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LEADERSHIP COMPETENCIES OF PRIMARY HEALTH CARE FACILITY MANAGERS AT BUFFALO CITY METROPOLITAN DISTRICT IN THE EASTERN CAPE PROVINCE.

By

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DECLARATION

I, Noxolo Beauty Makinana, declare that this dissertation is my original work and where other resources have been used or quoted have been acknowledged through complete referencing. I further declare that it has never been presented at any other institution to receive qualification.

Signed: **Date:** 09/10/2020

DEDICATION

This dissertation is dedicated to my family, my husband, and my three sons - Sive, Soso, and Siya for their patience, support, and assistance in the course of my studies.

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ABSTRACT

The study explored and described the perceptions and experiences of Primary Health Care facility managers regarding their leadership and management competencies in the Buffalo City Metro Health District in the Eastern Cape Province. The objectives of this study were to explore and describe the leadership competencies required for facility managers to exercise their leadership in Primary Health Care facilities and to bring about the recommendation. The population of this study comprised of facility managers who are appointed in facility management position permanently or on acting basis during the time of the study, in rural, urban, and semi-urban Primary Health Care facilities (clinics) in Buffalo City Health District. Non-probability convenience sampling was used to select the participants. Two focus group interviews with 10 participants per group were held to collect data. Thematic data analysis was used to analyze the data. The findings were discussed according to themes and subthemes. Four themes and 9 subthemes were identified from the data. Themes include departmental factors, individual factors, and political factors. The subthemes include managers lack of support, need for capacitation of staff, lack of uniformity in exercising leadership, work positions, infrastructure, staff shortages, lack of involvement in decision making, lack of resources, feeling of being a failure, not meeting expectation (workload) role of managers, pressure, the resistance of staff members to change, absenteeism, teamwork, compliance to policies, the 80/20 principle, nurse-patient ratio, and consultation. The trustworthiness of the findings was ensured by focussing on dependability, confirmability, transferability, and credibility. The study concluded that facility managers receive very limited supervision to perform their management duties in their facilities. They also need adequate resources, induction, training and a habitable work environment to ensure that quality care is provided. The study recommended that the Department of Health should have a program for supervision, mentorship, and guiding the facility managers in the Primary Health Care facilities. It should also establish a training and development program on leadership, finance management and technology. Lastly, there should be more accountability by facility managers at the different departmental levels i.e. national, province, district sub-district, and other internal and external stakeholders.

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LIST OF ACRONYMS

ANC	: Ante-Natal Care
ASELPH	: Albertina Sisulu Executive Leadership Program in Public Health
BCM	: Buffalo City Metropolitan Municipality
CCMDD	: Centralised Chronic Medicines Distribution and Dispensing
CHC	: Community Health Centre
DHS	: District Health System
HIV/AIDS	: Human Immuno Virus / Acquired Immuno Deficiency Syndrome
HRH	: Human Resources for Health
HST	: Health Systems Trust
IC	: Ideal Clinic
ICRM	: Ideal Clinic Realization and Maintenance
MDGs	: Millennium Development Goals
MEC	: Member of the Executive Council
NCS	: National Core Standards
NDP	: National Development Plan
NHC	: National Health Insurance
NHI	: National Health Insurance
NMM	: Nelson Mandela Metropolitan
OSD	: Occupational Specific Dispensation
PHC	: Primary Health Care
RPHC	: Re-Engineering of Primary Health Care
RTC	: Regional Training Centre
SA	: South African
SAHR	: South African Health Review
SD PPTICRM	: Status Determination by the Perfect Permanent Team for the Ideal Clinic Realization and Maintenance
SMART	: Specific, Measurable, Achievable, Reliable, Time Bound
SOPs	: Standard Operation Procedures
UN	: United Nations

WHO	: World Health Organization
WISN	: Workforce Indicators for Staffing Needs

SECTION B

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CHAPTER ONE: INTRODUCTION AND BACKGROUND

1.1 INTRODUCTION

This study sought to explore and describe the leadership competencies of Primary Health Care facility managers in the Buffalo City Metro Health District in the Eastern Cape Province. This is important because all health professionals should be educated and supported to deliver patient-centred care, as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics. In the course of life, patients have numerous encounters with health care professionals. Often, such encounters are effective, and patients leave feeling satisfied with the care received, hence improving their health. Unfortunately, this is not always the case, because health care professionals are often not supported by a system that aids them in providing optimum care.

Multiple studies in America demonstrate that, for health professionals, there are sets of core competencies that can advance adherence to the rules of a redesigned health care system as envisioned in the quality care reports. However, the extent to which current health professionals are implementing these competency areas does not meet the health care needs of the Americans (Greiner and Knebel 2003). Leadership and governance are recognised as a critical entry-point in strengthening health systems and attaining the Millennium Development Goals (MDGs). Indeed, the UN Millennium Project's task force on child health and maternal health emphasizes the importance of managers who lead the health systems transformation necessary to promote equitable health care and a rights-based health system.

According to the World Health Organization (WHO) change in the structures and financing of health systems must be married with concern for the human dimensions. The purpose is to transform every health system, so that they can meet the range of existing health challenges. The new policy reforms, which include the National Health Insurance (NHI), Re-engineering of Primary Health Care (RPHC), National Core Standards (NCS), Ideal Clinic Realization and Maintenance program (ICRM), HIV/AIDS 90 90 90 strategies, and the emerging disease burden demand expertise

from health care providers. These initiatives will require good leadership for implementation at a local level, which is the Primary Health Care.

Health care delivery and patient circumstances are constantly changing, and managers have to continue to learn and develop new abilities and skills to keep up. A significant portion of management involves skills and competencies. These include These include delegation, planning, decision making, conflict management, work organization, financial management, team building, motivating staff, communicating and negotiating with stakeholders, maintaining certain attitudes and behaviours that maximize staff discipline and performance. Managers also need to understand the basic technical aspects of the services delivered. For most of these competencies, training courses, though effective, are often not sufficient to provide all the necessary skills. Therefore, the question remains, how can managers create and foster teachable moments in a work environment so that the people they manage constantly learn (WHO 2008). One way is to clearly and regularly identify challenges that the service provision faces, and the skills and knowledge that the team needs to overcome these challenges. The ways to acquire the necessary skills and competencies may include continuing education and learning; structured "academic" courses; management training; shadowing/observation and study tours, which provide practical learning and examples of how others handle situations you will likely face (WHO 2008).

Moreover, mentoring and coaching relationships – experienced mentors provide insights into managing partnerships and relationships, opportunities to seek advice and explore options when managers are faced with difficult situations is recommendable. Finally, peer-learning – an opportunity to meet other managers at regular intervals, share experiences, challenges, and solutions, build a common understanding of processes, and support each other is important (WHO 2008). Leadership and management are at the core of achieving global health results. The overall goal is to identify best practices in global health leadership and management that can increase the efficiency and impact of ongoing global health programming.
The Rwandan School of Public Health supports the fact that global health research must continue to build the evidence base so that program planners, health officers and policymakers can appropriately and intentionally leverage leadership and

management skills to improve the efficiency, effectiveness, adaptability, and sustainability of investments in global health. Due to a limited health workforce, many health care providers in Africa usually take on health leadership roles with minimal formal training in leadership. Hence, the need to equip health care providers with the practical skills required to lead high-impact health care programs (Peterson *et al* 2011).

A primary Health Care facility should be managed by a skilled facility manager who can discharge quality and appropriate leadership functions for the effective and efficient Primary Health Care services that meet the health needs of the population served. Successful implementation of policies to promote equity and inclusion requires a focus on human interactions at the micro-level, as well as the development of supportive institutional systems for financing, information, and regulation (Hana *et al* 2012). The study conducted by Health Systems Trust (HST) (2016) on the Primary Health Care facility managers' competency assessments in South Africa indicate the following gaps: poor linkage between facility and district mission/vision and operational plans, lack of involvement in planning including the management of finances, lack of support, poor understanding of the processes at clinics, drug management challenges, poor dissemination of policies and any many tasks to accomplish in facilities leaving no room for personal development.

The development of a rights-based health system that increasingly addresses the systematic barriers to care experienced by poor and vulnerable groups requires managers who are more than administrators, but those who understand a given context and can take appropriate action (SAHR 2011). Actions to strengthen management and leadership are highlighted within the National Health Insurance (NHI) White Paper and the Human Resources for Health (HRH) (Strategy for the Health Sector 2012/13). The Minister of Health had identified as 'Priority Number 1' HRH management and leadership in the health sector. The Minister had attributed to the weaknesses evident in the health sector to the poor leadership and management at local levels of the health system. There are resources available to ensure adequate leadership competencies of facility managers. For example, the Albertina Sisulu Executive Leadership Public Health Program (ASELPH) candidates are a very relevant resource with contemporary knowledge and skills.

However, there has been limited open discussion about the nature of leadership required within the South African Health System or sustained engagement about how to develop leadership across the system and policy reforms. Leadership is a necessary element of strong health systems, and so South Africa must nurture and sustains leaders who can work strategically within their complex environments to develop a rights-based health system that promotes health equity (Gilson *et al.* 2014) The Ideal Clinic Realization and Maintenance program (ICRM), as one of the new policy reforms, require good quality leadership skills to spearhead the implementation of ICRM, which integrates all other priority programs for service delivery. The facility manager should be able to utilize his leadership skills and be evident in the Primary Health Care package outcomes.

Against this background, the study seeks to contribute to current policy debates by exploring the perceptions of Primary Health Care facility managers regarding their current leadership competencies. Facility managers are drivers of government policy mandates at the cold face of service delivery, which becomes imperative for them to provide focused and meaningful direction to the subordinates (Gilson *et al*. 2014). This equally demands that Primary Health Care facilities adopt new approaches, which require effective management and leadership (Dale and Lee 2016). Most countries in the developed world and more so third world countries are failing to adequately address the increasing demand for primary health care and the systems that are currently used are quite unsustainable. The lack of effective leadership and management is further burdening the Primary Health Care facilities (Hana and Kirkhaug 2014).

According to Hana and Kirkhaug (2014), although there have been increased calls for strengthening strategic and frontline leadership in many countries, it has not been accompanied by the concurrent leadership training for health care workers. In cases where training has been offered, it has been very minimal and inadequate, and this is also made complex by the fact that it is not clear as to which leadership styles should be developed (Hanna and Kirkhaug 2014). Building and growing a pool of people capable of taking on larger and more complex leadership roles can transform the organization. Throughout the system, leadership talent can be grown and supported

in multiple ways, including extensive use of feedback, coaching, and developmental assignments.

Resultantly, growth in nursing practice has been fostered by external factors such as the increased disease prevalence as well as workforce shortages. Therefore, the primary health care practitioners have effectively lost influence on the development of the health profession as well as on the delivery of Primary Health Care services. In South Africa and other countries, it has long been recommended that there is a need to develop practice nurse leaders and managers so that they take a clinical leadership role to ensure that maximum health outcomes can be realized when primary health care services are delivered. This also advances the status of Primary Health Care Practitioners (Halcomb 2008).

The White Paper for the Transformation of the Health System in South Africa highlights the framework for the establishment of the South African District Health System, the principles, long-term role, as well as the different governance options for the District Health System (DHS). The White Paper`s 12 principles on which the DHS is now based are equity, access to services, equality, overcoming fragmentation, comprehensive services, effectiveness, efficiency, local accountability, community participation, developmental, intersectoral approach and sustainability (Gilson et al, 2014). Before 1994, the financial implication of Primary Health Care provision was borne by the Provincial Health Departments, which would differ according to the different categories of municipalities, but the health care services delivered by these different categories of municipalities also differed. After this system, the Minister of Health and the nine Provincial Members of the Executive Councils (MECs) came into being and resolved that functional integration should be the guiding principle in the provision, delivery, and management of PHC services delivered by municipalities and provincial health departments. Functional integration was intended to bring together different functions and activities within and between District and Provincial Departments to address common problems and meet shared objectives to consolidate DHS and reducing fragmentation, duplication, cost and inefficiency (Health Act No.61 of 2003 as amended).

At this stage, it became clear that the local government was experiencing challenges in providing access to the selected basket of services. The National Health Council (NHC) ruled out that, provinces need to take responsibility for all PHC services. (District Health System Policy Framework and Strategy 2014). This policy further sights persistent difficulties of implementing PHC policy due to weak district capabilities, challenges faced by program managers, limited capacities for measuring and analysing health and health care and innovative ways to overcome challenges, practical difficulties of implementing policies due to poor management and collaboration, current limitations on referral and the potential benefits of integration. Governance, leadership, and community ownership as described in the DHS policy framework points to weak district management and leadership.

According to the structure of the Eastern Cape Province Department of Health, PHC facilities should start from the facility manager or operational manager to provide oversight in the activities of the facility and ensure good quality service delivery to the communities. The facilities are encountering gross staff shortages, which emanates from various factors including vast geographic terrain, budgetary constraints, high staff turnover, and other social determinants. This multifaceted challenging situation resulted in non-uniform, non-standard, and imbalanced service delivery platform with untoward service delivery performance outcomes (Eastern Cape Annual Report 2015).

The provincialisation process where a certain portion of remaining municipally run facilities had to be integrated to the provincial government came with a stake required systemic interventions like human resources and infrastructure (Eastern Cape Department of Health Annual Performance Plan 2014/15). The human resource investigations regarding the remuneration of the professional nurses in the country revealed that a certain degree of underpayment of salaries was one of the contributory factors of underperformance in nursing practice including Primary Health Care Nurses. A system of Occupational Specific Dispensation (OSD) was introduced to upscale the salary levels of health professionals, which was implemented vigorously in the Eastern Cape Province starting with nurses, improved the service benefits. The anticipation of this improvement would generate improved service delivery coupled with client

satisfaction, which was not looking at the performance outcomes. The previous municipal facilities could not automatically form part of this benefit due to varying Municipal systems from those of government. Subsequently, this was addressed.

Another government strategy employed to address performance issues in primary health care facilities was the employment of the recruitment process to bridge vacancy rates as a response to high vacancy rates at an operational level. The department embarked on the process of establishing the annual recruitment plan where filling of vacant posts for operational managers (facility managers) was prioritized. Buffalo City is one of the districts that embraced the opportunity of the recruitment process especially to fill the vacant facility management posts such that currently, almost all the posts are filled (EC, Annual Performance Plan 2016).

The human resource development aspect of the organizational management system also put up its strategic interventions to upskill the personnel. In this regard, a clinical training program starting with the skills audit process to identify skills gaps of operational staff became established. All the clinical programs have training plans responsive to training needs. The general leadership skills training especially for facility management has not been forming part of the training plan. The performance management system is also in place across all departmental units including facility managers, who also develop individual key performance areas aligned with district health plans and organizational objectives (EC, Annual Performance Plan 2016).

There are also performance review sessions that are set up at all levels within the organization to evaluate the progress made on planned strategic interventions to address key deliverables. The primary health care facility managers together with the district management team conduct periodic facility performance review sessions where achievements are shared and corrective measures are discussed. The primary health care facilities are allocated resources on an annual basis informed by available resources in the department. This is always below the minimum required levels due to budgetary constraints (Eastern Cape Department of Health Strategic Plan 2014). The above strategies aimed at improving the performance outcomes of the departmental set objectives are attained (Eastern Cape Department of Health strategic plan 2014).

The gap identified to necessitate this study is that there have been no previous studies conducted in Buffalo City Municipality (BCM) as well as in the Eastern Cape Province on leadership and management of PHC facilities. Therefore, there is a literature gap in the research area. This has prompted the researcher to conduct the study to explore and describe the perceptions and experiences of facility managers regarding their leadership competency in Primary Health Care facilities and to bring about the recommendation. The aim of the study is to explore and describe the perceptions and experiences of facility managers regarding their leadership competency in primary health care facilities. The questions therefore are, 'What are the perception and experiences of the facility managers regarding leadership competencies in PHC facilities at the BCM district, and what are the recommendations that can be brought forward?

1.2 PROBLEM STATEMENT

The underperformance at the Primary Health Care service delivery level poses a negative impact on the other higher levels of care, which raises concerns about quality of care provided to service consumers. The minimum performance in the Primary Health Care situation remains a challenge despite efforts of the Provincial Department of Health investing its priorities in people-centered Primary Health Care above Hospital-based curative care.

The implemented intervention strategies to address this challenge have not yielded the desired outcomes. The facilities have been capacitated by appointing managers to oversee the day-to-day operations. The Buffalo City Health District is one of the districts with the highest number of PHC facilities that have appointed managers but does not match the expected outcomes at the Primary Health Care level. The health care system aims to set up a strong Primary Health Care system that would lay the foundation for a service delivery platform and strengthen health care (National Health Care Act 61 of 2003).

Table 1.1 shows the number of facility managers appointed in the BCM district.

Table 1.1: Distribution of PHC Mangers per District

DISTRICT	ALLOCATION	APPOINTED
Amathole	45	14
Alfred Nzo	34	7
Buffalo City Metro	22	22
Chris Hani	32	0
Joe Gqabi	24	8
OR Tambo	49	8
Sarah Baartman	32	0
NMM	4	1
	242	**60**

The other set of resources injected to the district include budget allocations, and medical equipment as an effort to improve performance. Also, training of different categories of staff to increase capacity and skills on various aspects of service delivery programs and policies has been a regular practice. According to Dale and Lee (2016), within the Primary Health Care facilities, the managerial role is operationalized by limiting it to the knowledge, skills, and attributes necessary to skilfully manage the clinical care of a range of patients. However, the performance of the Primary Health Care facilities in the Eastern Cape Province has not been improving within the most priority performance indicators despite the intervention strategies employed.

The Ideal Clinic Program being one of the new policy reforms towards ensuring Universal Health Coverage is a national priority to strengthen quality Primary Health Care provision in the clinics. Thus, it is the prerogative of the PHC facility managers to comply with this imperative. Table 1.2 shows the report of the performance of the districts based on the number of clinics, which achieved the Ideal Clinic status. The Buffalo City District is amongst the poorly performing districts despite the availability of permanent facility managers in the clinics.

Table 1.2.: Ideal Clinic Outcomes of PPTICRM SD IN 2017/18 and 2018/19

	2017 (Apr-Mar)			2018 (Apr-Mar)		
Facility	SCORE %	Category	SD Role	SCORE %	Category	SD Role
Alphendale Clinic	52	Not achieved	SD PPTICRM	51	Not achieved	SD PPTICRM
Amahleke Clinic						
Beacon Bay Clinic	38	Not achieved	SD PPTICRM			
Bhisho Gateway						
Bulembu Clinic	46	Not achieved	SD PPTICRM	54	Not achieved	SD PPTICRM
Cambridge Clinic	56	Not achieved	SD PPTICRM	38	Not achieved	SD PPTICRM
Dimbaza CHC	57	Not achieved	SD PPTICRM	56	Not achieved	SD PPTICRM
Drake Road Clinic	27	Not achieved	SD PPTICRM	28	Not achieved	SD PPTICRM
Gompo C Jabavu Clinic	22	Not achieved	SD PPTICRM	58	Not achieved	SD PPTICRM
Gonubie Clinic				39	Not achieved	SD PPTICRM
Grey Gateway	48	Not achieved	SD PPTICRM			
Ilita Clinic	52	Not achieved	SD PPTICRM	43	Not achieved	SD PPTICRM
Imidange Clinic				80	Silver	SD PPTICRM
Jafta Clinic				67	Not achieved	SD PPTICRM
Kwelera Clinic	48	Not achieved	SD PPTICRM	30	Not achieved	SD PPTICRM
Masakhane Clinic (Zwe)	38	Not achieved	SD PPTICRM	54	Not achieved	SD PPTICRM
Masele Clinic				66	Not achieved	SD PPTICRM
Mdingi Clinic	47	Not achieved	SD PPTICRM	61	Not achieved	SD PPTICRM
Mpongo Clinic	61	Not achieved	SD PPTICRM	48	Not achieved	SD PPTICRM
Mt Coke CHC	46	Not achieved	SD PPTICRM	43	Not achieved	SD PPTICRM
Mxalanga Clinic	32	Not achieved	SD PPTICRM			
Ncera Clinic	54	Not achieved	SD PPTICRM	58	Not achieved	SD PPTICRM
Needs Camp Clinic	72	Not achieved	SD PPTICRM	44	Not achieved	SD PPTICRM
Nobuhle NU 8 Clinic	39	Not achieved	SD PPTICRM	53	Not achieved	SD PPTICRM
Noncampa Clinic	46	Not achieved	SD PPTICRM	38	Not achieved	SD PPTICRM

Nontyatyambo CHC	71	Silver	SD PPTICRM	70	Not achieved	SD PPTICRM
NU 13 Clinic	57	Not achieved	SD PPTICRM	29	Not achieved	SD PPTICRM
NU 17 Clinic	52	Not achieved	SD PPTICRM			
Openshaw Clinic				74	Not achieved	SD PPTICRM
Pakamisa Clinic				41	Not achieved	SD PPTICRM
Pefferville Clinic	48	Not achieved	SD PPTICRM	56	Not achieved	SD PPTICRM
Philani NU 1 Clinic	47	Not achieved	SD PPTICRM	43	Not achieved	SD PPTICRM
Pirie Clinic	55	Not achieved	SD PPTICRM			
Qurhu Clinic	50	Not achieved	SD PPTICRM	52	Not achieved	SD PPTICRM
Sinebhongo Clinic	38	Not achieved	SD PPTICRM			
Sweetwaters Clinic	44	Not achieved	SD PPTICRM	43	Not achieved	SD PPTICRM
Tshabo Clinic				46	Not achieved	SD PPTICRM
Twecu Clinic	52	Not achieved	SD PPTICRM	53	Not achieved	SD PPTICRM
Tyutyu Village Clinic				83	Gold	SD PPTICRM
Zanempilo Clinic (Zwel)	57	Not achieved	SD PPTICRM	63	Not achieved	SD PPTICRM
Zingisa NU 5 Clinic						
Zwelitsha Zone 5 Clinic						

1.3 CENTRAL THEORETICAL FRAMEWORK

This study was guided by Adair`s Action Centred Leadership Model. Adair's model's main argument is that the action-centered leader gets the job done through teamwork and relationships with fellow managers and staff. According to Adair's explanation, an action-centered leader must:

- Direct the job to be done (**task** structuring),
- Support and review the **individual** people doing it, and
- Co-ordinate and foster the work **team** as a whole.

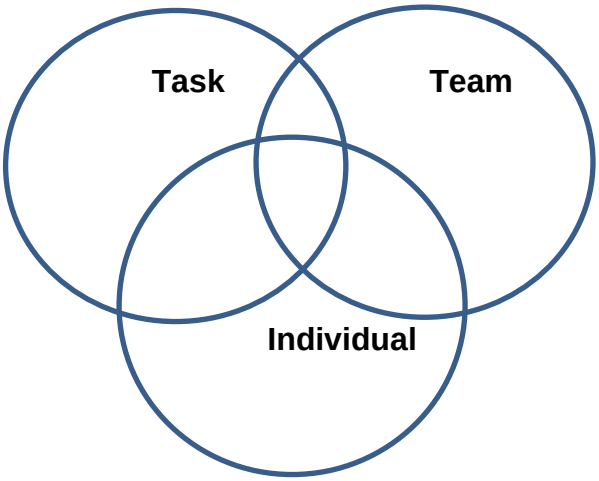

Figure1.1: Action-Centred Leadership Model (Adair, 2020).

Adairs`famous three-circle diagram is a simplification of the variability of human interaction but is a useful tool for thinking about what constitutes an effective leader/manager concerning the job he/she has to do. The effective leader/manager carries out the functions and exhibits the behaviours depicted by the three circles. Situational and contingent elements call for different responses by the leader. Hence, imagine that the various circles may be bigger or smaller as the situation varies i.e. the leader will give more or less emphasis to the functionally-oriented behaviours according to what the actual situation involves. The challenge for the leader is to manage all sectors shown in the diagram.

Table 1.3: Explanation of Action-Centred Leadership Model

Task	• define the task • make the plan • allocate work and resources • control quality and rate of work • check performance against plan • adjust the plan
Team	• maintain discipline • build team spirit • encourage, motivate, give a sense of purpose • appoint sub-leaders • ensure communication within the group • develop the group
Individual	• attend to personal problems • praise individuals • give status • recognize and use individual abilities • develop the individual

Source: Adair `s Leadership Model 2020.

1.3.1 Application of the theoretical framework concepts in the study

(i) Task

In this study the task is associated with the actions and abilities the facility manager should display proving his competencies as he manages the facility and applicability is discussed below: -

The Strategic Plan of the Department of Health sets the goals to be achieved in the health sector. This is further detailed in the Departmental Operational Plan that informs all tasks to be performed by various categories of employees. Therefore, based on this background the facility manager is responsible for ensuring that all members of his/her team (subordinates) including her/himself clearly understand the tasks they are entrusted with, and developing a plan on how to perform such tasks. Allocation of tasks to be carried out by everyone as well as resources to perform such tasks should be clear as well. The availability of the required resources become imperative in realizing the allocated tasks.

It is the responsibility of the facility manager to ensure the provision of good quality care and compliance to set standards. The supervision of daily activities should be the order of the day in the Primary Health Care facility. The monitoring of the work towards meeting the daily, weekly, monthly, quarterly and annual targets contributes to the achievement of the overall goals of the Health Sector, which then becomes crucial to, directly and indirectly, supervise the rate in which the allocated task is done.

Performance management and development systems in place should be complied with to continuously evaluate if activities performed were done according to the plans. The facility manager should have ability and agree with her/his team on how to reach the set goals in the facility. The facility manager should also account for and give progress on the plans made about the facility and develop quality improvement plans and interventions to address existing gaps. The manager together with his/her team is expected to review the facility's performance against set objectives regularly.
In this study the task part of the model indicates the actions and abilities the facility manager should display proving his competencies as he manages the facility.

(ii) Team

In each Primary Health Care facility, there is a team of health care providers of different categories with specific job descriptions led by the facility manager. The tasks of each member of the team are meant to address the plans and objectives of the facility. The nature of the relationship among team members should be of professional one to maintain a good relationship and cohesion. The facility manager should hence be competent to carry out this role. The facility manager is the engine of open communication and transparency to maintain the team in good spirit. Each team member should be able to lead in his sub-area with the guidance of the manager e.g. Data capture should spearhead the process of data management and account to the facility manager who in turn gives overall accountability.

(iii) Individual

Whilst facility performance strives well with team effort, it is also equally important for the facility manager to become very close to each member to ensure that proper work is followed. This helps in identifying any individual's shortfalls e.g. the cleaner must be knowledgeable about the set standards for cleaning the facility. The facility manager needs to identify different and important talents of every individual and utilize them appropriately. Within the team, there are different personalities that need particular support. Therefore, this becomes the role of the manager to understand the individual and handle him/her appropriately. Emotional as well as professional support are key to facility performance (Centre for Leadership studies 2003). It is hence critical for the facility manager to be able to lead her facility to achieve the departmental goals.

1.4 AIM OF THE STUDY

The broad aim of the study was to explore and describe the perceptions and experiences of Primary Health Care facility managers with regard to their leadership and management competencies in the Buffalo City Metro Health District in the Eastern Cape Province.

1. 5 RESEARCH QUESTION

The research question for the study was:

- What are the perceptions and experiences of Primary Health Care facility managers regarding their leadership competencies in BCM Primary Health Care facilities?

1.6 OBJECTIVE OF THE STUDY

The objectives of the study were:

- To explore and describe the perceptions and experiences of facility managers regarding their leadership competencies in BCM Primary Health Care facilities.

1.7. SIGNIFICANCE OF THE STUDY

This study will contribute to the existing body of knowledge and research concerning the issue of leadership and management in Primary Health Care facilities in Buffalo City District. The study provides insights for policy planning and how the government can implement and effectively intervene in enhancing leadership and management related issues in Primary Health Care facilities. The study will also sensitize communities on how they can improve their livelihoods through the utilization of Primary Health Care services in their respective areas. Lastly, the study can capacitate the Primary Health Care managers in understanding their leadership functions in strengthening PHC service delivery. The health professionals, policymakers, and health workers in general, can also benefit immensely from the findings of this research.

1.8 DELIMITATIONS OF THE STUDY (SCOPE)

The Eastern Cape Province is a very huge and vast province with 772 Primary Health Care facilities. In particular, the Buffalo City Health District is comprised of 76 PHC facilities which are difficult to cover all of them within a short period. Therefore, the study, focused only on the selected facilities. This study is also limited to the subject of leadership and management in the Primary Health Care facilities. Since South Africa is broad, the study has been narrowed down to the Eastern Cape Province specifically the Buffalo City Health District.

1.9 LIMITATIONS OF THE STUDY

The study covered the Primary Health Care facilities and not Community Health Centres (CHCs). So, the results can only be applied to Primary Health Care facilities. Thus, this study mostly will only benefit clinics. This means a similar study should be conducted for Community Health Centres in the future.

1.10 OPERATIONAL DEFINITIONS OF KEY TERMS AND CONCEPTS

Leadership

The term *leadership* refers to a process of social influence, which maximizes the efforts of others towards the achievement of a goal. It is the art of motivating a group of people to act towards achieving a common goal (John C. Maxwell:2011). In this study, leadership means leadership competencies of the facility managers in the BCM district.

Competencies

The Oxford dictionary defines the term *competencies* as the set of demonstrable characteristics and skills that enable and improve the efficiency or performance of a job.

In this study, competencies refer to abilities that are displayed by PHC facility managers during their period of overseeing the activities that are carried out in the facility they are managing in the Buffalo City Metro Health District. These competencies include delegation, planning, decision making, conflict management, work organization, financial management, team building and communication.

Primary Health Care Facilities

The term *Primary Health Care facilities* refer to any fixed clinics, community health center, satellite and mobile clinics of different sizes situated in specific geographical areas of the country, which provide the primary health service package according to PHC norms and standards. In this study, primary health care facilities refer to selected urban and rural clinics in Buffalo City Health District where the study was conducted (PHC Norms and Standards 2002).

Buffalo City Health District

Buffalo City Health District is a metropolitan municipality situated on the east coast of Eastern Cape Province, South Africa. It includes the towns of East London, Bisho, and King William's Town, as well as the large townships of Mdantsane and Zwelitsha (Buffalo City Metropolitan Municipality 2011). This health district is amongst the health districts that underwent the provincialization process where the health services were previously administered by the Municipal Council were transferred to the Department of Health. In this study, the Buffalo City Health District refers to the same geographic area.

M**anager**

A manager is a person who is in charge of a certain group of tasks or a certain subset of a company. In this study, a manager refers to the facility personnel who is a professional nurse working in the selected clinics in the BCM district.

1.11 RESEARCH APPROACH

A qualitative, explorative, descriptive, and contextual design was used to conduct this study. This study employed a qualitative methodology and research design to explore the leadership competencies of Primary Health Care managers the Buffalo City Health District health facilities.

1.11.1 Qualitative research

A qualitative research methodology is defined as a system of inquiry that seeks to build a holistic, largely narrative, description to inform the researcher's understanding of a social or cultural phenomenon. It is also argued that qualitative research tends to be associated with the idea that social life is the product of social interaction, relationships, and actions that characterize the social world. This means that qualitative researchers study subjects in their natural settings and attempt to make sense of or interpret phenomena in terms of the meaning people bring to them (Burns and Grove: 2016).

Therefore, a qualitative research method was useful for this study because it emphasizes the importance of the leadership environment for understanding the professional world. The descriptive design was used to develop conceptual categories to illustrate, support, or challenge theoretical assumptions held before the data gathering about the phenomena. This means that the researcher studied subjects (facility managers) in their natural settings (work environment) and attempted to make sense of or interpret the phenomena of leadership and management in terms of the meaning they attach to it.

1.11.1 Explorative research design

An exploratory research is defined as research used to investigate a problem, which is not clearly defined (Burns and Grove 2016). It is conducted to have a better understanding of the existing problem but will not provide conclusive results. In such cases, a researcher starts with a general idea and uses this research as a medium to identify issues that can be the focus for future research. An important aspect here is that the researcher should be willing to change his/her direction, subject to the revelation of new data or insight. It is often referred to as the grounded theory approach or interpretive research as it used to answer questions like what, why, and how (Burns and Grove 2016).

1.11.2 Descriptive research design

Descriptive research refers to research studies that have their main objective, the accurate portrayal of the characteristics of persons, situations, or groups (Polit and Hungler 2004). A descriptive approach in data collection of qualitative research gives the ability to collect accurate data and provide a clear picture of the phenomenon under study (Mouton and Marais 1996).

In the present study, the descriptive approach was particularly appropriate because an accurate and authentic description was required of the experiences of PHC facility managers regarding their leadership competencies. Streubert, Speziale and Carpenter (2003) state that a descriptive method in data collection in qualitative research is central to open, unstructured qualitative research interview investigations.

1.11.3. Contextual design

The researcher aimed to describe and understand events within the concrete, the natural context in which they occur. In a contextual research strategy, the phenomenon is studied for its intrinsic and immediate contextual significance focussing on specific events in “naturalistic settings”.
Naturalistic settings are uncontrolled real-life situations sometimes referred to as field settings. Research done in a natural setting refers to an inquiry done in a setting free from manipulation (Burns and Grove 2016).

The unique context used for this research was the PHC facilities in which the facility managers function as leaders in the Buffalo City Health District. This research was context-bound because it described the leadership competencies of the Primary Health Care managers in the fixed clinics, rather than hospitals or mobiles or community health centres, which fall under other health care facilities. The research had to take place within the Buffalo City Health District as the interviews focused on mangers of the clinics (fixed) in the province.

1.11.4 Population of the study

According to Denzin (2005), a population is a set of entities where all the measurements of interest to the researcher are represented. It is a set or group of observations relating to a phenomenon under statistical investigation. It comprises of everyone who shares those characteristics defined by the researcher as relevant to the investigation. The population of this study comprised of facility managers who are appointed on a facility management position permanently or on acting basis during the time of the study, in rural, urban and semi-urban PHC facilities (clinics) in Buffalo City Health District. The (clinics) were of different sizes, that is, small, medium, and large clinics.

1.11.5 Sampling

Sampling is the process of selecting units (e.g. people, organizations) from a population of interest so that by studying the sample we may fairly generalize our results back to the population from which they were chosen. A non- probability

sampling technique was used to select the participants for this study. The selection criteria of the study participants were based on the following characteristics: -

1.11.5.1 Inclusion Criteria

The selection criteria for the study participants was based on the following characteristics: -

i) Facility managers of fixed PHC facilities or clinics
ii) Appointed as facility managers in the Buffalo City District for more than 5years
iii) Professional Nurses appointed as facility managers in Buffalo City District on an acting basis.
iv) Rural, semi-urban and urban clinics.

1.11.5.2 Exclusion Criteria

The following were excluded from the study:

i) All facility managers who were on leave were excluded.
ii) All absent facility managers or day off during the day of data collection.

1.11.6 Data Collection

This study made use of semi-structured in-depth interviews that lead to narrative descriptions. An English written interview guide was used. It consisted of the question: What are the perceptions and experiences of facility managers regarding their leadership competencies in BCM primary health care facilities. The same interview guide was used for all the participants without alterations. The interview guide consisted of probing questions to direct the interview. There were no names attached in the interview guide to ensure anonymity. An audiotape recorder was utilised to record the interviews after the researcher was granted permission by the participants.

1.11.7 Data Collection Process

The researcher made an appointment with the participants after the permission was granted by the employer. The participants were invited to a common venue as the facilities are geographically separated. An interview guide was used to facilitate the interviews as per the research questions and objectives. Further, the interviewer made use of probes to capture more information in the process of the interview. The

researcher collected data on the leadership and management competencies, the experiences and challenges encountered in PHC facilities in the study area. Since the participants were asked similar questions, the researcher could make comparisons across interviews. The audio recording of data from the participants was done, to avoid missing any information during the interview process, field notes were also used to complement the audio recording.

On the day of the data collection, the researcher met the participants in a central venue. There was a notice at the door, reading ‘no disturbance’ as a sign of maintaining privacy. The seating arrangement was of a horseshoe shape so that all the participants were visible to each other. Before starting with the data collection, an explanation was done to the participants about the study and its content. The consent issues were explained to them and requested to sign it if one was willing to participate. It was made clear that everyone participating in the study is allowed to withdraw any time they wanted. The researcher was sitting away from the person who was taking field notes and was both sitting next to the door to allow quick going out when the need warrants.

The researcher also made the colleagues outside aware that she is inside the venue where the interview was taking place. The main researcher was the one who was operating the audiotape. Non-verbal communications were also taken into consideration and noted in the field notes. The interview continued in English until the end of each session. There were 2 focus groups with 10 participants each. The participants were interviewed until saturation was reached. Saturation was reached in the second group. Each group was interviewed for 30 minutes.

During the interview, the researcher ensured that all the participants were given a chance to talk and the domination of the group was also avoided. Probing was done according to what the participants were saying including clarification and summarization of what had been said.

1.11.7 Trustworthiness

In this study the principle of **trustworthiness** was applied by observing the following principles: -

i) **Credibility:** – This means the truth value, to demonstrate that a true picture of the phenomenon under scrutiny was presented.

In this study, the support staff involved was oriented on how to collect data to fulfill the assistive role during data collection.

ii) **Confirmability**: – means neutrality of information.

The study findings emerging from data collected, should not be the researcher`s disposition. All the steps encountered during the study are kept in clear records.

iii) **Transferability**: – means applicability of data.

The detail of the data gathered during fieldwork served as empirical evidence for the possible use of the findings to other situations.

iv) **Dependability**: –

It means consistency. This study can be repeated by another researcher in the future by providing clear information.

1.11.8 Ethical Considerations

i) Informed consent

Informed consent is an ethical principle that involves formalizing voluntary participation and protecting the participants from harm. It has three major elements: The type of information needed from the research participant; the degree of understanding that the participant must have to give consent; the fact that the participant has a choice of whether or not to give consent (Polit and Beck 2017). The consent was given in written and was in English. The participants were well informed about the general nature of the research. All the participants signed the consent forms before engaging to the interviews. They were made aware that they had a right to withdraw from the study any time they wished.

ii) Justice

This refers to the participant's right to fair selection and treatment. Participants should be selected for reasons directly related to the research problem, and not because of their availability (Polit and Beck 2017). Only those who have consented and are willing to take part should be interviewed. Participants in this study were informed about any potential

challenges or problems that could occur in the research before the study commenced.

iii) **Confidentiality**

This refers to the participants' responsibility to prevent all data gathered during the study from being linked to the individual participant, divulged or made available to any person (Polit and Beck 2017). Confidentiality was maintained to ensure that the participant's information is protected including data on audiotapes was secured in a safe place.

Information or data obtained from participants was not divulged unnecessarily to any departmental stakeholder unless consent was secured from the participants. The researcher did not do any harm to research participants or those who may be affected by the research. The participants were also informed that they were free to decline participation at any stage.

iv) Privacy

This refers to the fact that the researcher must respect the participants` right to privacy. The participants have the right to determine the extent to which, and the general circumstances under which his/her private information will or will not be shared with others (Polit and Beck 2017).

This should be accorded to all research participants. In this study, a safe and professional venue away from the working environment was used to conduct the interviews to obtain valuable data that yielded a positive impact on the health system.

v) Anonymity

Anonymity means namelessness. It refers to the act of the researcher to keep the participant's identities a secret about their participation in the research study. The participant should not be linked with his or her data (Polit and Beck 2017).

Despite any possible researcher`s familiarity with the participants, they were informed that information that they contribute is to be discarded and that if

it is to be communicated in any way, pseudo names will be used so that the information cannot be associated with any of the participants.

vi) Permissions

An ethical clearance certificate was sought from the University of Fort Hare and Eastern Cape Department of Health Ethics Committees to ensure that the researcher abides by the institution's ethical guidelines and obeys the ethical obligations expected from her in conducting the study (Brink, van der Walt and van Rensburg 2015). The permission was also obtained from the clinics before data collection commenced.

1.11.9 Data Analysis

In this study, the thematic analysis was used. Thematic analysis is a process of identifying patterns or themes within qualitative data. These are important or interesting issues relating to the research problem. The identified important and interesting words are summarised, organised and then analysed (Brink:2010). The researcher analysed the data concurrently with data collection. Typical basic strategies were utilised, such as bracketing, intuition and describing.

The researcher set aside her preconceived beliefs regarding the phenomenon being researched whilst creating awareness of lived experiences without forcing prior expectations in the process. The data was read several times to acquaint herself with it. The data gathered was grouped according to themes following a process of open coding, grouping similar codes together to generate themes. Broad categories were determined by the objectives of the research, whilst specific categories were developed from a detailed examination of data after the identification of frequent or significant themes. Headings were assigned to categories to identify their content and meaning (Burns and Grove 2016).

1.10 OUTLINE OF THE CHAPTERS

Chapter 1: Overview of the study

Chapter 2: Research design and methods

Chapter 3: Interpretation of results

Chapter 4: Conceptualization

Chapter 5: Discussion, Summary, limitations, and recommendations

1.11 CONCLUSION

The introduction and the background of this study were presented in this chapter to justify the need for the current study. The background to the study aids in understanding the leadership and management issues in the health care system in South Africa. Leadership competencies among the PHC facility managers are perceived as a foundation for good quality health care. Therefore, this study will benefit the leadership in the district health system and health sector broadly.

CHAPTER TWO: RESEARCH METHODOLOGY

2.1 INTRODUCTION

Chapter one focused on the introduction and background of the study. This chapter provides an in-depth discussion of the methodology as implemented in this study. The discussion in this chapter focuses on the research design, population, sampling, data collection method, data collection process, data analysis, and ethical consideration as well as data trustworthiness.

2.2 AIM OF THE STUDY

The aim of the study was to explore and describe the perceptions and experiences of Primary Health Care facility managers' leadership and management competencies in the Buffalo City Metro Health District in the Eastern Cape Province.

2.3 RESEARCH QUESTIONS

The research question is an organized and more specific inquisitive statement of the topic under study that can be translated into a research project (Burns and Grove 2011)

The research questions for the study were:

- What are the perceptions and experiences of facility managers' leadership competencies in BCM Primary Health Care facilities?
- What is the recommendation that can bring forward regarding the facility managers' leadership competencies in BCM Primary Health Care facilities?

2.4 OBJECTIVE OF THE STUDY

The objective of the study was:

- To explore and describe the perceptions and experiences of facility managers' leadership competencies in BCM Primary Health Care facilities.

2.5 RESEARCH SETTING

The location in which the research is conducted is referred to as a setting (Burns and Grove, 2011:40). The study was conducted at the public Primary Health Care facilities in Buffalo City Health District in the Eastern Cape. The Buffalo City Metro Health district is both a rural and urban district of which, two thirds (2/3rd) of its health facilities are located in the urban areas and a third (1/3rd) is located in rural areas. It has five CHCs, 79 PHC facilities, which include two Satellite clinics and twelve Mobile clinics. Buffalo City Metro Health district is geographical spread over East London, King Williams Town and Bisho Municipal areas.

The PHC facilities render preventive and promotive health services such as Mother and Child Health care, Women and Reproductive Health care, Curative services for chronic diseases such as TB and HIV/AIDS, prevention and rehabilitation of Non–Communicable Diseases such Hypertension, Diabetes, and Mental disorders. The PHC facilities operate under the ambit of the Department of health whose practice is legislated by the Health Act, Nursing Act, and other complementary legislative formations.

The health indicators of TB Defaulter rate, HIV positive clients remaining to ART, Maternal Mortality and Immunization coverage remain a challenge in the district. Each facility was manned by a facility/operational manager, whom some were appointed permanently and others on acting positions. Each facility would provide services to communities or a catchment population of various racial backgrounds from different locations, townships, and suburbs. Some of these facilities operate from 07h30 to 16h30, some from 07h30 to 19h00, Monday to Friday. The facilities are also responsible for coordinating the departmental priority programs including Reengineering of Primary Health Care, Ideal Clinic program, and 90, 90, 90 strategies.

Each facility manager is responsible for overseeing the provision of health services to the communities as an administrative duty. The Primary Health Care facility is allocated personnel of different categories including professional nurses, sometimes doctors, administration personnel, cleaners and allied workers. The functionality of the facility governance structures is also the responsibility of the facility manager.

They are also expected to collaborate with other government departments, civil society or any other organization and stakeholders participating in the provision of health services in a particular population. Their duties also entail to ensure compliance to all governmental policies in service delivery processes and this includes meeting the set service delivery targets with optimal utilization of available resources.

Given the poor state of infrastructure of the district, renovations are an on-going project. However, there is still a need to create easier access for disabled patients. The district is faced with a challenge of resources to install appropriate Information, Communication and Technology, and network connectivity in clinics to support service delivery. One of the challenges faced by the district is an inequitable provision of health services in the three local municipal sub-areas namely Bisho, East London and Mdantsane. In the quest to improve service delivery, 33 facilities have filled the post of Operational /Facility Managers in the clinics. It is these facility managers that the study focused on to generate insights on their leadership and management competencies.

2.6 RESEARCH DESIGN

2.6.1 Qualitative approach

Qualitative research is defined as a system of inquiry, which seeks to build a holistic, largely narrative, description to inform the researcher's understanding of a social or cultural phenomenon (Hale 2009). On the other hand, Babbie (2010) also argue that qualitative research tends to be associated with the idea that social life is the product of social interaction, relationships, and actions that characterize the social world. This means that qualitative researchers study participants in their natural settings and attempt to make sense of or interpret phenomena in terms of the meaning people bring to them.

According to Leedy (2013), qualitative research is based on the belief that the first-hand experience provides the most meaningful data. The main characteristic of qualitative research is that it is most appropriate for small samples, while its outcomes are not measurable and quantifiable.

It is also believed that qualitative data give large volumes of quality data from a limited number of people. Its basic advantage, which also constitutes its basic difference with quantitative research, is that it offers a complete description and analysis of a research subject, without limiting the scope of the research and the nature of participant's responses. Whilst conducting qualitative research, the researcher is in continuous interaction with the participants in an attempt to discover the participant's meaning of their lifeworld (Mashego 2000; Neuman 2000).

2.6.2 Explorative design

An exploratory research is defined as a research approach used to investigate a problem, which is not clearly defined (Burns and Grove 2011). It is conducted to have a better understanding of the existing problem but will not provide conclusive results. For such research, a researcher starts with a general idea and uses this research as a medium to identify issues that can be the focus for future research. An important aspect here is that the researcher should be willing to change his/her direction subject to the revelation of new data or insight. It is often referred to as the grounded theory approach or interpretive research as it used to answer questions like what, why and how (Burns and Grove 2011).

This study was an exploratory research as the researcher explored a phenomenon of which very little was known, that is, the experiences and perceptions of facility managers on their leadership competencies in Buffalo City Health District. The researcher also aimed to acquire new insights into the full nature of the research problem (Polit and Hungler 1997). This method implied that the researcher would be willing to study new ideas and possibilities tapping from the participants' responses and would not allow predetermined ideas and hypotheses to direct the research (Mouton and Marais 1990).

2.6.3 Descriptive design

Descriptive research refers to research studies that have, as their main objective, the accurate portrayal of the characteristics of persons, situations or groups (Polit and Hungler 2004). A descriptive approach in data collection in qualitative research gives the ability to collect accurate data and provide a clear picture of the phenomenon under

study (Mouton and Marais 1996). In the present study, the descriptive approach was particularly appropriate because an accurate and authentic description was required of the experiences of PHC facility managers on their leadership competencies. Streubert, Speziale and Carpenter (2003) state that a descriptive method in data collection in qualitative research is central to open, unstructured qualitative research interview investigations. This means that the researcher facilitated the PHC facility managers' descriptions of their own experiences and perceptions regarding their leadership competencies by applying and intuiting so that the phenomena under study could unfold without unnecessary hindrances.

2.6.4 Contextual design

According to Babbie and Mouton (2001), the researcher aims to describe and understand events within the concrete and the natural context in which they occur. In a contextual research strategy, the phenomenon is studied for its intrinsic and immediate contextual significance (Mouton 1998). Burns and Grove (2003) point out that contextual studies focus on specific events in "naturalistic settings". Naturalistic settings are uncontrolled real-life situations sometimes referred to as field settings. Research done in a natural setting refers to an inquiry done in a setting free from manipulation (Streubert Speziale and Carpenter 2003).

The unique context used in this research was the PHC facilities in which the facility managers function as leaders in the Buffalo City Health District. This research was context-bound as it described the leadership competencies of the Primary Health Care managers in the fixed clinics, rather than hospitals or mobiles or community health centres, which are 'other health care facilities. The research had to take place within the Buffalo City Health District as the interviews would be conducted at the clinics (fixed) in the province.

2.7 STUDY POPULATION

A population in a research study is a set of entities where all the measurements of interest to the researcher are represented. It is a set or group of observations relating to a phenomenon under statistical investigation. It comprises of everyone who shares those characteristics defined by the researcher as relevant to the phenomenon under

study (Denzin 2005). The population of this study comprised professional nurses appointed as facility managers during the time of the study, in fixed rural, urban and semi-urban PHC facilities (clinics) in Buffalo City Health District. The clinics were of different sizes, that is, small, medium and large clinics. These participants were relevant for this study as they were knowledgeable about the leadership and management in PHC facilities.

2.8 SAMPLING METHODS AND TECHNIQUES

A sample is defined as a subset of the target population (Parahoo 1997; Polit and Hungler 1997). The intention of sampling is to get a group of representative members of the larger population so that conclusions about the population of interest can be reached (Stewart, et al. 1990). This method provides rich context-bound information (De Vos. 1998; Babbie and Mouton 2001).

The non-probability purposive sampling was used in this study to select participants for focus group interview. This method of sampling was used to select professional nurses who assumed facility management positions in fixed clinics in the Buffalo City Health District. In non-probability sampling, not everyone stands a chance to be selected; whereas, in probability sampling, everyone stands a chance of being selected to participate in the study. The purposive sampling is used to select the participants on the basis that they were the relevant target group to provide the required information and in this case, knowledge, relationships, and expertise on how to exercise leadership and management in Primary Health Care facilities. They had a special attribute about the phenomenon under study. These participants were selected to explore and describe their perceptions and experiences as facility managers in the PHC clinics on their leadership competencies (Freedman et al. 2007).

According to Neuman (2000), the focus of the qualitative researcher is more on the selected participants' ability to clarify and deepen the understanding of social life than its representativeness. He further indicated that the qualitative researcher should be concerned with obtaining cases that can enhance his learning process about social life in a specific context, and that is the reason why they tend to use a non-probability

sampling method. In this case, reasonable experience in running a PHC facility was key to meet the objectives of the study.

Again, the researcher used a purposive type of non-probability sampling. Neuman (2000) describes purposive non-probability sampling as making use of experts who work with the prospective participants to get that informative cases. He further indicated that this method is mostly useful in exploratory research where it is difficult to reach a group as the researcher uses the locations she knows to access the suitable cases for attaining the objectives.

2.81 The Inclusion Criteria

This comprises the characteristics that the participants must possess to be part of the population that is targeted (Burns and Gove 2011). In this study, the participants who met the inclusion criteria were the professional nurses who were appointed by the Eastern Cape Department of Health in PHC facilities (clinics) in the Buffalo City Health District; and who had more than five years of working experience as the facility or operational manager in the Primary Health Care facilities. Moreover, they had to be from the Buffalo City Metro District in the Eastern Cape at the time of the study as district comprises community set up which is rural and urban and hence representative of the Eastern Cape set up. Five year work experience would provide data required in the study.

2.8.2 The Exclusion Criteria

Exclusion criteria relate to characteristics that can result in a person being excluded from the target population (Burns and Grove, 2011). In this study, the professional nurses who were absent or off duty on the day of data collection were excluded.

2.9 DATA COLLECTION

Data collection is a precise, systematic gathering of information relevant to the research purpose or the specific objectives, and questions of a study (Burns and Grove 2011). There are different techniques used to collect data, which the researcher should be familiar with to select the correct technique for the study being conducted.

2.9.1 Preparation of the field

Various steps were followed before the collection of data was conducted. Firstly, ethical clearances and permissions was obtained for the University of Fort Hare and the Department of Health Research Unit, as well as the Primary Health Care facilities under study.

2.9.2 Data collection method

Data was collected using a semi-structured interview guide, which was in the English language to guide the discussion and keep the respondents on the topic. It consisted of the question: What are the perceptions and experiences of facility managers regarding their leadership competencies in BCM Primary Health Care facilities. The same interview guide was used for all the participants without alterations so that they were exposed to the same questions.

The interview guide consisted of probing questions to direct the interview. There were no names attached in the interview guide or anywhere in the research documents. Only numbers were used to ensure confidentiality. An audiotape recorder was used to record the interviews, with permission from the participants. The use of field notes proved to be useful. The interviews lasted for one and a half hours for each group.

2.9.3 Data collection process

Data collection is a precise, systematic gathering of information relevant to the research purpose or the specific objectives, questions or hypothesis of a study (Burns & Grove, 2011: 52).A variety of techniques are used when a researcher is collecting data (Burns & Grove, 2011: 52). It is also of utmost importance for the researcher to be familiar with different techniques of data collection so as to be able to select the correct one for the study being conducted.

The researcher made an appointment with the participants after the permission was granted by the employer. On the day of the data collection, the researcher met the participants in a central venue at Lilitha College of Nursing East London Campus. There was a notice at the door, stating ‘no disturbance’ as a sign of maintaining privacy. The sitting arrangement was of a horse-shoe manner so that all the participants were visible to each other. In this study the researcher used focus group

interviews. An interview guide with unstructured questions was used to elicit information from participants. A brief explanation was done to the participants about the study and its content before starting with the data collection. The issues of consent were explained to them and were requested to sign the consent forms if one was willing to participate. It was made clear that everyone participating in the study was allowed to withdraw from participation at any time (Interview guide attached for reference).

Group rules for the focus groups were established such as respecting each participant's views and giving each other time to freely participate with no intimidation or disputing other people's views. The researcher was sitting away from the person who was taking field notes to avoid distraction and to focus and was sitting next to the door to allow quick going out when the need warrants. The researcher also made the colleagues outside aware that she is inside the venue where the interview was taking place. Only people who were part of the research were present at the venue.The principal researcher was operating the audiotape. Non-verbal communication gestures were also taken into consideration and noted in the field notes. The interview continued in English until the end of each session.

There were two focus groups with ten participants each. The participants were interviewed until saturation was reached. Saturation was reached in the second group. This was confirmed by participants repeating the same information. During the interview, the researcher ensured that all the participants were given the chance to talk and the domination of the group was also avoided. Probing was done according to what the participants were saying including clarification and summarization of what had been said. Probes are queries made by a researcher to obtain more information from the participants about a particular interview question (Burns & Grove, 2011: 85).

2.10 DATA ANALYSIS

Data analysis is a mechanism for reducing and organizing data to produce findings that require interpretation by the researcher. It is a challenging and creative process characterised by an intimate relationship of the researcher with the participants and

the data generated. Data analysis requires that researchers dwell with or become immersed in the data. It is done to preserve the uniqueness of each participant's lived experience while permitting an understanding of the phenomenon under study (Burns and Grove 2013).

The researcher used thematic analysis on the data collected. In this study, the researcher started the process of data analysis by organizing the data. This begins with listening and transcribing the participants' views from the audio recording. This is followed by reading and rereading the verbatim transcriptions to familiarize with the content of the data. The field notes were also used to close the gaps where necessary. This was done for the researcher to go back to the original research questions, keeping in mind the intention of conducting the interview. The researcher has to pick up topics, recurring words, ideas, concepts and words frequently emerging from the data thus generating initial codes. Once this was done, the researcher searched for themes and categories (Burns and Grove: 2013).

After the researcher translated and transcribed the tape-recorded interviews, she started reading and re-reading the interviews in their entirety, reflecting on the interviews as a whole. Notes were used continuously to complement the audio-recorded data. Then, the researcher summarised the interviews after which the coding of the data was done. Coding is defined as breaking text done into subparts and giving a label to the parts of the text. Once identified, the themes that appeared to be significant and linking substantial portions of the interviews were written down and subthemes were derived from the themes (Burns and Grove:2013).

2.10.2 Trustworthiness

Trustworthiness establishes the validity and reliability of qualitative research (Brink: 2010). The research demonstrates trustworthiness when the experiences of the participants are accurately represented. The trustworthiness of data in the triangulation method is demonstrated through the researcher's attention to and confirmation of information discovery. This is referred to as rigor. The goal of rigor in qualitative research is to accurately represent the study participants' experiences (Burns and Grove:2013).

Four criteria are used to measure the trustworthiness of data, these are credibility, dependability, transferability, and confirmability. This was maintained in this study by bracketing, whereby the researcher had put aside her preconceived beliefs regarding the phenomenon being researched during the inquiry. The researcher was just guiding the interview and probing, but the participants were left to give their perceptions and experiences regarding leadership competencies in PHC facilities. This was done to prevent data from being influenced and manipulated.

For this study, Guba's model for establishing the trustworthiness of qualitative research was used because it is well developed conceptually and has been extensively used by qualitative researchers. Lincoln and Guba's (1985) model identifies the following four criteria for establishing trustworthiness:

• Truth value – strategy: credibility measure
• Applicability – strategy: transferability measure
• Consistency – strategy: dependability measure
• Neutrality – strategy: confirmability measure

(Polit and Hungler 2004; Streubert *et al*. 2003).

2.10.3 Dependability

Dependability is another criterion used to measure trustworthiness in qualitative research. Dependability is met through securing the credibility of the findings (Lincoln and Guba 1985; Streubert *et al*. 2003).It is the stability of data over time and is obtained with stepwise replication and inquiry audit (Polit and Hungler 2004). It is a criterion that is met through obtaining credibility and cannot be present without credibility (Streubert *et al*. 2003). Since there can be no validity without reliability (and thus no credibility without dependability), a demonstration of the former is sufficient to establish the latter.

According to Holloway (2005), dependability is related to the consistency of findings. This means that if the study was repeated in a similar context with the same participants, the findings would be consistent. In qualitative research, the instruments to be assessed for consistency are the researcher and the participants. For the findings of a research project to be dependable, they should be checked and audited

through external checks. A more direct technique is the “overlap method”, which is simply one way of carrying out the first argument, and not a separate approach.

In this study, dependability was ensured using literature to support the data collected.

2.10.4 Credibility

Credibility is demonstrated when participants recognize the reported research findings as their own experiences (Streubert Speziale and Carpenter 2003). It is the truth of how the participants know and experience the phenomenon (Talbot 1995). To ensure credibility the researcher must make sure that those participants are identified and described accurately (Holloway 2005). In this study, credibility was achieved by ensuring that the findings were convincing. The researcher, by using a voice recorder, captured the data directly from the participants. Notes were taken with the help of a research assistant. The researcher also is an experienced Primary Health Care Manager with more than twenty years of experience in the field.

Moreover, the participants were properly identified and described to ensure the results were convincing. A member check was also done. The researcher did member checks with the participants’ feedback. The members/participants checked categories that emerged from the data, and after the themes were finalized the researcher discussed the interpretation and conclusions with them to confirm the meaning derived represented the truth.

2.10.5 Transferability

Transferability refers to the probability that the study findings have meaning to others in similar situations. Transferability is also called “fittingness” for it determines whether the findings fit in or are transferable to similar situations. The potential user, not the researcher, determines whether or not the findings are transferable (Streubert *et al*. 2003). It is the extent to which the findings from the data can be transferred to other settings. Generality and applicability are irrelevant in qualitative research because the researcher wants to describe the particular phenomenon. It is the researcher’s responsibility to provide a dense description of the research context and sufficient descriptive data that the reader can assess and evaluate the applicability or

transferability of the data to another context. The researcher needs to describe the data sufficiently to allow comparison.

Lincoln and Guba (cited in Polit and Hungler, 2004) state that with purposeful samples, the selection of participants should fulfil the need of the study. The researcher approached the participants that had experience and knowledge of the phenomenon under study, i.e. that were working in fixed PHC facilities as managers. In the present study, transferability was ensured through the process of member checks. This would enhance the possibility that the findings have the same meaning for other facility managers.

A dense or thick description of the participants' experiences, regarding their interpretation and feelings of the phenomenon in the disciplinary context, were discussed (Holloway 2005; Mertents 1998). This was to provide rigor, a clear and comprehensive decision so that the reader can consider if the findings could be transferable to other situations (Holloway 2005). In this study, the researcher ensured the trustworthiness of the findings by exposing the study to colleagues for constructive criticism. Finally, the supervisors were responsible for examining the findings, interpretations, and recommendations, hence attesting that they are supported by the data.

2.10.6 Confirmability

Confirmability is a neutral criterion for measuring the trustworthiness of qualitative research. If a study demonstrates credibility and fittingness, the study is also said to possess confirmability (Lincoln and Guba 1985; Streubert, Speziale and Carpenter, 2003). It is a creation for evaluating data quality and refers to the neutrality or objectivity of the data by an agreement between two or more dependent persons that the data is similar (Polit and Hungler 2004). Confirmability is achieved by ensuring that the findings, conclusion, and recommendations are being supported by the collected data and the fact that there is an internal agreement between the investigator's interpretation and the real problem (Brink, 2009). This was ensured by taking notes, correct interpretation of results and transparency of the process to facilitate replication of the research.

Confirmability occurs in the presence of credibility, transferability, and dependability (Holloway and Wheeler 1996). The researcher utilised the following auditing criteria:

(1) Collected the raw data using tape recorders.

(2) Analysed the raw data and findings of the study through de-contextualization.

(3) Made a synthesis of the analysed data through re-contextualization.

(4) Carefully planned each phase of the research process, research design, sampling design, and data collection process.

(5) Made sure that the conclusions of the study are supported by the analysed data.

2.11 ETHICAL CONSIDERATIONS

Ethical clearance was obtained from the University of Fort Hare before the research was conducted. Ethical considerations were enlisted through applying the principles of consent, confidentiality, right to self-determination, justice, privacy, permission, and beneficence. Ethical measures are as important in qualitative research as in quantitative research and include ethical conduct towards participant's information as well as honest reporting of the results. The ethical measures considered in this study include consent, confidentiality, and anonymity, privacy, dissemination of results and the right to withdraw from the study.

2.11.1 Permissions

The researcher requested permission to conduct the study from the Head of the Provincial Health Department of the Eastern Cape Province. Permission was also sought from the District Management where the study was conducted.

2.11.2 Consent

Written permission (informed consent) was sought from participants to be engaged in the interviews (LoBiondo-Wood and Harber 2002; Polit and Hungler 2004). Following this request, the participants gave consent to participate before the interviews began.

2.11.3 Confidentiality and anonymity

Polit and Hungler (1999) state that *confidentiality* means that no information that the participant divulges is made public or available to others. The anonymity of a person or an institution is protected by making it impossible to link aspects of data to a specific person or institution. Confidentiality and *anonymity* are guaranteed by ensuring that data obtained are used in such a way that no one other than the researcher knows the source (LoBiondo-Wood and Harber 2002).

The participants were fully informed regarding the objectives of the study and were reassured that their answers will be treated as confidential and will be used only for academic purposes. Except the above, the intention was also not to harm or abuse the participants, both physically and psychologically, during the process of the research instead the researcher attempted to create and maintain a climate of comfort. In this study, no names were attached to the information obtained, but instead, codes were used.

2.11.4 Privacy

According to De Vos (2002), *privacy* refers to agreements between persons that limit the access of others to private information. Privacy refers to the freedom an individual has to determine the time, extent and general circumstances under which private information will be shared with or withheld from others (Burns and Grove 2003).

In this study, the researcher ensured that when participants described their experiences regarding their competencies in managing PHC facilities, it would not be divulged anyhow except for publishing the research findings. Privacy was also maintained by not attaching the participant's names to the raw data.

2.11.5 The right to withdraw from the study

As part of the informed consent, the participants were informed that they could withdraw from the study at any time if they wished to. The aim was to reassure participants that their participation in the research was voluntary and that they were free to withdraw for any reason. This right was explained to them before engagement in the study, that is, before the interview (Holloway 2005).

2.12 DISSEMINATION OF RESULTS

Results are disseminated in the form of a research report. The report should stimulate readers to want to study it and also determine its feasibility for implementation (De Vos 2002). The report should not expose the secrets or weaknesses of the participants to the readers but should recommend improvements in the service. The results will be disseminated by:

- Sharing a report with the district office as well as to the clinic supervisors to ensure accessibility to clinics.
- Publishing them in the journals
- Meetings
- Internet
- Workshops
- Media

2.13 LIMITATIONS OF THE STUDY

The study would have covered the Community Health Centres (CHCs) so that the results can be applied to all Primary Health Care facilities. Therefore, this study will only benefit clinics alone. This means that in the future a similar study should be conducted focusing on community health centres.

The portfolio for the researcher includes overseeing the functionality of Primary Health Care facilities in the Eastern Cape. This imply that, some participants might have been hesitant to give as much information as possible due to the fear of jeopardizing their jobs irrespective of assuring them about confidentiality and no harm. Moreover, some participants were just reluctant to speak against their organizations.

2.14 SUMMARY

This chapter focused on the methodology used in executing this study. A discussion on qualitative research as an approach for data collection and analysis has been done. The sampling methods and how the data was analysed have been discussed.

CHAPTER THREE: PRESENTATION OF FINDINGS

3.1 INTRODUCTION

This chapter focuses on the presentation of findings. The previous chapter presented a discussion on the research methodology used in the current study. The presentation of findings is as follows: demographic data of participants, main themes, categories and sub-categories that emerged from data. Four main themes emerged in this study concerning the perceptions and experiences of PHC facility managers' leadership competencies. Each theme has subthemes and will be discussed in detail in the subsequent sections.

3.2 DEMOGRAPHIC DATA OF PARTICIPANTS

All participants were professional nurses appointed as operational or facility managers in Primary Health Care facilities /clinics in the Buffalo City Health District, in the Eastern Cape Province. Gender was both males and females.

3.3 THEMATIC FINDINGS

The main findings are presented according to themes and subthemes. Four themes were identified from the data and subthemes were derived from each theme. There were also recommendations made by participants in this study. Theme one had nine subthemes, theme two had four subthemes, and themes three and four had three subthemes respectively. Table 3.1 presents these themes.

Table 3.1. Presentation of Themes and subthemes

Themes	Subthemes
1.Departmental factors	1.1. Lack of support
	1.2. Capacitation of staff
	1.3. Lack of uniformity in exercising leadership
	1.4. Work positions
	1.5. Infrastructure
	1.6. Staff shortages

	1.7. Lack of involvement in decision making
	1.8. Lack of resources
2. Individual factors	2.1. A feeling of being a failure
	2.2. Not meeting expectations (workload)
	2.3. Role of managers
	2.4. Pressures
3. Staff members factors	3.1.Resistance of staff members
	3.2. Absenteeism
	3.3. Teamwork
4. Political factors	4.1.Compliance to policies -
	4.2. The 80% /20% Principle and Nurse – patient ratio
	4.3. Consultation

3.3.1 Departmental factors

This theme was supported by nine subthemes, which include lack of support, capacitation of staff, and lack of uniformity whilst exercising leadership, work positions, infrastructure, and decision making. These subthemes are analyzed and discussed below.

3.3.1.1 Lack of support

In this study, lack of support surfaced as one of the experiences of Primary Health Care facility managers that affect their leadership competencies. The facility managers need all the support they can receive from their supervisors as mentioned in the study. This means that a facility manager cannot portray her/his competence in service delivery outcomes or achieve set targets without it. With regard to support, a participant opined that:-

"I felt like one of these good leaders that have been thrown in the deep end, there is no emotional and wellness support"

3.3.1.2 Capacitation of staff

The participants highlighted the need for training to be able to effectively handle the facilities with knowledge and insight. They also reported lack of in-service training on the newly developed guidelines. There was expectation that for an induction program when they were recruited, which would include leadership, mentoring and coaching. The following comments were made by different participants regarding the capacitation of staff:

> *"Facility managers must be taken for courses".*
>
> *"We are using guidelines that we don't even understand, no one is explaining them to us."*

Further, emphasizing on the need for induction, the participants indicated that:

> *"There should be induction for facility managers".*
>
> *"We need formal training to improve our skills like leadership, mentoring and coaching skills".*

3.3.1.3 Lack of uniformity in exercising leadership

Equal distribution of tools for trade and resources is one of the key aspects of ensuring staff satisfaction as well as fair monitoring on compliance with the policy. Clear guidelines should be communicated throughout the entire system regarding the distribution of resources to uphold fairness and eliminate dissatisfaction. The following comment regarding this subtheme was made by one of the participants:

> *"When clinics are given something to refer like posters, they should be the same in all the clinics for uniformity, not to get it in this clinic and not in another, they make your clinic fail as a result".*

3.3.1.4 Work positions

In this study, some of the participants highlighted a gap in the organizational structure, wherein the nursing profession is mostly not represented by an incumbent with the nursing qualification or background at decision-making level to make appropriate decisions about the nursing fraternity. The following comment from the participant illustrates this contention.

"There must be a professional nurse leading the nursing side because we are never satisfied with how things are done"

3.3.1.5 Infrastructure

The participants indicated that the buildings housing the health facilities were dilapidated. They had very limited space, which was old and dirty. These conditions indicates that the maintenance of clinic buildings had been poor. The views from different participants about infrastructure were captured as follows:

"*Clients are standing outside the veranda because the clinic is full, they have no space.*

"Since I have been an operational Manager painting has never been done, it's dirty, dirty, and dirty!"

3.3.1.6 Staff shortages

This subtheme was empathized by three participants in the study, highlighting that staff shortage has been a great concern within the district health system in general and the Primary Health Care system in particular. In this study, it was reported that the implications of staff shortage were that facility managers had to spend more time on clinical than administrative work. The participants` expressed their views as captured below:

"I don't have even the gardener who should manage the grounds"

"Shortage in the facility as if somebody resigned or died in the facility, there is no replacement"

In the same manner, another participant stated that:

"There is a shortage of staff and then you neglect your administration work".

3.3.1.7 Lack of involvement in decision making

This findings established participants' complains with regard to lack of inclusion in decision making by the decision-makers, including their immediate supervisors. They indicated that decisions about their facilities and the Primary Health Care system are made on their behalf, whilst they are regarded as facility managers. They further

highlighted the issue of planning where goal setting is done at higher levels without checking feasibility to achieve such targets from them (facility managers). The following interview extracts illustrate the disappointment in the decision making process:

> "*There is no proper consultation like to say ok guys how can we achieve this, how do you think you can achieve this"*
> *"A nurse is supposed to consult patients and also there is no time of ordering medication if I can have Pharmacist Assistant that will reduce the workload".*

3.3.1.8 Lack of resources

The study found that lack of resources was a great challenge for managers to implement their leadership roles. These resources include medical equipment, equipment for information, communication and technology, as well as machines to measure patients' blood pressure, computers, printers and cartridges for printers. Sharing of equipment with other facilities as well as using own resources to ensure that service delivery continues was reported. During the focus group discussion some participants shared the following about the lack of resources:

> *"I am trying to meet all the required processes, but there is the obstacle of a shortage of resources".*
> *"There are challenges with the equipment, sometimes you don't even have the ink or toner for the printer".*
> *"I don't have a computer, the one we use for the data, I borrowed from another facility".*
> *"I even have got 2 blood pressure machines, I took one of my machines and use it at the clinic."*

3.3.2 Individual Factors (Facility Managers)

Four subthemes emerged from this theme, that is, fear of being a failure, not meeting the expectations, role of managers, and pressure.

3.3.2.1 Feeling of being a failure

The findings showed that the facility managers were not able to comply with the set work principles. In the Primary Health Care setting, the operational / facility manager should perform 80 percent administration and 20 percent clinical work. However, it was found in this study that the current practice was the opposite. The following participants' verbatim supports this finding:

> *"As a manager, I should apply 80/20 rule, but when I look at myself, it`s the opposite, I do 80 percent clinical and 20 percent management."*
>
> *"I would tell myself that I am not a capable leader. I don't know if I am making sense of how I perceive myself."*

This situation makes the managers perceive themselves as not being good managers or compliant to the set rules, hence feeling as a failure.

3.3.2.2 Not meeting expectations

The participants cited failure to meet expectations by making an example of all the administrative processes such as data verification. It was also revealed that at times the week could come to an end without even verifying one data set. This is because the facility managers ended up consulting clients instead of doing administrative work to meet their expectations. The participants had the following to say about failure to meet expectations.

> *"For example the expectations that you must all have the administration processes in place e.g. data verification".*
>
> *"Sometimes the week goes off without even verifying one data set".*
>
> *"As managers, we end up consulting patients not doing administration work because we need to meet that expectation"*.

3.3.2.3. Role of a facility manager

The role of the Primary Health Care facility manager is being responsible for all activities taking place in a facility. The knowledge about PHC programs is one of the skills that the manager should have. The facility manger must ensure that the patient information is correct and accurate each day. Further, leading by example was

mentioned as an important manger's role. In this study, the roles of the facility manager were also to manage the budget for the clinic. However, they find it difficult to exercise their roles in this area, as there lacked transparency on the budget. The following were views made by the participants:

"The facility manager oversees all the activities happening in a facility."

"The facility manager must be knowledgeable about all the programs in a facility."

"The facility manager must see to it that the data is correct each day."

"As a facility manager, you must lead by example."

"One of the roles of the facility manager is to manage budget but, in our case, we can't manage because we don't know how much it is, sometimes we are told that the budget is centralized".

"So you must be that leader who is well equipped, who is flexible, who listens to the subordinates and work as a team"

3.3.2.4. Pressure

The findings revealed that the participants felt a lot of pressure as they strived to meet the set standards. They reported that the work pressure that prevails in a PHC setting makes them unable to meet the set standards. They also lamented that things just occurred unexpectedly and made the leadership difficult. The participants had the following to say about the work pressure at the facility:

"I am striving to meet the standards but due to some pressures that come, you know"

"Sometimes when you try to be a perfect manager there are things that come unexpectedly and then that makes the leadership not become what you think you expected to do".

3.3.3 Staff Members' Factors

Three subthemes were derived from this theme, which are the resistance of the staff members, absenteeism and teamwork.

3.3.3.1. The resistance of staff members

The study established staff resistance to change despite the encouraging mechanisms that the facility manager would employ. Facility managers had to force situations to ensure that the set targets are met and this made leadership roles very hard for them. This created a feeling that some staff members do not accept them as their leaders. The comments below support this finding.

> *"When you have to apply change management, you find people who have been doing things their way"*
>
> *"You get resistance from them "*
>
> *"It is better to force things…Ja" it`s hard."*
>
> *"We tell colleagues that let us work hard this much and this much to get the targets".*
>
> *"My experience is that you want to lead people that don't want to work".*

3.3.3.2 Absenteeism

The participants reported absenteeism tendencies as one of the problems experienced by facility managers in leading the clinics. It was reported in this study that staff members would sometimes fail to report for duty without genuine reasons. This resulted to the facility managers feeling let down by their colleagues. Failure to report to work creates inconveniences as some other workers could be on sick leave or training, thus constraining service delivery. The following interview extract support this finding:

> *"Subordinate sometimes they are not on duty, they are always taking sick days"*
>
> *"You know subordinates let us down, the sick leave, absenteeism and other one is on training*".

3.3.3.3 Teamwork

The study revealed that the facility managers had to deal in a special way with team members with untoward influence. The study also reported lack of teamwork and this retarded the progress of facility activities. This is because the managers had to attend

to other responsibilities outside the facilities and on return they find no progress. The following participants' views about teamwork were captured.

"There are always some people who are influential in the wrong direction, it's really difficult because you will be called to go there and when you come back you find things stagnant."

"We are overloaded."

"But if you get some people to be on your side in terms of working together there is a relief."

3.3.4 Political Factors

3.3.4.1 Compliance to policies

The findings revealed six ministerial priorities that the facility managers had to ensure that their facilities complied with them. They include cleanliness, infection prevention and control, medicine availability, staff attitudes, patient waiting times and patient safety and security. In general, cleanliness in the facility was difficult to achieve due to a lack of cleaning materials since the budget was decentralized. It was also highlighted that the facility manager should ensure the safety of the patients in the facility. However, it was reported that the department does not provide the necessary support since the function lies with the Department of Public Works.

The study further established that facility managers found themselves having to deal with conflicting policies. For the example, the Ideal Clinic and National Core Standards. The participants reported that there is a need for clear goals and smart objectives from the department. They also reported that the provincialization of municipal clinics had a negative impact in Buffalo City Health District, where the transfer of some clinics resulted in huge human resource gaps. Some positive areas in policy issues were also reported which include improvement in professionalism. Also, the introduction of the Ideal Clinic Program generated some support from supervisors. The participants had a lot to say about this issue, and the following are some of their views.

"Different visions from the same top management like Ideal Clinic and National Core Standards "

"Need clear visions and SMART objectives"

"Transfer from Municipalities to Provincial Government left a huge gap in staffing and is still a problem"

"Lost lots of benefits"

"Wearing of uniform has also improved, it is better now we try that nurses wear uniform and identification with name tags"

"We are getting support now from our Managers and Supervisors because at first, we didn't have anything. Now they are researching Ideal Clinic Standard Operating Procedures (SOPs).

3.3.4.2 The 80% /20% Principle and Nurse–patient ratio

The findings revealed that the rule that requires the facility manager to do 80% administration and 20% clinical work was not practical in the absence of adequate resources, particularly human resources. This was also evidenced by the nurse-patient ratio of 1:40. This issue attracted the following comments from the participants during the interview:

"The 80 /20% rule is the opposite "

"The target of 40 patients per nurse is not practical in the new era of newly developed policies."

"By the time I get to 10 patients I feel physically drained, e.g. Ante Natal Care (ANC), HIV Counselling takes too much time".

"I`m not satisfied with quality because it's just next, next! [sic]."

3.3.4.3 Consultation

The study revealed that there was a need for wider consultation in new policy development and decision-making. Practical strategies were also found as key areas when new policies and decisions are made. A participant lamented that:

"The new guidelines! new registers! But no one will take you through and at the end of the day you have to orientate

3.4 SUMMARY

This chapter presented the findings of the data collected from PHC facility managers. The findings have been presented according to themes and sub-themes.

Table 3.1 shows all the themes and subthemes. The findings were supported by direct quotes from the participants. The findings illustrate various experiences and perceptions of PHC facility managers on their leadership and management competencies.

CHAPTER FOUR: CONCEPTUALIZATION

4.1 INTRODUCTION

The previous chapter focused on the presentation of findings. In this chapter, focuses on the literature control and conceptualization of leadership competencies of facility managers in the Primary Health Care (PHC) settings.

4.2 THE CONTEXT OF LEADERSHIP COMPETENCIES OF FACILITY MANAGERS IN THE PHC SETTING

Generally, the complex demands for bringing change within health systems require good leadership. In the context of this, leadership is not a luxury to be pursued when 'the management is right', but a vital aspect of health system strengthening. According to Gilson and Daire (2011), the critical importance of leadership lies in the fact that it comprises a complex set of people and organizations – inside and outside the health sector and inside and outside of government. They all work within a dynamic environment of changing health needs, medical and technological advances and resource conditions. Given this complexity, leadership is necessary to guide and enable the different parts of the system to work towards common goals. As Management Sciences for Health argue, based on experience in many different countries, health managers must therefore always be 'managers who lead' (Gilson & Daire 2011).

Strong management and leadership competencies have been identified as critical to strengthening health systems (Egger et al. 2005; de Savigny & Adam 2009). While this is true in all health systems, the resource scarcity and crises of low and middle-income country settings make it more important that leadership supports health workers to do their best to deliver quality and responsive care afforded by the available resources (Daire et al. 2014).

The past decade has shown tremendous interest and support for advancing health care on a global scale. This is coupled with the growing awareness that well led and managed global health solutions are required to achieve effective, efficient and

sustainable health programs, especially at the scale needed to attain Millennium Development Goals and other global targets. The PHC leaders should have a vision and then communicate to others and develop strategies for realizing the vision. The leaders motivate people and can negotiate for resources and other support to achieve their goals (Peterson et al. 2011*).* Becoming a manager who leads well requires significant changes in an individual's mind-set. Instead of understanding management as primarily a mechanistic or administrative function, entailing efficient implementation of predesigned roles, tasks, and instructions, such a manager must see management as a dynamic and strategic process occurring in conditions of uncertainty. Such leadership demands a focus on promoting the common good and taking responsibility for working with others on solving the problem to achieve the set goals (Gilson et al. 2014).

Facility managers use a wide range of data and information in decision making. They go beyond the statistics normally produced by health information systems to draw on field-level experimentation and adaptation and identifying operational and systemic constraints. They exercise authority through participation and negotiation, rather than control and command, establishing fair and transparent procedures that engage key stakeholders (political authorities, the scientific community, health professionals, civil society and citizens) in the process of decision making, to generate legitimate decisions and contain the influence of particular interest groups. Further, they develop and guide implementation, compliance with legislation, policies, systems, set of norms and standards to enhance the provision of the comprehensive primary health care package (WHO 2007).

4.3 SOME CRITICAL AREAS TO ENHANCE LEADERSHIP COMPETENCIES

Every organization that operates towards meeting its ultimate goal through human capital needs a healthy working environment. Human capital forms an integral part of the drive that directs the systems. Hence, the organization should look at investing in the human resource component. This principle also applies to the health sector in which the workforce is key for service delivery. The following components about leadership competencies are discussed:

4.3.1 Employee Assistance Program (EAP)

The study established that facility managers do not fully benefit from the EAP. The public sector is challenged by the workforce behaviour of shying away from work as one of the conflict resolution mechanisms. In the Department of Health, broadly and PHC setting in particular, there was increased number of people who took leave whether it was authorised or not. In the study, it was revealed that despite the facility managers attempting to follow the human resource management systems in place to deal with this anomaly, it does not seem to resolve the problem of absenteeism. The lack of tools for enforcing punitive measures in such scenarios automatically increases the untoward tendencies of absenteeism. Consequently, this undermines the leadership abilities of PHC facility managers by their subordinates. In other cases, absenteeism is often mistaken for the shortage of staff, which results in inappropriate attention, despite the available policies to manage it.

In any organization, the employer should ensure that all employees are provided with a form of psycho-social and emotional support to enhance productivity. Employees or workplace wellness programs are an organized, employer-sponsored program that is designed to support employees as they adopt more sustainable behaviours that reduce health risks, improve quality of life, enhance personal effectiveness, and improve the organizations' financial position (Berry, Mirabito and Baun, 2010).

According to Zula, Yarrish, and Lee (2013), human resource professionals are primarily responsible for workplace wellness programs including assessing the impact on performance outcomes on these initiatives. It has been noted by Yach and Dugas (2013) that, "workplace wellness programs are gaining increased support, even though many rests on a shaky evidence base". Employers have the opportunity to develop workplace wellness programs, which can have a substantial impact on employee's income, insurance cost-sharing, and health. Although little research has been conducted to support a hard return on investment (Berry, Mirabito and Baun 2010), there is an increasing body of literature and research suggesting soft data to support the continuation of these programs (Mattke et al. 2013).

These workplace wellness programs are impacting the overall organizational effectiveness and efficiency through a reduction in absenteeism, presentism, and health-related productivity losses (Mattke et al., 2013).

Various research studies have indicated the most successful workplace wellness programs employ multiple modalities to engage employees in wellness activities. The crossover of these research studies has established best practices for employers to develop, implement, and evaluate a successful workplace wellness program. These guidelines would indicate the most successful programs are utilizing five pillars to operate a successful workplace wellness program. These five strategic factors include: (1) effective and efficient communication strategies; (2) leadership engagement and commitment; (3) relationships and partnerships to leverage resources; (4) accessible and involved employees; and (5) relevance as well as continuous improvement.

Healthy employees stay and work longer with the company. A study by Towers Watson and the National Business Group on Health shows that organizations with highly effective wellness programs report significantly lower voluntary attrition than those whose programs have low effectiveness (9% vs. 15%). Various studies confirm that poor health conditions contribute to low productivity. Often, potential of the employees' wellbeing to strengthen an organization's culture and to build employee pride, trust, and commitment is overlooked. The inherent nature of workplace wellness—a partnership between employee and employer—requires trust. Continuous improvement and relevance to the workforce are ingredients to workplace wellness, which are not ignored by successful programs. Therefore, the primary health care facility managers need intensive employee assistance programs since they are vulnerable to psychological and physical stresses from the service users, colleagues, and subordinates. It is therefore the responsibility of the supervisors to ensure that employees are exposed to these programs (Mattke et al. 2013).

4.3.2 Work ethics and professionalism

The organization culture, which includes the normative beliefs, norms, values, and shared behavioural expectations is an integral element of the professional image and it affects the management and leadership strategies.

The climate in an organization forms the basis of attitudes, feelings, and behaviours, which characterize life in an organization and how people perceive their work environment (Isaksen and Ekvall 2006). Though most facility managers in this study perceived themselves to be competent in the staff management, their supervisors and subordinate staff need further development in how to maintain teamwork. The study indicated that the staff sometimes act in contradiction to the principle of good working relationships especially in the absence of the facility managers.

According to Ekvall et al. (2006), a culture of innovativeness (creative work) includes maintaining support for ideas, open relationships, mutual trust and confidence; challenge and motivation, commitment to the goals and operations of the organization; the freedom to seek information and show initiative; maintain pluralism in views, knowledge, and experiences; and having an open exchange of opinions and ideas. Thus, culture and work environment impact work attitudes and subsequent staff turnover. The focus of health care system has been on effectiveness and productivity, and little attention on developing job satisfaction. Job satisfaction is essential for high-quality health care provisioning (Kramer and Schmalenberg 2004).

Nursing as a profession relies on relations and caring for others, which affect the leadership and organization of nursing. If the manager leads with kindness and respect, it is more likely that the staff will show the same behaviour towards the patients. This is important in the current economic dispensation when there is a high risk of losing the aim to care for the patient, as a result of the pressure for productivity and the economic goals of the administrators (Bondas 2006). Positive leadership qualities and strong facilitative leadership behaviour of the first line managers are important in creating an environment that increases job satisfaction and low turnover.

A creative work environment has the strongest relationship to job satisfaction, and the manager is an important link in creating such a condition. When organizational changes occur and the work environment is unstable, it is the manager who should remain calm and motivate the staff. It is important to know how to develop functional workgroups as well as what individual needs are to be met. To create an open-minded creative culture, the manager has to support new ideas and initiatives from

subordinates. In small units like primary health care facilities, where managers work with their staff and where work teams are stable, it is easier to foster a creative work climate. The employees must be allowed to feel joy at work even if they are working in a very serious area. However, the manager should clearly articulate the organization's most important values and then link them to that organization's mission and vision. When this type of work climate is created, it is more likely that subordinates will have job satisfaction and remain in their jobs (Bondas 2006).

4.3.3 Labour relations

Human resource issues such as policies and interventions have received little attention within strategic agendas, except managerial challenges for improving efficiency and productivity. Changes in models of care, particularly at the basic level, require improvement in workers` preparation with emphasis on skills in health care promotion and prevention, for general work and effective teamwork. The study shows that resistance to change is one of the stumbling blocks to effective and efficient service delivery innovations. The PHC staff members rather stick to their traditional way of doing things despite the introduction of new strategies, which become tantamount to some insubordination.

The inherent PHC challenges coupled with changes in the system are forcing the managers to develop new responsibilities for leading the emergence of new projects for institutional strengthening. The greatest problem seems to be the workload, more especially of limited human resources, as a result of unfilled vacancies and the need to supervise low category personnel. Apart from an enhanced theoretical understanding of nurses' work, the importance of this study lies in its potential to inform the development of public policy designed to improve nurses' quality of working life, to attract, and retain nurses in the profession. In this study, nurses identified the consequences of staff shortages as increased responsibility within their duties, increased stress levels, lack of work-life balance and overall frustration. All of these have long-term health implications for nurses and, ultimately threaten the health care system itself.

Moreover, given the general recognition by practitioners, policymakers and scholars alike, retention and recruitment of nurses are increasingly problematic. In particular, the concerning issue is the increased stress levels evidenced by the likelihood of nurses leaving their jobs (Zeytinoglu et al., 2006), thus compounding the challenge of retention and recruitment. Work intensification is often associated with the effects of a neoliberal political agenda that includes a drive for efficiency at work along with the reductions in public sector funding, which often lead to deterioration in workplace health and safety. In the current study, nurses referred to a gradual increase in workload over time - a form of work intensification, where one described it as 'the expectation to do more with less' leading to nursing jobs being more stressful.

The government attempts to tackle nursing shortages and increasing workload, but the labour relations climate for the last decade has been generally acrimonious in the political context of health care board restructuring. All of this feeds into the need for more effective retention and recruitment. More competitive wages will not be enough to make nursing more attractive unless working conditions are improved. Policymakers need to put into considerations that the industrial relations climate, occupational health and safety, and retention and recruitment are strongly linked. If health care is to be effective, the nursing shortage has to be resolved, and existing nurses need to experience work as less stressful and frustrating by having more work-life balance (Ilcan 2009).

4.3.4 Leadership and Governance

The study showed that compliance with policy directives and guidelines was a challenge within the PHC. This emanated from different supervisors visiting the facilities from various administration levels. In so doing, they brought different views, opinions, and preferences in guiding the facility staff. Further, this study found that the use of disintegrated monitoring, evaluation, and supporting tools by various program managers at the facility level contributed to management and leadership challenges. According to the World Health Organization, leadership and governance are associated with the role of the government in health care and its relation to other actors whose activities have an impact on health system. This involves overseeing and guiding the whole health system to protect the public interest (WHO 2007).

Stewardship, therefore, goes beyond ministries of health playing a leadership role in the health sector (stewardship in health) to include focusing on responsibility and tasks for the strategic management of the health system (stewardship of health), as well as inter-sectoral, socio-political environment within which the health system operates (stewardship for health) (WHO 2002).

Chigozie et al in a study conducted in Nigeria indicates that the lack of effective leadership and governance (stewardship) in the health sector has remained a major challenge in most low to middle-income countries, including Nigeria. This has contributed greatly to the failure of these countries' health systems. Nigeria's Federal Ministry of Health has observed that the lack of performance of the country's health system is attributable to the weakness in the leadership/stewardship role of government in health (FM OH 2004). The Federal Ministry of Health has identified up to eight constraints that impede the stewardship role of government in Nigeria's health sector. These constraints are:

(a) poor definition of the roles and responsibilities of key actors;

(b) lack of the requisite enabling management and stewardship tools, such as relevant policies, and operational health sector strategic development framework and so on;

(c) the challenges of fostering inter-sectoral collaboration with other arms of government and the wider society;

(d) poor dissemination and enforcement of health policy implementation;

(e) absence of legal and constitutional backing for some major policy thrusts;

(f) the fact that current policies do not include the definitive roles and responsibilities of the private sector;

(g) the generally depressed state of the evidence-based budget and plan management practices; and

(h) inadequate funding of the health sector (FM OH 2004).

Through its National Health Workforce, Leadership and Stewardship Capacity Initiative, WHO supports member states to strengthen their leadership capacity in the process of developing, implementing, monitoring, and evaluating HRH policies, plans, norms and standards (WHO 2009).

4.4 CONCLUSION

The processes of leadership can promote the relationships necessary for effective team engagement, and can encourage actors to trust each other to exercise productive discretion. This can enhance the ability of managers to engage with their colleagues in a more supportive way. Nonetheless, space and time available for leadership in the PHC setting are limited by the dominance of bureaucratic management and accountability processes. Given this context, the facility managers have limited exposure to PHC leadership approaches. It is, therefore, crucial that higher-level managers gain a greater understanding of leadership approaches and experiences and put them into consideration as they seek to strengthen health system governance.

CHAPTER 5: DISCUSSION, LIMITATIONS, SUMMARY, CONCLUSION, AND RECOMMENDATIONS

5.1 INTRODUCTION

This chapter entails the discussion of findings on the perceptions and experiences of facility managers of Primary Health Care facilities regarding their leadership competencies. The chapter also provides the conclusions and recommendations of the study.

5.2 DISCUSSION

The study revealed various factors, which inhibit facility managers' leadership functions and operations in improving the Primary Health Care service delivery. Some of these factors are related to departmental, individual, staff, as well as political. These among other obscures their functions and they being proven as competent leaders at Primary Health Care facilities.

The participants indicated that lack of emotional and wellness support was negatively affecting their functioning. The nature of nursing services provided to service consumers is dynamic such that, at times it becomes traumatic to the service provider, and may result into emotional strain. The results showed that sometimes the subordinates would be trained instead of their managers. This practice strained the leadership process. Notably, representation of the nursing fraternity at the executive level in the organizational structure was lacking. This representation gap affected work positions in the health department, thus posing leadership challenges. In order to address these gaps, the participants believed that having incumbents with a nursing background to occupy top management positions can improve the current situation of the Primary Health Care system. Consequently, this would lead to staff job satisfaction. The Public Service Management Policies emphasize that, placement of staff in different positions should be informed by the possession of appropriate and relevant qualifications, skills, and expertise on the field (Pascalia et al., 2016).

The study also revealed that infrastructure and resources such as human, material as well as financial were inadequate. Moreover, lack of uniformity in the clinics (where some clinics were well staffed and others not) posed management challenges. According to Karina, Nielsen, Morten, et al (2017), resources increase the wellbeing and performance of employees. Therefore, the Primary Health Care facilities should improve on resources mobilization to enhance the wellbeing and performance of its employees.

In terms of personal factors, the study revealed that the participants had low self-esteem, as they felt unable to perform to the required expectations due to the gaps identified. The negative attitudes of staff members who did not want to carry orders from the managers contributed to low self- esteem of managers. The failure to take orders led to staff resistance to change, absenteeism and lack of teamwork. On the other hand, pressure associated with poverty and low socioeconomic factors were reported as one of the obstacles that affect managers' leadership in the study area.

The findings indicated that, the health care system lacks a well-established, comprehensive, collaborative and consultative system and strengthening programs for Primary Health Care facilities. This results in PHC staff finding themselves in a conflicting role situations. The findings also revealed that non-compliance with the policy directives and guidelines. Perhaps, this emanated from different supervisors visiting the PHC facilities from various administration levels, hence bringing different views, opinions, and preferences in managing the facility. This shows a gap in collaboration and developing integrated tools to support the Primary Health Care system. This may lead to poor implementation of policies and non-compliance thereof.

At the Primary Health Care facilities, there are so many demands from the Department of Health and the communities that the facility managers have to deal with. When the department is not performing well, the pressure is put on the facility managers. However, as the managers respond to this pressure, there is limited or lack of support in the process. The facility managers are expected to ensure safety and care for the clients, and good quality of the services provided. The Health Systems Trust (SAHR 2017) highlighted the need for greater support of health workers so that they would be

more caring and compassionate. The feeling of being neglected was evident in the study. For instance, the clinic supervisors did not visit their facilities regularly, and worst of all, the whole year goes with no support visit to the facility. This is against the Clinic Supervision Policy Directive, which requires a supervisor to pay a monthly support visits to each Primary Health Care facility.

Further, the findings indicated that, the Employee Health and Wellness Section was yielding minimal results in contributing to the improvement of Primary Health Care managers as expected. The support was direly needed because sometimes the Primary Health Care service providers are exposed to incidents of violence and crime in their workplace. The study also showed the need for improving the capacitation of facility managers by developing new guidelines, short course training on leadership and rigorous induction. The adequate capacity of staff in any institution yields to effective and efficient provision of services to the customers. All Primary Health Care facility managers should ensure that the provision of a comprehensive Primary Health Care package is delivered. This means that all staff members of different categories within PHC facilities should be well capacitated for them to provide good quality care to the service consumers.

In current practice (when this study was conducted), there is no implementation of a standardized induction program. Some departmental units or individual districts organises their induction programs, which would not benefit every new employee.

The need for capacitation of staff is in line with Mourao and Fernandes (2018) who indicated that staff development should be part and parcel of the organization, as it influences the productivity of the organization. The new health reforms like National Health Insurance (NHI) necessitate a stable and well-coordinated training program for all employees, most importantly the Primary Health Care facility managers. This is important for managers because they find themselves on with management leadership and managerial responsibilities, but with little assistance from their supervisors at sub-district, district, and provincial levels. The evolving disease burden also demands ongoing in-service training for facility management leaders who will, in turn, capacitate their subordinates. The World Health Organization`s (WHO) Health systems strengthening building blocks emphasis on workforce development to provide good quality health care (WHO 2007).

This study showed that the facility managers in Buffalo City Metropolitan district had not been consistently exposed to any facility management and leadership program. This contributed negatively to the health performance outcomes at both provincial, district and facility levels. This is again clearly stated in the Human Resources for Health Policy regarding the adequate implementation of the Performance Management Systems to yield better results. Sherr et al. (2013) reported that the current practice in the PHC governance is that the facility manager would be appointed and be expected to function optimally without any form of training, which poses a great challenge for them to lead efficiently. The results also showed that sometimes the subordinates would be trained instead of their managers, thus, straining the leadership process.

Equal distribution of tools for trade and resources is one of the key aspects of ensuring staff satisfaction as well as fair monitoring on compliance to policy. Clear guidelines should be communicated throughout the entire system. The distribution of resources to uphold fairness and eliminate dissatisfaction is vitally important in PHC governance. In this study, lack of standardized practice was reported in the PHC facilities in the country. This was contrary to the fact that, the health care service delivery is a legislated practice by the Health Act, Nursing Care Act, Primary Health Care Norms and Standards, National Core Standards, and Ideal Clinic Standards including all the other relevant legislative formations. The set legislation seeks to ensure that all health establishments provide universal services that meet the desired goals and objectives. It is hence very important that managers and supervisors from different departmental levels support the Primary Health Care facilities in realizing this goal and comply with the set standards. Contrary to this, in this study, the participants stated that the expected standardization is compromised as there is a lack of necessary resources to ensure compliance.

The White Paper for the National Health Insurance (NHI) states that, to enhance Universal Health Coverage (UHC) all health facilities should meet the set standards, which include the PHC Norms and Standards, National Core Standards (NCS) and Ideal Clinic (IC) Standards. This also implies that there should be equitable distribution of available resources (Sherr et al., 2013).

Every service has to be provided in a dedicated service area. Some of the Primary Health Care facilities in the Buffalo City Health District do not comply with this prescription. This compromises the health status of the patients. The study revealed infrastructural challenges as evidenced by congestion and overcrowding in health facilities due to limited space. The infrastructure improvement is one of the National Development Goals (NDP Vision 2030) of the country, which is emphasized with the principle of Universal Health Coverage of the NHI strategy.

Evidently, with the current state of the PHC facilities, it is not easy to achieve the set objectives and it hinders a competent leader to exercise his/her duties. The South African Constitution upholds the principle of a safe, habitable and clean environment for progressive and holistic human development. It further states that the health services should be provided in a building with adequate infrastructure. Khan, Azhar, Parveen et al. (2019) indicated that the work environment that is conducive for workers leads to high productivity and improved well-being, and the workers end up being dedicated to their work.

Staff shortages in the facilities were cited as one of the challenges the facility managers experienced. Ideally, each facility should have a staff component that is aligned with the population served. This is coupled with a clear job description highlighting the roles and responsibilities of all personnel. However, once a gap exists in personnel allocation, it impacts on the available staff who become overworked, hence affecting the quality of work. Staff shortage in facilities among other issues leads to the disgruntled staff and patients, long waiting times, and negative attitudes. Filling of vacant posts has been reported to be an ongoing challenge in PHC facilities irrespective of the new policies that come with additional work. The facility managers perceive this as another area of lack of support from their principals. The Eastern Cape Department of Health embarked on a staffing determination process based on Workload Indicators for Staffing Needs (WISN) with proposed staff compliment outcome displayed in each PHC facility. In any country, a “well-performing” health workforce is one, which is available, competent, responsive and productive. To achieve this, strategic and deliberate actions are needed to manage dynamic labour

markets that address entry into and exits from the health workforce, improve the distribution, and performance of existing health workers (WHO, 2011).

The study showed that the participants were willing to comply with the regulation, which stipulates that 80% of their working hours should be spent performing administrative duties with the remaining minimal time (20%) doing clinical work. This becomes unrealistic in situations where resource scarcity is predominant. The mentioned gap becomes evident when the outcomes of the performance management process are reported. The positive contribution of each employee in realizing the organizational goals and objectives is a critical and should be facilitated by an enabling environment. It is, therefore, the responsibility of the employer to ensure that the necessary tools of the trade are available at disposal, particularly for Primary Health Care, which is the backbone of the health care system.

The study showed that the facility managers had an obligation to meet all the administrative expectations to deliver quality services. The expectations at various levels e.g. national, provincial, district and sub-district management tend to be overwhelming on facility managers to ensure adequate facility performance. Administrative responsibilities, which include systems management – human resource, finance management, data management, and verification of patient come up as one of the critical responsibilities of the facility managers. If the manager fails in this responsibility would have negative consequences on the service delivery outcomes. The facility manager is also expected to ensure that the information management system is put into practice according to the relevant policy categories (Kautzkyi et al., 2008).

The PHC facility managers are required to give positive feedback on performance, including appreciation to their subordinates. They should insist on transparency concerning errors, serious incidents, complaints and problems, and treat mistakes as opportunities for learning. They should act effectively to deal with poor performance and proactively address aggressive, inappropriate and unacceptable behaviours displayed by staff or patients/carers. They should promote the continuous development of the knowledge, skills, and abilities of staff to improve the quality of

patient care, safety, compassion, and the patient experience. Moreover, they should consistently encourage, motivate and reward innovation and introduce new and improved ways of working. This because the study found the following personal factors inhibiting performance in PHC facilities: low self-esteem, lack of self-confidence, lack of passion, poor self-image, lack of professionalism, not being self-driven (depend on supervisors), not being creative nor innovative, being more reactive than proactive, more followers than leaders, inadequate knowledge and lack of role modelling.

The emerging of the new health reforms such as NHI, Ideal Clinic, CCMDD, etc. within the health care system is a strategy to meet the demands that face the health system particularly the increased disease burden, and social determinants of health. These reforms give rise to the need for change management strategies at all service delivery institutions. The Buffalo City Health District has been identified as one of the districts implementing key focus areas of NHI. Inherent in this evolution, is the recognition that providing a sense of direction to health systems requires a set of specific and context-sensitive reforms that respond to the health challenges of today and prepare for the future.

The study shows that resistance to change is one of the stumbling blocks for service delivery innovations. The PHC staff members rather stick to their traditional way of doing things despite the introduction of new strategies. This becomes tantamount to some insubordination. According to Belita et al. (2013) absenteeism has been reported to be common in the public sector, especially in high and low-resource settings. The public sector is challenged by the workforce that perceives shying away from work as one of the conflict resolution mechanisms. In the Department of Health broadly and PHC setting in particular, this is evidenced by the increased number of people who take leave whether they are approved or not. In the current study, it was reported that despite the facility managers following the human resource management systems in place to deal with this anomaly, it doesn't seem to resolve the problem of absenteeism as they do not receive any feedback from their supervisors. According to Cucchiella, Gastaldia and Ranieri (2014) absenteeism can lead to less productivity, leading to the target goals of the organization being not met. This at the same time leads to disturbances in the organizations' strategies.

Bermingharm (2013) indicated that stress is regarded as one of the leading factors to absenteeism and most of the companies are affected by it. Lack of enforcing punitive measures in such scenarios automatically increases the untoward tendencies of absenteeism. Consequently, this undermines the leadership abilities of PHC facility managers. Absenteeism is often misinterpreted as a shortage of staff, which results in inappropriate attention despite the available policies to manage it. The most alarming consequence of absenteeism in the health facilities is increased medico-legal litigations, which culminate into poor quality of care (National Department of Health Annual Report 2014/15).

The literature also shows that absenteeism is a continually rising workforce problem that needs investigation (HRH Strategy for the Health Sector: 2012-13 /2016-17). The current study also showed that training is becoming a problem than a solution due to a lack of integrated, collaborative and comprehensive programs. This results in so many training programs that move staff away from their workplaces leaving critical duties unfulfilled. To address this particular challenge, the Human Resource Development Unit should coordinate training through its Regional Training Centre (RTC).

Most PHC facility managers in the study perceived themselves to be competent in management roles. However, their supervisors and subordinate staff need further development in maintaining and managing teamwork. The findings showed that some staff contradicts the principle of good working relationships as they tend to bring incitement and negative influence to the work station. This behaviour, which gets more profuse in the absence of the facility managers. However, facility support and monitoring visits indicate that managers need to pay more attention in steering complex health system changes and facing people's dynamics. This aligns with the study on an evaluation of competencies of Primary Health Care clinical nursing managers in two South African Provinces conducted by Global Health in 2016.

5.3 LIMITATIONS OF THE STUDY

Limitations are restrictions that may decrease the credibility and generalizability of the study findings (Burns & Grove, 48). This study is limited to small sample of participants.

The participants of the study were drawn from the Primary Health Care clinics of one district only. The Community Health Centres (CHCs) that also form part of Primary Health Care facilities with facility managers were not included in the study. Based on this, therefore, the study cannot be generalized to all CHCs.

Methodologically, this study would have provided a broader picture if it had included the Primary Health Care supervisors (Clinic Supervisors) to give their views and experiences. This is significant because of their proximate to their subordinates.

5.4 SUMMARY

This chapter discussed the findings of the study and highlighted the limitations. The conclusion as well as the recommendations are made.

5.5 CONCLUSION

This study focused on exploration and description of the perceptions and experiences of Primary Health Care managers on their leadership competencies in the Buffalo City Health District. The findings of this study showed that the Primary Health Care facility managers receive very limited support from their supervisors and management of the department in general. This exposes them to challenging situations as they strive to lead and manage in their facilities. It has been also evident that there is no induction nor in-service training program in place to empower the PHC facility managers for the provision of quality care in the Primary Health Care settings. This makes them lose confidence and lack the necessary skills as they exercise their leadership responsibilities. The study revealed challenges such as lack of resources including staff shortages hindered the managers' functions and delivery of quality services. The study also revealed inequality in the distribution of available resources to run the facilities.

The study also revealed lack of standard approach by different managers when implementing supervision in their facilities. This is despite the availability of standard guidelines and policies such as Ideal Clinic and National Core Standards. Therefore, they sometimes feel excluded in decision making during new interventions and

departmental developments, whereas they are expected to implement such interventions at the local level. The issue of high workload due to staff shortages came up emphatically, which reportedly compromises the effective and efficient practice.

The facility managers also cited the inhabitable infrastructure environment of the buildings where services are provided. They maintained that there is no proper maintenance of clinic buildings, which also adversely affect the health of service providers and consumers. The human resource matters that include staff resistance, negative attitudes towards work and themselves as facility managers, absenteeism and inadequate teamwork came was reported in this current study. Consequently, this affects the day-to-day operations in the facilities. The study revealed that various circumstances that prevail in the Primary Health Care environment inhibit managers' growth and willingness to realize the ultimate goal and vision of the department and the entire health care system.

5.6 RECOMMENDATIONS

The study recommendations are as follows:-

5.6.1 Recommendations regarding clinical practice

- The Human Resource Development Unit of the Department of Health should guide the districts with a standard induction and orientation program for newly appointed Primary Health Care facility managers.
- There should be a well-developed, structured mentorship, and coaching ongoing program for Primary Health Care facility managers.
- The district health system should establish integrated structured monitoring, support, and evaluation strategy for the entire Primary Health Care system.
- There needs to be a generic leadership and management program for Primary Health Care managers to complement the health-related competencies expected.
- Primary Health Care managers should be exposed to the financial management systems to enable them to manage the budget.

- The curriculum for training nurses should include leadership, digital technology, and computer modules to prepare them for leadership positions especially during this era of NHI with multiple stakeholders at the local level.
- There should be a system for the resource audit of Primary Health Care facilities to inform equitable resource allocation.
- The costed infrastructure maintenance plan for Primary Health Care facilities needs to inform the prioritized implementation of infrastructure improvement, rather than the staggered approach.
- Primary Health Care facility managers should also be developed and trained on how to account for the responsibilities entrusted on them by the different departmental levels i.e. national, province, district, sub-district, and other internal and external stakeholders.
- Lastly, the Department of Health should put mechanisms in place to restore professionalism within the Primary Health Care environment.

5.6.2 Recommendations for future research

- The future research studies could focus on other clinic staff members since the current study focused on managers only. This would enhance the understanding of leadership and management issues in Primary Health Care Facilities in the district.
- Another study could look into management in higher levels such as the province and district responsible for managing the facilities.
- Lastly, a quantitative research study should be conducted on the same topic to be able to generalize the findings.

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APPENDENCES

Appendix A: Ethical Clearance from University of Fort Hare

University of Fort Hare
Together in Excellence

ETHICAL CLEARANCE CERTIFICATE
REC-270710-028-RA Level 01

Certificate Reference Number:	SEE191SMAK01
Project title:	**Leadership competencies of primary health care managers in Buffalo City Health District, Eastern Cape.**
Nature of Project	Masters in Health Sciences
Principal Researcher:	Noxolo Beauty Makinana
Supervisor:	Prof E Seekoe
Co-supervisor:	N/A

On behalf of the University of Fort Hare's Research Ethics Committee (UREC) I hereby give ethical approval in respect of the undertakings contained in the above-mentioned project and research instrument(s). Should any other instruments be used, these require separate authorization. The Researcher may therefore commence with the research as from the date of this certificate, using the reference number indicated above.

Please note that the UREC must be informed immediately of

- Any material change in the conditions or undertakings mentioned in the document;
- Any material breaches of ethical undertakings or events that impact upon the ethical conduct of the research.

The Principal Researcher must report to the UREC in the prescribed format, where applicable, annually, and at the end of the project, in respect of ethical compliance.

***Special conditions**: Research that includes children as per the official regulations of the act must take the following into account:*
Note: The UREC is aware of the provisions of s71 of the National Health Act 61 of 2003 and that matters pertaining to obtaining the Minister's consent are under discussion and remain unresolved. Nonetheless, as was decided at a meeting between the National Health Research Ethics Committee and stakeholders on 6 June 2013, university ethics committees may continue to grant ethical clearance for research involving children without the Minister's consent, provided that the prescripts of the previous rules have been met. This certificate is granted in terms of this agreement.

The UREC retains the right to

- Withdraw or amend this Ethical Clearance Certificate if
  - Any unethical principal or practices are revealed or suspected;
  - Relevant information has been withheld or misrepresented;
  - Regulatory changes of whatsoever nature so require;
  - The conditions contained in the Certificate have not been adhered to.

- Request access to any information or data at any time during the course or after completion of the project.

- In addition to the need to comply with the highest level of ethical conduct principle investigators must report back annually as an evaluation and monitoring mechanism on the progress being made by the research. Such a report must be sent to the Dean of Research's office.

The Ethics Committee wished you well in your research.

Yours sincerely

Professor Pumla Dineo Gqola
Dean of Research

05 March 2018

Appendix B: Permission from Ministry of Health Eastern Cape Province

Province of the
EASTERN CAPE
HEALTH

Enquiries: Zonwabele Merile
Email: Zonwabele.Merile@echealth.gov.za
Tel no: 083 378 1202
Fax no: 043 642 1409

Date: 04 JUNE 2018

RE: LEADERSHIP COMPETENCIES OF FACILITY MANAGERS IN PRIMARY HEALTH CARE FACILITIES OF BUFFALO CITY METROPOLITAN HEALTH DISTRICT IN THE EASTERN CAPE PROVINCE. (201805_019)

Dear Noxolo B. Makinana

The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted amended protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.

3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.

4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.

5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

Appendix C: Letter of Permission from Buffalo City

Province of the
EASTERN CAPE
HEALTH

BUFFALO CITY METRO HEALTH DISTRICT
OFFICE OF THE DISTRICT MANAGER
18 Shefield Road • Westbank •East London •5200, Eastern Cape
Private Bag X 9015 •Main Post Office, East London • 5200 • Eastern Cape
Tel.: +27 (0)43 708 1797 • Fax: +27 (0)43 708 1836/ 086 245 5023 • Website: www.ecdoh.gov.za
Enquiries: Ms Z Mntuyedwa

INTERNAL MEMORANDUM

To:	Hospital CEOs Acting Sub-District Manager CHC Facility Managers Clinic Supervisors
From:	District Manager
Subject:	Permission to conduct Research Study: Mrs Noxolo Makinana
Date:	9 July 2018

Purpose
The purpose of this memorandum is to inform relevant Buffalo City Health District staff and patients of permission granted on research study to be conducted by Mrs Noxolo Makinana towards a Masters in Public Health Degree with the University of Fort Hare.

Background and Exposition of Facts
Mrs Noxolo Makinana is currently studying towards a Masters in Public Health Degree with the University of Fort Hare. The title of her research study is "**Leadership Competencies of Primary Health Care Facility Managers in Buffalo City Metropolitan**".

She has requested for permission to do research in Buffalo City Metro Health District at 60 health care facilities. Mrs Makinana has submitted all the required documents for a research study in the Eastern Cape Department of Health facilities and as such permission has been granted to her by the Research unit to conduct the study in terms of her research protocol and methodology.

United in achieving quality health care for all

Fraud prevention line: 0800 701 701
24 hour Call Centre: 0800 032 364
Website: www.ecdoh.gov.za

PERMISSION TO CONDUCT RESEARCH STUDY: Mrs Makinana

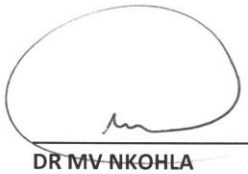
Approval by the District

1. Kindly note that this memorandum serves as an approval at district level for Mrs Makinana to conduct her research study in terms of the approved research protocol, ethical clearance and permission letter from the research unit subject to producing all necessary supporting documentation on request to prospective participants in the research study and management of the district;

2. All posters advertising the research must first be tabled with the CEOs and Sub-District Manager to ensure compliance with departmental policies;

3. Patient details and addresses will only be provided to the researcher on those who have consented to participate in the research subject to the terms and condition of the letter of approval from the Research Unit of the Eastern Cape Department of Health.

APPROVED



09/07/2018

DR MV NKOHLA
DISTRICT MANAGER
BUFFALO CITY METROHEALTH DISTRICT

DATE

Appendix D: Letter for Permission to Conduct Research

Albertina Sisulu
Executive Leadership
Programme in Health
Excellence. Innovation. Transformation

University of Fort Hare
Together in Excellence

The Head of Department

Eastern Cape Department of Health

Private Bag x 0038

Bisho

14 December 2017

RE: REQUEST PERMISSION TO CONDUCT A RESEARCH STUDY

Researcher: Noxolo Beauty Makinana

The Superintendent General

The researcher is a student at the University of Fort Hare (Student Number 200909897). The research topic is "Leadership competencies of Primary Health Care (PHC) Managers in Buffalo City Health District in the Eastern Cape Province.

I wish to apply for permission to conduct the research study in partial fulfilment of the requirements for the Master`s Degree in Public Health (MPH). The ultimate aim of the study is to improve the quality of health services in PHC facilities by developing an understanding of the leadership competencies of primary health care managers in their facilities. The findings of the study will enable the department to develop informed strategies and interventions towards strengthening the leadership role of PHC facility managers for better outcomes.

Participants in the study will be the operational managers from Buffalo City Health District primary health care facilities. Ethical clearance has been obtained from the University Research Committee. The findings of the study will be also shared with the department.

Yours faithfully

Mrs Noxolo Beauty Makinana

Mobile no: 0833780105

Fax: 086 600 9528

Appendix E: Consent Form Sample

Albertina Sisulu
Executive Leadership
Programme in Health
Excellence. Innovation. Transformation

University of Fort Hare
Together in Excellence

RESEARCH TOPIC: LEADERSHIP COMPETENCIES OF PRIMARY HEALTH CARE FACILITY MANAGERS AT BUFFALO CITY METROPOLITAN DISTRICT IN THE EASTERN CAPE PROVINCE.

Consent Form

Focus Group Discussion

RESEARCHER: Mrs N.Makinana

PARTICIPANT'S INFORMED CONSENT

I hereby declare that I understood the explanation given to me and agree to participate in the study about my perceptions of management and leadership roles in primary health care facilities in the Buffalo City Health District.

Participant's name ……..…….. (Please print)

Participant's signature: ……. Date: .....

Signed at (Place) :……

I hereby further agree to have the information I provide included in a research study in accordance with the conditions of the research process.	Yes	No

Appendix F: Interview Guide

University of Fort Hare
Together in Excellence

PERCEPTIONS OF PRIMARY HEALTH CARE FACILITY MANAGERS IN BUFFALO CITY HEALTH DISTRICT IN THE EASTERN CAPE PROVINCE ABOUT THEIR LEADERSHIP AND MANAGEMENT COMPETENCIES

FACULTY OF SCIENCE & AGRICULTURE

SCHOOL OF HEALTH SCIENCES

NAME: N. B. MAKINANA **STUDENT NO: 200909897**

SUPERVISOR: PROFESSOR E. SEEKOE

QUALITATIVE RESEARCH STUDY

FOCUS GROUP DISCUSSION INTERVIEW GUIDE

TIME ALLOCATION: 1 HOUR 30 MINUTES

NO.OF GROUPS: 2

1. What are your perceptions regarding your leadership competencies in primary health care facilities?
2. What are your experiences regarding your leadership competencies in primary health care facilities?
3. What are the expected leadership responsibilities of a facility manager with respect to your duties in your facilities?
4. What are the expected management responsibilities of a facility manager with respect to your duties in your facilities?

5. What are the challenges associated with your ability to exercise the leadership and management roles in primary health care facilities in your district and province?

6. What are your recommendations regarding possible means of exercising appropriate leadership and management functions in PHC facilities by facility managers in Buffalo City Health District?

Compiled by: N.B.Makinana