UNIVERSITY of the WESTERN CAPE

INSTITUTE FOR SOCIAL DEVELOPMENT
University of the Western Cape

Private Bag X17, Bellville 7535, Cape Town, South Africa

Telephone :(021) 959 3858/6 Fax: (021) 959 3865

E-mail: pkippie@uwc.ac.za or spenderis@uwc.ac.za

FACULTY OF ECONOMIC AND MANAGEMENT SCIENCES

A discursive exploration of managers' competencies at community health centres in low socio-economic status communities in Cape Town

Monalisa Ayabulela Jantjies (3765907)

Submitted in fulfilment of the requirements for the degree

Master of Development Studies

in the

Faculty of Economic and Management Sciences

at the

University of the Western Cape

Supervisor: Prof. F. Waggie

2019

DECLARATION

The mini-thesis submitted in fulfilment of the requirements for the degree Master of Development Studies in the Faculty of Economic and Management Sciences at the University of the Western Cape

FULL NAME: Monalisa Ayabulela Jantjies

- I know that plagiarism is wrong. Plagiarism is to use another's work and pretend that it is my own.
- I have used the `APA convention for citation and referencing. Each significant contribution to and quotation in this thesis from the work or works of the other people has been acknowledged through citation and referencing.
- This thesis is my own work.
- I have not allowed and will not allow anyone to copy my work with the intention of passing it off as his or her own work.
- I have done the word processing and formatting of this thesis myself.

_____

M.A. Jantjies

University of the Western Cape

_____

Signed at

17 September 2019

_____

Date

DEDICATION

This mini-thesis is dedicated to all managers and health professionals in the primary healthcare sector, committed to collaborating with the education and capacity building sector in the higher education arena to enable skills development, improved resource management, better service delivery and encourage a positive lifestyle for community members who are classified as vulnerable.

ACKNOWLEDGEMENTS

I would like to express my sincere appreciation to all people listed below without whom this mini-thesis would never have been possible

Prof Firdouza Waggie, my supervisor, for her tireless motivation, structure, support, patience and guidance for my personal as well as academic development. This could not have been possible without her encouragement and direction.

My parents, **Anderson P Jantjies** and **Nwabisa N Jantjies** as well as my sister, **Sinoyolo A Jantjies** for their love, sacrifice, support, encouragement and understanding.

Ms Priscilla Kippie, for her support and guidance.

Mrs. Alicia North, for her fine eye editing, supporting and mentoring me through the journey of completing the thesis.

Mr. Laurence Hill, for editing the thesis.

Mr. Maxwell Magobolo for the thorough transcriptions.

Ms Lebohang K Makobane, for her unwavering support and co-coding.

UWC Library and Interlibrary staff, for your assistance in sourcing the literature needed to complete this study.

The participants, for your willingness to partake in my study

Table of Contents

List of Figures

List of Tables

List of abbreviations

ANC African National Congress

CA capability approach

CHC Community Health Centre

COPC Community Oriented Primary Care

CPD continuing professional development

EPHS essential public health services

HPCSA Health Professions Council of South Africa **HRH**

Human Resources for Health

HDCA Human Development Capabilities Approach

MMed Master of Medicine

MPH Master of Public Health

NDP National Development Plan

NCDs Non-communicable diseases

PHC primary health care

RDP Reconstruction and Development Programme

SDGs Strategic Development Goals

TB tuberculosis

WC Western Cape

WHO World Health Organisation

WISN WHO's Workload Indicator of Staff Needs

ABSTRACT

South African health professionals' competencies, especially those of managers have been placed under the spotlight. In the community health centres (CHCs) situated in low socio-economic status areas in Cape Town, a shortage of human resources has been an area of importance, as it exacerbates the impact of competence and service delivery by the healthcare managers. The predominance of burden of disease in low socio-economic communities in South Africa is the direct reflection of disparities in service sectors of South Africa. It is because of the aforementioned reasons that the study is situated in low socio-economic status areas communities of Cape Town such as the Cape Flats. The study explored the healthcare professionals' perceived competencies required of a manager in the CHC level, that could inform the postgraduate health professionals' specialised curriculum, which could aid in ultimately improving service delivery at a CHC level.

METHODS:

The researcher elicited data directly from health professionals at five CHCs in the Cape Flats; through face-to-face semi-structured interviews as a mechanism to collect data. The researcher selected the human resource manager (n=1) of the district, facility managers (n=5), a doctor at each CHC (n=5), a professional nurse at each CHC (n=5) and psychosocial personnel (n=5) at each CHC. A total of 21 people were interviewed for this study. The Human Development Capabilities Approach as the theoretical paradigm was the lens to which the community healthcare managers' competencies have been analysed and wherein recommendations were derived.

FINDINGS:

Compassionate leadership and management was at the core of the competencies that were highlighted by the participants. The healthcare context, teamwork, a strong support base in the workplace and training that addresses the health trends healthcare professionals face on a daily were said to be the competencies healthcare managers require most. It is therefore a recommendation that, management readiness specialised training be undertaken by managers and for a manager to be aware of their personal traits.

TAKE HOME MESSAGE:

Healthcare management is a phenomenon that requires further investigation, especially in the district level healthcare sector. In healthcare, it is recommended that management be a specialisation and not promotion based. Specialisation for healthcare manager must be 1 year in service training whereby supervision (academically at a tertiary institution and an a practice or on the job) is granted to a healthcare professional who wishes to be a manager. This specialised training interplays in the managers functioning in the ever-changing dynamic healthcare arena.

Key words:

Primary Health Care Approach; Public Health; Service delivery; Management; Leadership; South African Health system; Competencies; Human Development Capabilities Approach; Burden of disease, Low socio-economic status

CHAPTER ONE

OVERVIEW OF THE STUDY

1.1 Introduction

Le Chen, Dean, Frant, & Kumar (2013) describe *'service delivery'* as a phrase in South Africa used to describe the distribution of basic resources to citizens; these are inclusive of resources such as water, health, electricity, sanitation infrastructure, land, and housing. Unfortunately, the government's delivery and upkeep of these resources is unsatisfactory. Because of poor service delivery, the number of service delivery protests or protests demanding better service delivery, have become rife and have become a norm in recent years. In a recent South African study, it was suggested that there are three fault lines identified in the health care system (Rispel, 2016). These are namely; tolerance of ineptitude as well as leadership, management and governance failures, lack of a fully functional district health system and inability or failure to deal with the health workforce crisis. In most instances, health leaders and managers in developing countries are trained health professionals (doctors, nurses, clinical/medical officers and pharmacists) who rarely have any training or experience in managerial positions (World Health Organization, 2009; Byleveld et al., 2009; Dorros, 2006; McConnell, 2002) cited in (Daire, Gilson, & Cleary, 2014). To further strengthen the argument pertaining a lack in competencies of managers in the South African public health sector, according (Waddington, 2007; Egger & Ollier, 2007) cited in (Daire & Gilson, 2014), *"Managers in South African health sector are often promoted on account of clinical expertise. They may be ill prepared for their new responsibilities and may be expected to gain managerial capacities by learning on the job or through brief training courses"*.

It is the need for improvement of service delivery that this study formulates its exploration and argument. Ehrlich, Kendall, Muenchberger, & Armstrong(2009) and Waggie & Laattoe (2013) cited in (Yee, 2017) stipulated that interprofessional coordinated care in the primary healthcare setting can be broadly defined as the delivery of "*systematic, responsive and supportive care*" to persons with health problems. This network of service delivery heavily relies on concepts such as

partnerships, collaboration, knowledge transfer, person-centred practice and selfmanagement support. A recent analysis of the competencies within the Western Cape Province Department of Health was conducted and indicates limited and insufficient competencies in a number of occupational groups (Whitford, 2016). The department has taken the initiative to hone and harness scarce skills through mechanisms such as traineeships/learnerships, internships and bursary programmes. A number of training and development interventions have been identified to address scarce skills in health occupations with higher education institutions (HEIs), nursing colleges, schools and key stakeholders with regard to occupational training (for professional nurses, associate nursing professionals, pharmacists, medical and pathology laboratory technicians and midwifery professionals (Health and Welfare Sector Education and Training Authority (HWSETA) (2017) and (WC Annual Report 2014/15, 2015).

The Western Cape Annual Report 2014/15 (2015) highlights the challenges in service delivery in relation to clinical as well as managerial staff. These service delivery challenges allude to issues of disparities in the landscape of South African healthcare services. There are noticeable disparities, including an influx or overcrowded public healthcare services, which exacerbate the already scarce resources and infrastructure. Due to socio-economic issues and lifestyle choices, poor communities are faced with the greatest population of health related issues. Poor health causes the poorer communities to require the healthcare services due to ill health. These communities epitomise the vast majority of the country's burden of disease. Shortage in public health human resources also is another challenge. This is affirmed by the inability to fill vacant positions in the healthcare sector states (HWSETA, 2017). The aforementioned issues have created an environment that makes managing healthcare services a difficult task. Mal-practices by managers such as their inability to lead, unavailability of healthcare managers, corruption and mismanagement of already scarce resources only place an even more strenuous burden on an already dire situation. The focus of this study therefore was placed on the competencies required by managers for effective service delivery at a community health centre level.

Dorros (2006) and Kotter (2001) cited in Daire et al (2014) describe management as the set of task-oriented processes of planning, organizing, budgeting,

staffing, controlling and problem solving operation and skill-set functioning. On the other hand, leadership is viewed as a process of enabling or facilitating others to work in a specific context (Daire et al., 2014). Leadership involves the creation of a strategic plan or goals for the organisation, inspiring, motivating and aligning all stakeholders to the organization's mandate (Daire et al., 2014). Dorros (2006) Vriesendorp et al. (2010) cited in Daire et al (2014) suggest that *"managers who lead provide a holistic approach to running health care programmes, organizations, or facilities, where strong leadership and managerial practices strengthen organisational capacity and result in higher-quality services and sustained improvements in health".*

In the following sections, the researcher presents an overview of the situation and background to the study.

1.2 Background and conceptualisation of the study

1.2.1 Health Care in South Africa

South Africa presents with paradoxical societal circumstances and inequality. The extremely wealthy - the haves and extreme poverty - the have nots. According to Bell, Houweling, Taylor, Marmot, & Friel (2008) majority of the country's population was marginalised and social services which are inclusive of health, housing, water and sanitation due to the exploitative oppressive apartheid regime. In the present day, economic development programmes that were employed to aid sustainable development, have not placed health at the top in the list of priorities.

The Reconstruction and Development Programme (RDP) which was a proequity and socio-economic policy was mainly aimed and established to aid government in addressing injustices of the past segregation laws in South Africa Aliber (2001) cited in (Ataguba & Alaba, 2012). Its constructs were posed in poverty alleviation and any other setbacks brought about by the apartheid regime (with special emphasis placed on social services). Additionally, to a complex reconstruction of primary health care (PHC) facilities, the RDP introduced free child and maternal health care (Kautzky & Tollman, 2008). These services were extended to include: free PHC for everyone utilising the public health care sector; the comprehensive extension of social welfare grants to previously disadvantaged populations; national school

nutrition programme; and infrastructural development targeted at increased water, sanitation and electricity for all South Africans.

A subsequent consequence of the apartheid legacy of "*separate development*" of service provision was that of all service provision which also included health services (Kautzky & Tollman, 2008). These inequality measures or separate development have translated into what South African government today is trying to equalise in terms of service delivery. The separate development of health service was coupled with the privatisation of health care, inequality in the distribution of clinicians and resources across private and public sectors. As a result, obstacles to health systems development and the adequate provision of services have prevailed in South Africa post-apartheid (Coovadia, Jewkes, Barron, Sanders, & McIntyre, 2009) and (Kautzky & Tollman, 2008). Kautzky & Tollman (2008) have displayed statistical evidence to show the detriments in health service provision.

"*In 1998, 53% of general practitioners, 57% of professional nurses and 76% of all specialists worked in the country's private sector, despite this sector catering to the needs of less than 20% of the population. In present day, this trend has worsened with an estimated 63% of general practitioners now working in the private sector, nearly twice as many as in the public sector. Similarly, the private sector now absorbs an estimated 62% of national health expenditure providing medical care to approximately seven million people, while the public sector absorbs only 38% and provides for an estimated 35 million*".

Government has a mandate laid out by the African National Congress's (ANC) 1994 Health Plan (Gilson, Pienaar, Brady, Hawkridge, Naledi, Vallabhjee, & Schneider, 2017) to have healthcare services that are accessible, free and that have quality of care that makes use of good practices in the cascade of service delivery. The vast majority of the South African population access health services through government operated public clinics and hospitals. According to Mahlathi & Dlamini(2015) the South African health system comprises the public sector which is state owned or operationalised by the government and the private sector. Mahlathi & Dlamini (2015) continue and state that the public health services are divisible into primary, secondary and tertiary levels of care, through which health facilities are

located in and managed by the provincial departments of health. The provincial departments are thus the direct employers of the healthcare professionals while the National Department of Health is responsible for policy development and coordination (Mahlathi & Dlamini, 2015). The purpose of this Ministry is to transform and create equality in health systems in South Africa. These mandates, relayed as the health plan, were passed as a law in 2003, better known as the National Health Act (NHA) (Gilson et al., 2017). Within the public healthcare system, it is at the district level where this study is situated. The community healthcare (CHC) or the district level of healthcare is conclusively described as a primary health care service where first level of contact is administered as per the needs of the community (Rispel, Molomo, & Dumela, 2008). In the South African context, the CHC centre operates on a provision of 24-hour maternity, accident and emergency services and beds where health care users can be observed for a maximum of 48 hours and which normally has a procedure room but not an operating theatre (Steve Reid & Burch, 2016).

The Western Cape (WC) inherited a legacy of socio-economic advantage in comparison to other provinces in South Africa, which translates to better health indicators (Scott & Gilson, 2017). The WC is globally reputable for its high quality and innovative hospital care, has significant "*academic health capital*" and with a wellresourced public health sector (Gilson, Barasa, et al., 2017). Nationally, WC health services has been an instrument in achieving the apartheid goals, and this has left an imprint difficult to dismantle in the WC (Gilson et al., 2017;Gilson, Elloker, Olckers, & Lohmann, 2014; Gilson, Brady, et al., 2017).

According to Gilson et al. (2017) there are three major challenges for the WC service-delivery model, highlighting additional lessons for PHC re-engineering in the province as well as the nation as a whole. These are namely:

- "*The need for new PHC models better oriented to the wider health and social challenges facing populations in the 21st century;*
- *Relatedly, the development of intersectorial partnerships, and, recognising their vital role as a health resource, multiple forms of patient and community engagement; and*
- *Innovative action to address the health challenges of particularly vulnerable groups and communities*".

The public health care system is inclusive of health care delivery of preventive, promotive, curative and rehabilitative health care (Hattingh, Dreyer and Roos, 2008) cited in (Orth et al., 2013). More specifically, where the CHC falls under the District system, the CHC is at the mercy of the communal influx as they are often the first point of contact for the community. CHC have to thus adapt to the community culture and nuances.

1.2.2 Burden of disease

Non-communicable diseases (NCDs) according to Vawda (2016) cited in (Parker, Steyn, Levitt, & Lombard, 2012) place a significant growing burden on the health, economy and the overall development of South Africa, and currently accounts for a startling 43% of recorded deaths. NCDs have exacerbate wide inequalities in longevity and quality of life in South Africa (Vawda, 2016) cited in (Niessen et al., 2018). It is argued by Vawda (2016) cited in (Mayosi et al., 2009) that the very nature of NCDs is chronic and requires long-term care which places a greater demand on an already overstretched healthcare system. The South African health system is already boggled down to cope with HIV/AIDS epidemic, maternal and child mortality, a high level of tuberculosis (TB) as well as violence and injuries Vawda (2016) cited in (Pillayvan Wyk, Msemburi, Laubscher, Dorrington, Groenewald, Glass, Nojilana, Joubert, Matzopoulos, Prinsloo, & Nannan, 2016).Among other NCDs following the aforementioned high ranked disease burden are diabetes, coronary disease and head injuries Vawda (2016) cited in (Bradley, Lehmann, & Butler, 2015).

According to (Pillay-van Wyk et al., 2016) the legacy left by apartheid displays the disparities population group and the stage of health transition of the groups. As a direct result of the disparities; Black and Coloured individuals are faced with the quadruple burden of disease while profiles for Indians or Asians and white individuals are dominated by non-communicable diseases (Pillay-van Wyk et al., 2016). The population of South Africans that have been mostly affected and bear the brunt of HIV/AIDS and TB have been Black Africans, exacerbating mortality differentials (Pillay-van Wyk et al., 2016).The aforementioned statement postulates a review of socioeconomic, health, and demographic disparities in South Africa (Pillay-van Wyk et al., 2016).

Amongst the low socio-economic communities in Cape Town are the communities situated on the Cape Flats. As one of the poorest areas of the city, it is not surprising that the current health status of the population is also poor with problems that reflect South Africa's burden of disease (Daire & Gilson, 2014). It is social, economic as well as some ecological phenomena that affect CHC service delivery. It is this outlook to health that this study wishes to highlight as a contributory factor to competencies of health professionals and managers. This study was based in the low socio-economic status areas of the Cape Town Metropole where the burden of disease is greatest.

1.2.3 Human resource challenges

Hattingh et al (2008) cited in (Mayosi et al., 2012) suggest that human resources (HR) are a crucial element of planning strategies. Supporting Hattingh et al (2008), (Maree et al., 2017) state that HR is the most important and challenging function of management because the organisation's outcome performance is heavily dependent on the staff. For procedural practices and service provision at the CHC centre the following establishments must be derived:

- "*the number, category and grade of health nursing and non-health related personnel*
- *the qualifications, level of experience and specific skills, together with the special equipment required*
- *the availability of personnel and area of recruitment*
- *the extent of training, support systems needed and additional facilities for training*
- *the legal requirements and labour contracts*
- *salaries and fringe benefits*
- *accommodation and transportation needed*
- *staff norms and expectations*
- *constraints in terms of HR provision, and*
- *cost implications*"

According to Vawda (2016) barrier to improved health outcomes is a direct result of poor knowledge about the health workforce, its size, function, and optimal skill

mix. The challenge that remains in retaining healthcare professionals permanently is the lack of financial gain. Another challenge that has been analysed is the shortage of skilled clinicians. It is predicted that due to a relatively high percentage (12%) of health professional groups nearing retirement or early retirement age, difficulty in filling up vacant positions may occur (WC Annual Report 2014/15, 2015). The very nature of health care professional practices is not glamorous and is thus not attracting the youth in the country. These challenges impose negatively on health service delivery and strategies to mitigate such challenges need to be introduced.

Gilson et al (2017) described public health care provision in the WC as being severely fragmented between multiple authorities, preventive and curative services, and along racial lines, with particular consequences for primary care in Cape Town. On the other hand, the private health care, mainly targeted at the higher-income and white population, simply means a low populated well-functioning (often privileged) health service provision (Gilson et al., 2017). The inequalities facilitated by the apartheid administration still remain and the trajectory of equalising health care service is snail paced. Health facility managers as well as healthcare professionals have to work on a daily basis under frustrating circumstances.

According to (Labonté et al., 2015) the International Organisation for Migration (IOM) raised concerns in 2003 about the ability of the public health workforce to provide essential public health services (EPHS) and the ability of the public health education system to adequately prepare public health professionals with the requisite knowledge and skills for this vital work is lacking. According to Milicevic, BjegovicMikanovic, Terzic-Supic´ & Vasic (2010) cited in (James et al., 2018) there have been growing concern and discussions around health care measurement of competence and performance. As a result of this growing demand Milicevic et al (2010) cited in (SANAC, 2017) state that in the past 15 years the World Health Organisation (WHO) have developed approximately 120 management training tools or modules. Competency in public health care services in the international context, according to Wikström & Dellve (2009), is inclusive of plan making; financial management; policy development and implementation; strategy development and orientation; human resource management; equipment and infrastructure management; information management; risk and disaster management; self-

management; quality assurance and management; monitoring and evaluation, investigation; supervision; ethics knowledge.

In South Africa there seems to be a disjuncture between health professionals' and managers' training on service delivery needs and health system priorities of PHC, in particular population and intersectorial approaches for impact on health outcomes (Naledi, Barron, & Schneider, 2011). Vawda (2016) states that in the past in South Africa, public health (PH) training was allocated for the training of doctors through tertiary education systems, and training them to be managers in the health service sectors. Vawda (2016) states for the most part, programmes such as Master of Medicine (MMed) and Master of Public Health (MPH) were developed by Community Health departments previously offering PH training for doctor managers only. Presently, managerial positions have opened up to professional nurses too. It can therefore be concluded that managers in healthcare service sectors are not trained to be managers and are merely promoted into managerial roles. Managers have to acquire a set of operational and interpersonal skills that mechanise control, leading and managing both staff and facilities.

Human resources play a pivotal function in health care service delivery. The readiness, experience and training for managers as a human resource affects managers' competence, and thereby affecting the performance of service delivery. This study therefore explored the competencies required by managers at community health care centres so that service delivery be improved by informing training deemed necessary for managers.

1.3 Problem statement, Research question, Aim and objectives

1.3.1 Problem statement

An analysis conducted in 2009 of the underlying factors, preceded by overspending in provincial health departments revealed leadership and management weaknesses, particularly with regard to the health department's core business of service delivery and the quality of such service delivery (Rispel, 2016). General lack of accountability according to Rispel (2016) further aggravates the crisis of incompetence, ineffective management and failure of leadership and governance at

all levels of the health system. A large proportion of recent graduates expressed feeling that they were not equipped with competencies to address health systems challenges in their work situations (Mukinda, Goliath, Willems, Zunza, & Dudley, 2015). It also has been highlighted by Volmink (2018) that in healthcare professions' practice, the focus has largely been on the development of technical competencies, rather than attitudes, team work, community outreach and management skills.

A growing need for South African medical curricula to address health systems challenges and changes faced by health professionals has been an area of concern (Mukinda et al., 2015). Von Knorring, Alexanderson, & Eliasson(2016) concur with the statement by Mukinda et al (2015) in saying that healthcare education challenges require addressing in order to successfully deliver health services at the level of community and district healthcare in South Africa. These challenges are inclusive of physical teaching space within clinics, which are not designed to accommodate students, often with large volumes of clinical workloads of health care professionals seeing to large numbers of patients each day, and a small number of academics willing to teach and work in primary care settings (Burn & Reid, 2011) cited in (Rycroft-malone et al., 2016). The focus has been on improving the competency-based curriculum to ensure graduates are able to address the needs and context of countries' health system (Mukinda et al., 2015). Pálsdóttir et al (2016) strengthen the argument by Mukinda et al (2015) by suggesting that the foundational and key component of the educational curricula should be the health needs of the population and the needs of the health system. The educational structure should be founded upon the health needs and should be altered from its current static nature. With this being said, specialisation to the health trends and needs should trickle into the upgrading the higher education training system. Furthermore, health needs must inform the competencies that graduates need to acquire, and should in turn inform the outcomes, content and design of our curricula van Heerden (2013) cited in (Akintola & Chikoko, 2016). The disjuncture or inadequate partnership and collaboration between the higher education and health sectors creates an evident gap between realities in healthcare service delivery and professional education and development states (Mukinda et al., 2015). In addition, there are inadequate teaching, learning and assessment opportunities for health system research (HSR) in order to develop health graduates' engagements with

the health system (Pillay (2010); Mukinda et al 2015 and Towle et al 2016). Clarification of health systems competencies which are important for undergraduates have been identified, gaps in the current curriculum and opportunities for developing these competencies have also been alluded. Based on the aforementioned findings of Rispel (2016) and Mukinda (2015), the purpose of this study was to explore the competencies required by managers of Community Health Centre (CHC) in the Cape Town Metropole, which could inform the undergraduate health professionals' curriculum thereby ultimately improving service delivery at a CHC level.

1.3.2 Research Question

What are the competencies required for CHC managers to deliver health care services at community health care centres on the Cape Flats?

1.3.3 Research Aim

To explore the competencies required for healthcare managers to deliver health care services at community health care centres situated on the Cape Flats.

1.3.4 Research Objectives

1. To describe the perceptions of CHC managers with regards to the required competencies for effective service delivery and their challenges at the community health centre.
2. To explore the experiences of healthcare professionals regarding the management and service delivery challenges at the community health centre.
3. Explore the perceptions of healthcare professionals' management competencies required at the community health centre.

1.4 Outline of the thesis

This thesis is presented in five chapters.

Chapter 1: Introduces the study, providing a brief background on the current health context of Cape Town's and its public health service, the research problem, the main aim and specific objectives of the study.

Chapter 2: The Literature Review and Theoretical Framework. This chapter provides a literature review of, and poses empirical component of the study in light of the theoretical framework.

Chapter 3: Methodology. This chapter presents the research design and includes the sampling method utilised, sample size, criterion of sample selection, and data analysis.

Chapter 4: The Results and Discussion Section. This chapter presents the findings of the study and provides a discussion of the findings with reference to the aim and objectives of the study.

Chapter 5: Conclusion. This chapter summarises the main findings of the research, limitations, and presents a conclusion of the study as well as recommendations.

1.5 Summary of the chapter

It is crucial to analyse community health care management competency in a non-linear fashion. There are numerous factors that interplay in managers' day to day operations. These functionings must ensure efficiency and effective service delivery; which in most cases than not, are stringent in South Africa, and even more so in low socio-economic communities. This chapter has looked into the context and the tone of the South African healthcare system; the background of what conditions the healthcare professionals as well as leaders have to render a service under; the role of the educational and training system in equipping the healthcare professionals in their competencies, in order to deliver a comprehensive health service to communities of South Africa. This chapter also clearly depicted the need for this study and the context this study has been conducted under. There was a brief outline of this thesis.

The following chapter will entail the literature review which stipulates the point of enquiry and rationale in which managers' competencies are regarded in Cape Town's community health centers.

CHAPTER TWO

LITERATURE REVIEW AND THEORETICAL FRAMEWORK

2.1. Introduction

In essence, this chapter aims to lay the foundation of the context for healthcare in South Africa. In granting a context, an understanding of the environment community health centre managers need function under, can be established. Therefore, in assessing competence, the context for functioning must be kept in mind for analysis and recommendations.

2.2. Mapping South African Health System after democracy

South African health system comprises of mainly two systems, the private and the public sector. The South African health system also comprises of a traditional as well as an alternative health system (which is namely inclusive of; homeopathy, naturopathy, phytotherapy or herbalism, Chinese medicine and acupuncture). The state governed public health system is managed and is divisible into the primary, secondary and tertiary healthcare systems. These systems are further sub-divided into the following levels of service delivery namely; national, district and local sectors. All the aforementioned levels of health sector provision are interlinked and are mandated to deliver primary health care. The community healthcare centres (CHCs) work under the premise of providing primary healthcare. This is a free healthcare service that (historically, presently and in future) aims to interchange and interlink with the other levels of service delivery. Challenges facing CHCs in terms of human resources are the discerning issue facing managers. It is therefore vital that competence not only be measured in accordance with training, knowledge, skills and experience, but attitudes as well which allude to the necessary practice of interprofessionality. The literature review has zoomed into the background in terms of context that South African healthcare practices must be operational under, the CHC management and leadership proficiency, the theoretical framework and the training received by managers and healthcare professionals at CHC, including continuing professional development

(CPD). All the topics undertaken in the literature review are aimed at areas that may affect the competence of managers at CHCs.

2.2 Background of healthcare in a South African context

After twenty years of democracy, the country is still wrestling with massive health inequities (Eyles, Harris, Fried, Govender, & Munyewende, 2015); Brookesumner, Petersen-williams, Kruger, Mahomed, & Myers, 2019). Modifications however, have occurred over the past years as described in the Lancet 2009 series on health in South Africa. The Lancet 2009 series has highlighted the challenges within the South African health system and the country's multiple disease burden of HIV, tuberculosis (TB), violence and injury, and non-communicable disease. According to Mayosi et al (2012) cited in Eyles et al (2015), there have been improvements in leadership, greater linking of tackling health care daily operations. These operations are often aligned to health service management's competencies.

Cowling, Newman, & Leigh(1999) stated that the recent interest in competencies has arisen from the recognition that the acquisition of training, knowledge, skills and experience does not single handily lead to an improvement in performance by healthcare professionals. It is equally as important to possess appropriate attitudes (of which motivation is usually the most important), and the provision of adequate support services and equipment in South African healthcare service (Cowling et al., 1999). The term competencies has largely come about in pursuit of higher levels of performance.

The paradigm shift in healthcare professionals' development efforts, moving towards a more diverse range of skills supporting primary care, is a motion to upscale health service delivery (Pálsdóttir, Barry, Bruno, Barr, Clithero, Cobb, De Maeseneer, Kiguli-Malwadde, Neusy, Reeves, & Strasser, 2016). D'Amour & Oandasan(2005) suggestively express the fact that, *"interprofessional education and interprofessional collaboration have not often found a place in the education and practices of health professionals".* The idea of introducing interprofessional education is to enable future healthcare professionals to fluidly work as a multidisciplinary team and not only tackle the multidisciplinary team dynamics once working as a professional.

Hatcher, Onah, Kornik, Peacocke, and Reid (2014) discursively point out the fact that South Africa is characterised by inequitable distribution of health services. The disparities in urban South Africa are under the spotlight because of the private and public divide in healthcare services. The inequalities are further exacerbated by the growing inadequacy in the labour force versus the burden of disease amongst low socio-economic areas of the country; this compromises health care delivery and poor health indicators impact progress towards the Millennium Development Goals (MDG's) in South Africa (D'Amour, Goulet, Labadie, Martín-Rodriguez, & Pineault, 2008) and (Hatcher et al., 2014).

Despite the aforementioned constraints that healthcare services experience in South Africa, Eyles et al (2015) have stipulated that the improvement in managing HIV and tuberculosis (TB) has upscaled the recognition of the need for better integration of all health care services to positively influence the social determinants of health. The government recognizes the importance of the need for systemic changes to ensure the enhancement in competencies in the health care in the country, much of this being enshrined in the national development plan (Eyles et al., 2015).

As part of national development the Department of Health (DoH) stated that the main objective of the community service programme is "to ensure improved provision of health services to all the citizens of our country" (Hatcher et al., 2014). Hatcher et al (2014) further state that the inclusion of community service in health services provides young professionals with an opportunity to acquire knowledge, develop skills, behaviour patterns and critical thinking that will aid in their professional development.

Rowe, Frantz, & Bozalek(2012) and (Wyk & de Beer, 2017) have emphasised that clinical education is an important component of any healthcare curriculum. Rowe et al (2016) and (Towle et al., 2016) have suggested that with exposure to patients in clinical settings, creating an environment for clinical practice cannot be replicated in a classroom. Clinical practice is challenging to the healthcare professional because the healthcare professional must review and re-prioritise poorly defined clinical problems in an undertaking of active interpretation during the management of the patient (Rowe et al., 2016).

A mechanism utilised in South African health care domain is interprofessionality. South Africa is shifting towards team driven approaches to healthcare (Musinguzi, Namale, & Kekitiinwa, 2018). D'amour, & Oandasan (2005) suggested that "*interprofessionality is a response to the realities of fragmented health care practices*". This is a practice by professionals who come from different disciplines and from different health care organizations, each carrying different conceptualizations of the patients or client systems, of the clients' needs, and the type of response needed to address the clients' multiple and complex health care circumstances (D'amour & Oandasan, 2005). Interprofessionality is defined by D'amour & Oandasan (2005) as " *the development of a cohesive practice between professionals from different disciplines. It is the process by which professionals reflect on and develop ways of practicing that provides an integrated and cohesive answer to the needs of the patients'/client systems*". Interprofessionality comes from the state of professionals being engrossed with the need to reconcile their differences and their sometimes opposing views when it comes to healthcare provision (D'amour & Oandasan, 2005). This practice also involves continuous interaction and knowledge dissemination between professionals to solve or explore a variety of education and care issues without the exception of optimizing the patient's well-being (D'amour & Oandasan, 2005).

Rowe et al (2012) support D'amour & Oandasan (2005) by suggesting that clinical practice can be developed through sharing knowledge and experiences within an interprofessional environment. Present day healthcare graduates have the immense pressure of not only possessing the technical skills necessary to practice but must also be proficient in other competencies that interplay on their professional practice (Rowe et al., 2012). This is inclusive of the awareness of their own attitudes, values and responses to varying health and illness (Rowe et al., 2012). Additionally, they must also be able to share and educate others effectively, critically evaluate their own professional practice and have good communication skills (Rowe et al., 2012). Most importantly, and this is the most vital of the competencies, is the ability to articulate the rationale behind patient management (Rowe et al., 2012).

Then there is the issue of pressure on managers, who in most cases lack confidence in themselves and the wider health system (Gilson, Barasa, Nxumalo,

Cleary, Goudge, Molyneux, Tsofa, & Lehmann, 2017). In spite of healthcare demands across countries, primary health care (PHC) facility managers (and even hospitals) are often appointed with very little preparation or relevant training (Gilson et al., 2017). Kilifi in Kenya's PHC facility managers often shared feelings of how unprepared they were to manage facilities on their first appointments as managers. These managers often relayed how overwhelmed and shocked they were by the extent of demand their roles required (Gilson et al., 2017). Gilson et al (2017) and Reeves, Perrier, Goldman, Freeth, & Zwarenstein (2013) state that in most cases, facility managers maintain their focus on clinical roles, where they feel confident, rather than proactively addressing issues pertaining to facility functioning or financial management, and neglect other important managerial decisions and activities. In South Africa, managers express the same sentiments as the ones shared by managers in Kenya (Gilson, Barasa, et al., 2017).

In Cape Town, innovative measures have been established to aid role readiness to managers. According to Gilson et al (2017) in Mitchells Plain, sub-district managers have mechanised training and skills to strengthen their support for front-line health professionals and service delivery. This was done in response to the routine challenges. These mechanised innovative measures include engaging healthcare professionals, especially environmental health practitioners, in mapping local health resources and needs with the aid of community participation (Gilson et al., 2017) and (Volmink, 2018). The aforementioned statement further highlights the necessity for interprofessionality for improved function as a manager.This complex multidisciplinary engagement is aimed at addressing local problems; inclusive of "*encouraging facility managers and their staff to develop locally specific priorities [*for the needs of the community in which they operate]; *adapting the processes of routine meetings to encourage greater reflection and more proactive problem-solving through collaboration across managerial levels; and deliberate role-modelling of inclusive managerial practices by more senior managers, through respectful behaviour and* [professional] *language* [use]" (Gilson et al., 2017; Etheredge, Penn, & Watermeyer, 2017). The researcher placed emphasis on literature that delves deeper into exploring the competence of the managers at the community health centres (CHC), CHC interventions experienced by the managers, unpacking the theoretical framework

under which competencies will be assessed, and lastly health professionals' and management development training.

2.3. Leadership & Management Competencies

Munyewende, Levin & Rispel (2016) define competency as the technical skills, knowledge, and attitudes required to perform a particular occupation. Management competencies are inclusive of strategic, human resource management and financial; service delivery innovation; client orientation and patient focus; and communication skills are all essential for achieving organisational or institutional goals (Munyewende et al., 2016). In complex and intricate CHCs of low socio-economic communities of Cape Town, health care managers are required to take on additional competencies to complement the generic management functions of directing, planning, coordinating, and controlling to be effective (Munyewende et al., 2016). This is because managerial competencies are important for unsurpassed optimum patient care and ongoing quality of health improvement, while competent managers play a pivotal role in the implementation of universal health coverage of institutional practices (Munyewende et al., 2016).

There is an emanating conflict between the nature of the top-down practices and real-world managerial decision-making at primary healthcare level (Scott & Gilson, 2017; Brooke-Sumner, Petersen-Williams, Kruger, Mahomed & Myers, 2019). Healthcare strategic planning make up is bureaucratic in nature, but healthcare managers at CHCs have to gain competence in creating a shared strategic plan. Below is the figure depicting the levels of information within the healthcare system in the Western Cape.

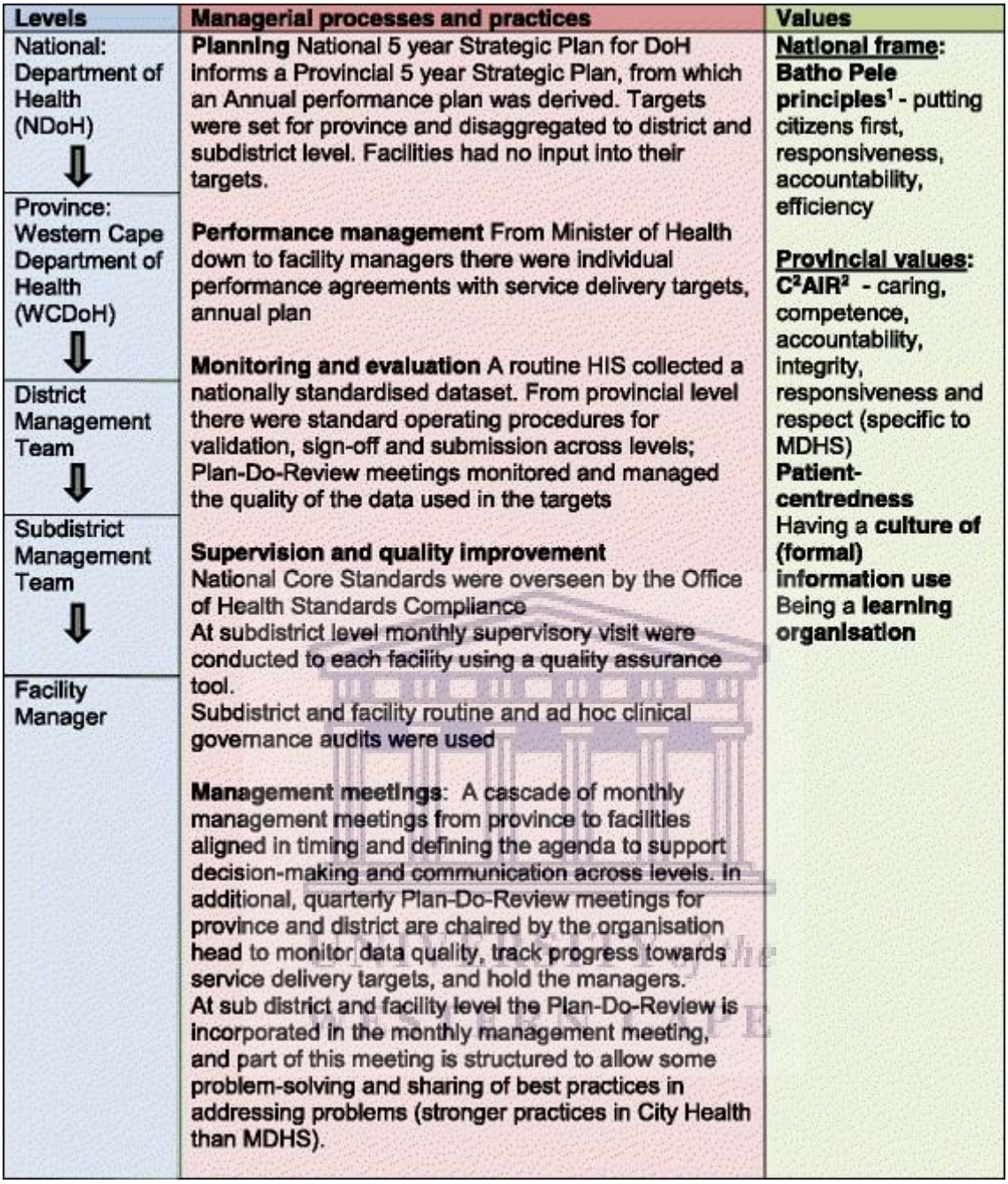


Figure 1: Managerial communication and procedural practices

Accessed from Google images on 11 June 2019 as seen in (Scott & Gilson, 2017) https://www.google.com/search?q=governance+operating+through+managerial+processes+and+practices,+and+values,+across+the+health+system&safe=active&rlz=1C1CHZL_enZA843ZA844&source=lnms&tbm=isch&sa=X&ved=0ahUKEwje2YaVqOHiAhWztHEKHfM_D90Q_AUIECgB&biw=1280&bih=561#imgrc=gSHqjEv0vBmdQM:

A study by D'Amour, Goulet, Labadie, San Martín-Rodriguez, & Pineault (2008) re-emphasised the aforementioned competency demand of healthcare managers and health professionals. The health professionals according to D'Amour et al (2008) are therefore confronted with a demand for both inter-organizational and interprofessional collaboration, suggesting a new division of clinical labour between professionals in different disciplines and between different types of primary, secondary and tertiary care institutions (D'Amour et al, 2008). In these new forms of organizational practices, responsibility for operation, service delivery and coordination is shifted to the care providers (rather than the managers) and must therefore become more explicit and transparent (D'Amour et al, 2008).

Furthermore, Gilson et al (2017) explain competencies vary from capacity attainment. Cognitive capacities according to Gilson et al (2017) include the shared values which influence practices of power and the development of trust, in combination with deliberate use of language and symbols to build shared meanings and decisiveness despite uncertainty. Behavioural capacities include an organisational acceptance of risk, treating excessive demand as an opportunity not a critical period (Gilson et al., 2017). This affords the organisation the belief that the institution will cope, due to past experiences of positive challenge adjustment in response to resourceful creativity, useful routine processes and practices that aid first-line response to unexpected challenges, or according to Gilson et al (2017) "*encourages employees to speak up about failures, question assumptions and learn from errors, are other capacities*". Contextual capacities constituted of willingness to take personal risks, the establishment of social capital built on respectful interactions within the organisation, decentralise power within the organisation and resource networks outside it in order to spread the ownership of healthcare practice to aid improved service delivery (Gilson et al., 2017). The abovementioned capacities by managers aid resilience in the community healthcare setting which is at the coalface of the context healthcare services must be rendered under.

The evaluation of the competencies of managers explained by Munyewende et al (2016) is imperative for establishing and identifying training needs and to benchmark the performance of CHC facilities. Competent managers facilitate the implementation of health care changes for improvement, through ensuring healthcare professionals'

participation and managing complex change (Munyewende et al., 2016). On the negative spectrum of health practices Munyewende et al (2016) suggest managerial incompetence has negative consequences on well-being, service delivery, and retention of healthcare professionals and healthcare system performance. More often than not, management competencies are evaluated and strongly aligned to "*health systems strengthening, staff retention, and job satisfaction*" (Munyewende et al., 2016). Competency assessments enable managers to enhance the training, skills and experience needed to perform in complex health care systems (Munyewende et al., 2016).

In South Africa, the required competencies for a health professional according to the Health Professions Council of South Africa (HPCSA, 2014) are:

1. "*Healthcare practitioners, healthcare professionals integrate all of the graduate attribute roles, applying profession-specific knowledge, clinical skills and professional attitudes in their provision of patient/client centred care. The healthcare practitioner is the central role in the framework of graduate attributes.*
2. *As communicators, healthcare professionals effectively facilitate the carer-patient/carer-client relationship and the dynamic exchanges that occur before, during and after interventions.*
3. *As collaborators, healthcare professionals work effectively within a team to achieve optimal patient/client care.*
4. *As leaders and managers, healthcare practitioners are integral participants in healthcare organisations, organising sustainable practices, making decisions about allocating resources, and contributing to the effectiveness of the healthcare system.*
5. *As health advocates, healthcare professionals responsibly use their expertise and influence to advance the health and well-being of individuals, communities and populations.*
6. *As scholars, healthcare professionals demonstrate a lifelong commitment to reflective learning as well as the creation, dissemination, application and translation of knowledge.*

7. *As professionals, healthcare professionals are committed to ensure the health and well-being of individuals and communities through ethical practice, profession-led self-regulation and high personal standards of behaviour*."

Rispel (2016) re-emphasises the fact that healthcare managers routinely face instability, in terms of changes in governance structures and financing mechanisms, and other resource provision delays, and consistently imposed policy directives thrust into managers' capacity. Healthcare managers are frequently operating in an environment with unstable authority delegations, often expected to manage unpredictable staff, address ever-changing patients' needs and community expectations (Achmat & Sciences, 2015; Gilson et al, 2017). The aforementioned circumstances, according to Gilson et al (2017), are often not taken into cognisance when discussing health system resilience; these conditions are not acute and external shocks often looked at as derivatives that interplay in healthcare service delivery. "*Instead they are internally generated chronic stresses, some of which are even infused into the routine organisational life of health systems (as in the case of centralised, command and control management practices"* (Gilson et al., 2017; Scheffler, Visagie, & Schneider, 2015). These shocks and stresses (both internal and external) occur simultaneously in the same system, impacting the same set of individuals, and they interact and rise above the circumstances to deliver quality service delivery (Gilson et a.l, 2017). An unstable organisational structure or resource disparities and diversification deficits generate tension in relationships among healthcare professions and the community, which therefore consequently affect the standard of service delivery (Gilson et al., 2017; Musinguzi et al., 2018). Management often goes hand in hand with the type of leader a particular individual is.

Managers at healthcare institutions require the opportunities to refine their leadership skills through personal formal training, mentorship and reflection (Munyewende et al., 2016). Such leadership and management development programme opportunities often influence healthcare professionals' and managers' confidence in practice and job satisfaction (Munyewende et al., (2016).

Gilson et al (2017) state that leadership is exercised by managers throughout district health systems to execute everyday resilience in healthcare institutions.

Leadership is all encompassing, enabling healthcare professionals to face difficult situations and achieve results under complex conditions (Gilson et al., 2017). Gilson et al (2017) suggest that being triumphant in leadership and in operation, it is vital to strengthen the value system in the healthcare institutions; these values include respect, sense of duty, empowering others (in terms of delegation) to be trusting of their decision making process and their innovative response to challenges. Leadership entails role-modelling, a deliberate use of persuasion to encourage innovative models of viewing and perceiving problems and opportunities in the workplace, especially in complex healthcare environments (Gilson et al., 2017). Most importantly, according to Gilson et al (2017), this form of leadership provides an enabling environment for the front-line managers and health professionals to perform daily tasks confidently, with commitment and with motivation to ensure a resilient health system.

Theory of resilience is denoted by the fact that behavioural processes such as the constant engaging of the healthcare professionals in a manner whereby organising the operative function of all healthcare professionals and clarifying job descriptions so that roles are clear (Achmat & Sciences, 2015). Staff resilience is vital because it aids the capacity to catalyse the processes of learning, innovation and new organisational routines that aid response to future challenges. The leadership that sustains everyday resilience is thus adaptive and distributes responsibility that is traditionally exercised by managers, to be performed by healthcare professionals across the system (rather than only by higher-level managers) (Aitken & von Treuer, 2014; Gilson et al, 2017). This affords the opportunities for the functioning of leaders and subordinates in interlinking chains of teams, and also collectively influences others in responding and adapting to challenges (Gilson et al., 2017). Relational interaction among healthcare professionals and managers affects workplace experiences. This is also important interplay into service delivery.

2.4. Community Health Care in South Africa

According to Sanders & Chopra (2006) ; Gilson et al (2017) the West African ebola crisis of 2014–2015 extensively emphasised the importance of resilient health systems that can recognise and respond to health crises. In organisational theory, according to Gilson et al (2017), resilience means provision of insight into a manner in

which organisations continually achieve desirable outcomes despite adversity, strain, and significant barriers to adaptation and development. Adashi, Geiger & Fine (2010) disclosed that the CHCs are solely dedicated to the delivery of primary medical, behavioural, dental, and social services to underserved populations in underserved areas. Seven out of ten CHC patients live in poverty, in the international context (Adashi et al., 2010). This is the case in South Africa as well where CHCs are situated and cater for communities in the low socio-economic areas. Adashi et al (2010) further state the CHCs have been demarcated for the instinct ability to deliver affordable, patient-centred and comprehensive, coordinated care in facilities geographically or physically proximate to the patients who need it. According to Adashi et al (2010) CHCs pride themselves equally on providing community-accountable and culturally competent care with the direct mandate of minimising health disparities associated with race, poverty and culture. Adashi et al (2010) stated that healthcare in CHCs driven by multidisciplinary teams are well supplied with primary care providers.

Resilience is therefore defined as "*the maintenance of positive adjustment under challenging conditions such that the organisation emerges from those conditions strengthened and more resourceful*" (Gilson et al., 2017). Resilience of health systems is of utmost importance given diverse and changing health and social needs, and its interface with other sectors and community systems (Gilson et al., 2017).

Bam, Marcus, Hugo, & Kinkel (2013) shared the fact that the South African health sector initiated reforms in the year 1994. The state adopted a primary health care approach to strengthen the health system and achieve public health outcomes through health promotion and disease prevention (Bam et al., 2013). The desired outcomes in the health sector led to the building of many new clinics to make health services more accessible, equitable, affordable (Bam et al., 2013). However, little attention was given to community partnerships and multi-sectoral collaboration of the South African health sector, because resources are limited for quantifiably large population (Bam et al., 2013). Primary health care has consequentially become a passive and low quality service for individuals in clinics; whilst on the other hand, hospitals have become overburdened with referrals and patients seeking medical service (Bam et al., 2013). The aforementioned predicament in the South African

healthcare is further emphasised by Bam et al., (2013) in the following statement "*the healthcare system is compounded by a burgeoning burden of disease, pressure on the system increased exponentially and it was therefore not able to improve health outcomes*". Community Oriented Primary Care (COPC) according to Bam (2013) is solidly rooted in the notion that people's health is determined by their social environment. In other words, the improvement of a person's health cannot be achieved without changing the social determinants that shape health more generally; that exercise will be deemed futile.

Bam et al (2013) suggest that COPC addresses individual health needs as well as that of the collective context; namely, family and community. COPC is characterised by a specified local context that is based on cultural, social and the behavioural characteristics of people who live in particular areas (Bam et al, 2013; van Ginneken, Lewin, & Berridge, 2010). COPC also integrates research, teaching and learning into the practice of healthcare delivery, which is fruitful for innovative healthcare reform (Bam et al., 2013).

Bam et al (2013) COPC interplay in a wider spectrum of advancing social capabilities, health literacy and human development. Not only does it look advancing service deliver but also looks at social determinants such as politico-cultural and socio=economic interactions in health and diseases. As a result of understanding the aforementioned interplay, health care is achieved through empowerment as much as through improved service delivery. The aforementioned statement is closely aligned to the theoretical framework chosen from the study.

In recent studies, it has been suggested that healthcare professionals integrate their learning with multiple disciplines in order for a holistic approach to be undertaken in healthcare service delivery in South Africa. Reeves et al (2013) define Interprofessional Education (IPE) as an intervention where the members of more than one health or social care profession, or both, collaboratively work and learn together for the explicit purpose of improving the health or well-being of patients or client system.

According to Pálsdóttir et al (2016) connections among individuals in social networks are strengthened by norms of reciprocity and trustworthiness. Integrated

health and education systems can increase impact and reduce costs by delving into social capital, local human resources and community assets to aid quality service delivery to the communities which the health system serves (Pálsdóttir et al., 2016).

The relational dimensions according to D'Amour et al (2008) are shared goals and vision of internalisation, formalisation and governance. Shared goals and vision refers to the existence of common goals shared by a group of individuals, the recognition of polar opposite motives and multiple allegiances, and uniformity in expectations is regarded as collaboration (D'Amour et al., 2008). Internalisation refers to a raised awareness by professionals of their interdependencies in a workplace setting and being able to manage own discipline value system versus that of the interdependencies, which will ultimately lead to a sense of belonging, knowledge of each other's values and discipline and mutual trust (D'Amour et al., 2008). According to D'Amour et al (2008) formalisation (structuring clinical care) is defined by Bodewes cited in (D'Amour & Oandasan, 2005) as *"the extent to which documented procedures that communicate desired outputs and behaviours exist and are being used";* formalization clarifies expectations, roles and delegated responsibilities. Governance according to D'Amour et al (2008) grants a form of guideline and supports professionals as they implement innovations related to interprofessional and interorganisational collaborative practices. Conjointly, these four dimensions and the interjections between them capture the processes inherent in collaboration; they are however, subject to the impact and influence of external and structural factors such as financial constraints, limited resource, scarce skills and policies (D'Amour et al., 2008).

Cowling, Newman, & Leigh (1999) state that having sufficient personal interest coupled with motivation to practice evidence-based healthcare; and having personal qualities such as, knowledge, skills and attitudes, in order to practice evidence based healthcare enables individuals to adopt a multidisciplinary or multi-professional approach to care and to change healthcare practice.

Conflicting beliefs and values are both vital to enhance interdisciplinary collaboration (Sicotte, D'Amour, & Moreault, 2002). The factors that affect or interject in interdisciplinary collaboration are the ''*agreement with interdisciplinary logic,* [and these are often in tension with and factor into] *social integration with work groups and*

the level of conflicts associated with interdisciplinary collaboration" (Sicotte et al., 2002).

Given the complexity, multi-layered and multifaceted nature of healthcare and the needs to which it responds, the diverse ever-changing knowledge base and the importance of addressing the range of factors that impact health and wellbeing, require the development of diverse healthcare teams (Pálsdóttir et al., 2016).

IPE is regarded as an effective approach to providing education experiences to support developments in the delivery of a wide array of varied health and welfare services (Pálsdóttir et al., 2016). According to Pálsdóttir et al (2016) "*IPE in both undergraduate and postgraduate programmes was one of the 11 recommendations in the WHO evidence-based guidelines on transforming and scaling up health professional education and training*"; this is essentially aimed at improving healthcare service delivery.

The interdisciplinary collaborative service delivery model is a model that aids the coordination of a group of health professionals from multiple different groups to improve healthcare (Sicotte et al., 2002). This collaboration aims at going beyond the traditional mode of healthcare provision, in which professionals work in a parallel fashion, continuing to pursue disengaged professional goals with little coordination or dissemination of responsibilities and duties with a group of professionals (Sicotte et al., 2002). Sicotte et al (2002) support and restate what was expressed by D'Amour et al (2008) and Reeves (2013) in stating that interdisciplinary collaborative service delivery model promotes a collaborative work organisation in which professionals share goals, unified collective decision-making and share responsibilities and duties. Improved collaboration also means that professionals use multiple modes and intensity of collaboration depending on the patients' or client systems' needs (Sicotte et al., 2002).

2.5. Theoretical framework

The human development and capabilities approach which is rooted in the people centred approach is the conceptual framework that underscored this study. AlAmeen (2014) and Biggeri, Ferrannini, & Arciprete, 2018) describes the people centred approach so eloquently as a paradigm that is built on tested theoretical

accounts such as Sen's capability approach and Coleman's idea of rights. McCormack & McCance (2011) discursively came with the perspective that the term personcentred is, in present day, being used more freely within health and social care strategy, policy and practice. Moreover, McCormack & McCance (2011) highlight the danger that the term is being used in a tokenistic way and without any deep sense of what it means for practice and decision-making. Idealistically, the person is at the centre of interventions, the development or transformation plan and must reflect the person's capacity. The paradigm also emphasises what is important to the person and specifies the support requisite to make a valued contribution to their communities. The development plan is derived and is built on a shared commitment to attain that which will uphold the person's right. People centred approach prides itself with inclusivity and the fact that people develop themselves, therefore are self-determined. Nussbaum (2011) states that the bottom-up approach is often advocated because it has a potential for thoroughness and can quickly pin-point stances that are often overlooked by top-down management.

The development capabilities approach is a complex interdisciplinary framework used to evaluate multiple aspects of people's well-being (Robeyns, 2005). The well-being of an individual or the standard well-being of the members of a society, may be evaluated in the context of poverty and inequality (Robeyns, 2005). Fukuda-Parr (2003) suggests that Sen's theory of development is an expansion of capabilities as the catalyst of human development. Its perspective denotes that the purpose of development should be aimed at improving the lives of human beings by expanding the range of things that a person can be and do (Fukuda-Parr, 2003). Summatively, according to Clark (2005) Sen's capability approach (CA) has emerged as the leading shift in ideological thinking to the normative frameworks of economy for an alternative outlook on poverty, inequality and human development generally.

Human development is a process of expanding people's choices (Fukuda-Parr, 2003). Robeyns (2005) in addition states that *"ultimately, the most important part of human development is that people have the freedoms or valuable opportunities (capabilities) to lead the kind of lives they want to lead, to do what they want to do and be the person they want to be. The capability approach evaluates policies according to their impact on people's capabilities*". Robeyns (2005) boldly stipulated that the

capability approach thus covers all dimensions of human well-being; these are namely, material, mental and social well-being, or the economic, social, political and cultural dimensions of life. The capability approach also examines social constraints that influence or restrict both well-being of the human being; as a result, it can also be applied to efficiency evaluations (Robeyns, 2005).

People centred development is centred around two core themes that Sen coined as the *"evaluative aspect"* and the *"agency aspect"* Sen (2002) cited in (Fukuda-Parr, 2003). "*People are not simply beneficiaries of economic and social progress in a society, but are active agents of change*" (Fukuda-Parr, 2003). Alkire & Deneulin (1991) suggested the notion of empowerment being an expansion of agency. Agency is embodied in empowerment because it is on one branch; the ability to act on behalf of what one values, whilst on the other spectrum or branch, places institutional environments at the mercy of offering people opportunities to exert agency fruitfully (Ibrahim & Alkire, 2007).

According to Robeyns (2005) the Human Development Capabilities Approach also examines social constraints that influence or restrict both well-being of the human-being; as a result, can be applied to efficiency evaluations. The HDCA is centred around two core themes that Sen coined *"evaluative aspects"* and *"agency aspects"* (McCormack & McCance, 2011). Empowerment is an expansion of agency (FukudaParr, 2003). Agency is embodied in empowerment because it is on one branch; the ability to act on behalf of what one values, whilst on other spectrum or branch, places institutional environments at the mercy of offering people opportunities to exert agency fruitfully (Fukuda-Parr, 2003).

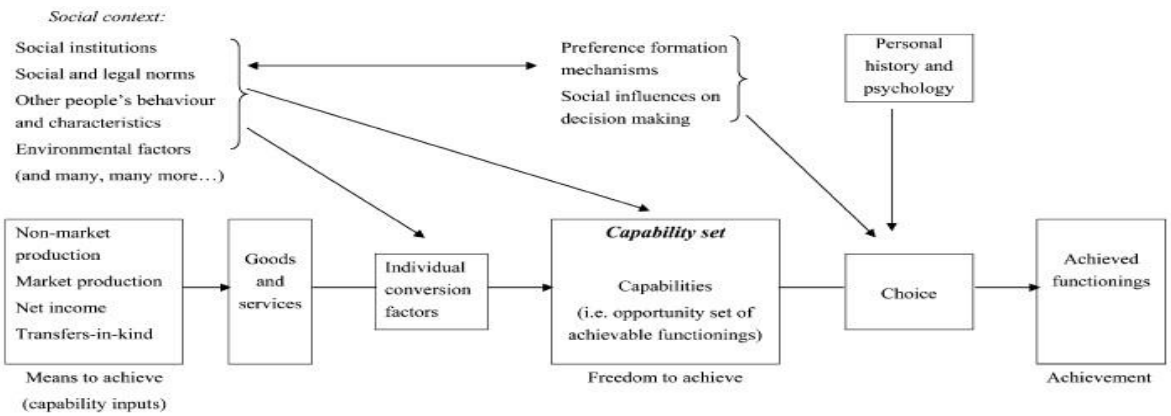


Figure 2: A stylised non-dynamic representation of a person's capability set and their social personal context Source: Robeyns (2005) cited in Lopez-Fogues (2014). Accessed:

https://www.researchgate.net/figure/A-stylised-non-dynamic-representation-of-apersons-capability-set-and-her-social-and_fig3_308879987

Ibrahim &Alkire (2007) stated that development plan is derived and is built on shared commitment to attain that which upholds the person's right. According to Ibrahim & Alkire (2007) the well-being of individuals or standard well-being of members of society may be evaluated in the context of poverty and inequality (Robeyns, 2005). In this study it is crucial to understand the context in which healthcare professionals have to function and how that interplays in behaviour, collaboration among healthcare professionals and managers and service delivery networks (Robeyns (2005).

The human development capabilities approach's line of reasoning is pursued to evaluate social change in terms of the richness of human life (Al-Ameen, 2014). The approach sees human life as a set of "doings and beings" and also can be deemed to be functionings according to Nussbaum cited in (Clark, 2005). Accordingly Clark (2005) assesses and benchmarks the evaluation of the quality of life to the capability to function. Functioning is often a reflection of the capability set individuals have. Capability set represents a person's freedom to achieve various functioning combinations. Choices are informed by resources (Nussbaum, 2011). Conversion factors contribute to functioning; these are inclusive of personal, social and environmental conversion factors (Zulueta, 2016). Personal conversion factors are internal to the person (these are skills, intelligence, physical conditions and sex); social conversion factors are derived from the society in which one lives (public policy and social norms) and environmental conversion factors emerge from the physical or built environment in which a person lives (climate, disaster and pollution) (Gasper, 2002).

Gilson et al (2017) suggest that individual agency does not underpin everyday resilience in isolation. It must rather be incumbent of transformative and adaptive strategies to nurture organisational resilience (Gilson et al., 2017). Organisation as well as individual capacities are therefore intertwined. Gilson et al (2017) suggest "*an organisation's capacity for resilience is embedded in a set of individual level*

knowledge, skills, and abilities and organisational routines and processes by which a firm conceptually orients itself, acts decisively to move forward, and establishes a setting of diversity and adjustable integration" that enables it to overcome challenge.

Social networks and relational ties within the health system also interplay and determine everyday resilience (Gilson et al., 2017). Relationship building as a transformative and adaptive strategy aids the establishment of new practices; it also aids managers to purposely act to strengthen relationships with their staff or staff in other organisations (Gilson et al., 2017).

The use of this theoretical framework is to analyse the context of the study and the findings. Conclusively, the human development and capabilities approach is questioning functionality and seeking to analyse how structural constraints affect functioning. In identifying and understanding the choices, the agency, conversion factors and capability set that the managers have to render a service under, we can then ascertain which competencies are needed. It is for the abovementioned reason the researcher saw it fit to use this approach as a conceptual framework.

2.6. Training received by managers and healthcare professionals

D'amour &Oandasan (2005) suggested that through the thorough investigation of interprofessionality. This inventory will aid a body of knowledge that describes the types of competencies that are required of health practitioners to work optimally in collaborative practice settings in the South African health sector (D'amour &Oandasan, 2005). This thereby informs the reform in professional development in the health sector. An extrapolation of the competency inquiry will provide an understanding of some of the *"knowledge (group functioning, roles and responsibilities of different professionals), skills (communication and reflective practice, leadership) and attitudes (mutual respect, willingness to collaborate, openness to trust) that should be learned*" in the interprofessional body that the healthcare service delivery requires, state (D'amour & Oandasan, 2005).

Sicotte et al (2002) suggest that the professional training programmes must be realigned and redefined to foster collaborative relationships among different groups of professionals in the healthcare sector. More specifically, results of a study conducted

by Munyewende et al (2016) suggest that nursing managers require additional training in planning and priority setting. In current practicum experience, students at universities in the country learn within a unidisciplinary clinical model during training, and are placed in a context where they mainly interact and work with professionals of their own discipline (Sicotte et al., 2002). It is therefore advised that in present day training models, improved and inclusive interdisciplinary values within the traditional professional model must be designed and put in place (Sicotte et al., 2002). Sicotte et al (2002) poignantly recommend the following functioning in healthcare services, "*The interdisciplinary model has been mostly promoted as an ideal model that stands on its own. It is not surprising that professionals in their day-to-day practices have difficulty reconciling their basic training with a stand-alone interdisciplinary model. Renewed training programmes in which interdisciplinary values are accommodated within the traditional professional model should facilitate the emergence of a more coherent shared work group model within the workplace*".

D'amour & Oandasan (2005) support and reemphasise the need for interprofessional function in the healthcare services sector as suggested by Sicotte in suggesting that, as far as the interactional dimensions are concerned, sharing common goals and a common vision are of prime importance in patient orientated service delivery. Another crucial interactional dimension according to D'amour & Oandasan (2005) refers to the bonds that are founded between team members and their willingness to work together. These are solely developed due to the elements that contribute to a sense of mutual trust among the health professionals working in a team (D'amour &Oandasan, 2005). It is also imperative to recognise that collaboration exists not only within a team, but also in the context of a larger organisational setting, as well as between organisations within the healthcare network (D'amour & Oandasan, 2005). It is also important to understand that these teams play a significant role in the service delivery functioning optimally (D'amour & Oandasan, 2005).

2.7. Summary

The main purpose of this chapter was to elaborate on the literature review and provide the reader with an array of sources regarding management competencies in the health care sector in South Africa. The theoretical framework utilised provide a

context for the communities under which community healthcare centres are physically located. This thus interplays on the functionality and the competence of the healthcare professionals' limitations and capability set (opportunities in terms of resources). The recent interest in competencies has arisen from the recognition that the acquisition of training, knowledge, skills and experience does not single-handedly lead to an improvement in performance by healthcare professionals. The paradigm shifts in healthcare professionals' development efforts, moving towards a more diverse range of skills supporting primary care, is a motion to upscale health service. Interprofessional interaction is advocated for and is crucial for quality and efficient patient oriented service delivery. In the next chapter the research methodology will be discussed.

CHAPTER THREE

RESEARCH DESIGN AND METHOD

3.1 Introduction

The purpose of this chapter is to explain in detail the research design and methods employed for this study. The chapter explains the choice of research approach, the research design, as well as the advantages and disadvantages of the research instrument chosen. This will be followed by an intricate discussion of how the research design and methods were able to produce valid results, meeting the aims and objectives set by this study. The chapter then goes on to discuss the sample size and the sampling strategy applied by the researcher, the data analysis method utilised, and the limitations of the study. It concludes with a brief discussion on the ethical considerations applied in this study.

3.2 Research Approach and Design

The research design selected for this study is an explorative qualitative study. The qualitative approach is suitable to answer the study's research question as perception regarding competency levels is the driving force of this study, in order to ultimately aid improvement in community health care sector's service delivery in the Cape Town Metropole. The qualitative research approach and design are necessary for a detailed examination of the participants' lifeworld states (Smith & Osborn, 2003). An explorative qualitative study aims to explain personal experiences and is concerned with an individual's personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself (Smith & Osborn, 2003).

In support of the aforementioned description of qualitative design, Powell & Single (1996) suggest that, even though definitions vary, the aims of qualitative research are generally directed at providing an in-depth and interpreted understanding of the social world, by acquiring knowledge about people's social and material circumstances, their experiences thereof, perspectives and their histories.

Therefore the researcher, in choosing this approach, aimed to describe what the life world consists of, or more specifically, what concepts and structures of experience give form and meaning to the CHC managers' and health professionals' daily function (Kitzinger, 1995). This design was selected, because the aim of this study is to explore through the view of the CHC managers and healthcare professionals the competencies required by CHC managers. In ascertaining the perceptions of the required competencies, opportunities and challenges were derived by the participants of this study with the hope of aiding betterment in health care service delivery at CHCs in the Cape Town Metropole.

3.3 Research Setting

This study was based in the low socio-economic status areas of the Cape Town Metropole. The Cape Flats townships according to (Wilkinson (2000;Dixon-woods, Mcnicol, & Martin, 2012) are located in the low socio-economic settlements to the northeast of Cape Town. These townships are riddled with overcrowding and lifestyle choices that impact negatively on the communities' health (Ataguba & Alaba, 2012) and (SANAC, 2017). Faced with these disadvantages, the health professionals are forced to deal with a large number of service users which further exacerbate the efficacy of service delivery (Ataguba & Alaba, 2012). As one of the poorest areas of the city, it is not surprising that the current health status of the population is also poor with problems that reflect the country's burden of disease (Daire & Gilson, 2014).

Cape Town has 49 Community Health Centres (CHC) and the researcher stratified 5 CHCs in Cape Town Metropole. The CHCs were selected on the grounds of being located in the low socio-economic status areas in Cape Town Metropole, because 80% of South Africans are within these communities(Harris et al., 2011) and its continuing association with health disparities and socio-economic status (McIntyre et al, 2002; Sorsdahl,Flisher, Ward, Mertens, Bresick, Sterling, & Weisner 2010). The community health care centres were chosen based on the geographic coverage of Cape Town, so that the data was widespread and representative of low socioeconomic areas in Cape Town. One centre was chosen in each of the following districts: i) Athlone, ii) Central, iii) Mitchells Plain, iv) Nyanga and v) South Peninsula District. The

researcher chose the CHC's on the basis that they are representative of the country's divercity in terms of ethnicity, community, social and political constructs.

3.4 Participant Selection

For this study, the researcher has chosen purposive sampling of the participants. This technique was of best assistance during data collection because it seeks to find a sample that will best serve the purpose of the study. The researcher had specific population parameters for the study, so that a sample that reflects the rest of the population successfully was selected. Purposive sampling is useful in the researcher selecting a sample in accordance to criterion specific to the study's needs (Maree, 2007). De Vos et al (2011) concurs with Maree in stipulating that purposive sampling aids a clear identification and formulation of pre-selected criteria of respondents is therefore of cardinal importance. This technique assisted the researcher with the goal of the study as it allowed the participants to describe their experiences to provide an understanding for the researcher. The researcher attained data pertaining competencies, and for this reason purposive sampling was fitting. The researcher selected the human resource manager (n=1) of the district, facility managers (n=5), a doctor at each CHC (n=5), a professional nurse at each CHC (n=5) and psychosocial personnel (n=5) at each CHC. A total of 21 people were interviewed for this study. The following section will demonstrate how the data was collected and analysed.

3.5 Data collection instrument and procedure

Burns & Grove (2011) describe data collection as the precise systematic gathering of information relevant to the specific objectives of the study. The data collection instrument used in the study is a semi-structured interview.

The semi-structured interview guide for public health leaders (Marais, 2014) was adapted for this study. The guide was intended to ascertain the public leaders' competencies. Applicable to this study, the researcher adapted the questions to suit the collection of data about both leadership and managerial competencies at the CHSs in South Africa. The guide was adapted to ascertain the human resources. The CHC managers and health professionals' interpretation of managerial competencies can be

seen in *Appendix A*. Face-to-face semi-structured interviews enabled the researcher to have control over the line of questioning as well as helping the participants provide elicited information (Creswell, 2009).

After ethics clearance for the study was granted, the researcher contacted the facility managers at each CHC telephonically to schedule appointments. Face to face semi-structured interviews with the facility managers took at the CHC and interviews were no longer than 45 minutes. The discussion with the facility managers included a briefing on the research study, the researcher requested permission to collect data at their institution and seek participants within the CHC. Once that permission was granted, the researcher requested permission from the facility managers to select suitable health professionals (key informants) to partake in the research study. After participants were identified and selected, dates and times suitable to the participants were arranged. The data collection tool was explained; this enabled the researcher the opportunity to gather the data required in order to compare the data collected to the literature and to make credible recommendations pertaining competencies.

Rowley (2012) alludes that interviews are utilised in conducting qualitative research. The researcher in a qualitative context is interested in collecting a participant's worldview and gaining insights into or understanding of opinions, attitudes, experiences, processes, behaviours, or predictions. Every data collection tool is not without its pros and cons. The semi-structured face to face interview as suggested by (Shuy, 2003; Irvine, Drew, & Sainsbury 2013) contends that, '*face-to face interaction compels more small talk, politeness routines, joking, nonverbal communication, and a platform in which people can more fully express their humanity'*. This can be deemed an advantage because then it grants the researcher a humanistic feel and a chance to probe and delve deeper on responses granted by the participant. It can also be deemed a disadvantage because it is time consuming. Which may take the health professionals away from their day-to-day operations.

Going into field, the researcher had preconceived notions regarding healthcare professionals and managers alike. The perceived ideas of emotional fatigue (which often looked like the ill-treatment of patients from the outside), the immunity to the dreary circumstances that healthcare manages and healthcare professionals must

function and work under makes them not to care anymore. The researcher thought that the aforementioned notions were thought to be the core factors for poor service delivery. The researcher in observing and interaction with the healthcare professionals noted that the patients came first. The researcher spent a whole day at the facilities observing that the healthcare professionals were so passionate about their work that they would miss lunch or even postpone scheduled appointments. This is solely because they are aware of the sacrifice and costs made by patients just to seek healthcare. They (healthcare professionals) are bogged down by the facility's overcrowding, scarce resources (which the healthcare managers need to be equipped with the necessary skills set to manage the resources) and at times colleague personality traits in the workplace. The resilience of healthcare professionals is really profound. The specialisation to community needs in terms of changing operation hours and the most efficient referral systems for patients just further proves their level of care. It has to be highlighted however, that the researcher's subjective views were not a bearing in discussion with research participants.

3.6 Data analysis

Coding according to De Vos et al (2011) helps identify themes, recurring ideas and patterns of beliefs that link people and their settings together. This is useful and purposeful in this study as the researcher has been able to work out themes that arose during the interviews. The researcher had to be mindful of interpretation when analyzing data (Creswell, 2014). The researcher grouped the perceptions, ideals, ideas and views of the competencies required. The researcher used category generating and coding the data approach as the study sought to explore the competencies needed for CHC managers. These views are subjective to the study participant. It is in light of the aforementioned procedure of extracting the views of the study participants and analysing those perspectives, the ideas they associate to their real life experiences are to be expressed with the nuances of the participants so that the context is not altered by the researcher.

The researcher adopted the coding approach and data analysis process as described in Tesch's model (Tesch,1992). The method of data analysis that has been used is Tesch's model involved the following steps:

1. Get a sense of the whole by reading all the transcriptions carefully and jotting down ideas that come to mind.
2. Select one transcription or interview - it should be the most interesting one, the shortest. Go through it, asking yourself “what is this about?” Do not think about substance of data but the underlying meaning. Write thoughts in the margin.
3. After completion of this task for several of the participants, make a list of all the topics. Cluster together similar topics. Form these topics into columns that might be arrayed as major topics, unique topics and left-overs.
4. Take the list and go back to your data. Abbreviate the topic as codes and write the codes next to the appropriate segments of the text. Try this preliminary organizing scheme to see if new categories and codes emerge.
5. Find the most descriptive wording for your topics and turn them into categories. Look for ways of reducing your total list of categories by grouping topics that relate to each other. Draw lines between categories and show interrelationships.
6. Make a final decision on the abbreviation for each category and alphabetize these codes.
7. Assemble the data material belonging to each category in place and perform a preliminary analysis.

In addition to following Tesch’s model steps the researcher has utilised the Atlas Ti 8 for the data analysis process.

3.7 Trustworthiness

The researcher has utilised principles of trustworthiness by Lincoln and Guba; Babbie& Mouton, 2014) which are namely; credibility, transferability, dependability and confirmability. Credibility has been attained through a process of referential adequacy in that audio taping provided a good record of the researcher’s findings. The researcher returned to the participants their transcripts and asked for verification to validate the participants’ responses through a process called member checking, this further ensured credibility in the study. After transcribing, to ascertain the transferability and to confirm that the data collected is dependable, the researcher had another researcher go through the transcriptions to derive codes. This was to cross check that

the researchers have similar or the same codes. The utilisation of purposive sampling maximises the range of specific data attained by selecting specified information and participants. How transferable the data is in a similar context with professionals selected by another researcher can be the determining factor for ascertaining the study's trustworthiness. In doing so the findings of the researcher can be deemed dependable. The researcher has allowed the raw data to be audited by the ethics team at the Institute of Social Development (ISD) Department at UWC for confirmability of the study. This has therefore afforded the opportunity to prove the analysis of the findings are unbiased, methodical and objectively synthesised.

3.8 Limitations of the study

This study was based on a sample of managers and healthcare professionals working in CHCs in the low socio-economic areas of the Cape Flat, which obviously limits the generalisation of its results. The results of the study, however, do offer the reader a good sense of the experiences, challenges and the competencies of managers in the CHCs in Cape Town.

The available time of both the healthcare professionals, managers and researcher for face to face interactive interviews had to be scheduled in between seeing patients or lunch times. At times, the researcher had to schedule and reschedule interviews which led to time and financial constraints. Taxi strikes, management meetings and gang wars also were another cause for interview rescheduling even when interview appointments were honoured by researcher.

Regardless of this, these findings raise important feedback regarding competence, interprofessionality, attitudes and the general functioning of the CHC to render a well operating service delivery. Concerns were raised by healthcare professionals regarding intimidation by managing personnel. Fear by participants about being brutally honest during audio taping was a really serious limitation (only off record after the interview would the conversation be brutally honest).

3.9 Ethics statement

This research is not intended to cause any harm to any participants involved. Should any harm befall the participants the researcher would have had to refer the

participant to psychotherapeutic resources. The researcher was responsible for conducting research in an ethical manner from the conceptualisation phase, planning phase, implementation phase and dissemination phase. The researcher was guided by fundamental ethical principles during the research process such autonomy, beneficence and non-maleficence (Brink, van der Walt & van Rensburg, 2012). Permission was requested from the Human and Social Science Research Ethics Committee (HSSREC) at University of the Western Cape and the Institute for Social Development before the study was undertaken, as well as from the Department of Health in the Western Cape. The study followed the ethical procedures necessary and has been approved (*page 96 & 97*). The researcher stored the primary data collected in the ISD Department's storage for safe-keeping. To ensure confidentiality the researcher has ensured that the participants' names are not used in the study.

Electronic backing of the data was stored in the researcher's external hard drive in the private capacity of the researcher. during the interviews, participants were afforded the opportunity to exit at any point in time (Appendix E, F and G). This is due to the fact that participation is voluntary. The findings of the study will be given in a day seminar for health sector professionals, including the participants after the examination board have approved the thesis.

3.10 Summary

In this study qualitative, exploratory design was utilised to determine managers' competence at Cape Town CHCs. The intent for the study that took place on the Cape Flats was established and explained. The rationale for participant selection and data collection instrument was explained. The research method and analysis employed by the researcher was explained in detail in order to justify the chosen research procedure. The trustworthiness of the study was determined through an extensive literature review, evaluation of research instrument by the research committees including research supervisor from UWC, data verification and co-coding were steps undertaken by the researcher to ensure that the study adheres to the research ethics standards. In the next chapter the findings of the data collected will be discussed.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter presents a discursive narrative of the findings explored by the researcher through interviewing participants. The analysis and interpretation of the data were carried out against the backdrop of the research objectives of the study to answer the following research question:

- *What are the competencies required for managers to deliver health care services at community health care centres on the Cape Flats?*

4.2 Demographic Profile of the Participants

Discussed below are the most noticeable characteristics of the interviewees. This profile may also affect analysis because of the perspective the participants are coming from. Therefore, some responses may be affected by the participant's demographic profile. This is the very reason why the researcher has taken demographics into consideration when analysing.

4.2.1 Gender Distribution of the Participants

The gender distribution of the study is depicted in a pie chart below. With (n=16) 76% of the participants being female and (n=5) 24% of the participants being male; this depicts the general landscape of the healthcare professional population outlook. Females are deemed natural caregivers and are more inclined to choose a career in healthcare. Furthermore, females are more inclined to sharing their thoughts and emote how they are feeling about certain issues for the better good.

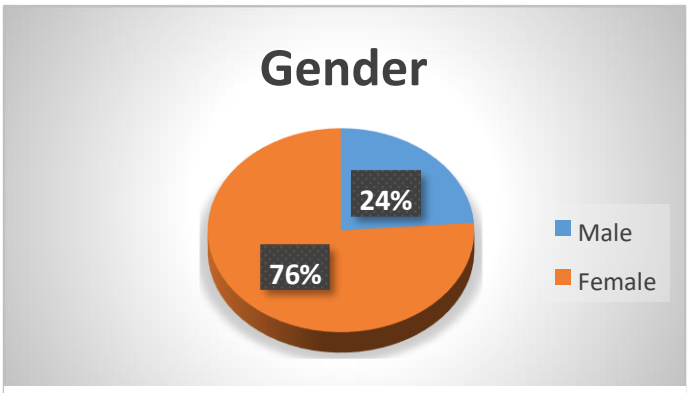


Figure 3: Gender distribution of participants

4.2.2 Age Distribution of the Participants

The ages are depicted below. They are crucial in the analysis as generational perspective and training plays a role in the viewpoints of the participants. Being in the fourth industrial revolution and the ever-changing healthcare environment versus training in the varied generations does influence the manner in which healthcare professionals and managers view competence.

In figure 4, age distribution of the participants is depicted. Participants aged 21-30 (n=3), participants aged 31-40 (n=9), participants aged 41-50 (n=7) and lastly, the study was inclusive of participants aged 51-60 (n=2). It can be deduced from the quantified observation of age distribution that healthcare professionals aged 31-50 were more inclined to partake in the study. Apprehension, scepticism and fear were more prevalent among the older and the newly appointed younger professionals. These factors are crucial to account for, as they affect the very nature of the data received in the study, in that the feedback cannot be generalised to the wider population, but it is vital to note that the middle-aged healthcare professionals are change makers and influencers in healthcare facilities. They have experience, have established themselves in the workspace and feel comfortable in expressing themselves more. And because this study is voluntary, it is crucial to note the participants who were not willing to partake in research that aimed to explore the phenomena that affect service delivery. The apprehension to participate observed by the researcher highlighted the possible dynamics and power struggles amongst the healthcare professionals and the plight to be able to bring about changes in the

workplace setting, and most importantly they feared partaking in the study, only to be victimised later by their superiors.

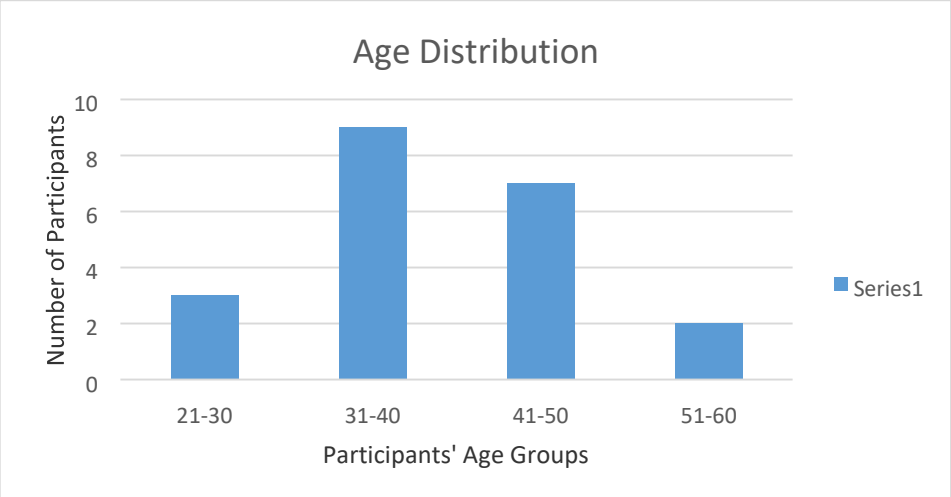


Figure 4 Age distribution of participants

4.2.3 Participants' Professional Orientation

Competence is a complex professional phenomenon. This is the very reason there is no clear definition of the notion. This is more so in the healthcare professionals' domain. The healthcare professionals are a wide stream of disciplines that have to work uniformly to deliver a service that enables an improved well-being of patients. Participants during the interviews were perplexed when they had to explain in their own words the definition of management. However, when they were asked to express their ideas about what they expect from a manager they could express their expectations more fluidly. These expectations inevitably spoke to the core of competencies that are required by healthcare managers to deliver a service at community healthcare centres in Cape Town. As literature has indicated, the healthcare managers are individuals who come from varied streams of disciplines and have been promoted on the basis of skill, experience and potential to lead. Table 1 below grants the reader an overview of the various professional orientations of the interviewees who consented to participate in this research study. This sample was purposefully chosen by the researcher to elicit the viewpoints of how clinicians perceived management in their varied disciplines. The researcher also wanted to get the perspective of managing competence from the managers themselves.

Table 1: An overview of professional orientations of participants

Professional Orientation	Number of Participants (N=21)
Facility Manager	**n=5**
Medical Officer	**n=5**
Professional Nurse	**n=5**
Social Worker	**n=5**
Human Resource Manager	**n=1**

4.3 Emergent Themes

In conducting interviews with healthcare professionals from varying orientation the researcher could identify the challenges, the experiences, the expectations and recommendations or remedies to influence improved management, thereby improving the working environment and inevitably better service delivery in the community healthcare centres.

Competencies required by managers are expressed through experiences shared by the managers themselves and by the healthcare professionals. Themes were identified through the emerging reoccurring categories in the interview responses.

Table 2 provides a summary of the themes indicating the experiences by the healthcare professionals and managers relating to service delivery and manager competencies.

Table 2 Experience of healthcare practitioners and managers

Themes	Sub-Themes
Healthcare context	Human Resources
	Financial Resources
	Support systems

	Infrastructure
Staff Support	Burn out
	Non-victimisation
Team Work	Interprofessional practices
	Staff morale
	Shared strategic plan
Training	Continuing professional development training

4.3.1 HEALTHCARE CONTEXT

It was evident that there are no clear descriptors of competencies in the healthcare sphere for managers apart from those denoted by the World Health Organisation (WHO) and the Health Professions Council of South Africa (HPCSA). The competencies suggested by WHO and the HPCSA are not speaking directly to the context under which the managers and healthcare professionals must provide a service. (Buse & Hawkes, 2015). It is not specialised nor does it speak to the needs of the service users or service providers (Armstrong et al., 2015). Socio-economic issues that each community is dealing with affect the service delivery of the CHCs. Even within the Cape Flats there are communities that are more volatile than others.

These communities are riddled with low levels of education, and high levels of unemployment, poverty and desperation that lead them to violent crimes and gangsterism, and a large growth in street communities due to homelessness. The context in which healthcare managers and healthcare professionals are expected to function in is well said by the interviewee, *"I think part of it has to do with socioeconomic circumstances, unemployment, poverty, lack of housing and back dwellers, you know that kind of thing; all those impact on violence and drug alcohol abuse, abuse on women and children and all of that. Single parent families and absent fathers and all that kind of stuff impact on gang violence." (*Interviewee 1*)* Having looked at the

paradigm as a lens of analysis, a backdrop that is difficult to function under, even with individual conversion factors, capability set and preference formation mechanisms, the social context which may make managers seem incompetent is a day to day struggle. Which begs the question, when looking at managers' competencies is it fair to base analysis solely on experience and training? The researcher in analysing competence took caution to the healthcare context and in recommending what managers can do to function, kept at the back of her mind that the competence of a manager is challenged by varying context. Being in the community means the managers also have to be accustomed to the community culture. Being in community means you are in the closest proximity to the community and you at the first point of care for the community (so you bear the brunt of the context of the community).

Healthcare professionals in the most volatile communities expressed that they do feel relatively safe in their spaces of work because they are known by the community. That very same community protects them because they understand that those healthcare professionals are there to aid the community. It is unfortunate that due to gang wars and taxi strikes, patients and healthcare professionals alike are susceptible to stray bullets that enter the facilities and hurt individuals in them. At the other end of the spectrum, safety is an issue when it comes to service delivery because gangsterism is rife. Community members end up lapsing on treatment. They fear leaving their homes, fearing for their lives. This thus causes a problem with appointment booking and overflow of patients in the infrastructure.

Another socio-economic issue that factors into the health of the patients, and that has been mentioned in literature, is the fact that health issues are caused by lifestyle choices. The individuals in the poor communities are most affected by poor health (Moosa, Derese, & Peersman, 2017). This is why the healthcare professionals are seeing returning patients and having the influx of patients in the facility (Gilson & Gilson, 2016). The socio-economic issues are governed by the income of the household and because of overpopulation and food insecurity, patients have to return to the healthcare facilities.

The aforementioned issues are the realities that healthcare professionals are dealing with. The perpetual growth of poverty and burden of disease in the

communities require stringent management. The healthcare professionals have expressed that they are stressed by the high volumes of work and are burnt out.

It is has been emphasised that teamwork is crucial in the public healthcare system, to buffer the conditions that stem from work related stress (feeling overworked, interpersonal or interprofessional clashes and feeling overwhelmed). The inadequacy in resources impedes the competencies of managers. Healthcare professionals expect the shortages in staff, finances and infrastructure to be rectified by managers. Failure for managers troubleshooting the aforementioned issues, managers are deemed incompetent by other healthcare professionals. The healthcare professionals also want their psychological well-being to be in the list of priorities; failure to do so, leads them to feel that their manager is incompetent and does not recognise nor appreciate them.

The community healthcare centres chosen for the study are in the low socioeconomic areas of the Cape Flats. Where income generation is low, poverty is rife and gangsterism is a daily activity. One of the participants makes a statement that correlates with the socio-economic effects that disable the operational functioning of service rendering. *"We don't know how far this gang violence and anti-gang campaigns will fare so; we don't know how long is that going to remain a stumbling block for us. When it comes to getting the preventative message out to schools, libraries and that kind of thing; I think there's a possibility for that because, we are currently doing that at schools and various work places. We do it at the library because it is in a close proximity with us so, in those cases, preventative messages can go through to those areas but; not in the houses of people as we would like"*, states (interviewee 2).

Healthcare professionals and managers are on a mission to drive the preventative care message throughout their communities. Lifestyle choices, treatment adherence, food security and management of chronic conditions, especially if one has predisposition to acquiring a chronic condition, are among the services CHCs are wanting to introduce. This will reduce the number of patients coming into the facility and re-entering the system created by the faltering in the cascade of care. Managers have also identified the community healthcare workers' contribution and its importance in service delivery, as a link between the facility and the community. The participant has expressed the importance of CHW in the following light,

"*I think if the services are based at the facility and we looking at the comprehensive integrated services, that shouldn't be an issue; I think our stumbling block is going to be the work in the community itself. Currently we do have community health care workers that work in various areas in the community and, we do liaise with them to be able to follow up on some work they do for us"* (interviewee 3).

This unfavourable social context exacerbates the circumstance of the healthcare manager and distinctively impedes competence. These conditions drastically toy with the capability set that the managers also have.

4.3.1.1 Human Resources

HR simply follows mandates by district level DoH. The HR manager alluded to the fact that there is a problem when appointing managers; in most cases, managers are healthcare professionals who have been in the profession for many years and are promoted and jolted into positions that they are not ready for. The following statement supports the aforementioned expression, *"Clinical manager in most instances are healthcare personnel that have been in healthcare for a while. Recently, nurses have come up and are now managers. They come with that experience when they get to the job. Recruiting and retaining health professionals has been difficult. Sometimes clinics can go over two months without a manager because most of them can't take the hot seat. Managers don't stay for more than years at the clinics"* (interviewee 4). The curriculum presently utilised by appointed managers, is training received under fragmented and outdated or rather outpaced for the ever-changing healthcare environment. Furthermore, HR is mandated by the Employment Equity Act to employ persons in all aspects or higher ranked jobs. Managers are required by HR's learning and development department or division to be trained in diversity inclusion, must possess supervisory experience, organizational excellence, financial planning and management, leadership development and change and transformation in an organisation. Coupling transformation in the workplace, mandate by the health ministry and imparting management and leadership training has been an uphill experience for HR managers in the department of health.

Human resources are at the centre of service delivery (Daviaud & Chopra, 2008). They are the capital of healthcare services and are to be valued as such. The

managers themselves are part of this imperative currency (human resource). WHO's workload indicator of staff needs (WISN) is utilised to weigh out the patient versus healthcare professionals ratio in South Africa (Daviaud & Chopra, 2008). However, the reality in public health spheres of Cape Town, but more specifically the low socioeconomic areas of Cape Town, the healthcare professionals attend to an overwhelming amount of service user ratio (Scott & Govender, 2017). South Africa is often reported to be facing a shortage in healthcare professionals (Labonté, Sabders, Mathole, Crush, Chikanda, Dambisya, Runnels, Packer, MacKenzie, Murphy, & Bourgeault, 2015). It also must be noted that South Africa has inherited an unequal distribution of professional healthcare, with the private sector being favoured, conditions of underfunding and short staffing in the public sector negatively impact service delivery (Labonté et al., 2015). The inadequacy in human resources and the constraints bared by the human resources make managing even that more difficult. We cannot look at competency without taking into cognizance the dynamics that may hinder the manager's ability to manage constructively. The dynamics of human resources for health (HRH) include skills imbalance, shortages and maldistribution of healthcare professionals (Labonté et al., 2015). Managers are faced with the obscure task of normalising everyday stress, insecurity, detrimental social contexts, increase productivity and improve patient-centred service delivery (Mahlathi & Dlamini, 2015).

4.3.1.2 Financial Resources

Healthcare managers have been pressurised into increasing the efficient use of scarce financial resources, and to demonstrate professional legitimacy (Dizon, Grimmer, Louw, Machingaidze, Parker, & Pillen, 2017). At national level, the ministry of health is working to introduce the National Health Insurance (NHI) to improve equality in healthcare for all service users (in both public and private healthcare sectors). Despite the overwhelming strain financial resources incur in the healthcare system, the introduction of the NHI will require large expenditure (Whiteside, 2019). Managers are therefore encouraged to have strong financial management competence (Munyewende, Levin, & Rispel, 2016). In the interviews conducted, managers have voiced that they still require the need to be equipped with the competence of financial management. This is an expectation by government. One of

the managers stipulated the following, *"for me the process of change is a non-issue, the difficult part is when leadership tells us to implement a change based on one factor. When I say one factor that speaks to wanting to save financial resources"* (interviewee 5). This participant is highlighting how budget constraints make it impossible to manage the health minatory mandates for healthcare service delivery. Financial implications in management are not only affecting service delivery, but, they also affect the choices and thus general functioning of the CHC. According to the paradigm, it would be a conversion factor and a question of the capability set that a manager needs to possess to bypass financial constraints or rather better manage monetary resources. One managers stipulated the following, *"It would just mean I'm not able to measure as effectively as I would like to; if we take stock, for example, and looking at stock levels. M and E would teach me what our Utilisation rate is in certain seasons. If there's no Diarrhoea in winter, why are we still ordering the same amount we are ordering during diarrheic season. So, that is what I would like to learn so that, if we can measure better, then we can manage much better"* (interview 6). It is therefore a requirement for managers to build financial management skills that innovatively buffer the budget constraints. Financial acumen by managers aids the ability to curb social related constraints, inability in health disparities in the community and management of the scarce resources within the healthcare facilities (Obuaku-Igwe, 2015).

4.3.1.3 Support Systems

Conversion factors are those personal conditions that are instrumental in either developing you or tearing you down (Biggeri, Ferrannini, & Arciprete, 2018). The manager must establish what are their healthcare service delivery assets and constraints; must be able to mobilise assets to overcome constraints. The assets that the managers need to establish are inclusive of solid relationships with the healthcare professionals and solid resource management. In the HCDA theoretical framework, opportunities allow freedom to troubleshoot and grant the best care practices. This realisation in their agency and real freedom in opportunities to render a fruitful service are imperative (Fukuda-Parr, 2003) and (Gutiérrez-Gutiérrez, Barrales-Molina, & Kaynak, 2018). Personal health and well-being (this is inclusive of the physical and psychosocial state) of the manager also enhances or impedes the

manager's ability to manage competently. A lot of the managers together with the healthcare professionals have expressed that they are experiencing burnout, feeling overwhelmed by the influx of the patients in the facility and having to manage the scarce resources, given the headcount that walk into the facility on a daily basis. The resources (human, financial, infrastructure) are tremendously strained to say the very least. From the point of view of the managers and the healthcare professionals, it must be understood as per requirements of the managers' role, managers attend a lot of meetings, in which transformation and operational strategies are discussed. These strategies are guided by the district level office of the DoH. At the centre of competencies highlighted by the healthcare professionals is the availability of the managers. Below is the experience of a healthcare professional's views about her manager:

"I feel like they see us as robots, they don't see us as people. In the three years that I've been here, I've been called once to be asked how I am" (interviewee 7).

The participant went on to reinforce the necessity for support or better interpersonal skills by their manager in saying, *"They [managers] should have more de-briefing sessions, sessions where you have meetings. Sessions where you come together and ask people "are you fine"; what are the issues in the clinic and try to make life more comfortable because people shouldn't feel uncomfortable at the work place. Just make things better for them; I don't see it as normal for clinicians to go through a whole resuscitation or anything … see a baby die, turn around and then take the next folder. So management in this institution is top-down and it's not from the grassroots. She is unavailable and not present at the institution"* (interviewee 8).

Closely linked to the conversion factors are the managers' personal preferences, personal history and choices. The preferences are personal to the psychological state, personality and leadership style. Their (preferences) are also closely related to the resources available for the functioning in the facilities. It has to be noted that each individual manages differently. The style of leadership and the type of manager the present day CHC managers are, are governed by their personal history (training professionally, past experiences

professionally and personally, supervision and their operational priorities). The older generation of managers utilise a top down approach; whereby subordinates cannot question them and whatever they wish to be implemented occurs without dispute. The middle aged and younger managers believe in a bottom up approach. The buy in of the healthcare professionals and nonprofessionals in patient orientated and service delivery decision making processes is important to these managers. The derivative of a conducive working space is meaningful communication. The abovementioned statement is supported by the following explanation by the participant:

"It's very interesting because I watch other managers who might be from a different generation from me … who are autocratic, "don't question me I'm the boss". I don't think that works and we haven't been discussing as managers recently. Some of them are battling because they are twenty years older than me and; they come from a different generation and that's how they were managed. I'm also saying I was managed like that when I was at school but you can't keep doing that; and I think they are battling, I think the different generations and the changes and rate is very different to what it was in, say, 1960. We had different changes but the rate of changes wasn't the same" (interviewee 9).

4.3.1.4 Infrastructure

There is a daunting impunity in infrastructural development in the low socioeconomic areas of South Africa. The strength in the human resources and management has aided functionality even in these unsatisfactory settings to some extent. Functioning is not optimum at the CHC's, (based on the HDCA) the social influences on decision making impedes the analysis of the capability set if a manager which influences real opportunities for managers to manage. Managers manage under constraint which influences the personal psychology of the manager. One of the participants stated the following when it comes to service delivery in the public healthcare setting, *"As a doctor here, I cannot say throw down this building, and it is ridiculous; I have to find my way to the emergency room. That is the job of the directors and the ministers of health to ensure that we are working in proper conditions; that they have actually placed this day hospital in an accessible location. So there are things that are outside of my control. "The day hospital should be appropriately staffed;*

it should have the necessary space. The actual building should be appropriate where there is adequate waiting area; where we uphold infectious control and have enough ventilation so that we can try to avoid the spread of TB and stuff like that." (interviewee 10).

To support the sentiments by the participant above, the following was stated, *"I think that is why we request more staff at the end of the day; where you are supposed to see a population of 20 000 and now you see 40 000; meaning that your head-count for the month, we are seeing I think 3000 patients … something like that; I'm not sure but something like that a month. Where your head-count is supposed to be 3000 and now it's 6000; meaning there's an increase in demand for service delivery and a burden of patients to be seen"* (interviewee 11). Spending restrictions for managers have often prevented training, the attainment of more healthcare professionals and the ability to invest in critical infrastructure (Cancedda, Farmer, Kerry, Nuthulaganti, Scott, Goosby, & Binagwaho, 2015).

4.3.2 STAFF SUPPORT

Staff support is closely related to team work; however, it hones in onto the psychosocial well-being of the staff. This issue was strongly appraised by the medical officers, social workers and the professional nurses in the facilities. Some managers underestimate this competence while others see the value of a strong support system for the healthcare professionals. It was passionately expressed by the social workers in the facilities that staff support is at a deficit. There is one social worker in each facility; this therefore means that all social or social development issues fall on their shoulders. There is no one to share the workload with nor seek supervision from; in most cases their supervisors are medical officers; doctors have no insight in their (social worker's) discipline. When asked about support structure the participant stated the following, *"No … nothing! You build your own support in the field; there's nothing given to you in way that is to assist you. When I got to the facility I had to read, hunt, follow up and make contacts with other organisations, you don't get the same cases every day. I no longer speak up when I have an opinion because I fear victimisation. I don't want to be labelled troublesome"* (interviewee 12).

These overburdened individuals are also taking on issues that affect their colleagues as well and have had to take on the role of being Employee Assistance Programme (EAP) officers. One participant expressed the following pertaining staff support, *"we have created a platform to fill that gap. So that's what I do and how I cope; so that's just the steps you need to take care of your own well-being and, especially when it comes to burning out. You don't want to be in a situation where you are burnout and possibly lead to depression"* (interviewee 13). Social workers did not only highlight the phenomenon of staff support, but literature in other studies points out the need for staff support for healthcare professionals (Reid, Conradie, & DanielsFelix, 2018).

Managers who lead with compassion, aid an environment that allows the containment of anxiety, support for healthcare professionals, and the modelling of positive adaptive responses to challenges (Zulueta, 2016) and (Khamisa, Oldenburg, Peltzer, & Ilic, 2015). This caring culture ensures that healthcare professionals are being valued, respected, and supported. A healthcare professional re-iterated the feelings disclosed by some healthcare professionals interviewed for this study. In the following statement, one participant shares dissatisfaction of support and compassion. *"Unfortunately, we are in an environment where time is of the essence; we don't always have the opportunity to make structured meetings. I also need a manager to be open, I don't always expect her to fix things for me but I need her to listen to me and understand. When I go and tell her about my problem, it doesn't always mean she must solve my problem; in reality I know she can't. I just need you to understand that, at this moment I'm a little on edge; I'm somewhat irritated by an incident that's just happened. I know you can't fix it but I want you to know how I feel"* (interviewee 14). Strong staff support by management assists in stress management and helps build healthcare professionals (Matheson, Robertson, Elliott, Iversen, & Murchie, 2016). Deficiencies in working conditions faced by healthcare professionals and the work environment result in stress, fatigue, frustration and poor job satisfaction (Mannava, Durrant, Fisher, Chersich, & Luchters, 2015). Another incidence highlighted by participants due to a lack of staff support was burnout.

4.3.2.1 Burnout

Burnout is an emphasised phenomenon amongst the healthcare professionals. It has been hailed the core reason that healthcare professionals and their managers suffer distress. Burnout therefore impedes the quality of care received by the patients. Self-perceived medical errors, a negative attitude towards colleagues and patients are associated with burnout, depressive symptoms, and decrease in quality of life, suggesting a cyclical relationship between medical errors and distress (Dyrbye, Shanafelt, Sinsky, Cipriano, Ommaya, West & Meyers, 2017). Burnout is characterised by three measures (Maslach & Leiter, 1997) cited in (Maricu, Sulea, & Iancu, 2017), namely exhaustion, pessimism, and inefficacy (or reduced personal accomplishment or achievement). Exhaustion is particularly a feeling of being drained physically and emotionally, having low levels of energy; pessimism or cynicism is conceptualised as a disconnected attitude towards work or people at work (Montgomery, 2014; Leiter & Maslach, 2016 and Salminen, Andreou, Holma, Pekkonen & Mäkikangas, 2017). Burnout is expressed by a participant in stating, *"It's enormously stressful to work in a day hospital; when I started working I could never understand why staff can be rude to patients. I don't think a doctor or a nurse could ever go to University and decides that is what they want to do for the rest of their lives thinking they are going to be shouting and being rude to patients. I have been in the public sector for a short period, it's six years now. Having started there now I can see that community member who is trying to beat the system and; you have to check yourself all the time because you are human. It's not like you want to be rude, I always say it takes so much energy to be horrible and to be rude than just to smile and be pleasant. So I'm not going to go the angry route however, I've had moments where I heard patients banging down doors because they want to know, when is their next appointment when I'm busy with another emergency. Then you have to have a certain level of degree of sternest to put them in their place. I think it's the stress levels; I think it is very stressful to work in a day hospital. It's very stressful because the pressure never goes; every day you are under pressure. You are constantly under pressure and you become burnt-out; I know as I'm sitting here I'm totally burnt-out. It's only your conviction that you have to be there and your work ethic that gets out of bed in the morning and get to work"* (interviewee 15)

Managers thus have the challenging task of identifying burnout in their teams and relieving healthcare professionals of the pressures that cause burnout. Above all

else, managers must be able to identify their own burnout. One of the participants placed an emphasis on the aforementioned statement by stating *"So it's not about ignoring and I can't fix it and; I think it has to do with my own burnout in my own levels of stress. If I can't manage that, then I can't lead my team. If a manager or leader is burnt out, they don't really care anymore about what the staff is going through and face each day and they don't have the energy to try and fix it"* (interviewee 16). Healthcare professionals and managers with high levels of burnout often report psychological and physical health problems states (Bakker & Costa, 2014). Burnout has been known to reduce the ability of healthcare professionals to respond empathically; it must be noted that being empathic draws a lot from personal resources and can also inevitably cause burnout; on the other hand, being empathic does alleviate healthcare professionals from burnout, as suggested by Zenasni et al (2012) cited in (Wilkinson, Whittington, Perry & Eames, 2017). Burn out for both managers and healthcare professionals speak to conversion factors in HDCA. The managers and healthcare managers are making a personal choice to take care of their mental health so that they can impart their skills to render services and function on a day to day. The aforementioned is a soft skill that healthcare managers and professionals have acquired on the job. To be kind to themselves so that they can render services in a kind nature. Their preference and choice to take care of themselves aids functioning and resilience. In unpacking this statement, it can be said that burnout is a complex state of being. Feeling for patients can aid in burnout reduction as it allows the healthcare professional to place their energy on the patient, but it takes energy to feel and place yourself in the patients' shoes. At times, the healthcare professionals do not have that energy to feel for the patient, as they are not only dealing with the patients, they have personal issues as well as work related issues to deal with. One of the highlighted issues that healthcare professionals expressed was the issue of victimisation by higher authority.

4.3.2.2 Non-Victimisation

Healthcare professionals fear speaking up and are often silenced. Workplace bullying and abusive supervision are common occurrences in many organisational settings (Deery, Walsh & Guest, 2011). This set of behaviour amplifies the effects of unconducive work environments which inevitably affects service delivery. Low morale

by the healthcare professionals leads to high absenteeism and employee turnover, and inefficient organisational performance (Wood, Braeken& Niven, 2013) and (Deery, Walsh & Guest, 2011). Effects of insider-initiated harassment from managers and colleagues with outsider initiated harassment from patients is a form of victimisation (Deery et al., 2011). Victims are more vulnerable when the instigator holds a hierarchically superior position in the organisation, states Ashforth (1994) cited in (Deery et al., 2011; Dellasega, 2009). It is a known phenomenon that ill treatment from managers causes healthcare professionals to lose confidence in their abilities, and to avoid aggressive behaviour in the workplace, exit strategies should be explored (Deery et al., 2011). Structural settings that are vested under the social context as stated in the HDCA have made healthcare professionals feeling that their leaders are victimising them and are individuals that aloof or far removed from their subordinates. The following statement alludes to these sentiments, *"I feel like they see us as robots, they [mangers] don't see us as people. In the three years that I've been here, I've been called once to be asked how I am. That was coupled with a complaint so, it wasn't how but it was more of a complaint and; they also asked how are you by the way. So, it might be more personal, maybe I feel like it is more personal than an overall feeling but, that's my overall feeling with management since I've been here. They [managers] should have more de-briefing sessions, sessions where you have meetings. Sessions where you come together and ask people "are you fine"; what are the issues in the clinic and try to make life more comfortable because people shouldn't feel uncomfortable at the work place. Just make things better for them; I don't see it as normal for clinicians to go through a whole resuscitation or anything … see a baby die, turn around and then take the next folder. I don't see that as normal. Sometimes I feel like they are actually as if I can compare it like a soccer match; people seating on lines are like always the best coaches … best soccer players, just kick the ball in. I feel like that's how work feels at times; I feel like we are on a soccer field and the management is sitting and they are the best coaches. So management in this institution is top-down and it's not from the grassroots. She is unavailable and not present at the institution"* (interviewee 17).

Healthcare professionals, when dealing with public, require greater emotional control than dealing with abusive colleagues and managers. Dealing with patients that may be difficult is increasingly stressful and exhausting (Deery et al., 2011). It can

therefore be declared that burnout and victimisation are a twofold interrelated psychological phenomenon that affects healthcare professionals negatively (Palanski, 2012). Good managers must gain competence in interpersonal skills and identify their error in abusing power (Wood et al., 2013). This competence also goes hand-in-hand with supporting staff members and being a leader that is reachable in times of adversity. This skill-set does not come naturally for managers and must be acquired through training.

4.3.3 TEAM WORK

Team work is the essence of healthcare service delivery for a holistic healthcare service (intervention) for the well-being of a patient (Atun, 2004). Etheredge, Penn & Watermeyer (2017) suggest that the mandate for patient-centred care is to provide individualised specialist skills in an interprofessional environment, where these interventions must come together. Communication is said to be the pivotal relational requirement and it needs to be well facilitated in team work. Communication is said to be hierarchal in the healthcare facilities (Etheredge et al., 2017). Subordinates often express doctors at the top of the hierarchy, and inadequacy in communication by the individuals at the top. The allied professionals, at the bottom of the hierarchy are not always included in communication. Allied professionals often appear to be communicating actively among one another (Etheredge et al., 2017). Teamwork reassures the healthcare professionals that union among them provides solidarity, that their opinions matter, they are represented in decision-making and they feel valued in all regards. Teamwork allows them to have a shared vision and there is no superiority and inferiority.

Teamwork yields staff support, which enables managers to build relationships with subordinates, making leading easier and builds staff morale. Shared experience builds a bond that breeds solidarity. A support structure allows for a safe space for debriefing and learning from one another for professional and personal development. Staff morale and appreciation upscale the working environment which inevitably improves service delivery. Despite constraints such as inadequacy in infrastructure, human and financial resources, which in most cases affect the competence of managers; support structures buffer the difficulties endured in the facilities and enable the functional operation and service delivery. Interprofessional practices are often

strained in and amongst healthcare professionals, coming from varied disciplines healthcare strategies and functions are different (Maree, Bresser, Yazbek, Engelbrecht, Mostert, Viviers & Kekana, 2017). Because attitudes, schools of thought and preferential priorities among varied healthcare professionals are so different, conflict and staff morale may be affected, and this inevitably affects service delivery (Moosa, Derese & Peersman, 2017).

It was stated by one interviewee that, *"For me good teamwork would be where everybody is informed and are able to support each other no matter where you sit on the ladder; the fact that you are on that ladder doesn't mean you can't come and assist at the bottom"* (Interviewee 18). As a key component of a manager's competence, facilitating communication amongst healthcare professionals is a vital skill to acquire. Transparency and fluid, open access to information by managers and healthcare professionals are crucial to competence as a manager. The manager (a participant) identified that they are as strong as their team. Therefore; equipping their team with the skills, knowledge and upscaling their training to keep up with the current trends in health and social needs is only going to increase the patient centred service delivery.

Another interviewee brought another perspective of teamwork and they stated the following, *"You should be aware of the challenges of your other team members because, sometimes you can lighten that up by being aware of that. For instance, if I have a nurse that is going to anticipate that, this patient has high sugar level; so the doctor will need to know what is the kidney function; so while they [the patient] is waiting for the doctor, they can do blood test or send the patient for urine. When it comes to [a] team player, it's really about doing your job; being there; being responsible and try to lighten somebody else's job by trying to anticipate what you can do"*, (Interviewee 19).

Good teamwork as described by this participant is having a good understanding of one's job description, good standard of work ethic and SWOT analyses to be conducted so that the team can know one another's strengths and weaknesses. Where some healthcare professionals are strong, others are weak. When pros and cons within a team are openly analysed to make the team complementary in functioning, the workplace environment will be conducive to users and providers alike.

Proactive collaboration amongst team players is another factor a participant highlighted insert a direct quote to this effect. This will curb or rather minimise the likelihood of patients returning unnecessarily.

4.3.3.1 Interprofessional Practices

Interprofessional practices in the global frontier have been hailed to improve the quality of health and health outcomes through teamwork by multi-disciplined healthcare professionals (Maree et al.,2017; Wyk & de Beer, 2017). It is a known phenomenon that interprofessional practices encourage team work. The department of health (DoH) in the re-engineering of primary healthcare endorse interprofessional practices(D'Amour, Goulet, Labadie, Martín-Rodriguez & Pineault, 2008; Maree et al., 2017). Because individuals come from different disciplines and schools of thought, attitudes, conflict and misconception about key healthcare services in varying disciplines arise. This has been deduced by Reeves, Perrier, Goldman, Freeth & Zwarenstein (2013) as being caused by the higher education system that only affords students the opportunity to practice multidisciplinary healthcare when at healthcare facilities during practicums.

Traditional health care practices required that healthcare professionals only look at the health care provision for patients in their designated discipline. They do not look at the human as a whole organism of wellness (that is a combination of physical, psychological, emotional and social) that has ailments affecting health from different spheres of being human. Prior practicing, multidiscipline team members were isolated in their specified disciplines (Pálsdóttir et al., 2016). This highlighted disjuncture between HEI and DoH practices makes it apparent why teamwork and gelling of the healthcare professionals does not come as second nature; it is a practice that must be intentionally facilitated by managers (Rowe, Frantz & Bozalek, 2012; Aitken &von Treuer, 2014). Managers are awakening to facilitating the interprofessional practices for a holistic patient-centred service delivery. The cohesiveness network amongst healthcare practitioners is perceived to reduce the unnecessary return of the patient and will eliminate expenditure for transportation to the facilities. In connection with the necessity of coherence in teamwork and interprofessional practices, one of the participants stated *"I often see patients that were seen the previous month and; their bloods could have been done then. So when they come to see me today I don't have*

that; then they have to come again the next month. So this affects the appointment book where we could have made an appointment for someone else", (Interviewee 20). The aforementioned statement by the participant alludes to the backlog and overcrowding that occurs in the facilities due to the fact that some team players (healthcare professionals) are not pulling their weight and lack of teamwork. This also can attest to the low morale, the feeling of being over exerted and being underappreciated by the healthcare professionals. Managers have to thereby address these issues and be competent as leaders. To counterattack demotivation experiences by the healthcare professionals, teamwork and properly facilitated interprofessional practices are crucial to improving service delivery and projecting competence by managers in CHCs.

4.3.3.2 Staff Morale

Staff morale is determined by external and internal factors. Internal can be the nature of the healthcare professional in a professional and personal stance. External determinants are legislatures, codes of conducts, professional councils, community that the professionals are working in and attitudes by the management, co-workers and patients. Some participants vehemently explained poor attitudes and stress as a contributory factor to low staff morale and a high staff turnover. *"I think at a very early stage I've learnt that every work place has attitudes and you just have to go on with personalities",* stipulates (interviewee 21). The participant discloses an intentional attitude towards co-workers in order to cope with the everyday work pressures.

Highlighting managers' competencies and some managers' effects to the workplace environment. Other managers in the study explained that they have yet to acquire the competence to support the healthcare professionals. *"The manager has never asked what our expectations are; we are all professionals and we have been taught how to support one another. We have been taught how our skills are effective to manage ourselves and others. When you feel your work is not appreciated and, I'm not talking only about nurses but across all sectors; that where you feel demoralised. Absenteeism increases, people come in demoralised because whenever the manager speaks to you it's just another order"*, states (interviewee 22).

Staff support in order to revitalise the healthcare professionals is a soft skill and a competence that managers sometimes overlook as a necessity. Deficiencies in working conditions in terms of the work environment, result in stress, fatigue, frustration and poor job satisfaction for healthcare professionals (Mannava, Durrant, Fisher, Chersich & Luchters, 2015). Mannava et al (2015) further make mention of the high absenteeism rate as a direct cause of staff demoralisation. Low staff morale results in neglect or abandonment of patients, limited availability or absenteeism, and refusal to deliver services by the healthcare professionals. Healthcare managers have to master the art of interpersonal skill as a competence because informal information in the form of verbal reports from staff members, overheard conversations, impressions and hunches, though not measurable, are seen as being valuable in assessing levels of staff morale (Scott & Gilson, 2017).

4.3.3.3 Shared Strategic Plan

It is imperative to filter information from top management right down to the healthcare professionals at grass root level. Being an active participant in decision making increases inclusivity and ownership. It is this structure that the managers have to work through in order to have decisions cut through the boundaries of healthcare professionals' scopes of practice, so as to deliver a service.

One of the managers in the CHC (interviewee 23) passionately explains shared decision making as follows, *"I manage the process by informing the management team that we all belong in the same system, this includes the receptionist, pharmacist, OPD, MOU; we are all connected to the one system. What is important is that we don't make unilateral decision, it's about how that decision affects everyone in your team".*

4.3.4 Training

Training is at the core of the requirements of competence as a manager. The expressions below are stipulated by managers themselves. They make mention of issues around the lack of readiness in their roles. It also places a special emphasis on the varying training healthcare managers possess. The facility managers, as stated before, come from varying streams of professions. *"I did my Masters in Family Medicine and during that we did some management. I do need to do some of the management courses and I think that would be helpful"*. Another manager stated the

following, *"I have a BSc in Physiotherapy, I have a Masters in Health Information management and I got Adult Training … the one thing I think I lack is; I want to monitor and to evaluate but I don't want to create these indicators. It takes time to create these indicators"* (interviewee 24). Acquirement of management and leadership training is an on the job on-going training. According to HDCA this speaks to the capability set (real opportunities to best function in the workplace). It is each manager's onus to get training for the readiness of being in the managerial role. In the healthcare sector, it has not been an absolute obligation for managers to undergo specialised training (Cancedda, Farmer, Kerry, & Nuthulaganti, 2015). The need for managerial training has arisen from the discovery by managers that they require a skills set that they do not possess. This skill set incorporates collaboration, team building, being capacitated in leadership skills, budgeting, business writing, report writing, project management, financial management skills, resource management, as well as strategic planning, which includes specialisations like monitoring and evaluation (Petersen, Fairall, Bhana, Kathree, Selohilwe, Brooke-Sumner, Fairs, Breur, Sibanyoni, Lund, & Patel, 2016) and (Cancedda et al., 2015). Alluding to the aforementioned statement, the participant loosely suggests the further training he requires to be able to function and be competent as a manager: *"It would just mean I'm not able to measure as effectively as I would like to; if we take stock, for example, and looking at stock levels. M and E would teach me what our utilisation rate is in certain seasons. If there is no Diarrhoea in winter, why are we still ordering the same amount we are ordering during diarrheic season? So, that is what I would like to learn so that, if we can measure better, then we can manage much better"* (interviewee 25). Administration has to be efficient by managers but this competence is not in their skill set. Managers therefore look to continuing professional development training to acquire skills that they wish to improve or acquire.

4.3.4.1 Continuing Professional Development (CPD)Training

Continuing professional development (CPD) training is not targeted at the managers alone, but the healthcare professionals as well. These trainings are open to all healthcare professionals that are looking to keep abreast with the current trends in healthcare and service delivery (Evans, 2018). Training is crucial for job requirement role readiness and upscaling managerial needs in a complex environment like

healthcare. For the most part, managers perceive themselves as being competent, with more training required for financial management (Munyewende, Levin, Rispel, et al., 2016). However, it can be deduced from the findings that managers also require the attainment of the soft skill set (an already stated set of competencies required are; communication, staff support, teamwork coordination and good interpersonal skills). The increase in demand for the training of health professionals has shaped health education to respond to labour market demands and aid in addressing service delivery needs (Evans, 2018). Supporting the necessity for CPD training for managers is the statement by Armstrong, Rispel & Penn-Kekana (2015), suggesting that the creation of an enabling practice environment and supportive managers is needed to qualify fruitful leadership and oversee the provision of consistent and high-quality patient care. In the training gained through CPD training, managers must be competent to administer and optimise resources as inadequacy in resources affects their competency ability. This is why it is it is advised in many interactions with the managers it is advised that healthcare management become a specialisation.

4.4 Summary of the Chapter

Relative to competence many entities and influential conditions or contexts were discussed in this chapter. In the results and discussion section of the chapter quotations were utilised liberally. The HCDA theoretical paradigm gave a context for the analysis and a structured view of the entities that factor into the competence and functioning of the managers. Socio-economic, resources and training deficits faced by the managers were highlighted in the findings. Constructs that affect the health of patients and the conditions that have patients returning to CHCs and continue increasing the headcount in the facilities. A strong interpretation also came from the healthcare professionals for insights regarding expectations they have of their managers versus the realities and common stresses in the everyday working space.

The participants' views were shared to highlight the analysis and the associated realities participants expressed through the interviews conducted. It can be concluded that managers require upscaling in skills so that competence and service delivery be improved. Competencies highlighted in this study were elicited from emergent themes which include team work collaboration, staff support, training and managing resources adequately. The following chapter will reflectively conclude findings of the study,

highlight areas of recommendations, limitations and is instrumental to future study assessment.

CHAPTER FIVE

REFLECTIONS OF THE STUDY

5.1 Introduction

This chapter grants a reader a summative context of the study conducted with a strong context and reflection on what is happening in the management and leadership of community health centres of the Cape Flats.

The research question posed in this study was: What are the competencies required for health care managers to deliver health care services at community health care centres in the Cape Flats? The intent of this research was to explore the competencies of CHC facility managers in the view of the managers and healthcare professionals by exploring influential factors to managers' competencies.

5.2 Mechanising the study

A qualitative research design was chosen for this research because of the appropriateness of this approach to best answer the research question developed for this study. The researcher employed non-probability sampling and used the purposive participants. It was possible to interview 21 participants using semi-structured interviews.

The interviews were audio taped and transcribed for a thematic analysis. The researcher focused on the distinctiveness of the experiences of the interviewees, how their experiences made meaning to them, and how these meanings manifested themselves within the context of the person, both as an individual and in the role of healthcare professional or a manager. This qualitative study provided information about the experiences, training, interprofessionality of healthcare professionals and their managers in low socio-economic area community health care centres in Cape Town. The nature of the study provided a deeper exploration of their experiences of working in the CHC. This study has attempted to extract and indicate through exploration, the competencies of managers in the CHC level. Special attention however must be considered in that the study was a small scale study. The findings,

however minute they are, can be deemed the trend of the happenings in CHCs in the low socio-economic areas of Cape Town.

These factors are inclusive of; challenges they are facing, the interplay between the mandated service delivery and requirement as associated with the South African health system functioning, such as retention and recruitment of human resources, coping with the burden of disease, training of the healthcare professionals, interprofessionality or multidisciplinary practice for the effective patient-orientated service delivery. Attention was given to the training so as to inform undergraduate training of healthcare professionals so that service delivery be improved by recommendations generated through this study.

This study was successful in addressing these issues as is evident from the previous chapter. This chapter discusses some steps and strategies that could be considered to improving interprofessionality, training of managers and healthcare professionals, leadership proficiency, clinical practice improvement, inform policy, inform further research, extract the expectation of healthcare professional conduct or mannerism for achieving an environment that allows the subordinates to feel supported and appreciated whilst the manager also receives the same validation.

5.2 Summary of the research

The focus of this study was to determine the social phenomena and ecological perspectives to service delivery pertaining to health that this study wishes to highlight as a contributory factor to competencies of healthcare managerss. The healthcare professionals were open in understanding that the managers' competency was not unilaterally explored. Factoring the socio-economic, ecological and resource (financial, infrastructural and human) constraints, underdevelopment of interprofessionality training and management readiness training as hindrances that may affect the competence of healthcare managers in the Cape Flats communities. The study also gave healthcare professionals a voice to disclose how they have experienced their managers and what they expect from management for improvement in service delivery at the CHC.

The background of this study was conducted by means of a literature review on the situation pertaining management in the healthcare sector in the spheres of the

international, national, the Western Cape and Cape Flats constructs. The background of the study covers healthcare practices in South Africa, burden of disease, human resource challenges, management training as there is a disjuncture or limited collaboration between the healthcare sector and higher education sector in undertaking the realities healthcare professionals and managers face when they are in the working environment. Learning on the job is an overwhelming norm and requirement on healthcare practices. Generally, management competence was defined, competence of a CHC manager was discussed, leadership proficiency within a CHC, the importance of a CHC intervention was explained, the HDCA theoretical framework and the reason for choosing the paradigm for the study was discussed and the importance of training for both healthcare professionals as well as managers to keep abreast of the healthcare needs of the community that they serve.

The objectives of the study were: to examine how human resource management facilitates competent leadership and management in CHC in the Cape Town Metropole; to describe the perceptions of CHC managers with regards to the required competencies for effective service delivery and their challenges in the Cape Town Metropole and to explore the experiences of clinicians regarding the management of human resources and service delivery challenges at the CHC in the Cape Flats.

The research approach utilised in this study was a qualitative explorative research approach. The research population were chosen on the premise that they are located in the Cape Flats, they represent the clinicians and managers of a CHC. This research setting is purposefully located in the low socio-economic area of the Cape Town Metropole. The CHC areas where the study was conducted were geographically stratified. One centre was chosen in each of the following districts: i) Athlone, ii) Central, iii) Mitchells Plain, iv) Nyanga and in the v) South Peninsula District). Due to time constraints and delayed responses (as per study limitations) the researcher also required another consent in the Athlone district. The CHCs consented were: Gugulethu, Delft, Retreat, Hanover Park, Mitchell's Plain CHCs and Maitland CDC. The research participants were professional nurses, doctors, social workers as well as facility managers. The interviews had a guide adopted form Marais (2011).

The scheduled semi-structured interviews were coded and analysed using Tesh's model and the Atlas ti 8 software. The findings were discussed and presented in Chapter 4 by referring to identified themes and subthemes with a backing of direct quotation transcripts from conducted interviews by participants. The findings revealed that the majority of participants were females (N=16) and the minority being the males (N=5). The thematic outcomes of the study under each objective were as follows.

Objective 1: To describe the perceptions of CHC managers with regards to the required competencies for effective service delivery and their challenges at the community health centre.

In alignment with this objective, the findings regarding the perceptions of CHC managers pertaining competencies are support based. Managers believe that without their team they will not be able to serve the community. The establishment of strategic planning and devising a structure or shared goal and vision with their team was a recurring feature in the interviews conducted. It is crucial for the healthcare professionals to be part of the decision making processes and specializing the operations in the facility. This is because this will create inclusivity, make the healthcare professionals feel important, getting to hear grassroots perspective of what the community's needs are and implementing programmes that will aid improvement in the well-being of the community. This manner of management makes managers less removed and in touch with the realities which occur within and around the healthcare facility.

Challenges that were disclosed by the managers were that of resource scarcity (these are namely; infrastructure, financial and human resources). To mitigate safety issues within facility some rapport had to be established with gangs and the general community at large. Ownership and care of the facility by the community has been the mechanism utilized by the managers to curb violent crimes occurring within the facility. It is also stated by the managers that the union in staff and service delivery commences at the gate, with the security guards as the gatekeepers. Employing a management style that is incorporative is a challenge, because requirements by the health ministries are bureaucratic in nature. Marrying those (DoH) requirements and goals with local or communal needs whilst creating a working environment that makes

healthcare professionals feel appreciated is difficult. This is made more strenuous by the fast paced overcrowded environment the healthcare professionals have to function in. But, because that is a movement of healthcare professionals to work together within their varying disciplines, team work has been their manner of addressing and overcoming and service delivery shortcomings.

Objective 2: To explore the experiences of healthcare professionals regarding the management and service delivery challenges at the community health centre.

This objective honed in or the lived experiences of the healthcare professionals. The healthcare professionals' experiences with their managers are often than not, negative. Healthcare managers to their subordinates are these distant mystical figures that are always unavailable to them. Managers are abrasive individuals who are often off to meetings and are hardly ever within the premises of the CHC's. The us and them notion makes managers not in touch with their staff and not knowing their daily challenges. The healthcare professionals also understand that managers are subjected to operational functioning and have other responsibilities that often overwhelm them. Therefore, even when their soft skills are bashed by their subordinates the health professionals, the healthcare professionals are well aware of the social backdrop of hardship that the managers face.

Objective 3: To explore the perceptions of healthcare professionals' management competencies required at the community health centre.

Under this objective the healthcare professionals were able to disclose what they required from a manager, their challenges and mechanisms to improve hierarchical and interprofessional challenges. The healthcare professionals have shared that there is limited support and real management by managers. Their managers are unavailable, attending managerial meetings, some changes are imposed without their buy-in and there is no time to touch base between managers and healthcare professionals due to high volumes of work. Communication and approaching the managers is not a problem at all for healthcare professionals as the managers are deemed approachable and avid listeners. It is the time to get to communicate with one another that is a problem. Within units or departments,

managers have implemented procedures so that there are managers that healthcare professionals liaise and raise concerns with.

Managers have delegated ownership of responsibilities and tasks through selfdetermined improvement goals for service delivery and ensuring patient satisfaction.

Not denoted under any specific objectives were the following findings that were disclosed by the participants:

The healthcare professionals have disclosed that they have a devastating task of turning away patients. Social workers in CHCs have no support nor supervision and are an isolated entity in the CHC or any healthcare service facility. Healthcare professionals are burnt out but have been working regardless, and that has become their new norm. Training is often granted; but channels to acquiring the training are not very clear for employees. It is with this reasoning in mind that recommendations are made.

5.3 Recommendations

The researcher based the following recommendations on the findings of the research study. Due to the limitations in management competencies recommendations are identified by the researcher; these recommendations can be classified into the following categories: research, administrative control, policy and legislature, healthcare professionals' education and clinical practices.

5.3.1 Recommendations related to research

Further research needs to be conducted concerning competence of managers in the healthcare profession domain; means of determining competence, improvements regarding knowledge, training and management skills development is vital. A quantitative research study enquiring about the knowledge and skill set needs of managers with a measuring method to determine competence would complement this current study in better understanding the challenges and possible solutions of management. The results from both studies could be used to contribute to further research, for more specific intervention and action research whereby primary health

care in community centres will inform education and training (curriculum) in healthcare management and in turn improve service delivery.

5.3.2 Recommendations related to administrative control

Administration control plays a crucial role in management, supervision, quality control and work ethics of primary health care centres, and change management to keep the community healthcare centre managers abreast with the new trends of development in health care services. It is recommended that management create an environment for initiative, creativity and become active participants in decision making processes with their subordinates with the intention of implementing a bottom up approach instead of a bureaucracy.

5.3.3 Recommendations related to policy and legislature

The policies and legislation are crucial for a sound practice base and government support. Policy guides the practices that govern the operations in the health sector. The real issue is not the policy, it is the implementation thereof. No real public based monitoring and evaluation is conducted by the healthcare department. Evaluation is often compliance based and is far removed from the real areas of concern or implementation challenges. This is the very reason no reform or change that satisfies the service user nor the service providers (which in this case are the healthcare professionals). In the context of the CHC it is vital to include the community healthcare workers (CHW) as part of legislation development and facility strategic planning processes. The researcher wishes to position herself in the evaluative implementation of policy, influence and change policy to suit the needs of the community healthcare centres. Thorough monitoring and evaluation aids improvement and even a redevelopment of intervention strategies. Policy makers are often shocked and appalled by circumstances in low SES communities, and the gripe with the policy makers as a researcher is that no real or effective reform is established. It is compliance based, when innovation is introduces in communities it is a top down approach, non-participatory, non-inclusive and it's done so that policy makers can report that a 'new' strategy has been implemented. Its efficacy is not monitored. The CHW is the connector between the facility and the community and is in the loop of when it comes to the community's needs. For a grassroots approach and improvement

in the implementation of policy it is thus recommended that monitoring and evaluation be part of policy checking and also utilising CHW to inform the changes required to addressing communal needs.

5.3.4 Recommendations related to healthcare professionals' education

Curriculum must be in line with the needs that healthcare professionals are dealing with on a day to day basis in the workplace. Close interactions between higher education training and the department of health are required to update the outdated training received by healthcare professionals. For patient orientated care and service delivery that is satisfactory for service users interprofessionality and respect for one another's disciplines is important. Clashes between different schools of approach are another problem in the healthcare services. Incorporating multidisciplinary training and an understanding of service delivery boundaries will curb workplace clashes and a healthier environment to produce improved service delivery.

5.3.5 Recommendations related to clinical practices

- Debriefing is crucial
- Addressing burnout and morale
- Addressing high turnover rate
- Leadership style affects subordinates
- Infrastructure is an issue
- Multi-skilled personnel are recommended
- Patient staff ratio is grossly disproportionate
- CHC workforce to extend working hours to convenience the community
- There has to be a high level of security in the extension of the hours
- Better management of resources (referring patients who already suffer a financial burden for transport is unfair on the service user)

5.4 Future Research

- Patient focused research study (getting the feel of the service user's experience).
- When measured against protocol lines (WHO, NDP and SDGs) what is the current baseline of managers' competence in SA?
- Addressing the measurement of competence (quantitative monitoring and evaluation study in order to develop a tool to measure healthcare managers'

competency). A base that determines where competency is currently (in measurement or scale) versus where we should be according to WHO guidelines.

- How can lack of competence be addressed in a middle income country like South Africa?

5.5 Conclusions

Conclusively, the study has managed to achieve its aim and objectives. Competence in management is not optimal due to personal lack of training and influential factors that make management a challenge. Management competence is a very controversial issue that requires dismantling as a phenomenon. This study had its limitations and this is the very reason why further investigation through further studies is required. Management for health systems should be a specialisation and not merely a promotion based practice. Specialised training and readiness will curb problems of competence. Interprofessionality will drive practices that are patient orientated and improve service delivery. Multidisciplinary practice should therefore not start in the workplace but through the preparatory education and training of healthcare professionals. The issue of subordinates fearing victimisation requires that the healthcare professionals be protected through legislature for freedom to report managers and their ill practices. Literature has been validated in the findings preceded by the study. It is with this reasoning that further studies regarding this phenomenon should be researched.

REFERENCES

Achmat, A., & Sciences, H. (2015). *Professional Health Care Workers ' Experiences of Care At Two Community Day Clinics on the Cape Flats*. (November).

Adashi, E. Y., Geiger, H. J., & Fine, M. D. (2010). Health Care Reform and Primary Care — The Growing Importance of the Community Health Center. *New England Journal of Medicine*, *362*(22), 2047–2050. https://doi.org/10.1056/nejmp1003729

Aitken, K., & von Treuer, K. (2014). Organisational and leadership competencies for successful service integration. *Leadership in Health Services*, *27*(2), 150–180. https://doi.org/10.1108/LHS-08-2012-0028

Akintola, O., & Chikoko, G. (2016). Factors influencing motivation and job satisfaction among supervisors of community health workers in marginalized communities in South Africa. *Human Resources for Health*, 1–15. https://doi.org/10.1186/s12960-016-0151-6

Alkire, S., & Deneulin, S. (1991). *Chapter 2 : Introducing the Human Development and Capability Approach*. 1–22.

Armstrong, S. J., Rispel, L. C., Penn-kekana, L., Armstrong, S. J., Rispel, L. C., & The, L. P. (2015). *The activities of hospital nursing unit managers and quality of patient care in South African hospitals: a paradox? 9716*(May). https://doi.org/10.3402/gha.v8.26243

Ataguba, J. E. O., & Alaba, O. (2012). Explaining health inequalities in South Africa: A political economy perspective. *Development Southern Africa*, *29*(5), 756–764. https://doi.org/10.1080/0376835X.2012.730962

Atun, R. (2004). What are the advantages and disadvantages of restructuring a health care system to be more focused on primary care services ? *World Health Organization Office for Europe*, (January), 18. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0004/74704/E82997.pdf

Bakker, A. B., & Costa, P. L. (2014). Chronic job burnout and daily functioning : A theoretical analysis. *Burnout Research*, *1*(3), 112–119. https://doi.org/10.1016/j.burn.2014.04.003

Bam, N., Marcus, T., Hugo, J., & Kinkel, H. F. (2013). Conceptualizing community oriented primary care (COPC) - The Tshwane, South Africa, health post model. *African Journal of Primary Health Care and Family Medicine*, *5*(1), 54–56. https://doi.org/10.4102/phcfm.v5i1.423

Bell, R., Houweling, T. A., Taylor, S., Marmot, M., & Friel, S. (2008). Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet*, *4*(3), 166–182. https://doi.org/10.1016/s01406736(08)61690-6

Biggeri, M., Ferrannini, A., & Arciprete, C. (2018). Local Communities and Capability Evolution: The Core of Human Development Processes. *Journal of Human Development and Capabilities*, *19*(2), 126–146. https://doi.org/10.1080/19452829.2017.1411896

Bradley, H., Lehmann, U., & Butler, N. (2015). Emerging roles and competencies of district and sub-district pharmacists: A case study from Cape Town. *Human Resources for Health*, *13*(1), 1–9. https://doi.org/10.1186/s12960-015-0081-8

Brooke-sumner, C., Petersen-williams, P., Kruger, J., Mahomed, H., & Myers, B. (2019). *' Doing more with less ': a qualitative investigation of perceptions of South African health service managers on implementation of health innovations*. (March), 132–140. https://doi.org/10.1093/heapol/czz017

Buse, K., & Hawkes, S. (2015). *Health in the sustainable development goals : ready for a paradigm shift ?* 1–8. https://doi.org/10.1186/s12992-015-0098-8

Cancedda, C., Farmer, P. E., Kerry, V., & Nuthulaganti, T. (2015). *Maximizing the Impact of Training Initiatives for Health Professionals in Low-Income Countries : Frameworks , Challenges , and Best Practices*. 1–12. https://doi.org/10.1371/journal.pmed.1001840

Clark, D. a. (2005). The Capability Approach : Its Development , Critiques and

Recent Advances. *Policy*, *23*, 1–18. https://doi.org/10.1007/s10550-005-0106-2

Coovadia, H., Jewkes, R., Barron, P., Sanders, D., & McIntyre, D. (2009). The health and health system of South Africa: historical roots of current public health challenges. *The Lancet*, *374*(9692), 817–834. https://doi.org/10.1016/S01406736(09)60951-X

Cowling, A., Newman, K., & Leigh, S. (1999). Developing a competency framework to support training in evidence-based healthcare. *International Journal of Health Care Quality Assurance*, *12*(4), 149–159. https://doi.org/10.1108/09526869910272509

D'Amour, D., Goulet, L., Labadie, J. F., Martín-Rodriguez, L. S., & Pineault, R. (2008). A model and typology of collaboration between professionals in healthcare organizations. *BMC Health Services Research*, *8*, 1–15. https://doi.org/10.1186/1472-6963-8-188

D'Amour, D., & Oandasan, I. (2005). Interprofessionality as the field of interprofessional practice and interprofessional education: An emerging concept. *Journal of Interprofessional Care*, *19*(SUPPL. 1), 8–20. https://doi.org/10.1080/13561820500081604

Daire, J., & Gilson, L. (2014). Does identity shape leadership and management practice? Experiences of PHC facility managers in Cape Town, South Africa. *Health Policy and Planning*, *29*(February), ii82-ii97. https://doi.org/10.1093/heapol/czu075

Daire, J., Gilson, L., & Cleary, S. (2014). Developing leadership and management competencies in low and middle-income country health systems : a review of the literature Working Paper 4. *RESYST Working Paper*, (April), 1–12.

Daviaud, E., & Chopra, M. (2008). How much is not enough? Human resources requirements for primary health care: A case study from South Africa. *Bulletin of the World Health Organization*, *86*(1), 46–51. https://doi.org/10.2471/BLT.07.042283

Dixon-woods, M., Mcnicol, S., & Martin, G. (n.d.). *Ten challenges in improving quality in healthcare : lessons from the Health Foundation ' s programme evaluations and relevant literature*. 876–884. https://doi.org/10.1136/bmjqs-2011-000760

Dizon, J. M., Grimmer, K., Louw, Q., Machingaidze, S., Parker, H., & Pillen, H. (2017). *Barriers and enablers for the development and implementation of allied health clinical practice guidelines in South African primary healthcare settings : a qualitative study*. 1–13. https://doi.org/10.1186/s12961-017-0243-3

Dyrbye, L. N., Clinic, M., Shanafelt, T. D., Clinic, M., Sinsky, C. A., Association, A. M., … Bhatt, J. (2017). *Burnout Among Health Care Professionals A Call to Explore and Address This Underrecognized Threat to Safe , High-Quality Care*.

Ehrlich, C., Kendall, E., Muenchberger, H., & Armstrong, K. (2009). Coordinated care: What does that really mean? *Health and Social Care in the Community*, *17*(6), 619–627. https://doi.org/10.1111/j.1365-2524.2009.00863.x

Etheredge, H. R., Penn, C., & Watermeyer, J. (2017). *Interprofessional communication in organ transplantation in Gauteng Province , South Africa*. *107*(7), 615–620. https://doi.org/10.7196/SAMJ.2017.v107i7.12355

Evans, T. (2018). *HEALTH PROFESSIONAL EDUCATION OPPORTUNITIES TO ACCELERATE PROGRESS TOWARDS UNIVERSAL A Special Report of the Health Professional Education Advisory Board*. (February). https://doi.org/10.12927/whp.2017.25304

Eyles, J., Harris, B., Fried, J., Govender, V., & Munyewende, P. (2015). Endurance, resistance and resilience in the South African health care system: Case studies to demonstrate mechanisms of coping within a constrained system. *BMC Health Services Research*, *15*(1), 1–12. https://doi.org/10.1186/s12913-015-1112-9

Fukuda-Parr, S. (2003). The human development paradigm: Operationalizing Sen's ideas on capabilities. *Feminist Economics*, *9*(2–3), 301–317. https://doi.org/10.1080/1354570022000077980

Gasper, D. (2002). *INSTITUTE OF SOCIAL STUDIES IS SEN ' S CAPABILITY APPROACH AN ADEQUATE BASIS FOR CONSIDERING HUMAN DEVELOPMENT ?* (June 2001).

Gilson, L., Barasa, E., Nxumalo, N., Cleary, S., Goudge, J., Molyneux, S., … Lehmann, U. (2017). Everyday resilience in district health systems: emerging insights from the front lines in Kenya and South Africa. *BMJ Global Health*, *2*(2), e000224. https://doi.org/10.1136/bmjgh-2016-000224

Gilson, L., Brady, L., Naldei, T., Shneider, H., Pienaar, D., Hawkridge, A., & Vallabhjee, K. (2017). Development of the Health system in the Western Cape: experiences since 1994. *South African Health Review 2017*, 59–70. Retrieved from http://www.hst.org.za/publications/south-african-health-review-2017

Gilson, L., Elloker, S., Olckers, P., & Lehmann, U. (2014). Advancing the application of systems thinking in health: South African examples of a leadership of sensemaking for primary health care. *Health Research Policy and Systems*, *12*(1), 1–13. https://doi.org/10.1186/1478-4505-12-30

Gilson, L., & Gilson, L. (2016). *Everyday Politics and the Leadership of Health Policy Implementation Everyday Politics and the Leadership of Health Policy Implementation*. *8604*. https://doi.org/10.1080/23288604.2016.1217367

Gutiérrez-Gutiérrez, L.J.; Barrales-Molina, V. and Kaynak, H. (2018). *The Role of Human Resource-Related Quality Management Practices in New Product Development : A Dynamic Capability Perspective Production Management (IJOPM)*. *38*, 43–66.

Harris, B., Goudge, J., Ataguba, J. E., Mcintyre, D., Jikwana, S., Chersich, M., … Jikwanac, S. (2011). Inequities in access to health care in South Africa reforms, and policy implementation in South Africa: Studies and perspectives on the 24th anniversary of the Centre for Health Policy. *Journal of Public Health Policy*, *32*, 102–123. Retrieved from http://www.jstor.org/stable/20868835?seq=1&cid=pdfreference#references_tab_contents

HPCSA. (2014). Core competencies for undergraduate students in clinical associate, dentistry and medical teaching and learning programmes in South Africa. *Medical and Dental Professions Board of the Health Professions Council of South Africa*, (February), 14. Retrieved from

http://www.hpcsa.co.za/uploads/editor/UserFiles/downloads/medical_dental/MDB Core Competencies - ENGLISH - FINAL 2014.pdf

Ibrahim, S., & Alkire, S. (2007). Agency and empowerment: A proposal for internationally comparable indicators. *Oxford Development Studies*, *35*(4), 379–403. https://doi.org/10.1080/13600810701701897

Irvine, A., Drew, P., & Sainsbury, R. (2013). “Am I not answering your questions properly?” Clarification, adequacy and responsiveness in semi-structured telephone and face-to-face interviews. *Qualitative Research*, *13*(1), 87–106. https://doi.org/10.1177/1468794112439086

James, S. L., Abate, D., Abate, K. H., Abay, S. M., Abbafati, C., Abbasi, N., … Murray, C. J. L. (2018). Global, regional, and national incidence, prevalence, and years lived with disability for 354 diseases and injuries for 195 countries and territories, 1990–2017: a systematic analysis for the Global Burden of Disease Study 2017. *The Lancet*, *392*(10159), 1789–1858. https://doi.org/10.1016/S0140-6736(18)32279-7

Kautzky, K., & Tollman, S. M. (2008). A Perspective on primary health care in South Africa. *South African Health Review*, 17–30. Retrieved from http://www.hst.org.za/uploads/files/chap2_08.pdf

Khamisa, N., Oldenburg, B., Peltzer, K., & Ilic, D. (2015). *Work Related Stress , Burnout , Job Satisfaction and General Health of Nurses*. 652–666. https://doi.org/10.3390/ijerph120100652

Kitzinger, J. (1995). Qualitative Research: Introducing focus groups. *Bmj*, *311*(7000), 299. https://doi.org/10.1136/bmj.311.7000.299

Labonté, R., Sanders, D., Mathole, T., Crush, J., Chikanda, A., Dambisya, Y., … Bourgeault, I. L. (2015). Health worker migration from South Africa : causes , consequences and policy responses. *Human Resources for Health*, 1–16. https://doi.org/10.1186/s12960-015-0093-4

Leiter, M. P., & Maslach, C. (2016). Latent burnout profiles : A new approach to understanding the burnout experience ☆. *Burnout Research*, *3*(4), 89–100. https://doi.org/10.1016/j.burn.2016.09.001

Mahlathi, P., & Dlamini, J. (2015). Minimum Data Sets for Human Resources for Health and the Surgical Workforce in South Africa's Health System. A Rapid Analysis of Stock and Migration. *African Institute for Health and Leadership Development*, 1–13. https://doi.org/10.1136/bmj.311.7010.947

Mannava, P., Durrant, K., Fisher, J., Chersich, M., & Luchters, S. (2015). Attitudes and behaviours of maternal health care providers in interactions with clients : a systematic review. *Globalization and Health*, 1–17. https://doi.org/10.1186/s12992-015-0117-9

Maree, C., Bresser, P., Yazbek, M., Engelbrecht, L., Mostert, K., Viviers, C., … Ed, M. (2017). *Designing interprofessional modules for undergraduate healthcare learners*. *9*(4), 185–188. https://doi.org/10.7196/AJHPE.2017.v9i4.853

Maricu, P., Sulea, C., & Iancu, A. (2017). *Work engagement or burnout : Which comes fi rst ? A meta-analysis of longitudinal evidence*. *5*(April), 35–43. https://doi.org/10.1016/j.burn.2017.05.001

Matheson, C., Robertson, H. D., Elliott, A. M., Iversen, L., & Murchie, P. (2016). *Resilience of primary healthcare professionals working in challenging environments :* (July), 507–515. https://doi.org/10.3399/bjgp16X685285

Mayosi, B. M., Flisher, A. J., Lalloo, U. G., Sitas, F., Tollman, S. M., & Bradshaw, D. (2009). The burden of non-communicable diseases in South Africa. *The Lancet*, *374*(9693), 934–947. https://doi.org/10.1016/S0140-6736(09)61087-4

Mayosi, B. M., Lawn, J. E., Van Niekerk, A., Bradshaw, D., Abdool Karim, S. S., & Coovadia, H. M. (2012). Health in South Africa: Changes and challenges since 2009. *The Lancet*, *380*(9858), 2029–2043. https://doi.org/10.1016/S01406736(12)61814-5

Montgomery, A. (2014). The inevitability of physician burnout : Implications for interventions. *Burnout Research*, *1*(1), 50–56. https://doi.org/10.1016/j.burn.2014.04.002

Moosa, S., Derese, A., & Peersman, W. (2017). Insights of health district managers on the implementation of primary health care outreach teams in Johannesburg ,

South Africa : a descriptive study with focus group discussions. *Human Resources for Health*, 1–10. https://doi.org/10.1186/s12960-017-0183-6

Mukinda, F. K., Goliath, C. D., Willems, B., Zunza, M., & Dudley, L. D. (2015). Equipping medical graduates to address health systems challenges in South Africa: An expressed need for curriculum change. *African Journal of Health Professions Education*, *7*(1), 86–91. https://doi.org/10.7196/AJHPE.511

Munyewende, P. O., Levin, J., & Rispel, L. C. (2016). An evaluation of the competencies of primary health care clinic nursing managers in two South African provinces. *Global Health Action*, *9*(1), 32486. https://doi.org/10.3402/gha.v9.32486

Munyewende, P. O., Levin, J., Rispel, L. C., Munyewende, P. O., Levin, J., An, L. C. R., … Rispel, L. C. (2016). *An evaluation of the competencies of primary health care clinic nursing managers in two South African provinces An evaluation of the competencies of primary health care clinic nursing managers in two South African provinces*. *9716*. https://doi.org/10.3402/gha.v9.32486

Musinguzi, C., Namale, L., & Kekitiinwa, A. (2018). *The relationship between leadership style and health worker motivation , job satisfaction and teamwork in Uganda*. 21–32.

Naledi, T., Barron, P., & Schneider, H. (2011). Primary Health Care in South Africa since 1994 and implications of the new vision for PHC re-engineering. *South African Health Review*, 17–28.

Niessen, L. W., Mohan, D., Akuoku, J. K., Mirelman, A. J., Ahmed, S., Koehlmoos, T. P., … Peters, D. H. (2018). Tackling socioeconomic inequalities and noncommunicable diseases in low-income and middle-income countries under the Sustainable Development agenda. *The Lancet*, *391*(10134), 2036–2046. https://doi.org/10.1016/S0140-6736(18)30482-3

Nussbaum, M. C. (2011). The Centra Capabilities. *Creating Capabilities. The Human Development Approach*, pp. 17–45.

Obuaku-Igwe, C. (2015). *Health Inequality in South Africa : A Systematic Review Health Inequality in South Africa : A Systematic Review*. *19*(2), 96–131.

Orth, H., Dreyer, Z. S., Makgotlho, E., Oosthuysen, W., Sinha, B., Wasserman, E., … Wasserman, E. (2013). Tygerberg hospital. *Southern African Journal of Epidemiology and Infection*, *28*(1), 22–27. https://doi.org/10.1080/10158782.2013.11441515

Pálsdóttir, B., Barry, J., Bruno, A., Barr, H., Clithero, A., Cobb, N., … Worley, P. (2016). Training for impact: The socio-economic impact of a fit for purpose health workforce on communities. *Human Resources for Health*, *14*(1), 1–9. https://doi.org/10.1186/s12960-016-0143-6

Parker, W. A., Steyn, N. P., Levitt, N. S., & Lombard, C. J. (2012). Health promotion services for patients having non-comminicable diseases: Feedback from patients and health care providers in Cape Town, South Africa. *BMC Public Health*, *12*(1), 1. https://doi.org/10.1186/1471-2458-12-503

Petersen, I., Fairall, L., Bhana, A., Kathree, T., Selohilwe, O., Brooke-sumner, C., … Patel, V. (2016). *Integrating mental health into chronic care in South Africa : the development of a district mental healthcare plan*. *101*, 29–39. https://doi.org/10.1192/bjp.bp.114.153726

Pillay-van Wyk, V., Msemburi, W., Laubscher, R., Dorrington, R. E., Groenewald, P., Glass, T., … Bradshaw, D. (2016). Mortality trends and differentials in South Africa from 1997 to 2012: second National Burden of Disease Study. *The Lancet Global Health*, *4*(9), e642–e653. https://doi.org/10.1016/S2214-109X(16)301139

Pillay, R. (2010). The Skills Gap in Hospital Management. *Journal of Health Management*, *12*(1), 1–18. https://doi.org/10.1177/097206340901200102

Powell, R. A., & Single, M. (1996). Methodology Matters-V Focus Groups. *Internation Journal of Quality in Health Care*, *8*(5), 499–504.

Reeves, S., Perrier, L., Goldman, J., Freeth, D., & Zwarenstein, M. (2013). Interprofessional education : effects on professional practice and healthcare outcomes (update) (Review) SUMMARY OF FINDINGS FOR THE MAIN COMPARISON. *The Cochrane Library*, (3).

Reid, S., & Burch, V. (2016). Fit for purpose? The appropriate education of health professionals in South Africa. *South African Medical Journal*, *101*(1), 25. https://doi.org/10.7196/samj.4695

Reid, S., Conradie, H., & Daniels-Felix, D. (2018). The effect of undergraduate students on district health services delivery in the Western Cape Province, South Africa. African Journal of Health Professions Education, 10(1), 56-60. https://doi.org/10.7196/AJHPE.2018.v10i1.959

Rispel, L., Molomo, B., & Dumela, S. (2008). *South African case study on social exclusion*. Retrieved from http://www.hsrcpress.ac.za/downloadpdf.php?pdffile=files/PDF/2235/exclusion_pr.pdf&downloadfilename=South African case study on social exclusion

Rispel L. (2016). Analysing the progress and fault lines of health sector transformation in South Africa. In: Padarath A, King J, Mackie E, Casciola J, editors. South African Health Review 2016. Durban: Health Systems Trust; *South African Health Review 20*, 17–23.

Robeyns, I. (2005). The Capability Approach: a theoretical survey. *Journal of Human Development*, *6*(1), 93–117. https://doi.org/10.1080/146498805200034266

Rowe, M., Frantz, J., & Bozalek, V. (2012). The role of blended learning in the clinical education of healthcare students: A systematic review. *Medical Teacher*, *34*(4). https://doi.org/10.3109/0142159X.2012.642831

Rowley, J. (2012). Conducting research interviews. *Management Research Review*, *35*(3–4), 260–271. https://doi.org/10.1108/01409171211210154

Rycroft-malone, J., Burton, C. R., Bucknall, T., Graham, I. D., Hutchinson, A. M., & Stacey, D. (2016). Collaboration and Co-Production of Knowledge in Healthcare: Opportunities and Challenges. *Kerman University of Medical Sciences*, *5*(4), 221–223. https://doi.org/10.15171/ijhpm.2016.08

Salminen, S., Andreou, E., Holma, J., Pekkonen, M., & Mäkikangas, A. (2017). Narratives of burnout and recovery from an agency perspective : A two-year longitudinal study. *Burnout Research*, *7*(August), 1–9. https://doi.org/10.1016/j.burn.2017.08.001

SANAC. (2017). *Let Our Actions Count South Africa ' S National Strategic Plan for*. Retrieved from http://sanac.org.za/2017/05/11/download-the-full-version-of-thenational-strategic-plan-for-hiv-tb-and-stis-2017-2022/

Sanders, D., & Chopra, M. (2006). Key challenges to achieving health for all in an inequitable society: The case of South Africa. *American Journal of Public Health*, *96*(1), 73–78. https://doi.org/10.2105/AJPH.2005.062679

Scheffler, E., Visagie, S., & Schneider, M. (2015). The impact of health service variables on healthcare access in a low resourced urban setting in the Western Cape, South Africa. *African Journal of Primary Health Care and Family Medicine*, *7*(1), 1–11. https://doi.org/10.4102/phcfm.v7i1.820

Scott, K., & Govender, V. (n.d.). *A health policy and systems research reader on human resources for health*.

Scott, V., & Gilson, L. (2017). *Exploring how different modes of governance act across health system levels to influence primary healthcare facility managers ' use of information in decision- making : experience from Cape Town , South Africa*. 1–15. https://doi.org/10.1186/s12939-017-0660-5

Sicotte, C., D'Amour, D., & Moreault, M. P. (2002). Interdisciplinary collaboration within Quebec community health care centres. *Social Science and Medicine*, *55*(6), 991–1003. https://doi.org/10.1016/S0277-9536(01)00232-5

Smith, J. A., & Osborn, M. (2003). *IPA Chapter Four*. 53–80. https://doi.org/10.1002/9781119975144.ch9

Sorsdahl, K., Flisher, A. J., Ward, C., Mertens, J., Bresick, G., Sterling, S., & Weisner, C. (2010). The time is now: Missed opportunities to address patient needs in community clinics in Cape Town, South Africa. *Tropical Medicine and International Health*, *15*(10), 1218–1226. https://doi.org/10.1111/j.13653156.2010.02606.x

Towle, A., Farrell, C., Gaines, M. E., Godolphin, W., John, G., Kline, C., … Thistlethwaite, J. (2016). *The patient ' s voice in health and social care professional education The Vancouver Statement*. https://doi.org/10.1108/IJHG-

01-2016-0003 van Ginneken, N., Lewin, S., & Berridge, V. (2010). The emergence of community health worker programmes in the late apartheid era in South Africa: An historical analysis. *Social Science and Medicine*, *71*(6), 1110–1118. https://doi.org/10.1016/j.socscimed.2010.06.009

Volmink, J. (2018). Reconceptualising health professions education in South Africa. *South African Journal of Science*, *114*(7/8), 7–8. https://doi.org/10.17159/sajs.2018/a0281

von Knorring, M., Alexanderson, K., & Eliasson, M. A. (2016). Healthcare managers' construction of the manager role in relation to the medical profession. *Journal of Health, Organisation and Management*, *30*(3), 421–440. https://doi.org/10.1108/JHOM-11-2014-0192

Whiteside, A. (2019). *South Africa ' s Key Health Challenges*. *652*(March 2014). https://doi.org/10.1177/0002716213508067

Whitford, F. J. (2016). *Health Service Delivery in the Western Cape: A Measurement of Perceptions*. (March). Retrieved from http://scholar.sun.ac.za/handle/10019.1/98668

Wikström, E., & Dellve, L. (2009). Contemporary leadership in healthcare organizations. *Journal of Health Organization and Management*, *23*(4), 411–428. https://doi.org/10.1108/14777260910979308

Wilkinson, H., Whittington, R., Perry, L., & Eames, C. (2017). Examining the relationship between burnout and empathy in healthcare professionals : A systematic review. *Burnout Research*, *6*(May), 18–29. https://doi.org/10.1016/j.burn.2017.06.003

Wyk, H. Van, & de Beer, M. (2017). *Inter-professional education : Healthcare students ' experiences*. *47*(2), 35–40.

Yee, D. (2017). paper SERIES. In *paper SERIES*. https://doi.org/10.5040/9781770916548.00000006

Zulueta, P. C. De. (2016). *Developing compassionate leadership in health care : an integrative review*. 1–10.

Private Bag X17, Bellville 7535, Cape Town, South Africa
Telephone :(021) 959 3858/6 Fax: (021) 959 3865
E-mail: pkippie@uwc.ac.za or spenderis@uwc.ac.za
Appendix A

Information Sheet for the Human Resources Manager Project

Title:
A discursive exploration of managers' competencies at community health centres in low socio-economic communities in Cape Town

The researcher is aiming to explore the competencies required by CHC managers in Cape Town Metropole; which could inform the undergraduate curriculum thereby ultimately improving service delivery at a CHC level.

You are requested to take part in this study. You are requested to give a written consent. You will be asked to partake in an interview which should not take longer than 75 minutes. Questions answered must please be done so as honestly and truthfully as possible. After completion of study you will be given feedback at a seminar to be held at the University of the Western Cape. Confidentiality will be maintained. If at any time prior to or during the interview you feel uncomfortable in any way, you can withdraw from the research project without fear of negative consequences or repercussions.

This research is being conducted by **Monalisa Ayabulela Jantjies** a student at the University of the Western Cape. His contact number is 0749323001.If you have any questions about the research study itself, please contact Prof Firdouza Waggie at The School of Public Health (SOPH), University of the Western Cape, her telephone number (021) 959 3627 / 2062. Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Dr Sharon Penderis
Acting Director
Institute for Social Development
School of Government
University of the Western Cape
Private Bag X17
Bellville 7535

OR
HSSREC, Research Development, Private Bag X17, Bellville, 7535,
Tel +27 21 959 4111
Email: research-ethics@uwc.ac.za

Private Bag X17, Bellville 7535, Cape Town, South Africa
Telephone :(021) 959 3858/6 Fax: (021) 959 3865
E-mail: pkippie@uwc.ac.za or spenderis@uwc.ac.za

Appendix B

Information Sheet for the Community Health Centre Manager

Project Title:

A discursive exploration of managers' competencies at community health centres in low socio-economic communities in Cape Town

The researcher is aiming to explore the competencies required by CHC managers in Cape Town Metropole; which could inform the undergraduate curriculum thereby ultimately improving service delivery at a CHC level.

You are requested to take part in this study. You are requested to give a written consent. You will be asked to partake in an interview which should not take longer than 75 minutes. Questions answered must please be done so as honestly and truthfully as possible. After completion of study you will be given feedback at a seminar to be held at the University of the Western Cape. Confidentiality will be maintained. If at any time prior to or during the interview you feel uncomfortable in any way, you can withdraw from the research project without fear of negative consequences or repercussions.

This research is being conducted by **Monalisa Ayabulela Jantjies** a student at the University of the Western Cape. His contact number is 0749323001.If you have any questions about the research study itself, please contact Prof Firdouza Waggie at The School of Public Health (SOPH), University of the Western Cape, her telephone number (021) 959 3627 / 2062. Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Dr Sharon Penderis
Acting Director
Institute for Social Development
School of Government
University of the Western Cape
Private Bag X17
Bellville 7535
Or
HSSREC, Research Development, Private Bag X17, Bellville, 7535,
Tel +27 21 959 4111
Email: research-ethics@uwc.ac.za

Private Bag X17, Bellville 7535, Cape Town, South Africa
Telephone :(021) 959 3858/6 Fax: (021) 959 3865
E-mail: pkippie@uwc.ac.za or spenderis@uwc.ac.za

Appendix C

Information Sheet for the Clinicians Project Title:
A discursive exploration of managers' competencies at community health centres in low socio-economic communities in Cape Town

The researcher is aiming to explore the competencies required by CHC managers in Cape Town Metropole; which could inform the undergraduate curriculum thereby ultimately improving service delivery at a CHC level.

You are requested to take part in this study. You are requested to give a written consent. You will be asked to partake in an interview which should not take longer than 75 minutes. Questions answered must please be done so as honestly and truthfully as possible. After completion of study you will be given feedback at a seminar to be held at the University of the Western Cape. Confidentiality will be maintained. If at any time prior to or during the interview you feel uncomfortable in any way, you can withdraw from the research project without fear of negative consequences or repercussions.

This research is being conducted by **Monalisa Ayabulela Jantjies** a student at the University of the Western Cape. His contact number is 0749323001.If you have any questions about the research study itself, please contact Prof Firdouza Waggie at The School of Public Health (SOPH), University of the Western Cape, her telephone number (021) 959 3627 / 2062. Should you have any questions regarding this study and your rights as a research participant or if you wish to report any problems you have experienced related to the study, please contact:

Dr Sharon Penderis
Acting Director
Institute for Social Development
School of Government
University of the Western Cape
Private Bag X17
Bellville 7535

Or
HSSREC, Research Development, Private Bag X17, Bellville, 7535,
Tel +27 21 959 4111
Email: research-ethics@uwc.ac.za

Private Bag X17, Bellville 7535, Cape Town, South Africa
Telephone :(021) 959 3858/6 Fax: (021) 959 3865
E-mail: pkippie@uwc.ac.za or spenderis@uwc.ac.za
HSSREC, Research Development, Private Bag X17, Bellville, 7535,
Tel +27 21 959 4111
Email: research-ethics@uwc.ac.za

Appendix D

Letter of consent to the HR: To partake in an interview

I……., have had the opportunity to ask any questions related to this study, and received satisfactory answers to my questions, and any additional details I wanted.

I agree to take part in this research. I consent to audio recording of the interview.

I understand that my participation in this study is voluntary. I am free not to participate and have the right to withdraw from the study at any time, without having to explain myself.

I am aware that the information I provide on the interview might result in research which may be published.

I understand that my signature on this form indicates that I understand the information on the information sheet regarding the nature of the questions.

I have read the information regarding this research study.

I agree to answer the questions to the best of my ability.

I understand that if I don't want my name to be used that this will be ensured by the researcher.

I may also refuse to answer any questions that I don't want to answer.

By signing this letter, I give free and informed consent to participate in this research study.

Date:……

Participant
Name:……..

Participant
Signature:…….

Interviewer
name:……...

Interviewer
Signature:……

Private Bag X17, Bellville 7535, Cape Town, South Africa
Telephone :(021) 959 3858/6 Fax: (021) 959 3865
E-mail: pkippie@uwc.ac.za or spenderis@uwc.ac.za

HSSREC, Research Development, Private Bag X17, Bellville, 7535,
Tel +27 21 959 4111
Email: research-ethics@uwc.ac.za

Appendix E

Letter of consent to the CHC managers: To partake in an interview

I……., have had the opportunity to ask any questions related to this study, and received satisfactory answers to my questions, and any additional details I wanted.

I agree to take part in this research. I consent to audio recording of the interview.

I understand that my participation in this study is voluntary. I am free not to participate and have the right to withdraw from the study at any time, without having to explain myself.

I am aware that the information I provide on the interview might result in research which may be published.

I understand that my signature on this form indicates that I understand the information on the information sheet regarding the nature of the questions.

I have read the information regarding this research study.

I agree to answer the questions to the best of my ability.

I understand that if I don't want my name to be used that this will be ensured by the researcher.

I may also refuse to answer any questions that I don't want to answer.

By signing this letter, I give free and informed consent to participate in this research study.

Date:……

Participant
Name:……..

Participant
Signature:…….

Interviewer
name:……...

Interviewer
Signature:……

Private Bag X17, Bellville 7535, Cape Town, South Africa
Telephone :(021) 959 3858/6 Fax: (021) 959 3865
E-mail: pkippie@uwc.ac.za or spenderis@uwc.ac.za

HSSREC, Research Development, Private Bag X17, Bellville, 7535,
Tel +27 21 959 4111
Email: research-ethics@uwc.ac.za

Appendix F

Letter of consent to the clinicians: To partake in an interview

I……., have had the opportunity to ask any questions related to this study, and received satisfactory answers to my questions, and any additional details I wanted.

I agree to take part in this research. I consent to audio recording of the interview.

I understand that my participation in this study is voluntary. I am free not to participate and have the right to withdraw from the study at any time, without having to explain myself.

I am aware that the information I provide on the interview might result in research which may be published.

I understand that my signature on this form indicates that I understand the information on the information sheet regarding the nature of the questions.

I have read the information regarding this research study.

I agree to answer the questions to the best of my ability.

I understand that if I don't want my name to be used that this will be ensured by the researcher.

I may also refuse to answer any questions that I don't want to answer.

By signing this letter, I give free and informed consent to participate in this research study.

Date:……

Participant
Name:……..

Participant
Signature:…….

Interviewer
name:……...

Interviewer
Signature:……

UNIVERSITY of the WESTERN CAPE

INSTITUTE FOR SOCIAL DEVELOPMENT
University of the Western Cape

UNIVERSITY of the WESTERN CAPE

Private Bag X17, Bellville 7535, Cape Town, South Africa
Telephone :(021) 959 3858/6 Fax: (021) 959 3865
E-mail: pkippie@uwc.ac.za or spenderis@uwc.ac.za

HSSREC, Research Development, Private Bag X17, Bellville, 7535,
Tel +27 21 959 4111
Email: research-ethics@uwc.ac.za

Appendix G

RE: REQUEST FOR PERMISSION FROM DEPARTMENT OF HEALTH

I am a student at the University of the Western Cape, pursuing a Master's Degree in Development Studies (coursework). As part of the requirements for the programme, a student is required to conduct a research study. The title of the study is: A discursive exploration of managers' competencies at community health centres in low socio-economic communities in Cape Town.

This letter serves to ask for your permission to conduct the research study in the community health care centres of the Cape Town Metropole. A recent analysis of the competencies within the Department of Health was conducted by the Western Cape Annual Report 2014/15 and indicates limited and insufficient competencies in a number of occupational groups. This thus formed the basis of the study and has led to the following question:

What are the competencies required for health care managers to deliver health care services at community health care centres in the Cape Town Metropole?

The researcher is aiming to explore the competencies required by CHC managers in Cape Town Metropole; which could inform the undergraduate curriculum thereby ultimately improving service delivery at a CHC level.

I shall request the participants to partake in an interview. It should not be longer than 75 minutes. Participants will not be coerced to participate. They will be allowed to withdraw from participating in the research study if they are not comfortable. Confidentiality will be adhered to. I have included a copy of proposal, consent form and an interview guide.

Upon the completion of the research study, I undertake to provide the institution with a bound copy of a full research report.

If you require any further information do not hesitate to contact my supervisors.

Contact details: UWC Institute of Social Development: (021) 959 3858/6

Supervisor Prof F. Waggie (021) 959 3627 / 2062

Thanking you.

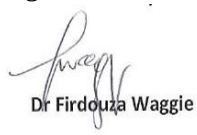
Yours faithfully

M.A. Jantjies Signature:

0636134943 Supervisor:

Prof F Waggie

Signature:



Appendix H

Human and Social Science Research Ethics Committee (HSSREC)

Appendix I

Biomedical Sciences Research Ethics Committee (BSREC)