.

Table 5.23 lists the respondents' reasons for answering "totally unimportant" or "unimportant" regarding the disciplinary code, grievance procedure and relevant Acts.

Table 5.23 Factors contributing to the unimportance of the disciplinary code, grievance procedure and relevant Acts (n = 31)

Strategies	Yes		No		n	Total
	n	%	n	%		
Lack of time due to the heavy workload of the clinic manager	19	61.0	12	39.0	31	100%
Lack of time due to the heavy workload of the staff	17	55.0	14	45.0	31	100%
The clinic manager's lack knowledge of the abovementioned documents and procedures	6	20.0	24	80.0	30	100%
The clinic manager does not consider it important for all the staff members to know	3	10.0	27	90.0	30	100%

A heavy workload seemed to be the main reason for answering *totally unimportant* or *unimportant* to ensuring that all staff members were conversant with the disciplinary code, grievance procedure and relevant Acts. Of the thirty respondents, 19 (61.0%) indicated that the main reason for answering "totally unimportant" or "unimportant" was the lack of time due to the heavy workload of the **clinic manager** while 17 (55.0%) indicated a lack of time due to the heavy workload of **the staff** as the main reason.

Of the respondents, 24 (80.0%) indicated that the clinic manager did not lack knowledge of the documents and procedures. This was encouraging because the respondents appeared to be conversant with the contents of the relevant codes, procedures and Acts.

The n-value in table 5.23 was incongruent to the n-value in table 5.22. This data was considered as it clarified some factors contributing to the fact that the disciplinary code, grievance procedure and relevant Acts were regarded as unimportant.

5.4.4.7 Leadership style followed by clinic managers

Leadership style has a marked effect on followers, as it influences their performance and attitude towards their work. The respondents were asked to indicate their preferred leadership style (see figure 5.37).

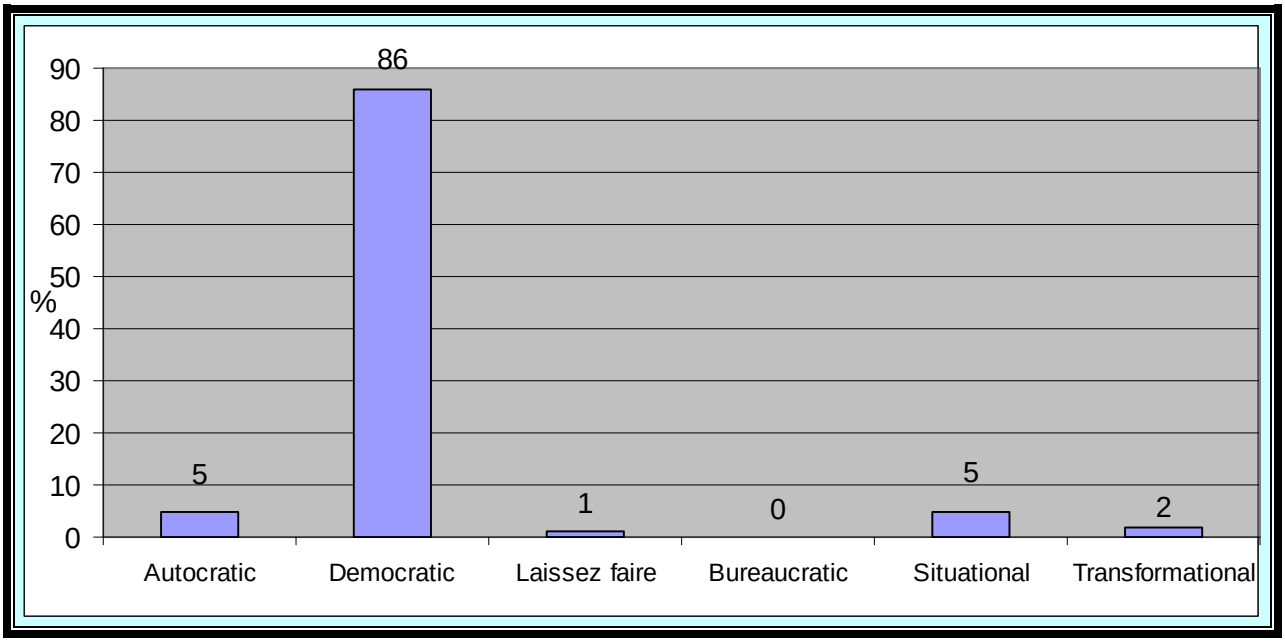

Figure 5.37 Respondents' leadership styles (n=94)

Figure 5.37 illustrates that most of the respondents (81; 86.0%) indicated that they followed the *democratic or participative* leadership style whereby subordinates were involved in decision-making. However, it should be noted that reaching consensus, in true democratic style, could be very time consuming.

This begs the question whether another leadership style, for example transformational leadership, might not be more appropriate in the clinic setting, given the many changes taking place in health services, and managers should be able to adjust their leadership style to address the challenges that occur in health services (Pettinger 2007:427). Of the respondents, only 2(2.0%) indicated transformational leadership as their preferred leadership style. According to Yoder-Wise (2007:31), the transformational leader seems particularly suited to the nursing environment.

5.4.4.8 Mechanisms used to influence the staff

The aim of leadership is to reach specific goals through the cooperation of colleagues and subordinates by influencing and empowering them. The respondents were asked to indicate the mechanisms they used to influence staff (see table 5.24).

Table 5.24 Respondents' mechanisms used to influence staff (n=94)

Mechanisms	Never		Sometimes		Almost all of the times		Always		n	Total
	n	%	n	%	n	%	n	%		
Assertiveness is expressed by the clinic manager	5	6.0	12	13.0	28	31.0	45	50.0	90	100%
Sanctions: threats are utilised to achieve goals	64	69.0	20	22.0	6	6.0	3	3.0	93	100%
Upward appeal: a higher authority should make a decision	26	29.0	51	56.0	8	9.0	6	7.0	91	101%
Exchange: exchange of opinions in order to persuade subordinates	6	6.0	27	29.0	35	37.0	26	28.0	94	100%
Coalitions: people form a group to negotiate with one voice	21	23.0	25	27.0	25	27.0	21	23.0	92	100%
Rationality: logical arguments are used to try to persuade followers	18	20.0	26	29.0	32	36.0	14	16.0	90	101%
Integration: the other person is made to feel important by either praising or acknowledging achievements	3	3.0	16	17.0	35	37.0	40	43.0	94	100%

Respondents ranked the following mechanisms to influence their staff:

- Sanctions: threats are not utilised by 84 (91.0%) of the respondents to achieve goals
- Upward appeal: according to table 5.24 only 14 (16.0%) make use of this method to influence staff
- Clinic manager's assertiveness (73; 81.0%)
- Integration: the other person is made to feel important by either praising or acknowledging achievements (75; 80.0%)

- Exchanging opinions in order to persuade subordinates (61; 65.0%)
- Coalitions: people form a group to negotiate with one voice (46; 50.0%)
- Rationality: logical arguments are used to try to persuade followers (46; 52.0%)

It was assumed that the respondents used mainly positive mechanisms to influence staff to do as desired.

5.4.4.9 Training sessions to improve skills of a clinic manager

Training and development is essential to stay abreast of new developments and enhance individual skills. The respondents were asked to indicate the type of training sessions they had attended to improve their clinic management skills.

Table 5.25 Attendance of training sessions to improve skills of a clinic manager (n=95)

Training sessions	Yes		No		n	Total
	n	%	n	%		
Formal management training	30	32.0	65	68.0	95	100%
Training in clinic management guidelines	29	31.0	66	69.0	95	100%
Training in assessment tools of various PHC programmes	46	48.0	49	52.0	95	100%
None	33	35.0	62	65.0	95	100%
Other	4	4.0	91	96.0	95	100%

Of the respondents, 65 (68.0%) indicated that they **had not** attended any formal management training; 66 (69.0%) had no training in the management guidelines of the clinic, and 49 (52.0%) denied receiving training in assessment tools of various PHC programmes (see table 5.25). Finally, 62 (65.0%) indicated that they had had **no** training at all to improve their management skills.

It was thus deduced that the majority of the respondents were not effectively trained in management skills. In a study in the King William's Town Health District (Eastern Cape),

Tembani et al (2003:67) identified inadequate training in role expectations as one of the factors resulting in clinic managers not performing their managerial function optimally.

5.4.4.10 Respondents' developmental needs

The respondents were asked to indicate their developmental needs as clinic managers (see table 5.26).

Table 5.26 Respondents' developmental needs (n=95)

Developmental needs	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
Planning clinic activities	4	4.0	9	10.0	46	49.0	34	37.0	93	100%
Acquiring sufficient staff	3	3.0	7	7.0	45	47.0	40	42.0	95	99%
Handling disciplinary procedures	1	1.0	10	11.0	39	41.0	45	47.0	95	100%
Handling conflict	1	1.0	8	8.0	47	49.0	39	41.0	95	99%
Being assertive	5	5.0	10	11.0	45	49.0	33	35.0	93	100%
Management of the clinic budget	5	5.0	4	4.0	31	33.0	54	57.0	94	99%
Report writing	6	6.0	12	13.0	40	43.0	36	38.0	94	100%
Managing PHC programmes in the clinic	5	5.0	12	13.0	40	42.0	38	40.0	95	100%
Interpreting data obtained from the MDS	4	4.0	11	12.0	41	44.0	38	40.0	94	100%
Handling grievances	4	4.0	11	12.0	36	38.0	44	46.0	95	100%

According to table 5.26, most of the respondents had the following developmental needs:

- Handling conflict (86; 91.0%)
- Management of the clinic budget (85; 90.0%)
- Acquiring sufficient staff (85; 89.0%)

- Handling disciplinary procedures (84; 88.0%)
- Planning clinic activities (80; 86.0%)
- Handling grievances (80; 84.0%)
- Interpreting data obtained from the MDS (79; 84.0%)
- Assertiveness (78; 84.0%)
- Managing PHC programmes (78; 82.0%)
- Report writing (76; 81.0%).

Tembani et al (2003:67) found that clinic managers had need of preparation for, and development of their managerial role, as it cannot be assumed that managerial skills are innate.

5.4.4.11 Management of clinic data

Clinic data is important to the clinic manager. Data is captured mainly on a daily basis in the clinic and a consolidated version is submitted monthly. Data is a useful tool in the management process, as it helps guide planning, organising, leading and control in an effort to reach the institution's goal.

Table 5.27 Respondents' actions based on clinic data (n=94)

Action	Yes		No		n	Total
	n	%	n	%		
Discuss the information with the staff	87	93.0	7	7.0	94	100%
Develop action plans to address deficiencies	83	88.0	11	12.0	94	100%

Table 5.27 indicates that of the respondents, 87 (93.0%) discussed the information with their staff while 83 (88.0%) developed action plans to address deficiencies, which meant that the available data was put to good use in managing the clinics.

The respondents who did not discuss information from MDS with staff or develop action plans were asked to give their reasons (see table 5.28).

Table 5.28 Respondents' reasons for not discussing information or developing action plans (n=50)

Reasons	Yes		No		n	Total
	n	%	n	%		
Staff not interested in results	3	6.0	47	94.0	50	100%
Data not collected on time	6	12.0	44	88.0	50	100%
No time available to give feedback because of workload	10	20.0	40	80.0	50	100%
The clinic staff has no time to attend a feedback session because of the heavy workload	9	18.0	41	84.0	50	100%

It was deduced that the reasons mentioned in the questionnaire as indicated in table 5.28 did not contribute to respondents indicating "no" to any part of item 61. Only 28 (56.0%) of the respondents confirmed that the reasons mentioned in table 5.28 contributed to their answering in the negative. It should be noted that the number of respondents (n=50) in table 5.28 is not in line with the number of respondents (n=94) in table 5.27.

5.4.4.12 Factors influencing the role of the clinic manager negatively

Nurse managers have a responsibility to ensure the well being of nurses and patients and to ensure that organisational objectives are met (Minnaar 2001:19).

Tembani et al (2003:66) found that managers had to perform a number of duties that influenced their managerial role and their supervisory roles were therefore often neglected. The respondents were asked to rate the factors that influenced the role of the clinic manager negatively (see table 5.29). *(*A score of 5 was a strong contributor and 1 did not contribute at all.)

Table 5.29 Factors influencing the role of the clinic manager *negatively* (n=94)

Factor	SCORE										n	Total
	1		2		3		4		5			
	n	%	n	%	n	%	n	%	n	%		
When I have to screen patients	21	24.0	4	4.0	18	20.0	17	19.0	29	33.0	89	100%
Shortages experienced in the clinics	6	6.0	6	6.0	7	8.0	7	8.0	67	72.0	93	100%
When I have to attend numerous meetings	12	13.0	10	11.0	23	24.0	18	19.0	31	33.0	94	100%
An increase in expectations and objectives of programmes by higher level/senior management	7	7.0	6	6.0	10	11.0	24	26.0	47	50.0	94	100%
When I have to perform non-managerial tasks	9	10.0	2	2.0	13	14.0	19	20.0	51	54.0	94	100%

According to the respondents, strong contributors affecting the clinic managers' role adversely were:

- Shortages experienced in the clinics (74; 80.0%). It was noted that the shortage of staff obtained the highest score, namely (74; 80.0%). Tembani et al (2003:67) also emphasise staff shortages.
- When the clinic manager has to perform non-managerial tasks (70; 74.0%)
- An increase in expectations and objectives of programmes by higher level/senior management (71; 76.0%)
- When the clinic manager has to attend numerous meetings (49; 52.0%)
- When the clinic manager has to screen patients (46; 52.0%).

5.4.4.13 Human resource management in the clinic

The respondents were asked to indicate their involvement in the management of human resources in the clinic.

Table 5.30 Respondents' involvement as clinic managers in human resource management in the clinic (n=94)

Responsibility	Yes		No		n	Total
	n	%	n	%		
Selection interviews to fill vacant posts in the clinic	15	16.0	79	84.0	94	100%
Disciplinary hearings	30	32.0	64	68.0	94	100%
Handling of grievances	45	48.0	49	52.0	94	100%

Table 5.30 indicates that the respondents were **not** involved in the following human resource management responsibilities:

- Selection interviews to fill vacant posts (79; 84.0%)
- Disciplinary hearings (64; 68.0%)
- Handling of grievances (49; 52.0%).

Of the respondents, only 30 (32.0%) and 45 (48.0%) had been involved in handling disciplinary hearings and grievances, respectively. The reasons for clinic managers not being involved in human resource management responsibilities were requested (see table 5.31).

Table 5.31 Reasons for clinic managers' non-involvement in human resource management responsibilities (n=88)

Responsibility	Yes		No		n	Total
	n	%	n	%		
No training in topic was offered	59	67.0	29	33.0	88	100%
No vacant posts available in clinic	77	88.0	11	13.0	88	101%
Interviews done by senior management	16	18.0	72	82.0	88	100%
Lack of transport to attend hearings	81	92.0	7	8.0	88	100%
Lack of transport to attend selection interviews	84	95.0	4	5.0	88	100%
No disciplinary hearings are held in the clinic	47	53.0	41	47.0	88	100%
Clinic manager is not asked to do interviews	36	41.0	52	59.0	88	100%
Clinic manager is not expected to handle disciplinary hearings	50	57.0	38	43.0	88	100%
Clinic manager is not expected to handle grievances	67	76.0	21	24.0	88	100%
Other	86	98.0	2	2.0	88	100%

It was noted that there was incongruence in the n-values in table 5.30 and table 5.31. Table 5.30 indicates n=94, but table 5.31 indicates n=88. This was attributed to the fact that six respondents did not answer the question (see table 5.31).

The respondents indicated that the following reasons contributed to their non-involvement in human resource responsibilities:

- Lack of transport to attend selection interviews (84; 95.0%)
- Lack of transport to attend hearings (81; 92.0%)
- No vacant posts available in clinic (77; 88.0%)
- Clinic manager not expected to handle grievances (67; 76.0%)
- No training in the topic (59; 67.0%)
- The clinic manager is not expected to handle disciplinary hearings (50; 57.0%).

At the same time, the respondents indicated that the following were not reasons for their non-involvement in human resource responsibilities:

- Senior management does interviewing (72; 82.0%)
- The clinic manager is not asked to do interviews (52; 59.0%)
- No disciplinary hearings are held in the clinic (41; 47.0%)

It was evident that the clinic managers' non-involvement in HR matters was mainly due to (a) certain issues not being relevant to their job descriptions and (b) much of the HR functions were handled at higher levels of authority.

5.4.5 Section E: Control function

Control involves a systematic process through which managers can compare performance with plans, standards and objectives. If any deviations occur, corrective actions should be taken (Crous 1995:443; Smit et al 2007:386). Crous (1995:443) states that the main aim of control is to ensure that objectives are reached by implementing effective activities.

5.4.5.1 Support received from supervisor

Management success at functional level is dependent on support from higher authorities. The respondents were asked to indicate the extent to which they were satisfied with the amount of support received from their supervisors (see table 5.32).

Table 5.32 Respondents' satisfaction with support received from their supervisors (n=95)

	Very dissatisfied		Dissatisfied		Satisfied		Very satisfied		n	Total
	n	%	n	%	n	%	n	%		
Human resource issues	16	17.0	32	34.0	30	32.0	15	16.0	93	99%
Provision and procurement of equipment	8	9.0	38	41.0	32	34.0	15	16.0	93	100%
Provision and procurement of supplies	6	7.0	32	39.0	33	39.0	12	14.0	83	99%
Labour relations issues	13	14.0	32	34.0	38	41.0	10	11.0	93	100%
Implementation of PHC programme	6	6.0	16	17.0	49	52.0	24	25.0	95	100%
General management issues	5	5.0	31	33.0	41	44.0	17	18.0	94	100%

It was noted that several of the negative and positive responses were similarly represented (see table 5.32).

	Dissatisfied	Satisfied
• Human resource issues	(48; 51.0%)	(45; 48.0%)
• Provision and procurement of equipment	(46; 50.0%)	(47; 50.0%)
• Labour relations issues	(45; 48.0%)	(48; 52.0%)
• Provision and procurement of supplies	(38; 46.0%)	(45; 54.0%)
• Implementation of PHC programme	(22; 23.0%)	(73; 77.0%)
• General management issues	(36; 38.0%)	(58; 62.0%)

Of the respondents, 48 (52.0%) were dissatisfied with the support they received from their supervisors relating to human resource issues, and only 22 (23.0%) were dissatisfied with the support received in the implementation of the PHC programme. However, 73 (77.0%) of the respondents were satisfied with the support they received with the implementation of the PHC programme. This was a positive result as the implementation of PHC programmes is the core of the PHC package (DOH 2001b:7).

It was noted that dissatisfaction with support in provision and procurement of equipment obtained the second highest score, namely 46 (50.0%) respondents. This might be due to the red tape related to the provisioning and procurement process. For example, quotations

have to be requested, expenditure of funds for the purchase must be requested and documentation should be processed with the issuing of an order number. The order number is submitted to the provider and delivery will depend on the availability of stock. Another reason might be that the critical equipment list, which is submitted annually to the Head of Health of the Free State for his approval, had to be revised several times due to a lack of finances. Ultimately, only a limited number of equipment could be purchased which was totally insufficient to address the needs of the clinics.

5.4.5.2 Frequency of clinic supervisor's visits to support the clinic manager

The role of the clinic supervisor is to support the clinic manager in his/her managerial role. The respondents were asked to indicate how frequently the clinic supervisor visited to support them.

Table 5.33 Frequency of clinic supervisor's visits to support the respondents (n=93)

Time period	n	%
Weekly	3	3.0
Bi-weekly	4	4.0
Monthly	49	53.0
Quarterly	4	4.0
Intervals exceeding 3-monthly	22	24.0
Never	11	12.0

Of the respondents, 49 (53.0%) indicated that the clinic supervisor visited them monthly; 22 (24.0%) indicated that the visits exceeded intervals of 3 months, and 11 (12.0%) indicated that the clinic supervisor never visited them. This was of concern, as clinic supervisors are expected to support clinic managers by giving feedback on their performance, rectifying issues in order to improve quality, updating them on changes and development regarding policy and practice, and providing them with a written report after every visit. According to the Clinic Supervisor Manual (FSDOH 2007b:[sp]), the Red flag and Regular Review Tool to monitor crucial aspects, for example availability of medicine in the clinic, absenteeism rate, availability of equipment should be performed on a monthly basis. Ideally, the clinic

supervisor should visit all clinics monthly. According to Lehmann and Makhanya (2005:144), good support and supervision improves work satisfaction and contributes to a high degree to well-functioning service delivery.

5.4.5.3 Training provided to the respondents by the Department of Health

The respondents were asked to indicate the training received from the Department of Health (see table 5.34).

Table 5.34 Respondents' training provided by the Department of Health (n=86)

Training	Yes		No		n	Total
	n	%	n	%		
Training in the "Handbook for clinic/CHC managers"	14	16.0	72	84.0	86	100%
Short courses in management, eg. a two-day course	28	33.0	58	67.0	86	100%
Training in the utilisation of assessment tools for various PHC programmes to assess the standard of service rendered for a specific programme	33	38.0	53	62.0	86	100%
Training in the implementation of the Performance Development Plan	66	77.0	20	23.0	86	100%

Most of the respondents indicated that they did not receive training in the following:

- "Handbook for clinic/CHC managers" (72; 84.0%)
- Short courses in management (58; 67.0%)
- Training in assessment tools for various PHC programmes (53; 62.0%).

Of the respondents, 66 (77.0%) were trained in the Performance Development System. This high score in comparison with the other scores might be due to the fact that it entails financial gain for themselves and their subordinates. If a supervisor does not conduct a performance appraisal, it might result in a labour relations issue, as it should be performed six monthly according to the policy.

It was of concern that only 14 (16.0%) of the respondents had training in the “Handbook for clinic/CHC managers”, as this serves as an important guide for a clinic manager on clinic management.

It is of concern that only 33 (38.0%) of the respondents were trained in the assessment for PHC programmes. This questions the quality of PHC programmes if 53 (62.0%) of the respondents were not trained in these assessment tools. Table 5.26 indicates that 82.0% of the respondents expressed the need for development in the management of PHC programmes. Table 5.25 indicates that 48.0% of the respondents had received training in the utilisation of the assessment tools of various PHC programmes. Programmes cannot be implemented unless clinic managers are knowledgeable.

Lehmann and Makhanya (2005:143) view continuing education as an enormous challenge. The need to make skills and capacity development in the public service a key priority was identified throughout government as indicated in the President’s speech and the State of the Public Service Report (Lehmann & Makhanya 2005:142).

5.4.5.4 Views pertaining to audits of records

Auditing is a method to assess the quality of nursing through complete and accurate documentation of all nursing tasks and is considered a professional and ethical requirement. It is thus assumed that professional nurses document all nursing tasks and that the auditing tool can assess the quality of nursing (Muller 1998a:610).

Table 5.35 Respondents' view of auditing of records (n=95)

Developmental needs	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
Clinic managers have to audit patients records on a regular basis	7	7.0	5	5.0	42	44.0	41	43.0	95	99%
Due to time constraints, clinic managers do not give feedback to staff on the outcome of audits	20	22.0	34	37.0	29	31.0	10	11.0	93	101%
Clinic managers do not have time available to audit patient records	14	15.0	21	22.0	30	32.0	28	30.0	93	99%

Table 5.35 indicates that of the respondents, 83 (87.0%) *agreed* that they had to audit patient records on a regular basis; 54 (58.0%) *disagreed* that they did not give feedback to staff on the outcome of the audit due to time constraints, and 58 (62.0%) *agreed* that they did not have time available to audit patient records.

5.4.5.5 Leave arrangements

According to du Preez (1998:7), the management of people in the workplace is a line function to be carried out by line managers, supported by the HR Department. To ensure that enough staff is available in the clinic, leave should be managed effectively.

The respondents were asked to indicate what they considered important aspects in the management of leave (see table 5.36).

Table 5.36 Important aspects in the management of leave (n=95)

Important aspects	Totally unimportant		Unimportant		Important		Vitally important		n	Total
	n	%	n	%	n	%	n	%		
Ensuring the availability of an annual leave plan in the clinic	0	0	0	0	24	25.0	71	75.0	95	100%
Implementing the annual leave plan of the clinic	0	0	0	0	32	34.0	63	66.0	95	100%
Approving and signing leave applications of subordinates before they are submitted to the clinic supervisor and local area manager	1	1.0	1	1.0	21	22.0	71	76.0	94	100%
Implementing the leave regulations of the Department of Health	2	2.0	1	1.0	24	25.0	68	72.0	95	100%

Most of the respondents rated the following aspects *important* with regard to the management of leave (see table 5.36):

- Ensuring the availability of an annual leave plan in the clinic (95; 100.0%)
- Implementing the annual leave plan of the clinic (95; 100.0%)
- Approving and signing leave applications of subordinates before submitting it to the clinic supervisor and local area manager (92; 98.0%)
- Implementing the leave regulations of the Department of Health (92; 97.0%).

This was encouraging as it could be deduced that the respondents managed leave according to the policy and procedures of the Department of Health (Annexure P).

5.4.5.6 Availability of written tools in the clinic for monitoring services

According to Muller (1998a:627), Muller et al (2006:496) and Yoder-Wise (2007:392), quality improvement in health care is the responsibility of everyone concerned and requires the commitment and dedication of all role players. To achieve quality of care in PHC, specific monitoring tools supplied/distributed by the Department of Health are available to assess the quality of services rendered for a particular PHC programme.

The respondents were asked to indicate the availability of these monitoring tools in the clinic (see figure 5.38).

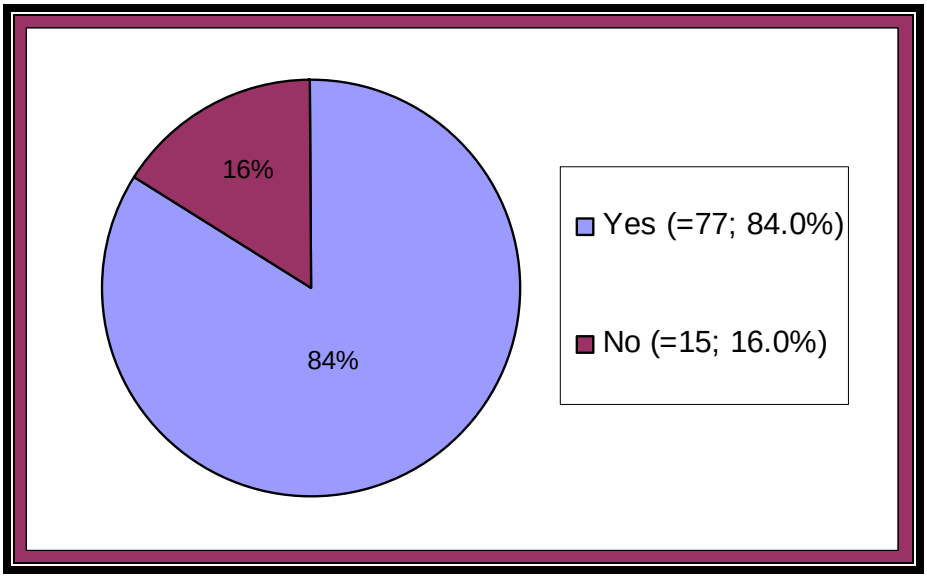

Figure 5.38 Availability of monitoring tools in the clinic (n=92)

Most of the respondents (77; 84.0%) indicated that the monitoring tools were available in the clinic (see figure 5.38). However, it was of concern that they were not available in all the clinics, as all clinics have to assess the quality of services rendered on a regular basis.

5.4.5.7 Importance of tools to monitor the quality of services

Quality assurance plays a vital role in rendering PHC services. Several tools were developed to monitor quality. The respondents were asked to indicate how important the various tools were in monitoring the quality of services (see table 5.37).

Table 5.37 Importance of tools to monitor quality (n=94)

Prescribed tools	Totally unimportant		Unimportant		Important		Vitally important		n	Total
	n	%	n	%	n	%	n	%		
Red flag	4	4.0	8	9.0	41	45.0	39	42.0	92	100%
Regular review	1	1.0	4	4.0	48	51.0	41	44.0	94	100%
TB tool	1	1.0	0	0	38	40.0	55	59.0	94	100%
EPI tool	0	0	0	0	38	40.0	56	60.0	94	100%
DISCA tool	1	1.0	3	3.0	38	42.0	49	54.0	91	100%
DHIS tool	0	0	0	0	40	43.0	53	57.0	93	100%
Antenatal tool	1	1.0	2	2.0	36	39.0	54	58.0	93	100%
Handbook for Clinic/CHC Managers	1	1.0	6	7.0	37	40.0	48	52.0	92	100%
Philani assessment tool	5	5.0	8	9.0	42	46.0	37	40.0	92	100%
Mental health tool	1	1.0	4	4.0	40	43.0	47	51.0	92	99%
The primary health care package – a set of norms and standards	2	2.0	2	2.0	38	41.0	51	55.0	93	100%
A comprehensive primary health care service package for South Africa	2	2.0	3	3.0	35	38.0	52	57.0	92	100%

The majority of the respondents rated the tools as *important* as follows:

- EPI tool (94; 100.0%)
- DHIS tool (93; 100.0%)
- TB tool (93; 99.0%)
- Antenatal tool (90; 97.0%)
- *The PHC package – a set of norms and standards* (89; 96.0%)
- DISCA tool (87; 96.0%)
- Mental health tool (87; 95.0%)
- *A comprehensive PHC service package for South Africa* (87; 95.0%)
- Regular review (89; 95.0%)

- Handbook for Clinic/CHC managers (85; 92.0%)
- Red flag (80; 87.0%)
- Philani assessment tool (79; 86.0%).

This was encouraging as the majority of the respondents took cognisance of the importance to monitor the quality of service in accordance with the prescribed tools.

5.4.5.8 Frequency of use of tools for monitoring

Monitoring and evaluation systems should be wide-ranging and reliable, as monitoring cannot be based on the auditing of documents alone (Muller 1998c:643).

The respondents were asked to indicate how frequently they used the assessment tools (see table 5.38). It was of grave concern that of the respondents, 20(16.0%) did not use *The primary health care package – a set of norms and standards* at all; 13 (15.0%) did not use the Philani assessment tool or *A comprehensive primary health care service package for South Africa*, and 29 (36.0%) did not use the *Handbook for Clinic/CHC managers* at all.

It was noted that the following listed tools were used monthly:

- Regular review (49; 60.0%)
- Red flag (40; 53.0%)
- DHIS tool (37; 43.0%)
- EPI tool (28; 32.0%)
- Antenatal tool (25; 32.0%)
- DISCA tool (24; 31.0%)
- TB tool (25; 29.0%).

The Philani assessment tool obtained the highest score (51; 60.0%) on yearly assessment. This might be due to the fact that the Philani event, which is a yearly event to acknowledge quality, only takes place once a year and health workers prepare well in advance for this

prestigious event. However, these preparations and maintenance of quality should be a continuous process exercised on a daily basis.

Table 5.38 Respondents' use of monitoring tools (n=87)

Tool	Weekly		Monthly		Bi-monthly		Quarterly		Yearly		Not at all		n	Total
	n	%	n	%	n	%	n	%	n	%	n	%		
Red flag	4	5.0	40	53.0	5	7.0	13	17.0	4	5.0	10	13.0	76	100%
Regular review	4	5.0	49	60.0	4	5.0	11	15.0	1	1.0	13	16.0	82	102%
TB tool	16	19.0	25	29.0	4	5.0	27	32.0	7	8.0	6	7.0	85	100%
EPI tool	14	16.0	28	32.0	5	6.0	23	26.0	11	13.0	6	7.0	87	100%
DISCA tool	6	7.0	24	31.0	7	9.0	15	19.0	17	22.0	9	12.0	78	100%
DHIS tool	6	7.0	37	43.0	7	8.0	18	21.0	10	12.0	8	9.0	86	100%
Antenatal tool	14	18.0	25	32.0	5	6.0	13	16.0	9	11.0	13	16.0	79	99%
Handbook for Clinic/CHC managers	5	6.0	19	23.0	3	4.0	10	12.0	15	19.0	29	36.0	81	100%
Philani assessment tool	2	2.0	5	6.0	2	2.0	12	14.0	51	60.0	13	15.0	85	99%
Mental health tool	4	5.0	22	29.0	4	5.0	14	18.0	12	16.0	20	26.0	76	99%
The PHC package – a set of norms and standards	16	19.0	17	20.0	5	6.0	13	16.0	19	23.0	13	16.0	83	100%
A compre-hensive PHC service package for South Africa	12	14.0	18	22.0	5	6.0	10	12.0	25	30.0	13	16.0	83	100%

5.4.5.9 Respondents' adherence to the implementation of standards

Adherence to standards contributes to rendering quality services to patients. The respondents were asked to indicate how they adhered to the implementation of standards.

Table 5.39 Respondents' adherence to the implementation of standards (n=93)

Protocol	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
Performance development system	10	11.0	7	8.0	41	45.0	34	37.0	92	101%
The disciplinary code	2	2.0	6	7.0	42	46.0	42	46.0	92	101%
The grievance procedure	1	1.0	6	7.0	44	48.0	41	45.0	92	101%
Batho Pele principles	1	1.0	1	1.0	39	42.0	52	56.0	93	100%
Patients' right charter	1	1.0	2	2.0	39	42.0	51	55.0	93	100%

The majority of the respondents *agreed* that they tried to adhere to and implement the standards of:

- The Batho Pele principles (91; 98.0%)
- The Patients' Rights Charter (90; 97.0%)
- The grievance procedure (85; 92.0%)
- The disciplinary procedure (84; 91.0%)
- Performance developmental system (75; 82.0%).

It was encouraging to note that most of the respondents *agreed* with the implementation of standards. These standards contribute to the desired and acceptable level of health care rendered in South Africa (DOH 2001b:7).

5.4.5.10 Interventions when deficiencies in performance are identified

In order to ensure a quality and efficient service, deficiencies should be identified and addressed. Table 5.40 depicts the respondents' application of interventions when they identify deficiencies in subordinates' performance.

Table 5.40 Respondents' interventions to address deficiencies in subordinates' performance (n=91)

Protocol	Strongly disagree		Disagree		Agree		Strongly agree		n	Total
	n	%	n	%	n	%	n	%		
Discuss action plans verbally with subordinate	1	1.0	2	2.0	48	53.0	40	44.0	91	100%
Avail written action plans in agreement with the subordinate	1	1.0	7	8.0	48	53.0	34	38.0	90	100%
Assess the outcome of the intervention to address deficiencies	0	0	5	6.0	48	53.0	37	41.0	90	100%

The respondents indicated that they implemented the following interventions to address poor performance of subordinates:

- Discussion of action plans with subordinate (88; 97.0%).
- Assessment of the outcome of the interventions (85; 94.0%).
- Availing written action plans in agreement with the subordinates (82; 91.0%).

These interventions equip employees to manage their own work and modify the structure and environment of work in ways that promote performance improvement (Du Preez 1998:15).

5.4.5.11 Control of resources

Resources are necessary for effective service rendering and valuable in terms of asset management, therefore resources should be controlled. Control of resources is one of the

clinic manager's responsibilities. Table 5.41 represents which functions the respondents considered important in controlling resources.

Table 5.41 Important functions in the control of resources (n=95)

Function	Totally unimportant		Unimportant		Important		Utmost important		n	Total
	n	%	n	%	n	%	n	%		
Checking the inventory of the clinic 6 monthly to control losses	0	0	2	2.0	39	41.0	54	57.0	95	100%
Checking the attendance register signed by subordinates when reporting for duty and when going off-duty on a daily basis	0	0	0	0	26	27.0	69	73.0	95	100%
Adding newly received equipment/furniture to the inventory	0	0	0	0	30	32.0	64	68.0	94	100%
Monitoring the correct utilisation of equipment and supplies	0	0	0	0	31	33.0	63	67.0	94	100%

The respondents considered the following functions *important* in terms of control of resources:

- Checking the attendance register signed by subordinates when reporting on duty and when going off-duty on a daily basis (95; 100.0%)
- Adding newly received equipment/furniture to the inventory (94; 100.0%)
- Monitoring the correct utilisation of equipment and supplies (94; 100.0%)
- Checking the inventory of the clinic 6 monthly (93; 98.0%).

This was encouraging as it indicated that the respondents valued the resources of the clinic.

5.4.5.12 Monitoring and controlling clinic expenditure

It is vital to manage the finances allocated to a PHC clinic. The respondents were asked to indicate whether they monitored and controlled clinic expenditure (see figure 5.39).

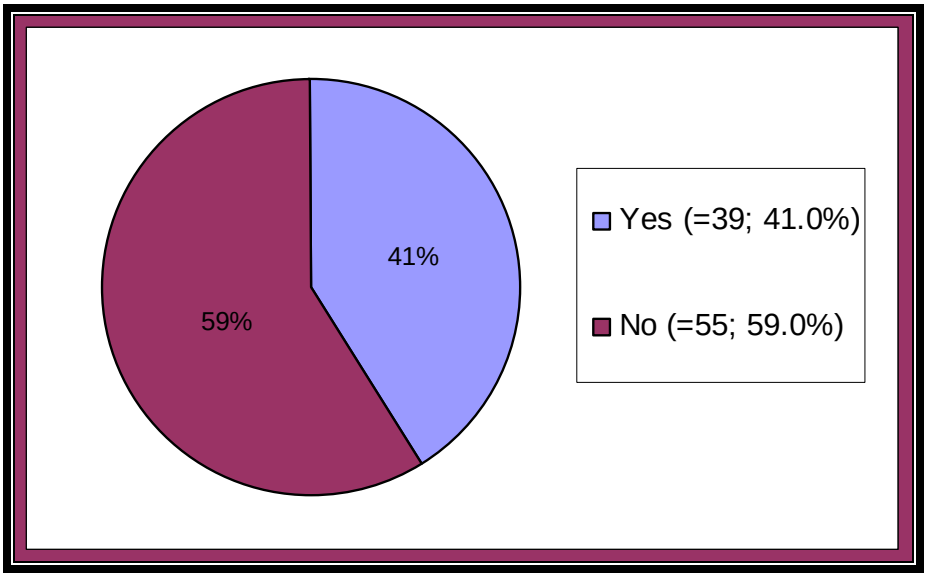

Figure 5.39 Monitoring and controlling of expenditure of the clinic (n=94)

According to figure 5.39, of the respondents 55 (59.0%) did not monitor or control clinic expenditure. This was of concern, as cost-effectiveness and curbing wastage is an inherent task of all managers.

- **Reasons for not monitoring and controlling clinic expenditure**

Table 5.42 lists the respondents' reasons for not monitoring and controlling clinic expenditure.

Table 5.42 Respondents' reasons for not monitoring and controlling clinic expenditure (n=61)

Training	Yes		No		n	Total
	n	%	n	%		
Lack of knowledge about the management of finances	21	55.0	17	45.0	38	100%
I am ignorant about the allocation of the clinic budget	15	44.0	19	56.0	34	100%
I do not view financial management as important	5	15.0	28	85.0	33	100%
Clinics are not regarded as individual cost centres	40	77.0	12	23.0	52	100%
Information on the budget is with management at local area level	53	87.0	8	13.0	61	100%
Information on the budget lies with management at district level	40	75.0	13	25.0	53	100
Other	4	40.0	6	60.0	10	100%

The respondents provided the following reasons for not monitoring and controlling clinic expenditure:

- Information on the budget lies with management on a local area level (53; 87.0%).
- Clinics are not regarded as cost centres (40; 77.0%)
- Information on the budget lies with management on district level (40; 75.0%)
- Lack of knowledge about the management of finances (21; 55.0%)
- Ignorance about the allocation of the clinic budget (15; 44.0%)
- Financial management is not viewed as important (5; 15.0%).

Although there were more "no" responses than in figure 5.39, the data was valued as it excluded contributing factors for not monitoring and controlling expenditure.

With regard to the reasons for not monitoring and controlling clinic expenditure, a significant difference ($f = 6$; $p = 0.022$) was noted between the respondents according to years of experience. Those with more than six years' experience had a higher mean score than those with five years and less. The respondents with less experience (0-5 years) could possibly feel that their financial management skills still needed to be developed and

their knowledge of financial management had to improve. The respondents with six years and more experience might feel knowledgeable and skilled with regard to financial management.

5.5 CONCLUSION

The objectives of the research was to

- Determine the current role expectations of a clinic manager in a PHC setting.
- Identify factors determining and influencing the role of clinic managers in a PHC setting.
- Determine what effect current role expectations of a clinic manager have on the management of services rendered at a PHC clinic.
- Establish the developmental needs of clinic managers to enable them to adhere to their role expectations.
- Identify realistic role expectations of a clinic manager in a PHC setting under current circumstances.

In general, the respondents agreed that the concern of insufficient posts on the staff establishment and vacant posts contributed enormously to staff shortages, which compelled them to render clinical service in the clinic.

Another important factor was the rendering of non-managerial tasks, which withheld them from performing their managerial tasks. Clinic managers need training in clinic management. Most of the respondents were neither properly trained nor skilled in clinic management. The study found that the respondents lacked training in financial and human resource management. The need for a specific support system for clinic managers was also identified.

Chapter 6 discusses the findings and presents recommendations for practice and further research.

CHAPTER 6

Findings and recommendations

6.1 INTRODUCTION

The purpose of this study was to explore the role of a clinic manager in a PHC setting. Kroon (1995:8) describes managers as people appointed in leading positions who have committed themselves to the task of taking the lead in the execution of specific tasks by concentrating on the employees under their control.

According to Kroon (1995b:8) and Hellriegel et al (2001:7), effective managers create a favourable work environment for employees and work with and through other people. They provide subordinates with the opportunity and incentives to achieve high performance within the constraints of limited resources available so that the aim of achieving an efficient and effective organisation can be reached.

The assumption guiding this study was that if clinic managers' workload was fair and feasible, the competent and committed ones would be able to manage a clinic effectively. However, the changes implemented in the health sector since 1994 resulted in increased demands on all clinic staff and a change in the clinic manager's role.

The objectives of the study were to

- Determine the current role expectations of a clinic manager in a PHC setting.
- Identify factors determining and influencing the role of a clinic manager in a PHC setting.
- Determine what effect current role expectations of a clinic manager have on the management of services rendered at a PHC clinic.
- Establish developmental needs of clinic managers to enable them to adhere to their role expectations.
- Identify realistic role expectations of a clinic manager in a PHC setting under current circumstances.

The research design for this study was quantitative, exploratory, descriptive and contextual. The researcher undertook a thorough literature study encompassing the district health system and the PHC package. The conceptual framework was based on Kroon's management model adapted by Uys (2005:5) emphasising the importance of the macro-, meso- and microenvironment in management (Kruger 1995a:52). Data was collected by means of questionnaires were submitted to randomly selected clinic managers in the Free State.

6.2 FINDINGS

The findings will be discussed according to the objectives of the study considering the results of the questionnaires.

6.2.1 Biographical data

In order to determine a data basis of the clinic managers who participated in the study, biographical data was included in the questionnaire.

6.2.1.1 Gender

Ninety-five percent of the respondents were female. However, the role of male and female managers is similar, as gender does not influence the expectations of a clinic manager.

6.2.1.2 Rank

Of the respondents, 84.0% occupied the rank of chief professional nurse; 13.0% were senior professional nurses, and 3.0% were professional nurses. The majority of the respondents were therefore experienced in nursing since professional nurses with a few years experience cannot occupy a chief professional nurse post, as it is a higher rank, with specific pre-requisites.

6.2.1.3 Years of experience as clinic manager

Of the respondents, 32.0% had been in the position of clinic manager for more than ten years while 26.0% had six to 10 years' experience.

6.2.1.4 Experience as professional nurse in a PHC clinic

Sixty-nine percent of the respondents had worked in a PHC clinic for more than 10 years as professional nurses. Taking into consideration their years of experience, the respondents should have been well acquainted with the functioning of a PHC clinic.

6.2.1.5 Age distribution of clinic managers

Of the respondents, 47.0% were between 40 and 49 years old and 27.0% were between 50 and 59 years old.

6.2.1.6 Academic qualifications

Of the respondents, 84.0% were in possession of a Diploma in Nursing and 27.0% possessed Bachelors degrees. It was not clear whether they had obtained a bachelor's degree as a post-basic course as the question was not formulated as such. However, many professional nurses tend to register for a Bachelors degree course post-basically to equip them for a managerial role.

6.2.1.7 Professional qualifications

Of the respondents, only 32.0% were registered nurse administrators with the SANC. This was identified as a deficiency, as the essential theoretical knowledge of management and management skills are extremely important for effective clinic management.

Only 46.0% of the respondents were registered PHC nurses. This was another deficiency, as a PHC qualification would enable the clinic manager to fulfil his/her management role with a sound theoretical grounding.

6.2.2 Current role expectations of a clinic manager

The respondents had to indicate to what extent they included their staff in the development of goals for PHC programmes.

- **Including staff in the development of goals for PHC programmes**

Most of the respondents indicated that they *included their staff in developing goals for the various PHC programmes* including minor ailments, chronic diseases, mental health, STIs, school health services, TB and HIV/AIDS.

- **Clinic manager's involvement in management functions**

Most of the respondents were of the opinion that they should be **involved** *in a variety of activities* when referring to the role of the clinic manager (see chapter 5, figure 5.10 on page 182 for the respondents' involvement in different activities). It was evident that the clinic manager had to be involved in a number of functions, including

- the clinic budget
- the staff establishment of the clinic
- the critical post list
- needs list for purchasing of medical equipment
- inventory of the clinic
- annual leave plan
- a formal training programme for staff
- an in-service training programme for staff
- dates for clinic committee meetings
- the district health plan for their district
- the local area plan for their local area

- **Conversant with budget**

Regarding the budget allocation, 73.0% of the respondents were mainly not conversant with the allocation for human resources and 66.0% were not conversant with maintenance of the clinic building and equipment (see chapter 5, table 5.2 on page 187). In addition, the respondents were also not conversant with the budget allocation for medicine, medical consumables, cleaning material and stationery. It was therefore deduced that respondents were not informed about the clinic budget and were thus excluded from financial management of the clinic.

Since the majority of the respondents indicated that *they were not conversant* with the budget allocation, their response that they did not get written feedback on budget expenditure (see table 5.3 on page 188) correlated with the information in table 5.2.

- **Organising the celebration of health events in the clinic and community**

Of the respondents, 83.0% agreed that clinic managers should be involved in organising the celebration of health events (see chapter 5, figure 5.17 on page 199).

- **Organising clinic committee meetings**

Most of the respondents (83.0%) indicated that clinic managers should organise clinic committee meetings.

- **Presenting in-service training to staff**

Of the respondents, 94.0% agreed that training of staff is a function of a clinic manager (see chapter 5, figure 5.17 on page 199).

- **Control of medicine in the store room**

Most of the respondents (90.0%) indicated that the clinic manager should check the medicine in the storeroom (see chapter 5, figure 5.17 on page 199).

- **Implementation of the performance development system**

Of the respondents, 94.0% agreed that it is a function of the clinic manager to implement the performance development system.

- **Medicine management**

The study found that 70.0% of the respondents ordered medicine and medical consumables, which should be the responsibility of a pharmacist assistant (see chapter 5, figure 5.20 on page 205). However, too few pharmacist assistants are trained, which causes a serious staff shortage and the vacant posts on the staff establishments are not filled or funded.

- **Implementation of the comprehensive PHC package**

Most of the respondents (92.0%) agreed that it is the responsibility of the clinic manager to *implement the comprehensive PHC package* in the clinics (see chapter 5, figure 5.23 on page 209). The comprehensive PHC package includes the services that should be rendered in PHC facilities (see chapter 3 on page 142).

- **Consultation/coordination with other stakeholders**

Clinic managers have to *consult/coordinate with other stakeholders*. Regarding consultation/coordination, of the respondents, 84.0% consulted *weekly* with DOT supporters, 82.0% consulted with home-based carers, and 70.0% consulted with the doctor visiting the clinic.

- **Performance of non-managerial tasks**

Of the respondents, 86.0% indicated the dispensing of medicine as the main non-managerial task affecting management performance, followed by 80.0% who indicated the booking of patients telephonically for appointments at a second level of referral.

- **Availability of a job description**

Of the respondents, 92.0% were in possession of a job description. The fact that 8.0% did not have job descriptions was of grave concern and raised the question of how a clinic could be managed by a clinic manager who had no job description. Managing a clinic effectively without knowing what is expected of a clinic manager would be impossible. According to the data, most of the respondents (82.0%) with job descriptions indicated that they were aware of the content.

- **Reasons for not adhering to the job description**

The respondents gave the following reasons for not adhering to the job description: staff shortages (99.0%), too many additional responsibilities (97.0%) and changing demands in managing a clinic (86.0%). The stipulated role expectation could be deduced from a clear and standardised job description.

- **Number of hours rendering a PHC service**

With regard to the *number of hours* clinics provided a comprehensive integrated PHC service, most of the respondents (88.0%) indicated that a service was rendered for 8 hours, five days a week. Although this was in line with the norms and standards for health clinics, the district hospitals were concerned about this as patients overwhelmed the district hospitals after hours without referral letters from the clinic. Most of the cases did not seem to be emergencies and could have been attended to at the clinic the following day. A need for extended hours in the clinics (more than eight hours per day) was identified, but

financial constraints and staff shortages made it impossible to extend the hours of service at this point in time.

- **Facilitation of PHC programmes**

Of the respondents, 96.0% *agreed* with the statement that *they facilitate the delivery of PHC programmes* in the clinic.

- **Rendering patient care simultaneously with management of the clinic**

With regard to clinic managers *rendering patient care simultaneously with management* of the clinic, 65.0% of the respondents indicated that they were obliged to do so.

- **Adherence to prescribed standards, guidelines and protocols**

Of the respondents, 97.0% indicated that health care was *provided by adhering to prescribed standards*, and 97.0% indicated that *treatment guidelines and protocols* were used to treat diseases (see chapter 5, figure 5.36 on page 231). It was thus the respondents' responsibility as clinic managers to ensure that health services were rendered according to these standards, guidelines and protocols.

- **Supervision of patient education**

The clinic manager is responsible for supervision of patient education provided in the clinic. Of the respondents, 83.0% indicated that recognised service providers gave patient education in the clinic on identified health problems. These recognised service providers were trained voluntary workers like home-based carers and DOT supporters. Most clinic staff (86; 91.0%) provides health education sessions in the clinic and the clinic manager has to ensure that it takes place on a regular basis. Health information material should be displayed in the clinic and it is the responsibility of the clinic manager to ensure that information material is available in the clinic.

- **Addressing under-achievement in PHC programmes**

The following actions were identified by the respondents as important *means* that could be used by clinic managers to *address under-achievement in PHC programmes*:

- the clinic manager to have meetings with the nursing team to find reasons for poor performance and to find solutions (84; 89.0%).
- the nursing team to draw action plans to address the under-achievement (82; 87.0%).
- the nursing team to evaluate outcomes of action plans on a monthly basis (75; 80.0%).

- **Involvement in the development of statements, policies and manuals**

Clinic managers *agreed* that the clinic staff should be involved in the development of mission and vision statements (93; 97.0%), policies (95; 99.0%) and procedure manuals (93; 99.0%) as indicated in Table 5.16 on page 237.

- **Involvement in communication**

With regard to *involvement in communication with staff*, the average of most of the respondents' (92.0%) communication was of a supportive nature (see chapter 5, table 5.17 on page 238).

- **Trust**

As it is important for subordinates to trust the manager, the aim was to determine what the respondents did to *engender trust in subordinates*. Most of the respondents indicated that the following conduct was important:

- Be honest and open about organisational problems (94; 99.0%).
- Share information that is in the interest of the employees (93; 97.0%).
- Do not divulge personal secrets and harmful information (92; 97.0%).

- **Credibility**

Credibility of a clinic manager plays a significant role in being a successful manager. Most of the respondents indicated that they did the following to build credibility:

- Encourage open discussions with staff on challenges (95; 99.0%).
- Ensure that goals are achievable (95; 99.0%).
- Carefully plan actions to achieve goals (95; 99.0%).
- Exhibit knowledge pertaining to PHC (92; 98.0%).
- Admit mistakes made by the clinic manager (92; 95.0%).

- **Management of change**

The aim was to identify the *strategies the clinic manager could apply* to accomplish *effective change* in the clinic. Of the respondents, 98.0% created an environment where employees could talk freely and challenge each other; 99.0% shared information widely amongst employees, and 93.0% discussed the future with employees to create excitement, increase motivation and stimulate teamwork (see chapter 5, table 5.20 on page 242).

- **Influencing of staff**

Regarding *mechanisms* to *influence* staff, of the respondents, 50.0% always used assertiveness; 36.0% used rationality to persuade followers almost all the time, and 43.0% always used integration to get subordinates to do what was desired. Less than 50.0% of the respondents thus used effective mechanisms to influence the staff.

- **Management of clinic data**

The respondents considered the management of clinic data important. Of the respondents, 93.0% *discussed the minimum data sheet* with their staff and 88.0% developed action plans to address deficiencies.

- **Involvement in human resource management**

Regarding the clinic manager's involvement in human resource management pertaining to clinic staff, of the respondents, only 16.0% were involved in *selection interviews* to fill vacant posts in the clinic; 32.0% were involved in *disciplinary hearings*, and 48.0% were involved in the *handling of grievances*.

Most of the respondents were *not involved* in the basic human resource management tasks of a clinic.

- **Auditing of patient records**

Of the respondents, 87.0% agreed that records should be audited. However, 62.0% indicated that they *did not have time available* to audit records, and 42.0% indicated that due to time constraints feedback was not given to staff on the outcome of audits done.

- **Adherence to the implementation of standards**

The respondents indicated their adherence to the implementation of standards as follows: the performance development system (82.0%); the disciplinary code (91.0%); the grievance procedure (92.0%); *Batho Pele* principles (98.0%), and the Patients' Rights Charter (97.0%) (see chapter 5, table 5.39 on page 266). Those standards pertaining directly to patient care (*Batho Pele* principles and Patients' Right Charter) were more widely adhered to than those related to human resources.

- **Interventions to address deficiencies in performance**

The respondents indicated that they *applied interventions when deficiencies were identified* in their subordinates' performance. Of the respondents, 97.0% discussed action plans with subordinates; 91.0% availed written action plans in agreement with the subordinates, and 94.0% assessed the outcome of the interventions. Therefore it was be deduced that the

respondents were of the opinion that they had to intervene to address deficiencies in performance.

- **Control of resources**

Most of the respondents indicated the following functions as *important*:

- Checking the attendance register (95; 100.0%).
- Adding new equipment/furniture to the inventory (94; 100%).
- Monitoring the correct utilisation of equipment and supplies (94; 100.0%).
- Checking the inventory of the clinic 6 monthly (93; 98.0%).

Control of resources is considered an important function of the clinic manager. The role of the clinic manager is thus divergent as it covers a variety of responsibilities.

6.2.3 Factors determining and influencing the role of clinic managers in a PHC setting

The respondents indicated that the following factors influenced their role as clinic managers:

- **Consultation of patients**

Due to the huge number of patients visiting the clinic, the respondents had to *support* the professional nurses with *consultations*. Of the respondents, 100.0% consulted patients every day, and 84.0% consulted between 21 and 70 patients per day.

Most of the respondents (67.0%) spent six to eight hours per day consulting patients due to staff shortages. The consultation of patients due to staff shortage was considered a major factor that impacted on the respondents' role. Of the respondents, 92.0% indicated staff shortages as a hindrance to managing a clinic; 85.0% indicated that they were involved in

too many tasks, and 93.0% indicated that the consultation of too many patients hindered them in their performance. (See chapter 5, figure 5.18 on page 201).

- **Aspects resulting in the *negative* rendering of PHC services in the clinic**

Various factors contribute to the negative rendering of PHC services (see chapter 5, figure 5.16 on page 196). Of the respondents, 83.0% indicated that the *number of posts available on the staff establishment* and 84.0% indicated that an *inadequate number of vacant posts* contributed to the negative rendering of PHC services in the clinic. Most of the respondents (55.0%) indicated that absenteeism had a negative influence on service rendering. Reasons for absenteeism included family responsibility leave, annual leave, sick leave, study leave and various training courses and meetings to attend.

According to the respondents, the PHC services rendered in the clinics included MCWH, EPI, communicable diseases, STI, mental health, HIV/AIDS, chronic diseases, geriatric and adolescent services (see chapter 5, figure 5.21 on page 206). The fact that only 88.0% of the respondents indicated that they rendered geriatric services and only 84.0% rendered adolescent services was of concern and deserves attention, as there is a common need for these services in most communities.

Of the respondents, 48.0% indicated that the supermarket approach contributed *negatively* to service rendering while 60.0% disagreed that specific services rendered on specific days negatively affected the rendering of PHC services. The finding was thus that 60.0% of the respondents had a positive view of and supported the rendering of specific services on specific days.

Of the respondents, 51.0% indicated that illnesses related to seasonal conditions had a negative influence on the PHC services. The reason was that the respondents consequently had to manage the influx of additional patients to the clinic with the available resources.

- **Reasons for not rendering some of the PHC services**

The respondents indicated the following reasons for not rendering some of the PHC services according to the PHC package:

- Unsuitable infrastructure of the clinic (65.0%).
- Staff shortages (63.0%).
- Insufficient equipment in the clinic (57.0%).
- Staff not trained to render services (51.0%).
- No need identified to render a particular service in the community (25.0%).

- **Average time spent per day to organise PHC programmes**

Regarding the *average time spent per day* to organise the different programmes in the clinic, of the respondents 37.0% spent one to two hours per day; 32.0% spent less than an hour per day, and 31.0% spent between three and eight hours a day organising PHC programmes. As the rendering of PHC programmes is the key objective of a PHC clinic, this raised the question of whether one to two hours per day could be considered enough to ensure the rendering of quality services.

- **Absence of the clinic manager due to attendance of meetings, training sessions and workshops**

Of the respondents, 26.0% indicated that they were absent from their clinics due to the attendance of meetings, training sessions and workshops once to twice a week. This implied that they were absent for approximately 16 hours out of a 40-hour week. The absence of the clinic manager has an effect on the functioning and management of the clinic, as it contributes to the existing staff shortage.

- **Performance of non-managerial tasks in the clinic**

Ninety-eight percent of the respondents indicated that they performed non-managerial tasks in the clinic (see chapter 5, table 5.6 on page 214) as follows:

- Dispensing medicine (86.0%)
- Booking patients telephonically for appointments (80.0%)
- Unpacking medicine (76.0%)
- Ordering medicine (70.0%).

Most of these non-managerial tasks were related to the management of medicine, which falls within the scope of practice of a pharmacist or pharmacist assistant.

- **Reasons for not adhering to the job description**

Of the respondents, 99.0% did not adhere to their job descriptions due to staff shortages; 97.0% indicated that too many additional responsibilities influenced their job description; 86.0% indicated that the demands of manage a clinic changed too often to adhere to their tasks and responsibilities, for example additional programmes were introduced from time to time, like the ART programme, a new programme allocated to the clinic that should be managed by the clinic manager.

- **Changes in the existing staff establishment**

An assessment was done with regard to the existing staff establishment in most of the PHC clinics since 1996. Of the respondents, 59.0% indicated that the staff establishment of the clinics had remained unchanged; 18.0% indicated that their staff establishments had been expanded, while 12.0% indicated theirs had been decreased due to the assessment. The reasons for decreasing the staff establishment were unknown, as this was not asked on the questionnaire, but it was deduced that the financial implications contributed to not expanding the staff establishment of some clinics, and decreasing that of others.

- **Availability of printed material in the clinic as stipulated by the PHC standards**

The majority (96.0%) of the respondents indicated that it was important to have printed material available in the clinic (see chapter 5, table 5.7 on page 225). If printed material were unavailable, the clinic manager would have to account for the non-availability of material in the clinic. The availability of this printed material contributed to effective service rendering as prescribed by the tool to assess quality care.

- **Availability of equipment/facilities in the clinic**

Regarding the extent to which equipment/facilities are available in the PHC clinics, the availability of equipment did not correspond with the essential equipment list, as not all the clinics had all the required equipment available (see chapter 5, table 5.8 on page 227).

The non-availability of Internet services in 90 percent of the clinics was related to the non-availability of computers in clinics. The clinic managers' task would be eased if clinics were equipped with computers and Internet. These tasks include registering of patients, compiling monthly data, bookings for patient transportation, patient record keeping and communication. Another concern was the non-availability of transport facilities (39.0%) at the clinics and the fact that the respondents (26.0%) had to transport staff personally.

- **Barriers to the supervisory function pertaining to patient education**

Of the respondents, 66.0% indicated *a lack of time* as the main reason for not providing patient education. This was attributed to the respondents' and professional nurses' high workload caused by high patient volumes and staff shortages.

- **Ensuring that all clinic staff members are conversant with the disciplinary code, grievance procedure and relevant data**

All the respondents (100.0%) indicated that all the staff should be conversant with the disciplinary code and grievance procedure, and 97.0% indicated that all staff should be conversant with the relevant Acts (see chapter 5, table 5.22 on page 244).

- **Leadership style**

The majority (86.0%) of the respondents preferred the democratic or participative leadership style. However, with all the changes taking place in health care, it was necessary to become acquainted with leadership styles more applicable to present-day situations like transformational or situational leadership styles.

- **Availability of a suitable infrastructure in clinics**

Most of the clinics were built before 1994 resulting in clinic buildings not suitable for the prevailing health needs. Where clinics had no suitable infrastructure, clinic managers had to use their skills and creativity to manage the deficiencies effectively. Of the respondents, 45.0% indicated that the clinics had insufficient consulting rooms. They had to try and increase the space available to ensure that the best possible services could be rendered to the community with the available resources.

- **Availability of proper mechanisms pertaining to the EDL, medicine and supplies**

The respondents indicated that they had the following mechanisms in place (see chapter 5, table 5.10 on page 230):

- for ordering supplies (96.0%)
- for maintaining supplies (94.0%)
- for control of supplies (94.0%).

Although the proper mechanisms for the ordering, maintaining and controlling supplies were in place, it was mainly the respondents' responsibility to ensure that orders were placed and stock levels maintained and controlled with regard to medicines and supplies.

6.2.4 Respondents' developmental needs to enable them to adhere to their role expectations

The respondents agreed that clinic managers should be involved in development programmes in order to build capacity for their management role.

- **Training needs of clinic managers**

Regarding the training needs of clinic managers, the respondents lacked training in the following aspects (see chapter 5, figure 5.19 on page 203):

- the disciplinary procedure (58.0%).
- the disciplinary code (57.0%)
- the grievance procedure (57.0%)

The respondents were thus not trained in essential aspects to support them in their management function. Of the respondents, 68.0% had no formal management training; 69.0% had no training in clinic management guidelines; 65.0% had no management training at all, and 52.0% had no training in the assessment tools of a variety of the PHC programmes.

It was clear that the majority of the respondents were not effectively trained in management skills.

- **Value of an orientation programme**

Seventy-four percent of the respondents agreed that attending an orientation programme improved their knowledge on several aspects (see chapter 5, table 5.14 on page 235). It

was of concern, however, that 38.0% felt that they did not benefit by attending an orientation programme. Ideally, 100.0% of the respondents as clinic managers would have benefited.

- **Respondents' (clinic managers') developmental needs**

The respondents indicated the following developmental needs:

- Handling conflict (91.0%).
- Managing the clinic budget (90.0%).
- Acquiring sufficient staff (89.0%).
- Handling disciplinary procedures (88.0%).
- Planning activities (86.0%).
- Assertiveness (84.0%).
- Handling grievances (84.0%).
- Interpretation of data from the Minimum Data Sheet (84.0%).
- Managing PHC programmes (82.0%).
- Report writing (81.0%).

It was noted with concern that of the respondents, 84.0% had no training in the "Handbook for Clinic/CHC Managers"; 67.0% lacked training in short courses on management, and 62.0% lacked training in assessment tools for PHC programmes. These identified needs should be addressed to equip the respondents for their managerial role. They need to be prepared for their managerial role, as it cannot be assumed that managerial skills are innate.

- **Financial management**

The respondents with less than 5 years experience indicated a need for developing their financial management skills because their knowledge of financial management had to improve. The respondents with 6 and more years' experience felt equipped and skilled with regard to financial management issues.

6.3 GENERAL CONCLUSIONS

The general conclusions will be highlighted according to the objectives of the study.

6.3.1 Determination of the current role expectations of a clinic manager in a PHC setting

It was found that:

- The respondents included their staff in the development of goals.
- The respondents involved their staff in planning, utilised data to indicate conditions in the clinic, and implemented the Performance Development System.
- The respondents indicated that they should be involved in a variety of management functions including the budget, staff establishment, the critical post list and a formal training programme for staff.
- Most of the respondents indicated that they had job descriptions, which indicated the role of the clinic manager.
- The respondents drew up action plans to address underachievement in the PHC clinics.
- Interventions were taking place in clinics to address deficiencies in the performance of subordinates.
- The respondents had effective communication skills, which enhanced communication with staff.
- The respondents valued resources, as control over assets and human resources were regarded as important.
- Proper mechanisms pertaining to the EDL, medicine and supplies were in place in the clinics.
- Standards and protocols were used to treat patients, which standardised treatment for specific conditions.
- The respondents were involved in the organising of health events in the clinic and community, organised clinic committee meetings and presented in-service training to staff.

- The respondents ordered medicine, received medicine, controlled stock monthly and dispensed medicine to patients.
- The respondents were responsible for the implementation of the PHC programmes.

6.3.2 Factors determining and influencing the respondents' role as clinic manager in a PHC setting

- Only one third of the respondents held the professional qualification of nurse administrator/manager.
- More than one third of the respondents had more than 10 years' experience as professional nurse in a PHC clinic and this implied that they should be acquainted with PHC matters that would enhance effective clinic management.
- A critical factor determining and influencing the respondents' role was the shortage of staff, which consequently resulted in the respondents' rendering a clinical service in spite of managing the clinic.
- The respondents' identified transportation of staff as another negative factor removing them from their managerial task.
- The respondents regarded the utilisation of tools to monitor the quality of service in the clinic as important. Most of these tools were used bi-monthly for assessment. The implementation of these tools contributed to quality PHC services.
- The supermarket approach challenged the respondents' organisational skills as they had to organise to cover all services that should be available at the clinic on a daily basis. The majority of the respondents preferred the principle of rendering specific services on specific days.
- The respondents' frequency of absence due to attendance of meetings, training sessions and workshops impacted on the functioning and management of the clinic as it contributed to the prevailing staff shortage.
- The non-availability of a suitable infrastructure in clinics consequently resulted in the respondents' having to be creative to ensure that the best possible services could be rendered with the available resources.
- The respondents regarded trust in and the credibility of the clinic manager as important.

- The respondents considered it essential for the staff to be conversant with the disciplinary code, grievance procedure and relevant Acts.

6.3.3 Respondents' developmental needs to enable them to adhere to their role expectations

The respondents identified the following developmental training needs:

- Assertiveness
- The disciplinary and grievance procedure
- Transformational leadership style
- General management
- Clinic management guidelines (*Handbook for Clinic/CHC Managers*)
- Management of PHC programmes
- The assessment tools for the variety of PHC programmes
- Interpretation of data from the MDS
- Financial management
- Measures to ensure the availability of protocols in clinics and training in the implementation thereof.

6.3.4 Support for the respondents in the execution of their managerial role

This will be addressed in the recommendations.

6.4 LIMITATIONS OF THE STUDY

As the study progressed, the researcher identified the following limitations in the study:

- Some of the questions in the questionnaire (for example, question 45 and 46) could have been combined.
- With regard to questions with a number of different subdivisions, it was noted that the number of respondents differed in relation to some of the subdivisions. In question 71

the number of respondents varied between 91 and 94. It also indicates that the respondents who completed the questionnaire (97) did not answer all the questions. The reason for this is unknown.

- Some of the questions could have been formulated differently to obtain more specific answers from the respondents. For example, question 75 should rather have been formulated as follows:

Question 75

Control of resources is one of the responsibilities of the clinic manager. Indicate the frequency with which you execute control over the following:

		Not at all	Daily	Weekly	Monthly	Quarterly
75.1	Checking the inventory of the clinic to control losses					
75.2	Checking the attendance register signed by subordinates when reporting on duty and when going off duty					
75.3	Adding newly received equipment/furniture to the inventory					
75.4	Monitoring the correct utilisation of equipment and supplies					

This would have indicated whether the respondents were performing this duty or not. Agreeing with the importance of a statement is no guarantee that the respondent is performing the function.

- Question 53 could have been excluded, as it did not provide valuable information.
- The study was performed in PHC clinics of the Free State province only. Thus the findings cannot be applied to the rest of South Africa's PHC clinics.

6.5 RECOMMENDATIONS

The findings of the study confirm the role of the clinic manager in a PHC setting as experienced and observed by the researcher. Based on the findings, the researcher makes the following recommendations, which should contribute to

- The availability of a standardised and clear job description for the clinic manager. To support clinic managers in the execution of their managerial role, a proposed job description of the clinic manager and an example of a submission to expand the staff establishment of a PHC clinic are attached (Annexure Q and R).
- The stipulation of clear role expectations of the clinic manager.
- Addressing the factors that influence the role of the clinic manager negatively.
- Supporting clinic managers in their managerial role in availing training in identified training needs, addressing staff shortage by the Free State Department of Health and the establishment of support groups for clinic managers.
- The rendering of quality services in a PHC setting.

6.5.1 Factors that influence the role and functions of the clinic manager

The factors that influence the role and functions of the clinic manager should be addressed. Accordingly, the researcher makes the following recommendations:

- **Availability of a standardised and clear job description for the clinic manager**

The availability of a clear job description for the clinic manager is a necessity to ensure effective clinic management. Without a job description, clinic management cannot be effective.

It is proposed that a standardised and clear job description for clinic managers should be available. This can be done as such:

- The job description should be standardised for all clinic managers of fixed PHC clinics in the Free State province. The researcher attaches a proposed job description that can be utilised as a standardised job description (see Annexure Q).
- The Director: District Health Services should arrange a workshop attended by relevant stakeholders to develop a job description, including the district managers, local area managers, clinic supervisors and clinic managers of all the fixed clinics in the five health districts of the Free State. The labour relations officers and the human resource department of the respective districts and the provincial office should also attend this workshop to ensure that all stakeholders are represented.

At such a workshop the proposed job description and role expectations of the clinic manager can be discussed in depth to set a standardised job description for clinic managers of the Free State.

- **Staff shortages**

Staff shortages are one of the major issues influencing the role and functions of the clinic manager. It is proposed that this staff shortage should be treated with urgency to support efficient clinic management.

- **Vacant posts**

It is proposed that the funded vacant posts (these are posts vacated by natural attrition, for example resignation, death of an employee and transfer) be advertised and filled without delay. It is advised that these posts be filled as a matter of principle, as it has become practice for the FSDOH to put the filling of vacant posts on hold should financial deficiencies occur towards the end of the financial year. This has a serious impact on service rending as the workload increases due to the non-filling of posts and the clinic manager is coerced into rendering clinical services.

- **Retention of experienced staff**

Recognising their value to the service should retain experienced staff. Money is not the ultimate reward. Other means of recognition might be the issuing of a certificate, getting an extra day off, or a letter of recognition. This would contribute to the retention of staff, as they feel valued and important to the service.

- **Utilisation of professional nurses in the hospitals**

Professional nurses employed at local hospitals should be requested to work overtime during their off-duty times at the clinics. They would be remunerated according to the Department of Health's approved overtime rate.

- **Effective utilisation of staff**

Clinic staff should be rotated to support those clinics that encounter a very busy day or a shortage of staff. This would contribute to effective and efficient management of patient care.

- **Staff establishment**

The effect of the expanded and changed health care system has had an enormous impact on the PHC clinics, resulting in increasing demands on clinic managers. According to the findings, more than a half of the respondents indicated that the staff establishment had remained unchanged since 1994. Eighteen percent of the staff establishment was expanded while twelve percent was decreased due to the assessment.

It is proposed that the staff establishment of all fixed PHC clinics in the Free State be revised. The responsibility for the revision of staff establishments lies with the Organisational Development Sub-directorate at the Provincial Department of Health. It is advisable that the opinion of the clinic managers be obtained before finalising the revised staff establishment as they are fully aware of the circumstances and needs in their clinics.

With regard to registering and booking patients, it is proposed that every clinic should have a clerk to assist with the registering of patients. Clinics accommodating a large number of patients should have two clerks to attend to all the logistical requirements of the clinic. This can also be addressed when the staff establishment of the clinic is reviewed.

- **Availing of funds**

It is proposed that the availing of funds be included in the strategic management plan of the Free State, taking into consideration that quality services cannot be rendered without sufficient resources. It would be advisable for a thorough investigation to be done to identify the number of posts and other resources needed with the urgent availing of funds to ensure quality health service provision to the community of the Free State.

- **Number of patients for consultation**

Taking the extent of the patient load into consideration, it is proposed that the number of patients for consultation be limited when the clerk had registered the maximum number of patients for the day. This can be implemented by taking the number of professional nurses on duty and multiplying it with the norm of 35 patients per professional nurse per day. The number of patients visiting the clinic should be controlled, as patients flock into the waiting areas awaiting a service, which the professional nurses (including the clinic manager to support them) cannot attend to. The availability of a “Customer desk” at the entrance of the clinic would contribute to the regulation of the flow of patients. The person at the “Customer desk” could be a professional nurse who would screen patients and ensure that they obtained treatment at the correct level. Emergency cases would be referred to the professional nurse for treatment.

Presently patients are dissatisfied if they cannot be provided with a service, but the clinic managers and their staff cannot continue to treat an unlimited number of patients.

It is proposed that top management support clinic managers and their staff by increasing the staff rather than challenging them to handle the situation with the available human resources. These challenges and demands increase the responsibility of clinic managers,

resulting in stress and burnout – affecting not only the clinic manager but also all the clinic staff.

- **Flexitime**

It is recommended that the principle of flexitime to the staff be introduced to ensure that staff is available to remain should it be necessary to work later than 16h00. The other person can work from 08h30 to 17h00 to attend to the rest of the patients. However, the clinic door should still be closed at 16h00 to prevent a continuous influx of patients. The ideal situation would be to have a twenty-four hour PHC service available per town, but taking the financial implications into consideration, this cannot be implemented overnight.

- **Changes in health services**

It is also recommended that the clinic manager and the professional nurses should not be mainly responsible for functions emanating from the changes in the health services. With the implementation of the EDL, the clinic manager and professional nurse had to take the responsibility for management of medication due to the non-availability of pharmacists or pharmacist assistants. Changes should not be implemented without having the required resources available as this has a serious impact on the clinic manager's responsibility.

- **Non-managerial tasks performed by the clinic manager**

The respondents performed non-managerial tasks such as the handling of medicine.

- **Medicine management**

  It was noted that the management of medicine, which includes ordering, unpacking, checking and dispensing, was one of the factors interfering with the management of the clinic as it took up a lot of the respondents' time.

- **Pharmacist assistant posts**

  It is proposed that the pharmacist assistant posts on the staff establishment be funded as a matter of urgency. A submission requesting the availing of funds can be submitted via the district managers of the five health districts and the General Manager: District Health Services for approval by the Head of Health in the province in this regard.

- **Training of pharmacist assistants**

Learnerships for training of pharmacist assistants should be increased to address the need.

- **Respondents' development and training needs**

It was identified that the respondents lacked knowledge and skills in a variety of management aspects. As staff is regarded as the most important resource in any health service, the planning and implementation of an intensive in-service training programme is necessary. To address the training needs, the following proposals are submitted for deliberation:

- **Financial management**

  - *Monitoring and controlling clinic expenditure*: It is proposed that all clinics should operate as individual cost centres, and the budget of the local area should be devolved from the district office to the office of the local area manager. The local area manager could support the clinic managers to manage the budgets of the clinics of a specific local area.
  - The Assistant Manager (Finances) of the district office should train clinic managers intensively in budget management. It is advised that this training take place according to a specific programme involving all aspects of financial management.
  - Written feedback reports should be provided to clinic managers on a monthly basis on all clinic expenditure, for example medicine, medical consumables, printing and

stationery, cleaning material, staff expenditure and official transport. These reports should be submitted by the Assistant Manager (Finances) at the district office to the local area manager responsible for PHC services of a specific local municipality. It is proposed that the local area manager distribute these reports to the clinic managers. It would be advisable for the local area manager to discuss these documents with the clinic managers who will share the information with the clinic staff.

- It is advised that the local area manager be trained in and have access to the computer program Basic Accounting System (BAS) for financial management, to enable him/her to have direct access to the financial reports and not to depend on the Assistant Manager (Finances).

- **Training in codes, procedures, Acts, standards**

It is proposed that training be offered in all the respondents' identified needs.

- It was noted that the respondents identified a need for training in the disciplinary code and procedure, the grievance procedure, Acts related to PHC services and standards with specific reference to *The primary health care package for South Africa – a set of norms and standards* and *A comprehensive primary health care service package for South Africa*.

  It is proposed that this need be addressed by giving the respondents' in-service training in the PHC package by a knowledgeable person. The best option might be to involve an official from the National Department of Health or the Provincial Department of Health. All clinic managers should attend this in-service training to ensure that they are fully aware of the contents and prescriptions of the PHC package.

  It is proposed that the Office of the General Manager: District Health Services take the lead in the organisation of this training session, as it is nearly seven years after publication of these documents and some of the respondents indicated that they were not yet aware of the contents of these two documents, which form the cornerstone of PHC services in the Free State and the other provinces.

- After the completion of the training, it will be the clinic manager's responsibility, guided by the standards, to successfully implement these two documents in the clinic to ensure that quality services are rendered as prescribed.

- **Skills development needs of the clinic clerk**

Clerks should be skilled by the clinic manager to book patients telephonically for appointments at a secondary level of referral and to book patients for commuter transport and rehabilitation services. It is not necessary for a clinic manager or a professional nurse to perform these tasks.

- **Leadership style**

Most of the respondents indicated that they supported the democratic/participative leadership style. Due to the changing health service, it is proposed that managers be trained in the *transformational* leadership style, as this will support them in the changing health environment. This training could be done at district level where the responsibility would lie with the Office of the District Manager to arrange the training.

The advantages of transformational leadership would be that the clinic managers act as role models for their staff. Another very important advantage is that trust building takes place by "walking the talk". Leaders produce norms for behaviour and attitude. Staff is encouraged to experiment and challenge existent constraints by taking risks, and continuous learning should be stimulated.

- **Training in codes, procedures and manuals**

The following is proposed regarding training issues:

- **Training in the *Handbook for clinic/CHC managers***

  Local area managers could conduct the training in the *Handbook for clinic/CHC managers*. It should be possible to do the complete training within 2 to 3 days.

- **Training in assessment tools for PHC programmes**

  The district coordinator for each programme could conduct the training in the assessment tools for the PHC programmes. Depending on the extensiveness of the tool, it might be possible to cover more than one tool per day.

- **Training in interviews**

  Clinic managers should be required to attend and observe selection interviews for professional nurses, clerks, cleaners and auxiliary nurses and be given the opportunity during the training to role-play an interview to enable them to be competent in interviewing.

- **Access to Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care**

  It is recommended that more professional nurses working in PHC clinics be given the opportunity to qualify themselves as registered PHC nurses. This could be achieved by continuing to avail bursaries and study leave to those who are interested. With the implementation of the Occupational Specific Dispensation (OSD), the primary health care qualification is identified a “specialty” qualification, which results in additional financial incentives for professional nurses. Professional nurses with this qualification working in PHC clinics would be able to progress up the salary scale while those without it would not progress at the same pace. Professional nurses who do not hold the Diploma in Clinical Nursing Science, Health Assessment, Treatment and Care should be trained in PHC according to the manual compiled by Susan Strasser ([Sa]:4).

6.5.2 Support for the clinic manager

The following is recommended to support clinic managers with their managerial role:

- **Management of PHC clinics should be marketed**

The study found that the respondents' average age varied between 50 years and older. Within a couple of years a new generation of clinic managers will take over clinic management, therefore it is necessary to ensure that sufficient and appropriately trained professional nurses for PHC clinics will be available. Professional nurses should be recruited by making bursaries available by the Free State Department of Health for nurses, to avail scholarships for training of professional nurses. The implementation of the Occupational Specific Dispensation might contribute to recruitment of professional nurses. However, this is still in an initial phase and will have to prove itself.

- **Availability of transport**

The non-availability of transport for clinic managers has a negative impact on the execution of their management functions.

It is proposed that the local area manager work hand in hand with the district hospital (which has cars available) to make a car available for PHC. Due to the financial implications, it would not be possible to provide a car for every clinic immediately, but at least an official vehicle would be available, if needed.

Clinic managers should indicate the need for purchasing vehicles on the clinic budgets.

- **PHC services rendered at clinics**

The respondents indicated that adolescent health services and geriatrics are not rendered at some of the clinics. The community development officers of the Department of Health should do a survey per town to establish the availability of these services. Depending on

the findings, clinic managers supported by the local area manager and district manager could draw up action plans to address the need.

- **Health education**

The respondents indicated a lack of time for health education in the clinic was a barrier to their supervisory function. It is recommended that clinic managers should make a specific time of the day, say early in the morning when the clinic is full of patients, available for health education. If clinic managers are not overburdened with non-managerial tasks, time will be available to plan, organise and control the health education sessions in the clinic.

- **Involvement of the clinic manager in the District Health Plan and Local Area Plan**

The District Health Plan is the foundation of the Local Area Plan. The Local Area Plan is the basis of the actions that should take place in the clinic to reach the set objectives. The involvement of all stakeholders/staff and clinic committee members is important in the planning of the local area plan.

Only 44% of the respondents indicated that the clinic manager should be involved in the District Health Plan and Local Area Plan. It is proposed that the importance of their involvement should be explained to them at the monthly clinical management meeting with the local area manager, and that clinic managers should attend the workshops on the planning of the District Health Plan and the Local Area Plan. Every clinic manager should be required to draw up a clinic plan to adhere to the objectives of the District Health Plan and Local Area Plan.

- **Organisation of PHC programmes**

To support clinic managers with the organisation of the PHC programmes, it is proposed that:

- A local programme coordinator's post be created on the staff establishment of the clinic who can support the clinic manager with the implementation, organisation and assessment of the programmes.
- The clinic manager should assess the quality of the services rendered according to the assessment tools in collaboration with the local area coordinator to enable the clinic manager to be acquainted with the status of the programmes in the clinic.
- The clinic supervisor should support the clinic manager during the supervisory visits by assessing the indicators and the objectives that should be achieved and by supporting the clinic manager to draw up action plans and to implement them.
- The clinic manager should allocate a specific time slot in the day for the organisation of the PHC programmes to ensure that the necessary time is devoted to them as they form the core function of a PHC clinic.
- The clinic manager should have the PHC programmes as a standing matter on the agenda of the clinic staff meeting.

- **Availability of equipment**

As the availability of equipment plays an major role in the effective functioning of clinics, it is proposed that:

- The clinic manager and supervisor should investigate the reasons for the unavailability of equipment and draw up action plans to address the shortage. These plans should be submitted to the district manager. Should funds be lacking to purchase equipment, a submission can be forwarded via the district manager's office to the General Manager: District Health Services and the Head of Health to make funds available.
- When purchasing equipment, quality instead of price only should be considered.
- Proper maintenance and repair mechanisms for equipment should be in place. It is proposed that a clinical engineer post be created on the staff establishment of the district to take care of equipment of hospitals and clinics.

- **Availability of Internet services at clinics**

The respondents indicated that Internet services were not available at the clinics.
It is advisable that clinics that do not have access to computers be provided with computers. This could be done in a staggered way due to the financial implications entailed.

As the computerised communication system of the Department of Health in the Free State is known as “Intranet”, it is proposed that all clinic managers should have access to this system. The advantage would be that the clinic administration such as registering of patients by the clerk, ordering of stock and entering of monthly data could be computerised, which would alleviate the burden of activities and record keeping which is done manually at present.

The Information Technology trainer of the district should train clinic managers and staff who are not computer literate.

- **Attendance of meetings**

To prevent clinic managers from attending meetings not applicable to them, it is proposed that invitations be sent via the local area manager and the clinic supervisor to the relevant clinic managers. No invitations should be sent directly to the clinic managers. Should invitations reach the clinic manager without the involvement of the local area manager and clinic supervisor, they should be returned to the local area manager and clinic supervisor for screening and approval for attendance.

- **Visits of the clinic supervisor**

It is recommended that:

- Clinic supervisors do regular monthly supervisory visits to ensure support to the clinic manager.

- Clinic supervisors visit the clinic monthly to assess the situation in the clinic by means of completing the Regular Review and Red Flag tools. During these visits the clinic supervisor can do on-the-job monitoring and coaching on aspects that need intervention identified during the supervisory visit. The clinic supervisor should submit a written report on the findings and the actions taken to the clinic manager and the local area manager for rectification by the clinic supervisor and record purposes.

- **Forum for clinic managers**

It is recommended that a forum for clinic managers be established to provide them with a platform where concerns and successes can be discussed. This could also serve as a platform for in-service training for clinic managers. Such a forum could be established for each district under the guidance of the local area managers. All the clinic managers of the district could attend this forum, which would take place three monthly. Clinic managers could assist in creating and maintaining support groups, which provide skills and training, foster the exchange of best practices, and promote peer learning.

- **Team building**

Team learning is vital because teams and not individuals are the fundamental learning units in modern organisations. Funds should be made available in the budget to ensure that team-building events take place annually to consider complex issues and realise the need for innovative and coordinated actions.

- **Improvement of quality of services**

To ensure that the quality of services is monitored, a quality improvement system should be in place.

- **Auditing of records**

  It is proposed that the clinic manager should make time available on a specific day of the week for auditing purposes. The auditing tool presently in use should be reviewed

and adjusted to becoming a user-friendly tool. The Quality Assurance Section of the Provincial Department of Health should take responsibility for this and it should be piloted by a number of clinics before approval.

- **Clinic managers should involve the professional nurses in the auditing**

  Professional nurses should be encouraged to participate in the auditing process by auditing clinic records. Feedback on the outcome of the auditing should be given verbally and in writing to all stakeholders. As record keeping has legal implications, the auditing of records may contribute to the quality of record keeping in the clinic as well as the rendering of quality services.

- **Principle of a "supermarket approach"**

  The respondents indicated that the rendering of specific services on specific days did not affect service rendering negatively. It would be advisable to reconsider the principle of a "supermarket approach". Patients needing a service would still be free to attend the clinic on any day for the initial visit and would not be denied assistance, but the return date would be according to the plan of service provision.

Should there be more than one PHC clinic in a town, it is recommended that a health plan per town be drawn up where specific PHC services would be provided in the town, but not at every clinic. It is recommended that this be done for a trial period of six months, after which the outcome could be assessed.

- **Educational material, prints and references**

The clinic manager's management competency is partly assessed against the availability of educational material, prints and references in the clinic. Since clinic managers are assessed negatively if these materials are not be not available when they are not available at the provincial office, it is proposed that these items be withdrawn. These items should be deleted from the tools if they are not available at either the National or the Provincial

Department of Health. The same would apply to policies that were not available at the Provincial Department of Health.

It was noted that education material was not available in local languages. It is recommended that it be made available with the cooperation of the Corporate Service Section at provincial level. At least the main languages of a specific area should be covered.

- **Tools for assessing the operationally of District Health Systems**

The researcher discovered this document during the literature review. This document, compiled by the WHO, was unfamiliar to the researcher. It is recommended that the contents of this document be made available to all stakeholders involved with district health, from top management to clinic level.

It is also recommended that the assessments should be done for health facilities as indicated in the abovementioned document. According to the outcome of these assessments, adjustments/changes could be made to the benefit of service rendering as strengths and weaknesses can be identified and ideas for improvement solicited.

6.5.3 Future research

This study focused on the role of the clinic manager in a PHC setting with specific reference to the clinic manager of a fixed clinic. Further research should be done on the circumstances of the PHC staff who render PHC services in mobile clinics in the rural areas.

As the “Supermarket approach” is the desired approach for service rendering in PHC clinics, the efficiency and effectiveness of this approach could be explored by further research.

6.6 SUMMARY

In this study the researcher attempted to determine the current role expectations of a clinic manager in a PHC setting, to identify factors determining and influencing the role of a clinic manager, to determine what effect the current role expectations had on the management of PHC services rendered at the clinic, to establish the developmental needs of clinic managers to enable them to adhere to their role expectations, and to identify and recommend measures to support clinic managers in the execution of their managerial role by addressing the identified deficiencies.

The researcher selected a quantitative, exploratory, descriptive and contextual design. A five-point Lickert scale was used to measure the respondents' attitude. Clinic managers of fixed clinics in the Free State were randomly selected to participate in the study and a questionnaire was utilised as data-collection instrument.

The study found that the clinic manager's role is comprehensive and varies from telephonic booking patients to assessment of the quality of PHC programmes. A number of non-managerial functions were identified, such as consultation of patients, management of medicine, dispensing of medicine and ordering of stock. It was also found that the respondents were not involved in a number of management functions such as financial and human resource management, and adherence to the implementation of standards.

Factors that negatively influenced the respondents' management role included:

- Lack of time due to the large number of patients they had to consult due to the shortage of staff.
- Shortage of staff.
- The execution of non-managerial tasks.

Although it was found that the current role of the clinic manager was confusing as it entailed much more than just clinic management, it is foreseen that the role of the clinic manager could in future be clarified if the recommendations are implemented.

The clinic manager is a professional nurse and because **nurses** are the backbone of PHC, the management of PHC clinics should be the responsibility of a nurse manager. Allowing the clinic manager to adhere to a clear job description, and addressing the factors that negatively influence the role of the clinic manager can result in quality PHC services offered to a community by a well-managed PHC clinic. However, this might take time due to the financial implications.

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