EXAMINATION OF MANAGEMENT ROLES AND FUNCTIONS OF THE CLINIC REGISTERED NURSE-IN-CHARGE IN ETHEKWINI DISTRICT

A Dissertation Submitted in Partial Fulfillment of the Requirements of the Degree

MASTER OF PUBLIC HEALTH

To the

School of Family and Public Health Medicine

Nelson R Mandela School of Medicine

University of KwaZulu-Natal

By

Victoria Nonsikelelo Shandu

October 2008

Supervisor : Dr Anna Voce

DEDICATION

I herewith dedicate this dissertation to my dearest mother, Ms Nomagugu Sigwili, my wonderful three sons and one lovely daughter and my loving husband, Mthiya for their undying support that saw me through this period of study.

DECLARATION

I, Victoria Nonsikelelo Shandu, do hereby declare that this dissertation, unless otherwise stated in the text, is the result of my own investigation and research. All sources used have been acknowledged. This work has not been submitted as part or in full for any degree in any University.

SIGNATURE : \'ty^U^a*»f^

DATE 2&-^ £ TJ&CZ

SUPERVISOR

SIGNATURE :

DATE <$>* cJ^atvfer £oo£

ACKNOWLEDGEMENTS

I firstly thank my creator, the Almighty God for the undying lead He has provided me with, particularly during the time of this piece of work.

My mother, thank you so much for the distant support through your prayers and encouragement.

My supervisor, Dr Anna Voce who supported me patiently through her guidance, constructive criticism, and motivation that I mostly needed in the compilation of this dissertation.

The Nelson R. Mandela Medical School campus library staff for their support during literature search.

My colleagues, Aneliswa Cele and Dr Victoria Mubaiwa without whom I would not have run the race to completion.

A special thanks to my ex-district Manager Mr. T. Msiza who accommodated my studies during tight work schedules.

My sincere thanks to the ex-Amawele PHC Coordinator, Mrs. O.T. Shandu, her clinic supervisors, Ms N. Wanda, Mr. R.S.A. Mthembu, Ms A. Perumal, all the Registered Nurses-In Charge including provincial, municipality and state-subsidized, and the clinic nurses who took part in the data collection process.

To my colleagues Mrs. Claire Frame and Ms L.Godlwana for availing themselves to participate in the study.

Lastly, my loving husband, Mthiya and my four wonderful children for your loving, understanding and relentless support through this long journey. Thank you once again.

ABSTRACT

Background

South Africa, similar to most developing countries is faced with ever increasing demands for health care emanating from various reasons, which include a quadruple burden of disease. More appropriate health policies have been developed since the new government dispensation post-1994. Most of these have been implemented. These include, inter alia, the District Health System (DHS) as a vehicle to deliver Primary Health Care services.

The decentralization principle was key to the implementation of the DHS and was intended to shift decision making to the periphery to improve overall responsiveness to local health needs.

Study Aim

The study aimed at exploring the management roles and functions of the Registered Nurse-In-Charge of Primary Health Care clinics in eThekwini District, both from a policy and operational perspective. It is envisaged that this body of knowledge will contribute to policy development for effective, efficient and economical management of PHC service delivery at clinic level.

Methodology

The study was conducted in eThekwini District and adopted a qualitative design. The target population was the Registered Nurses-In-Charge of clinics. The sampling method employed was purposive, *a priori* heterogeneous sampling. Data collection methods used included in-depth interviews with key informants and focus group discussions. Eight in-depth interviews were conducted on key informants. Two were from a municipal clinic, two were from a provincial clinic and two were from a state subsidized clinic. One was conducted on the District Programme Manager and one on the District Primary Health

Care Coordinator. Three focus group discussions were conducted: one with clinic nurses, one with Registered Nurses-In-Charge, and one with Primary Health Care Clinic Supervisors.

Data analysis was undertaken using the deductive content analysis which was done according to the predetermined categories guided by the objectives. Within these broad groupings of responses, themes, sub-themes and patterns were established, noting particular similarities and differences between respondents. The patterns were aligned to the study objectives in order to keep focus on the research question

Findings

The study revealed that although the Registered Nurses-ln-Charge of clinics possessed certain particular theoretical knowledge on the management roles and functions required of them at clinic level, most of these functions were not being performed. The policy documents, including the Registered Nurses-In-Charge's job descriptions, indicated gaps in relation to the management roles and functions required of Registered Nurses-In-Charge. In certain instances the policy omitted functions that were in the job descriptions and vice versa. This showed that the policy documents were not considered in the development of job descriptions. Major gaps were in leadership and planning, human resource management, financial management and information management.

The gaps in the policy documents and job descriptions were attributed to the narrow decision space transferred to the clinics. Most management functions of clinics are still held at support institutions be it at a hospital or community health centre.
Some of the reasons reported by the Registered Nurses-In-Charge themselves, as limiting the fulfillment of management roles and functions, were lack of orientation and training on management, lack of dedicated clinic managers, staff shortage and lack of support from clinic supervisors and the support institution.

Conclusion

The recommendations include building management capacity, and reviewing the degree of decision space transferred to clinics if they are to succeed in fulfilling the function of being the first entry point into the health system.

TABLE OF CONTENTS

ACRONYMS AND ABBREVIATIONS

BANC	- Basic Ante Natal care
CHC	- Community Health Centre
CN	- Clinic Nurses
CPHCSP	- Comprehensive Primary Health Care Service Package
CPN	- Chief Professional Nurse
CS	- Clinic Supervisor
CSP	- Clinic Supervision Policy
DHIS	- District Health Information System
DHS	- District Health System
DOT	- Directly Observed Treatment
EAP	- Employee Assistance Programme
EN	- Enrolled Nurses
ENA	- Enrolled Nursing Assistant
FGD	- Focus Group Discussion
GOBI-FFF	- Growth monitoring; Oral rehydration therapy; Breastfeeding; Immunization; Family planning; Food supplementation; Female education.
HB	- Hand Book for Clinic/CHC Managers
HIV	- Human Immune-deficiency Virus
INK	- Inanda Ntuzuma KwaMashu
KI	- Key Informant
KZN	- KwaZulu-Natal
MDG's	- Millennium Development Goals
MEC	- Member of Executive Council
MSR	- Municipal Supervisors' Report
NGO	- Non- Governmental Organization
OHSA	- Occupational Health and Safety
PEP	- Post exposure Prophylaxis
PFMA	- Public Finance Management Act

PHC	- Primary Health Care
PHCC	- Primary Health Care Coordinator
PHCP	- Primary Health Care Package
PM	- Programme Manager
PMTCT	- Prevention of Mother to Child Transmission
PSR	- Provincial Supervisors' Report
RDP	- Reconstruction and Development Programme
SANC	- South African Nursing Council
RNIC	- Registered Nurse-In-Charge
SSSR	- State-Subsidized Supervisors' Report
STI	- Sexually Transmitted Infections
TB	- Tuberculosis
UKZN	- University of KwaZulu-Natal
VCT	- Voluntary Counseling and Testing
WHO	- World Health Organization

LIST OF TABLES

LIST OF APPENDICES

CHAPTER 1 - BACKGROUND

1.1 INTRODUCTION

South Africa confronts a quadruple burden of disease, comprising of communicable diseases represented by Tuberculosis (TB), chronic diseases, trauma, and Human Immune-deficiency Virus and Acquired Immune Deficiency Syndrome (HIV and AIDS) (1). The country possesses well developed and high technology hospitals in the major cities (1) whilst basic health services remain underdeveloped in some parts of the country especially the former homelands and rural areas (2). Consequently, essential health services to large areas are frequently deficient. The District Health System (DHS) was introduced in 1994 as a vehicle to deliver Primary Health Care (PHC). The main purpose for the adoption of the PHC approach was to reduce such inequities in access to health care particularly in such rural areas and other deprived communities (3). Secondly, it was directed at addressing the basic health needs of persons in South Africa to enhance their health status in the most cost-effective means. This emanates from the 1996 National Health Policy citation that PHC has been accepted as the most suitable route to health for all (4). Finally, the improvement of health service delivery at all levels of care, i.e. primary, secondary and tertiary was strived for (4).

PHC is the cornerstone of the DHS. Effective and efficient provision of health care at clinic level is dependent upon the consequent implementation of PHC in the South African health system. As the first entry point into the health system, it is vital that PHC clinics receive efficient management in order to improve such health care delivery. This already constitutes an acknowledged reality (1).

A particular significant goal in the White Paper for the Transformation of the Health System in South Africa included basic health care for all persons in South African within ten years from the inception of the new political dispensation in 1994 (3). The adoption of the Comprehensive PHC service package conformed to this goal because it was viewed as paramount for access to health care by the nation's inhabitants.

The severe under-management of hospitals was identified as a major drawback factor as early as 1997. The following main reasons were cited as the main reasons:

- Limited responsibility and authority accorded to the hospital managers
- Ineffective and inappropriate structures and systems of management
- Limitations in the required range of skills possessed by managers
- Insufficient operational authority or incentives for managers to co-ordinate their control of budgets efficiently and the organizational culture that prevailed within the hospital (3).

As one strategy for securing the satisfactory health of all South Africans, emphasis on management support would focus on the following vital issues: financial management, human resource management and the operation of a comprehensive information management system. Additional efforts would be employed to reform organizational structures, strengthen support systems and improve staff skills (4). It is conceivable that PHC clinic management would constitute part of this proposal, accounting for the major emphasis that was placed on PHC as the approach to transform the health system of this country. However, these laudable policies have thus far only witnessed implementation in hospitals and Community Health Centres, despite the apparent priority directed towards PHC facilities (4).

Therefore it is an unquestionable reality that despite management support being crucial for the effective and efficient provision of health care at hospital level, this focus must be similarly targeted at clinic level.

1.2 BACKGROUND TO THE STUDY

1.2.1 Primary Health Care

The Primary Health Care service forms an integral part both of the country's health system, of which it is the central function and chief focus, and of the overall social and economic development of the community. It constitutes the first level of contact for individuals, family and community with the national health system, providing adequate and appropriate health care nearby to people's residence and place of employment as can reasonably be achieved, and forms the first element of the continuing health care process (4).

For the necessary success of the PHC Approach in South Africa, political will is required from government, and commitment is essential from both health service managers and communities. Thus government must formulate policies that suitably promote and prioritize PHC (4).

1.2.2 District Health System

The District Health System is defined as comprising all institutions, organizations and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional (5).

Much activity has occurred since 1994 towards the implementation of the DHS in eThekwini Health District. Additional District Hospital, Community Health Centres, and both fixed and mobile clinics have been constructed. EThekwini district is divided into three service areas which are South, West and North. A further sub division has resulted into eighteen PHC service areas, which are aligned to municipal boundaries. The division into three service areas is a functional arrangement. The legal demarcation of sub-districts by both MEC's for Health and Local Government as cited in the National Health Act No.61 of 2003 has not yet been done (6).

The eThekwini district consists of the district health office, 1 central hospital, 2 regional hospitals, 4 regional district combo hospitals, 2 district hospitals, 2 state subsidized district hospitals, 8 specialized hospitals, 11 private hospitals, 8 Community Health Centres and 142 clinics (6). The regional district combo hospitals form those hospitals that were designated as either district or regional, but currently provide both district and regional services because of particular needs that have arisen after such designation. These include those requirements attributable to lack of either a district or regional hospital within a geographic area to meet the necessary referral network demands (6).

The district management structure has been established and fully appointed. Six out of eight CHC's have since appointed their full management teams. Of the remaining two that have not so complied, one has employed both the CHC Manager and the Nurse Manager whilst the other has only engaged the services of the latter (6). The strengthening of management at clinics has, however not yet received attention. (6).

1.3 ROLE OF PHC CLINIC-BASED SERVICES

The PHC clinic-based services afford more persons, especially in rural areas, the initial and frequently the only access to health care (7). PHC clinics address the main potential health problems in the community through the provision of promotive and preventive health services (8). The PHC clinic-based services include, as a necessary minimum, the following components: education relating to potential and prevailing health problems and the methods of their prevention and control; promotion of food supply and nutrition; promotion of an adequate supply of safe water and basic sanitation; maternal, child and women health issues including reproductive health; immunization against the major preventable infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and, finally, provision of essential drugs (8).

1.4 PROBLEMS IN CLINIC-BASED SERVICE DELIVERY

In spite of the cited developments in the DHS, the PHC clinics still experience a wide range of problems attributed to socio-economic, community, policy and management failures. These problems negate the role of clinic-based services. The existence of unacceptable slow moving lengthy patients' queues and the turning away of patients, which are attributed to staff low morale and burn out, deny clients access to the necessary health care (9).

Currently, various reports indicate a number of gaps in relation to the provision of the full package of service as prescribed in the PHC Package of Service (2), (10). Several reports indicate the poor management of various health programmes (5). The community's dissatisfaction with poor PHC services at clinics remains a major priority in confronting health care challenges, and is underscored by both the continual under-spending of the PHC budget and the concomitant decrease in the PHC utilization rate (6).

The provision of health programmes and the achievement of improved health programme targets, such as TB cure rates and immunization coverage rates, are severely compromised. Clinics still exist that do not provide all priority programmes such as Prevention of Mother to Child Transmission (PMTCT) services either due to space constraints or a shortage of human capital (6). South Africa features among those countries highly criticized for their poor management of tuberculosis. It is ranked 5* among the world's 22 high-burden TB countries. The TB incidence rate in South Africa in 2004 was 718 cases per 100 000 people (11). In 2006, KwaZulu-Natal was ranked the highest TB burdened province in the country, followed by Gauteng, registering 34 928 and 22 755 respectively. In 2005 KwaZulu-Natal recorded the lowest cure rate in the country, 45.2 for new cases followed by Northern Cape which recorded a cure rate of 50.1%. In 2005 at the WHO - AFRO Region Committee meeting held at Maputo,46 Ministers of Health declared TB an emergency in Africa. In South Africa the National Minister declared TB a national crisis. The TB crisis management plan was focused in the four health districts that had the high TB burden and lower treatment outcomes (12).

EThekwini district was cited as one of the four districts in the country with the lowest TB cure rate i.e. 32% (13).

The core management of TB is at the PHC clinic level from its prevention, early diagnosis, treatment and rehabilitation.

1.5 PROBLEMS IN THE MANAGEMENT OF CLINIC-BASED SERVICES

A general reality remains that health demands are constantly multiplying whilst available scarce health resources persist in diminishing or, at a minimum are poorly managed. Most clinic-based service delivery problems and failures highlighted previously in this chapter are overwhelmingly attributable to clinic management failure.

In eThekwini district, the management failures at PHC clinics include the shortage of vital resources, particularly human capital. This dearth is attributed to poor attraction and retention of relevant staff and weak senior management support for PHC clinic-based services, equipment, surgical and pharmaceutical supplies and physical space. The latter are regarded as being due to poor clinic management at both the clinic level and support institution. The shortage of human capital encompasses both functional and supervision staff. Clinic supervision, ostensibly designed to strengthen clinic management, was severely compromised in this district until the latter part of 2006 (14), when both the west and the north service areas appointed dedicated clinic supervisors. Presently no dedicated supervisors are available in the south service area, because the clinic supervisors were only attached to CHC structure. CHC's are absent in the south service area. This is absent in the south service area (15, 6). The other relevant management failure concerning human capital was the slow process of appointment of clinic managers. They had merely been allocated to fulfill these roles. The actual appointment into clinic manager posts in the entire district was only effected from December 2007 (16).

The laudable policy intents post 1994 on PHC approach have, thus far, been fairly implemented. The remaining challenge however, is the actual attainment of these policy

objectives. The problems highlighted in the PHC clinic-based service and management thereof, are a clear indication of this stated reality. Failure to establish the root cause of non-attainment of policy objectives in spite of fair implementation and institute intervention will necessarily render the PHC clinic-based service ineffective, thereby failing to address the acute diverse health needs facing South Africans. Therefore a vital contribution in the exploration of problems of PHC clinic based services is both the examination of management roles and functions of a Registered Nurse-In-Charge at clinic level.

1.6. RESEARCH QUESTION

What are the management roles and functions of clinic Registered Nurse-In-Charge in the eThekwini North Service area?

1.7 PURPOSE OF THE STUDY

The study seeks to explore the management roles and functions of the Registered Nurse-In-Charge of the PHC clinics, both from a policy and operational perspective. It is envisaged that this body of knowledge will contribute to policy development on how clinics should be managed. This will further contribute to effective, efficient, economical and transparent management of PHC Clinics, which ultimately will result in improved quality of PHC service delivery.

1.8 RATIONALE FOR THE STUDY

In the health management literature a dearth of information exists on the management role and functions of the Registered Nurse-In-Charge of the PHC clinic. The problems highlighted earlier that could be attributed to ineffective clinic management indicate the urgent need for more information on management at clinic level.

The fourteen years of the researcher's personal experience in a PHC clinic which subsequently became a fully fledged CHC, eight of which were performed in a

'management' role as a Registered Nurse-In-Charge, as Nurse Manager and ultimately CHC Manager, convinced her that most service delivery problems are indeed related to poor and ineffective management of PHC clinics.

This observation is corroborated by a multi-national study conducted in Tanzania, Madagascar, Uganda, Mozambique, Ghana, in examining poor service delivery. The results demonstrate that inadequate management of human resources, weak supervision and unsatisfactory training contributed to service delivery problems (17).

The study results on "Voices of Health Managers (18), shed much needed light on challenges faced by health managers in South African health facilities, including PHC clinics. The researcher therefore identified the opportunity for further study, particularly the examination of management roles in PHC clinics.

1.9 STUDY OBJECTIVES

1.9.1 Establish the management roles and functions required at the clinic level in order to deliver the Primary Health Care service package.

1.9.2 Describe the current management roles and functions of the clinic Registered Nurse-In-Charge.

1.9.3 Identify the management role and functions at the clinic level that are currently not being performed by the clinic Registered Nurse-In-Charge.

1.9.4 Analyze the factors that limit the fulfillment of the management role and functions of the clinic Registered Nurse-In-Charge.

1.9.5 Make recommendations that would enable the clinic Registered Nurse-In-Charge to fulfill the management role and functions required at clinic level.

1.10 OPERATIONAL DEFINITIONS

1.10.1 Village Health Post

It is a community-based structure that is mainly operated by community health workers. No health professionals that render service in this structure exist. Core functions include health promotion and prevention activities.

1.10.2 PHC Mobile clinic

It is a clinic with PHC package provided on a vehicle.

1.10.3 Primary Health Care Clinic

It constitutes a fixed structure in which basic health services are provided, predominantly by nurses. It functions 8hrs per day for five days per week. It forms the facility in the referral system, which links the community to the formal health facility referral network. The clinic provides a comprehensive range of preventive, promotive, curative and rehabilitative services at a less specialized level (4)

1.10.4 Provincial Primary Health Care Clinic

It is as 1.10.3 above but has as its governance the provincial health authority. The staff is accountable to the district health manager at district level, through their line supervisors. The conditions of service are that of the public service.

1.10.5 Municipal Primary Health Care Clinic

It is as 1.10.3 but it is governed by local government. This means that the staff at these clinics is accountable to the Head for health in the municipality through their line supervisors. The conditions of service of staff are those of local government services. The municipality receives funding to provide primary health care service as it is the responsibility of provincial health to provide PHC clinic-based services (19).

1.10.6 State-Subsidized Primary Health Care Clinic

It is as 1.10.3 above, but is aNon Governmental Organization (NGO) which receives a subsidy from the government. The services that they are required to provide are appended and agreed upon by both parties in the Service Level

Agreement. The conditions of service for staff are decided upon by the individual NGO. The staff is accountable directly to the NGO.

1.10.7 PHC clinic Registered Nurse-In-Charge

It is a professional nurse who is allocated or appointed in the post to take the overall charge-ship of the PHC clinic.

1.10.8 Community Health Centre

It is the foundation of the National Health System and provides comprehensive services that include preventive, promotive, curative and rehabilitation services. In addition to the PHC clinic services, the CHC offers radiological, oral health, pharmaceutical, laboratory and full time medical services. The CHC provides 24hr maternity and casualty services (4).

1.10.9 District or Level 1 Hospital

It is the fixed structure where a range of outpatient and inpatient services are offered, mostly within the scope of general medical practitioners. It has a functional operating theatre in which operations are performed regularly under general anesthesia (20).

1.10.10 Regional Hospital

It is a fixed structure that provides services like the district hospital, with addition of specialist services like ear nose and throat, ophthalmology, urology, plastic surgery, cardiology, neurology,

1.10.11 Management

It is viewed as a more purposeful process of setting up a suitable plan of how best to achieve the intentions of the organization, and mobilize people to implement the plan (21).

1.10.12 Decentralization

It is seen as the delegation of authority for, responsibility for, and control over funds to the lowest level possible that is compatible with rational planning and the maintenance of good quality care (21). This refers to the management of the delivery of services to provinces, districts and institutions in order to increase efficiency (4).

1.10.13 Decision Space

It is the tool which is used to evaluate the set of management functions and the degree of choices transferred to the periphery during decentralization (22).

1.11 ORGANIZATION OF THE REPORT

The study aims at examining the management roles and functions of the PHC Clinic Registered Nurse-In-Charge. The lay out of the dissertation report will be as follows:

- Chapter 1 has given an overview of the background to the study, including the research problem and study objectives
- Chapter 2 will give an in-depth review of the literature related to the research topic to broaden the understanding of the study and describe the conceptual framework underpinning the study.
- Chapter 3 will discuss in detail the research methodology used for this study, which includes the study design, sampling method, data sources and analysis.
- Chapter 4 will provide the research findings as obtained from data sources.
- Chapter 5 will furnish an in-depth discussion of research findings against the conceptual framework and study limitations.
- Chapter 6 will finally provide the conclusions based on the results and recommendations for service delivery improvement and further studies

The references will be at the end of the dissertation report.

CHAPTER 2 - LITERATURE REVIEW

2.1 INTRODUCTION

As a critical part of the study, the researcher reviewed literature of various forms for the purpose of obtaining a broader understanding of the research topic: **management roles and functions of the clinic Registered Nurse-In-Charge.** The major areas of literature reviewed covered concepts of health systems like Primary Health Care, District Health System, decentralized management, key health management roles and functions, trends in health service management in South Africa and the legislative framework governing the management of clinic-based services.

The body of knowledge obtained through the review of the literature will be used to analyze and interpret the management roles and functions currently performed by the clinic Registered Nurse-In-Charge in eThekwini District. To obtain this knowledge, the researcher employed the following search strategies:

- Hand searches in University of KwaZulu-Natal Howard College and Nelson R. Mandela School of Medicine libraries and the eThekwini district office library.
- Electronic searches using Google, Pub-Med and KwaZulu-Natal Department of Health intranet sites.
- Hand searches of minutes of PHC meetings in eThekwini District Office.
- Consultation with lecturers in UKZN Nursing and N.R. Mandela School of Medicine, Department of Public Medicine.
- Consultation with N.R.Mandela School of Medicine and UKZN Nursing Institute librarians.
- Consultation with Department of Health and Health Systems Trust officials.

The key words used in the literature search were:

- Primary Health Care Management
- Primary Health Care Supervision

- Health Services Management
- Clinic Management
- Health Services administration
- Clinic administration

2.2 PHC

The research question examines the management roles and functions of a PHC clinic Registered Nurse-In-Charge. It is therefore important to discuss PHC briefly, including its origins and current application. This will form a context for further discussion in the study.

2.2.1 Definition of PHC

Primary Health Care is defined as: "essential health 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" (8).

2.2.2 The Alma Ata Declaration

Although PHC had come about long before the Alma Ata Declaration, the declaration strengthened the PHC concept because it was formulated based on the understanding that ill health is caused not only by physiological factors and organic deficiencies, but also by social and economic issues. The universal principles of PHC which were adopted by all members of the World Health Assembly were:

- Equity
- Community participation in planning and monitoring of health care
- Intersectoral collaboration in managing health issues
- Adoption and use of appropriate technology
- Health promotional activities
- Political will

- Social and economic justice (23).

It is important to mention the universal principles of PHC, as they form the context within which the clinic based services are provided. The declaration also listed essential services to be offered in a clinic-based service as follows:

- Education on prevention and control of prevailing health problems
- Promotion of food supply and nutrition
- Promotion of adequate supply of safe water and basic sanitation
- Maternal child and women health including reproductive health
- Immunization against the major preventable infectious diseases
- Prevention and control of locally endemic diseases
- Appropriate treatment of common diseases and injuries
- Provision of essential drugs (5).

2.2.3 Implications of the Alma Ata Declaration

The following were the direct implications of the declaration

- The design and implementation of a comprehensive health strategy to provide health services and address the underlying socio economic and political causes of poor health.
- The equitable distribution of resources required major changes in the political arena and national health policies. One of the great challenges was the transfer of the larger share of health resources to the majority of the underserved population that was not represented in policy-making processes.
- Efforts were required to raise community awareness on health issues, in order for them to be able to participate actively in policy making, and implementing and controlling health care programmes and projects (8).

A comprehensive approach to the implementation of PHC was thus required. The comprehensive PHC approach constituted a strategy for health development of the community including attending to issues of housing, sanitation, employment and poor environment. The comprehensive approach was aimed at holistic community development through intersectoral collaboration and community involvement. Many argued that the implications of implementing the declaration as a whole were too costly

and unrealistic particularly because it was to eventuate in a radical social reform (8). This argument was accompanied by the suggestion that health status could be improved by 'targeting' high risk/vulnerable groups through 'carefully selected' interventions. This was the selective PHC approach. The selective approach had its emphasis on the management of identified health problems, excluding the effects of environmental and economic factors on health. The examples of carefully selected interventions included the WHO's GOBI-FFF campaign, Expanded Programme on Immunization, and the Control of Diarrhoeal Diseases which emphasized oral rehydration (8). This implied that certain programmes were granted priority. Therefore the approach was going to be selective according to the prioritized programmes. Examples of the prioritized programmes were Maternal, Child and Women's Health including Reproductive Health. They were made to form the universal principles of PHC. This resulted in a selective approach to the implementation of PHC, which failed to address health within the social context. The selection of priority diseases for interventions reduced community participation, and therefore weakened one of the pillars of the Alma Ata Declaration (8).

PHC was seen to be the cheaper, simpler approach to the delivery of health care using basic health interventions.

2.2.4 Overview of PHC Development in South Africa

This section will briefly supply an overview of how PHC developed in South Africa in order to develop an understanding of the historical background to the management of PHC facilities and the management roles and functions of the Registered Nurse-In-Charge.

Although public health, disease prevention and health promotion were acknowledged and narrowly implemented historically, dating from the eighteenth century in South Africa, the PHC concept was soon taken over by the medical based health model (23). Public health measures of disease prevention and PHC services involved periodic quarantine measures, immunization campaigns, notification of certain diseases and environmental control. Therefore one could say that selective PHC which was disease based was

provided, as opposed to comprehensive PHC service which had its fundamentals in social equity (24).

The period between 1944 and 1950 was characterized by emergence of health centres, which represented a great achievement for the South African health system in respect of PHC. These health centers possessed particular elements and principles, which were subsequently embodied in the PHC approach. These include factors such as Community Based Health Programmes implemented through Community Health Workers, health education especially focusing on maternal and child health, and socio-economic upliftment. The implementation of universal PHC principles resulted in notable gains in such areas as a decrease in infant mortality and crude mortality rates, and a decline in malnutrition. The Nationalist government of Apartheid South Africa, whose policies resulted in the closure and dismantling of health centres, launched a major assault on the implementation of the PHC approach to its fullest extent. This demonstrated the role of political will in the implementation of the PHC approach (23).

Twenty years later, the Health Act of 1977 introduced a preventive and promotive approach to health. The Act had its emphasis on clinics, health centers, health teams and training of paraprofessionals as a mechanism of fulfilling its intentions. The Act, however, did not progress in transforming the curative concept of health care to community-based health care. It can be concluded that all its noble intentions were fruitless (23).

The National Health Service Facilities Plan of 1980 was directed at the provision of adequate health care underpinned by PHC. The PHC concept of this era was envisaged to include safe drinking water, sanitation, environmental health, waste removal, basic housing, nutritional supplements, health education, self care, community nursing services, community health centres and community service organizations (23).This initiative also did not materialize.

2.2.5 Building a New Health System on PHC - Post-1994 Era

The most notable feature that marked the difference between the pre-1994 and the post-1994 era, is identifiable as the legislative framework for the delivery of the PHC. The Reconstruction and Development Programme of 1994 and the National Health Plan of 1996 provided the legislative mandate for the establishment of district-based PHC. The DHS and PHC therefore formed the cornerstone of the South African Health Sector reform. Some academic institutions also acknowledged PHC as the foundation of national health policy. University of Cape Town heeded this call by its contribution of equipping students to meet the demands of change in the health system (25). This was seen as a move to the development of PHC. Further political will and commitment to address the health needs of people in South Africa were re-iterated in the Kopanong declaration on PHC in August 2003 (23). Consequently this particular period witnessed the building of many new clinics and CHC's. However, very little, as regards paradigm shift in the management of PHC clinic-based services, has eventuated, nor has a broadening of the implementation of the Alma Ata Declaration occurred.

2.3 THE DISTRICT HEALTH SYSTEM (DHS)

The DHS was adopted as a legislative vehicle to implement the PHC policy in South Africa after the commencement of the new political dispensation in 1994 (4).

The District Health System is defined as "a more or less contained segment of the National Health System. It comprises, first and foremost a well-defined population, living within a clearly delineated administrative and geographic area, whether urban or rural. It includes all institutions and individuals providing health care in the district, whether governmental, social security, non-governmental, private or traditional. A District Health System therefore consists of a large variety of inter-related elements that contribute to health in homes, schools, work places, and communities, through the health and other related sectors. It includes self-care and all health care workers and facilities up to and

including the hospital at the first referral level, and the appropriate laboratory, other diagnostic, and logistic support services" (5).

The South African Health sector reform implemented by the post 1994 government was particularly dependent upon the establishment of coterminous health districts nation-wide in order to decentralize management of the new national, unitary health system (23).

The following fundamental principles of the District Health System underpinned the implementation of the PHC approach in South Africa.

- Overcoming fragmentation, equity and comprehensive services. Pre-1994 the health system was characterized by fragmented services that were offered to certain groups while neglecting others. Selective PHC eroded the principles contained in Alma Ata Declaration, which stressed a broad multi-faceted approach to public health concerns.
- Effectiveness, efficiency and quality.
- Access to services, extending services to rural and informal settlement dwellers.
- Local accountability, community participation and decentralization, thus increasing responsiveness to local health needs.
- Sustainability, development and intersectoral collaboration to address health problems and their causes holistically (8).

The establishment of the DHS hinges on the implementation of a network of clinics, health centres and hospitals linked by a functional and effective referral system.
The establishment of the DHS in South Africa has confronted many challenges, resulting in slow progress towards full implementation. Such obstacles have included:

- The change of mindset from hospital-based health care to the PHC approach (4).
- The fragmented health services of the apartheid era and the old geographic boundaries occasioned certain difficulties to the expected pace of implementation of a fully-fledged DHS.

- The demarcation of new health districts coterminous with municipal boundaries.
- The appointment of District Health Managers and District Health Management Teams (18).
- The delay in publication of the National Health Bill, created a legislative vacuum for the establishment of the DHS (26).
- The delayed establishment of governance structures - the National Health Authority, the Provincial Health Authority and the District Health Authority, which were intended to strengthen governance and community participation (18).
- Some provinces established the District Health Authority despite the legislative vacuum. This created inconsistencies in the development of the district health system in the country.
- The promulgation of individual provincial legislative frameworks used as the basis for the district health system development further created inconsistencies in the development of DHS (26).
- Uncertainty about the role of the local government particularly on issues of human and financial resource provision.
- Persistent capacity weakness in the health system in general.
- Some reluctance of provincial governments and health departments to decentralize authority to lower levels (27).

2.4 DECENTRALIZATION

The principle of decentralization is key to the implementation of the DHS. The principle was intended to increase the responsiveness of health services to local needs. Decentralization involves the transferring of responsibility and accountability to the lowest level of the public sector (28). Various forms thereof have been identified in the literature and will be discussed in order to identify the appropriate form applied to the political, social and economic order prevailing in South Africa.

Deconcentration refers to the 'shift of power from the centre to the periphery within the same administrative structure' (22). This functions as the mildest form of decentralization because the centre is fully accountable for the activities of the periphery and therefore exercises authority over the periphery (21).
Delegation refers to the shift of responsibility and authority to semi-autonomous agencies. Examples thereof are a separate regulatory commission or an accredited commission (22).
Devolution is defined as 'the transfer of functions or decision making authority to legally incorporated local governments, such as states, provinces, districts, or municipalities' (21).
Privatization is the transfer of operational responsibilities and includes the transfer of ownership to the private provider (22).

Basically in all forms of decentralization some shift or transfer of responsibility and authority from the center to the periphery occurs, whilst a significant degree of authority and responsibility, particularly accountability, is retained by the center (22).
In the South African situation decentralization was initially implemented as deconcentration during the late 1990's and early 2000 where health planning, management, particularly of human resources and finances, and evaluation, remained predominantly centralized between the province and the national health ministry. During early 2000 a shift in emphasis towards devolution was visible, wherein responsibility and decision making authority gravitated to the periphery, although not only to local government (29).

Analysis of decentralization of health systems in developing countries is explored by Bossert where he examined the concept of decision space as a tool for evaluating the effectiveness of decentralization. The concept evaluates the set of management functions and the degree of choices transferred to the periphery (22). The relevance of the concept to the study lies in the reality that it will enable this particular investigation to identify the set of functions and the degree of choices transferred to the Registered Nurse-In-Charge of the PHC clinics. Analysis of the decision space as determined by the legislative

framework is necessary in relation to the changing management roles of clinic based services, given that more health programmes require implementation at clinic level.

2.4.1 Implications of Decentralization at Different Levels of the Health System

South Africa is among several countries which have advocated decentralization as a suitable policy in addressing questions of health service delivery. Decentralization, however apparently functionally appropriate, also possessed negative implications (21).

Positive Implications

- In the decentralized setting, the management function operates closer to the people, of whose needs and local environment the particular manager is aware. This knowledge equips such managers to adapt local policies to community needs and the prevailing environmental context.
- The conditions within which the communities reside fluctuate continually. This demands flexibility on the part of management as regards decision making in order to effect a prompt response to change. Decentralization satisfies this requirement.
- Decentralized decision-making allows for an opportunity to arise whereby local communities are empowered in the active participation in planning, monitoring and evaluation of services that, in reality, address their particular priorities.
- Apart from such benefits, innovative community initiatives are encouraged. The overlooking of the underserved areas is less probable since such possess the capacity to prioritize needs. In such a process, equity in service provision is promoted (21).

These afore-mentioned positive implications allow for the conclusion to be drawn that the clinic manager is most suitably positioned to input into adapting local policies, flexible decision-making and encouraging community participation.

Negative Implications

Collins (21) identified the following negative implications:

- Inequity may be experienced where certain districts are more adequately resourced than others.

- The central government may become weaker in capacity. This may arise as planning will be conducted predominantly by local communities according to their needs rather than national priorities that are based on party political mandates.
- Decentralization may reduce the role of the public sector in provision of health services, especially where privatization has been implemented as a form of such policy.
- Particular central governments may adopt this setting to employ a 'divide and rule' strategy in order to marginalize other communities in relation to central initiatives (21). This tactic was employed in 'homeland regions' of South Africa under apartheid. This was based on the self governing of such states.

The negative implications clearly focuses on the need for the appropriate careful consideration to be applied to decentralization with close monitoring and periodic evaluation, in order to mitigate against the possibility of such undesirable effects occurring (21).

2.4.2 Issues of Delegation

The decision space cited by Bossert (22) presumably provides clarity regarding what precisely is attached to the delegated duties, in respect of financing, service organization and human resources. Further, this approach provides a framework for evaluating the impact of a restricted or opened degree of variants of such a concept (22).

The essential guiding principle for delegation is to ensure that the person delegated to perform this function must be competent in its satisfactory implementation. Another crucial factor is the clarification of the appropriate authority and responsibility when delegating. Critical to this process is the reality that accountability itself cannot be delegated, and ultimate responsibility remains with the manager (5).

2.5 MANAGEMENT OF HEALTH SERVICES

Management of health services occurs at various levels, i.e. national, provincial and local. The functions of management within these levels assume different forms despite possessing the same generic roles. In this section the key management roles and functions of an organization will be discussed, with particular reference to health organizations. It will also be of value to discuss the precise nature of the concepts administration vis-a-vis management as these terms are commonly employed interchangeably because of their close symbiotic relationship.

This section will provide the framework wherein the particular results discussed will be situated.

2.5.1 Administration vs. Management

Administration is conceived of as a process of making rules and regulations, and the performance of sets of tasks within the frame of such rules. Subsequently it is interpreted as not focused on the objective, outcome and impact of these tasks because of its emphasis on rule conformity.

WHO defines health management as " essentially a system of administrative roles, functions and tasks carried out by individuals at various levels of administration in order to improve the health of the people". Stewart defines management as "deciding what should be done through objective setting, planning and organizing and getting other people to do it through motivation, communication, control and development of people". Keeling defines management as "the search for the best use of resources in pursuit of objectives subject to change" (21). The alternative understanding of the concept of management is that " it is regarded as that field which concerns itself with all the factors, methods, principles and processes involved in the successful functioning of an organization"(30).

2.6 KEY ROLES AND FUNCTIONS IN MANAGING HEALTH SERVICES

The management roles and functions discussed in this section are regarded as generic, although authors term them differently. An assumption might be drawn that these functions are applicable to clinic-based management; however, the degree of applicability requires further exploration. The 1996 National Health Policy emphasized that these management functions, namely planning, financial management, human resource management, co-ordination and integration, would be dealt with by future health managers at all levels (4). It is assumed that clinic managers are also included therein. However, the achievement of such a goal, accounting for the inclusion of clinic managers within this definition, is not clarified in any policy document.

2.6.1 Leadership

Leadership as a management role involves assuming authority in an organization, in directing and motivating human resource, and communicating organizational goals to all role players thereof. Issues of human resource management, inter alia, recruitment, training, promoting and dismissal are regarded as constituting leadership roles (31). Leadership is also conceived of as a management role for policy making in interpreting the direction that an organization needs to follow. Thus, the leader provides the vision of an organization (23). Others regard leadership as constituting the influencing and guiding of an individual's behaviour and activities in an organization. This also applies to stakeholders, in order for the achievement of the organizational goals to be attained (30). Such afore-mentioned leadership functions cited in literature involve:

- setting the direction for the organization through challenging the status quo, perceiving relevant matters as being within a broader framework, leading in decision making, exercising flexibility as opposed to rigidity and guiding the organization in developing the requisite vision, mission and strategies to achieve organizational goals.
- Aligning people by communicating with them through simple clear messages, accounting for language barriers when communicating with a community and

openness to constructive criticism and the questioning and recognizing of the nature and size of the task when delegating.

- Providing both motivation and inspiration through respecting and appealing to the values of staff and community, allowing autonomy within organizational policies, and encouraging people by recognizing and rewarding satisfactory performance of duties (32).
- Influencing people through role modeling towards the attainment of organizational goals (30).

2.6.2 Planning

This involves providing the required framework for the implementation of policies. This is achieved through the setting of the organizational vision, mission, goals and objectives. Processes of obtaining any necessary buy-in from getting buy-in stakeholders concerning such matters are then subsequently undertaken. The actual plan and program to achieve these objectives are thereafter formulated (21). In a health district, the planning process should include:

- Situational analysis which includes district features: its geography, demography and associated population trends, morbidity and mortality profile, including the prevalence and incidence of communicable diseases in particular, and community risk factors including their distribution according to age and location.
- Community profile, including the distribution of resources available within the community as regards its population (32).
- The active participation of community during the process of establishing clinic priorities through publicizing their health needs (9).
- Review of services currently provided and identification of gaps (32), with particular reference to prevention, promotion, curative and rehabilitative services. This accords with the package of service cited in the Primary Health Care Package for South Africa - A set of Norms and Standards.
- The service objectives must be developed in alignment with the gaps identified. Service gaps must be prioritized according to their level of importance, based further on their seriousness, prevalence, preventability and treatability.

- Critical to every plan is implementation. The implementation plan, with time lines and a monitoring and evaluation tool, must be constructed (32).

2.6.3 Human Resource Planning and Management

This is discussed under three headings, viz. human resource provisioning, performance management and human resource development

2.6.3.1 Human Resource Provisioning.

Personnel provisioning needs to be informed by the strategic goals of the organization so that the job descriptions and job specifications accord with the strategic direction of the organization. The process involves the identification of the human resources needs through both job analysis and the drawing up of job specifications. A job analysis has to be conducted before motivating for the filling of vacant posts in order to ascertain the necessity for its existence. This provides the manager of the post with the opportunity to review the urgency for the creation thereof in relation to work and different work units in the organization. The process includes drawing up a new job description and specifications, identifying the requisite skills and criteria for its suitably efficacious performance, and preparing a job request and advertisements (30).

Generically personnel provisioning involves the following:

- Designing human resource policy
- Organizing work, including division of work, delegation of duties and communication strategy through job descriptions and standardized forms
- Budget for personnel, provisioning
- Specially trained personnel charged with personnel provisioning responsibility
- Work procedures followed in all dealings with staff to ensure labour related issues are well cared for
- Work control through checks against the stipulated procedures and legislation (33)

Functional involves the following:

- Accurate maintenance of every staff file.
- Post creation for new services or establishment review.

- Remunerative packages known to manager
- Training and development of new recruits
- Staff promotion according to merit rating (33)
- Provision of such personnel services that Swanepoel (30) cites as hygienic factors such as comfortable rest rooms
- Implementation of Occupational Health and Safety Act (33). Relevant literature elaborated on the orientation and induction function.
- Recruitment and appointment according to the departmental policy involving the following tasks:

  Knowledge of staff establishment and recommendation of adequate staffing levels

  Ensure availability of human resource policies on recruitment.

  Identify duties, skills and requirements for the job

  - Develop or review existing job descriptions

  Prepare and submit job requisition (advertisement) and job description to manager or supervisor for approval (30).

2.6.3.2 Performance Management

In managing performance a shift has occurred, from the control of personnel to the management and development of performance. Performance management is defined in the literature as an "approach to managing people that entails planning employee performance, facilitating the achievement of work related goals, and reviewing performance as a way of motivating employees to achieve their full potential in line with the organizations objectives (30). An Employee Performance Management and Development policy has been developed in the health department to facilitate improvement of employees' performance (34).

Sound labour relations, which include discipline and grievance management, will be included under performance management for the purpose of this study because of their interrelatedness and impact on performance.

The aim of discipline is to ensure that all employees adhere to the performance and behavioral standards and criteria necessary for the successful operation of the organization. Constructive discipline as it is meant to be, facilitates both learning and opportunities for personal growth and ultimately the achievement of organizational goals (30).

Grievance management is the process through which management formally deals with the procedurally conforming presentation of a complaint by workers relating to the employment relationship (excluding disciplinary matters). Issues personal, social and family in nature, although impacting on work performance, do not constitute grievances. One of the principles of grievance management is to solve grievances as promptly and as close as practically possible to the point of origin (30).

The following constitute the functions involved in performance management:

- Performance planning, which outlines the organizational and unit vision, mission and goals; definition of roles and duties through job descriptions, establishing and agreeing on goals and performance standards and the setting up of time lines for performance reviews.
- Managing performance includes on-going maintenance of performance progress; mentoring and coaching; counseling, supplying feedback and managing absenteeism.
- Reviewing performance through review of outputs and outcomes against set and agreed standards; developing intervention action plans with time lines according to identified shortfalls
- Applying human resource department policies through maintenance of consistent discipline and training and development (30).
- Implementation of the Occupational Health and Safety Act (33).

2.6.3.3 Human Resource Development

Nadler and Nadler define human resource development as "a learning experience organized mainly by an employer, usually within a specified period of time, to bring about the possibility of performance improvement and or personal growth" (30). Human resource development involves the following main functions:

- Assessment of needs to identify staff members to be trained and the requisite skills demanded.
- The development of a training plan according to the objectives identified during needs assessment.
- Implementation and evaluation of the training plan and individuals who have thus experienced such (33).

2.6.4 Financial Management

This involves the following functions:

2.6.4.1 Budget preparation.

The manager prepares a budget as a means of expenditure control and goal attainment. In its preparation, it is essential that projections of revenue and expenditure are compiled and submitted through relevant channels to the Treasury. Critical to the budget preparation is the programme plan, which is based on the policy intent and objectives instead of traditional incremental budgeting (33).

2.6.4.2 Budget implementation and monitoring

This function deals with the actual budget implementation, which concerns the actual allocated expenditure thereof according to set objectives and the budget plan (33). The Public Finance Management Act 1999 clearly articulates the importance of the appropriateness use of a budget for its intended purposes (34). Budget implementation should be linked to monitoring and evaluation of the programme plan in order to identify deviations promptly and institute intervention measures to ensure the attainment of policy objectives. Procurement of goods and services need to be according to the departmental procurement policies and procedures. Each manager must maintain the records accurately

and meticulously in accordance with related prescripts. However, the accounting officers, through their subordinate supervisory officials largely conduct the financial managerial functions (33).

2.6.5 Control

This function ensures that in every organization unit, work is conducted in the appropriate manner and that the service recipients benefit as intended. For the purpose of this study only internal control measures will be discussed.

Every supervisor has to undertake the control function; therefore control measures must be included in all organizational policy statements in order to make control part of organizational culture. The following include examples of the formal internal control measures:

- Written reports
- Assessments and reviews
- Auditing
- Statistical returns (33).

The following are relevant examples of the perspectives held concerning precisely what control entails:

- Constant monitoring of performance and actions as aligned to plans
- This assists to identify and rectify deviations early (31).

2.6.6 Supervision

The functions that were not included under the management role of control will be discussed under supervision for the purpose of this study. Supervision is described as a process through which the manager monitors and controls organizational performance whilst providing support to the staff for the attainment of organizational goals (21). For the purpose of this study the supervisory functions within the clinic have been categorized as follows:

2.6.6.1 Governance

Governance for the purpose of this study deals with community and clients' consideration (9). It involves the following functions:

- Facilitation of community participation, particularly in planning, monitoring and evaluation of service delivery (21).
- Conduct in-service training with staff on Batho Pele, and patients' rights and responsibilities.
- Include Batho Pele, and patients' rights and responsibilities in patient education programme.
- Display Batho Pele, patients' rights' and responsibilities posters in local language.
- Ensure level of patients' satisfaction through surveys.
- Monitor and manage patients' service waiting times.
- Establish and manage patients' complaints mechanism.
- Ensure community involvement through functional clinic committees (35).

2.6.6.2 Organizing

Organizing involves the following:

- Delegation of authority where tasks are delegated to supervisees with a degree of authority to perform those tasks.
- Coordination of services in various units within the organization is important. This is achieved through meetings with unit heads in order to prevent unhealthy competition among units and encourage attainment of organizational goals.
- Communication among organizational units needs to be ensured through a clear communication strategy
- Public Relations. This is important in and outside the organization. Externally it is employed as a tool to assess the community's perception of the services provided. Internally it ensures a positive image of the organization through high staff morale and a suitably cared for facility structure. (33)

In clinics, organizing of service involves the following:

- Functional up and down referral system.

- Provision of services according to the comprehensive package thereof, daily in a supermarket approach.
- Patients flow managed to prevent long service waiting times (35).

2.6.6.3 Clinical Governance

For the purpose of this study, clinical governance will be employed for quality control functions that have not been cited in previous sections. The clinical governance functions include:

- Ensuring the availability and implementation of clinical protocols and procedures (35).
- Ensuring the adherence to clinical protocols through clinical audits and record reviews (31).
- Maintaining a schedule, register and report of supervisory visits, which are discussed with staff (36).
- Ensuring the implementation and adherence to quality control measures inter alia risk management, infection prevention and control policies and waste management guidelines (35).

2.6.7 Auxiliary Functions

These are important functions that do not directly achieve organizational goals, but without which such objectives can never be achieved (33). They are also termed supportive functions. Their enlistment follows:

- Record keeping
- Research
- Public Relations
- Public notification
- Information management
- Provisioning of supplies, equipment and infrastructure
- Transport (33)

2.6.8 Administrative Functions

For the purpose of this study, the following auxiliary functions are deemed as administrative functions, and are categorized as follows:

2.6.8.1 Resources

These resources exclude human capital as the role on human resource management has been discussed above. Included are the following functions:

- Ensuring uninterrupted availability of pharmaceuticals and other supplies.
- Ensuring the availability of good working and adequate relevant equipment.
- Submitting the weekly transport plan through supervisor to support institution.
- Monitoring the plan, utilization and transport running cost (35).

2.6.8.2 Facility

The facility in this case refers to the physical and telecommunication infrastructure of the clinic. Functions include:

- Ensuring a well maintained and safe facility.
- Ensuring uninterrupted communication through two way radio and official use of a telephone.
- Ensuring the ability to contact patients' emergency transport (35).

2.6.8.3 Information Management

It is known that information is the basis of management in any organization as it forms both a decision-making and planning tool. It also enables managers to meet the districts' provincial and national accountabilities and obligations (32). Information management functions include:

- Participating actively in the establishment, implementation, evaluation and sustaining of community based Health Information Management System (5).
- Ensuring the accurate collection, collation, analysis, interpretation of information and its submission to higher level (35).
- Monitor organizational performance using information (32).
- Manage information technology equipment such as computers.

The following table (Table 2.1) summarizes the generic management roles and functions of organizations. This particular table will form the conceptual framework for discussing the results.

Table 2.1 The generic management roles and functions of organizations

MANAGEMENT ROLE	FUNCTION
1. Leadership	1.Setting the direction 2. Aligning people 3. Motivating and inspiring
2. Planning	1.Situation assessment 2.Priority setting 3. Development of goals 4.Monitoring and evaluation
3. Human Resource Planning and Management	1. Human Resource Provisioning 2. Performance Management 3. Human Resource Development
4. Financial Management	1. Budget preparation 2. Budget implementation and monitoring
5. Control / Supervision	1. Governance 2. Service organization 3. Clinical Governance
6. Administration / Auxiliary	1. Resources management 2. Physical and telecommunication infrastructure 3. Information management

2.7 **TRENDS IN HOSPITAL** MANAGEMENT

In this section the background and current trends of hospital management up to the present will be discussed because the hospitals were established as health institutions prior to the opening of clinics. As a result clinic management was subsumed under the hospitals' functions. To date certain clinics continue to retain their management support in hospitals, although others are now categorized as falling under Community Health Centres (37).

In previous eras, i.e. approximately more than 100 years ago, hospitals were operated by matrons or stewards principally financed by charity organizations (23).
The 1800's saw the establishment of the first public hospital. During the 1920's administrators took over hospital management.

2.7.1 History of South African Hospitals

The establishment and control of hospitals remained uncoordinated until the 1800's. Thereafter, the Cape government and other colonial regions established a department governing hospital services and exercised control over them.

By the 1900's hospital management was placed under the authority of Provincial Councils (33). During the middle of the twentieth century the exercise of hospital management was subsumed under the medical superintendents at institutional level. Such individuals were of necessity medical doctors.

During this era, most management functions of hospitals, in terms of matters relating to finance, human resource management and development, certain aspects of procurement including capital equipment and infrastructure development, were centralized at provincial level.

A major reason for the transformation of the health system during the post-1994 era, relates to the dearth of formally trained hospital managers. This deficiency posed a

challenge in the decentralization of management (3). In addition, no legislation existed to regulate hospital management.

The hospital reform programme, among other goals and functions, contained a Hospital Strategy project. This held, as a major objective, the active decentralization of hospital management (23).

In the present prevailing dispensation, the role of medical superintendents assuming the hospital management function has been completely expunged and no longer exists. Hospitals are now managed by hospital managers (8). It is vital to note that these hospital managers originate from different vocational qualification backgrounds. These include doctors, nurses, finance managers and human resource managers. A proposal has been mooted to employ the term Chief Executive Officers to designate their title, as cited by the President in his State of the Nations address of February 2006. The new term is intended to accord hospital managers greater power and accountability for hospital management purposes (38).

2.7.2 Trends in Clinic-Based Services Management

Clinic based services have derived their management support from the hospitals and later CHC's although some clinics still retain their management support at hospitals. This prevails particularly in areas that have no CHC's (37). During the afore-mentioned health sector reform, instituted in the post-apartheid era, it was specified that district hospitals would be responsible for the support of PHC services (23). The consequence of this new policy was that the Clinic supervisor constituted the only link between the support institution and the particular clinic, where management is entrusted to the Registered Nurse-In-Charge. Recent developments in 2006 have resulted in PHC support occurring at different levels of care. In certain districts it is located in CHC's, whilst in others where their presence is either limited or non-existent, it is located in district hospitals. Mpumalanga Province forms one such province where PHC support is located entirely in CHC's (5).

During the early 2000's in KZN it was resolved to delink clinics from hospitals and attach them to district offices. This decision was reversed prior to its full implemented on a province-wide basis (39). Unfortunately, a trial and error approach had occurred, which demonstrated that even in its legislative framework minimal attention had been paid to the management of clinic based services at clinic level. The circular did not clarify the rationale for the reversal of the decision. However, the researcher's assumption based of the long practical experience in this field, was that districts did not have capacity to manage clinics particularly in terms of corporate services.

2.8 LEGISLATIVE FRAMEWORK GOVERNING MANAGEMENT of CLINIC-BASED SERVICES

Limited attention appears to be accorded in the literature to the management of clinic-based services at clinic level. However, certain policies employed include clinic management, although not directed at the clinic manager. Policies discussed in this section concentrate on the management roles expected from the clinic supervisor or the CHC manager.

2.8.1 Clinic Supervision Policy

This document cites the management roles and functions of the clinic supervisor in support of clinic-based service. The main areas of management that the supervisor focuses on at each clinic visit are:

- Clinic administration
- Information system
- Referral system
- Quality of clinical care
- Community involvement
- Training of staff on updates, and appropriate coaching
- In-depth programme review
- Problem solving (36).

2.8.2 Hand Book for Clinic/CHC Managers

The document was designed to assist clinics and CHC managers to manage their facilities in a more satisfactory manner and thereby improve service delivery at PHC level. The document contains a checklist that guides managers in their execution of day-to-day management roles and functions. It highlights and details the management functions under the broad roles of general leadership, staff matters, budget, transport, community involvement, Batho Pele principles and equipment and supplies (35). Of considerable concern is the fact that clinics and CHC managers are regarded as performing synonymous functions, whereas a vast difference exists between the two facilities, particularly in terms of capacity. The CHC has the Centre Manager as the overall Manager with an Executive Management structure comprising Nurse Manager, a Medical Manager, a Human Resource Manager, and a Systems and Finance Manager. On the other hand, the clinic only affords this function to the Registered Nurse-In-Charge as the overall Clinic Manager, without any other management structure.

2.9 INITIATIVES TO STRENGTHEN MANAGEMENT OF CLINIC-BASED SERVICES

A dearth of information appears to prevail in the literature regarding initiatives to strengthen the management of clinic-based services.

In the South African Health Review of 2001, on "Voices of Facility Managers", where it was not explained whether the facilities were clinics, community health centres or hospitals, a window was opened to the problems of facility managers (18). The document cites the reality that such findings could not be generalized owing to the following reasons: Of the nine South African Provinces only nine PHC / facility managers were interviewed, one in each province. The majority of the nine managers interviewed were from urban facilities; crucially, rural managers were not adequately covered in the study sample.

The document therefore clearly prohibits any possible generalization of its conclusions. This therefore necessitates further research to be conducted on the subject, with suitably proportioned sample of potential respondents.

Evidence is available that minimal attention is paid to the topic of management of clinic-based services. This is exceedingly crucial if quality PHC service delivery is to be achieved.

A study conducted by School of Public Health in Western Cape University in 1991 investigated the roles and functions of the PHC Clinic supervisor (40). Notable among the study participants is the absence of any reference to the Registered Nurse-In-Charge of the PHC clinic. The clinic supervisor at the support facility, health care personnel at the clinic and community constituted the study participants therein. The findings therefore neglect to indicate the perspective of the Registered Nurse-In-Charge. The methodology used was participative action research and collaborative inquiry. The methodology used involved the clinic supervisors as the co- researchers.

The study article relating to the improvement of equity in the provision of primary health care from decentralized planning and management experienced in Namibia, cited the importance of equipping health managers at local level to be skilled in assessing service provision needs. This serves as a mechanism of ensuring an improvement in first level services (41). However, the precise possible value attachable to this statement was unclear as the definition of local managers in this study went as far as regional level, which is furthermore higher than district level. The study also cited the authority to influence decisions at higher level. This becomes particularly relevant for the study as it is necessary to establish the degree to which the Registered Nurse-In-Charge has the capacity to influence decisions about service delivery issues, particularly at the support institution or support office.

A baseline survey conducted in South Eastern Nigeria on its primary health care system cited, inter alia, poor management practices as the cause for the destruction of efficient

PHC service delivery (42). The survey findings revealed the rating of PHC service provision by many respondents as fair to poor. Long service waiting times at clinics were also cited as the perceived important quality indicator of PHC service delivery. The conclusions also revealed a low utilization rate at PHC, attributable either to a poor or entire absence of service delivery (42). Little appears to differ from the situation prevailing in South Africa. The study recommended, inter alia, that the appropriate management tools should be developed to strengthen the foundations of the PHC system, and thereby hopefully develop an implementation, monitoring and evaluation strategy (42).

A study conducted in Bangladesh cited the importance of a health information management system in managing health programmes at PHC level (43). This constitutes an important management function at PHC level in addition to the management of the health programme. The Registered Nurse-In-Charge therefore has a crucial role in fulfilling this function.

The KwaZulu-Natal Department of Health engaged in a process of restructuring the PHC staff establishment during late 2006. The proposed structure contains certain management posts that will, in all probability be accorded stronger management responsibilities (44).

The problem of infrequent clinic visits arose as a distinct concern in a study conducted in Zaire in 1991. Only 21% of 57 village workers reported a supervisory visit in the previous three months as scheduled. In Niger 66% of CHC'S were visited once in six months. This situation deteriorates further in clinics (17). In South Africa, it was discovered that remote and inaccessible clinics were only visited at least once per year. Furthermore, such visits were very brief and unstructured (45). The eThekwini district PHC supervision rate for 2006/2007 was recorded as 75% (6). Achieving 100% supervision rate, which involves a monthly supervisory visit at all clinics, remains a major challenge.

One example in the literature cited that the following common challenges are currently experienced by local health service managers. The researcher argues that management appears to be a common problem arising within the current PHC service setting. Further difficulties include the following: lack of management role clarity; uncertainty concerning such matters as timeous salary payments and the delivery of supplies; lack of a strategy to attract and retain staff; lack of direction on how to use the facility budget; inadequate knowledge of staff utilization; lack of skill in balancing managerial and clinical duties and time management; lack of knowledge of management tools and techniques to maximize performance (11).

2.10 CONCLUSION

This chapter has provided an in-depth discussion on PHC approach, the DHS and its development in South Africa, and decentralization. All these factors remain linked to the focus of the study, as the clinic based services operate within the health system contexts described. The chapter also supplied an overview of trends in hospital and clinic based management. The in-depth exploration of key management roles and functions in managing health services was discussed as it forms the conceptual framework of the study. Lastly, the legislative framework governing the management of clinic based services and initiatives to strengthen management of these services, which included studies conducted on management of clinic based services, was discussed. The following chapter focuses on the data collection process.

3.2.2 OBJECTIVE 2. -

Describe the management roles and functions that the clinic Registered Nurse-In-Charge are currently performing

3.2.2.1 What management roles and functions are the Registered Nurses-In-Charge currently performing, according to:

a) Supervisors reports
b) Registered Nurses-In-Charge of clinics
c) District PHC Coordinators
d) District Programme Managers
e) Clinic nurses?

3.2.3 OBJECTIVE 3. -

Identify the management roles and functions that the Registered Nurses-In-Charge are currently not performing at clinic level.

3.2.3.1 Which management functions are the clinic Registered Nurses-In-Charge currently not performing compared to the roles and functions as defined in 3.2.1 and 3.2.2.?

3.2.4 OBJECTIVE 4. -

Analyze the factors that limit the fulfillment of the management roles and functions of the clinic Registered Nurse-In-Charge

3.2.4.1 What are the factors that hinder the fulfillment of management roles and functions of clinic Registered Nurses-In-Charge according to:

a) Registered Nurses-In-Charge of PHC clinics
b) Supervisors of PHC clinics
c) Clinic nurses
d) District PHC Coordinators
e) District Programme Managers?

3.2.5 OBJECTIVE 5. -

Make recommendations that would enable the clinic Registered Nurses-In-Charge to fulfill the management role and functions required at the clinic level.

3.2.5.1 What factors would enable the clinic Registered Nurses-In-Charge to fulfill the management roles and functions required at clinic level according to:

a) Registered Nurses-In-Charge of PHC clinics
b) Supervisors of PHC clinics
c) Clinic nurses
d) District PHC Coordinators
e) District Programme Managers?

3.3 STUDY DESIGN

The research question sought to ascertain the current condition and state of matters in relation to the management roles and functions of a Registered Nurse-In-Charge at clinic level. The researcher therefore believed that the most suitable means of eliciting in-depth information on the research question was to obtain the perceptions and views of key stakeholders according to their personal experiences in the work situation. The design chosen was therefore a qualitative approach using naturalistic inquiry.

The naturalistic inquiry in qualitative research allows the researcher to understand the situation from the respondents' point of view, as this relates to how the respondents experience the world around them. The naturalistic approach enabled the researcher to understand the individual's perceptions of the research question. It strived to gain insight rather than statistical analysis (7). Naturalistic enquiry elicits perceptions of human experience. Some authors term naturalistic enquiry constructivism as reality is constructed by the subjective experience of individuals (46).

3.4 RESEARCH SETTING

EThekwini Health District is situated on the Eastern part of KwaZulu-Natal province. It is bordered by Ugu District in the southern part, Umgungundlovu District in the western

part, iLembe District in the northern part and the Indian Ocean in the eastern part. This district forms 1/3 of the provincial population which is estimated at 3.4million of 10.4 million (46).

It is divided into North, West and South service areas, which form a functional arrangement whilst sub-districts have not been demarcated according to requirements of the National Health Act 61 of 2003. This study was conducted with respondents from different governance structures, which are state-subsidized, municipality and province, from both south and north service areas in the eThekwini Health District office.

3.5 STUDY POPULATION

The target population for the in-depth interviews for this study included Registered Nurses-In-Charge from municipal, provincial and state subsidized clinics. The target population for the focus group was Registered Nurses-In-Charge. The respondents included key stakeholders who, were somehow involved in clinic-based services and therefore had knowledge of the subject.

3.6 SAMPLING

In most qualitative studies, the aim is to obtain significant information from the sample in order to address the research question (48). Thus, qualitative research focuses on insight as opposed to generalization. Therefore study participants are selected on the basis of their level of experience and insight on the research topic (49).

A priori sample is the approach employed. The researcher, prior to data collection, defines the characteristics and structure of the sample based on the research problem and purpose of the study (49). Purposive sampling is utilized as a tool with participants being selected on the basis of their knowledge and insight on the research question. The size of the sample does not constitute the guiding principle in purposive sampling because the purpose is not to generalize findings, but to obtain the wealth and depth of information to answer the research question. Caution is necessary not to confuse purposive sampling

with convenient sampling, which is motivated by easy access to the participants (49). A heterogeneous sample consists of diverse respondents. The intention is to obtain different, multi-faceted perspectives of the research question. Consequently, the sampling method used for this study was purposeful a priori and heterogeneous because both the characteristics and structure of key informants for focus group discussions were defined before the data collection process was commenced, as illustrated in Table 3.2 (49). This was based on the reality that respondents were identified precisely on the grounds that they had previous experience on the research topic and would thus possess an insight into the topic. The management issues at clinic level were regarded by the researcher as cross cutting in provincial clinics, municipal clinics and state- subsidized clinics and for different health care workers. Registered Nurses-In-Charge were therefore selected from all these governance structures. Other respondents included programme managers, PHC coordinators, clinic supervisors and clinic nurses, which resulted in the sample being heterogeneous (49).

The participants that might have had a different perspective with regards to clinic management were chosen as follows.

a) Clinic nurses
b) Registered Nurses-In-Charge of clinics
c) Supervisors of clinics
d) District PHC Coordinators
e) District Programme Managers

The following table illustrates the informants selected, the number interviewed, the rationale for selection and the recruitment process.

Table 2.2 Respondents' recruitment process

Informant	Rationale for selection	Recruitment process
District programme manager n = 1. Key Informant	The senior technical manager for PHC at the district level would provide district level expert opinions and views.	The researcher made an appointment with the programme manager through the District Manager
District PHC coordinator, n = 1. Key Informant	The PHC coordinator forms the first line of support to the Clinic Supervisor for clinic management issues.	The researcher recruited the informant through the programme manager giving contact details and permission.
Clinic supervisor n = 3 Focus Group Discussion	The clinic supervisor is the go-betweener between the clinic and support institution. Currently she/he takes the management responsibilities for the clinics	The participants were recruited by the District PHC coordinator
Registered Nurses-In-Charge Focus Group Discussion n = 6 Key Informants n = 6	Registered Nurses-In-Charge is the person managing the clinic, directly practicing the management functions at clinic level.	For focus group discussion Registered Nurse-In-Charge were recruited through their supervisors. The researcher recruited the key informants' through the supervisors giving contact details contact head
Clinic Nurses n = 6 Focus Group Discussion	They are part of the PHC service where the Registered Nurse-In-Charge executes the management functions.	They were recruited through the PHC coordinator, Clinic Supervisor and Registered Nurse-In-Charge

The written requests for permission to recruit participants were forwarded to the respective authorities. Only after written permission had been granted did the process of recruiting participants commence.

3.7 DATA COLLECTION

3.7.1 Study Period

The actual fieldwork for this research, which included focus group discussions and in-depth interviews, was conducted over a period of four weeks from 2005.08.29 to 2005.09.26. Feedback on focus group discussions and follow up in-depth interviews occurred over a period of two weeks from 2006.11.13 to 2006.11.24. The markedly lengthy gap between the first data collection session and the feedback session arose as a result of a change of work environment by the researcher.

3.7.2 Data Collection Methods and Techniques

3.7.2.1 Document Review

A review of policies, reports and other related documents was conducted. The following documents were reviewed with the intention of both exploring the requisite management roles and functions at clinic level and verifying their fulfillment.

- Job description of the Registered Nurse-In-Charge of provincial, municipal and state subsidized clinics, refer Appendix 01.
- Provincial, municipal and state subsidized Clinic supervisor's reports
- Clinic Supervision Policy, KwaZulu-Natal Department of Health 2001
- Comprehensive Primary Health Care Service Package for South Africa September 2001
- PHC Package for South Africa - A Set of Norms and Standards. Department of Health 2001
- Hand Book for Clinic / CHC Managers.
- Other documents existed that were intended for review but could not be established during the period of the study. These were Registered Nurse-In-Charge clinic report - monthly/quarterly/annually, PHC Coordinator's report and Programme Managers' report

3.7.2.2 Key Informant In-Depth Interviews

Key informant in-depth interviews were conducted with a total of eight individuals. Of these, six were Registered Nurses-In-Charge; two were recruited from the municipal clinic, two from the provincial clinic and two from the state-subsidized clinic in the north service area. The initial study plan involved conducting in-depth interviews with three Registered Nurses-In-Charge. This was undertaken during the first round. On initial analysis of data, gaps that could limit the ability to fully address the research question were identified. The second round of key informant interviews was then conducted in the same clinics with specific attention being devoted to areas with particularly identifiable gaps. Of note was that all the previous key informants from the three clinics had moved: two had since retired and one had been relocated as the periodic rotation of Registered Nurses-In-Charge constitutes common practice in the municipality. The former two who had retired had been employed by provincial and state-subsidized clinics. Acquiring different informants increased insight derived from differing perspectives.

The other key informants interviewed were the District PHC Coordinator and the District Programme Manager. These key informants were carefully selected based on their knowledge and insight of clinic management and the role of the Registered Nurse-In-Charge of the clinic. This approach allowed the informants to relate freely to the researcher, expressing their views and opinions with respect to the research question. Interviews were conducted following an interview guide with a few broad topics of open-ended questions guided by research objectives as per Appendix 02. Follow up questions and probing techniques were used.

The researcher herself conducted the interviews in order to be afforded the opportunity to probe informants and observe non-verbal cues. The interviews were undertaken during the afternoon as the Registered Nurses-In-Charge had proposed this period of the day during the scheduling of appointments, because of the low patient volume. Consequently, only one interview was planned per day. But it was not possible to conduct interviews on a daily basis because of the dependents of availability of the Registered Nurse-In-Charge. The interviews of the Programme Manager and the PHC Coordinator were also

conducted during the times convenient to their work schedule as suggested by them. All interviews were conducted in English since all participants were fluent in this language.

The study details were explained telephonically to the informants on recruitment prior to the day of the interviews and verbally on the actual day. Written consent was obtained from the informants after receiving questions for further clarity on the study, before the interviews were actually conducted. It was also explained to the participants that a right existed to withdraw from the study at any stage without prejudice. Assurance was also supplied that the information obtained there from would not be used against them as honesty in answering was a crucial factor in ensuring the quality of the study.

The interviews for the key informants were conducted at private venues within the clinic setting, such as duty rooms. Careful consideration in selection of venues with minimal disruptions was taken. The average duration of the interview was between 60 - 90 minutes.

3.7.2.3 Focus Group Discussions

A field assistant was recruited for the purpose of taking notes whilst recording the focus group discussion. The south service area PHC Coordinator was recruited as the field assistant as it was convenient for the researcher to train her in the subject of which she was already familiar. It was also convenient to the field assistant to undertake the task at her office of work.

The researcher conducted three focus group discussions; one with the Clinic Supervisors, one with the Registered Nurses-In-Charge and one with the Clinic Nurses. All members of the focus group came from provincial clinics and offices. The primary purpose was to obtain their respective perspectives on the management roles and functions of the Registered Nurses-In-Charge of the clinics to verify the opinion that an interactive group approach would yield more rewarding data for the research question (49). The focus group discussions were conducted at the south service area office. These were conducted during afternoon session to avoid any negative impact on service delivery. The Clinic

Supervisors focus group consisted of five members. The focus group of Registered Nurse-In-Charge consisted of six members. The clinic nurses focus group consisted of six members, who were both Enrolled Nurses and Enrolled Nursing Assistants. The numbers in each group depended largely on the availability of members that were thought to be most resourceful on the research subject. The focus group discussion relied on the use of the focus group discussion guide for purposes of direction thereof, as per Appendix 03. Each focus group discussion consisted of an average 75 minutes in its duration.

The study was explained to the study participants prior to the discussion and time was allowed for any questions raised in clarifying the study. Verbal consent was obtained from all participants after explaining that a right existed to refuse further participation and withdraw at any stage without experiencing any negative consequences. Confidentiality was maintained by prohibiting observers or by-standers listening to the discussion.

3.7.3 Data Management

The transcripts were coded per facility from which respondents came.

3.7.3.1 Key Informant In-Depth Interviews

Audio tape recorder was used to capture responses accurately. During the introduction to the interviewee, permission to verify the data collected was sought. It became impossible to provide feedback immediately after the interview to the key informant to verify facts, as had been planned, because of the time constraint. Therefore the feedback was provided after the researcher had completed the process of transcription of data from the tape. The tape recorder and the cassette were retained in a lockable cupboard. The field notes were also held in a file in a lockable cupboard. All tapes and newsprint were transcribed by the researcher herself to ensure accuracy. Data was checked for the purpose of identifying potential gaps, as the iterative process, after transcriptions from the tape and notes to ensure that data collected addressed the research questions. This process indicated certain gaps in the data collected and demonstrated the need to return and collect further data. This was successfully performed by visiting the three clinics individually.

3.7.3.2 Focus Group Discussion

Focus group discussions were audio taped and transcribed. The observation of non-verbal cues that possessed the potential to influence the discussion was recorded simultaneously by the field assistant. During the relevant discussion, the researcher identified a summary of broad groupings and transcribed these on a newsprint sheet per broad idea. These were then verified during the discussion to confirm facts and written as pattern. The patterns were then matched to the research objectives. Audiotapes and newsprints were stored in a lockable cupboard for purposes of safety and confidentiality.

3.8 DATA ANALYSIS

Analysis was undertaken throughout data collection as probing, reflecting, requestioning and paraphrasing. This technique was employed to ascertain additional relevant data on the research question. It is essential to remember that the respondents' answers might possibly be providing a description of external and or internal reality. The researcher used this knowledge in the segregation of responses into facts i.e. external reality from perceptions and emotions (50). The advantage of qualitative research lies in the fact that it provides an opportunity to explore and elicit the subjective reality of respondents. Deductive content analysis according to predetermined categories guided by the objectives, was conducted which enabled the researcher to arrange the responses according to specific research questions. Within these broad groupings of responses, themes, sub-themes and patterns were established, noting particular similarities and differences between respondents. The patterns were aligned to the study objectives in order to keep focus on the research question.

A thematic framework was devised making use of the following steps. The patterns of perceptions in responses were identified. In the next step, all data related to already identified and classified sets of patterns were then explained in detail. This permitted data fitting to specific pattern to place accordingly. Thereafter, the related patterns were combined and catalogued into sub themes. Finally, inferences were derived from

collected data to formulate theme statements that were utilized as findings (51). The respondent validation was a particular technique employed to limit mistakes in data whilst allowing for simultaneous generation of further data (52). This was achieved through reflection and paraphrasing during the interviews and discussions. It was also conducted during feedback provided to the key informants to validate results and address gaps that were identified during data analysis. The contradictory responses from all respondents were both identified and discussed in the study findings.

3.9 ASSURING THE QUALITY OF THE STUDY

A strong debate continues to rage concerning the use of similar criteria to ensure quality in qualitative and quantitative research. Certain views are that individual elements of the criteria utilized in quantitative research can also be applied in qualitative research (52). **Trustworthiness** is the fundamental criterion for the judgment of quality of qualitative research (49). The following criteria were therefore employed to ensure the quality of this study.

3.9.1 Triangulation

This constitutes the process undertaken to compare results from two or more different data collection methods such as in in-depth interviews and focus group discussion or from two or more data sources, with relevant examples thereof being interviews from different interest groups. Thereafter the patterns of convergence are identified from the results to accurately devise an interpretation thereof. However, triangulation is not a legitimate indicator of the genuine test of validity because of the assumption that if one particular method was flawed, it would be compensated for by the other. Therefore it could be conceived of as a means of establishing comprehensiveness of data and encouraging more reflexive data analysis (52).

In this study triangulation was utilized through the application of different methods of data collection namely focus group discussion with different staff categories, in-depth

interviews with the key informants, and documents review to derive comprehensive data, compare and converge responses into patterns, themes and sub-themes.

3.9.2 Respondent Validation

This is where the researcher's account is compared with those of the research subjects for the purpose of validating the results. This technique should however be used as part of a process of reducing errors in data collected and in data analysis, because of its limitation in the roles played by both the researcher and the research subject in the research process (52).

The study applied this technique during the process of data collection whilst the researcher was re questioning and reflecting. During the initial data analysis this was also applied, hence the second round of data collection.

3.9.3 Reflexivity

Reflexivity refers to sensitivity towards the means whereby both researcher and research process have shaped the collected data as influenced by the former's bias. This particular researcher's bias is visibly identifiable in the researcher's prior assumptions and experience, which retain the potential to influence the data collection and analysis. Therefore, paramount importance is attached to this for the purpose of assuring credibility of the study and to manifest these personal and intellectual biases already understood at the outset (52).

The researcher is the District Clinical and Programmes manager whose experience includes that of a Registered Nurse-In-Charge for ten years. During such past conduct of her profession as the Registered Nurse-In-Charge of such a clinic, she experienced lack of management support from the support institution, which also prompted her to undertake the study to establish what happens to other colleagues. Therefore, it is most probable that researcher bias might be introduced. To reduce bias, the researcher undertook all attempts possible to maintain an ethical standard. The other possible bias lies in the current professional status of the researcher. The researcher's continuous

working within the PHC clinic environment where her visible role as an authority figure to respondents and colleague to the Programmes Manager, might introduce bias. Thus, the researcher reviewed the study setting for the in-depth interviews to the north service area which does not fall under her area of operation. However no changes to the setting for the focus group discussion could be undertaken for reasons of convenience.

3.9.4 Credibility

Credibility is sometimes referred to as 'truth value' has its focus on confidence in the truth of findings. This would be established using the following framework:

- Logical relationship of findings with each other which is demonstrated in consistency of explanations that are supported by the data.
- Grounded in findings that are substantiated by sufficiently rich narrative data.
- The original study population considers the results to be accurate (49).

3.9.5 Dependability

- This looks at consistency of the research process and that it was carried out in alignment with qualitative research methodologies. In essence it is the ability to replicate the methodology in other studies to obtain the study outcomes (49).

3.9.6 Conformability

It refers to ensuring a clear distinction between the personal values of the researcher and those of the study participants (49).

3.9.7 Transferability

Transferability refers to the process of establishing whether conclusions of a particular study are transferable to another context. This enables the production of data which is conceptually, but not statistically, representative of people in a specific context (49).
The above standards were carefully considered in the design and plan for the undertaking of this study (49).

3.9.8 Assumptions Underlying the Study

The under-lying assumptions held by the researcher at the beginning of the study include:

- Clinic management has not been decentralized to the clinics as the lowest level of health care
- The Registered Nurses-In-Charge of the clinics do not possess the adequate knowledge and skills for their management roles and functions at clinic level
- The Registered Nurses-ln-Charge of the clinics do not fully perform their management roles and functions at clinic level as is required. Therefore, poor and ineffective management of clinics at clinic level arises.
- The quality of health care and implementation of health programmes at clinics remain sadly inadequate, a factor attributable to ineffective management of clinic based services.

3.10 LIMITATIONS

Had enough resources in terms of field workers and enough time been available, the focus group discussions would have been conducted with participants from both municipal and state-subsidized clinics as well. This would permit a broader and more diverse understanding of knowledge in answering the research question. Further studies might focus on and explore such factors.

3.11 ETHICAL CONSIDERATION

The research protocol was submitted to the Ethics Committee of the University of KwaZulu-Natal to obtain ethical approval for the study before the necessary permission could be acquired from the respective Heads of Health governing the PHC clinics within the areas wherein the study was located. Refer Appendix 04.

Written permission to conduct the study was sought from the Superintendent General of Provincial Health, the Head of Health in the eThekwini municipality and the Head of

Health of state-subsidized PHC clinics. On obtaining this aforementioned authority, refer Appendix 05, telephonic permission was received from the clinics' supervisors, telephonically. Further permission was obtained from individual informants before their participation in the focus group discussion or in-depth interview.

3.12 CONCLUSION

This chapter focuses on the discussion of the type of the study design selected and the rationale thereof. Research questions were explained in detail, connecting them with the sampling and data collection methods employed to assist in the answering the relevant research question. The data management, with a particular emphasis on analysis, thus providing a guide in drawing inferences and conclusions, was discussed. Finally, the chapter explained how both study credibility and ethical consideration therefore were addressed.

CHAPTER 4 - RESULTS

4.1 INTRODUCTION

The aim of this study was to examine management roles and functions of the Registered Nurse-In-Charge at a clinic level. This chapter presents a summary of the findings, based on an analysis of data obtained through document review, focus group discussion and in-depth interviews. The presentation of the results conforms to the objectives set for the study.

4.2 MANAGEMENT ROLES AND FUNCTIONS REQUIRED AT CLINIC LEVEL

The management roles and functions required from the Registered Nurse-In-Charge at clinic level were established from the available policy documents, documented job descriptions and from informants through focus group discussions and in-depth interviews.

4.2.1 General Leadership and Planning

The Hand Book (HB), Clinic Supervision Policy (CSP) and Primary Health Care Package (PHCP) cite that the Registered Nurses-In-Charge must facilitate the development and the display of the vision, mission and core values of the facility and ensure the development of an annual clinic business plan. Whilst the policy documents governing the management of clinic based services cite leadership and planning as one role, in most literature these are discussed as two. Therefore, in terms of themes, they are still treated as two different roles. The provincial job description stipulates that the Registered Nurse-In-Charge should plan and organize services to ensure cost effective use of resources.

Clinic Supervisors agreed that the Registered Nurses-In-Charge conduct a service needs assessment, thereby informing the business plan. The plan should include the aims and objectives of the service.

"Planning, planning is one of the responsibilities of a clinic Registered Nurse-ln-Charge. Of course they have to know the needs of their communities and services before they make plans" (FGD-CS-1)

Most Registered Nurses-In-Charge reported that their functions include conducting needs assessment to inform plans which include the drawing of a business plan. It was further reported that they should display good leadership qualities, including acting as agents of change and role models.

"A Registered Nurse-In-Charge must be a good leader and role model. For instance you have to do things right, like going off at 4 o 'clock You can 7 go off say, at half past three and you expect to tell your staff to go off at 4 o 'clock. (KI l-RNIC-2). When there is something new, you must do it first and be the change agent. " (FGD- RNIC-2)

Certain clinic nurses also reported role modeling as a management function a Registered Nurse-In-Charge should perform.

"The Registered Nurse-In-Charge should have a positive attitude towards us, be approachable, flexible and not autocratic. She must also be knowledgeable, experienced and competent in clinic matters. "(FGD-CN)

The Programmes Manager reported that the Registered Nurse-In-Charge requires good leadership skills, coupled with good human relations conduct.

"I think that is really important and may be it is something that we haven't worked on enough in the institutions so that we regard the Registered Nurse-In-Charge as the leader of the team rather the boss of the team (KI-4-PM)

4.2.2 Human Resource Planning and Management

4.2.2.1 Human Resources Provisioning

All three documents with the exception of the Comprehensive Primary Health Care Service Package (CPHCSP) cited that the clinic manager requires a knowledge of the staff establishment and needs to provide written motivations for the filling of vacant posts through the clinic supervisor. The PHCP was the only document that remarked that the

Registered Nurse-In-Charge must necessarily ensure the availability of, and access to, the District human resources policies on recruitment at clinic level.

The provincial job description asserted that the Registered Nurse-In-Charge needs to assess staff requirements based on their workload in order to contribute to maintaining adequate staffing. The other two documents omitted any mention of this function.

Most Registered Nurses-In-Charge reported that the availability of adequate staffing levels must be maintained. This was reported with other resources such as equipment.
"We have to see that resources are available and adequate, like staff and equipment control. We send our request to mother hospital" (FGD-RNIC-1)

Certain Registered Nurses-In-Charge reported that a pressing need for their involvement in the recruitment of competent staff exist. This incorporates such crucial functions as the identification of vacant posts and the submission of motivations for the filling thereof.

4.2.2.2 Performance Management

The HB, CSP and PHCP listed the development of the job description, management of absenteeism, the documentation of disciplinary problems and the copying of such to their supervisors. The PHCP cited the establishment of a performance and training plan with performance appraisal for each staff member annually. The PHCP also mentioned ensuring the availability of, and access, to the District human resources policies on grievance and disciplinary procedures at clinic level. (PHCP)

The municipal document elaborated on this aspect. It identified the progress assessment of new subordinates which includes the documentation of the relevant incidents of both Registered Nurse-In-Charge and her supervisees; periodically conducting performance appraisal interviews, whilst feedback on performance is provided, the record of which is submitted to the supervisor. Based on these reports, nominations for merit awards are made. Further to this, staff is delegated according to skills and talents, the failings and shortcomings of which are addressed through training and encouragement.

The provincial document noted that the Registered Nurse-In-Charge needs to carry out performance evaluation of nursing staff and apply sound and fair labour relations measures as provided for in the Labour Relations Act and departmental policies. The state-subsidized document only listed conflict, discipline and grievance management and offered no advice on the remaining functions on the rest of performance management role.

All Clinic Supervisors and certain Registered Nurses-In-Charge reported that the latter should design clear job descriptions for all staff members.

"I have to ensure that every staff member has a job description that is part of your performance management and development" (FGD-RNIC-2).

Most Registered Nurses-In-Charge agreed that it is essential for them to supervise staff at clinic level through implementation of performance and development system policy. The policy involves drawing of job descriptions and work plans, staff development, motivation and delegation.

Most Registered Nurses-In-Charge concurred that it is part of their management function to provide supportive supervision to their staff, which entails observing and assessing the individual staff member as a holistic being with physical, psychological, and social needs. All of these require that the Sister-In-Charge accommodate the reality of their existence, including referral to EAP if it is required (FGD-RNIC), (KI-2-RNIC-2).

"// is important to understand their behavior so that you will be able correct it if it is an unacceptable behavior so as to perform well. The psychological aspect of staff is also important. You must make every effort to meet their needs, like for instance, you know their behavior, in case of psychosocial problems, you must be therefor them, more especially because you know they have a lot of frustrations and burn out at clinic level and also that there are a lot of nurses who are sick, so you have to understand and you must be supportive to them. In case of serious psychological or social problem you have to refer them to the appropriate person i.e. EAP "(FGD-RNIC-2).

The PHC Coordinator also agreed that supportive supervision formed one of the important functions of Registered Nurse-In-Charge of clinics (KI V-PHCC).

Most Registered Nurses-In-Charge and clinic nurses concurred that the Registered Nurse-In-Charge needs to identify conflict at an early stage and manage it promptly to prevent divisions arising among staff (FGD-RNIC-2) (FGD-CN-1).
All clinic supervisors and particular clinic nurses reported that the Registered Nurse-In-Charge must manage absenteeism. Clinic supervisors included management of staff grievances and ensure that staff remains well disciplined (FGD-CS), (FGD-CN).
Most respondents (Registered Nurses-In-Charge, Clinic nurses, Programme Manager) concurred with the opinion that the Registered Nurse-In-Charge need to delegate tasks to other staff members according to their level of knowledge, skills, preparedness and scope of practice. The clinic nurses added that delegation of tasks according to level of competence would prevent medico-legal hazards.

"For me there needs to be a change of how we view the Registered Nurse-In-Charge. She needs to be a team leader and has got to be able to use that strength in her team rather than just allocate tasks. She should be able to assess that that person I could really use productive there and that person. That in itself is a skill and for me it's very important"(KI V-PM).

"Ifirstly consider the training level, knowledge, skill and preparedness of the individual to take up the task"(Kl-2-RNIC-2).

One Registered Nurse-In-Charge reacted in a very emotional manner concerning this function because of the reality of her work situation, either when sometimes alone or with certain lower categories of staff to whom she is required to delegate duties that fall outside their scope of practice. She expressed this in the following manner:

"Whilst still there, that scope of practice here we like to practice that and we know the scope of practice but tell me we are two, sometimes I'm alone, how do I do it when I'm all by myself and as a result look at my age I come to work because I think that the clinic

will not be opened, because the other professional nurse is not on duty and I think that the staff nurse cannot be left alone. So can you see that if we were to tell the truth there are things that we are failing to do correctly. In hospital it is known that this work is to be done by the Sister, this is to be done by the staff nurse but here Is this patient going to stay or I must chase her to go to another clinic when she is at the gate she would say ah nurses do not want to help me with anything and you end up doing something for that patient even if it is not the proper thing" (KI-l-RNIC-2).

The Programme Manager reported that she viewed delegation as one other important function of a Registered Nurse-In-Charge that needs to be fully understood what is meant thereby and the impact this factor has on the delegated. She expressed herself thus:
"I think part of a good manager is the ability to delegate which is also a skill because delegation is not about giving out accountability, its about accepting accountability but also being able to give that person a space to grow and so on. " (KIIV-PM).

The study participants were asked to distinguish between tasks that may or may not be delegated if indeed any existed. The purpose thereof was to establish whether the participants understood what delegation meant.
General disagreement was discernible in respect of tasks that may or may not be delegated. Most respondents agreed with the proposition that every management task may indeed be delegated. A few respondents disagreed with this latter response and listed the following examples of those tasks which need attention at senior level: budget, accountability and authority.

4.2.2.3 Human Resource Development

All three documents, except the CPHCSP, asserted that the Registered Nurse-In-Charge should design, implement, monitor and evaluate an orientation and induction programme for all new staff members. All three job descriptions identified the implementation of an orientation and induction programme. The provincial document specified that the orientation and induction programme was directed at nurses whilst the state-subsidized and municipal documents claimed the function for all the staff.

Certain Registered Nurses-In-Charge reported that they need to implement an orientation and induction programme for new staff.

"I also talked about the induction it is very important especially to new staff. It is very important especially before that staff member assumes new duties so that the staff is acquainted with whatever he is doing in work situation ". (FGD- RNIC-2)

The HB, CSP and PHCP cited the tasks required of the Registered Nurse-In-Charge as being the identification of learning needs and the skills required for the successful delivery of the full package of primary health care service. This function was of paramount importance and would be performed through the use of job descriptions and the PHC service delivery gaps resulting from lack of skills. These documents further observed that the Registered Nurse-In-Charge needs to develop a training plan based on identifiable needs. Only the HB and CSP regarded the need to keep documentation on the training sessions, meetings and workshops attended by the Registered Nurses-In-Charge and clinic staff.

Whilst both provincial and municipal job descriptions listed assessment of learning needs, the provincial one specified that this function would have to be executed on the basis of type of patients consulted in the clinic and the developmental needs of nursing staff. This information would be further used to develop, implement, monitor and evaluate a human resource development programme.

Most Registered Nurses-ln-Charge reported that staff development constituted their management function. They reported that they need to do this through identifying staff learning needs, which informs development, implementation, monitoring and evaluation of a human resource development programme (FGD-RNIC), (KI-RNIC).

" We are responsible for staff development. We get to see learning needs during supervision when the junior staff is doing something wrong, we then plan in house training which we have on less busy days "(FGD-RNIC-2).

"I do skills audit to identify learning needs, also some issues are raised at meetings. I am also responsible to identify the candidates for outside training like workshops and post basic courses "(KI-2-RNIC-2).

One Registered Nurse-In-Charge disagreed vehemently with this function. Frustration was most evidently identifiable on her face as she expressed her emotion in this statement *"I can only identify that when I come across a problem, because we are short staffed. May I not answer the question of in- house training because here that is not practical. I do not want to lie about it. From the offices our supervisor sends people for courses but we do not know how she does it. She doesn 't even tell the Registered Nurse-In-Charge (KI- l-RNIC-2).*

4.2.3 Financial Management

The HB and CSP asserted that Registered Nurse-In-Charge need the requisite knowledge of their clinic budget according to the main categories and manage cash flow at clinic level. The PHCP cited that, as a cost centre, the clinic requires its budget to be divided into main categories and its cash flow managed, but did not specify the role of the Registered Nurse-In-Charge in this.

However the document remarked that not all clinics may be responsible for this as yet. (The document was compiled in 2000. However, data obtained from respondents revealed that the status quo nevertheless remains).

4.2.4 Supervision

4.2.4.1 Governance

The HB, CSP and certain respondents, mainly Registered Nurses-In-Charge identified the management areas that the Clinic Manager (Registered Nurse-In-Charge) is required to manage and review monthly through the checklist. These are: education of staff and clients and display of Batho Pele principles, patients rights charter and responsibilities, and service charter in local language; use of complaints registers and suggestion boxes to manage clients' complaints; and management of patients' service waiting times.

"Patient care. It's my duty to see to it that all the patients are attended to properly and no one leaves the clinic complaining who will come back to me and say 'Sister I was not happy there I complained of that and Sister responded in a bad way. So we develop one another on that - relationship, the nurse patient relationship "(KI-I-RNIC-1).

"Informing the patients about their rights and responsibilities is part of my work. So health education and having posters on these and those posters must be in local language so that people may understand" (FGD-RNIC-2).

In addition to these functions the HB cited ensuring community involvement in developing clinic priorities and the provision of support service programmes through clinic committees; creating courteous, youth and elderly persons friendly service; and providing audio visual privacy during patients consultation. Most Registered Nurses-In-Charge reported these functions, in addition to the above: ensuring that patients are satisfied with the service they receive at the clinic, as measured through patient satisfaction surveys; and maintaining community participation, where community members articulate their particular opinions and assist in educating the community on health issues through a clinic committee.

"Patients satisfaction is part of my supervision. That you can do by doing satisfaction survey where you issue the questionnaire and the patients will make the comment about the care given to them " (FGD-RNIC-2).

In addition to the above management roles, the CSP insisted that the Registered Nurse-In-Charge have a duty to ensure a user-friendly service to pregnant women.

The PHCP only mentioned community involvement in helping with clinic facility needs through the clinic committee.

The municipal document identified the following functions: ensure motivation of the community to utilize PHC services; assist in compilation and updating of community profile; communicate community felt needs for health education to CPN (Nursing

Service Manager); identify the learning needs of individuals and groups within the community and educate accordingly; identify community hazards and educate the community on impact reduction and mitigation; identify cultural parental practices and record in community profile. The provincial document mentioned maintenance of relationships with appropriate organizations and relevant role players to ensure a multidisciplinary approach to primary health care. The state-subsidized document cited provision of community-based programmes, including home visits through community health workers and establishment and supervision of community development projects such DOTS.

4.2.4.2 Service Organization

All four documents articulated the provision of service through a supermarket approach. The CPHCSP identified ensuring provision of services according to the comprehensive package of service. Only the HB and CSP explained in detail the management roles with regards to service delivery. The four documents referred to the following factors: organizing a daily work schedule; patients information through posters at waiting areas in the local language; provision of specialist or medical services through periodic visits; functional referral network and community outreach services.

This particular area was not well addressed in the three job descriptions. The municipal and state-subsidized documents merely enlisted services to be provided without reference to the package of service documents, which further explains norms and standards for each service. The provincial document referred to planning and service organization in relation to cost effective use of resources.

Most Registered Nurses-In-Charge agreed that it is essential to assess community needs and disease profile and provide clinic services accordingly; ensure effective implementation and evaluation of all health programmes; conduct community awareness campaigns to increase patients' information, as indicated below:

" TB we know that TB is escalating in our community so we should do awareness as much as we can so that they should know the signs and symptoms and you must encourage then to come to clinic to check whether they have TB or not"(FGD-RNIC-2).
One respondent reported that as a Registered Nurse-In-Charge, she was required to assess the workload in relation to available staff on duty and she expressed her view in this way,
"Like today, because I'm the only professional nurse. I delegate myself to functional duties" (KI-l-RNIC-2)
Some Registered Nurses-In-Charge concurred that, as their management function, it remains their duty to coordinate services and collaborate with other services like environmental health, social welfare including community health workers and indigenous healers (FGD-RNIC).

4.2.4.3 Clinical Governance

This aspect was only mentioned in the HB and CSP documents as follows: ensuring the implementation of infection control (now termed infection prevention and control) policy and practices; implementing standard treatment guidelines; dispensing properly labeled drugs with written and verbal instructions; implementing waste management guidelines and implementing the policy for Post-HIV Exposure Prophylaxis for employees.

The provincial document cited additional functions on this aspect. These included the maintenance of appropriate effective primary health care nursing based on current legislation, standards and guidelines, and scientific nursing principles; implementation of Occupational Health and Safety Act as applicable; conducting research on current practices, locally based standards etc.; monitoring the use of nursing standards, care and departmental guidelines and implement remedial action where required.

The state-subsidized and municipal documents only mentioned the provision of certain services including the conducting of PAP smear according to National policy and antenatal care according to SANC and Provincial Health Service Guidelines. The former document referred to the supervision of adherence to standards, protocols and procedures.

Certain Registered Nurses-In-Charge reported that according to their designated function, the conducting of patient-held card audits is necessary to assess whether clinical protocols and policies are followed in managing patients appropriately. This would facilitate the requisite prompt institution of remedial action (FGD-RNIC-2)

One Registered Nurse-In-Charge articulated this sentiment concerning the importance of checking equipment for effective service delivery *"Like that scale I have to ensure that it is working well because if not we will get the wrong reading of weights and therefore be misled with the management of that baby" (KI-l-RNIC-2)*

She continued further, " *Being responsible for everything I easily get irritated because of this. I do not know about my management work So being here alone, there is a lot that I'm doing" (Kl-l-RNIC-2)*

One respondent stated that a Registered Nurse-In-Charge is duty bound to ensure availability of skilled staff, policies and protocols for the effective implementation of health programmes (KI-2-RNIC-2).

Other Registered Nurses-In-Charge expressed the opinion that an alternative form of supervision would involve employment of the supervision tool for each programme *"Ifyou want to supervise patient care you must have a checklist a tool for each programme, may be today you are doing maternal health. You use the checklist for this programme " (FGD-RNIC-2).*

The HB, PHCP and CSP cited ensuring the availability of the supervisory schedule with time lines and a record of monthly supervisory visits at clinic level.

This function was not addressed at all.

4.2.5 Administrative Functions

4.2.5.1 Resources

The HB, CSP, state-subsidized job description and most Registered Nurses-In-Charge respondents claimed that the Registered Nurse-In-Charge need to ensure the availability of adequate and uninterrupted availability of essential equipment, pharmaceuticals and other supplies. The HB, CSP and state-subsidized job descriptions further indicated that the equipment ought to be maintained in satisfactory working condition and the inventory

kept updated. The PHCP only cited updating the inventory of clinic equipment and compiling a list of broken equipment but included the maintenance of pharmaceuticals and other supplies as well. The HB, CSP and PHCP mentioned the Essential Drug List as a necessary tool in guiding the maintenance of the supply of necessary pharmaceuticals. In addition to such identified functions, the HB, CSP and PHCP included ensuring safe storage to limit unnecessary expiry of stock.

The HB, CSP and PHCP cited submission of a weekly transport plan through the supervisor to the transport coordinator, to ensure fulfillment of clinic transport needs. The provincial job description referred to the maintenance of adequate and appropriate transport in addition, whilst the municipal document regarded these functions on transport as essential: ensuring the conducting of regular maintenance; reporting faults and monitoring the appropriate use of transport.

The HB further cited the role of effective management of transport and monitoring of transport utilization and cost. The HB, CSP and PHCP cited that the Registered Nurse-In-Charge possess a major role in maintaining uninterrupted communication through two-way radio and official use of the telephone.

The provincial document further identified the cost effective use of resources. The municipal document merely cited cleaning and storage of equipment. Ordering and repairs were not noted as part of this function. There was no mention of supplies and pharmaceuticals.

All clinic supervisors reported the importance of control of use of clinic resources (FGD-RNIC-1).

"The stock, the staff any equipment that is used, medicines, all the equipment that is involved as far as service running is concerned you need to see to whether it needs to be ordered or sent for repairs " (Kl-3- RNIC-2).

4.2.5.2 Facility

The HB, CSP and the provincial job description asserted that the Registered Nurse-In-Charge has the responsibility to ensure a clean and well-maintained facility to promote the provision of health care, whilst the PHCP only insisted on a well-maintained facility.

Most Registered Nurses-In-Charge agreed that the management function of overseeing clinic maintenance and security to ensure that health care is provided in a conducive milieu rested on their shoulders (FGD-RN1C).

" I'm also responsible for the building itself because any leaks any problems any breakages any damages that is there, that need to be seen to, any maintenance that need to be seen to, becomes my responsibility" (KI-3-RNIC-2).

4.2.5.3 Information

The HB and CSP noted that the Registered Nurse-In-Charge is tasked with ensuring the availability of and supervise the correct use of references, resource material, clinic and programme registers, patients' records and reporting forms. The PHCP document omitted any references and resource material in its citation. The three documents indicated the provision of sound data and information management according to the departmental policy. This includes accurate recording and reporting, analysis of data and its use in management. This further comprised the availability of catchment maps.

The state-subsidized document identified the compilation of monthly, quarterly and annual reports whilst that of the municipal argued that the Registered Nurse-In-Charge is required to ensure the completion of a daily attendance register and the analysis and interpretation of daily attendance records.

Certain Registered Nurses-In-Charge merely reported some aspect of information management in the relevant evaluation of programmes such as VCT and PMTCT at clinic level, as part of supervision of service organization (FGD-RNIC-2)

It was only the provincial document that had any comment on this role. It cited the management of the PHC budget at clinic. The other documents remained silent on this role.

One respondent mentioned the budget as a management function that she would not delegate. This was a response to a question of distinguishing between functions that permitted delegating and those that did not, if any of the latter existed (KI-I-RNIC-2). One respondent reported that Registered Nurses-In-Charge have a responsibility of financial management coupled with an understanding of value for money.

"I think the other area may be its important that perhaps there is a shortfall in the level of understanding of value for money in other words for me and may be my perception Registered Nurse-In-Charge often think that finance is done by somebody else and for them as a manager its not really important they just ask that finance person but for me if she does not know what value for money she is getting out of that clinic she is actually not manager herself. If I offer this service and it costs so much money, am I getting value for my money, which is another ballgame altogether (KI-4-PM).

4.3 CURRENT MANAGEMENT ROLES AND FUNCTIONS OF THE REGISTERED NURSE-IN-CHARGE AT CLINIC LEVEL

The establishment of management roles and functions that are required of the Registered Nurses-In-Charge at clinic level provided the foundation for establishing the management roles and functions that are currently being performed by Registered Nurses-In-Charge at clinic level. These were acquired from an analysis of the Clinic Supervisors reports and respondents. The management roles and functions currently being performed were established from the supervisors' reports from the three clinics i.e. Municipality, State Subsidized and Province and those as reported by the respondents. The use of supervisors' reports also assisted in verifying the reported management roles and functions. The referencing of supervisors reports will be as follows: Provincial Supervisors' Report (PSR); Municipal Supervisors' Report (MSR); State-Subsidized

Supervisors' Report (SSSR). The respondents will be referenced as in the previous section.

4.3.1 Human Resource Planning and Management

4.3.1.1 Human Resource Provisioning

The supervisor's report indicated that additional staff has been employed in this clinic following a motivation from the Registered Nurse-In-Charge (PSR).
The compilation of motivation for an additional enrolled nurse and relief professional nurse illustrated that such a function is currently being performed.

Certain Registered Nurses-In-Charge agreed that only motivation for staff replacements and additional staff for new programmes occurred. None reported proceeding beyond this level of involvement (RNIC). One respondent reported that Registered Nurses-In-Charge are involved in interviewing staff for their clinics. (PM)

"I was working alone from May up until now in November when Kwa-Mashu Poly Clinic [support institution - CHC] has employed two professional nurses. But there was moonlighting 2 Professional Nurses. It was very difficult because I had to orientate new people every now and then. I motivated for more staff that is why they have employed two professional nurses. At that time there was one enrolled nurse, so we have motivated for two. They have already been employed" (KI-2-RNIC-2).

4.3.1.2 Performance Management

The report revealed that the attendance register for staff was maintained dutifully; however, no evidence was presented indicating that absenteeism was currently being monitored and managed (PSR).

Most respondents agreed that staff performance is managed through compilation of job descriptions, motivating and delegating staff, monitoring and management of absenteeism (FGD-RNIC-1), (FGD-CS), (KI-2-RNIC-2). Some reported that their functions include managing conflict and staff social problems, of which certain individual cases are referred to Employee Assistant Programme at a support institution when

necessary (FGD-RMC-2), (KI-2-RNIC-1). One reported that she does counsel and discipline staff as a corrective measure but not as a punitive measure.

" As a unit manager I do discipline staff when done something wrong like leaving work before time, but I discipline and counsel so that I don't use discipline as a punitive measure " (FGD-RNIC-2).

4.3.1.3 Human Resource Development

None of the reports indicated orientation and induction as being currently performed. Particular respondents agreed that the orientation of new staff according to individual facility orientation and induction programme is conducted by them (FGD-RNIC-2)

The report (PSR) illustrated the reality that the management functions currently being performed in human resource development include in-service education, which is conducted twice monthly as a minimum, and team briefing meetings.

Most respondents concurred with the opinion that they develop their staff through in-house in-service education. Some respondents reported that staff is sent out to formal and informal courses, for which the responsibility for coordinating remains theirs through the selection of candidates in their clinics according to departmental policy (FGD-RNIC-2).

4.3.2 Supervision

4.3.2.1 Governance

The following functions were being performed currently: ensuring implementation of Batho Pele principles; making certain that patients were informed of their rights and responsibilities; management of the flow of patients (PSR) and implementation of community out-reach programmes through functional clinic committee. The most prominent example of this function was like TB Directly Observed Treatment Short course (MSR).

Most respondents reported that they do display Batho Pele principles and patients rights (FGD-RNIC), (KIIII-RNIC). Few respondents indicated that education of patients and

staff occurred thereon (FGD-RNIC). Certain respondents agreed on the explaining to the patients the reasons for longer waiting service times at their facilities, such as staff attendance at in-service education and that a lack of the necessary personnel prevails

"It becomes important to let them know the services that we give also to let them know that much as may be sometimes they are waiting so long we know they are waiting, although we are in the consulting room. It sometimes is due to staff shortage when some staff are sick or have resigned for greener pastures or because of in - service education or feedback from meetings and workshops" (KI-3-RNIC-2).

One respondent asserted that clients' complaints are managed by her through use of a complaints register (FGD-RNIC-2).

4.3.2.2 Service Organization

The following functions were identified in the reports as being performed currently: ensuring the provision of PHC services according to the comprehensive package of service through introduction of new services, inter alia Ante Natal Care, Voluntary Counseling and Testing and Prevention of Mother To Child Transmission; making certain of regular visits by a doctor and social worker (PSR) and, in addition securing that an appropriate working referral system is in operation at the clinic (MSR).

Most respondents agreed that Registered Nurses-In-Charge submit motivations for additional physical space for the provision of new health programmes like VCT, PMTCT to support institution through the supervisor (KI-2-RNIC-2).

Certain respondents narrated the fact that service delivery was coordinated to make certain of the implementation of the supermarket approach (FGD-RNIC-2). All Registered Nurses-In-Charge concurred that they assume accountability concerning all matters transpiring at the clinic. Such an example cited in the report was the unavailability of schedule 5 and 6 drugs which resulted in clients receiving such medications as Valium for epilepsy, being referred to another clinic approximately 20km away. The Registered Nurses-In-Charge, as was asserted, motivated for such urgent

needs through the Clinic Supervisor to order the schedule 5 and 6 drug order book and the register from the pharmacy at the support institution (PSR).

4.3.2.3 Clinical Governance

Evidence was presented of the implementation of such programme policies as Vitamin A supplementation. There was however no record of any in-depth programme reviewed.

Certain respondents indicated that supervision of the implementation and evaluation of health programmes occurs through the use of the in-depth programme review supervision tool. TB was identified as an example of a programme reviewed by most respondents, constituting a case where the challenge of a high defaulter rate was noted as a prominent factor (FGD-RNIC-2).

"We implement and evaluate health programmes like TB. The challenge is the defaulter rate which is high. I then designed and implemented default tracing system through CHW" (FGD-RNIC-2).

4.3.3 Administrative Functions

4.3.3.1 Resources

It was also expressed that the lack of stock-outs was an indication that the Registered Nurses-In-Charge do fulfill their function in securing the maintenance of levels of pharmaceutical supplies (MSR). Whilst reference was made that no problems with medical supplies prevailed, the same report also mentioned that no order books for schedule 5 and 6 drugs existed because the pharmacist serving the support institution declined to issue it. Therefore patients on such drugs were referred to alternative clinic supported by the same institution (PSR). It was further established that certain equipment items such as vaccine fridge and scales, were reported to be functioning adequately (MSR).

All Registered Nurses-In-Charge agreed that they ensure the uninterrupted availability of appropriate levels of resources, including pharmaceuticals, equipment and other supplies. (FGD-RNIC-1), (KI-3-RNIC-2)

4.3.3.2 Facility

The research findings identified the fact that the Registered Nurse-In-Charge currently oversees a well maintained facility in respect of the yard, waste management, building and medicine store- room. Some respondents indicated that they perform their oversight function by ensuring that clinic maintenance of particular areas of attention such as paint, leaks are taken account of (FGD-RNIC-2), (KI-2-RNIC-1), (KI-3-RNIC-1).

4.3.3.3 Information

The report only revealed the existence of crude data on morbidity profile, VCT, Vitamin A supplement and headcount (PSR). The TB register was noted to have been correctly completed and submitted periodically as prescribed (MSR). No evidence was detectable from both these particular reports that data was analyzed, interpreted and used for management.

Most respondents agreed that they maintain clinic records and collect, collate and analyze data.

"I collect and collate statistics also analyze for the purpose of programme evaluation like PMTCT, VCT" (FGD-RNIC-2).

4.4 MANAGEMENT ROLES AND FUNCTIONS NOT PERFORMED BY THE REGISTERED NURSE-IN-CHARGE AT CLINIC LEVEL

One objective of the study was to establish those management roles and functions that are currently not performed by Registered Nurse-In-Charge at clinic level. The data collected and analyzed provides a reasonable volume of information enabling the identification of unattended areas in management roles and functions. These were assessed from respondents reports as constituting self-reported gaps, and from the researcher's personal analysis of such tasks lacking. The researcher used the following sources of data in analyzing these gaps in the fulfillment of management roles and functions:

- Policy documents and legislative framework

- Job Descriptions
- Supervisors reports
- Respondents' responses

This analysis is also illustrated in the summary of required management roles and functions Table 2.

4.4.1 General Leadership and Planning

Specifically the leadership role with its functions was not mentioned in either of the two job descriptions. The supervisor's reports and responses obtained from all study participants did not indicate this role as being currently performed. This role was also omitted from the reported management roles and functions required at clinic level by study participants and job descriptions.

4.4.2 Human Resource Planning and Management

4.4.2.1. Human Resource Provisioning

The two job descriptions did not list human resource provisioning, whereas the provincial document cites the responsibility to assess staff requirements and contribute towards the maintenance of adequate staffing levels. Ensuring the availability of, and access to the district human resource policies on recruitment was identified as a gap.

Most Registered Nurses-In-Charge stated that proceeding beyond the level of motivating for additional staff was not considered among their functions (FGD-RNIC-2), (KI-2-RNIC-2), whilst the Programme Manager reported that the Registered Nurses-In-Charge are involved in interviewing for their clinics.

" / *think some management roles in terms ofHR are probably fulfilled in terms of interviewing for their staffing" (KI-4-PM).*

4.4.2.2 Performance Management

The management of performance according to the Performance Management and Development System or staff appraisal was not mentioned as occurring currently. This indicated a vacuum exists in terms of performance assessment and evaluation.

Some respondents reported that Registered Nurses-In-Charge still fail to discipline staff, instead they refer cases of discipline to the Clinic Supervisor (FGD-CS).

4.4.2.3 Human Resource Development

Certain respondents indicated that although Registered Nurses-In-Charge attend workshops and meetings as a management function, they do not cascade information to other role players including staff members (FGD-CS).

4.4.3 Finance

It could not be established both from respondents and reports whether the Registered Nurses-In-Charge possess knowledge of their respective clinics budget by categories. Monitoring of monthly expenditure and instituting intervention measures through the cash flow meetings at clinic level was not reported from any source. None of the respondents even reported this role as constituting a vacuum.

4.4.4 Supervision

A difference of opinion occurred on supervision as being currently performed. Certain Registered Nurses-In-Charge agreed that they were currently overseeing governance, service organization and clinical standards within a very limited scope (FGD-RNIC) whilst some Registered Nurses-In-Charge indicated that they were not undertaking this role, because of various hindrances (KI-l-RNIC-2). One respondent expressed the belief that management of the clinic did not fall under their jurisdiction.

She said, "We are here to work, the oversight function is for the supervisor. When they allocate staff to the clinic, they don 7 take you as a person who must manage. You are also involved with the consultation of the clients " (KI-l-RNIC-1).

4.4.4.1 Governance

The following functions were identified as not being performed currently by all Registered Nurses-In-Charge respondents: conducting community profile and planning accordingly; maintaining relationships with appropriate organizations and relevant role players and ensuring user friendly facilities and services for vulnerable groups.

Most respondents reported the following functions as not being performed currently: monitoring patients waiting times and ensuring community participation through functional clinic committees (FGD-RN1C), (KI-RNIC). Some respondents reported that they were unable to conduct a patients' satisfaction survey and ensure the implementation of Batho Pele and patients rights (KI-RNIC).

4.4.4.2 Service Organization

The following functions were identified as not being undertaken currently: ensuring the provision of daily comprehensive package of service; planning, implementing, monitoring and evaluation of community out reach programmes; planning and organizing of services and resources.

4.4.4.3 Clinical Governance

The following constitutes the functions identified as not being performed currently: conducting monthly in depth programme review; researching on current practices; supervising the constant utilization of departmental guidelines; monitoring of nursing standards and care, and implementing remedial action where required and the Occupational Health and Safety Act as applicable.

All respondents reported these functions as unattended areas currently: ensuring the availability of, and supervision of implementation of clinical standards and protocols and formulation of policies at clinic level. (FGD-CS). Maintaining the supervisors schedule, register and report of supervisory visits and discussion of such with both staff and relevant role players constituted glaring omissions in the self reported gaps.

4.4.5 Administrative Functions

4.4.5.1 Resources

The following functions were identified as not being performed currently: submission of weekly transport plan to the support institution through the supervisor; monitoring of the implementation of transport plan, transport utilization and running cost and ensuring the uninterrupted communication through two-way radio.

4.4.5.2 Information

Aspects of data management, inter alia, verification, analyzing data and the utilization of information could not be established from any data source. Accounting for the availability of references and resource material was also absent.

The respondents disagreed as to whether this function was currently being performed. Whilst the Registered Nurses-In-Charge asserted that they collected and collated data for submission to the district office, the Clinic Supervisors indicated that most Registered Nurses-In-Charge did not collect nor collate data consistently.

"They hardly collect and collate appropriate data, hence we have to ask for routine stats submission now and again and do not get it, until we go to the clinic. Some however do " (FGD-CS).

4.5 FACTORS THAT LIMIT THE FULFILLMENT OF THE MANAGEMENT ROLES AND FUNCTIONS OF REGISTERED NURSE-IN-CHARGE AT CLINIC LEVEL

The participants of the study were aware, to some extent, that unattended areas in the fulfillment of the management roles and functions of Registered Nurse-In-Charge existed. A number of factors were identified as limiting the fulfillment of these roles and functions. These realities are presented according to category type of respondents

4.5.1 Programme Manager

It was reported that the department both at district and support institution level failed to encourage the innovative role of Registered Nurse-In-Charge to view themselves as leaders of the clinics. This was demonstrated in the role of financial management.

" The financial management, but also understanding the value attached to the service in other words its not just about the rand and cents but its about if I offer this service and it costs so much money am I getting value for my money" (KI- 4-PM).

4.5.2 Primary Health Care Coordinator

Staff shortage was identified as impacting negatively on the management roles and functions of the Registered Nurse-In-Charge in that even when they want to see things done correctly they do not have adequate time to supervise patient care and service delivery in particular.

4.5.3 Clinic Supervisors

All supervisors agreed that the following factors limit the fulfillment of management roles and functions of the Registered Nurse-In-Charge at clinic level.

- The conflicting roles between the district office and the support institution in respect of acquisition of resources and attending to maintenance problems.

  "Sometimes you send a clinic request to support institution to get shelter for patients' waiting area, and you get to be told only after say six months that you must send it to district office because they are responsible " (FGD-CS)
- Communication breakdown. The district periodically communicates with the clinics through the support institution and similarly through the service area primary health care office.
- Response time to acquire equipment and linen procured for the clinics was reported to be sometimes as long as more than a year. The unacceptably lengthy response time also applied to the matter of attending to clinic maintenance issues. The clinic supervisors reported that the support institution prioritized its own needs vis-a-vis the clinic services.
- Low morale among Registered Nurses-In-Charge was indicated, resulting from factors relating to salary level. Thus supervisees often received similar remuneration. Evidence of low morale was reported as influencing Registered Nurses-In-Charge's ignorance concerning important clinic reference material.

  "You go the clinic today and supply the clinic with reference material like immunization policies and procedure manuals, the following week when say provincial or national officials visit that clinic will not find any of those materials when asking for them. I think they do not care about us, after all we all earn the same" (FGD-CS).

- Ignorance concerning matters of support required from the supervisors was also evident. This was attributed to a lack of training and awareness concerning the supervisor's manual and staff shortages (FGD-CS).

4.5.4 Registered Nurse-In-Charge

All respondents agreed that the following factors limited the fulfillment of their management roles and functions at clinic level.

- The long turn around time for equipment repairs, which was partly attributable to the unavailability of transport to the clinics.
- Lack of competence in specialized services such as Occupational Health and Safety which they are expected to perform.
- Limited knowledge and competence for management of absenteeism.
- Staff shortages require the Registered Nurses-In-Charge to be permanently in the consulting rooms. The reality that they are not dedicated managers, results in neglect of their management functions.
- Lack of orientation and training for the position of Registered Nurse-In-Charge.
- Lack of support from the clinic supervisors in informing the Registered Nurses-In-Charge of their management roles and functions.
- Lack of a job description for the post of Registered Nurse-In-Charge. As chief professional nurses that were rank promoted all possess the same job descriptions including those that serve in posts.
  "We all have the same job description because our ranks are the same, all Chief Professional Nurses. There is nothing that separates our job descriptions " (FGD-RNIC-1&2).
- When allocated to the clinics the Registered Nurses-In-Charge are not assigned as managers, they are merely regarded as functional staff (FGD-RNIC-1&2), (KI-1-RNIC-1).

4.5.5 Clinic Nurses

All respondents agreed that, because of staff shortages Registered Nurses-In-Charge devote most attention to clinical functions in the consulting rooms (FGD-CN).

4.6 RECOMMENDATIONS TO ENABLE THE REGISTERED NURSE-IN-CHARGE TO FULFILL THE MANAGEMENT ROLES AND FUNCTIONS

The study participants cited the following recommendations after they had responded to all research questions. The above mentioned factors were utilized in an attempt to improve the fulfillment of management roles and functions by the Registered Nurse-In-Charge at clinic level. It is envisaged that these will contribute greatly to the general provision of PHC service delivery at clinic level.

4.6.1 Human Resource Management and Planning

4.6.1.1 Human Resource Provisioning

Respondents of all categories agreed that the following factors would facilitate fulfillment of management roles and functions of a Registered Nurse-In-Charge at clinic level:

- Review clinic staffing structure according to the package of service and workload (FGD-CN), (FGD-RNIC-1), (KI-l-RNIC-2), (KI-4-PM).
- Provide dedicated posts of Clinic Manager at Assistant Manager salary level 9. Only Registered Nurses-In-Charge recommended salary level 10 for the clinic manager and level 9 for the deputy clinic manager (FGD-RNIC-1), (KI-2-RNIC-1).
- Staff establishment of the clinic to be brought to the attention of the clinic manager. Thereafter, the latter must ensure that the remaining staff are aware thereof.
- The problem of red tape in the process of recruitment needs to be addressed (FGD-RNIC-1).

4.6.1.2 Performance Management

All Registered Nurses-In-Charge agreed that their rank need to maintain a copy of their own job descriptions in order to facilitate the implementation of their management roles and functions.

Some respondents reported that an allowance for charge-ship would constitute an enabling factor in their management functions (FGD-RNIC), (KI-RNIC).

4.6.1.3 Human Resource Development

A strong agreement emerged among Registered Nurses-In-Charge that a proper programme of orientation and induction for the Clinic Managers must be conducted. It must, of necessity, be implemented systematically, and monitored and evaluated (KI-RNIC-1).

Registered Nurses-In-Charge and Programme Manager developed a strong emphasis on the following:

- Training of the Registered Nurses-In-Charge on clinic management, general management and transformational leadership (FGD-CS), (KI-4-PM).
- Continuous in-service training must be provided on departmental policies and current management practices.
- Mentoring and coaching of Registered Nurses-In-Charge (KI-4-PM).
- Joint regular meetings of Registered Nurses-In-Charge, Clinic Supervisors and PHC Coordinators as a form of development to Registered Nurses-In-Charge (FGD-CS),
- Establishment of a mechanism of cascading information, from in service, workshops and meetings, to the remaining staff (FGD-CN), (FGD-RNIC-**1).**

4.6.2 Finance

Some Registered Nurses-In-Charge agreed that transparency in the clinic budget is of paramount importance if proper fulfillment of their management roles and functions is to be achieved (FGD-RNIC-2).

4.6.3 Supervision

4.6.3.1 Service Organization

Certain Registered Nurses-In-Charge recommended that the decision making powers of a Clinic Supervisor and Registered Nurse-In-Charge such as planning and organization of the service and financial management, be increased to facilitate fulfillment of management roles and functions of Registered Nurse-In-Charge (FGD-RN1C), (KI-RNIC).

4.6.3.2 Clinical Governance

Some respondents agreed that regular supervisory visits would provide an enabling environment for the fulfillment of management roles and functions by the Registered Nurse-In-Charge.

4.6.4 Administrative Functions

4.6.4.1 Facility

Most respondents recommended that the clinic environment be improved in respect of security with good quality fencing, an alarm system and upgrading of physical clinic infrastructure (FGD-RNIC-1), (FGD-CN).

Appendix 06 illustrates the summary of results with regards to the role and functions that were identified from the various data sources. The ticks (V) reflect that the function was cited in the data source. The stars (*) denote the function that was not noted in the respective data sources.

4.7 CONCLUSION

The results were presented according to the data sources. Firstly from the literature and the respondents as per various categories that were interviewed. The results were presented under the objectives of the study as the main topics. They were summarized in

the attached table. The next chapter will discuss the results based on the reviewed literature.

CHAPTER 5 - DISCUSSION

5.1 INTRODUCTION

This chapter deals with the researcher's discussion of findings. The results will be discussed under the three main headings viz. statement of results which will summarise the results, comments on results, which will include the interpretation of results and suggested reasons for unexpected results and finally the limitations of the study. The basis of the discussion will be the conceptual framework discussed in the literature review and the study objectives. The study objectives will ensure a focus on the original purpose of the study, which is the examination of management roles and functions of the clinic Registered Nurse-In-Charge, is not lost.

5.2 CONCEPTUAL FRAMEWORK

In the article on 'Decentralization and Health System Reform' (53), the degree of decision space is described using the continuum along which concentration of choices is spread. At one end limited choices and discretion are available to the lower level with the centre maintaining strong control. At the other end, as central control progressively decreases, choice and discretion increase at the lower level. Where strong central control prevails, the decision space for the periphery is narrow. The middle of the continuum denotes moderate decision space. The end of the continuum with increased choices indicates that the decision space is wide (53).

For the purpose of this study 'involvement', 'responsibility' and 'authority' were used to determine the degree of decision space at clinic level. 'Involvement' denotes the narrowest decision space, 'responsibility' serves as indication of moderate decision space and 'authority' the widest decision. 'Involvement' is defined as 'taking part in something or with somebody'. It is also related to commitment: where involvement is present so is

commitment (53). 'Responsibility' is defined as 'having an obligation to account for something and being answerable to somebody'; 'applies to one who has been delegated some duty or responsibility by someone in authority and who is subject to penalty in case of default' and refers to the 'duty to perform function satisfactorily' (54). It is also defined as 'the ability to choose response' and 'being able to respond is the basis for effectiveness' (55). 'Authority' is defined as 'the right or power to enforce rules or give orders, and 'power to act on behalf of somebody' (53). The researcher supports the use of the latter definition of authority, as it would apply to the power to approve staff appointments, supplies and equipment orders, procurement of goods and services, and payments.

The conceptual framework has assisted the researcher to clarify the results of various management roles and functions into various levels of decision space. This is displayed in table form in Appendix 07. The table also illustrates those functions both currently performed and those that are not.

A narrow decision space denotes that the Registered Nurse-In-Charge is only involved in that particular function without taking responsibility for the function. The lack of responsibility means that there is no accountability to anyone at clinic level. The lack of authority for the management functions means that the Registered Nurse-In-Charge has no powers to act on deviations other than forwarding such to the support institution, which is most often located miles away. This situation seems to greatly contribute to the poor service delivery at PHC clinics.

The scenario of most functions having narrow decision space may mean that these functions are not performed at all i.e. even at the support institution or office. This leads the discussion to an important question for further study. At what level are clinics managed and what is the model used to ensure that management functions that are normally performed in an organization to ensure quality service and responsiveness to clientele needs are indeed implemented. What capacity is available at the support

institution or office as an enabler for the fulfillment of these important management roles and functions.

5.3 STATEMENT OF RESULTS

The study revealed that although the Registered Nurses-In-Charge of clinics possessed some theoretical knowledge on the management roles and functions required of them at clinic level, most of these functions were not being performed. Furthermore, the policy documents and job descriptions, in their description of the management roles and functions of the Registered Nurse-In-Charge of a clinic attribute a narrow decision space to the clinics. For most functions, the Registered Nurses-In-Charge had neither clearly defined responsibility nor authority. This was mostly evident in general leadership and planning and in financial management. Most management functions of clinics are still held at support institutions, be it at the hospital or community health centre. Table 5.3 in Appendix 07 presents the huge gaps that exist in clinic-based service management and shows that these are mainly attributable to the narrow decision space transferred to the clinic level. It must also be noted that some functions were identified as gaps by the researcher on the basis of lack of evidence of these functions being performed currently. Presumably some are being performed but as they were not reported, they were recorded as not being performed.

Some of the reasons reported by the Registered Nurses-In-Charge themselves, as limiting the fulfillment of management roles and functions, were lack of orientation and training on management, lack of dedicated clinic managers, staff shortage and lack of support from clinic supervisors and the support institution.

5.4 COMMENTS ON RESULTS

5.4.1 Management Roles and Functions Required at Clinic Level

5.4.1.1 Leadership

The researcher believes the leadership role to be a key management role as it gives direction to the functioning of every organization. It is regarded as the road map directing the organization towards its goals, channeling employee behavior towards the achievement of its organizational goals and objectives, and providing a framework for monitoring and evaluating organizational performance (30, 31)

Certain authors view leadership and planning as separate management roles, whilst being very interrelated (30). However, the policy documents guiding the management of clinic based services describe leadership and planning roles combined. Furthermore the documents focus on the planning rather than the leadership management functions. This may imply that a clinic manager is only responsible for a planning rather than a leadership role. It may also imply that the Registered Nurses-In-Charge is not regarded as a manager, and is thus not expected to perform leadership roles. This carries the implication that leadership is not required at clinic level.

A further critical function of the leadership role is communication. This function was omitted in policy documents and by the respondents. It is possible that the Registered Nurses-In-Charge did not conceive communication as a management function, although in the experience of the researcher, it is a function that does occur at a clinic level: through staff meetings, policies and circulae; and externally, between the clinic and the departmental officials, supervisors, support institution, higher level managers and the community. However if communication is not overtly recognized as a management function of a Registered Nurse-In-Charge, it may well be conducted in a haphazard manner. This undermines the paramount importance of communication in any organization.

It must be borne in mind that the clinic level is the first entry point into the health system, and reflects the entire health system. This is the vehicle through which health services are provided to meet the multitude of health needs of people in South Africa (4). Effective leadership at clinic level can contribute to effective service delivery and can improve the performance of clinic based-services. Effective leadership can align people's activities to organizational priorities and monitor the achievement of goals (22).

The adoption by the South African Department of Health of a decentralized model was intended to improve service delivery (22). However the decentralization model requires review, given the degree of decision space transferred to the clinic level.

5.4.1.2 Planning

The Registered Nurses-In-Charge need to understand national, provincial and district priorities in order to be able to guide the planning process during which the clinic priorities are set. Setting clinic priorities will enable the Registered Nurses-In-Charge to influence and guide people in the organization towards the achievement of departmental goals (30).

Key planning functions include: conducting a situation assessment; identifying service delivery priorities; and promoting community participation (32,37,5). The situation assessment is a tool for identifying community and service delivery needs by means of identifying the organizational strengths, weaknesses, opportunities and threats. The gaps and needs identified during the situation assessment inform the priorities of the organization (32). A study conducted in Namibia cited the importance of local managers skilled in service needs assessment to improve first level services (41). Community participation is one of the pillars of Primary Health Care, as stated in the Declaration at Alma Ata (8). In the Mpumalanga Province it is the function of the clinic manager to facilitate and encourage community based health initiatives through community participation (5).

However policy documents guiding the management roles and functions of the Registered Nurse-In-Charge omit to mention any one of these planning functions. This suggests that planning for clinic service delivery is intended to occur at a higher level, without the involvement of the Registered Nurses-ln-Charge, and is not decentralized to clinic level.

One of the intentions of decentralization as a policy is to increase the responsiveness of health service to local needs (28). The involvement of communities in planning for their health services also assists to identify underserved areas, thus promoting equity in service provision (21). A narrow decision space at clinic level removes the responsiveness to local priority health needs.

The omission of recognizing planning as a key management role of the Registered Nurse-In-Charge is considered to be another contributory factor to the consequent ineffective management of clinic-based services. Although most respondents gave recognition to the planning roles and functions, it could not be established whether this function is currently being performed at clinic level. Even if the planning function was being performed at a higher level, the Registered Nurses-ln-Charge remain uninformed about those plans. As a consequence, Registered Nurses-ln-Charge do not incorporate plans in their activities, thus hindering the achievement of departmental targets, including the achievement of global targets such as the Millennium Developmental Goals like 85% TB cure rates and two thirds reduction in under-5 mortality rates (38).

5.4.1.3 Human Resource Planning, Development and Management

The non involvement of the Registered Nurse-In-Charge in the human resource provisioning process further limits the scope of management at local level.

All sources referred to this critical management role. However, in the description of the human resource related role and functions of the Registered Nurse-In-Charge at clinic level, all indicated a narrow decision space overall. This further highlights the dependence of clinic-based services on the support institution.

The job description called for the involvement of the Registered Nurse-In-Charge in the pre-recruitment stage, in the assessment of staffing requirements, based on workloads. But the Registered Nurses-In-Charge are not required to participate in the recruitment and selection processes. Therefore although the Registered Nurses-In-Charge are required to maintain adequate staffing levels, their capacity to do so is limited by the narrow decision space delegated to them.

All sources gave very limited attention to labour relations issues, and particularly to grievance management and disciplinary procedures. The authority to discipline staff remains with the support institution, thus undermining the principle that constructive discipline facilitates learning and provides opportunities for growth (30). Furthermore, deferring the management of grievances to a higher level defeats the principle that grievances must be managed promptly and as close as possible to the point of origin (30)

A huge gap was manifested in the area of performance management, in establishing behavioural standards and criteria, and in monitoring the attainment of these. The decision space was narrowed to the point that the Registered Nurses-In-Charge felt they were required to motivate staff members, which they did by public recognition of the competent performance of their duties. The area of performance management is one in which an increase in decision space could be delegated to the clinic, which could in turn facilitate the attainment of departmental goals.

All sources clearly identified the role of the Registered Nurse-In-Charge in human resource development. However it was not possible to verify that this function was being suitably performed at present.

With regard to orientation and induction, the job description cites the responsibility of the Registered Nurse-In-Charge to orientate and induct nurses. This creates an impression that the non-nursing staff is not the responsibility of the Registered Nurse-In-Charge. If indeed this were true, particularly concerning the orientation of the non-nursing staff, it remains unclear whose responsibility it would be at clinic level. The practical situation

prevails that all staff categories at the clinic are entrusted to the Registered Nurse-In-Charge, as no other managers are present at this level.

A glaring omission in the policy documents was on the orientation and induction, training, mentoring and coaching for the Registered Nurses-In-Charge themselves. This in itself limits the capacity of the Registered Nurses-In-Charge to fulfill their management roles at clinic level.

A practical reality further limiting the human resource management scope of the Registered Nurse-In-Charge is the gross shortage of staff experienced by some clinics. This calls for the Registered Nurse-In-Charge to carry larger service delivery responsibility and neglect management responsibilities. The staff shortages contribute to a generally low morale.

5.4.1.4 Financial Management

This is one of the critical roles in management in any organization. It was given very limited attention from all data sources.

The policy documents did not address the financial management function adequately. The Hand Book further created ambiguity in a statement that not all clinics may be responsible for this function as yet. It is therefore unclear what financial management role and functions are required to be performed at clinic level at this stage. This is a cause for concern considering that every activity in the organization has financial implications. Leaving this function entirely at the support institution defeats the provisions of Public Finance Management Act of effectiveness, efficiency, economic and transparency (31).

The provincial job description required the Registered Nurse-In-Charge to manage the PHC budget at clinic level. The job description failed to specify the level of the Registered Nurse-In-Charge's involvement in financial management, especially because there is no finance manager at clinic level. The job descriptions for state-subsidized and

It was noted that the job descriptions for the state-subsidized clinics cited the supervision of community development projects including the DOTS programme and home visits. Perhaps this function of facilitating community based health development initiatives may receive better execution or support by NGO's because they possess the capacity to provide the necessary expertise. This approach proved to be very successful in the 'bare foot doctor' programme in China, which was characterized by active community participation, with non government organizations supported by the government hospitals (8).

Supervision of service organization was not adequately addressed. Only the HB and CSP addressed the service delivery issues from a management perspective. The main focus was on internal and external supervision; the provision of a comprehensive package of service in a 'supermarket' approach and community outreach programmes. The documents on clinic management omitted the following functions that form an aspect of organizing. They are:

- Co-ordination of services within units in the organization. This is achieved through conducting meetings with various units. Coordination reduces unhealthy competition within the organization, whilst promoting attainment of organizational goals (30).
- Maintaining public relations. This applies internally for the good image of the organization through high staff morale and a satisfactorily maintained facility physical facility infrastructure. Externally the organization assesses the manner whereby community perceives the services provided to them (30). This could be achieved through patients' satisfaction surveys, open days and community imbizo's.

The other two documents only focused on the actual package of service, with their norms and standards. This, however, was not unexpected as these documents are specifically a PHC package of service documents, although some management roles are cited therein.

The job description did not address the supervision of service organizations adequately. The huge factor missing was the package of PHC services according to the CPHCPS. The

supermarket approach, which involves the patients being attended to within the stipulated service time for all services in the said package, was omitted in municipal and state-subsidized job descriptions. This has negative implications for access to health services, which is formally enshrined in the constitution of the country (55) and the principles of PHC. The provincial job description required the Registered Nurse-In-Charge to organize services for the cost effective use of resources. This job description appears to be biased towards the management of resources as opposed to overseeing patient care. All three job descriptions omitted the management function of arranging a schedule for visiting of doctors and, or other specialist services, such as rehabilitation services. This omission may create an impression that it is the responsibility of the clinic supervisor to fulfill this function. This may supply credence to the opinion that the Registered Nurses-In-Charge are not managing the clinics. In this case this is as a result of complete lack of decision transferred to the clinic Registered Nurses-In-Charge in respect of this function. This means that the needs identified at clinic level have to be referred either to the PHC supervisor or to the support institution. This further completely defeats the purpose of decentralization which is local responsiveness to health needs. The organizational functions cited above in terms of coordination, communication and public relations were omitted in the three job descriptions.

The article on 'Building Management Capacity to Rapidly Scale up Health Services and Health Outcomes' calls on establishment of two-way communication systems between managers and health workers within the facility and between managers and external stakeholders. This includes also senior managers (52). Two-way communication in any organization is important for both feedback and support, particularly at the peripheral facilities. This is regarded as a tool for creating the enabling environment for improved service delivery (52).

Supervision of quality of care at clinics was adequately addressed in the legislative framework. However from the respondents reports there were huge gaps. For example, there was no mention of the establishment of clinical audit teams to conduct periodic

clinical audits and record reviews. These teams would measure implementation and adherence to clinical protocols and standards. The job description for municipal clinics only made reference to protocols in relation to patients' referral. The implementation of quality control measures like risk management, infection prevention and control and waste management were completely lacking.

External supervision remains very critical in strengthening clinic-based management, owing to the reality that a greater part of clinic management continues to be the responsibility of the support institution. It is the supervisor who forms the link between the clinic and the support institution (32). All job descriptions omitted external supervision in the management functions of Registered Nurse-In-Charge. This omission may result in Registered Nurses-In-Charge failing to assume responsibility for supervisory visits through the maintenance of a supervisory visit schedule, ensuring that the clinic supervisor punctually performs all aspects of the schedule of visits and visit reports are discussed with clinic staff. Evidence indicates that the clinic supervision role continues to witness a failure by supervisors to fulfill their duties, of conducting monthly supervisory visits as required by the policy documents (7). This is evidence of failure of limited decision space transferred to the clinics managers which was intended to be supplemented by clinic external supervision.

Some Registered Nurses-In-Charge possessed an understanding of the supervision of quality of care. In addition, an awareness was prevalent that the supervision tool also formed their management tool, particularly for supervising particular health programmes such as maternal health.

5.4.1.6 Administrative Functions

Key administrative functions include the management of resources: the monitoring of transport; ensuring the availability and maintenance of equipment, including telecommunication equipment; ensuring the uninterrupted availability of adequate supplies; and information management. All sources made reference to the importance of

managing these resources. However it remained unclear whether all such functions would be performed in the same manner at clinics as at Community Health Centres. For example, in the area of managing transport running costs, the Registered Nurses-In Charge cannot monitor these unless trained.

A present the function is performed at the level of the support institution. The detail afforded to transport management in the policy document did not correlate with the actual situation, in that clinics do not possess clinic-based vehicles. Vehicles are held and managed at the support institution of office. This would account for the respondents not considering transport management as falling within their ambit of responsibility.
The management of resources was addressed by the policy documents and respondents reports. However, it remained unclear whether all such functions would be performed in the same manner at the clinics and CHC's. This arises because the Hand Book made reference to clinics and CHC's as if their care levels were similar. It is the researcher's considered view that the Registered Nurse-In-Charge cannot monitor transport-running costs unless trained. The reason lies in the fact that the function is performed at the support institution. Ensuring availability of adequate equipment in premium working condition does not lie entirely with the Registered Nurse-In-Charge as orders proceed through supply chain management procedures at that particular support institution wherein the Registered Nurses-In-Charge are represented by the clinic supervisor. Furthermore, equipment repairs are undertaken at the support institution.

All job descriptions omitted telecommunication equipment although the policy documents addressed this aspect as an enabler of effective communication. Telecommunication is vital, especially in the remote, isolated conditions in which some of the clinics are situated. Communication between the clinic and the external world, particularly with emergency services, was therefore not afforded the necessary attention. Omission of this function may result in its neglect. This could create the impression among Registered Nurses-In-Charge that they are indeed isolated thereby permitting, the closure of certain clinics without the knowledge of the authorities and, more disturbingly, the turning away of patients. It also implies that in occasions of dire emergencies, the

Registered Nurse-In-Charge may fail to summon emergency assistance, resulting in undue loss of life.

The policy documents and job descriptions addressed facility maintenance adequately. Respondents demonstrated an acceptable understanding of this function because the security aspect, was included, which is critical, particularly at clinics situated in remote areas and high crime areas. Townships and informal settlements are the most prominent examples of the latter.

The policy documents, municipal and state-subsidized job descriptions conceived of information management very narrowly, whist the provincial document completely failed to mention this function. Critical aspects omitted are:

- Active participation in the establishment, implementation, evaluation and sustaining of a community based Health Information Management System.
- Ensuring accurate collection, collation, analysis, interpretation of information and the submission to a higher level.
- Monitoring of organizational performance using information.
- Management of such information technology equipment as computers.

Information informs planning, from facility-based knowledge to the measurement of the disease burden in the population in the catchment area (52). Information is also used for monitoring and evaluating all activities within the health organization including the performance of various health programmes. Some reports have attributed poor performance of particular health programmes including TB, to poor data and information management (13). It is also a reality that the bulk of data captured in the District Health Information System is obtained from clinic data. Therefore, it is essential that information management is correctly and accurately performed at the very initial stage of data collection. As a general management competency, the Registered Nurse-In-Charge ought to possess the capacity to manage information systems and information technology such as computers for the efficient running of the organization (53).

The respondents possessed limited knowledge of information management as a management role. They only reported collection, collation and analysis of data to evaluate health programmes. This accords with the narrow attention given to this function by policy documents and job descriptions.

The emerging impression is that both internal and external supervision is barely done at clinics. Of particular note with internal supervision is the element played by the decision space transferred to the clinics. The moderate decision space transferred to clinic managers for supervision, where the clinic is only responsible for supervision, does not afford them authority to act on identified service delivery challenges. In other words supervision becomes ineffective if identified challenges are not addressed. As a consequent this dampens the drive to undertake supervision.

The narrow decision space transferred to the clinic managers limits the execution of management roles and functions. This results in a situation where the so called clinic manager is, in actual fact not managing the clinic, but just carries out clinical functions like other staff members. The obvious scenario then is that clinics are only remotely managed, if at all they are.

5.5 STUDY LIMITATIONS

Time constraints did not allow for the study to be undertaken in more than three clinics, which would have supplied a wider representivity and therefore broader knowledge base. The results of the study therefore cannot be generalized.
The principal researcher, being part of the system (Clinical and Programmes Manager in South Service Area) could not maintain objectivity throughout the study as she was periodically required to step out of the researcher's position and attend to problems raised. The examination of the management role and functions of Registered Nurse-In-Charge was only conducted through their responses, and through the analysis of policies and reports. No verification through records review at each clinic was possible because of time constraint. The duration of the study proved too lengthy due to change of work

environment of the principal researcher. As a result thereof all Registered Nurses-In-Charge interviewed had witnessed a variation in their work or allocation by the time feedback was conducted to verify the findings from the initial interviews. The positive aspect of this loss to follow up was that a new set of information could be obtained supplementary to that provided by the initial informants. The negative aspect was that the original informants could not receive feedback which might serve in developing their capacity.

The focus group discussions were conducted in another 'sub district' because of the time constraint. It was convenient for the researcher to recruit participants who were known to be knowledgeable concerning the subject in her area of work.

5.6 CONCLUSION

A number of gaps identified from data sources and literature were highlighted with the possible implications thereof. This suggests that too little attention has been paid to the management of clinic-based services. The concept of district based PHC services, which was aimed at decentralized management for improved health service delivery, obviously failed to include clinics. The decision space transferred to a clinic is very narrow and non existent for some management functions. The above implications indicate that decentralization of management merely to the level of CHC's and district hospitals as constituting the lowest levels of care negates the entire purpose of decentralization and its attended benefits. Paradoxically, it renders PHC service ineffective and overburdens the entire health system.

CHAPTER 6 - CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

The study sought to establish the management roles and functions of the Registered Nurse-In-Charge at clinic level, within the context of decentralized management in the DHS. The main purpose behind the study lay in the poor quality of health care and the poor implementation of health programmes at PHC clinics which hitherto were assumed to be attributable to ineffective management of PHC clinic based services.

This chapter will discuss the summary of conclusions and recommendations that emanated from the results and literature maintaining the objectives of the study constantly in focus.

6.2 THE REQUIRED MANAGEMENT ROLES AND FUNCTIONS OF REGISTERED NURSE-IN-CHARGE AT CLINIC LEVEL

The policy documents governing the management of PHC clinics and job descriptions failed to provide adequate guidance for the management of clinics as they omitted critical managerial roles and functions applying to any organization. These include leadership, planning, human resource planning and management and financial management. The functions that were cited under these roles were very operational, particularly in human resource planning and management. This demonstrated a very narrow decision space prevailing at clinics with regards to these management roles. The financial management role, although listed in provincial job description, neglected to specify these functions. Hence, no respondent regarded it as a management role. The assumption that these functions, despite no indication of their performance at clinics, are conducted at a higher level than such clinics as support institutions render the management of PHC clinics ineffective.

The respondents of various categories, including Programme Managers and PHC Coordinators, did not demonstrate an adequate theoretical knowledge of the required

- Establish the extent to which clinic managers receive support in executing their management roles, from the support institution with a comparison being drawn of hospital and CHC support.
- Establish the role of management training and experience in clinic management with regard to coping with the consistent burden of increase in the demands on clinic based service delivery.
- Conduct a study between districts and or provinces on different models of PHC with regards to management support and the extent to which the decision space is expanded to the clinic level. This study would be coupled with performance of health targets in order to establish to what extent effective management support and expanded decision space contribute to the attainment of health targets.

6.5 CONCLUSION

This study succeeded in establishing the management roles and functions required and performed at clinic level by the Registered Nurses-In-Charge, which led to the establishment of those roles that are not performed. Indeed huge gaps were identified with regards to currently performed management roles and functions at clinic level. The limiting factors and recommendations reported by the clinic managers at the coal face demonstrated that they remain committed to the PHC clinic based service despite of its challenges.

The commitment of the government to the PHC approach was visible in the most recent development of restructuring PHC staff structure.

REFERENCES

1. Bradshaw D, Groenewald P, Laubscher R, Nannan N, Nojilana B, Norman R, et al. Initial burden of disease estimates in South Africa. South African Medical Journal. 2003;93:682-8

2. Health Systems Trust. The National Primary Health Care Facility Survey 2003. Durban: Health Systems Trust and Department of Health. 2004

3. South Africa. The White Paper for Transformation of Health System in South Africa. National Department of Health; 1997

4. The African National Congress. National Health Plan for South Africa. Johannesburg: South Africa Government Policy Document; 1996

5. Mpumalanga Department of Health, Welfare and Gender Affairs. Primary Health Care in Mpumalanga: The Guide to District based Action. Durban: Health Systems Trust; 1996

6. KwaZulu-Natal Department of Health. eThekwini District Health Plan 2007/2008. Durban: 2006

7. Lehmann U, et al. Investigating the Roles and Functions of Clinic Supervisors in Three districts in the Eastern Cape Province. HST Technical Report. Durban: Health Systems Trust; 2001

8. Werner D, Saunders D. Questioning the Solution: The politics of Primary Health Care and Child Survival. California: Health Wrights; 1997

9. KwaZulu-Natal Department of Health. Annual report 2003/2004. Pietermaritzburg 2004

10. South African National Department of Health. Mapping Gaps in Primary Health Care Service Delivery in KwaZulu-Natal. Centre for Health Systems Research & Development. University of Free State. Bloemfontein: 2003

11. USAID, the American People. Infectious Diseases. Global TB Control: World Health Organization Report 2006. Available at http:www.usaid.gov/our work/global health/id/tuberculosis/countries /Africa/safrica Down loaded on 2008. 10.17

12. Republic of South Africa. Department of Health. Tuberculosis Strategic Plan For South Africa, 2007 - 2011

13. South Africa. National Department of Health. Dr M.E. Shabalala-Msimang, The National Health Minister. Celebration of National Tuberculosis Day. 2006.03.24. Speech on the Launch of South African TB Crisis Management Plan. King George V Hospital, Durban; 2006

14. KwaZulu-Natal Department of Health. Quarterly Report (Quarter 3). Area 1. eThekwini District. Durban. 2006

15. KwaZulu-Natal Department of Health. Quarterly Report (Quarter 2). Area 1. eThekwini District. Durban. 2007

16. KwaZulu-Natal Department of Health. (2007) eThekwini District Health Plan 2008/2009. Durban. 2007

17. O'Connor R.W. Managing Health System in Developing Areas. Canada, USA. 1998

18. Mc Coy D and Engelbrecht B. Establishing the District Health System. South

African Health Review. Durban: Health Systems Trust. 1999

19. The National Health Act no. 61. 2003. South Africa.

20. South Africa National Department of Health. Health Facilities Definitions. Pretoria. 2006

21. Collins C. Management and Organization of Developing Health Systems Oxford: Oxford University Press; 1994

22. Bossert T. Analyzing the Decentralization of Health Systems in Developing Countries: Decision Space, Innovation and Performance. Social Science Medicine Vol. 47. 1998

23. Van Rensburg H.C.J. Health and Health Care in South Africa. Pretoria: Van Schaik; 2004

24. Magnussen L, Ehiri J and Jolly P. Comprehensive Versus Selective Primary Health Care: Lessons for Global Health Policy. Health Affairs. The Policy Journal for Health Sphere, 23 no. 3 (2004): 167 - 176. Available at http://content.health affairs.org/cgi/content/full/23/3/167. Down Loaded on 17.10.2008

25. http://www.primary health care.uct.ac.za/approach/background/background.htm. Down loaded on 17.10.2008

26. Haynes R and Hall W. District Health System and Local Government Development. South African Health Review. Health System Trust. Durban: 2002

27. Hall W, Ford-Ngomane T and Barron P. The Health Act and the District Health System. South African Health Review. Health Systems Trust.

Durban: 2005

28. World Health Organization. Health Systems: Improving Performance. World Health Report. Geneva. Switzerland. 2000

29. KwaZulu-Natal Department of Health. Hospital Service delegations. Pietermaritzburg. 2003

30. Swanepoel B, Erasmus B, van Wyk M, Schenk H. editors. Second Edition. South African Human Resource: Management Theory and Practice. Cape Town: Juta; 2000

31. Smit P.J. & Cronje G.J. de J et al. Management Principles: a contemporary edition for Africa. Second Edition. Kenwyn: Juta; 1997.

32. World Health Organization. Regional Publications, Western Pacific Series No. 22. District Health Facilities. Guidelines for Development and Operations. 1998

33. Cloete J.J.N. Administration and Management of Health Services. Pretoria: Van Schaik; 1993

34. Public Finance Management Act. (No. 1 of 1999 as amended by Act No. 29 of 1999. South Africa

35. South Africa. A Hand Book for Clinic/CHC Managers. National Department of Health. 2000

36. KwaZulu-Natal Department of Health. Clinic Supervision Policy. 2001

37. Sewnath S. Role Clarification on Management of Clinics in South Service Area: Proceedings of the eThekwini District Management Meeting; 2007 December 21.

eThekwini District Office. Highway House, Mayville Durban

38. South Africa. The State of the Nations Address. President T. Mbeki. February 2006. Pretoria

39. KwaZulu-Natal Department of Health Circular Minute No. G44/2002. Reference 4/1//3/1. Clinics in Durban Umlazi Area (Part B)

40. A Research Report. July 2001. Investigating the Roles and Functions of Clinic Supervisors in Three Districts in the Eastern Cape Province. Durban: Health Systems Trust. July 2001. Available at www.hst.org.za

41. Bell R, Ithindi T and Low A. Improving equity in the provision of primary health care: lessons learnt from decentralized planning and management in Namibia. Bulletin of the World Health Organization 2002,80. 2002

42. Chukwuani C, Olugboji A, Akuto E.E, Odebunmi A, Ezeilo E, Ugbene E. A Baseline Survey of Primary Healthcare System in South Eastern Nigeria. Health Policy 77. 2006

43. Mercer A, Khan M.H, Daulatuzzaman M, Reid J. Effectiveness of an NGO primary health care programme in rural Bangladesh: Evidence from the Management Information System.2006

44. KwaZulu-Natal Department of Health. The Proposed New Structure for eThekwini District Primary Health Care Clinics. 2007

45. Supportive Supervision to Improve Integrated Primary Health Care. Occasional Papers. Management Sciences for Health. 2007

46. Denzin N.K. and Lincoln Y.S. Hand Book of Qualitative Research. California: Thousand Oaks; SAGE Publications 1994

47. South African Population Survey 2006. Statistics South Africa

48. Patton M. Q. Qualitative evaluation and research methods. Second Edition. Newbury Park: CA; 1990

49. Ulin et al. Qualitative Methods: A Field Guide for Applied Research in Sexual and Reproductive Health. Family Health International. 2002.

50. Knodel J. The Design and Analysis of Focus Groups Studies. In D.L.Morgan (ed). Successful Focus Group Newbury Park: Sage; 1993

51. Silverman D. Doing Qualitative Research. A Practical Hand Book. London: Sage; 2000

52. Mays N, Pope C. Qualitative research in health care: Assessing Quality in Qualitative Research. British Medical Journal Volume 320 p50 -51. 2001 Downloaded on 2005.02.18. Available at:http://bmj.com/cgi/content/full/320/7226/50

53. Decentralization and Health System Reform. Insight for Implementers. Partners for Health Reforms plus. 2002

54. Encarta World English Dictionary. 1999. Bloomsbury Publishers, London

55. Searle C and Pera S. Second Edition. Professional Practice. A South African Nursing Perspective. Butterworth; 1994

56. Covey S. The Seven Habits of Highly Effective People. Fireside: USA; 1990

57. Dorros G.L. Building Management Capacity to Rapidly Scale Up Health Services and Health Outcomes, pi9 - 26. 2006

58. Filerman G.L. Closing the Management Competence Gaps. Commentary. Human Resources for Health. Georgetown University. Washington DC. 2003 Available at http://www.human -resources-health.com/content/1/1/7

59. Perumal A. Clinics Financial Status: Proceedings of South Service Area Primary Health Care Meeting. 2007.10.19. Amawele Office, Umlazi. Durban

60. South Africa. Constitution of Republic of South Africa 1996. Pretoria

61. KwaZulu-Natal Department of Health. eThekwini District. South Service Area Community Imbizo. 2006.10.27. King Zwelithini Stadium, Umlazi Township. Durban

APPENDIX 01

JOB DESCRIPTIONS - MUNICIPAL, STATE SUBSIDIZED AND PROVINCIAL CLINICS

NORTH LOCAL COUNCIL

JOB DESCRIPTION

COUNCIL	NORTH LOCAL COUNCIL
JOB TITLE	PROFESSIONAL NURSE
DEPARTMENT	COMMUNITY SERVICES
BRANCH	HEALTH
DIVISION	CLINICAL SERVICES
SECTION	NURSING
INCUMBENT	
LOCATION	
SUPERVISOR	SPNANDCPN

PURPOSE OF THE POST

The development provision and implementation of extensive, efficient and effective Primary Health Care Nursing Service within the North Local Council.

REQUIREMENTS FOR THE POST

Personnel Administrative Standards
Condition of service are laid down by the employing body, and this includes any agreement made between the North Local Council and the KZNPA Health Department. To be registered with the South African Nursing Council.

QUALIFICATIONS

Registered Nurse and Midwife.
Community Health Nursing is a recommendation.

SKILLS

Good organisational, teaching, leadership and communication skills.

PERSONAL ATTRIBUTES

Mature, responsible with good interpersonal relationship.
Jn possession of a valid drivers licence.
Willingness to travel.

COMMUNICATION CHANNELS

Throuch the SPN to the CPN to the NSM to the Assistant Director.

SUMMARY OF DUTIES

Implementation of effective of PHC service.
Monitoring of health status of the community.
Provision and treatment of minor illness and injuries.
Prevention of Communicable Diseases.
Keeping and submission of accurate records and statistics.

WORKING CONDITIONS

Post is clinic based, however, it involves travelling to sub clinics, hospitals, home visiting, mobile clinic posts in informal settlements, and fonner Section 30 Areas and attendance of courses at other centres.

RISKS

Entering areas of unrest and violence.
Possible exposure to Communicable Diseases.
Accidental exposure to HIV eg. needle stick injury.

DETAILED JOB DESCRIPTION

Management Process

Carry out in a responsible manner all duties assigned by the supervisor.
Manage tasks of subordinates, ie. SASO, ENA, EAN.
Ensure correct growth monitoring of children.
Effective health education is given.
Ensure effective immunisation.
Ensure effective FP service is rendered to clients.
Ensure that the motivation of the community to utilise the PHC service is effective.
Ensure that subordinates function according to the scope of practise.
Ensure that the personnel are developed to their full development.

PERSONNEL DEVELOPMENT

Orientation and Induction of Subordinates Appointed.

Orientate staff members according to standardised programme.
Assess progress of new subordinates.
Communicate these learning needs to the CPN.
Provide subordinates with feedback about performance.
Write up and submit the reports of incumbent on probation.

Identify Training and Learning Needs

Assess learning needs of subordinates and self.
Communicate the learning needs to the CPN.
Conduct performance appraisal, interviews regularly.
Write up subordinates, supervisors reports following this interview.
Nominate subordinates for merit awards, when functioning is sustained at an excellent level.

UTILISE STRENGTHS AND TALENTS OF PERSONNEL

Identify specific skills and talents of individuals.
Delegate subordinates tasks according to skills and talents.
Develop skills and talents through encouragement and training.
Assess subordinates functioning.
Keep up to date regarding knowledge, trends and philosophy regarding nursing matters.
Documentation of incidents for herself and her subordinates.
Conduct nursing research.

COORDINATION AND CONTROL OF RESOURCES

Transport

Check that regular maintenance and service is carried out, tyre pressure, radiator, water and oil.
Report any malfunctioning of ^he vehicle.
Record kilometres travelled daily.
Correctly complete requisitions for petrol and repairs.
Report and complete documentation of all damages and collisions incurred by self or subordinates.

Statistics

Completion of daily attendance record.
Analyse and interpret daily attendance records.

Equipment

Clean and store equipment according to recommendations/procedure manual.
Utilise equipments for correct purposes.

CLINICAL FUNCTIONS

Plan and Present Effective Health Education
Bring expressed Health Education needs of the community to the notice of the CPN.
Participate in planning through health education at the clinic.
Present group health education at the clinic.
Identify individual health education needs.
Provide individuals with health information.
Participate in evaluation of the effectiveness of health education.

Provide Parental Guidance about Children Health Needs

Identify learning needs of individuals and groups within the community.
Identify cultural parenting practices and record these in community profiles.
Give appropriate advice and guidance to individual parents especially on nutrition and basic child care.
Organise groups of parents to discuss parenting skills.

Assess **Developmental Progress of Children attending Clinic**

Obtain an adequate history of ant-natal birth and development of the child.
Assess child according to task analysis.
Provide advisory service on parenting and stimulation for the child's age tothe parent or the care giver.
Identify developmental problems and offer referrals to appropriate agency.

Provide a Family Planning Services

Educate and motivate individuals and groups to space pregnancies.
Obtain history screen and prescribe contraception according to task analysis, protocols and individual needs.
Motivate women about the need for annual general physical examination and cervical screening at regular intervals.
Use task analysis for physical examination and taking of cervical smears.
Counsel individuals and couples about sterilisation and completion of their families.
Counsel families of retarded individuals on sterilisation.
Prepare individuals preoperatively for sterilisation.
Book clients for sterilisation recording to local procedure.
Organise transport to and from the hospital if required.

Provide adequate ante- natal care

Educate the community about the need for antenatal care.
Provide individual and group education to antenatal clients.
Provide antenatal care according to SANC and Provincial Health Services Guidelines.
Make appropriate and timeous referrals according to protocols.

Provide an effective Counselling Service

Guided by clients rights and needs, provide a confidential counselling service.
Refer individuals to appropriate agencies when necessary.

Assist in compilation and updating of the community profile

PREVENTATIVE HEALTH SERVICE

Provide an Effective Health Education Service

Identify hazards within the geographical area, record these in the community profile.
Educate groups about hazards, healthy habits, protection against infectious diseases present in the community.

Provide an Effective Immunization Service

Order vaccines needed to maintain adequate stock.
Ensure correct storage of vaccines as per task analysis.
Prescribe vaccines as per schedules.
Administer vaccines as per task analysis.
Record vaccines given on Child Health Care and central sheet.

Provide an Effective Screening Service against Cervical and Breast Carreer

Educate the community about the predisposing factors of cervical cancer.
Educate groups and individual women re - breast examination
Provide a services for general examination of women.

Provide Accurate Diagnosis and Treatment for Common and Minor Ailments

Obtain an adequate history from client and /or family.
Undertake the necessary examination for the client.
Make a diagnosis and select intervention.
Refer clients beyond the Professional Nurses scope or if requiring further investigation to the nearest appropriate medical service.
Prescribe appropriate and adequate medication where necessary,
Dispense medication with full instruction and expected outcome of treatment.
Record prescribed medicatior as per legal requirements.
Record diagnosis and treatments as per legal requirements.
Provide appropriate information in the prevention and/or limitation of the condition.
Notify infectious diseases to the appropriate Health Officer.

Provide regular Out Patient treatment for Tuberculosis Sufferers

Incorporation with the S.A.N.T.A, SASO, FOSA obtain DOT supervisors in the community.
Identify clients with possible TB, conduct pre - treatment investigation and diagnose.
Assess TB clients monthly.
Provide individual and group health education on identification, prevention and treatment of TB.
Screen all close contacts of TB clients.
Carry out the necessary investigations during treatment and on completion of treatment.

Provide Prophylactic Treatment to Contacts under Two years of age and Two to Five years

Identify close child contacts of TB clients.
Prescribe prophylactic Treatmont as per schedule for contacts.
Carry out investigations when necessary.
Educate parents/care givers on prevention of TB and signs and symptoms of the disease.

Provide Syndromic Management and Treatment of Sexually Transmitted Diseases

Educate community groups about signs and symptoms, prevention and treatment.
Diagnose and prescribe treatment using syndromic approach.
Counsel clients to inform sexual partners, give contact cards for partners.
Offer individual clients condoms, educate clients on their use.
Educate clients about transmission and prevention of HIV.

Monitor and Control the Outbreak of Communicable Disease and implement the Disease Surveillance Procedure

Provide regular follow up medication for Psychiatricaiiy 111 Clients

Dispense medication as prescribed by Psychiatric Service.
Observe client and enquire about possible side effects to the medication.
Refer clients back to Psychiatric Service for regular assessment when necessary.

Provide Food Supplement according to Department Policy

Educate the community about the signs and symptoms of malnutrition.
Identify children under 5 years, pregnant and lactating women, chronically ill and geriatric client with protein energy malnutrition and malnourished.
Issue available food supplement as per Departmental Policy.
Keep records of clients supplied with supplements, also record issue on growth chart and carrier card.
Provide parent/care giver with nutritional information.
Introduce self help schemes to the community eg. food gardens.

PROVISION OF REHABILITATIVE SERVICE

Provide screening service and referral for clients

Identify community resources which provide rehabilitation services. Keep a community resource file up to date with this information.
Stimulate interest among community leaders and health workers, where there are no services.

MANAGEMENT AIDS

Health Act 1977 (No. 63 of 1977) and Regulations.
Nursing Act 1978 (No. 60 of 1978 and relevant amendments) and regulations.
Medicine and Related Substances and Control Act 1965 (No. 101 of 1965)
The National Health Care Plan and Reconstruction and Development Plan Document (R.D.P).
Government Vehicle Books including relevant Transport Circulars.
The Health and Welfare matter Amendment Act 1993 (No. 118 of 1993)
Procedure Manual
Personnel Assessment Questionnaire Manual.

BEKIMPILO TRUST
JOB DESCRIPTION

Job Title : Professional nurse

Administrative Duties

1- Implementation of organisation's policies and procedures
2- Setting of standards for jhe procedures
3- Monitors staff time book
4- Delegation of personnel according to their scope of practice
5- Control of day to day operation of the services
6- Arrangess the leave roster in consultation with the staff
7- Ordering of stock, i.e. equipment, dispensary and surgical sundries
8- Inventory taking, check if all equipments are in good workig order
9- Attends meetings, workshops and updates, and cascade information to the rest of the team
10- Manages conflict that may arise, i.e. personnel or staff vs clients or client vs client
11- Liaise with multisectoral personnel to identify available resources
12- Safe keeping of equipment, drugs and keys
13- Applies (in a polite manner) discipline to personnel and clients
14- Handling and forwarding of grievances accordingly
15- Compiling of reports, i.e. monthly, quartely, annually or if need arise
16- Compiling of monthly statistics
17- Keeping of all relevant records

Supervisory Duties

1- Supervises day to day operation of services: Assess, Plan, Implement and Evaluate
2- Implementation of TB DOTS programme
3. Supervises clients for DOTS
4. Establishes and supervises community development projects in the unit
5. Monitors environmental hygiene
6. Monitors proper medical waste disposal
7. Wearing of proper uniform at all the time
8. Stock control
9. Following of standards, protocols, standing orders and procedures

Community Health Work

1. Establishes and maintains good relationships wit the staff, key figures in te area, school and community at large
2. Prepares for the day's work :
   - set cooler box with enough vaccines for the day
   - set all functional trolleys, eg. family planning; immunisations; STIs management and dressings
3. Post - Natal care, i.e. Mother and Child - Physical examination and education
4. Monitors babies' growth and development
5. Administers immunisations
6. Motivates clients for Family planning
7. Prescribes medications according to Section 38A of the Nursing Act No. 50 of 1978 as amended
8. Administers family planning methods as per client's choice if not contra-indicated

KZN DEPARTMENT OF HEALTH
JOB DESCRIPTION

JOB INFORMATION SUMMARY:

A.4 **Job / Domestic Title** : Primary Health Care Sister-in-charge

A.S **CORE Title** : Nursing & Support Personnel

A.6 **Occupational Classification (consists of CORE Code and Occupation)**

CORE Code **:**

0	4	6	1	0	0	0	0

Occupation **:** Professional Nurse

A.7 **Safjry Level** **:**

A.8 **Jo^Domestic Title of Supervisor's post:** Matron

A.9 **Salary Level of Supervisor's Post**

A.13 **Working Conditions / Environment:**

B. **PURPOSE OF THE JOB:**

To co-ordinate professional nursing services at a Primary Health Care (preventative, promotive, and curative) level at——Clinic (or for the——district) to contribute towards the good health of the community

KEY **RESPONSIBILITIES / MAIN OBJECTIVES OF** THE JOB:

£ 33CS*

Plan and organise services and resources to ensure cost effective use of resources:

- Assess staff requirements based on workload and contribute towards maintaining adequate staffing levels
- Maintain adequate appropriate equipment, supplies, medicines and transport
- Maintain safe and hygienic facilities which promote the provision of health care

2. Maintain appropriate effective primary health care nursing based on current legislation, standards and guidelines, and scientific nursing principles

- Research current practices, locally based standards etc.

Utilise guidelines from the Oept. of Heajfli

Consult with relevantroie players with regard to appro riate standards

Communicate 6$^rertinjpdates with regard to primary health care practice to all rfjpvant role players, ihursingjstandards and care and implement appropriate remedial action where required.

3. Develog impl monitor the human resource development programme for nursing staff in consulfStion witjj role player

Implemint Oriejlaiielllfid Induction Programme for nurses

Preparpa situational analysis with regard to existing competencies

- Assess requirements for nurse development based on needs of the patient as well as the developmental needs of the nursing staff
- Develop the human resource development programme based on requirements
- Implement programme
- Monitor appropriateness of human resource development programme for nurses and evaluate success thereof
- Review human resource development programme to ensure that the identified patient needs are being addressed.

4. Manage the primary health care budget at — clinic.
5. Maintain relationships with appropriate organisations and relevant role players to ensure a multidisciplinary approach to primary health care.
6. Implement the Occupational Health and Safety Act as applicable.
7. Maintain appropriate equipment.
8. Carry out performance evaluation of nursing staff.
9. Apply sound and fair Labour Relations measures as prescribed by Head Office and the Labour Relations Act

D. KEY RESULT AREAS , KEY ACTIONS, PERFORMANCE INDICATORS:

KEY RESULT AREA (KRA)	TARGET DATE	KEY ACTIONS	PERFORMANCE INDICATOR (Only ONE per KRA)
KRA 1 Review poiicy and procedure manuals To ensure adherence to current Legislation and nursing practices	31.7.2001	1. Research current standards of primary health care to establish appropriate standards 2. Review policy and procedure manuals to assess compliance ,*wM0* 3. Ensure that policy .amk^^JdiM manuals are updated	1 Up-to-date poiicy and procedure manuals
KRA 2 Develop a system / mechanism to ensure that staff are kept informed of *jm* current changes j o ^ ^ ^ h K h cai W1 •*&	31^J0jyW	1. Consult witrjj|>le pfeyeif to elic fisugQ^tions H Develop aJra%solutioi|for imrJPrienting the education fegramme *m* keel staff ||onnec|pf changes. *m* Liaise wJpgSSS^ayeril pps***^ ||Describ|ffinal sy^fem /mechanism in written document	2 Developed system which will ensure that staff are kept informed of changes In primary health care practices
			3

KEY RESULT AREA	TARGET DATE	KEY ACTIONS	PERFORMANCE INDICATOR (Only ONE per KRA)
KRA 4			4
KRA 5			5
KRA 6			6

APPENDIX 02

INTERVIEW GUIDE

Interview Guide

(The same interview guide will be used for all key informants. The responses and unique codes shall indicate which responses belong to which key informanti.

The Principal Investigator will administer the interview and circle the appropriate answers below

SECTION A: DEMOGRAPHIC/CONTEXTUAL INFORMATION

Position in Clinic Management	Sister-In-Charge Clinic Supervisor PHC Coordinator Program Manager None
Duration in current position	< 1 year 1 - 3 years 3 - 5 years >- 5 years
Age	<30 30 - 40 41 - 50 51 - 60 61 - 70 > - 70
Qualification	Diploma in PHC Certificate in PMC Diploma/Degree in CHN Diploma/Degree in NAd.
Location	PHC Clinic CHC (support) Hospital (support) District office
Clinic governance	Province Local Municipality State subsidized Org.

Key : NAd. - Nursing Administration
CHC - Community Health Centre
CHN - Community Health Nursing Science
Org. - Organization
PHC - Primary Health Care
PMC - Primary Medical Care

SECTION B.

1. What are the major demands of health se vice delivery at clinic level?

2. a) What do you think are the managemei t roles and functions required at the clinic level in order to meet the above demands a id deliver an effective PHC service?
(Space below is for the researcher to ta ce notes)

b) Follow-up: Can you elaborate on an; of these roles and functions?

3.What has been your experiences with r gard to current management at Emaphephetheni clinic / Bhekimpilo clini: / Verulam clinic?

4.Do you think the management roles and unctions you mentioned earlier are fulfilled at Emaphephetheni clinic / Bhekirr pilo clinic / Verulam clinic?

5. If not, which management roles and fur :.tions do you think are not fulfilled, and substantiate

6. In your opinion what would you recorr ivend to enable the Sister In Charge to fulfil the management roles and functions?

Thanks for youfZ'ommitment

APPENDIX 03

FOCUS GROUP DISCUSSION GUIDE

FOCUS GROUP GUIDELINES

CLINIC NURSES

- What are the clinic nurses experiences with regards to management roles and functions of the Sister In Charge
- Do the clinic nurses see the Sister In Charge fulfilling her/his management roles and functions?
- What management roles and functions do they expect the Sister In Charge to fulfil?
- What would be the hindrances to the Sister In Charge fulfilling her/his management roles and functions?
- What recommendations would be made to enable the Sister In Charge fulfill his/her management roles and functions.

SISTER - IN - CHARGE

- How do the Sisters- In Charge see PHC clinic management
- How do the Sisters- In Charge describe the ideal management roles and functions of PHC clinic management
- What are the work experiences of PHC clinic Sister In Charge - both negative and positive?
- Does the Sisters In Charge see themselves fulfilling their role of clinic management completely? If not, where do they think they fall short?
- What would be the contributory factors to the shortfall according to them?
- What would the Sisters In Charge recommend to get their management roles and functions completely fulfilled?

CLINIC SUPERVISORS

- How do the clinic supervisors see PHC clinic management
- How do the clinic supervisors describe the expected roles and functions of PHC clinic management?
- How do the clinic supervisors view the reception of clinic service by the community
- Do the clinic supervisors see the Sisters In Charge fiilfilling their role of clinic management completely? If not, where do they think they fall short?
- What would be the contributory factors to the shortfall according to them?
- What would the clinic supervisors recommend to get the Sisters In Charge management roles and functions completely fulfilled?

APPENDIX 04

ETHICAL APPROVAL

UNIVERSITY OF
KWAZULU-NAL

16 August 2005

Mrs V N Shandu
eThekwini District Office
Private Bag X54318
Durban 4000

e-maii: h001378@dohho.kzntl.gov.za

Dear Mrs Shandu

PROTOCOL : Examining the management roles and functions of the clinic Sister-in-Charge in the eThekwini South sub-district. V N Shandu, Community Health. Ref.: H096/05

The Postgraduate Education Committee considered the abovementioned application and made various recommendations. These recommendations have been addressed and the protocol is approved for your MPH degree.

May I take this opportunity to wish you every success with your study.

Yours sincerely

1. *'JUS-**

PROFESSOR M ADHIKARI
Chair: Postgraduate Education Committee

c.c. Ms A Voce, Community Health.
Mr S Siboto, Postgraduate Education

Nelson R Mandela School of Medicine, Faculty of Health Sciences,
Medical Research Administration

Postal Address: private Bag 7, Congella 4013, South Africa

lone: +27(0)31260 4495 **Facsimile:** +27(0)31260 4529 **Email:** borresen@ukzn.ac.za **Website:** www.ukzn.ac.za

ng Campuses: **BBS Edgewood** EBB **Howard College** **Medical Srhnni**

UNIVERSITY OF
KWAZULU-fMATA

16 August 2005

Mrs VN Shandu
eThekwini District Office
Private BagX54318
Durban 4000

e-mail: h001378(a>dohho.kznti.gov.za

Dear Mrs Shandu

PROTOCOL : **Examining the management roies and functions of the clinic Sister-in-Charge in the eThekwini South sub-district. V N Shandu, Community Health. Ref.: H096/05**

The Biomedical Research Ethics Committee considered the abovementioned application and the protocol was approved at its meeting held on 3 May 2005 pending appropriate answers to queries raised, translation into isiZulu of the Information to Participants and Informed Consent documents and approval from the Postgraduate Education Committee. These conditions have now been met, the study is given full ethics approval and may begin as at today's date : 16 August 2005.

Please ensure that letters of permission are obtained from the eThekwini Municipality and the Department of Health before the study begins. Copies of these letters must be forwarded to this office.

This approval is valid for one year from 16 August 2005. To ensure continuous approval, an application for recertification should be submitted a couple of months before the expiry date.

May I take this opportunity to wish you everything of the best with your study. Please send the Biomedical Research Ethics Committee a copy of your report once completed.

Yours sincerely

PROFESSOR A DHAI
Chair: Biomedical Research Ethics Committee

c.c. Ms A Voce, Community Health.
MrS Siboto, Postgraduate Education

UNIVERSITY OF KWAZULU-NATAL

FACULTY OF HEALTH SCIENCES

MEMORANDUM

TO:	**FROM:**
Dr A Voce Public Health Medicine Nelson R Mandela School of Medicine	Debbie van Rooyen Postgraduate Administration Nelson R Mandela School of Medicine 10 July 2008

Dear Dr Voce

Master of Public Health MPH
Title: "Examining the management roles and functions of the clinic Sister-In Charge in the Ethekwini district" Shandu SV, H 096/05
Supervisor: Dr A Voce
Department of Public Health Medicine

On the 01 July 2008, the Postgraduate Education Committee suggested and approved the title change from:
Examining the management roles and functions of the clinic Sister-In Charge in the Ethekwini district.
To
Examining the management roles and functions of the Registered Nurse - in Charge in the Ethekwini district.

Many thanks,
Yours sincerely

Debbie van Rooyen

Postgraduate Administration

cc Mrs VN Shandu

APPENDIX 05

PERMISSION LETTERS TO CONDUCT THE STUDY: MUNICIPAL, STATE-SUBSIDIZED AND PROVINCIAL CLINICS

#£KIMPILO 1RUST

P. O. Box 65
New Germany
3620
03 August 2005

To Whom It May Concern

This is to confirm that Ntsiki Shandu is granted permission to conduct a study at Hiengimpilo Unit (clinic) for the period that will suit her requirement.

We will appreciate feedback at the end of the study for us to improve where we need to.

ThankiiigYou

S.A.Ndamane K o ^ ^ ^ ' K<^W Setf*Xe

PROVINCE OF KWAZULU-NATAL

E\k -C3- 2 4

District Office : eThekwini
Office of the District Manager
Prince Wing - cnr Prince Street and Hospital Road - Durban 4001
Private Bag X54318 - Durban - 4000
Tel.: 031 3277801 - Fax 031 3321229
e-mail: h.952823@dohho.kzntl.gov.za

Enquiries: Mr T E Msiza

Date: 24 August 2005

Index: 388/08/05

Prof R W Green-Thompson
Superintendent-General
Department of Health
KwaZulu-Natal

REQUEST FOR APPROVAL OF RESEARCH PROPOSAL -VN SHANDU - PERMISSION TO CONDUCT A STUDY ON CLINIC MANAGEMENT IN eTHEKWINI DISTRICT

Ms V N Shandu - Deputy Director in the eThekwini District - would like to conduct the abovementioned research.

See attached:

a) Research Proposal
b) Ethics Committee Approval
c) Questionnaire (Interview Guide)
d) Consent from University of KwaZulu-Natal

The District supports her request.

Looking^fefward to your approval.

DEPARTMENT OF HEALTH
eTHEKWINI DISTRICT OFFICE
24 AUG 2005
DISTRICT MANAGER
P/BAG X54318 DURBAN 4000

T E MSIZA
DISTRICT MANAGER
eTHEKWINI

Approved/Not Applied

/M.**}0*

Prof R W Green-hompsc
Superintendent-General
Department of Health
KwaZulu-Natal

Date

Umnyango Wezempilo *Departement van Gesondheid*

Health Safety and Social Services Cluster
Health unit

P O Box 2443
Durban tOOO

Tel- 1031)300 3911
' Fax: (031)300 3030
Website' http:,'.'www.durban.org.za

Our Ref:

Ypur Ref:

Enquiries;

PERSONAL HEALTH SERVICES
(Clinical)
(Dr. R. Gajee)
Telephone: 300-3179

2005-08-29

Mrs. N.V. Shandu
C 831 Ntuzuma
P.O. Box 808
DURBAN, 4000

Dear Mrs Ntuii

RE- RESEARCH REQUEST ; EXAMINING MANAGEMENT ROLE AND FUNCTIONS OF CLINIC SISTER -IN- CHARGE IN THE ETHEKWINI NORTH SUB DISTRICT.

Permission is granted for the above study to be conducted at Redcliffe Clinic Please contact Sr Nishani Govender (032-5333431) or Mrs Yasmin Akbar (032-J533 3837) before you commence the study.

Please ensure that you adhere to our attached list of requireme nts.

Yours faithfully

U.Sanka
HEAD : HEALTH

A

APPENDIX 06

SUMMARY OF MANAGEMENT ROLES AND FUNCTIONS REQUIRED OF REGISTERED NURSES-IN-CHARGE AT CLINIC LEVEL

TABLE: SUMMARY OF REQUIRED MANAGEMENT ROLES AND FUNCTIONS AT CLINIC LEVEL

		POLICY DOCUMENTS						RESPONDENTS				
MANAGEMENT ROLE	MANAGEMENT FUNCTION	HB	PHCP	CPHCSP	CSP	JD	SR	CS	RNIC	CN	PHCC	PM
General Leadership and Planning	Develop clinic • Vision and mission • core values • operational plans	***S*** ^ ***S***	***S*** ***S*** ***S***	* * *	***V*** ***S*** ***S***	* * ***V***	* * *	* * ***S***	* * ^	* * *	* * *	* * *
Human Resource Planning and Management	**Recruitment, selection and appointment** • Know staff establishment and discuss vacancies • Ensure availability and access of District human resource policies on recruitment at clinic level.	^ *	***S*** ***V***	* *	* *	***V*** *	***S*** *	* *	^ *	* *	* *	^ *
	Orientation and Induction • Design, implement, monitor and evaluate orientation and induction programme for all new staff members	•	***S***	*	>/	***V***	*	*	^	*	*	*

	Staff development • Identify learning needs and skills required for the delivery of full package of primary health care service, through use of job descriptions and PHC service package document. • Plan,implement, monitor and evaluate training plan.	* * ^	* * S	* * *	* * S	* * V	* * S	* * V	S -/	* * *	* * *	* * *
	Performance Management • Draw job descriptions • Estimate workload • Delegate staff according to competence and scope • Monitor and manage absenteeism. • Keep staff files. • Evaluate staff performance • Ensure the availability and access to District human resource policies on grievance and disciplinary	S S * V * * *	V * * S •/ S S	* * * * * * *	V * * V •/ < *	* * * * * y *	* * S V *	* * * * * *	V * < S * * *	* * S V * * *	* * * * * * *	* * V * * * *

	procedures • Document disciplinary problems and copy to supervisor	</	</	*	***y***	*	*	*	*	*	*	*
SUPERVISION	**Patient Care** • Display Bathopele principles in local language. • Display Patients rights charter • Conduct in-service education to staff on Bathopele, patients rights and responsibilities • Manage clients satisfaction • Monitor and manage patients waiting times • Establish patients complaints management	•/ •/ * * ***V*** </	***S*** ***S*** * * * * *	* * * * * * *	* * * 	* * * * *	* * * * * * *	* * * * * * *	 	* * * * * * *	* * * * * * 	* * * * * *

	mechanism • Involve community through clinic committee	*S*	*S*	*	∧	*V*	*	*	*V*	*	*	*
	Service Delivery • Ensure that services are offered daily • Ensure that the clinic has a functional referral system • Ensure provision of services according to the comprehensive package of service. • Manage patient flow • Involve the community in the clinic plan • Involve community in implementation of the programmes support like DOTS , home based care etc. • Ensure availability and implementation of	•/ *V* * *S* * *y* *S*	*S* </ *V* •/ * * *v*	•/ •/ *S* * * * *	•/ *S* * * * * </	*S* * *V* * * * *S*	* * * * * ∧ *	* * * * * * *	* * * * * </ *	* * * * * * *	* * * * * * *	* * * * * * *

	clinical protocols • Keep a schedule, register and report of supervisory visits which is discussed with staff.	*V*	*V*	*	*V*	*	*	*	*	*	*	*
ADMINISTRATIVE ROLE	Resources • Ensure uninterrupted availability of pharmaceuticals and other supplies. • Ensure availability of good working and adequate relevant equipment. • Submit weekly transport plan through supervisor to support institution. • Monitor plan, utilization and transport running cost. **Facility** • Ensure a well maintained facility. • Ensure uninterrupted communication through two way radio	•/ </ *S* </ *S* *S*	*V* *S* *S* *S* •/ </	* * * * * * *	./ *S* *S* *S* *S* *S*	*S* *V* * *V* ./ *	*S* •/ * * *S* *	>/ </ * * * *	^ *S* * * </ *	* * * * * *	* * * * * *	* * * * * *

S

	and official use of telephone.											
	Finance • Establish clinic team to conduct cash flow meetings to monitor monthly expenditure and institute control measures.	^	*S*	*	>/	*V*	*	*	*	*	*	*V*

Key:

HB	: Hand Book for Clinic/CHC Managers
PHCP	: Primary Health Care Package
CPHCSP	: Comprehensive Primary Health Care Service Package
CSP	: Clinic Supervision Policy
JD	: Job Description
SR	: Supervisor's Report
CS	: Clinic Supervisor
RNIC	: Registered Nurse-In-Charge
CN	: Clinic Nurse
PHCC	: Primary Health Care Coordinator
PM	: Programmes' Manager

APPENDIX 07

DECISION SPACE IN MANAGEMENT ROLES AND FUNCTIONS OF CLINIC REGISTERED NURSES-IN-CHARGE AT CLINIC LEVEL

TABLE: DECISION SPACE IN MANAGEMENT ROLES AND FUNCTIONS OF CLINIC REGISTERED NURSE-IN-CHARGE

MANAGEMENT ROLE	**THEORETICAL FUNCTION**	**Degree of Decision Space in relation to level of responsibility**		
		Involvement (Narrow)	Responsibility (Moderate)	Authority (Wide) "
General Leadership and Planning	**Leadership**			
	1. Setting the direction			
	- Challenging the status quo	None	None	None
	- Making choices and decisions	None	None	None
	- Creating a vision and strategies	Yes but not linked to leadership role	None	None
	2.Aligning people			
	-Communicating the direction to all stakeholders	None	None	None
	3.Motivating and inspiring			
	- Appealing to the values of the organization	None	None	None
	- Allowing autonomy and space	Motivation not linked to leadership role	None	None
	- Encouraging and rewarding excellence (28).	None	None	None
	- Influencing people (26)	Yes	None	None
	- Policy making and interpretation (22).	None	None	None
	Planning			
	1. Situation assessment including community needs and service needs	None	None	None
	2. Priority setting	None	None	None
	3. Development of goals and objectives to achieve priority needs.	None	None	None
	4. Development of monitoring and	None	None	None

	evaluation tool (28).			
Human Resource Planning and Management	**Personnel Provisioning**			
	1. Designing human resource policy	None	None	None
	2. Organizing work, including division of work, delegation of duties and communication strategy through job descriptions	None	None	None
	3. Secure budget for personnel and provisioning	None	None	None
	4. Keeping of every staff file accurately	Yes	None	None
	5. Post creation for new services or establishment review (30).	None	None	None
	Recruitment, selection and appointment			
	1. Knowledge of staff establishment.	Yes	Motivate for the filling of vacant posts	None
	2. Ensure the availability of district human resource policies on recruitment (29).	None	None	None
	3. Recommend adequate staffing levels.	None	None	None
	4. Identify duties, skills and requirements for the job.	None	None	None
	5. Develop or review existing job description	None	None	None
	6. Prepare job requisition (advertisement)	None	None	None
	7. Submit job requisition and description to manager for approval (26).	None	None	None
	8. Participate	None	None	None

	throughout the selection process (departmental recruitment and selection policy).			
	Performance Management 1. Performance planning - Outline organizational and unit vision and mission - Define roles and duties through job description - Establish and agree on goals and performance standards 2. Performance managing - On going maintenance of progress - Mentoring and coaching - Managing absenteeism - Counseling - Giving feedback 3. Performance review - Review outputs and outcomes against set and agreed performance standards. - Developing intervention action plan according to identified shortfalls 4. Human Resource department application - Maintenance of consistent discipline.	None Yes None None None Record absent staff Yes None None None Limited to politely correcting an individual. Disciplinary procedure not applied.	None None None None None Report to supervisor Refer further problems to supervisor None None None None	None None None None None None None None None None

	-Training and development(26) - Implementing Occupational Health and Safety Act (30).	General, not performance specific None	None None	None None
	Staff development 1. Design, implement, monitor and evaluate orientation programme for all new staff members 2. Identify learning needs and skills required for job output and outcomes 3. Plan, implement, monitor and evaluate staff development programme plan (29)	Yes but not evaluated Yes Yes but not evaluated	Yes Yes Yes	None None None
Financial management	**Budget preparation** - Prepare budget according to business plan. **Budget implementation and monitoring** - Spend the allocated budget according to budget plan (30). - Establish and maintain clinic cash flow committee. - Monitor monthly expenditure category by category and institute control measures.	None None None None	None None None None	None None None None

Supervision	**Governance**			
	1. Facilitate community participation in planning, monitoring and evaluation of service delivery	None	None	None
	2. Conduct in-service training on Batho Pele, patients' rights and responsibilities to staff	Yes	Yes	None
	3. Include Batho Pele, patients' rights and responsibilities in patients education programme	Yes	Yes	None
	4.Display Batho Pele, patients' rights and responsibilities posters in local language (29).	Yes	Yes	None
	5. Ensure patients satisfaction	Yes, but done per individual clinic tool whilst waiting departmental tool	Yes	None
	6. Monitor and manage patients waiting times	Individual clinics use own tools whilst awaiting district tool	Yes	None
	7. Establish patients complaints mechanism	Yes	Yes, resolves complaints at clinic level	None
	8. Ensure community involvement and participation through functioning clinic committee (29).	Yes	Yes	None
	Service Organization			
	1. Ensure that clinic has a functional referral system.	Yes, limited to knowledge of referral CHC's and hospitals	Yes	None
	2. Ensure provision of services according to the comprehensive package of service daily in a supermarket	Limited to motivation for resources according to gaps in comprehensive	None	None

	approach	package		
	3. Manage patients' flow (29).	Yes	Yes	None
	4. Coordination of services in various units through meetings with unit heads.	None	None	None
	5. Develop clear organizational communication strategy.	None	None	None
	6. Ensure good public relations internally and externally (30).	Yes externally	None	None
	Clinical Governance			
	1. Ensure the availability and implementation of clinical protocols and procedures (29).	None	None	None
	2. Ensure adherence to clinical protocols through clinical audits and record reviews (27).	Minimal adherence ensured through in-depth programme review	Minimal implementation of intervention	None
	3. Keep a schedule, register and report of supervisory visits, which are discussed with staff (32).	None	None	None
	4. Ensure implementation and adherence to quality control measures like risk management and infection prevention and control policies.	Limited to infection control	Minimal Implementation of interventions	None

Administration	**Resources**			
	-Ensure uninterrupted availability of pharmaceuticals and other supplies	Yes	Yes	None
	-Ensure availability of good working and adequate relevant equipment.	Yes	Yes	None
	-Submit weekly transport plan through supervisor to support institution.	None	None	None
	-Monitor plan, utilization and transport running cost (29).	None	None	None
	- Ensure uninterrupted communication- through two way radio and official use of telephone.	Yes	Yes	None
	Facility			
	- Ensure a well maintained safe facility	Yes	Yes	None
	Information management			
	- Participate actively in the establishment, implementation, evaluation and sustenance of community based Health Information Management System (5).	None	None	None
	- Ensure accurate collection, collation, analysis, interpretation of information and submission to higher level (29).	Limited to collection, collation and submission to higher level	None	None
	- Monitor organizational performance using information.	None	None	None
	- Manage information technology equipment like computers	None	None	None