The management of support groups for patients with chronic diseases

by

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DESSERTATION

Submitted in fulfilment of the requirements of the degree

MAGISTER CURATIONIS

in

PROFESSIONAL NURSING SCIENCE

in the

FACULTY OF EDUCATION AND NURSING

at the

RAND AFRIKAANS UNIVERSITY

Supervisor: Prof ME Muller

NOVEMBER 2001
ACKNOWLEDGEMENT

AS I BEGIN TO REFLECT ON THE MAGNITUDE OF THIS STUDY, I AM REMINDED OF THE MULTITUDE OF ALL THE PEOPLE WHO HAVE PARTICIPATED AND CONTRIBUTED TOWARDS ITS COMPLETION, ALL THOSE WHO HAVE BEEN RELENTLESSLY AND SELFLESSLY SUPPORTIVE THROUGHOUT THE STUDY.

With sincere gratitude I wish to express my appreciation to the following people:

- **Professor M Muller**: For the tolerance, patience, expert guidance and the willingness to drive me throughout the process of the study.

- **Mr P Adams**: For the continuous support, encouragement and always being there for me.

- **Ms Ngoaneso Dlamini**: For being my source of inspiration, spiritual supporter and provider of unconditional love. Mom, I feel so enriched and inspired.

- **My sisters**: Thandi and Lindi for the continued support, encouragement, the incredible love and confidence they have displayed throughout the study.

- **Mr T Mhlongo**: For the willingness, assistance and the sacrifice he has made towards the success of the study.

- **Mr J Hlophe**: A dear friend for all the creative and outstanding typescripts.

- **Mrs M Mosidi**: For believing in me, motivating me and being supportive throughout the study. I sincerely thank her for bringing out the best in me.

- **Mandela-Sisulu Clinic Support Groups**: My great source of inspiration; for the contribution they have made towards the success of the study.

- **Participants**: Without their contributions in terms of time, experience and interviews this study would have remained beyond my reach. You are the heart and soul of this study.

- **District Health System Authorities**: For their co-operation and understanding in allowing me to conduct this study.
THIS STUDY IS DEDICATED TO:

GOD ALMIGHTY
WHO HAS GIVEN ME HEALTH, STRENGTH,
WISDOM AND DETERMINATION TO CONDUCT
THIS STUDY UNTIL ITS COMPLETION.

'I Can Do All Things Through Christ
Who Strengthens Me'

and:

THABISILE AND THULI
MY WONDERFUL DAUGHTERS
FOR THE UNDIVIDED, INCOMPARABLE
SUPPORT, MOTIVATION AND
UNDERSTANDING.
SUMMARY

The role players participating within the support groups for patients with chronic diseases in Primary Health care services are facing a difficult task of managing support groups effectively. They are confronted by managerial challenges involved in the managing of support groups for patients with chronic diseases, such as careful planning, organising, leading and controlling the support groups. This is evidently confirmed by the disintegration of support groups and patients openly and deliberately rebelling and ignoring participation in support groups. The resistance and opposition is also displayed by other staff members within the clinic. The general dissatisfaction and frustration among the primary health care facilitators serves as proof of the poor management of support groups. The need to investigate and address this dilemma is important. It is therefore the reason why the researcher embarked on this studying order to explore the experiences of the role players with regard to the management of the support groups for patients with chronic diseases within the clinic context, and then utilise the results ad basis for formulating guidelines for quality management of support groups within Primary Health Care clinics in Soweto.

The following research questions are therefore relevant:

- What are the experiences of the primary health care facilitators with regard to the management of support groups for patients with chronic diseases with primary health care clinics in Soweto?
- What are the experiences of the facility managers with regard to the management of support groups for patients with chronic diseases within primary health care clinics in Soweto?
- What are the experiences of patients with chronic diseases with regard to the management of support groups?
- What guidelines should be formulated to ensure quality management and sustainability of support groups for patients with chronic diseases within the primary health care clinics in Soweto?

The following research objectives were formulated:

- To explore and describe the experiences of facility managers with regard to the management of support groups for patients with chronic diseases within primary health care clinics in Soweto.
- To explore and describe the experiences of the primary health care facilitators with regard to the management of support groups for patients with chronic diseases within primary health care clinics in Soweto.
- To explore and describe the experiences of the patients with chronic diseases with regard to the management of support groups within primary health care clinics in Soweto.
- To formulate guidelines for quality management and sustainability of support groups for patients with chronic diseases within the primary health care clinics in Soweto.
A qualitative explorative, descriptive and contextual design was followed to answer the research questions. Phenomenological focus group interviews were conducted to collect data. The role players in the study were selected within the primary health care clinics, which have existing support groups. The sample of the participants comprised of the three groups of role players. The method of selection used was the non-probability purposive sampling as described by Thomas (1990:93) and Burns & Grove (1997:349).

The data was analysed, using Tesch’s guidelines for content analysis (in Cresswell, 1994:115). An independent researcher was selected to actively participate in the collection of data and data analysis. Trustworthiness was ensured by employing the principles suggested by Lincoln & Guba (1985:290). The ethical standards were adhered to as set by the Democratic Nursing Organisation of South Africa (1998) and Burns & Grove (1997).

In terms of the results, two main categories emerged in accordance with the experiences of the role players with regard to management of support for patients with chronic diseases. Management and facilitation were the main categories that emerged during the discussion of the results: there were both positive and negative experiences that were identified with regard to the management of support groups for patients with chronic diseases within primary health care clinics in Soweto. These results formed a basis for conceptual framework for this study as well as basis for developing guidelines for quality management, the sustainability of support groups as well as the patient satisfaction.

The guidelines were classified into service delivery, management process as well as community satisfaction. Management issues such as communication, conducive environment, integrative policies, procedures and role classification were addressed and seen as essential for service delivery. The components addressed in relation to the management process were management activities such as the human resources based on management support, training, development, empowerment, recognition, group dynamics as well as staffing. Other management activities were conflict management, participative management and time management. On the aspect of community satisfaction the application of the Batho Pele principles, the patient satisfaction as well as community participation were suggested. Recommendations were made, focusing on the management of support groups, testing of research hypothesis as well as nursing education and patient empowerment. The continuous monitoring and evaluation of the quality of management of support groups was recommended.
**OPSOMMING**

Die rolspelers van die ondersteuningsgroepe vir pasiënte met kroniese siektes word met verskeie uitdagings gekonfronteer waarvan effektiewe bestuur deel vorm. Bestuurstake soos organisasie, beplanning, begeleiding en beheer van die ondersteuningsgroepe is dus van die grootste belang. Die stelling word bewys deur die disintegrasie van die ondersteuningsgroepe. Pasiënte toon 'n openlike opstandigheid om deel te neem en in sommige gevalle word die groepe geïgnorereer.

'N Negatiewe houding en optrede word ook bespeur by personeel van die kliniek. Hierdie gevoel van frustrasie en ontevredenheid word dan ook beleef deur die primêre gesondheidsorgfasiliteerders wat 'n bewys is van swak bestuur. Daar is dus 'n behoefte geïdentifiseer om die probleem te ondersoek en aan te spreek. Na aanleiding van die behoefte het die betrokke navorser haar studie gerig op die onderronding van rolspelers tydens die bestuur van ondersteuningsgroepe vir pasiënte met kroniese siektes binne 'n kliniekkonteks.

Die bevindinge sal aangewend word vir die ontwikkeling van riglyne om die bestuur van groepe te bevorder. Die volgende vrae is van toepassing vir die navorsingstudie:

- Wat is die Primêre Gesondheidsorgfasiliteerders se ervaring ten opsigte van die bestuur van ondersteuningsgroepe vir pasiënte met kroniese siektes?
- Wat is die gesondheidsorgfasiliteitbestuurders se ervaring ten opsigte van die bestuur van ondersteuningsgroepe vir pasiënte met kroniese siektes?
- Wat is die pasiënte se ervaring/belewenis ten opsigte van die bestuur van ondersteuningsgroepe vir kroniese siektes?

Die formulering van die volgende navorsingsdoelwitte is van toepassing:

- Om die ervaring/belewenis van fasiliteitbestuurders ten opsigte van die bestuur van ondersteuningsgroepe vir pasiënte met kroniese siektes te ondersoek en beskryf.
- Om die ervaring/belewenis van Primêre Gesondheidsorgfasiliteerders ten opsigte van die bestuur van ondersteuningsgroepe vir pasiënte met kroniese siektes te ondersoek en beskryf.
- Om die ervaring/belewenis van pasiënte ten opsigte van die bestuur van ondersteuningsgroepe te verken en te beskryf.
- Om riglyne te ontwikkel vir kwaliteitbestuur en om die voortbestaan van ondersteuningsgroepe vir pasiënte met kroniese siektes te verseker.

'N Kwalitatiewe, beskrywend en kontekstuele navorsingsontwerp was gevolg om data te versamal. Die rolspelers in die studie was gekies vanuit klinieke wat bestaande ondersteuningsgroepe het. Die groep persone wat gebruik is vir die navorsing het uit lede van al drie groepe rolspelers bestaan. Die metode om die groep te selekteer was soos beskryf in Thomas (1990:93), Burns en Grove (1997:349) op 'n nie-waarskynlike doelbewuste steekproefwyse gedoen. Die Tesch-metode (in Cresswell 1990) vir data-analise is gebruik. 'N Onafhanklike navorser was gekies om deel te neem in die data-analise.

Die beginsels van Lincoln en Guba (1985:290) was gebruik om vertrouenswaardigheid te verseker. Etiese standaarde soos uiteengesit deur DENOSA (1998) was geïmplimenteer.
Volgens die studie het twee hoofkategorie na vore gekom ten opsigte van die bskrywing van ondersteuningsgroep vir pasiënte met kroniese siekte. Tydens die bespreking van die resultate het bestuur en fasilitering as twee groep na vore gekom. Daar was positiewe en negatiewe punte geïdentifiseer. Die resultate het 'n konseptuele raamwerk gevorm vir die ontwikkeling van riglyne ten opsigte van die bestuur en voortbestaan van die ondersteuningsgroep sowel as die pasiënt-tevredenheid.

Die riglyne was gerig op die bestuur van die groepe sowel as die tevredeheid van die gemeenskap. Bestuursaangeleenthede soos kommunikasie-bevorderlike omgewing, beleidsprosedures en rolverdelings was aangespreek. Beginsels van menslike hulpbbronbestuur soos byvoorbeeld opleiding, ontwikkeling, indiensopleiding en erkenning was ook deel daarvan. Aktiwiteite soos konflikhantering, deelnemende besluitneming en tydsbenutting was ook aangespreek.

Die Batho Pele-beginsels was gebruik om aan die behoeftes van die gemeenskap en die pasiënt te voldoen. Daar is voorgestel dat die gemeenskap meer betrokke raak by die proses. Die aanbevelings fokus op die bestuur van die ondersteunings-groepe. Die opleiding van verpleegpersoneel sowel as pasiënt-opvoeding word ingesluit. Die hipotesis voortspruitend uit die navorsing moet ook in die proses getoets word.

Deurlopende monitering en evaluering van die kwaliteitbestuur van die ondersteuningsgroep word aanbeveel. Die evaluering van die studie was gebaseer op die bydrae en beperkende faktore soos reeds bespreek.
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<td>ANC</td>
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<td>DEMOCRATIC NURSING ORGANISATION OF SOUTH AFRICA</td>
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<tr>
<td>FM</td>
<td>FACILITY MANAGERS</td>
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<td>NDP</td>
<td>NATIONAL DRUG POLICY</td>
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<td>PHC</td>
<td>PRIMARY HEALTH CARE</td>
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CHAPTER 1

ORIENTATION TO THE MANAGEMENT OF SUPPORT GROUPS FOR PATIENTS WITH CHRONIC DISEASES AS EXPERIENCED BY THE ROLE PLAYERS.

1.1. RATIONALE AND BACKGROUND.
The health care system in the Gauteng province is gradually changing in the management of chronic diseases. There are significant changes that the Gauteng health special group directorate has embarked on to create quality service for the patients with chronic diseases. Important manifestations of these changes have been the growing influence of the greater patient and community participation in their own health care. The services are being people driven, promoting the agenda for health care (ANC, 1994:5). Health providers help promote and facilitate the self help programme, enabling partnership to develop between the health service and the community. Sawyer (1995:18) and Owen (1995:24) are of the same opinion as they state that the enormous changes need to occur in the health delivery system to create patient participation in health. The programmes such as support groups system have been initiated for patient with chronic diseases. All these initiatives undertaken by the Gauteng health department special group directorate are in line with the White Paper for the Transformation of health system in South Africa (South Africa: 1997a), which act as a framework for health reforms. It gives direction to the primary health care approach based on accessibility, acceptability, affordability, availability, appropriateness and equity.

In 1997, the Gauteng health special group directorate developed guidelines for the establishment of support groups for patients with chronic diseases. The chronic diseases which stand out in terms of prevalence in Gauteng and their impact on health services are epilepsy, hypertension, diabetes mellitus and asthma. All primary health care clinics in Soweto were to establish support groups for the above-mentioned diseases. The purpose of support groups for patients with chronic diseases as stated in the guidelines for the establishment of support groups (Gauteng Health Special Groups Draft, 1997) are as follows:

- To promote autonomy and confidence in dealing with chronic diseases
- To better disease outcome
- To provide and promote peer group support
- To share skills and ideas among group members
- To promote self care approach.

The role players involved in support groups and actively participating in this study are the facility managers (FM), Primary Health Care Facilitators (PHC), as well as the patients with chronic diseases. They all play significant roles in the management and sustainability of support groups. Their partnership is critical for the success of the programme and needs maximisation and protection.

Primary Health Care facilitators (PHC) are directly involved in the management of support groups. Their role includes leading, implementing and revitalizing support groups (Brown & Olshanske, 1997:41; and Ferrinho, 1993:35-38). This role forces the Primary
Health care facilitators (PHC) to move from one role to the other in order to meet the individual or group needs (Poggenpoel & Muller, 1996:2-9). The patients with chronic diseases play a major role in support groups, in that they are recipients of the service. The sustainability of support groups depends solely on their participation. The failure to sustain and manage the support groups has raised concern to the researcher who is involved in the management of support groups, and warranted exploration and description of the experiences of all the role players. The data collected in the study will benefit all role players and improve the quality management and ensure sustainability.

Managing support groups for patients with chronic diseases within PHC clinics in Soweto is difficult. The researcher and PHC facilitator have experienced and observed some stressful moments related to the management and support of groups in terms of quality service delivery. Despite the well and clearly spelt need for established support groups, not all clinics are coping with the demands. In some clinics some support groups are unsustainable and dying. Role players are losing interest in support groups. It is unclear as to what the reasons could be behind this and has become a cause for concern for the researcher. It therefore warrants exploration and description of the experiences of the role players involved and affected by this programme. The data that will be collected will benefit everyone: - the facilitators, the patients, the facility managers and the community in general.

1.2. PROBLEM STATEMENT
Based on the rationale of the study, it is clear that the support groups for patients with chronic diseases, within the Primary Health Care clinic context in Soweto are poorly managed and not sustainable. Most support groups in the Soweto clinics have ceased to exist, some are struggling to cope with sustainability (Gauteng Health Department, Special Groups Directorate Document, 2000:9). The PHC facilitators are under great pressure and continuously blamed for ceasing and failure of support groups. The facility managers seem too sceptical and resistant towards support groups. The patients are deliberately rebelling against and withdrawing from participating in support groups. The quality patient care as well as the well being of support groups is compromised as a result of poor management experienced by role- players.

Therefore it is inevitable for the researcher to ask the following research questions arising from the above problem statement to guide the study:

- What are the experiences of the PHC facilitators with regard to the management of support groups for patients with chronic diseases within the Primary Health Care (PHC) clinics in Soweto?

- What are the experiences of the facility managers with regard to management of support groups for patients with chronic diseases within the Primary Health Care clinics in Soweto?

- What are the experiences of the patients with regard to the management of support groups for patients with chronic diseases within the Primary Health Care clinics in Soweto?
What guidelines could be formulated for PHC facilitators to ensure quality management and sustainability of support groups for patients with chronic diseases within the Primary Health Care clinics in Soweto?

1.3 OBJECTIVES OF THE STUDY

The objectives of the study are:

- To explore and describe the experiences of the PHC facilitators with regard to the management of support groups for patients with chronic diseases within the Primary Health Care clinics in Soweto.
- To explore and describe the experiences of the facility managers with regard to the management of support groups for patients with chronic diseases within the Primary Health Care clinics in Soweto.
- To explore and describe the experiences of the patients with regard to the management of support groups for patients with chronic diseases within the Primary Health Care clinics in Soweto.
- To formulate guidelines for the facilitators to ensure quality management and sustainability of support groups for patients with chronic diseases within the Primary Health Care clinics in Soweto.

1.4 THE CENTRAL THEORETICAL STATEMENT

The following central statement serves as a central argument for this study:

An exploration and description of the experiences of the role players should give direction to the formulation of guidelines to facilitate quality management and sustainability of support groups.

1.5 ASSUMPTIONS OF THE STUDY

The following assumptions are relevant to this study:

- Support groups are a patient directed service and thus have to meet patients' needs, desires and expectations (Mhlongo, 2000:67).
- The participative management process (Muller, 1995) is relevant in ensuring quality management, sustainability of support groups as well as patient satisfaction, as based on the following principles:
  - Interactive decision-making and problem solving.
  - Shared governance/ownership.
  - Organisational transformation.
  - Empowerment/Enablement
- All internal and external factors impacting on the quality management and sustainability of support groups should be addressed.
- The South African Patient charter (SA 2000) is accepted as a point of departure in the management of support groups for patients with chronic diseases in a primary health care approach.
- A functional approach is adopted in this study as described by Botes Research model (1995) to provide a holistic approach of the research process, and to improve the quality management of support groups for patients with chronic diseases.
1.6 DEFINITION OF CONCEPTS
Within the context of this study the following concepts are defined:

Management
Management refers to the tasks/activities, which the facility managers perform, namely planning, organizing, leading and controlling the work to improve the quality.

Quality management
Quality management is compliance to the predetermined standards set in relation to the service delivery as described by Gauteng Special Groups Directorate Draft (1997).

Role players
This refers to anyone who has a major role and has input into the management of support groups.

Support groups
These groups refer to group of patients with similar chronic diseases and common concerns in relation to promotion of self-care.

Primary health care (PHC) facilitator
Primary health care facilitators refer to primary health care trained nurses in health assessment, diagnosis, treatment and care entrusted with facilitation role of support groups for patients with chronic diseases.

Patient
Patient refers to the recipient of primary health care service who is the members of the support groups who attends regular check-up on a monthly basis.

Chronic diseases
Chronic diseases refer to non-communicable diseases that are not easily cured, last for long duration, causing impairment or pathological deviations. It requires long periods of supervision, observation or care. It causes major alterations in the life style of the afflicted individual as well as family or support system.

Facility managers
They are registered nurses with the South African Nursing Council additional qualifications in nursing administration who are responsible for the effective and efficient functioning of the clinics to ensure quality patient care.

Experiences
Experiences are the reality, which the role players find themselves confronted with in the management of support groups for patients with chronic diseases.

1.7 RESEARCH DESIGN
A qualitative design which is explorative, descriptive and contextual in nature will be utilised in this study, in order to explore and describe the experiences of the PHC facilitators, the facility managers and patients with chronic diseases regarding the
management of support groups within the Primary Health Care clinics in Soweto. The phenomenological method of data collection as described by Smith (1996:28) will be utilised. The focus group interviews will be conducted to collect data as described by Krueger (1994:16) and supported by Holloway and Wheeler (1996:144). The data collected during focus group interviews will be tape recorded and field notes will be taken. The method of data analysis will be pursued according to the guidelines adopted from Tesch (in Creswell, 1994:142-145). An independent researcher acquainted with Tesch method will be selected to conduct the interviews. The population of this study will consist of twelve primary health clinics, where support groups for patients’ with chronic diseases have been established. These clinics will be included in the study on the basis of a non-probability, purposive sampling. The sample population will be drawn from the three role players involved in the management of support groups, namely facility managers, PHC facilitators as well as patients with chronic diseases within the context of the twelve clinics. The population of this study will consist of twelve primary health clinics, where support groups for patients’ with chronic diseases have been established. These clinics will be included in the study on the basis of a non-probability, purposive sampling. The sample population will be drawn from the three role players involved in the management of support groups, namely facility managers, PHC facilitators as well as patients with chronic diseases within the context of the twelve clinics. A non-probability, purposive sampling method will be used to select the participants from the twelve clinics in Soweto, which offer the primary health care services Thomas (1990:93) and Burns & Groves (1997:240). These participants will be selected in accordance with set criteria, which will be described in detail in the next chapter. Guba’s model (Lincoln & Guba 1985: 290), for qualitative research will be used to establish and maintain trustworthiness. Guba’s strategies, namely credibility, transferability, dependability and confirmability will be utilised to ensure trustworthiness.

1.8. ETHICAL CONSIDERATIONS
The approval to conduct the study will be obtained in writing from the appropriate authorities and all the participants. The human rights of all participants will be recognised and protected in accordance with the standards of the DENOSA on ethical standards for nurse researchers (DENOSA, 1998) as well as Burns and Grove, (1997). The following aspects will be dealt with in order to meet all the requirements for ethical considerations: Quality of the research, consent, confidentiality and anonymity and privacy and termination (DENOSA, 1998; Burns & Grove, 1997 as well as LoBiondo-Wood & Haber, 1994).

1.9. DIVISION OF THE CHAPTERS
The chapters of this study will be divided as follows:

Chapter 1: Overview of the study.

Chapter 2: The research design

Chapter 3: The experiences of the facilitators, the facility managers and patients with regard to management of support groups in Soweto clinics.

Chapter 4: Conceptual framework for management of support groups for patients with chronic diseases.

Chapter 5: Overview of the study research design formulation of guidelines, recommendations, evaluation and conclusion of the study.
1.10. CONCLUSION
The management of support groups for patients with chronic diseases is poor within the PHC clinic context in Soweto. Many frustrating factors that contribute to the poor management of support groups have been observed, leading to inability to sustain the support groups. It is therefore essential that the researcher who is the facilitator of the support groups to explore and describe the experiences of the role players, with regard to management of support groups, so as to have insight and understanding into their experiences. A background and motivation as to why this study is necessary have been addressed. All stages of the research process, the problem statement, objectives as well as assumptions have been described. This chapter forms the structural framework of the whole study in which the experiences of the PHC facilitators, facility managers and patients with chronic diseases with regard to management will be explored and described, in the following chapters. A full detailed description of research design will be discussed, as well as the justification of their use will follow in chapter two. Trustworthiness and ethical consideration will also be described fully in chapter two.
CHAPTER 2

RESEARCH DESIGN FOR THE MANAGEMENT OF SUPPORT GROUPS FOR PATIENTS WITH CHRONIC DISEASES

2.1. Introduction
This chapter describes the structured framework briefly mentioned in chapter one. The detailed description of the research design with all its components, namely the research strategy and method, the population and sampling, the data collection and analysis methods, as well as the methods to ensure trustworthiness. The ethical considerations will be described.

2.2. RESEARCH STRATEGY
The research strategy followed in this study will be a qualitative, explorative, descriptive contextual and phenomenological in nature as described by Mouton (1996: 103 - 109). The aim is to explore and describe the experiences of the role players with regard to the management of support groups within the context of Soweto clinics and then formulate guidelines for quality management and sustainability of support groups for patients with chronic diseases within the PHC clinics in Soweto.

2.2.1. Qualitative
In this study qualitative research is conducted to describe, promote and gain better understanding and insight of the experiences of the PHC facilitators, the facility managers as well as the patients with chronic diseases in Soweto clinics (Burns & Grove, 1997:27). The researcher wants to explore the experiences of the role players and thus conduct an in-depth study with regard to the management of support groups in order to formulate the guidelines for the quality management of support groups within context of the clinics.

2.2.2. Explorative
The goal of the researcher in this study is to gain insight and generate meaning to the management of support groups within PHC Soweto clinics, since there is very little that is known about it Mouton (1996:103). Through this explorative study the researcher will obtain richer familiarity and better clarification on the management of support groups, as all concepts and factors related to the study phenomena will be identified and described as stated in Talbot (1995: 35) and supported by Polit & Hunger (1993: 14). The researcher will not allow pre-conceived ideas to influence the research; instead will remain focused and open to the experiences of the three groups of role players (Mouton 1996:70).

2.2.3. Descriptive
This research study is a descriptive study as it is directed towards understanding and describing the lived experiences of the PHC facilitators, the facility managers and the patients with chronic diseases regarding management of support groups. The researcher would like to have the picture as it naturally happens, make judgement and thus formulate guidelines for management of support groups within PHC clinics in Soweto (Burns & Grove 1997: 250-251). The researcher believes that through the descriptive
study, the truthful and accurate description of how groups are managed within the clinic context, the relevant information describing the actual state of management will be enhanced (Mouton 1996: 102).

2.2.4. Contextual
The study is contextual since it is only conducted within the context of Soweto clinics and the results will only apply to Soweto clinics (Botes 1995:10). The results will be unique, valid only within the context of those clinics, where they can be understood. The researcher does not intend to generalize the findings into large population (Burns & Grove 1997:29), as the experiences of the role players in this context may be completely different in another context.

2.2.5. Phenomenological
The phenomenological method will be pursued in order to discover and grasp the meaning that is connected to the experiences of the PHC facilitators, facility managers and patients regarding the management of support groups within the PHC clinic context in Soweto. The researcher wants to understand, examine and interpret the management of support groups as experienced by the role players. They will be allowed to talk and freely describe their experiences from their own perspective. In so doing they will reveal the true nature of their experiences. The method that the researcher will use is as suggested by Smith (1996:28) which focuses on the following:
- Revealing the essence of the phenomenon.
- Understanding of the situation that is being investigated.
- Describing how the role players experience the situation

2.3. POPULATION AND SAMPLING
The population will consist of twelve PHC clinics in Soweto and participants comprising of the facility managers, PHC facilitators and patients with chronic diseases from these clinics.

2.3.1. Clinics
There are twelve clinics, which offer primary health care services in Soweto, and they are all involved in the management of support groups. Of the twelve clinics, four are classified as big “mother clinics” and eight are small clinics. Big clinics offer services until 19:00 and accommodate more than double the patient population within small clinics, and they offer more comprehensive services like Pharmacy department, X-ray departments, Physiotherapy department and support services as well. Unlike the small clinics they also have large physical structure in terms of space with more consulting rooms and have boardrooms. They also have more human resources in terms of nurses and doctors. The study will be conducted from clinics with existing support groups, some of these clinics have about three up to four support groups. (For clarification, refer to figure 2.1).

In the study only eight clinics will be purposively selected and included because they have well established support groups. Each clinic consists of the facility manager who ensures smooth running of the clinic and coordinates the management issues of the clinic. One PHC facilitator may manage any two to four support groups, which would either be
the Diabetes, Epilepsy, Asthma or Hypertension groups. All these clinics provide PHC services to people within a specific area for ambulatory patients of all ages, with either acute or chronic diseases. The clinics selected in this study are considered representative, as both big and small clinics are included, and a broad spectrum of patients in terms of chronic diseases and patient population per clinic. Attention will mainly focus on patients with chronic diseases that come for review and maintenance care (check-ups) on monthly basis. The average population of patients per clinic in terms of chronic diseases seen per month is about three hundred, including both the members and non-members of the support groups.

**FIGURE 2.1: SCHEMATIC PRESENTATION OF THE BIG AND SMALL CLINICS IN SOWETO.**

2.3.2 **Participants**

The participants of this study will consist of the eight PHC facilitators and eight facility managers who will be purposively selected and included in the study. They are classified as group A and B respectively. The third group of participants will consist of patients with chronic diseases, and will be classified as group C. These patients will also be selected and included purposively in the study (Thomas, 1990:93). All three groups of participants will be included in the study, based on the inclusion criteria described below.

The total patients' population who are members of the support groups is two hundred, of which only forty five members will be included because they meet the inclusion criteria.

To be included in this study, role-players will be selected in accordance with the following inclusion criteria. The first population group consisting of primary health care nurse facilitators (group A) are included because of the following criteria:

- They are registered with South African Nursing Council.
• They are all primary health care trained, and are actively practicing in their respective clinics and facilitating support groups.
• Have been facilitating support groups since its inception in 1997 or at least between 1997 to 1999.

The second population group comprising of facility managers representing group B will be included in this study because of the following:
• They are coordinators of the clinics where support groups have been established between 1997 to 1999.
• They must have been in one clinic and in a managerial position at least between 1997 to 1999 and be willing to participate.

The third group consists of patients from all eight clinics representing group C that will comply with the following criteria:
• Only regular clinic attendees (i.e. monthly check-ups), and have not broken the chain of attendance.
• Must be active participants of support groups between 1997 – 1999.
• Have been diagnosed with any of the selected chronic diseases (i.e. diabetes mellitus, hypertension, epilepsy or asthma.
• Executive members of the committees of all the support groups from the eight clinics.
• Mixed group of males and females.
• Representative of various chronic diseases per clinic.

Their availability on the day of interviewing and willingness to participate in the study was taken into consideration. Care will be taken towards gender inclusivity. The interview will continue until data is saturated as demonstrated in repeating themes as described by Tesch, (in Cresswell, 1994). Each interview will be estimated for duration of 45 minutes to an hour with intervals in between if need be. Refreshments will be available. Figure 2.2 gives an illustration of the participants including their profiles.
FIGURE 2.2. PROFILE OF THE SAMPLE POPULATION OF THIS STUDY

SAMPLE POPULATION

PHC FACILITATORS (F) 8

* All PHC trained
* Registered with SANC
* All actively practicing as PHC
* All facilitators of support groups since 1997 - 1999.

FACILITY MANAGERS (FM) 8

* Coordinators of clinics with established support groups.
Have been exposed to support groups since 1997 - 1999 but not physically involved in the actual facilitation.

PATIENTS (PT) 45

* Active members of support groups.
* Regularly (on monthly basis) attending clinic for review.
* Never broken chain.
Have various selected chronic diseases like;
* Diabetes
* Epilepsy
* Asthma
* Hypertension

F = Facilitator;
FM = Facility manager;
PT = Patients

2.4. DATA COLLECTION

In this study the experiences of the three groups with regard to management of support groups will be collected through the use of the phenomenological method of focus group interview, as described by Holloway & Wheeler (1996:144) as well as Krueger (1994:16). The in-depth focus group interview is of the researcher's choice as it makes it possible for the researcher to probe some statements in more depth as stated by Talbot (1995: 476). It will also help the researcher to have insight and understanding of the management of support groups for patients with chronic diseases.

2.4.1. Focus group interviews

The researcher aims to use focus group interviews since it encourages interaction between the group members as described by Holloway & Wheeler (1996:144) and Kruger (1994: 16). It helps the researcher to probe some statements in more depth as stated in Talbot (1995: 476) and will provide with richer and more diverse data from interviews. This study is of a qualitative nature. The focus group interview generates
qualitative data and open-ended questions will be used allowing participants to answer openly and freely. It is a purposive discussion between a group of people from a common background, with a group leader to facilitate the discussion (De Vos, 1998: 313 – 315). The independent researcher will then become a facilitator or moderator of the group during discussion (Holloway & Wheeler, 1996: 148).

A series of five focus group interviews will be conducted. In each focus group the researcher aims to include six to fifteen participants. The three groups namely C1 and C2 and C3 will represent the patients as they make a big number, group A consisting of facilitators and group B is represented by facility managers. The size of each group is big enough to generate information from the participants in all the groups. The researcher aims at elucidating the three groups’ experiences without imposing any of the researcher’s views on them but will ensure that all participants’ views are captured. The richness of data collected on these experiences is of interest and the researcher will ensure that all participants get a chance to speak. The central open-ended question relating to the topic under study that will be posed to all participants irrespective of group classification to maintain the discussion will be asked as follows:

**WHAT ARE THE EXPERIENCES OF PHC FACILITATORS, FACILITY MANAGERS AND PATIENTS WITH CHRONIC DISEASES REGARDING MANAGEMENT OF SUPPORT GROUPS FOR PATIENTS WITH CHRONIC DISEASES IN SOWETO CLINICS?**

A course of non-directiveness will follow, allowing each participant an opportunity to openly and freely express himself/herself. They will not be pressurized to reach consensus (Krueger, 1994: 16) instead through the use of open-ended question they will be allowed to feel their stories in the narrative fashion (Polit & Hungler, 1995: 271). The researcher and independent researcher throughout the interviews will employ the following guidelines of focus group interview as described by Holloway & Wheeler (1996: 148):

- The environment will be conducive for focus group interviews.
- Ground rules will be established.
- The focus group interview is intended to be conducted during the off duty time.
- The interview will last 45-60 minutes.
- The focus group interview will be audio taped and later transcribed.
- A tape recorder with inserted cassette will be used with participant’s permission.
- Field notes will be directly made after the interviews as a verifying measure.

2.4.2. Interviewer/Independent researcher
The researcher is not experienced in leading focus group interviews, so for proficiency of the study, the expertise of an experienced independent researcher will be utilised. The researcher is an expert at conducting interviews because of her daily interviewing activities. She is a Masters degree graduate involved in extensive interviews involving post basic students and counselling patients. Her expertise in the form of establishing rapport, probing, listening and paraphrasing issues will facilitate identification of the
most important themes and feelings (Krueger, 1994: 15 and Gmeiner & Van Reenen, 1994:159). The independent researcher was selected on the basis of her proficiency to facilitate the whole process of data collection, and to guard against any bias by the researcher who is also a facilitator of support groups and is known to potential participants. The researcher will be more of an assistant and observer to the independent researcher.

2.4.3. Role of the researcher
Initial contact with participants will take place immediately after the granting of permission by the District Health System Directorate. The researcher works in one of the PHC clinics in Soweto, and will personally contact and verbally explain to the primary health care nurse facilitators, and their facility managers respectively, prior the actual commencement of data collection. A considerable amount of time will be invested into all participants in their respective clinics clearly, patiently and carefully explaining the circumstances surrounding the nature of this study such as: the purpose and objectives of the study, the procedures to be followed, method of data collection, the use of tape recorders, ethical considerations, benefits of participants in the study, venue, date, time and duration of each session per interview. All details of the study will be thoughtfully explained to them to give them basis to decide to participate or not to participate. After ensuring that the participant understands the nature of the study clearly, written consent forms will then be sent to each prospective participant, requesting individual permission to interview them. All those who agree to participate voluntarily will then be asked to sign them. The researcher will provide assistance and observe the unfolding process. She will be taking field notes, operating the tape, handling the environmental conditions and logistics such as sitting arrangements, background noise as well as responding to unexpected interruptions.

2.4.4. The setting
All focus group interviews will be conducted on a date, time and venue central and convenient to all participants and in the boardroom of one of the four big clinics that will be selected. A venue of choice will be non-threatening, comfortable, spacious, well ventilated, noise free and non-disruptive. It will be a familiar venue, where they usually conduct their monthly meetings. The atmosphere will be as relaxed and informal as possible that will encourage participants to respond freely and openly to questions that will be asked. The room will be well arranged with comfortable chairs placed in circular manner, to allow face-to-face interaction. A tape recorder will be placed at a strategic point where discussions can be easily recorded.

2.5. DATA MANAGEMENT
The tape recorder will be used to obtain word-to-word discussions between the interviewer and the participants (i.e. the facility managers, the facilitators and the patients). Field notes will be taken during interviews to supplement the recorded data. Safekeeping of taped cassettes will be in the hands of the researcher. Personal information will be disguised. These will be labelled with numbers instead of using names or clinics to ensure confidentiality and to avoid identification. Audio transcription will be done as soon as possible after the session to prepare for data analysis, and will be disposed immediately after completion in a manner that leaves no trace. Written consent
from the participants regarding undertaking the study and for the tape recording will be obtained. Participants will only be allowed to gain access to their own interviewed data. The taped cassettes will be transcribed verbatim independently by the researcher and independent researcher.

2.6. PROCESS OF DATA ANALYSIS
Data analysis will be done according to Tesch (in Creswell, 1994: 142-145) described as follows:

• Getting sense of the big picture through repeated listening and writing down of important ideas.
• Picking one summarised and transcribed interview, which is most interesting and analysing the meaning. Write thoughts on the margin.
• A list of topics will be made out of several information which may be formed into columns which will lead to major topics, unique topics and leftovers.
• Topics will be abbreviated as codes written next to the appropriate segments of the text.
• Descriptive wording will be utilised on the topics and into categories. Topics will be grouped according to the relationship.
• Final decision on abbreviation for the categories will then be undertaken and codes arranged in an alphabetical order.
• Data material belonging to each category will be assembled for preliminary analysis.
• The existing data will then be recorded.

The researcher together with independent researcher who is acquainted with Tesch method of analysis will analyse data. All unstructured data will be transcribed. The researcher will immerse herself thoroughly in the data to reduce the voluminous amount of information. They (together with the independent researcher) will carefully read through each transcription, focusing mostly on topics, issues and feelings mentioned by participants of the three focus groups. Aspects with similar meanings will then be grouped together to make up sensible categories. Data will be coded according to identified categories. They will then review and analyse the themes to reach final agreement. Figure 2.3 illustrates the summary of the research design followed in this study.
2.7. TRUSTWORTHINESS

The researcher will strive to adhere to the principles of trustworthiness as suggested by Lincoln & Guba (1985) throughout the various stages of this study. This will be done without sacrificing reference. The principles will be used to ensure the trustworthiness of this study. Lincoln & Guba (1985:290). The strategies and the four criteria suggested will always be taken into account and applied. The four criteria refer to truth-value validity, applicability, consistency and neutrality; strategies identified are credibility, transferability, dependability and confirmability. As the researcher is known to the role players, and is a facilitator of the support groups in one of the clinics, an independent researcher will conduct the process of data collection and analysis through focus group interviews. The independent researcher will conduct all the interviews throughout the process and will be consistently asking the same central question to all the groups, while the researcher will be observing in the background, only offering necessary assistance. Enough time will be allowed to establish rapport so that those interviewed can respond and verbalise their experiences in an open and free atmosphere without any fears. The discussion of results will be accompanied by relevant literature to maintain clarity and confirmation. To ascertain truth and accuracy of the data collected, the participants will
be played back the recorded cassettes, and where need arises a follow up interview will be conducted. The researcher will provide a new and thorough description of data collection and analysis. The end-result will then be interpreted. Measures to avoid bias will be ensured. They will be clearly identified. Independent checking by the independent researcher will also be done. The researcher’s capabilities will be nurtured and supervised throughout the study by an expert who is a professor in the field of nursing dynamics and research.

2.8 ETHICAL CONSIDERATION
The researcher will observe the ethical obligations of the profession as set out by the Democratic Nursing Association of South Africa. DENOSA, (1998) and Burns & Grove, (1997). All precautions measures will be taken to ensure that the rights of those involved in the study are not violated special attention will be based on the following:

2.8.1 Informed consent
Consent will be obtained in writing from all prospective participants and from the Soweto District System Directorate. The researcher will give a clear explicit explanation about each essential aspect of the study, so that participants can fully understand what is entailed in the study, and thus can have an adequate basis on which to make a decision whether to participate or not Burns & Grove (1997:209), DENOSA (1998). The information that will be disclosed in the consent will be the objectives, methods, the duration, potential risks and discomforts, the benefits of the study, as well as the type of participation expected from the participants. The researcher will also introduce herself to the prospective participants and Soweto health authorities so as to build trust and good relationship with them.

Furthermore the researcher will conduct an open discussion with the patients with chronic diseases concerning permission of their participation so as to dispel their doubts and fears. The researcher will take time to explain those few things in the consent that patients do not understand or want clarity. The researcher promises to be patient, careful and thoughtful when explaining to the patients. All explanation will be given according to patients’ desire and interest for information. Some may want more than others. The researcher believes that by conducting these open-discussion sessions with patients, prior participation in the study will probably give them adequate basis on which to make a decision whether they want to participate, and believes that it is a way of ensuring their understanding and voluntary consent. Open discussion sessions will also provide with opportunities for unanswerable questions to be raised, also an opportunity to increase the patients’ sense of power by pointing out options and emphasizing their right to arrive at a decision freely.

2.8.2 Right to self-determination
The researcher will make clear to the participants that they have the right to choose to participate or not to participate in this study; - Burns & Grove, (1997) and Lo Biondo-Wood & Haber (1994). It will also be pointed out to the participants especially the patients and primary health care nurse facilitators that they have the right to withdraw from the study without any penalty at any stage DENOSA, (1998); Burns & Grove, (1997) and Lo Biondo-Wood & Haber, (1994). All participants will be told that
participation is to be free of force, fraud, deception, duress or any form of coercion or harassment. Any participant participating in this study will do so voluntary and with full knowledge of what the study is all about, and will be well informed about the research activities.

2.8.3 Right to privacy
The right to privacy of all participants of this study will be ensured by the researcher and will be protected throughout the study from embarrassment or feelings of anxiety, guilt or shame. The researcher will not collect private data that is not relevant to the study. During data collection no conversation will be collected through the tape without the participants knowledge. They will all be informed that tape recorders will be utilised to collect data. The information collected will not be shared with any other persons. A place conducive to privacy for interviews to take place will be used, venues for follow-ups, where necessary, will be known / accepted by participants if necessary.

2.8.4 Right to confidentiality and anonymity
The researcher of this study has the “duty to maintain confidentiality” that goes beyond ordinary loyalty Levine (in Burns & Grove, 1997: 204). The researcher will be accountable for maintaining this right to confidentiality and anonymity. Personal information will be disguised. Code numbers will be used instead of using names of participants and clinics for identification purposes. Tapes will be disposed off after completion of the study. No unauthorized person will be allowed to gain access to raw data of the study Burns & Grove (1997: 204) that contain information about participants identity or responses creating a potentially harmful situation for patients with chronic diseases and the primary health care nurse facilitators. LoBiondo-Wood & Haber (1994: 325). Data will be analysed as group data so that no participants are identified by their responses. After reporting all data will be destroyed in such a manner that it leaves no trace of identification. Where anonymity is threatened, all research records will be destroyed DENOSA (1998).

2.9. CONCLUSION
A qualitative research design has been pursued in order to explore and describe the experiences of all the role players regarding the management of support groups for patients with chronic diseases within the PHC clinics in Soweto. The nature of this design will bring to light the reasons for poor management of support groups for patients with chronic diseases within the PHC services. The research design and ethical considerations have been described in this chapter. The process that has to be followed has been brought to light on the experiences of the role-players regarding management of support groups to be explored. In the next chapter, the discussion of the results of the three groups of participants will be discussed and integrated with relevant literature. This will provide basis for conceptual framework for the management of support groups for patients with chronic diseases within PHC clinics Soweto.
CHAPTER 3

THE RESULTS OF EXPERIENCES OF THE PRIMARY HEALTH CARE FACILITATORS, THE FACILITY MANAGERS AND PATIENTS WITH CHRONIC DISEASES REGARDING THE MANAGEMENT OF SUPPORT GROUPS

3.1. Introduction

In this chapter a detailed description of the three groups of participants with regard to their experiences on management of support groups in selected Soweto clinics is given. The description will include the following: Realization of method and sample, data collection, data management, data analysis, the presentation and the discussion of results.

3.2. REALISATION OF METHODS AND SAMPLE

The intended commencement of data collection for this study did not go according to the researcher’s planning, as there were difficulties encountered during this process. There was a delay of about six months from September to March before the District Health System Directorate granted permission. This delay impacted negatively on the researcher, it was very frustrating, tiring and stressful as data collection had to be postponed until permission was granted.

3.2.1. Sample Realisation

The researcher had purposefully conducted the study within all the twelve (12) Soweto clinics, with each clinic represented by the primary health care nurse (PHC) facilitator, the facility manager and the group of patients who are members of support groups. The aim being to have 3 focus groups of facilitators, a group of facility managers and members of support groups. Each group to have about twelve participants. The study was not conducted as intended by researcher within the twelve (12) clinics but only four (4) clinics were excluded because of the unavailability of the established support group. However, eight (8) clinics, each with accessible participants consisting of the eight PHC facilitators, six the facility managers and forty five patients participated. Two facility managers were excluded because they excused themselves from participating because of their busy schedule. Their right to refrain from participating was respected. Representativity was ensured, and every prospective participant voluntarily agreed to participate in this study. The sampling method utilized for selecting the participants of this study is the non-probability purpose method. Data was collected by means of phenomenological focus group interviews from the PHC facilitators, facility managers and the two groups representing the patients with chronic diseases. Patients were divided into three groups of fifteen (15) participants per focus group, from all the eight selected Soweto clinics. All the participants in five focus group interviews conducted were named as Group A, B, C1, C2 and C3 respectively. For the purpose of reference and clarification see figure 3.1
All five focus group interviews progressed until a point of saturation was reached, participants at this stage were repeatedly describing same views, and had no new information to add onto the discussion.

3.3. CONTACT WITH PARTICIPANTS

Initial contact with participants took place immediately after the granting of permission by the District Health System Directorate. The researcher works in one of the clinics in Soweto, personally contacted and verbally explained to the primary health care nurse facilitators, and their facility managers respectively before the actual commencement of data collection. A considerable amount of time was invested to all participants in their respective clinics clearly and carefully explaining the circumstances surrounding this study. The purpose and objective of the study, the procedures to be followed, methods of data collection, the use of tape recorders, ethical considerations, benefits of participating in the study, venue, date, time and duration of each session per interviews were explained to participants. The right to refrain from participation was also explained. After ensuring that the participants understood the whole explanation conveyed verbally to them, written consent forms were sent to each prospective participant, requesting individual permission to interview them. All those who agree to participate voluntarily signed the forms. Date, time and venue convenient to all participants was chosen and agreed upon, after taking Factors such as accessibility and availability of public transport, space and comfortability of the venue with less disruptions were taken into consideration. All interviews were
scheduled during on duty time, an hour after general monthly meetings of each group as permitted by those in authority.

3.3.1 The setting
All focus group interviews were conducted in a venue central to all participants in the boardroom of one of the selected clinics. A venue that is non-threatening, comfortable, spacious, well ventilated, noise free and non-disruptive. All participants were familiar to each other and the venue, as it was the venue in which they usually conduct their monthly meetings and forums. The atmosphere was as relaxed and informal as possible. The room was well arranged with comfortable chairs placed in circular manner, to allow face-to-face interaction. The tape recorder was placed in a strategic point where discussion can be easily recorded.

3.3.2 The roles of the independent researcher and researcher
The independent researcher was selected by researcher for her proficiency to facilitate the whole process of data collection, and guard against any biasness from the researcher who is also a facilitator of support groups and a colleague to some participants. She was selected on the basis that she has a Master’s degree in Psychiatric Nursing she is a psychiatric trained person a remarkable expert interviewer and counsellor interviewing post basic students. Her daily activities involve teaching post basic students research and interviewing skills in one of Gauteng Nursing Colleges. Her experience in establishing rapport, probing, active listening and paraphrasing issues will help in identifying important themes and feelings from participants. The researcher was more of an assistant and observer to the independent researcher, taking fields notes operating the tape, handling the environmental conditions and logistics such as seating and background noise as well as responding to unexpected interruptions.

3.3.3 Focus group interviews
The actual interviewing process of the focus groups took place after permission was granted. Five (5) focus groups interviewing sessions took place. The interviews were all conducted during on duty time, an hour after each groups monthly meeting, between 14h:30 – 15h:30 hours. Groups A and B focus group interview sessions were conducted within the same month but different weeks and dates, while the three focus groups C1, C2 and C3 were conducted within two months and on different dates. Participants were all on time, for scheduled sessions as they had attended their monthly meetings in the same venue.

Greetings were exchanged among participants, the researcher as well the independent researcher. The researcher introduced the independent researcher. Explaining clearly, the role of independent researcher as she was not known to the various group members. Her presence was most welcomed, and they were all at ease with her. Before the commencement of interviewing sessions, a brief verbal explanation was again given to participants by the independent researcher on all the procedures to be followed, such as the duration of each session, presence of tape recorder, and the necessity of taking of field notes. The topic was introduced, and main purpose based on exploring and describing their experiences regarding management of support group for patients with
chronic diseases within the PHC clinics Soweto clinics. Ground rules were set that will guide the process by the independent researcher. The medium of language used was English as all participants felt comfortable with it. They (participants) were all re-assured and made to feel free to voice their opinions and concerns. Refreshment were offered, but all preferred to be served after completion of interviews. Generally they all seemed relaxed, and all interacted freely and openly with one another. Most of them were actively participating in the discussions. They seem to be disclosing their views, feelings and concerns honestly to the independent researcher.

During the interviews, the independent researcher gave every participant an opportunity to express himself/herself freely without any fear of intimidation or exposure to embarrassment. She encouraged them to talk using minimal responses like “mm ...” “yes” and “oh ...” as well as nodding her head. She conducted a lively and interesting discussion in which every participant wanted to talk and share one experiences. She could tactfully control and lead those who were off the topic by developing questions from their responses. She also politely asked those dominating the discussion to allow others an opportunity to express their own views. Passive participants were encouraged to share their experiences. Most responses from participants in all focus group interviews were dominated by negative experiences, which came out as barriers to quality management of groups than the positive experiences. At the end of each focus group interviewing session all participants regarded these sessions as being very much fruitful and a platform for openness to vent out their concerns. They hoped that their concerns might help the researcher collect and assimilate different viewpoints into a clearer, and more objective picture that will eventually enhance the quality in the management of support groups for patients with chronic diseases in Soweto clinics.

3.4 DATA MANAGEMENT
The data management was a time consuming exercise; - a very difficult and tiring process experienced by the researcher, as she had to prepare data collected by re-arranging it and placing it appropriately. With total consideration, data from field notes, recorded cassettes, observed verbal and non-verbal communication was properly analysed. Important themes and expressions as well as data from the field notes were discussed with independent researcher. All data from the five 90 minutes recorded cassettes were listened to, word for word on repeated occasions. The accuracy of data on the transcripts was determined by repeatedly reading through each script. On completion of transcribing five transcripts were produced, representing all the groups interviewed. Copies of each transcript and recorded cassette per group were handed to the independent researcher for further coding and verification before the final editing. The final editing was done; the copies of transcriptions were given to the independent researcher and the study supervisor.

3.5. PROCESS OF DATA ANALYSIS
Data analysis was done, according to Tesch’s guidelines as adopted (in Creswell, 1994:142-145). Researcher and independent researcher who are acquainted with Tesch method of analysis conducted this independently. Transcripts were read repeatedly, words and phrases describing the participants’ experiences on management of support groups were identified and interpreted to get the sense of the whole. All those, words
which described similar aspects, were taken into consideration for discussion. Similar aspects were later grouped together given topics, assigned categories and then coded. These were further clarified and clustered together into identified subcategories. The results were quantified based on number of participants whose experiences had reference to some selected categories. Copies were forwarded to independent researcher for discussion of results. Results of both the researcher and independent researcher were reviewed and compared to reach consensus.

3.6. PRESENTATION AND DISCUSSION OF RESULTS
According to the results obtained during data analysis of the three focus groups, two main themes were identified namely the management and facilitation. Positive and negative categories emerged. Negative experiences identified by participants such as lack of conducive environment, lack of supportive policies, lack of training and development, poor communication were some of aspects that were described as adversely impacting on the quality management of support groups. Positive experiences such as patient satisfaction participation as well as empowerment were some of the few aspects identified as positively impacting on the effective management of support groups. See figure 3.2 for illustrations of the distribution of categories and subcategories as they emerged during data analysis.
For the purpose of results, the responses of three (n=3) or more participants who experienced similar aspects were considered for discussion. Examples of individual quotations from the transcripts will be included to support of identified aspects to ensure that the quality of meaning is maintained. Figure 3.3, displays an overview of results as
experienced by the participants in all the five focus groups in accordance to the two main themes, that emerged, namely the management and facilitation as well as with related positive and negative sub-categories regarding the management of support groups. Positive and negative results identified from the three groups group A (Facilitators), Group B (facility managers) and group C (patients) are discussed next in details and supported with direct quotations.

FIGURE 3.3: SCHEMATIC PRESENTATION OF RESULTS REGARDING EXPERIENCES IDENTIFIED BY PARTICIPANTS OF THE FIVE FOCUS GROUPS.

3.6.1 Positive experiences.
Participants from all the focus group interviews identified positive aspects in the management of support groups, which positively ensures the quality care during the management and facilitation functions. The positive experiences identified that has an impact on the management function are, community participation, patient directed service
and cost effectiveness. The positive experiences identified, impacting on facilitation function are, positively empowerment, participative approach, professionalism and patient satisfaction. Figure 3.4 illustrates the summarized positive experiences identified that impact on management and facilitation.

FIGURE 3.4: SCHEMATIC PRESENTATION OF POSITIVE EXPERIENCES AS IDENTIFIED BY PARTICIPANTS REGARDING MANAGEMENT AND FACILITATION FUNCTIONS.

3.6.1.1 Management positive experiences
The following are experiences which emerged during focus group interviews and that impact positively mainly on the management function.

- Community participation
All eight PHC facilitators experienced active community participation in support group programmes, as compared to passive involvement that patients and community used to display in their own health care. Strong partnership, acceptability, accountability, responsibility and an element of humanity (ubuntu) have been echoed by all participants as positively influencing the effective management of support groups. Examples of direct quotations from participants are as follows:

"Availability of unpaid volunteers who have shown interest and commitment in support group activities are carrying out educational programmes to the community... promoting the value of support groups, its accessibility, the availability as well as creating awareness is becoming acceptable".
The above statement is supported by Curtin et al (in Bouzidi and Fischer 1991:46) who clearly state that there is little doubt that community participation increases the likelihood of long term sustainability of a programme, this is because the more involved the community is in a programme, the more likely its members are to be committed to its continuation. In further support (Oakley 1989:4) states that communities with more understanding take preventative measures themselves, become consumers of the service, health education becomes their daily life, and community health worker becomes resource to the community.

"It is encouraging to see patients showing a sense of belonging and ownership, that they are very much involved, committed, they share responsibility and every one has a role to play."

"They fully take part in decision-making process and contribute to issues related to support groups, and they are accountable."

"A strong relationship is developing between myself and the patients as well as their families; we meet at regular basis to participate on promotive and preventive measures, to promote and improve their health status, and most are patients becoming more responsible."

Changes must aim at improving community health through partnerships between the community and health workers (Dennill, et al. (1995: 72 - 73); Clark, (1997:149); Poggenpoel & Muller (1996: 10 –13). Stanhope & Lancaster (1992: 256 - 257) in further support state that when nurses implement change a partnership between nurse and community develops. Vaughn (1997:170) also echoes the same sentiments, and states that with this partnership and increased knowledge, the patient and community will become empowered.

Four facility managers also experienced community participation. Direct quotations are as follows:

"It is good that through support groups patients are now beginning to realise and assume their role as integral vital members of the health care team, they attend to their needs, and now take the ownership and control of their own health."

Vaughn (1997:170) supporting states that patients themselves will become part of the multidisciplinary team with extra knowledge they become empowered, changing power balance between the patients and the health providers.”

According to Toscani & Patterson (1998:2) patients play a larger role in the emerging health care environment because they are now being asked to share increasing responsibility for the state and care of their health.

“What I have realised since the establishment of support groups is that patients and community value the service provided, they share power and control of support groups, they also plan and work hand in hand with us and we now act as their resource persons and help them meet their needs.”

26
This is supported by Oakley (1989:39) when clearly stating that the role of the nurse has changed from that of a prime planner to that of a resource person.  

“They are now actually the drivers of this process, they seem to know exactly that this service belongs to them, participating actively, giving meaningful input, and taking greater responsibility for their own needs. They are not dependent on whom or what but how their contribution can improve and sustain the group.”

Kraus (in Tjale, 1999:14) points out that people who function in a collaborative way are those who are aware of themselves, who they are, what they stand for, what their skills are and what pushes their buttons. Sawyer (1995:17) states that internationally the nursing profession has embraced the concept of community participation as an integral part of the strategy to improve the health of the World’s People.

- Patient directed service  
Six participants in the focus group A (facilitators) described the support groups as having positive effects and contributing towards a patient directed service. They pointed out that the support groups are geared for the patients; - their needs are being prioritised, and respected unconditionally to improve and enhance the quality of patient care. Examples of direct quotations are:

“This is one programme that keeps us on our toes at all times; - we are forced to understand and apply the Batho Pele and Patients Rights’ Charter principles into practice everyday.”

According to Ramokgopa (2000:7) patients charter and Batho Pele principle are to be reinforced to ensure that clinic managers, understand and apply them emphasizing that these rights must not only exist on paper but must live daily in the service.

“Patients are more aware of their health care rights, they demand to be consulted at all times, to be kept informed, given feedback so that they can make informed decisions, they demand openness and transparency.”

“Support groups have been tailored to favour and satisfy them. The programme features active queue management, booking system, no time restriction or limits, improved complaint system, as well as the special clinic days.”

“They are very much vocal and demanding. They demand appropriateness not over delivery or under promise service; - they complain if they are dissatisfied with the quality of service provided.”

“It’s a real challenge to all facilitators because we are expected and obliged at all times to provide high quality service delivery, we always try our best to be effective, acceptable, accessible and efficient to meet the needs of the patients.”

“We do our best to give them what they want, they are the chief definers of their
needs and kings of the service.”

These views are endorsed in the White paper (SA 1997:14-15) where principles of equity accessibility, appropriateness and efficiency are emphasized. Muller (1998:3) defines appropriateness as the service or interventions which the individual, group or community really needs, the right decision and care at the right time. According to Cheales (2000:28-29), confirming the above statements states that, in the past the organization led the individual. Today the individual leads the organization and customers are the ones who count. Muller (1998:9) in support states that the purchaser of health care can also be seen as the customer with needs that must be satisfied. Swansburg (1993:6) is also of the same opinion when stating that nursing management performs the activities needed to determine what patients see, think, believe and want, and further points out that patients are the starting point, at which the business of nursing is defined.

- Cost effectiveness

Cost effectiveness emerged from the focus group interviews conducted from the facilitators and the facility managers. Facilitators expressed that support groups are cost effective and positively contribute towards reducing the escalating health care. Unnecessary clinic visits are reduced, improved compliance, less drug and service abuse as well as reduction in defaulting are some of the aspects that were expressed as positively contributing to cost effectiveness. Examples of direct quotations from transcribed focus group interviews:

“There is a remarkable decrease of unnecessary clinic visits ... patients come only per appointment.”

“Defaulters have been reduced, compliance has improved, and people come now regularly, and are responding effectively to appropriate recommended treatment.”

“The educational programmes offered to empower them to cope with their conditions and become self-sufficient.”

This view is confirmed by Simpson (2000:10) pointing out clearly that if we want reduced health care cost we must find ways to effectively manage chronic illnesses, reduce risks and help patient to care for themselves with education that can help them cope with their illnesses, Toscani & Patterson (1998:9) confirms this notion and states that cost of health care has been reduced by patient education interventions which lower the demand on health care system, and the educational all interventions have shown to optimise physician time, improve clinical outcome and minimise unnecessary visits and cost.

“Risks from complications have been reduced, because of increased patient awareness enhancing early detection, early prevention and medical intervention.”

“Most of the patients within support groups use self-monitoring equipment to monitor themselves, to make appropriate informed management decisions based
on signs and symptom.”

Toscani & Patterson (1998:1) agrees with the notion stating that patient involvement and empowerment are crucial to improving outcomes and lowering health care cost. When the community is involved, the service becomes cost effective and the communities with more understanding will take preventative measures themselves (Oakley, 1989:4) Green (1998:24), is also of the same opinion stating that involving the community and the improvement in health care will generate cost savings.

“Many patients are managed on non drug therapy, because they are well under control, so less or no drugs are being used thus saving on drug cost.”

This statement is confirmed by Rispel (2000:7) when she reveals that a strategy to save cost is to reduce the prescription of drugs that are not on the essential list. According to a study conducted by Monamodi (1998:60) it is reflected that fewer medicines mean better compliance with treatment and saving on drug costs. These views are in agreement with the view of Ramokgopa (2000:7) who points out that treating diseases early and avoiding complication is a real cost saver.

3.6.1.2 Positive facilitation experiences
Patients also experienced some positive factors from the support groups. Empowerment, participative approach, patient satisfaction as well as professionalism are factors that positively influence the quality in the facilitation function.

• Empowerment
In this theme, many participants in group C (patients) identified empowerment as positively impacting on the facilitation function and further influencing quality in the management of support groups. Most participants felt empowered, knowledgeable, equipped with coping skills, feeling self directed, self reliant and sufficient to take control of their own lives.

“I have learned so much about my condition. I feel good about myself and I can now take control of my own life; I’m no longer dependent on the medicine...”

“To add to what she has just said I have even forgotten that I am diabetic on Insulin, I have since developed better coping skills, I can now stand on my own.”

“Thanks to the educational programmes offered, I can confidently check on my blood glucose level and can interpret and tell the outcome, I can identify problems and find solutions to problems”

“Anytime, anywhere, to anyone when given an opportunity I can gladly with confident share my knowledge and empower others on hypertension, asthma and diabetes.”

The above comments are supported by Burkey (1998:50) pointing out that people need to have confidence in their knowledge and skills, in their ability to identify problems and
find solutions in order to make improvements in their own lives and self reliance is doing things for oneself, maintaining one own self-confidence, making independent decision. Klopper (1994a monography 1:4) further supporting the above views states that adults have a deep psychological need to be self directive and self regulating, but may temporarily be dependent in specific situations. Self-direction implies that adults want to make their own decisions and take control of their own lives.

“I've been well supported and guided towards understanding my condition, the sisters have really worked.”

“I have learnt a lot about my condition, I can tell about signs and symptoms, emergency treatment especially when my sugar level is low, I no longer depend much on the nurse’s intervention.”

“My family also know much about my condition, I have taught them how to deal with my condition, they now understand everything about asthma.”

“I mean the type of education we get here, is so relevant to every one’s needs. You can ask personal questions and you are given answers accordingly. I have learnt and gained a lot since joining the group, it’s worth it. I can cope on my own, and I only ask for assistance where I am not sure.”

According to Vaughn (1997:170) and Hugo (1990:19) in support of the above notion points that patients are becoming empowered through increased knowledge, while a change in the power balance between the health care givers and health care recipients is occurring. The same is raised and supported by Chalton (1992:33) when describing empowerment as the act of investing and authorizing, where people and organizations are enable to achieve goals. This involves sharing power and authorizing people to think by focusing on needs of individuals and encouraging self-responsibility by altering self-limiting beliefs. Empowering people not only improve the quality of care they receive but enable them to play an active role in sharing responsibility for their own care (Allgot, 2000: 45) In conclusion Toscani & Patterson (1998:5) are also of the same opinion stating that properly designed and conducted patient education programmes have demonstrated their value by improving patient compliance and comprehension enabling patients to become active participants and thus improve overall health.

• Patient satisfaction
Patient satisfaction was experienced and expressed by participants. Patients were generally satisfied with the way support groups were managed. They expressed appreciation and gratitude on the facilitators’ performance. The interaction of members to one another as well as the service all impacted positively on the management of support groups. From a transcribed data, participants’ quotations are as follows:

“There is reason to be hopeful that the support groups will stay because of the type of care that is provided by our nurses. I am very happy and satisfied.”

“Our aspirations and interests are represented, we are being provided with good
care, no ... I cant complaint especially when my needs are so well met.”

“The aggression, negativity and inhumanity that used to exist among nursing staff to their patients is not there, there is hardly a trace; - the nurses are very nice and friendly”.

“We are sharing a good nurse-patient relationship... are very happy with this service.”

“They have changed to our benefit they are behaving and displaying the attitude we all expect from them”

“I’m impressed because we now exchange greetings, with them, they listen, talk to us with respect and treat us equally irrespective of who we are or come from, there is humanity”.

Tadd (1998:127) in support indicates that attitude that people have is influenced by the quality of the relationship they share with their colleagues.

“There is warmth, compassion, caring and high degree of commitment among group members, its just unbelievable, we are really pulling together as a team.”

“As members we share a rich and rewarding interpersonal relationship and sensitivity among each other.”

“We treat each other with respect dignity and trust, we are one big family.”

“Even those who left the group are now coming back, encouraged by the presence of the spirit of ubuntu that exists.”

“We are all supportive to one another, no one is judgemental or being discounted we are just one happy lot.”

Tschudin (1994:85) states that to be human is to care and to care is to be human. Tjale (1999:12), (who is also in support of the participants’ notion), identifies the core values of ubuntu as human dignity, respect, conformity, compassion and group solidarity. Mutual respect implies recognition of the body of knowledge, talents, skills, uniqueness and valuing each discipline by others; - Stapleton (1998:12-18).

“The atmosphere is informal, non- threatening, the service is just good, - waiting time has been reduced, and we no longer stand in long queues.”

“Our nurse leader sees us as one, she does not discriminate against anyone of us.”

“She is patient consistent reliable and committed; - I trust her.”
"There is harmonious co-operation between ourselves and our leader; she recognises and supports our participation within the group."

Swansburg (1993:6) in support states that it is the patient who is to be satisfied, because they buy their care and therefore buy satisfaction of wants.

- Participative approach

Participation was experienced by participants in focus group C. Ten patients mentioned that participative approach applied by the facilitators in their groups was positively influencing positive facilitation function and enhancing the quality in the management of support groups. Transparency in decision-making, consultation, and availability of platforms to discuss and solve problems were some of the factors raised as positively impacting on the quality of the management of support groups. The statements are direct quotations from the patients:

"What I like here is that the facilitator does not take decisions for us, she is very much transparent ... involves everyone who is affected."

"At least once a month we hold meetings with the nurse leader where we collectively discuss our problems and make decisions, there are structures put in place for that."

"She invites and give every one an opportunity to make contributions, we sit down and discuss and plan together, she does not instruct us or enforce decision onto us."

"Everyone is free to express his or her opinion, without any fear from the above ... I mean the nurse facilitator..., there is freedom of speech."

In support Braxton (1995:22) explains that participation by all, transparency in decision-making, involvement of those that are affected by decision and democracy in the work place is generally accepted as fundamental survival in the nineties. Marquis & Hudson (1994:15) are of the same opinion when stating that all individual who may be affected by change should be involved in planning for the future. Although it could be time consuming to get a group together to make a joint decision, it is far more advantageous than one-way decision, which is made and enforced by the unit manager (Muller, 1996:195).

"We exchange our views with her, disagree to agree, not necessarily accepting what others or what she says, but to reach consensus."

Consensus in decision-making promotes ownership of a decision and makes it easier to implement it (Muller, 1996:193).

"We take nothing for granted, every advice, suggestion, input given by group members is considered, and none is seen as irrelevant."
According to Muller (1995: 15-21) participative management is a process of dynamic decision making and problem solving, shared governance, ownership and empowerment, as well as applicable internal and external communication. Participative management tends to increase feelings of responsibility among employees towards organizational goals and objectives, better working relationship develop because of increased trust and mutual support (Booyens 1998:135).

- Professionalism
Participants expressed their experiences on the way the PHC facilitators display professionalism. They describe this as positively impacting on the management of support groups. This was evident from the following quotations:

"She is a very responsible, accountable and committed person, someone you can rely on, we like her a great deal."

"She is our library and keeps us updated with information."

"... well disciplined, respectful and conducts herself in a professional manner, I like her style."

"Patients are her first priority, she sees to it that our needs are met."

"She understands group feelings and interactions, she is part of us, and she appreciates our uniqueness and gives us unconditional support."

The above statements are supported by Muller (1996: 20-30) describing the characteristic that determine the professionalism.

"She is a role model, she takes criticism positively and is well accepted by the group members."

According to Nelms, Jones & Gray (1993:19) role model is defined as a traditionally accepted method of teaching professional attitude and behaviour.

3.6.1.2 CONCLUSION
The positive results were described on both the management and facilitation functions. These results have a direct positive influence on the quality management and will be used for formulating the guidelines. The negative experiences will be discussed in detail and supported by direct quotations.

3.7 NEGATIVE EXPERIENCES
Various negative experiences were identified by participants in all five focus group interviews regarding the management of support groups and their impact on quality of management and facilitation of these groups. These will be discussed fully with supportive quotation from participants. The negative experiences identified regarding management function are lack of supportive clinic policies, lack of role clarity, lack of support from management, lack of recognition, poor communication, lack of training and
development, lack of conducive environment and free primary health care services. The negative experiences on facilitation are lack of sufficient time, poor group structuring and poor conflict management. A visual presentation is shown in figure 3.4 for clarification purposes.

**FIGURE 3.5. SCHEMATIC PRESENTATION OF NEGATIVE EXPERIENCES OF PARTICIPANTS IN ALL FIVE FOCUS GROUPS REGARDING SUPPORT GROUPS ON MANAGEMENT AND FACILITATION FUNCTIONS.**

![Fig 3.5](image)

3.7.1 Negative management experiences

It is evident that participants in all five focus groups interviewed experienced that management of support groups have a negative impact on the management function. Negative experiences with regard to management function identified are lack of clinic support policies, lack of role clarity, poor communication, lack of recognition, lack of conducive environment, lack of training and development, as well as the free primary health care services.

- Lack of training and development

From the data it become evident that participants from two of the five focus groups lacked the necessary appropriate group facilitation and management skills and knowledge for effective and successful management of support groups. Seven facilitators mentioned that lack of training and development creates a negative impact on the facilitation and management functions. They fell inadequately trained, incompetent, lacking confidence, not updated with current information to deal with the demands of groups. They strongly
emphasized the need for formal or informal training to improve their skills and keep themselves updated, and competent. This is evidenced by the following direct quotations:

"I sometimes become threatened, lacking in confidence during group facilitation because of insufficient knowledge and appropriate skills".

"My competency is tested many a times. I want to become a competent and knowledgeable facilitator... to be well prepared and equipped to provide quality facilitation to the groups".

"Only if they (management) can arrange regular in-service programmes to keep us updated with relevant and current knowledge and skills to cope with the demands, we can surely manage these groups successfully".

"At the moment its just trial and error with no workshops, seminars, in-service training programmes, conferences are organized for continuing education to keep with current trends in facilitation and managing support groups."

"We really need to be empowered so as to empower the patients effectively, and the only way is through in-service training where we can improve our skills and competencies. Unfortunately none has been arranged."

"Those in-service training programmes must be on regular basis in order to share ideas with people with expect knowledge, to develop ourselves because dealing with groups is quiet dynamic and complex, it needs a knowledgeable person with latest information to cope with the demands of facilitation and managing groups."

In support of the statements experience Redshaw (1994:1028) maintains that some training is needed for all those expected to teach and that further training and support is vital to empower them to cope effectively with the present demand and pressures of health care. Cilliers (1994:36) is of the same opinion stating that for social and organizational change to take place peacefully the facilitation process should be used correctly and soundly, this implies the training of facilitators in terms of necessary skills. In further support of the above discussion, Klopper (1994b, Monography 2:9) indicates that learning accompanist must have the knowledge and skills to select the most suitable strategies, methods and techniques in order to facilitate effective goal achievement.

According to Muller (1996:317) in-service training improves the professional knowledge skills and attitudes according to demands of the nursing unit. Fodor & Dalis (1989:160) further expand on in-service training stating that in-service education is the primary purpose to improve teacher competencies and improving the standards of the profession in general mainly by exchanging ideas with resource persons and colleagues.

Facility managers also expressed the lack of appropriate training and development with regard to facilitation skills. They cited that inappropriate skills had caused lack of authority, confidence and knowledge, as well as barriers towards the overall management of support groups.
In their response they also strongly emphasized the need for training and development to improve on their skills, to keep in touch and abreast with latest information. This is evidenced by the following direct quotations:

"I am not comfortable with my skills and knowledge regarding facilitation of support groups. I am not so sure what is expected of me as a manager, hence I am not actively participating nor providing input to the successful management of groups."

"I really don’t have authority or confidence to deal with the groups, I need to develop appropriate skills to do that."

"Honestly speaking I also feel outdated not confident to deal with support groups ... yes, managers need to train and develop through formal or informal training as long as they can improve their skills."

Supporting above statements, Mahne (1987:79) mentions that no one wants to be unsure and unable to handle people, things or situations. Muller (1996:316) describes that personal and professional development of nurse practitioner is through formal and informal training in line with his / her job requirement and job description, stating that nursing practitioners have a personal responsibility to keep up to date with the latest knowledge. Sawyer (1995:17) emphasises the need to improve the status of the health nurses to enable them cope with the demand made to them.

"The lack of in-service training, seminars, conferences or any other form of empowerment will not help us in gaining knowledge and skills that will empower and enable us as managers to grow and develop and help the facilitators with appropriate facilitation skills."

"I acknowledge the fact that as managers we need to play our role effectively in empowering the facilitators, but it becomes difficult because we are not well equipped nor resourceful, I feel we need training first in order to do our role professionally in an acceptable way."

This is supported in the literature as in Muller (1995:20) stating that empowerment fosters mutual personal and professional growth of both the persons being empowered and the person empowering others, She further mentions that leaders and facilitators are employed for the purpose of supporting, counselling, educating, acting as resource consultants, resource mobilisers, advocates and enablers. On the same theme, Stanhope & Lancaster (1992:250) expands by stating that a group that is itself not empowered is not really in a position to uplift others who need assistance. Cilliers (1996:38) confirms these sentiments by pointing out that trained facilitators are able to provide real learning opportunities and growth to employees or team.

- Lack of supportive clinic policies

Lack of support clinic policies to guide facilitators in managing support groups is evidenced by statements from participants in focus group A. Eight (facilitators) expressed
concerns with regard to clinic policies. Direct quotations on the lack of clinic policies are reflected as follows:

“\textit{It is so awkward, you just don’t know what to do, and policies are rigid, restrictive and inflexible to support group related activities.}”

“\textit{It is very much unworkable as nothing is guiding ... assisting us in managing support groups as stated in clinic standards.}”

Mahne (in Tsele 1998:79) indicates that written policies ensure that delivery of care is according to set standards. They prescribe steps to be followed in order to confirm to or carry out procedures. Policies must be kept up to date and be available to all members of the nursing personnel in the unit (Mellish, 1980:94)

“\textit{It is almost three years now since inception of support groups, and none of available policies include support groups’ management guide, they are all outdated, not renewed and we are still using old non-inclusive discriminatory ones.}”

“\textit{Working under such circumstances is kind of uncomfortable as none outlines support groups’ activities, these policies need overhauling.}”

Red Shaw (1994:1027) confirms the above statements by stating that policies must be updated to prevent policy practice gaps.

“\textit{My hands are tight ... it is really putting me off, I can’t keep on working like this ... not in line with clinic policies, it is not bringing any joy, but lot of dissatisfaction.”}”

“\textit{There is nothing, - absolutely nothing that makes the facility manager not incorporate the support group guidelines into the clinic policies so that we can work comfortably, within accepted clinic norms.”}”

In relation to the above statements, Douglass (1996:251) explains that policies made at the top level are interpreted and implemented through each division’s own standards and objectives. Policies must be reviewed, revised as necessary and updated to indicate the time of most recent review. They must be abandoned when obsolete (Swansburg, 1993:171).

• Lack of recognition
Six from the eight facilitators expressed that they experienced lack of recognition. They felt that they were not appreciated, and that facility managers did not acknowledge all their efforts. Although they remained committed to facilitating support groups, but expressed that these were some aspects they experienced that negatively hamper with their feelings of self worth, personal and professional esteem and work performance.
They felt isolated, exploited, and not being part of the team. Their responses were as follows:

“Facilitating support groups is not rewarding, nor enriching as no one seem to take notice or care to appreciate what you do as a facilitator.”

“…we feel so isolated, worthless; - It’s like you are not part of the team, no matter how hard you try to work, you are not being acknowledged or supported by your facility manager.”

In support the study conducted by Cilliers (1991:30), which revealed that nurses felt that no recognition was given to them for their important work performance within the organization. This concern is also raised by Hingley & Copper (1986:52-53) who found that recognition was also perceived to being lacking from nursing service managers and nurses felt they needed more support and acknowledgement. Effective manager uses recognition and rewards to encourage desired behaviours and retain good employees (Tappen, 1995:67).

“I have now come to a point where I just work for the sake of working, there is no drive. I have no interest. I’m frustrated and emotionally exhausted and burnt-out and as a result patient care is compromised.”

“There are times when I feel like quitting and giving up this whole facilitation of support groups. I feel like I am not valued, but for patients sake I’m going to just hang in there … maybe one day things will improve.”

“I do slap – dashing, just to get over and done with, and that in itself discredits my work performance.”

“…that is why patients vote with their feet and withdraw from support groups… they can sense that we are not providing (them with) quality service.”

This experience is confirmed by Gillies (1996:359) that burnout symptoms caused subjects to feel callous towards patients concerns and treat them as impersonal objects. Chaska (1990:307) supports the notion by stating that nurses and patients are dehumanised as things or when they are treated as things or objects without feelings.

“Hey – we don’t need any prize tags placed onto us, but just want to be recognised and encouraged through simple priceless ways like saying ‘Well done, keep it up.’”

Lachmann (2000:19) supports this notion by pointing out that recognition is the most powerful reward because everybody needs to feel appreciated, and that whatever form recognition takes, employees must see it as a genuine appreciation, not as political trickery.
Two participants expressed a need for motivation. This was played by the following facilitators’ quotations.

"To survive you need to be self-driven; have inner motivation and do the best you can to avoid job dissatisfaction as there are no motivators."

"I am self-driven, self directed, committed, and dedicated to facilitation work, but I do experience some job dissatisfaction, I feel I need some motivation from my supervisor."

According to Gillies (1996:354), support of this notion, he states that a nurse manager’s most important task is to maximize subordinates work motivation. On the same theme Swansburg (1993:215) states that managers should aspire to building a milieu to develop and enhance the self-esteem of all nurses.

• Lack of role clarity
Facilitators raised lack of role clarity as another area of concern. Eight facilitators experienced role conflict, role inconsistency, dissatisfaction under role expectations, lack of job description, lack of autonomy and as well as the work overload were some of the factors that contributes negatively to management function, creating difficulties in providing quality management of support groups. The following are examples of supportive quotations verbalized by participants:

"I am never sure, and feel a bit insecure; I work haphazardly with no proper planning of my daily activities because of inconsistency of the role I have to assume."

"I am confused, I don’t know my exact role, and I find myself wearing too many hats, with overlaps and gaps in responsibilities."

"I cannot complete my work satisfactorily, nor can expand beyond traditional nursing activities because of the unclear role that is expected from me."

"I cannot expand beyond the routine traditional nursing activities because I am either overworked or unsure whether I am still doing what is expected of me. The whole thing is confusing."

Tappen (1995:19) shares the same opinion with participants above, and states that without adequate guidelines you cannot be sure that you are fulfilling the role according to expectations. Schulz & Johnson (1990:282) refer to the role ambiguity as the uncertainty about the way one’s work is evaluated by superiors and about scope of responsibility, opportunities for advancement, and expectations of others for job performance. They further relate to role ambiguity to role conflict and role overload. In a healthy organization, everyone knows his or her role, and the roles mesh in a way that encourages co-operation and reduces dysfunctional conflict. Systematic clarification of interdependent tasks and job behaviour is of vital importance (Douglass, 1996:71).
"It is unworkable, very stressful to work like a robot ... remote control, directionless. Working without any autonomy, always dependent on the management prescriptions."

"There are too many constraints, one cannot go beyond and focus on the whole picture of managing support groups successfully because of lack of clear role definition."

"It is quiet frustrating and tiresome to work under such conditions where there is so much role confusion impacting negatively on my work."

"It is essential that we are provided with clearly defined roles or job description so that we can know what our role entails, what is exactly expected of us in this newly added responsibility."

According to Swansburg (1993: 211-212) explains that role theory indicates that when employees face inconsistent expectations and lack of information, they will experience role conflict leading to stress dissatisfaction and ineffective performance. Schulz & Johnson (1990:286) state that role definition through job description and administrative manuals can also help reduce role conflict and ambiguity.

- Poor communication

Poor communication was expressed as of great concern by the three focus groups, six facilitators five-facility managers and thirteen patients. This is seen as a barrier towards providing quality management of support group. Facilitators experienced lack of consultation, lack of meetings lack of sufficient information, and one-way communication as factors that contribute to poor communication emanating between them and the facility managers. This is indicated by participants' direct quotations as:

"This is a real problem ... information is very little, it is so telegraphic, and you're left unclear of what it is all about ... We just want to know what is going on."

"At times I even think that there is something that is hidden, because feedback is sometimes delayed, censored or just not given at all!"

According to Swansburg (1993: 315) information is based on the need for a purpose ... it should be passed to the person who needs to know it and that person must be able to receive it and act. The enlightened manager is direct, honest and believes that employees need all the information they can get to do their jobs (Swansburg 1993: 321).

"We are not consulted, things are being imposed on us, and now we feel bad to see changes implemented without anyone being informed or consulted."

"Things are just being decided for us, we are not asked to contribute, ... a child is told what to do, it is a one-way communication system."

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In support of the discussion Gillies (1996:184) describes a one-way communication as simply the direction of information towards another, without regard for its reception or interpretation.

"I believe that we need to be involved and informed; - allowed to attend meetings with management to discuss about all supported group related issues."

"I seldom hold meetings with the facility manager, so there’s half a chance of me expressing my concerns.”

"Circulars, memos, notices, meetings not discussed or circulated timely.”

"I am barred from high level meetings where only the top meet. No junior personnel are allowed, there is too much red tape creating barriers to vent own ideas.”

O’ Day (in Flarey, 1995:107) supporting the above discussion, and states that processing, managing perceptions, providing opportunities for venting, face to face accessibility to higher authority, feedback sessions and news letters / memos are always for nursing managers to keep people informed during implementation. Gillies (1996:187) also reveals that in staff meetings where change is being discussed the head nurse must invite subordinates to freely express their objectives to a change in health care delivery. It is advisable to hold meetings at least once a month to discuss general matters in the unit and maintain group cohesion. (Muller, 1996:252). Facility managers experienced poor communication between the facilitators and themselves:

"The facilitator is very secretive, she withholds information..., not transparent at all, especially with information pertaining to support groups. She does things on her own.”

"We do not need as a team to express our opinion, it is time that we form a consultative team between ourselves and the facilitators and serve members of the group.

Swansburg (1993:321–322) mentions that some middle managers tend to treat information as a private properly and further states that communication of information is a joint responsibility of employer and employee.

"We also need feedback, we want to be involved, and we want to be informed, to participate in this, and to work as a team.”

"The reports or feedback is not widely distributed to all members, it is frustrating to keeping on asking for information or feedback that is never given, it is just not the way to go about.”
"This is creating, strained relationship between the facilitator and myself, she sidelines and ignores me – It is very rare that we share and exchange information."

In support of this concern Gillies (1996: 194) maintains that sharing of information creates common interest and strengthens relationship.

Poor communication emerged during interview as negatively affecting the quality of management and facilitation functions leading to poor management of support groups. Thirteen participating patients experienced poor communication between facility managers, some with their facilitators as well as amongst themselves. Much reference was made to insufficient or no feedback, fear of victimisation lack of two-way communication and lack of openness. Examples of direct quotations are:

"Some nurses seem to forget that we are also members forming part of the health team...they dictate to us and don’t update us...."

"There is nothing that motivates us, that is why some members just withdraw membership."

"We cannot make sound decisions because of the lack of sufficient relevant information or report back, we are just blank."

"We are not allowed to openly express our frustrations to the facilitator. She is not open and transparent."

"It is just a waste of time because we are not given fair hearing."

"Our facilitator does not take anything from us, she really owns the support group, very much domineering and intimidating."

"I just don’t feel able to talk to the clinic matron when I am dissatisfied about things within the group because she is too much of a boss, who does not take anything from anybody – worse still a patient, She is not encouraging."

"There is no way that we discuss face to face like partners instead we are treated like little school girls and boys in grade 1 who are there passively, agreeing and adhering to instructions."

"We cannot freely challenge or criticize any wrong because we fear victimization and being labelled."

Swansburg (1993:315) states that people want to know what they have accomplished and where they stand. Feedback influences behaviour. Schulz & Johnson (1990:67) describe communication as a two way street and people should be encouraged to be open, honest and express their true feelings without fear or retribution. One-way communication prevents input or feedback and interaction; it causes nurse to depersonalise their
relationship with patients and families. (Swansburg, 1993:315) and Buch (in Burkey 1998:129) expand by stating that good feedback will be best achieved when people find out that they can openly criticize the programme without giving rise to bad feelings or repercussions and that their suggestions will be acted upon.

- Lack of support

Lack of support emanating from the facility managers and clinic doctor was experienced as adversely retarding the facilitation and management functions towards achieving quality management of support groups. Participants from two focus groups had a lot to express on this aspect. Five of the eight facilitators and fourteen patients responded in various ways how lack of support affected them. Five facilitators experienced the lack of support emanating from the facility manager and clinic doctors. They emphasized need for support during their facilitation and management function. The examples of direct quotations are illustrated as:

"Our facility manager has detached herself from all group activities, not at all interested nor bothered, she is so aloof she does not know what is happening."

"I feel so neglected because she is always not available, does not give input and is always claiming to be busy at all times, I feel deprived of valuable guidance, support and encouragement."

"It is so stressful, my working relations with the facility manager has changed to the worst, it's unbearable ... I mean I need her support ... but as things are like this I feel isolated, not cared for especially in times of need."

"She is very much unpredictable, insensitive and uncaring to support group-related issues, so inconsistent you cannot bank on her support."

"We need then, maybe they are not aware, - there are times when the situation is not manageable and need their help, guidance and supervision to solve whatever problem, or mistakes done, with her around you feel being supported."

According to Swansburg (1993:214) in one of the activities indicated, states that a manager to promote an organisational climate has to help practicing nurse to overcome their shortcomings and develop their strengths and promote teamwork. Hein & Nicholson (1994:234) maintains that, the leader should teach empowering behaviour, provide coaching, guidance, feedback and make suggestions for future improvement and coordinate the self-leadership practices of others. Douglass (1996:175) supports this view.

"Doctors don't take kindly to suggestions from facilitators because they don't regard them as their equals."

"Most of them are not approachable, looking down upon us."

This notion about doctors is supported by Khanyile (in Mavundla & Mabandla; 1997) stating that doctors see themselves as superior and do not consider nurse as an equal in
the health care team. Pope (1993:53) echoes the same sentiment in her study indicates that doctors are not reachable, and do not recognise the capabilities of the nurse. Similar Cilliers (1991:30) is also of the same opinion when stating that nurses do not experience recognition from doctors. Swansburg (1993:360) further corroborates the view regarding the doctors.

Fourteen participants in general experienced lack of support emanating from the facility manager and staff. This is mostly experienced during the facilitator’s absence causing barrier to effective management of support group. Examples of direct quotations are listed as:

"The whole group is not approachable, you are afraid even to ask for help when in need."

"It becomes a problem when the facilitator of the group is not on duty ... you really get frustrated as no one fills the gap ... no one takes the responsibility."

"We feel so isolated, they appear harsh and unfriendly it's like we are trespassers unlawfully entering the clinic."

"We don't feel comfortable there, it's like we are not welcomed, there is no relief team."

"Some of us do not come to group sessions when the facilitator is not there ... people actively stay away from treatment ... they break the continuity of care and default."

"We are not treated like other patients, but we are discriminated against, called names, I don't think they are happy with us."

Schulz & Johnson (1990:136) maintain that management not just doctors and other professions have primary responsibility to ensure that patients’ needs are met. According to Bernhard & Walsh (1995:104) formal and informal plan has to be in place to determine a member that will take care of another member responsibilities while she is away.

- Lack of conducive environment

From the three focus group interviews it was evident that the management and facilitations were negatively influenced by unconducive environmental factors. Participants consisting of eight facilitators, six facility managers and sixteen patients experienced lack of a conducive environment. Various environmental factors were identified such as lack of space and privacy, staff shortage, drug shortage, lack of equipment and overcrowding.

- Lack of space and privacy

Lack of space and privacy was experienced by five of the eight facilitators. The physical layout of their respective clinics presented them with extreme difficulty during facilitation of support group. The examples below illustrates the direct experiences quoted as:
Our consulting rooms are very small, there’s no privacy."

"No privacy for individual consultation and counselling during group sessions."

"Patients are all cramped up in one small room ... not free and relaxed to express themselves."

"... Not well ventilated, the rooms are dark and uncomfortable to facilitate and undertake procedures, under such conditions."

"Patients privacy is very much compromised."

Ten patients expressed dissatisfaction on the size and notion of the consulting rooms they were using for group sessions. They made mention of the fact that it was negatively contributing to facilitation and management functions and as well retarding quality management of support groups. This is evidence by the following statements:

"Something must be done, these rooms are very small."

"Floors, walls not cared for..."

"There is poor lighting, rooms not ventilated, its like everything is just not in good condition."

"Very little space to perform tasks comfortable."

"Too much interruptions, no privacy for individual consultation."

In support of the statements raised by participants regarding lack of space and privacy Cilliers (1991:5) noted that nurses were concerned about the lack of privacy due of the physical layout. The privacy must always be maintained during physical examination of patients. It is also stated in the patients’ right charter 2000) that privacy for patients must be respected. Regarding space, in support of the notion above Swansburg (1993:360) mentions that working in such crowded space causes stress and burnout to nurses.

➤ Shortage of staff
This experience is reflected in two focus group interviews by six facilitators and five facility managers as negative factors impacting on delivery of quality care to patients in general. Shortage of staff was expressed in relation to workload. Facilitators expressed staff shortage especially emanating from the primary health care nurses as creating facilitation and management functions unbearable, regarding management of support groups. The responses were as follows:

"Lack of sufficient PHC- trained nurses, and an increasing resignation of available ones, is really affecting the facilitation of support groups."

"Increasing number of patients and workload are some of the factors making facilitation and managing support group unpleasant and professionally not
fulfilling."

"The staff shortage with increased workload is compromising the quality of work."

"The continuous staff shortage is a cause for concern if quality management and facilitation functions are to be rendered."

"We are always in a hurry to finish, we actually do "slap-dashing" which can be hazardous and discrediting to our abilities."

"It is not possible to maintain proper PHC standards under such conditions it is stressful to both patients as recipient and us as providers of health care."

All six-facility managers expressed staff shortage and an increased workload, especially among primary health care nurses. Facilitators identified this aspect as a stumbling block to quality facilitation and management functions. The following are the examples of supporting statements made by facility managers:

"The PHC nurses are terribly understaffed and most unfortunately they are the worst overworked group in our clinics."

"More PHC nurses are taking severance package and this is causing more staff shortage of PHC nurses, and in turn affecting the quality service delivery."

"Our clinics are overpopulated with patients putting a great demand on the stressed overworked and understaffed nurses as clinic managers there is not much we can do, provision of staff is done by top management."

"The resistance encountered from other practicing PHC nurses to facilitate support groups and provide relief these facilitating nurses poses problems and difficulty in rendering quality management of support groups."

"Some even tell you when asking for a co-facilitator that it is not in their job description and were never trained in facilitation of support group."

Chaska (1990:308) supports the discussion above by stating that sources of stress in the workplace are associated with excessive workloads related to inadequate staffing. In further support of this notion Swansburg (1993:60) states that understaffing has a negative effect on staff morale, delivery of quality care and nursing care modality, it causes absenteeism from staff fatigue burnout and professional dissatisfaction. Tappen (1996:314) states that the team cannot fulfill all of its responsibilities effectively if the staffing is inadequate, and that the leader/manager can ensure that people in administration are aware of inadequacy and its detrimental effects, pointing out the losses to the organisation in terms of failure to meet legal requirements, lower quality care, reduced efficiency, poor public relations and inability to expand operations that results.
Shortage of drugs
Most participants from three focus groups experienced shortage of drugs. They expressed their concerns on the continuous shortage of drugs supply, which affected the provision of quality service delivery with regard to management of support groups. Most facilitators experienced shortage of drugs on the Essential Drug List and the supply impacting negatively on the facilitation and management functions as it continuously involved them in non-nursing activities. It made them to appear incompetent and disorganised, and it also discredited their performance. Examples of direct quotations are illustrated as follows:

“There is an acute shortage of drugs in Soweto. Patients move from one clinic to the other for drugs.”

“Patient care time is compromised, while more time is spent on trying to obtain desired stock.”

“Drugs are not delivered in time – too much delay, our ordering system is very poor, and sometimes drugs are not supplied.”

“We do a lot of running, asking drugs from other departments.”

“You look as though you are not sure of what you are doing because you are always out of stock or have incorrect supply.”

“Some drugs have expired or unavailable – thus making it impossible to run effective an service.”

“Drugs on the essential drug list are not all readily available and accessible to the clinic. Patients are referred to the hospital for supply or given alternatives if available.”

Twelve patients also expressed concern over the continuous shortage of drugs and its supply to the clinics, as impacting negatively on the sustainability of support groups. They indicate that it contributes to poor drug compliance, decreasing and irregular attendance to support groups’ session’s time wasting and poor disease management and control. The following supporting statements as described their responses:

“My condition is gradually complicating because of the unavailability of drugs. I cannot even afford to buy them from the chemist.”

“Attending support groups is no so good if drugs are not available, or you are given short supply, at times expired drug delivery.”

“I will attend the group sessions only when drugs are available ... in the meantime I will use my son’s medical aid.”

“I am about to give in and withdraw my membership.”
"I don't trust them now... everyday we are told there are no drugs... they are taking us for granted."

"To be a support group member does not guarantee availability of drugs."

"I am not happy... I think drugs are being withheld by sisters to force us to attend group sessions."

"It is almost a month now without my treatment – they... are off code, when are they going to be on code?"

"It is time consuming, costly and tiring, going from one clinic to another for unavailable drugs."

"We are being tossed around... drugs available today, tomorrow you are told they are on or off code, it is sickening."

In support of these statements Marrelli (1993:215) comments on the decreased job satisfaction when the staff are continuously engaged in non-nursing activities. According to Swansburg (1993:51) nurse managers must avoid assuming responsibility for non-nursing services and plan to encourage the appropriate departments to assume such services. In support Dannenfeldt (1996:40-43) when clarifying the aims of the National drug policy (NPD) launched in 1996 states some of the objectives to have prompt and equitable distribution of essential drugs to health care facilities, ensure drugs reaching patients are safe effective and meet the approved standards and specifications.

Lack of equipment

Lack of equipment was identified by participants from focus groups as negatively influencing the facilitation and management functions regarding the management of support groups. Only ten participants from the Group C responded to lack of equipment – while some participants preferred not to respond. They did not comment as they felt that it was pointless as nothing is being done about their concerns. Examples of direct quotations (by patients) are given below:

"The available equipment is in many instances out of order... I mean things like HGT machines."

"We are provided with equipment of poor quality – we don’t rely on the readings from these machines... that is why we have bought our own equipment... BP machine and out HGT machines."

"Very, very insufficient teaching aids for supplied during educational group session. Available ones I think... were last used 1997."

"Much information in these booklets is outdated, - we are updated by some members who are subscribers of magazines."
“Chairs in our consulting room are just good for dustbin ... they are falling apart and available equipment, I mean self-monitoring are not enough for all group members.”

“It’s like these tools are not regularly checked ... as some damages are discovered on the day of use.”

“Maintenance of equipment is very poor, repairs takes quite sometime to return to an extent that other activities are not done, I mean simple exchange of batteries can take almost a month!”

“Furnishers such as cupboards, chairs, are just in bad state.”

Facility managers expressed a general lack of equipment as a barrier to the effective implementation of support groups. Inappropriate, inadequate and damaged equipment were the facility managers’ concerns. They indicated that this negatively impacted on the delivery of quality facilitation and management of support groups for patients with chronic diseases. The following are their complaints:

“ It’s embarrassing, the nature of our equipment ... mostly of inferior quality, you can say 3rd grade and very much outdated.”

“Equipment like BP machines, HGT machines is usually never replaced if sent for maintenance – if it does it takes a period lasting + 3 months for fixing.”

“They fall apart all the time, making it impossible to provide adequate care.”

“The instruments we are using are of 3rd grade nature ... of substandard.”

“Most of these instrument are damaged, some are torn, too small, or too big, expired; - leaving the user with incorrect measuring.”

In support Douglass (1996:160) maintains that unpleasant working conditions can result from factors such as malfunctioning equipment. Booyens (1998:289) remarks that it is imperative to provide adequate and technologically advanced equipment in specific environment. Rispel (2000:7) points out that well functioning equipment is as important as to improving patient care.

• Free primary health care services
The free health care services implemented in 1996 was expected by participants in two focus groups A and B as impacting negatively on both management and facilitation functions thus hindering the quality of management of support group. A significant
number of participants identified free PHC services as influencing the management of support group negative. This is verified by the following quotations:

"Due to an increasing and uncontrollable number of patients coming to the clinic for consultation, managing support group facilitation is compromised, as little time is spent with them."

"My workload is now doubled, I have an added two groups of clients (support groups and ordinary patients) because of this ever-increasing service."

"There's increased workload, increased patients, inadequate resources, creating difficulties in providing quality care to all patients and the situation is worse with facilitation of support groups."

"I am struggling, I cannot deal with all these challenges, and it is frustrating and stressful."

"We push queues, more concerned about how many patient we see, than the quality. Is it quality that we provide or not?"

Four facility managers also identified free health care services as impacting negatively on the management of the support groups in Soweto clinics. They cited various factors such as resources, equipment and overcrowding as affecting the delivery of all health care adversely. Direct quotations from transcribed group interviews are as follows:

"Clinics are overcrowded, rendering the clinics unmanageable, proper planning for daily PHC activities becomes impossible and I can't even make myself available for group session."

"Some patients are abusing the service, they come every day or move from one clinic to the other. The other reason is that drugs are not always readily available."

"General lack of resources, (supplies and staff), inadequate planning due to increased workload creates barriers to effective management of support groups."

"Team work is affected, nursing staff is overworked, stressed, burnt-out, and resistant to the additional support group-related activities."

Wilkinson (1997:52) observed that the government policy of free health care has improved the accessibility, but has been traded off by marked increased in demand for curative services, great demands on staff resulting in the services are becoming strained. The balance between the important preventative services is in danger of being lost, and further says that this policy has failed to take into account the impact it have on health services. This observation is in agreement with a study conducted by Monamodi (1998:70), which revealed that factors such as overcrowding, shortage of manpower,
drugs and lack of working space affected the skills of primary health care nurses negatively.

3.7.2 Negative facilitation experiences
Participants in all five focus groups identified various factors of their experiences regarding management of support group and the impact on the facilitation function. Negative experiences identified were poor conflict management, lack of sufficient time, and poorly structured groups. Detailed discussion of negative experiences with supporting quotations follows below:

• Lack of sufficient time
Lack of sufficient time was described during two focus group interviews as a major stumbling block to effective management of support groups and impacting negatively on facilitation function. Eight facilitators and twelve patients expressed their concerns with regard to lack of sufficient time. Facilitators experienced lack of sufficient time, which they expressed in the following direct quotations:

"The two hours allocated for facilitating support group sessions is not at all enough to attend to all those activities ... there is too much to be done."

"It is funny ... I am allocated at least the whole morning ± four hours but I still cannot cope in finishing my facilitation tasks."

"I suppose it is not the duration of time allocated that is creating the problem, but it is how we use it, maybe ... just maybe we spent most time on unimportant tasks."

"I am always pressurized for time, I cannot manage my daily activities, nor spent quality time with members of the group."

"It is stressful to work – work and still not finish your tasks within allocated time period."

"I am always rushing behind time like a disorganised person, - I cannot plan and set my priorities appropriately to deal with my activities...I agree time management training is essential for us to cope."

The nurse manager needs to plan and schedule activities in order to accomplish the set goals (Booyens, 1998:284). Agreeing to Booyens statements – Bernhard & Walsh (1995:99) indicate that a nurse leader (and anyone) who learns to manage time effectively will be more productive in both their professional and personal lives. According to McFarland et al (1984:271-2) indicates that situations that give rise to time wasting include the failure to set plan or schedule daily activities, unrealistic time frames failure to work on priority tasks, neglecting to plan because of pressure leaving tasks unfinished. Dissatisfaction on time allocation for support group sessions was expressed by fifteen participants (n=15) citing too much interruptions, poor planning, reviewing of time are
some of the factors that deprive them of quality group session time. Examples of direct quotations are listed as:

"I am not happy about the time allocated us to us to do our activities ...."

"Our nurse is so overworked, pressurized and spends most of the time with her daily routine work than with us."

"We need the whole day ... not 2 hours, that is very little ...

"Hours allocated are not user friendly and not flexible ... from 8 – 10 hours only? It’s not enough to meeting our needs.

"I wish they can change and review time to accommodate every one ... extend hours for at least 6 hours."

"We also need some quality time with her, I feel that our time is compromised."

"There are lots of interruptions ... depriving us of two hours of quality time, she is always busy with other things not related to support group issues."

"I feel the time has come for her to prioritise her activities, we also need her."

"We are not consulted nor supervised properly because there is no time for all that."

"She is being pushed around by her colleagues and that is why she spends most of her time helping others instead of coming to us."

"Our facilitator is always pressurized by time – always complaining of a tight schedule preventing her from spending time with us, she does not even finish her own work."

"Not all our problems are addressed because of time constraints."

In support of the above discussion Muller (1996:294) maintains that pressure of work in the unit is, however, a factor, which has the greatest impact on time management in the unit. Many daily pressures can be reduced through effective time management (Douglass 1996:154).

- Poor conflict management
  Participants in group C identified that facilitators lacked skills for effective conflict management. Twelve expressed dissatisfaction on how facilitators manage conflict among the group members. This is impacting negatively on the facilitation function thus retarding the attainment of quality management of support groups. This is evidenced by the following direct quotations:
"Our facilitator is too soft ... cannot handle conflict well, she just agrees to everything, she does not assess what people tell her, ... that is very wrong."

"She cannot decide and take a stand, she brushes aside issues that cause conflict instead of dealing with them."

"Our groups are doomed to failure if she does not improve on handling conflict, she needs urgent training otherwise by the time she realises, the group members will have long gone ... because they are frustrated and helpless."

"She either superficially resolves the problem, or ignores it, and that in itself is not good, for the problem or conflict will crop up again."

"She would rather change the topic as a way of handling conflict than of properly controlling the situation or facing the situation."

"Some members are bullish,- they like to dominate,- causing stress among group members ending up in confrontation, which at times leads to conflict, she will ignore, and pretend as if nothing happened."

"At times she is the one causing conflict (unintentionally) among group members by agreeing to everyone, thus creating some misunderstanding. Otherwise she is fine, she only needs some conflict-handling lessons."

In support of these statements Burkey (1998:82) warns change agents to be well acquainted with management of conflict, since their work lead to conflict situations. People should be made aware of possible conflict situation that might arise so that conflicts may be anticipated and properly handled. One of the main task of those leaders is to manage conflict in a healthy and productive manner and realising that individuals have different interests, aims and objectives and will likely use their membership in a group to advance their own ends (Ellis & Fisher, 1994:239) Douglass (1996:232) expands further stating that poorly managed conflict can tear apart on individual or a group, and that ineffective responses to conflict lead to frustration, helplessness and low self-esteem.

- Poor group structuring
Poorly structured groups were experienced by participants of groups B and C as negatively impacting on the facilitation function, which in turn affected quality management of support groups. Four facility managers and ten patients. Various factors were made mention of as contributing to poor group structuring. Facility managers presented out factors such as lack of role and clarity clear defined group objectives / purpose, which contribute negatively to the unity of the group. Direct quotations verifying the poor group structuring are as follows.

"Some of the participating members appear confused, clueless at what support group is all about; - its goals and its benefits."
“They are not organized; - appear directionless. Some don’t even agree to role or task allocation and do not complete tasks.”

“These groups are uncontrollable, there is no uniformity, - it is like they have been forced to join the group, I mean they don’t know what they really need, why are they involved...”

“In my clinic they do come for group sessions, but they do not understand the value of support group (just coming in to be counted), not motivated, ...”

Schwarz (1994:29-30) state that an effective group requires an effective structure, characterised by clear goals, motivating tasks, appropriate membership, clearly defined norms, shared values and beliefs. And further states that a group cannot achieve its goal if goals are ambiguous or missing. Booyens (1998:343) explains that groups exist for a reason and that the reason is often that individuals have a common goal. Burkely (1998:131) is of the same opinion when stating that the groups objective is to awaken in each member of the group a better understanding of themselves and of the realities of their situation. Muller (1996:251) confirms this notion stating that identification of group objectives keeps the functioning of the group in focus.

Ten participants in-group C expressed dissatisfaction about the way some groups are structured. Most participants experienced group related problems that are negatively impacting on the facilitation function thus retarding effective and successful management of support groups. Various factors were raised such as lack of togetherness, poorly defined roles, membership problems, lack of shared norms. This is evidenced by the following group extractions:

“Our group lacks unity, their group attendance is very poor. People come whenever they feel like, and there is no sense of belonging.”

“We are also experiencing passive involvement from some of our group members, people here are not committed nor dedicated to group work.”

“Group activities are being handled by some few people, and it is causing strain and stress among group members.”

Booyens (1998:240) indicates that the leader has to facilitate group participation to the fullest degree encouraging all members to contribute their energy and so maximize output. Supporting Booyens views Burkely (1998:161) indicates that although there is no one way to promote successful group participation groups and certainly no simple “inoculation” against group failures, groups are less likely to fail if they are helped to become aware of these common causes.

“The atmosphere during group sessions is tense, unfriendly, some of us are over-dominated and controlled in the group, some are hostile and it is just not right here.”
“In our group we have these group leaders who want to impose decisions on us, forcing people to participate; as a result people are leaving the groups.”

“I don’t like it ... I was forced to join the group against my wish ... I mean forced membership benefits no one instead prevents group development.”

“Actively I am not happy about few things, looking at the way roles are allocated, based on who you are not what you can offer towards group’s sustainability.”

“Sometimes I don’t know what is expected of me because of confusing roles, rules and objectives.”

In support, Muller (1996:258) states that a person who is forced against his/her will reacts against this is bound to offer resistance. It is unwise to force groups to go through a process that they are unwilling or unprepared to experience (Ellis & Fisher, 1994:143).

3.7.3. CONCLUSION

In this chapter, the realisation of the sample method data collection, data management, and data analysis have been described. The results that emerged from the role players’ experiences have been presented and discussed in relation to relevant literature control. Positive and negative experiences were identified accordingly. Positive experiences were identified as influencing the quality in the management of support groups, whilst the negative results were identified as compromising the quality of care. The negative experiences identified clearly indicate that support groups are not well managed within these clinics. In view of the references consulted during literature review, it is clear that unless these negative obstacles are addressed, support groups will not be sustained.
3.8. CONCLUDING STATEMENTS

The concluding statements are summarized as follows:

In this chapter, the results that emerged from the experiences of all role players were discussed in relation to the literature review. Experiences that either influence the management of support groups positively and those that compromise the quality management were grouped accordingly. Therefore, from these results, the following concluding statements are made according to their influence on management and facilitation of these support groups. These concluding statements are summarized in table 3.1 below.

POSITIVE AND NEGATIVE CONCLUDING STATEMENTS

TABLE 3.1: Positive concluding statements

<table>
<thead>
<tr>
<th>Experiences</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Community participation</td>
<td>Patients and their families are becoming actively involved in their own health, thus strengthening partnership and buying in the idea of support groups.</td>
</tr>
<tr>
<td>• Patient directed service</td>
<td>Support groups are geared to meeting patients' needs, where patients' rights and Batho Pele principles are effectively put into practice.</td>
</tr>
<tr>
<td>• Cost effectiveness</td>
<td>They expressed that through support groups, the high escalating chronic diseases health care cost is reduced due to good compliance.</td>
</tr>
<tr>
<td>• Empowerment</td>
<td>Empowerment as positively identified as an important strategy that equips patient to take control and ownership of own health, and improve compliance and outcome.</td>
</tr>
<tr>
<td>• Participative approach</td>
<td>Participative approach applied by PHC facilitators was identified as enhancing active participation among members of the support groups and ensuring that they fully assume their responsibility.</td>
</tr>
<tr>
<td>• Patient satisfaction</td>
<td>Patients experienced satisfaction in the way support groups were managed by PHC facilitators, as their needs were adequately met.</td>
</tr>
<tr>
<td>• Professionalism</td>
<td>Professionalism displayed by PHC facilitators enhances easy and effective facilitation of support groups, as well as encouraging ethical responsibility among facilitators to function in the patients' best interests.</td>
</tr>
</tbody>
</table>
### TABLE 3.2 Negative concluding statements

<table>
<thead>
<tr>
<th>Experiences</th>
<th>Statements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of supportive clinic policies.</td>
<td>The lack of supportive clinic policies is a major stumbling block in the management of support groups to guide, and direct management and facilitation of support groups. Need for a fully integrated policy is vital.</td>
</tr>
<tr>
<td>Lack of role clarity</td>
<td>Lack of role clarity creates confusion thus contributes negatively to the management function and sustainability of support groups.</td>
</tr>
<tr>
<td>Lack of recognition</td>
<td>Lack of recognition hinders quality management of support groups; - creating dissatisfaction among role players.</td>
</tr>
<tr>
<td>Lack of training and development</td>
<td>There must be adequate, quality and appropriate training and development for all role players to equip them with necessary skills.</td>
</tr>
<tr>
<td>Poor communication</td>
<td>Poor communication, lack of feedback, openness and transparency among role players impact negatively on the quality management of support groups.</td>
</tr>
<tr>
<td>Lack of conducive environment</td>
<td>Lack of a conducive environment characterised by lack of equipment, staff shortage with workload and overcrowding, shortage of drugs and lack of privacy and space identified, negatively impact on the quality of the management of support groups.</td>
</tr>
<tr>
<td>Lack of support</td>
<td>Lack of support is identified as a barrier to quality management of support groups, due to resistance displayed by health personnel.</td>
</tr>
<tr>
<td>Free health care services</td>
<td>Free health care services have increased patient population and thus the workload, thus impacting negatively on the management of support groups, and brought about job dissatisfaction.</td>
</tr>
<tr>
<td>Lack of sufficient time</td>
<td>The amount of time spent on support groups is identified as insufficient and negatively impacting on the quality management of support groups.</td>
</tr>
<tr>
<td>Poor group structuring</td>
<td>Groups are poorly structured due to lack of group norms and unclearly defined goals and roles resulting in the withdrawal and resistance of members.</td>
</tr>
<tr>
<td>Poor conflict management</td>
<td>Poor conflict management hinders progress on facilitation of support groups in that it results in dissatisfaction, as well as confrontation among patients.</td>
</tr>
</tbody>
</table>

### 3.9 CONCLUSION

In this chapter, the experiences of all the participants regarding the management of the support groups have been described. The results are grouped according to management and facilitation into positive and negative categories. These results are presenting various challenges to both PHC facilitators and facility managers with regard to the management of support groups. They reflect the need to function as a team to enable quality and effective management and sustainability of support groups. Active participation among role-players is vital. A re-look at the training and development of health personnel (facilitators and facility managers) need to be reality-based, focussing on support groups. Patients need to be included in decision-making and problem solving of support groups related activities. The identified results will be taken into consideration and utilised as they basis to formulate guidelines for quality management of support groups.
CHAPTER 4

CONCEPTUAL FRAMEWORK FOR THE MANAGEMENT OF SUPPORT GROUPS FOR PATIENTS WITH CHRONIC DISEASES.

4.1. Introduction
In this chapter, the conceptual framework for management of support groups for patients with chronic diseases is developed. The researcher will explore and describe the conceptual framework from the results discussed in the previous chapter based on the experiences of the PHC facilitators, the facility managers and the patients with chronic diseases, regarding the management of support groups for patients with chronic diseases in Soweto clinics. The conceptual framework will be presented in a clearly integrated manner within methods to give the actual meaning and understanding of the research results obtained (Mouton, 1996:109). The conceptual framework is developed to form a structure of the management of support group (Talbot, 1995:652). This structure or map will be used to direct and guide the development of guidelines for this study. Relevant literature will be integrated and used to provide an in-depth knowledge that is necessary and vital for the management of support groups. The conceptual framework will be developed and presented in six dimensions viz. the context, purpose, role players, process, dynamics and the definitions. For the purpose of clarification figure 4.1 depicts the six dimensions of conceptual framework. The six dimensions will be described separately.

Figure 4.1: SCHEMATIC PRESENTATION OF DIMENSIONS OF THE CONCEPTUAL FRAMEWORK.
4.2 THE DIMENSIONS
The conceptual framework consists of the following dimensions: context, purpose, role-players, dynamics and the process.

4.2.1. Context
The study is conducted within the eight clinics in Soweto that provide support group services for patients with chronic diseases. The focus of this study is aimed at the experiences of the PHC facilitators, the facility managers and the patients with chronic diseases with regard to management of support groups in Soweto clinics. The results will not be generalized to the larger population outside Soweto (Burns & Grove 1997:29). They will only be applied locally within the Soweto clinics to improve the management of support groups.

4.2.2. Purpose
The purpose of management of support groups for patients with chronic diseases in Soweto clinics is to ensure quality management is rendered to all patients with chronic diseases aimed at attaining clinic objectives of quality service delivery based on appropriateness, efficiency, equity, acceptability and accessibility as described by Muller (1998:3). These principles are further described and emphasized in the White Paper for transformation of Health (SA 1997:14-15) as part of the goal of the new health system. The second purpose is to ensure that the support groups are sustainable. The facility managers and PHC facilitators will jointly strive towards achieving that the support groups are successfully sustained. They will reframe, restructure, revitalize and even renew their strategies in order to accommodate participative management that will lead to realization of the purpose. As evident in the results obtained from the study negative aspects are dominating, and are a threat towards sustaining the groups. The PHC facilitators and facility managers will react appropriately to avoiding all aspects that are perceived negative. Third purpose behind the management of support groups is to ensure that patient satisfaction is provided to all patients with chronic diseases and their needs will be satisfactory met. Patient satisfaction is necessary and has great potential towards life style modification among patient with chronic diseases and patients take control of their own lives.

4.2.3 Role players
The role players participating in this study are the PHC facilitators, the facility managers as well as the patients with chronic diseases. They all play significant roles in the management of support groups for patients with chronic diseases in Soweto clinics. They all have equal responsibility in assessing needs, making decisions, planning, implementing as well as evaluating the quality of support groups service delivery. Through active involvement of these role players professional accountability and patient responsibility will become enhanced, and partnership between them will be facilitated as described in the White Paper for the Transformation of Health System in South Africa (SA 1997:33-34). The role players in discussion are described as follows:
4.2.3.1. Primary health care (PHC) facilitators
The PHC facilitators' roles with regard to facilitation of support groups for patients with chronic diseases in Soweto clinics are widened enormously and they vary. Their responsibilities include facilitating the groups, revitalizing existing groups, liaising and educating. They educate and empower patients with chronic diseases about the various chronic conditions, the signs and symptoms as well as coping strategies. They coach, enable, advise and encourage self-management of patients. Their leadership role is also critical to the successful outcome of the support groups. They need to know when to delegate and then move into an advisory role. They co-ordinate group structures guide members in their responses to problems encountered. They design strategies that suit individual patient. They interpret information in an understanding manner for the patient. Their responsibilities stretch well beyond their traditional role. As described by Muller & Poggenpoel (1996:2-9) when stating that professional responsibility of the nurse is to be involved in a multi-professional health team where she has to move out of his / her traditional role. Also another part of their role is to strengthen the capacity of the community to enable it to attend to its needs and facilitate change so that people can take ownership and control of their own destiny. They build network both internally and externally to the organisation.

4.2.3.2. Facility managers
These are nurses in charge of the clinics in Soweto. Their responsibilities include co-ordination, supervision as well as facilitation of all strategic operational plans and actions so as to achieve organizational goals. They are responsible for the smooth functioning of the clinics. They plan, organize, and take lead, co-ordinate all services within the clinics. They also evaluate the outcome of care provided to all patients that receives the service, including all those patients with chronic diseases participating in support groups. According to Flarey (1995:35) managers need to display all the necessary managerial skills, knowledge and attitudes. Though not directly involved in the facilitation and management of support groups for patients with chronic diseases, facility managers' role is to facilitate the achievement of the goals towards quality management of support groups for patients with chronic diseases in Soweto clinics. Facility managers who co-ordinate clinics with support groups for patients with chronic diseases, need to facilitate and pioneer appropriate management approach in achieving sustainability the objectives aimed at ensuring the quality sustainability of support groups in their clinics. They are expected to become actively involved in the effective management of support groups, by applying, organizing, staffing, activating and controlling. Muller (1996:133) supports this notion by stating that managers facilitate the achievement of objectives by means of the application of management activities of planning, organizing, directing and controlling. They are expected to perform all these management functions in some way or another by initiating change, as the concept understudy is relatively new in Soweto. With the introduction of support groups for patients with chronic diseases in Soweto clinics, facility managers role has become critical as they have to develop and model appropriate management approach in order to successfully create an environment conducive to ensuring quality management of support groups. Managers are expected to set this process in motion as successful change agents by effectively addressing participation in decision making and problem solving, empowerment, communication, training and development, customer orientated service delivery and effective time management.
Addressing issues pertaining to cost effective care, role clarity recognition, group formation will also positively facilitate quality management of support groups for patients with chronic diseases.

4.2.3.3. Patients
Patients with chronic diseases who are actively participating in support groups in Soweto clinics are also role players involved in this study. They are consumers of this special service. Their role in support groups is very much valued. Their involvement in sharing ideas and self-empowerment is important. Their participation and increasing responsibility in their own health care benefits all role players involved with support groups, the PHC facilitators and facility managers in Soweto clinics. According to Muller (1996:133) a patient is the most important person who should make an input in the provision of services. Toscani & Patterson (1998:2) are also of the same opinion, and state that patients play a larger role in the health care environment because they are now being asked to share an increasing responsibility for the state and care of their own health. To ensure that quality management of support groups, is rendered patients are encouraged to be actively involved and participate in all levels of health care that pertains to support groups activities. Their responsibilities within support groups include planning, setting clear group goals, problem solving, decision making, exchanging of information, group discussions, and implementation of projects with view of creating awareness. They also have a motivating task, formation of executive committees and fund raising. Other responsibilities include skill sharing, empowering each other, group identification and sense of ownership. Their co-operation, accountability commitment and collaboration are vital to the improvement of quality management of support groups. See figure 4.2. which illustrates the presentation of all the role players involved in this study.

FIGURE 4.2. SCHEMATIC PRESENTATION OF ROLE PLAYERS.
4.2.4 The dynamics
In order to ensure that support groups for patients with chronic diseases in Soweto clinics are managed effectively through quality principles, role players especially the facility managers and PHC facilitators need to know and understand the relevant dynamics. These dynamics have the ability to influence and impact either positively or negatively on the management of support groups. The future of ensuring quality management and sustainability of support groups depends on the understanding and interaction with these dynamics. If recognised carefully, diagnosed and taken into account while managing support groups, the facility managers and facilitators will react appropriately and develop a plan for handling each of them. The dynamics are forces within the environment. Some of these forces are outside the clinic, and are referred to, as the external forces and some are inside the clinic level known as the internal forces. Facility managers and PHC facilitators need to know and be aware of the impact they have, determine their relevance and the relationship to the organisation in order to ensure quality management of support groups in Soweto clinics.

4.2.4.1 External environmental forces
The National level consists of many forces that need to be taken into consideration. These are all environment forces outside the clinic and are forces found at national and provincial level. These forces are normally broad (especially at National level) in scope and have an impact on the management of support groups for patients with chronic diseases in Soweto clinics because the clinics exist within these levels. These forces have the ability to enhance or hinder the progress of reaching the goals of support groups. (Schwarz 1994:34, and Krejci, 1999:21) both support this statement as they state that every small organisation exist within a larger organisation that has an influence on the smaller one. External forces at national level include policies, acts, laws and constitution. The forces at national and provincial level significant and specific to support group services where the Soweto clinic management derives its mandate and direction are:
The WHO (1993:14) emphasis the primary health care approach promoting agenda for primary health care reform where self reliance and responsibility by people in respect of their own health following the adoption of “Health for all by the year 2000”(WHO, 1986).
The Reconstruction and Development Programme (RDP) (ANC 1994:45) provides framework for community participation and empowerment, cost effective care as well as preventive and promotive health care emphasising the primary health care approach. The RDP (1994:48) further encourages establishment of programmes that will ensure prevention and early detection and treatment of specific priority diseases such as diabetes, hypertension as well as the programmes to provide appropriate care for patients with chronic diseases and the promotion of healthy lifestyle. The Constitution (SA 1996), affirms the right to health care. It gives direction by recognizing health as a basic human right.

The white paper for transformation of health system in South Africa published in (SA 1997), which has become the basis for health plan of action within which the transformation of public service delivery can be implemented. In his foreword to the White Paper, the minister for Public Service and Administrations, Dr. Zola Sikweyiya, stated that service delivery must be judged in terms of the practical differences people see
in their everyday lives. This document emphasis community participation, promotes appropriateness, equity accessibility effectiveness as well as efficiency. It also focuses on consultation / communication with staff and service users.

The Batho Pele: white paper on public service delivery (SA 1999) sets out principles to be adopted internalised as own values and be applied daily. Principles stated are consultation, courtesy, transparency openness, information, quality service standard, Redress and value for money. Community participation (SA 1997) encourages active involvement and patient participation in health services in its area. Public Service Regulations (SA 1999). This regulation contains code of conduct for public service, which binds and impacts on the conduct of those role players providing support group services to patients with chronic diseases. Some of the guidelines provided on this code are the right of access to information, promoting transparency and timely information. Also includes relationship among employee where co-operation is encouraged where support and help is emphasized, where the “Get off my territory” syndrome is not permitted. Optional development, motivation and utilization of staff are some of the guidelines that are emphasized. These are some of guidelines that impacts on the management of support groups, which needs to be understood for effective and quality of support groups.

• Provincial level
Forces that affects the management of support groups at provincial level, outside the clinic consists of economic components such as the cost effectiveness related to chronic diseases management, which includes drug compliance. The availability of equipment that are of quality and acceptable standards provided for the management of support groups.
The social component is another aspect of great importance, which includes characteristics within the communities in which these clinics are situated. The language, the beliefs, the status symbol, the attitudes as well as the needs and desires of that particular community. To attain successful and quality management of support groups for patients with chronic diseases all characteristics of that community has to be taken into account. Political components includes the community health committees involvement in the management of support groups as some of these patients are health committee members. Their participation in decision-making, planning raising community consciousness about health issues, identifying and prioritising health needs and goals are some of their functions. These have to be considered during support groups management. Other political components that are to be considered and political organizations, community organizations, and all stake holders that have an indirect powerful influence on the sustainability of support group for patients with chronic diseases in Soweto clinics. Included in the political component is the Gauteng Health Special Groups Department Chronic Diseases, which has drafted various guidelines that mandates and directs the establishment of support groups. The Service Pledge document that outlines the mission and vision of Gauteng Health Department in which people of Gauteng are promised provision of better health care services and securing better value for money and effective organisation.
4.2.4.2 Internal environmental forces

Environmental forces within the clinic context, which have immediate and specific implications for managing, support groups for patients with chronic diseases. Number of aspects considered important for influencing the support groups includes the personnel colleagues (PHC), doctors, and the interpersonal relationship. The organisational aspects such as the mission and policies, culture of the clinic, consultation management approach applied. Also the production aspects, which relates to working conditions such as physical layout equipment, availability and supply of drugs for chronic patients, research aid the development. These are some of forces that can either positively or negatively impact on the quality management and sustainability of support groups for patients with chronic diseases. The marketing aspects, which include the strategies, used reputation of the service, and patients’ complaints. Just as it is important for role players to know and understand that the success of support groups for patients with chronic diseases in Soweto clinics is influenced by the above mentioned dynamic, environmental forces, they must also realise that the impact on the support group management a concerted effort, commitment and active involvement by all role players is necessary. Figure 4.3 below illustrates the dynamics of this study and their relationship to one another, and the various components that make up each environmental force.

**FIGURE 4.3 THE SCHEMATIC PRESENTATION DYNAMICS OF THE MANAGEMENT OF SUPPORT GROUPS FOR PATIENTS WITH CHRONIC DISEASES.**

- **EXTERNAL FORCES**
  - NATIONAL
    - CONSTITUTION
    - LEGISLATION
    - ACTS/REGULATION
  - PROVINCIAL
    - SOCIAL
    - POLITICAL
    - ECONOMICAL
- **INTERNAL FORCES**
  - ORGANISATION ASPECTS
  - PERSONNEL / STAFFING ASPECTS
  - PRODUCTION / WORK ASPECTS
  - MARKETING STRATEGIES
4.3 MANAGEMENT OF SUPPORT GROUPS

4.3.1. Introduction
Quality management of support groups for patients with chronic diseases in Soweto clinics will not come automatically but requires certain management skills, knowledge, attitudes and competencies as well as desire to manage groups. Since the purpose of support groups is intended to serve and meet the needs of the patients with chronic diseases, it is then a people-driven service. Therefore it is important that all the role players involved forge and build a partnership and work together. This partnership between role players needs to be expanded and maximised. Active participation of all those affected will bring about positive results. They will collaborate and cooperate effectively. Quality in group decision-making and proper planning will be kept on course. Empowerment will result, capabilities will be developed to reach their full potential. Patients will take full responsibility of their own health. Everyone will become responsible and will share the same vision and work towards a common goal. The support group service delivery will be accepted and transformed into a people-driven service.

4.3.2 DEFINITION OF CONCEPTS
The following concepts are defined in relation to the management of support groups for patients with chronic diseases as:

- Management
  Management refers to planning organizing leading and controlling the people, working in the organisation and the ongoing set of tasks and activities they perform (Hellriegel & Slocum, 1999:8).

- Management process
  A continual shift from one phase to the other in a reasonably constant sequence characterized by series of steps aimed at keeping the clinic and support groups appropriately matched to its environment.

- Participative management process
  It is the continuous interactive process of management characterized by four elements of dynamic interactive decision making, shared governance, and accountability, the organisational transformation and empowerment / enablement to achieve desired organisational goals.

- Decision-making and problem solving
  Decision on making and problem solving form the first stage of the participative management process adopted for the support groups management so as to meeting the desires, need and expectations of all those affected by challenges of support group for patients with chronic diseases. Decision making refers to the process of choosing among alternatives for which the “best” or “correct” answer is agreed upon by all those affected by the decision through consensus, negotiation, majority vote and proactive or reactive decision making methods.
• Problem solving
Is making adjustment, taking an action or carrying out measures to a gap identified between what is desired by the group to what exist, to achieve desired goals.

• Shared governance
It is the second stage of the participative management process. It refers to the accountability-based system characterized by trust relationship, shared power, responsibility and control for the consequences of the decision-making.

• Organisational transformation
Organizational transformation is the third stage of participative management process that precedes the shared governance stage. It refers to the fundamental rethinking and radical shift to redesigning of the bureaucratic organizational structure characterised by the vision, mission and objectives, processes and strategies and the people to accommodate the participative management process and appropriately respond to the changing external and internal environment.

• Empowerment
Refers to the deliberate planned social process of recognizing, promoting and enhancing peoples abilities to meet their needs, desires and expectations related to participative management in a health care organisation. Muller (1995:20) A purposeful process of personal and professional development of every staff member in the nursing unit to facilitate participative management process (Muller 1996: 131)

• Sustainability
It implies the ability to successfully keep the support groups functional for a long period by appropriately reacting to the external and internal environmental challenges threatening the survival of support group for patients with chronic diseases.

• Quality
Implies the degree of excellence of how a service (support groups) for patients with chronic diseases are managed, characterised by appropriateness, effectiveness efficiency, accessibility and acceptability resulting in measurable and acceptable benefits to the customer (role player).

• Patient satisfaction
A satisfactorily fulfilled patient whose desires, needs and expectations have been satisfactorily met by the satisfied health providers (facility manager and PHC facilitator) characterised by greater self esteem, trust, empowerment, sense of ownership joint decision making and problem solving, less stress and healthy working and user friendly environment resulting to improved image and cost benefit to the department and health benefits to the individual and the community, and sustainability of support groups.
4.3.3 PROCESS OF PARTICIPATIVE MANAGEMENT

The management process adopted for this study is derived from Muller (1995:15-21) and (1996:126-132) participative management process. This process is characterised by the participative management activities namely the Interactive decision-making and problem solving, shared governance / ownership, the organisational transformation and enablement / empowerment. The four activities are linked with continuous appropriate and dynamic communication that is applied throughout the process. Furthermore, in conjunction with these activities are four other elements used and these are named assessment, planning, implementation and evaluation as described by (Muller 1995:15-21). As a point of departure, each component of participative management process will be discussed separately, though they are not independently from each other as their actions are interrelated and interdependent. Muller (1995:17). See Figure 4.4, a schematic presentation of the participative management process.

FIGURE 4.4: SCHEMATIC PRESENTATION OF THE PROCESS OF PARTICIPATIVE MANAGEMENT (Adopted from Muller, 1995)
4.3.3.1. Interactive decision-making and problem solving

According to Muller interactive decision making and problem solving means active involvement and participation of all role players affected by the decision taken to the problem identified. It is not done unilaterally, where the unit manager makes decisions alone but it means group involvement in decision-making. It is characterised by joint decision making and problem solving, environmental analysis, defining environmental factors, gathering of information, generating ideas and deciding and agreeing on the course of action to be taken. During this initial step of the process, the internal and external environmental assessment is very important. A thorough and careful diagnosis of both internal and external environment is undertaken before a decision can be made. These forces can represent significant threats or opportunities and are likely to have negative or positive influence on the decisions that will be taken with regard to management of support groups. Both the facility managers and facilitators perform the environmental assessment so that they can react appropriately to problem that are likely to affect and prevent change and negatively affect the management of support groups. This notion is supported by Flarey (1995:23) who states that the assessment of both environments is necessary, and must be done. Hellriegel & Slocum (1999:235) further elaborate that assessment of the internal environment helps to identify the organisation’s care competencies and determine those that need to be improved.

Once the assessment has been done, strengths, weaknesses, opportunities and threats are brought to the fore. Adequate and relevant information is gathered, forcing the role players to generate ideas and decide on the course of action that needs to be taken in order to attain the desired goals. A clear picture at this stage becomes obvious as to where the support groups are presently, what do they want to achieve and then brings the problem to light and then clearly identify it. Adequate planning strategies will be then developed focusing on all identified problems. Strategies that accommodate active participation will not be overlooked. Simultaneously a sense of purpose also develops among all role players and directs them in terms of decision-making strategy and problem solving as well as determining the intensity of involvement that is required. During this stage, they all become integral part in planning as well as mechanism to achieve the desired objectives. The facility managers will not make any decisions. Alone they will all come together, share ideas and present suggestions or even make decisions to solve the identified problems. Involvement of role players in decision-making promotes cooperation, collaboration and sense of ownership. It mobilizes, inspires them and make them feel valued, thus evoking the best they can offer all focusing on a common goal. It also increases the probability of the excellence and goal.

Unless the facility managers in Soweto clinics realise this fact, and make major paradigm shifts and employ participative / involvement approach in decision making and problem solving, the quality management and sustainability of support groups for patients with chronic diseases will be threatened. All pressing and threatening environmental factors
will not be successful solved. Yet with joint decision-making and problem solving strategies, such factors will be thoroughly assessed, appropriate and effective solutions will be taken and implemented. Sound, timely and objective decisions will be openly and constructively discussed within co-operative goals. Through joint decision making and problem solving role players develop an accurate view of identified factors. They incorporate their different and sometimes opposing views, and then come to understand and appreciate other peoples' views. They jointly develop alternatives and arrive at a solution responsive to the complete situation. During joint decision making, they all argue, debate and disagree co-operatively and skilfully while keeping focus on their desired common goals. Joint decision making and problem solving has great potential only if different decision making strategies are skilfully and appropriately used such as consultation, consensus decision, making, negotiation as well as democratic decision making. Muller (1995:18-19) clarifies the different strategies such as follows:

- **Consultation**: implies that the manager who earnestly seek ideas, advise and help from employees approaches the subject with open mind, attempt to solicit criticism and suggestions with sincerity in relation to contemplated problem.

- **Consensus decision making**: refers to unanimous or adequate agreement by members, implying that adequate must be held on the subject with regard to advantages, disadvantages and impact analysis of the options. Ellis & Fisher (1994:141) further elaborate that consensus imply group agreement with decision reached, and the degree of personal commitment members feel toward the decision after it has been reached.

- **Negotiation**: refers to a process whereby two or more parties need to arrive at a mutually acceptable agreement in respect of conflict and dispute, and further emphasis that good faith negotiation, where information is not distorted is very important. Democratic Decision Making is referred to as the context analysis classification and grouping of ideas and suggestions into logical manner and formal voting take, and majority rules.

The following negative results identified during focus group interviews, clearly indicated the lack of quality decision making:

- **Lack of supportive clinic policies that comprehensively integrates all support groups related activities is viewed as a barrier and hindrance to positive performance. This is viewed as a barrier because there is no guidance, or direction available to enable PHC facilitators to work and perform their duties in accordance with existing policies. This indicates that there was no team spirit and decisions were unilaterally made.**

- **Lack of role clarity is another area of significance raised by facilitators to clear all misunderstanding and lot of confusion as to what role are facilitators expected to assume with regard to support groups. It is indicated in the results that the PHC facilitators were uncertain about their roles, because these roles were not communicated to them. There was no interaction between the facility managers and PHC facilitators.**

- **Training and development of facility managers and facilitators is another issue that is raised as a concern and a need in the implementation of effective support groups for patient with chronic diseases. Insufficient time, poor group structuring as well as poor conflict management are raised as other constraints to the quality management and sustainability of support groups for patients with chronic diseases.**
As stated above, the negative experiences expressed by role players is evidence enough that other role player participation in some clinics non-existent. Participation of all role players was not applied in some clinics. These results support the fact that the support group processes have not in any significant way been transformed into the involvement driven process, hence some groups have ceased to exist. According to Blancett (in Flarey 1995:75) communication is the most important leadership skill to drive change. Communication is vital to directing some functions. People relate to each other while solving problems, while working, and sharing ideas. Therefore management is encouraged to use effective communication to communicate ideas within the work place with role players. Muller (1995:20) states that effective communication is the lubrication for effective participative management. It is therefore vital that facility managers take account of the communication system that is practiced within their clinics to ensure cooperation among role players. As it emerged in the empirical data, poor communication in its various ways has been a source of dissatisfaction among role players, and a barrier towards participative management.

Supporting this notion O’ Day (in Flarey 1995:340) states that communication is vital to the change process. With so much at stake, facility managers cannot afford to ignore this challenge; they ought to be exceptionally concerned about the quality of communication interaction that exists and being practiced. All necessary changes and communication methods must be put in place that need to be employed to govern conditions under which effective communication have to take place, for the effective management and sustainability of support groups for patients with chronic diseases. Farley (1989:27) refers to effective communications as the bricks in the road to co-operate excellence. As reflected in the empirical data, areas of communication that are impacting negatively on management of support groups are lack of accessibility of information, the lack of clear messages, transparency and consultation, and the communication channels. Consultation is very important for it promotes acceptance and sense of ownership. It brings change in an acceptable manner that requires joint efforts from all role players. It is so essential that people are kept informed of any thing that affects them. Schuitema (1995:16) states that people have the right to know things that affect them. This is further supported by Ellis & Fisher (1994:28) who state that members of the group want to be told that their contributions are valued. Managers have to embark on consultation strategies to address this area of communication.

Meetings must focus on information sharing and participation. Muller (1996:252) suggests that it is advisable to hold meetings at least once a month with staff to discuss general matters. Further support for meetings is substantiated by Gillies (1996:187) when stating that staff meetings where change is being discussed, every one must be invited to freely discuss and express themselves. Accessibility of information is also considered very essential. Giving feedback and responding to role players concerns is important. People need to understand positions of others in order to perform their task adequately. People need to be informed and included in discussion and decision-making. Managers must try not to withhold information, be selective and manipulative in disclosing information to prevent a purely reactive situation. It is therefore necessary that information filters down to all role players affected by the support groups. Transparency and openness is necessary in providing feedback to allay fears that accompany support
groups. It increases confidence and trust among role players and can lead to increased risk taking and creativity Haslett & Ogilvie (1992:351-355) provides suggestions for effective feedback as follows:

- Be specific and be direct when giving feedback.
- Give evidence and provide data, by providing statements of facts and give justifications for opinions.
- Separate issues from the people, focusing on the task and subject matter.
- Use good timing by giving feedback soon after an issue is raised.
- Respond to people about immediate issues.

According to the data revealed, role players did not share, nor generate ideas among each other. They did not vent out their ideas. They felt isolated and not supported. They complained of lack of consultation, lack of autonomy, and that things are just being imposed, and decided upon. It is just one way communication system of management that is practiced. Imposing decision without involving those affected role players creates problems. Managers need to involve them, allowing people opportunity to question issues, which they see as problems. According to Hellriegel & Slocum (1999:515) managers give little thought to allow employees to respond in a downward channel, which is often a one-way communication. Schulz & Johnson (1990:67) describe communication as a two-way street where people can express their feelings openly and honestly without any fears. Facility managers are seen by both facilitators and use patients as not listening and being insensitive as well as not hearing their needs, requests and suggestions. According to Pope (1998:35) management need to employ open communication strategies. Openness, consultation and transparency must be encouraged to enhance realization of desired objectives. Managers need to listen actively, give feedback encourage contributions, provide means to keep all role players informed. Suggestion boxes, message books, writing memos or newsletter must be encouraged and as a means of providing information. O’Day (in Flarey 1995: 107) confirms this notion when stating that newsletter / memos are means that nursing managers can use to keep people informed during implementation and provides them with opportunities to vent out their opinions, and face to face accessibility to higher authority. A supportive and communicative climate must always be promoted.

Yet, despite all these negative findings which clearly indicate that most facility managers in Soweto clinics are still dominating and controlling. They are still reluctant to allow any significant participation in the day-to-day management of support groups. It is encouraging to observe and determine that there are few facility managers that are aware of the importance of participative management, where all role players are involved in decision making. These managers have adopted participative approach as their strategic initiative to successful sustainable quality managed support groups. This initiative has indicated positive results like patient empowerment, rendering a patient orientated service, community participation, and patient satisfaction. In these clinics patients are given opportunities to freely and openly share their ideas and information, as well as make contributions towards developing high quality solutions. Every suggestion or advice made is taken as a contribution; nothing is taken for granted or seen as irrelevant. Views are exchanged freely without any fear of victimization. In these groups all role players pull together and work together as a team. Various groups have indicated various
positive issues as well as the benefits brought there of facility managers also indicate that there is that sense of responsibility and high degree of commitment displayed by most patients. Proper strategic planning that is inclusive of all those affected is always put in place. Every one participating in support groups is seen as an integral part of planning. The PHC facilitators cited that they now understand the Batho Pele principles as well as Service Pledge much better and were applying them daily in their practice. They stated that support groups were tailored to satisfy the patients' needs, and thus were presenting a challenge to provide acceptance, accessible, efficient and an appropriate service.

Patients with chronic diseases where support groups were successfully managed and sustained were full of praise of the way groups were managed. They expressed their satisfaction without mincing any words. They raised the issues that they were empowered and can now take control of their own health. They also indicated that they were impressed about the professionalism that was displayed and thus were hopeful about the future of the support groups. They expressed their gratification and stated how satisfied they were as most of their needs and expectations are met. In support, Swansburg (1993:6) states that patients have to be satisfied as they buy satisfaction of wants when they buy their care. It is therefore important that facilitators and facility managers work together and build partnership with patients and meet their needs by providing of quality service to all those that receives it. The commitment, dedication and active participation are prerequisites to successful service delivery. Swansburg (1993:6) confirms this notion by stating that nurses need to perform activities needed to determine what patients see, think, believe and want, and that patients are the starting point at which the business of nursing is defined. According to Cheales (2000:28-29) customers are the ones who count. These views were further echoed by Muller (1998:9) stating that patients must be seen as customers with needs that has to be satisfied. Supporting this statement, Sunter (1996:60) mentions that half-hearted efforts are simply not going to work if business is to become competitive. They also pointed out that they are actually involved in joint decision making and problem solving of support groups related issues. They strongly emphasised that as of benefit to every one involved and affected by support groups. The participative approach is therefore important for effective service delivery. Health care organisations cannot hope to survive without contributions from its employees. Role players within the organisation have to become part of the organisation strategic plan to ensure the attainment of desired goals and maximize opportunity of survival and sustainability of support groups for patients with chronic diseases. Role players must be actively involved in decision making and problem solving activities of support groups.

The White Paper for the Transformation of the Health System in South Africa (South Africa 1997:34) gives support to the statement above stating that people need to be afforded opportunity to actively participate in different aspects of planning and implementation of the health care service. Braxton (1995:22) is also of the same opinion and states that participation by all, transparency in decision making, involvement of all the role players affected by decision are generally accepted as fundamental to business survival According to Schulz & Johnson (1990:22) all role players have to be on board when planning. This notion is also confirmed by Marquis & Huston (1994:75) stating that all those affected by change must be involved in planning therefore managers are facing challenges of involving all role players in planning of management activities and
decisions making that enhance quality management of support groups. Krairiksh & Anthony (2001:16) state that involving staff in decision that directly affect patient care is needed to achieve patient, nurse and unit goals. Facility managers have to share responsibilities and accountability by delegating authority to other role players. They have to work together with patients with chronic diseases and staff especially the facilitators to ensure that quality management of support group is provided. It is therefore imperative that joint decision-making in the management of support groups is not overlooked, but instead practiced. According to Stander (1992:68-69) participative management is a dynamic process of mutual decision-making and creative problem solving through active participation of the employees, with the distribution of authority and shared accountability. Booyens (1998:124) further states that participative management tends to increase feelings of responsibility among employees towards organisational goals and objectives and better working relationships develop because of increased trust and mutual support among employees. In support of Booyens views Swansburg (1993:250) states that trust, goals and objectives, autonomy and informed commitment are all components of participative management. Facility managers as well as PHC facilitators have to practice and utilise their skills to motivate patients to actively participate in decision-making and problem solving, in order to prevent them from withdrawing or rebelling against support groups. As evidenced from the empirical data, clinics where facilitators are practicing participative approach support groups were successfully sustained as patient expressed satisfaction and felt important. Participating in decision making and problem solving make them feel that their contribution is valued, and they develop the sense of responsibility and ownership. So for the survival and sustainability of support groups for patients with chronic diseases, all strategies that actively involve all role players must be designed and implemented. Programmes/ interventions on participation or on similar intentions and objectives must be adopted.

Facility managers and PHC facilitators must see themselves as leaders and facilitators of support groups and not as the “bosses”. They must work with patients and make the most of their abilities and potential, by actively involving them in problem solving and decision-making. Problem solving is an ongoing process and an integral part of working. So to be effective in problem solving, managers need to empower and develop other role players with skills to identify problems and make decisions. Getting solutions to problems is important in decision-making. Solutions based on thoughtful analysis and relatively complete information from all role players is important, not from selected individual, ideally managers need to involve every role player, and need to be more informed and be able to create and implement high quality solutions. Although facilitators and patients recognize facility managers' right to make decisions, they usually see it as fairer and proper if they have participated in making the decision. Participation contributes greatly to the quality of decision-making; it meets the needs to express one, encourages commitment to implementation of solutions and promotes oneness.
4.3.3.2 Shared governance/Ownership

It is the second element / phase of the participative management process. According to Muller (1995:19), this phase refers to the establishment of a trust relationship amongst all role players through direct, interactive involvement in decision making and problem solving, with the subsequent shared responsibility and accountability for the consequences of the decisions whether successful or not. Porter-O'Grady (1992:5) describes shared governance as a system of accountability that relies on individual, autonomy, authority and control within a decision framework. In order to respond to the challenges of support groups and achieve work effectiveness facility managers have to pursue shared governance principles described by Muller (1995:19) as follows:

- Concerns in terms of shared values; philosophy, objectives and standards (congruently between individual and organisation values) must be reached.
- Guidelines for decision-making must be drawn up within the group context, so that an “I” approach becomes an “Us” approach.
- Management responsibilities must be delegated with authority for both process and outcome related decision-making and problem solving.
- Involvement of every role player in every management activities like, planning, organizing directly, and controlling on long-term basis.
- Granting of autonomy and initiative to the subordinates with regard to the way in which goals should be achieved in accordance with the level of role players empowerment, reliability and informed facility managers in Soweto clinics are challenged to realise this fact and develop a course of action aimed at ensuring that all role players buy-in the clinic values and develop a sense of ownership, and shared governance.

Shared governance is important as it binds all role players together, it also foster trust and co-operation. Every individual involved need to work and live by the clinic values. Once role players have bought in the values, they will become aware and understand the importance of this charge. A sustained understanding, desired action and reinforcement necessary to change will result. Effectively facility managers will have to ensure that everyone continually understands the purpose and vision of the clinic and the support groups, not ignoring the performance, which makes the vision real. Any changes in the purpose, will remain connected to performance. All role players will be made aware of reasons why his/her performance and change matter to the whole clinic. Managers will arrange workshop sessions so that role players can question, discuss and then adopt and identify themselves with clinic values as well as develop strong feelings of pulling together and ownership. The statements above are supported by Ellis & Fisher (1994:28) stating that mutually understood and accepted standards make co-operation, and co-ordination easier as members appreciate and take pride in them. According to the findings revealed from the empirical data, it is stated that role players are not pulling together and do not share same goals; - there is lack of sense of ownership and accountability. Policies were found to be old and never reviewed to include support group related issues. Some patients did not even know the value of support groups, because they were not communicated well. Some role players were thus rebelling and withdrawing from participating, while there were those who are not involved and less interested in support groups, and were not pulling together towards common goals. Prince (1997:29) supports this notion by stating that not everyone actively want to be part of shared governance. 

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Schwarz (1994:33) further elaborates by mentioning that members often have difficulty in understanding shared vision because it has not been explained to them or not approved of them. The cornerstone of the shared governance is to develop and create common vision and mission, strategies and shared values in order to ensure that the integrity and direction to policies, practices, standards as well as expectations are ensured.

Role players that are affected by the change need to devise means and pull together ideas and other fundamentals that guide and direct the organisation as to where it wants to be and what it wants to achieve from where it is presently. Shared values have the potential of enhancing employee commitment and effective participation. People or employees channel their reluctance into active participation. Slowly the understanding of change and the desire to participate will begin to spread and managers will seize this opportunity to drive purpose and performance. Managers need to work everyday to accommodate participative management emphasizing shared values and ownership. They need to connect purpose, and performance to achieve desired goals by correcting all the negative results that hinder the management of support groups.

The PHC facilitators' role needs to be clarified to enhance positive working relationship. Literature by various authors indicates that individuals must understand clearly what role each person plays and what behaviours people expect of each role. When roles are understood clearly and agreed upon, members can co-ordinate their actions more easily. According to Swansburg (1993:211-212) role theory indicates that when employees face inconsistent expectations, will experience role conflict leading to stress, dissatisfaction and ineffective performance. Douglass (1996:71) emphasized that systematic clarification of interdependent tasks and job behaviour is of vital importance. Tappen (1995:19) states that some roles are vaguely and inadequately defined and further says that without guidelines one cannot be sure that he/she is fulfilling the role according to expectations. PHC facilitators cited the lack of role clarity as a stumbling block on performing and completing tasks effectively. Issues such as role confusion, lack of job description, role conflict, work overload, and inconsistency were verbalized. Therefore to ensure effective performance and clear out all above mentioned concerns and achieving desired goals, role clarification is vital, all necessary legal empowering document need to be developed. Clear job description is suggested containing specifications, responsibilities and organisational relationship.

Recognition or acknowledgement oriented strategies focusing on ways in which employees are rewarded for their contributions increases efficiency in work performance. It also increases chances of obtaining desired goals. Employees' performance needs to be rewarded or recognised to enhance drive and accomplish tasks. According to Tappen (1995:67) effective managers use recognition and rewards to encourage desired behaviours and retain good employees. Knox & Irving (1997:37) states that managers have to provide reward and recognition for success in staff performance. The motivated staff takes assigned tasks seriously, plan how they can complete them, take pride and satisfaction in their achievements. They work very hard to ensure that whatever they do meets the desired standards. PHC facilitators who felt that they were not recognised or appreciated verbalized that they were experiencing burnout and felt that facilitating support group was not enriching. They emphasized the need for recognition. Swansburg
in support states that employees affected by change should receive sympathetic understanding from the nurse manager. Effective cognition programs have to be put in place in order to motivate PHC facilitators. These will uplift the morale and motivate them. According to Hellriegel & Slocum (1999:485) finding ways to ensure that employees believe that better performance will result in greater rewards is a source of continual challenge for employers. Rewards are not the only motivators of people but they are very powerful ones. When they are misaligned with organisation they can be equally powerful demotivators. Kelly (1995:11) mentions that reward structure builds a sense of gratification among individuals in the organisation.

The success of effectively managing support groups depends on the quality of support displayed by the management. Managers who can effectively influence the behaviours of others as individual and in groups, their values, their ways of thinking and doing and their expectations through support determines the success of the organisational change. Any intention and outcome of behaviours and interactions that foster and promote agreement, understanding, acceptance, guidance and teamwork by the management enables subordinate to come closer to reaching desired goals. Provision of accurate information trust respect, praise educate is viewed as supportive, and facilitates participation and the success of the clinic management. According to the empirical data, facilitators and patients with chronic diseases cited lack of support emanating from the facility managers. A strong desire for supportive management was emphasized. Hein & Nicholson (1994:234) maintains that the leader should teach empowering behaviour, provide coaching, give guidance, feedback and make suggestions to co-ordinate the self-leadership practices of others. According to the study conducted by Winn & Minnick (1996:33) they suggested a visible communication and support from top management be encouraged as well as input and feedback regarding the original plan and many revisions from managers as other ways or methods of offering support. Knox & Irving (1997:37 describe the important nurse manager’s behaviour as they relate to changing environment as follows:

- Frequent communication of plans and progress during transition.
- High visibility on work units during the organisational change.
- Verbalised commitment within the institutions for staff welfare.
- Empowerment of staff to accomplish changes for which they are responsible for
- Presentation of opportunities for staff to clarify issues in a non-threatening environment.
- Follow up on staff suggestions and questions related to the transition.
- Offers of support and assistance for problem solving during transition.
- Presentation of informational and educational programmes prior to implementation.

According to Knox & Irving, a nurse manager’s negative attitude will alienate co-workers and others with whom she or he works. As it is with the case among PHC facilitators, lack of support has a negative impact on their performance, producing feelings of neglect and isolation as they lacked guiding, coaching to problem solving. Strategies that can cement and hold a band between facility managers, facilitators and patients in general is trust and mutual respect. It is therefore essential that facility managers in Soweto clinics formulate such strategies to sustain and reinforce the sense of belonging and ownership among all role players.
Conflict situations cannot be eliminated nor is desirable. Sources of conflict within the group need to be determined, whether they are functional or dysfunctional. Where people work together conflict is inevitable it must therefore be recognised and accepted. Swansburg (1993:359) confirms this notion stating that in any organisation where people interact there is a potential for conflict. Conflict can be managed, managers and their subordinates should use conflict to solve problems, reduce frustration and enhance productivity. Knowledge about conflict has important implication for nearly all managed work. Conflict need to be confronted and discussed constructively. According Burkey (1998:82) people should be made aware of possible conflict situations that might arise so that conflicts must be anticipated and properly handled. Group members disagree, clash, quarrel and argue with one another. The dependence at times can lead people to conflict.

Some members come into the group with opposing positions, hidden agendas and difficult ideas about how things have to be done. If not properly handled can tear relationship apart, delay work. So a well managed conflict is a manager’s delight for it improves the quality of work life and stimulate motivation. Findings in the empirical data also indicate that conflict is poorly managed by PHC facilitators in Soweto clinics. This concern has been raised by patients, expressing dissatisfaction about facilitators who cannot decide but ignore instead of confronting the conflict. Conflict resolution is a major requirement or goal of participatory management Swansburg (1993:249). It is this essential that facility managers in Soweto keep and encourage a healthy working environment. This can be achieved through joint planning and, problem-solving Burkey (1998:171) mentions that participation must not only emphasise effective struggle but also constructive conflict resolution. Facility managers in Soweto clinics need to understand that conflict and cooperation are not only comparable, but most conflict occurs when role players share common goals. They argue as they set objectives as they decide how to proceed, assign task. Therefore conflict is inevitable, managers and other role players in Soweto clinics need to know how to manage it. They need to develop procedures, attitudes and skills to manage it. Shared governance enables managers to effectively manage and respond appropriately to support groups. It emphasizes the sense of common interest, hopes aspirations and co-operative dependency. Role players develop similar hopes, trust each other, feel united, and develop a “we are in this together” attitude. They share rewards and burden of their joint efforts. They solve problems together, and resolve conflicts so that they continue working together. They develop and demonstrate personal growth. Shared governance and ownership is therefore a journey based on trust, commitment, autonomy, authority accountability and responsibility. Through shared governance and ownership effective organisational change can be, renewed and restructured, all the needs, desires and expectations of role players can be met with ease.

4.3.3.3 Organizational transformation
According to Muller (1995:20) organisational transformation implies dynamic personal, professional, organisational change and renewal to meet the needs, desires and expectations in terms of internal and external environment, and as well as to accommodate the principles of participative management. Muller further elaborates that organisational transformation implies a dynamic re-engineering or re-alignment of health care vision, mission, policies and the structures. Kelly (1995:6) defines organisational
transformation, as the orchestrated redesign of genetic architecture of the organisation, achieved by working simultaneously, although at different speeds with the four dimensions of retraining, restructuring revitalisation and renewal. Therefore organisational transformation means a shift from the unilateral strict bureaucratic management to rather a collaborative and participative management approach aimed at keeping the organisation appropriately matched to the changing environment through proper planning. This implies focusing on radical redesigning the organisational context (environment tasks material), organisational development (people-focused), Organisational Process (vision, mission, values procedures). This means striving towards achieving common vision, mission and values, the right climate and empowerment. The emphasis on teamwork, caring, and moral contract with all role players is encouraged. It means a deep sense of purpose and alignment of role players with the clinic vision. Managers in various clinics need to understand that organisational transformation can be a long and difficult task that requires concerted effort to having the information gathered after environmental analyses in hand. The management can determine the performance gap between what the organisation wants and what it actually does with regard to quality management of support group for patients with chronic diseases. During this stage, facility managers need to identify sources of resistance such as fear, vested interest, misunderstanding, and different assessment of the situation. These sources may hinder effective change. Participation is the appropriate approach that facility managers need to pursue for managing resistance. Resistance becomes lower when all role players are involved and actively participate in identifying areas where change is needed. Swansburg (1993: 205) supports the above statement stating that to stiffen resistance to change is by planning with all those that are to be affected. Marquis & Huston (1994:75) confirm by stating that all individuals affected by change must be actively involved in planning for change.

To be successful it is imperative that the clinic defines itself as a service that is committed to continuous improvement and innovation, managing the culture along to create patient – focus throughout the clinic. Facility managers must develop and design strategies that will ensure that the organisation achieves its objectives. Facility managers must encourage and inspire other role players to actively participate in goal, policies and procedures formation. These must be realistic and consistent with overall goals, providing frequent opportunities for problem identification and problem solving. Managers must always monitor to assess the results. All role players, patients, facility managers and PHC facilitators have to agree, accept and be committed to the core purpose to the philosophy of partnership, vision and mission of the clinic. All marketing strategies must be developed that will encourage and increase patient participation in support groups. Strategies will inspire and stimulate staff members to identify themselves with the clinic vision and values, and develop a sense of belonging. To propel the clinic into the future, role players must be assigned responsibilities placed according to availability of skills and willingness of the person (Muller, 1996: 131). They must be encouraged to become active and accountable. They must be provided freedom to act and make informed decisions and self-reliant to develop themselves. According to Burkey (1998: 205) self-reliance means the expression of the individual’s faith in his or her own abilities and foundation on which genuine development takes place.
and identification of all those factors within the organisation that can impede or promote patient outcome and organisational transformation is important. Several important environmental forces within the organisation that determines the organisational effectiveness as described by Schulz & Johnson (1990:10) are characterised by the following:

- Environmental forces, which consist of resources, constraints, regulations and competition.
- Institutional characteristics, which implies the size, ownership and the structure.
- Patient characteristic, which predicts patient outcome, are the socio demographics and severity.
- Professional characteristics, which include technology.
- The inter- organisational relationship, which is competitive, symbiotic.
- The management practices and strategies.
- The organisational culture.
- The organisational performance, which constitutes of the functional (access, quality, efficiency and patient satisfaction) and Institutional (job satisfaction and organisational slack.)
- Patient outcomes.
- Community health (inputs to health).

The empirical data indicates that there are internal environmental aspects that impact negatively on the effective management of support groups. These are indirectly impending on the organisational transformation. Environmental aspects such as the physical structure, in terms of size, space and privacy as well staff shortage; drugs and equipment were all identified and raised by all role players. Buys (2000: 79) states that successful transformation requires adequate and sufficient provision of material resources. It is unfortunate that the inadequate and malfunctioning substandard equipment were identified and raised as one concerns by all role players. Douglass (1996:160) elaborates by stating that malfunctioning equipment causes unpleasant working condition. So it is up to the facility manager that all equipment is kept in well functioning manner. According to Rispel (2000:7) who indirectly support this notion, states that well functioning equipment is important to improve patient care. Facility managers must ensure that all equipments are in good working order. They need to put a proactive maintenance and replacement programmes in place. Well functioning equipment will facilitate implementation of strategies and desired goals will be achieved. All equipments need to be upgraded. Sufficient equipment has to be provided in order to deliver quality care to patients with chronic diseases. To respond appropriately to the organisational transformation, adequate supply of stock is required. Visser (1997:12) states that any product or service that fully addresses the needs of the customer must be available.

Shortage of drugs was raised by all role players, and viewed as a serious concern that was negatively impacting on the quality service delivery. Patient/ Customer retention and participation to support groups was affected and the sustainability of support group is threatened. Dannenfeldt (1996: 40-43) commenting on the National Drug Policy (NDP) developed in 1996 objectives states that successful implementation of the NDP depends on a commitment from all role players and stake holders. Active participation and
commitment is required from everyone. Muller (1998:6) further states that this commitment must go beyond lip service to include participation in the process of initiation review and modification to ensure that people receive drugs they need at a cost that is affordable. The National Drug Policy (SA 1996) as described by Dannenfeldt aimed at the following:

- To reach patients in a safe effective and meeting approved standards and recommendation.
- To promote the availability of safe and effective drugs at lowest possible cost.
- Ensure adequate supply of effective and safe drugs of good quality.
- Support the informed and appropriate use of drugs by the community.
- Develop expertise and human resources to support the successful implementation of the policy and promote the concept of essential drugs.
- Promote research that will facilitate the implementation.

Regarding the situation of drugs in Soweto clinics, the aims stated above are not met. Patients are sent from one clinic to the other due to inadequate, shortage of drugs. Some are not in the essential drug list. Patients are complaining daily. Physical layout of the environment is raised as a concern to effective implementation of support group. Privacy and space are seen as not adequate to accommodate all patients with chronic diseases. The physical layout of the clinics needs to be reviewed. If possible facility must be restructured to accommodate the support group services. According to Schwarz (1994:36) working environment need to match the group’s need for co-ordination and privacy, and during planning or process sessions an environment that minimizes interruptions is required. Privacy is further emphasized in the Patients Rights Charter (SA 2000) and the Gauteng Public Service Pledge, and these documents recognize and provide patients in Gauteng access to their rights such as the right to privacy terms. These clinics are not appropriately designed to meet the support groups’ related issues. According to The African National Congress (ANC, 1994:88) it is indicated that existing structures need to be improved to accommodate the anticipated clinic crowds.

Shortage of staff especially in the PHC was raised as a serious problem and negatively impacting on the service delivery and survival of support groups, is threatened. According to Bismilla (2000:7) sustainability of facilities depends on the department ensuring sufficient primary health care personnel available to staff facilities. Gerber (1995:30) confirms the statement made and states that acute shortage of staff experienced by South Africa has resulted in decreased productivity because of the lack of enough skilled employees available to cope with work allocated. Working under such conditions is creating difficulties and this quality becomes compromised quantity work result available staff is over burdened and loses interest in what they do. A mechanism need to be developed to attract PHC nurses to support group. Without those nurses support groups will not be reordered as expected and sustained. Patients on the other hand will not be satisfied about the service delivered to them.

In contrast to the negative findings revealed from the empirical data on aspect the internal environment of the organisation, with reference to patient outcome, patient expressed satisfaction on the support group management. They expressed that there was some improvement noted on the nurses’ attitude. They expressed gratitude and appreciation as
their needs were met. According to Perkins (1997:28) if the employer and employee meet the needs of the people with dignity and respect, the customers will look after them. Covey (1996:4) points out that the real challenges of leadership is to recognise that if needs of the people are not fulfilled, the neglected capacity will work contrary to their organisation, they will choose not to follow and align themselves with the vision and mission. He also suggest the five dimensions; that brings about satisfaction to people as:

- **Acceptance and love.** People have a need to belong and be accepted and engage in a win-win relationship to give and receive love.
- **Challenge and growth.** People have a need to experience challenge and opposition, to grow and develop and to be well utilised, leaders must recognise, identify and develop talent, otherwise people will go elsewhere either physically or mentally to find their satisfaction, and sense of growth.
- **Purpose and meaning.** People have a need for purpose and meaning – for making contribution to that which is meaningful.
- **Fairness and Opportunity.** People want to be recognised and rewarded.

Klakovich (1996:44) states that patient satisfaction is based on the following four dimensions; - the art of care, the technical quality of care, the physical environment and the efficacy, as well as the attributes and behaviours. Patients need to be respected, trusted listened to and their contributions valued. All factors that have an invest relationship to patient satisfaction must be avoided; behaviours that are perceived negative are abruptness, disrespect and behaviours that elicit shame, guilt or emotional or physical pain. (Klakovich 1996:44) must be avoided at all times.

The ability of facility managers to sense environmental change whether it carries threats or opportunities is essential. In order to rethink, and radically redesign the organisation in accordance to the environmental changes encountered. Each aspect within both internal + external environmentally is judged and where necessary, renewed, scrapped or restructured to accommodate participative management and meet the needs desires and expectations of those providing and receiving the care.

### 4.3.3.4 Empowerment/ enablement
Empowerment usually takes place during implementation and evaluation phases. Muller (1995:20) defines empowerment as a deliberate planned social process of recognizing, promoting and enhancing people’s abilities to meet their needs, desires and expectations related to participative management in a health care organisation. The personal and professional development of every staff member in the unit to facilitate participate management is imperative, and cannot be overlooked. Buys (2000:75) confirms this statement by stating that empowerment is an unavoidable consequences of participative management. During this phase an environment that encourages all role players to work towards achieving their potential is created. Existing values are being revised, new values defined to accommodate participative management. Advantages of empowerment according to Tebbit (in Naude 1997:35) include the following:

- **Emphasis on collaboration, compromise and consensus building as problems and people are dealt with directly.**
- **Promotes seeking of productive solutions to problems – it facilitates involvement and commitment A “can do” attitude and a high energy level is sustained.**
➢ Promotes self-expression and self-growth.
➢ It is a way of getting the best from the leader and followers by enhancing and expanding personal skills.
➢ Improves customer service (quality nursing unit management).
➢ Enables the organisations to react quietly, appropriately and effectively to a fast changing environment.

Through empowerment role players develop and increases their decision and problem solving skills, as well as sense of control. They are allowed to make own decision and accept the consequences, there of. The facility managers educate, and then delegate authority, and autonomy to enhance feeling of commitment. Chalton (1992:33) states that empowerment is the act of investing and authorizing where people are enabled to achieve goals. To empower role players facility managers need to be self-empowered, to enable them to use their skills, knowledge and experience to the fullest. Muller (1995:20) bases empowerment for participative management on the following:

➢ Mutual respect among role players.
➢ Transformational leadership.
➢ Total involvement of role players in the implementation of change.
➢ Deliberate disempowerment of traditional practices.
➢ The support, counselling, educating, acting as a resource person, advocate and enabler.

Patients in all eight clinics felt very much empowered. They all perceived support groups as empowering, expressing feelings of self directedness, and equipped to take control of their own lives. Some even mentioned that they could identify problems make decisions and find solutions. They want on to express that they were fully supported and guided by their facilitators. However, empowerment is that knowing the what, why, how, when of a needed action. Therefore facility managers and facilitators need this to be equipped with relevant and appropriate skills, knowledge before they can empower their patients with necessary skills. Investment in new knowledge and education is very much important, inability to realise that can be a hindrance to empowerment for participative management. Crow (1996:63) points out that it is an unacceptable risk to rely and learn duties and responsibilities from past experiences in today's dynamic and ever changing environment, which is increasingly placing pressure upon individuals. Staff development is essential in any organisation and should form an integral part of every organisation's manpower training policy. Investing in staff has positive effects in participative management, like identification with the organisation, better understanding of organisational values, and increased participation among role players. The survival and sustainability of support groups depends upon the facility managers and facilitators ability, knowledge and skill to facilitate, manage and empower patients. They are expected to facilitate and manage groups successfully despite whether they have appropriate skills or not. They are expected to make it right from the start. They are faced with a mammoth of a task. They have to implementing newly designed models and measure successful patient programmes. They are also expected to set rules, take responsibilities, structure and direct at a content level. They are expected to stimulate self-development, team building, as well as cross cultural communication among patients.
However this is not easy and possible to meet these expectations, because there is lack of appropriate skills, knowledge in facilitation and managing support groups. The solution to this is relatively simple. The training and development system geared at supplying necessary skills is needed and must be put in place. It has to be well planned, structured and integrated, to improve and develop facility managers and facilitators skills, in order to enhance psychological quality work life. Each clinic then faces a task of training and developing their personnel affected by support groups. No matter what approach they apply, continuous skill building is imperative if they hope to sustain the support groups. All the opportunistic, disorganized, and haphazard way of managing will have to come to an end. Training must be shaped to long-term skill retention, emphasising on the transfer of skill to work setting. Such type of training will ensure that role players are competent and motivated to do their work. Schalkwijk (1997:6) in support of this notion states that it is the responsibility of business tenders and management to ensure that people are competent, committed and motivated. He further says that an organisation that gets that right will be a winner.

Livni (1996:53) states that training focuses on the ability to perform and improve competence, and further points out that managers can be measured by the efficiency and effectiveness of the unit they manage. As evident in the empirical data, a desire and compelling hunger for knowledge, skill development and training and competency in application was expressed by PHC facilitators and facility managers. They verbalised the need to keep themselves updated, keeping on tract with current knowledge, while some wanted continuous in-service training. Maister (1996:44) points out the fact that continuous professional developmental opportunities must be offered to all those who have identified the need to develop their skill and continuously build on the existing skills, so as to meet challenges of changing environment. Avolio (1996:12) echoes the same sentiments as Maister stating that transformation leaders have love for learning they don’t want to just exist, but want to continue to add to their intellectual capacity. Both role players indicated the need to have appropriate facilitation skills. Cilliers (1996:36) points out that training facilitators in terms of necessary facilitation skills is critical, because facilitation is misused to control and manipulate groups to suit the needs of the authority and at the same time, possibly hurting people and processes. Facility managers have to encourage a culture of life long learning to foster personal and professional growth of those being empowered and those empowering others. Every role player will be prepared for his or her roles. Continuous and growth and development through continuous in-service training, seminars, conferences workshop must be often conducted to keep themselves abreast with current support group related issues. An ideal training and skills development will include the following:

- All facilitation related skills issues such as the influential skill, which is characterised by coaching, advising, enabling and empowering skills.
- The must also include change management skills so that role players respond to change, cope with the uncertainty of managing support groups.
- Change management skills will enable them to manage multiple assignments of facilitating groups and will enable them to practice their daily PHC routine duties.
- The interpersonal skills where they can learn about encouraging collaboration, appreciate diversity must also be included.
Conflict management skills are a must to be included in the training of facilitators. Poor conflict management was raised by the patients. According to Cremer (1980:22) conflict disrupts vitality necessary for co-operation and coordination. Understanding the source of discord, and selecting effective resolution techniques greatly influence the nurses’ effectiveness in managing conflict.

Time management is another aspect that must be included. Facilitating and managing support groups need effective time management. There are constant pressure, due dates that can affect the attainment of goals. Both PHC facilitators and patients with chronic diseases expressed lack of sufficient time.

As discussed in chapter three facility managers, PHC facilitators need to have more knowledge about time management in order to create workable time frame, and complete their tasks successfully.

According to Schwarz (1994:31) states that a group needs time to complete its tasks and the two kinds of time need is process time and performance time.

Douglass (1996:154) points out that many daily pressures can be reduced through effective time management.

Group dynamics is another important aspect that needs to be looked at and must be included in the training of facilitators. Seago (1996:39) states that it is important to understand the individual work group because to assist managers in decision making about education program or hiring and orienting new people. Therefore understanding group dynamics could assist the facility manager in decision making about forming and managing groups. PHC facilitators and facility managers have to know and understand group dynamics very well if they hope to sustain their groups. Group formation is very important, how to manage is even worse. As indicated in the empirical data, some members do not get along well; in some groups, members have expressed a feeling of are frustration and even think of quitting. Some do not even understand the importance of support groups. As a result most of the group are ineffective, their survival is threatened, and some have even ceased to exist. To contribute towards group effectiveness, facility managers and facilitators need to undergo group dynamics training to determine group members’ behaviour and recognise elements that contribute to group ineffectiveness. According to Muller (1996:257) identification of group objectiveness will keep the functioning of a group in focus. Schwarz (1994:29-30) states that an effective group requires an effective structure characterised by clear goal, membership, motivating tasks, group roles and norms, sufficient time and effective group culture. Training is thus essential for the success of participative management (Swansburg 1993: 255). Empowerment / enablement is essential for participative management, very much essential for equipping role players and for sustainability of support groups. Tasks get accomplished; implemented problems get solved, and well managed. Enablement is not just something nice to know but the key to personal and organisational success. Role players develop to know their present ideas, understand new ones and their implications. They need to experiment with applying ideas and reflect on the ideas. Facility managers need to acknowledge that empowerment is essential to empower others to discover and use their unique skills, knowledge, experience and creativity. Empowerment through participative management encourages role players to take responsibility for the success of the organisation. It promotes active participation and job satisfaction.
4.4 SUMMARY
In this chapter, the researcher has described a conceptual framework for the management of support groups for patients with chronic diseases, based on the results and relevant literature in chapter 3. Also, a participative management process in which four dimensions namely, interactive decision-making and problem solving, shared governance, organisational transformation and empowerment have been described. While it is apparent that some role players have adopted participative management approach to further the aims of support groups and improve service delivery, role players in other clinics are still struggling to cope with management of support groups. Forging of lasting relationship and participation between role players where support groups are not well managed is viewed as urgent, and a challenge in bringing about quality management of support groups. The concepts derived from the conceptual framework will be utilised to develop guidelines for quality and sustainability of support groups. These guidelines will be used by all role players to guide and direct them in the management and evaluation of the quality of management of support groups. A schematic presentation of conceptual framework is shown in figure 4.4 in the next page. The guidelines for quality management of support groups are presented in the next chapter.
FIGURE 4.5. CONCEPTUAL FRAMEWORK FOR THE MANAGEMENT OF SUPPORT GROUPS FOR PATIENTS WITH CHRONIC DISEASES.
CHAPTER 5

OVERVIEW, RESEARCH DESIGN, RESULTS, GUIDELINES, RECOMMENDATIONS, EVALUATION AND SUMMARY OF THE STUDY.

5.1. Introduction
In chapter three and four, the results were discussed and compared with relevant literature. The conceptual framework based on the results was developed in relation to relevant literature. This chapter constitute the overview of the study, guidelines based on both the results and the conceptual framework, recommendations, evaluation and summary of the study. As the need for establishment of support groups for patients with chronic diseases was identified, it is vitally important that all role players become actively involved and participate in the management and sustainability of these support groups. Managing the support groups is very challenging; there are many problems that the role players encounter, which in turn affect the quality management of support groups. Therefore, this raised concerns and a desire to explore and describe the experiences of the role players regarding the management of support groups.

5.2. OVERVIEW OF THE STUDY
This study arose from the researcher's observation that primary health care facilitators in Soweto clinics were experiencing difficulties in managing support groups for patients with chronic diseases. As the study progressed, it became more evident that they were experiencing more pressure and resistance from the management, thus making management of support groups more difficult. They experienced issues such as lack of support, lack of guidelines and lack of acknowledgement. There was a lot of dissatisfaction, some facilitators even wanted to withdraw while patients on the other hand openly rebelled against the support groups. The progress was uneven and the majority of support groups were gradually dying and only a few were sustained. The research question posed for the study was, what are the experiences of the role players with regard to management of support groups for patients with chronic diseases? The objective of this study was to explore and describe the experiences of the facility managers, PHC facilitators and the patients with chronic diseases regarding the management of support groups in Soweto clinics. Secondly, it was to formulate the guidelines for quality management and sustainability of support groups of patients with chronic diseases in Soweto, in order to enable and empower all the role players regarding management of these groups. A qualitative, explorative, descriptive and contextual study was conducted to answer the above question. Phenomenological focus group interviews were conducted, with each group consisting of facility managers, primary health care facilitators and patients with chronic diseases respectively. All these interviews were conducted in a central venue conveniently selected by the participants.
5.3. RESULTS
The results of the focus group interviews revealed both positive and negative experiences that were expressed by role players. These results were then categorized into management and facilitation themes, of which positive and negative experiences were identified. The experiences that impacted positively on the management function were community participation; patient directed service and cost effectiveness. The positive facilitation results identified include participative approach, empowerment, patient satisfaction as well as professionalism. The experiences that impacted negatively on the management function were lack of supportive clinic policies, lack of role clarity, poor communication, lack of support, lack of recognition, lack of training and development, lack of conducive environment and free primary health care services. The negative experiences identified that impacted on facilitation function were lack of sufficient time, poor group structuring and poor conflict management. The conceptual framework which consisted of six dimensions namely, the context, role players which included Facility managers, PHC facilitators and patients with chronic diseases; purpose, to ensure quality management of support groups and sustainability as well as patient satisfaction; dynamics were categorized into internal and external forces. All internal and external factors impacting on the management of support groups were identified and discussed. The process adopted, was the participative management process described by Muller (1995:15-21). This process is characterised by four management activities namely, interactive decision making and problem solving, shared governance/ownership, organisational transformation and empowerment/enablement.

5.4. GUIDELINES FOR QUALITY MANAGEMENT OF SUPPORT GROUP FOR PATIENTS WITH CHRONIC DISEASES.
As stated in the previous chapters, the overall purpose of this study is to formulate guidelines for quality management of support to ensure its sustainability as well as providing satisfaction to all role players. The important aspect about formulating these guidelines is that they will form a solid foundation for the quality service delivery within the PHC clinics in Soweto. Role players to meeting their needs will also utilize them as a planning tool. To ensure that the purpose is realized, the guidelines will be formulated within specific dimensions of quality, characterized by appropriateness, acceptability, accessibility, effectiveness, efficiency, continuity, equity, inter- personal relations, competency as well as safety. The information drawn from the results will be utilized to formulate practical guidelines that are also essential and comprehensive and that will describe experiences identified. The guidelines are formulated, interpreted and classified into three sections that address service delivery, management process and community satisfaction. For the purpose of clarification, a schematic presentation of guidelines is provided in figure 5.1. For each, the detailed description of related components are discussed.
5.4.1. Service Delivery
The vehicle to ensure that quality management, sustainable support groups and patient satisfaction is achieved, depends on the nature of service delivery that provides skilful and sound management. Service delivery in relation to this study refers to the provision of management activities that effectively accommodate the needs of the role players. The core managerial activities being communication, policies and procedures, role clarification as well as conducive environment.

5.4.1.1. Communication
Effective communication cannot be ignored, as it is the vehicle towards achieving organisational excellence. Communication is the chain of understanding that integrates the role players in an organisation from top to bottom, bottom to top and side-to-side. Through communication one can coach, coordinate, counsel, evaluate and supervise. It is therefore important that managers take and implement the following suggested solutions towards effective communication:

- Remove and avoid all barriers to effective communication, things such as bias, background, notice, perceptions and the “Me” generation.
- Become an active listener that listens with a purpose.
- Provide feedback timeously.
- Provide a formalized consultation system, arrange regular meeting, and organize workshops.
- Provide with information to affected by means of newsletter, memos, telephones, and hold regular meetings.
- Provide opportunities for people to freely and openly state their opinions.
- Discuss matters of importance, with specific focus on the management of support groups.
- Transparency about information that requires consultation must be encouraged.

5.4.1.2. Policies and procedures
As previously indicated, it is imperative that policy regarding effective provision of support groups to be formulated will mandate and direct how a service has to be managed. They mandate and direct how a service has to be managed. They act as a vehicle towards reaching a desired destination. They will assist people to plan in accordance with organisational policies. They enhance positive performance among staff. Policies are a means through which objectives are expressed. They also act as constraints or control towards a course of action that is to be followed. A need for a local comprehensive and integrated clinic policy has emerged from the empirical data. PHC facilitators have expressed this need to include support group related activities into clinic policies, so that they can manage support groups within and in accordance with the policies. It is therefore important that:
- Existing clinic policies are reviewed periodically and updated.
- They must be communicated to all role players and ensure that they are well understood so that people can buy-in and align themselves with.
- Policies must be clearly written and explicit.
- Management must ensure that all support group activities are included.
- New policies must be developed in consultation with all those affected.
- Design policies and procedures to support and assist facilitators to perform their role effectively.

5.4.1.3. Role clarification
Role clarification remains the facility manager’s responsibility. Managers need to clarify PHC facilitators’ role with regard to management of support groups. Clarifying role will decrease dissatisfaction, reduce stress, prevent confusion and ambiguity, and positively increase performance effectiveness. So in order to prevent dissatisfaction, but promote some sense of responsibility among PHC facilitators. The facility managers will have to consider the following aspects:
- Develop a job description containing specifications, responsibility and this must be written in a statement form.
- Role must be clearly defined.
- Time frame must be clearly specified for each activity.
- Orientate on the role job description for effective work.
- Make copies available of job descriptions and copies to all teams.
5.4.1.4. Conducive environment
Management should remain responsible for providing a conducive environment where the PHC facilitators can satisfactorily manage and facilitate support groups. They must create a context within which patients can achieve their goal. Environmental factors such as the physical structure in terms of space and privacy, drugs, equipment are aspects that can either enhance or impact negatively on the quality management of support groups. It is therefore important to ensure that support groups are rendered in a reliable and conducive environment.

- Space
  The physical layout of most the clinics in Soweto are inadequate to accommodate support groups. There is a need to review the present facilities. The designs and size of these clinics need to be restructured to accommodate large numbers of support group members. Facility managers need to motivate for bigger space. It is therefore important that:
  ➢ Construction of clinics with spacious and adequate rooms to accommodate support group services is necessary.
  ➢ The physical structure of the clinics must be user-friendly.
  ➢ Upgrading of existing clinics in order to meet the needs of the patients.
  ➢ The venue must be suitable for support groups for rendering activities.
  ➢ There must be enough furnisher e.g. chairs.
  ➢ Must be well-ventilated, draught tree and be comfortable.
  ➢ Try to choose a room/space that is as appropriate as possible to the type of session planned for that day.

- Privacy
  Due to inadequate space in the clinics, it is not possible to offer total privacy and confidentiality when need arises. Some of the procedures are not properly done due to lack of privacy. Therefore the following suggestion are made:
  ➢ Presently more time and special room must be arranged temporarily for procedures that need total privacy and confidentiality.
  ➢ A temporal space for conducting such procedures must be seen a priority in the physical layout of the present clinics.
  ➢ Flexibility and collaboration among staff members who are not facilitators must be promoted so that they adopt to changes to meet present needs.
  ➢ Provide a quiet and private room for the duration of the session.

- Equipment
  Equipment is an integral part of service delivery. It is therefore necessary that adequate equipment be provided to effective quality support service. The following suggestions need to be taken into consideration:
  ➢ Provision of high standard equipment.
  ➢ Developing a system for regular checking of faulty equipment.
  ➢ Developing a maintenance and repair programme that is flexible and can adapt to the needs at particular time when need arises.
  ➢ Provision of user-friendly equipment.
  ➢ Implementation of cost awareness programmes to prevent waste.
  ➢ Motivation for new equipment where necessary.
Drugs
Drugs have to be available at all times for optimal health care delivery. The existing shortage of drugs to the quality management and sustainability of support groups and patient satisfaction, therefore the following points require attention:

- Effective use of drugs by using protocols.
- Drugs to be dispensed as in accordance to the essential drug list.
- Conduct workshops on the essential drug list among facilitators.
- Ensure that all drugs on essential drug list are available.
- Avoid crisis situation by implementing prompt, enough and timeous ordering system.
- Check regularly for expired drugs.
- Ensure that drugs reaching the patients are always safe and effective and meet set standards and specifications.
- Develop system for effective continuous patient education on drug care, on issues such as importance of compliance, abuse of drugs where patients “shop around” unnecessarily for drugs.
- Encourage and provide for drug management courses where staff can be updated.
- Keep drugs in a safe locked area to prevent loss.

5.4.2 Management process
Managers who make the difference in an organization are those who, regardless of job or level, figure out how to plan, organize, lead and control people, ensure that activities are being performed and facilitate change, growth and learning among individuals. In the context of this study, the management process refers to all the activities that the PHC facilitators and facility managers have to undertake in order to ensure that quality management of support groups is rendered. The management process is based on the following:

- Participative management
- Conflict management
- Time management
- Human resources management

5.4.2.1. Participative management
Involvement of all role players, not only in daily practices/activities but also in management activities and decision-making enhances quality service delivery and quality work life within the workplace. It promotes greater motivation and satisfaction among employees. It is therefore important that facility managers actively involve PHC facilitators in the planning and implementation of support group related programmes. The following are suggestions that can be applied for participative management within the workplace to facilitate quality service delivery:

- Create a climate of openness to facilitate problem solving and interactive decision-making by joint planning, consultation, consensus and negotiation.
- Facility managers to facilitate rather than direct, instruct or prescribe to facilitators.
- Have regular interaction to hold meetings with all relevant role players.
- Empowerment/enabler of all the role players to increase efficiency and high performance.
- Improve clinic communication by providing opportunities to all role players to ventilate ideas without any fear of victimization, provide feedback and always-keeping channels open.
- Provide autonomy by allowing role players to make decision, and delegate authority, responsibility and accountable.
- Involve all role players in undertaking activities such as creation of awareness.

5.4.2.2. Conflict management
Conflict between individuals and groups in the work place and among groups is a common and inevitable aspect. If not properly managed it can hinder quality service delivery. Employees need skills to manage conflict well. A criteria that is effective and that can be used to deal with conflict is suggested as follows:
- Develop a climate in which it is fine to conflict.
- Indicate that everyone benefits from a resolution.
- Emphasise organisational goals and dependency.
- Do not blame others for the problem.
- Never make others look weak and incompetent.
- Do not brag that you out witted others, and concentration on another’s weaknesses.
- Build a bridge of understanding.
- Keeping communication open to all role players.

5.4.2.3. Time management
Time management is important to set and adhere to deadlines and to accomplish tasks. Facility managers need to arrange courses where role players (PHC facilitators) can undertake time management courses, so that they can accomplish their tasks. The following recommendations are made:
- Set time limits for all tasks and adhere to them.
- Develop a work plan with specific time allocations for daily activities.
- Prioritise all the activities, considering elements of urgency and importance.
- Arrange in-service training and workshops on time management.
- Avoid interruptions during activities.
- Be conscious about on and off duty times.
- Develop techniques to manage interruptions.

5.4.2.4. Human resources management
The sustainability of support groups depends on successful human resource management. This requires an over emphasis on efficient and effective management and utilisation of available manpower to optimal levels, to achieve most of desired organisation objectives. Human resource management within the context of this study is based on the following activities, staffing/workload, recognition, training and development, empowerment and management support:

- Staffing/workload
Shortage of staff is a threat towards effective and excellent service delivery. It creates added responsibilities to the already over worked nurses. To achieve the desired goal, effective staff utilisation is essential. This requires the following:
- Equal and fair delegation of duties.
- Reduce workload by making use and actively involving members of support groups in performing non-nursing duties such as health education, recruiting of new members.
- Encourage special clinic days, repeat system for patients with chronic diseases to minimize overcrowding.
- Provision of adequate personnel to facilitate quality care.
- Perform need analysis pertaining to personnel to address imbalances.

- Recognition
Recognition and acknowledgement of talents, performance and experience of individuals is crucial in bringing about progress and facilitating the achievement of desired goals. Therefore it is a requirement that facility manager’s give acknowledge and recognition where it is due. The following are required:
- Develop moral and team spirit.
- Provide with recognition and reward to bring about a feeling of being honoured.
- Give praise and show appreciation to committed individual.
- Reward performance that sets good example for others be a role model.
- Create reward system that works like rewarding critical performance rather than routine tasks.
- Let role players be part of planning and problem solving process.
- Staff appraisal for performance at least quarterly must be done.
- Allow needs of the role players to coincide with the needs of the organisation
- Make the work of facilitators challenging exciting and meaningful.

- Training and development
Training and development of role players is necessary for acquisition of skills, rules, personal knowledge and right attitude for effective management and facilitation of support groups, as this is a new concept in Soweto. Staff needs to acquire appropriate skills, knowledge in order to increase performance. To make this a reality, the following critical success factors are applied:
- Continuous in-service education programmes are planned to keep staff abreast with current support group related issues.
- Arrange seminars and workshops to improve knowledge and skills as well as competencies, on facilitations and group related issues.
- Encourage short courses for staff.
- Develop a staff development programmes, and encourage staff involvement.
- Delegate by authority and facilitate learning.
- Develop a success orientation and expectation programme to address-to-address change necessary for quality for quality service delivery and individual skills development.

- Empowerment
Patient empowerment through participation can successfully help patients to drive the support groups towards quality service delivery and the sustainability of the groups. Patients need to be empowered to create change in the power balance between the health provider and themselves. This shift is necessary to enable them to take control of their own lives. Empowerment patients facilitate and create an environment for participation,
and betterment of patient care. To achieve this goal, patient empowerment requires the following:

- Empowering patient with decision-making and problem solving skills.
- Develop and properly design patient education programmes, focusing on patient needs, prevention, early detection and treatment regulatory.
- Develop a comprehensive list of community empowerment projects in which they will take charge, and drive the process.
- Create an open climate where patients can utilise their unique skills, knowledge, experience and creativity to the fullest i.e. facilitate change while using local potential and resources.
- Stimulate by expressing the benefits that empowerment can bring to individuals, the group and the service.
- Monitor the progress and continuous evaluation of charge.
- Promote healthy life styles through health promotion, education and self-care.
- Develop and organize information booklets for group members.

- Management support

Management support is essential for promotion of personal and professional growth of staff in terms of skills and competencies necessary to achieve organisation goals. Managers will have to promote a supportive climate to all role players. The support expected is both human and material support, which form part of quality service delivery and human resources management. For effective management it is important to take note of the following:

- Provision and supportive climate characterised by trust and respect.
- High visibility of management support, where the manager is seen going from one department to another giving word of encouragement to role players and support groups.
- Be friendly; approachable and show concern to all role players.
- Active involve all role players in planning and decision making in matters that affect them.
- Formulate strategies that will reinforce the sense of belonging and ownership.
- Put people in position to learn by doing and provide them with information and support.
- Effective and open communication must be encouraged at all times.
- Guide, provide coaching, feedback and make suggestions to co-ordinate self-leadership.

5.4.3 Community satisfaction

Since support groups are a patient directed service, they need to provide satisfaction to community needs. This service needs to be accessible, accepted and affordable at all times. It is important that the patients and the community as the recipients and drivers of this service receive what they perceive as a necessity and satisfying their needs. To address the expectations, the needs and desires of the community, the following suggestions need to be taken into account:

- Batho-Pele principles
- Patient satisfaction
- Community participation
5.4.3.1 The Batho-Pele principles
The vision for providing an efficient, effective and sustainable support groups is to meet the needs of the community. It is therefore important that these needs are addressed. The effective way of meeting these needs is best summarized in the Batho-Pele white paper. The Batho-Pele contains a vision for managing performance. It is not just aimed at providing services but also at improving service delivery. The application of the Batho-Pele principles within the support groups will form basic guide towards the desired delivery goals. The Batho-Pele framework consists of eight service delivery principles:

➢ Consultation
Regular consultative sessions with all the role players must be encouraged where everyone involved can state their point of view with regard to the service delivery. The patients must be given a choice about the way support groups are managed.

➢ Service standards
The community must be informed about the level and quality of the management of support groups. Policies and procedures must be communicated to all role players.

➢ Access
The patients and community must have access to support groups services to which they are entitled. The support group services must be marketed to all members of the community who are not aware of such services. Creation of awareness must be undertaken.

➢ Courtesy
To ensure courtesy the facility managers must specify the standards in which the members of the groups should be treated. The standards should cover among other things, the ordinary good manners.

➢ Information
All patients with chronic diseases and their families must receive full and up to date and accurate information about the support groups. The information must be provided in a variety of languages to meet the differing needs of the patients.

➢ Openness and transparency
Members of the support groups must be kept updated about everything that influences the progress of support groups. The progress and wellbeing of the support groups as well as the resources must be communicated to the members. All role players must be involved in the planning, scrutinizing and monitoring of support groups related activities.

➢ Redress
The capacity and willingness on the side of the facility managers and PHC facilitators to take action when support groups are not well managed is the way to take. They have to take full account of the whole management of support groups.
Value for money
Support groups must be managed within the appropriate standards of quality, time and cost that are affordable to all patients and community.

5.4.3.2 Patient satisfaction
The high levels of patient satisfaction is linked with quality care. Factors that positively contribute towards patient satisfaction which need to be considered are:

- Provision of quality care.
- Provision of autonomy to patients so that they can exercise own judgement.
- Be sensitive to patients needs, be flexible, and make slight adjustments to accommodate them.
- Keep group alive and healthy and prevent stagnation and boredom setting in.
- Have regular interviews with patients to identify their needs.
- Respect and value everyone's contribution.
- Patience, friendliness and sincerity are positive attributes that are necessary for patient satisfaction.
- Active involvement of patient in decisions making and problem solving in all matters that affect them.
- Effective and open communication is a must towards patient satisfaction.
- Provide support at all times, guide, coach when need arises.
- Respect and treat them equally irrespective who they are and where they come from.

5.4.3.3 Community participation
Community participation in health care delivery promotes self-reliance, sense of ownership among group members. Community participation contributes towards sustainability of support groups. Patients tend to assume their role as integral part of the health team. They start to realise the importance of taking charge of their own health. To ensure and promote community participation among patients and community members into health care delivery, the following suggestions are made and recommended:

- Establish support group committees with members of groups.
- Involve all role players in projects that are community or people driven.
- Propose and recommend aspects of development to ensure that all available and planned resources are used to the best of community.
- Ensure that all role players are involve in planning, managing delivery, review and evaluation of support groups.
- Consult affected parties and role players on all proposals before forwarding to relevant authorities.

5.4.3.4. Group structuring
A well-structured group is a prerequisite to its sustainability. An effective group requires an effective structure. So a well-structured group is characterised by roles, norms, size shared values and beliefs. Managers need to ensure that effect group structures are developed for its sustainability. They need to take into account of the following group development activities these include:

- Establish ground rules at the outset.
- Ensure that there is open communication and trust between members, where group members are free to express attitude and discuss tasks frankly.
➢ Ensure that there is mutual acceptance among group members to facilitate information sharing.
➢ Ensure that motivation and productivity is enhanced to facilitate cooperation among group members and tasks will be creatively performed.
➢ Encourage the development of members and roles within the group.
➢ Take objectives of the group members and group as a whole into account, as well as keeping to the set ground rules.
➢ Ensure that the group has all the group-components that make up a well-structured group such as size, members, roles and group norms.
➢ Group goals must be in line and consistent with the mission and vision of the organisation.
➢ Set up strategies to minimise group dominance among group members.

5.5 CONCLUSION
The following conclusions are made:
• The experiences of primary health care facilitators, facility managers and patients were explored and described.
• The results consisted of positive and negative experiences. The positive facilitation results identified included participative approach empowerment patient satisfaction. Positive management results identified were community participation directed service and cost effectiveness. The negative results identified on management function included aspects such as lack of supportive clinic policies role clarity, poor communication, lack of support, lack of recognition, lack of training and development, lack of conducive environment and free primary health care services. The negative experience identified that impacted on facilitation function were lack of sufficient time, poor group structuring and poor conflict management.
• Similarities and differences between the role players were also identified.
• Guidelines for management of support groups were formulated in relation to the results identified. These guidelines were classified into three categories namely service delivery, management process and community satisfaction.

5.6. RECOMMENDATIONS
The following recommendations are made based on the results of this study as follows:
➢ The guidelines must be implemented to ensure that quality management and the sustainability of support groups and patient satisfaction are achieved.
➢ A continuous evaluation and monitoring of the quality management of support groups for continuous improvement of service delivery.
➢ The development, implementation and evaluation of skills development programmes on management of support groups for patients with chronic diseases will empower the role players and enhance quality management and sustainability of support groups.
➢ Further research in quality management of support groups and the relationship between quality and other dynamics/variables.
➢ The relationship between the participative management and the outcome of the support groups for patients with chronic diseases should be enhanced to ensure quality management of support groups and community satisfaction.
5.7. EVALUATION OF THE STUDY
The evaluation of this study is based on the limitations and contributions encountered through the research.

5.7.1. Limitations
The following are regarded as the limitations encountered:
• Permission to conduct a study.
  There was a delay of six months before the permission was granted, thus data collection had to be postponed until the permission was obtained.

• Population and sampling.
  Of the initial twelve Soweto clinics, only eight clinics with accessible participants were included in the study. Within the participated clinics two facility managers excused themselves. This made it difficult to generalize beyond the context of the study. The results might be biased especially with regard to the facility managers. Initially, some primary health care facilitators were reluctant to participate, as they feared victimisation and intimidation, which created another delay.

• Resources
  The available Soweto clinics library was under equipped had no relevant support group-related material. This created difficulties in having access to information.

5.7.2. Contributions
• The results of the study provide a tool that can be used to enhance and improve the quality management of support groups in Soweto clinics.
• The study in general has brought to light all positive and negative experiences within the context of Soweto clinics, that either contributed to the survival or demise of support groups of patients with chronic diseases.
• The study clarifies the challenges that the facility managers and primary health care facilitators are faced with in managing support groups effectively and efficiently.
• The results of the study enable the researcher to develop the guidelines, which will give direction to be pursued in managing support groups in a sustainable manner.
• The study has improved the relationship between all the role players and strengthened the partnership.

5.8. SUMMARY
The overall purpose of this study was to develop guidelines that will enhance the quality management of support groups of patients with chronic diseases in Soweto clinics. The above purpose has been realised in that the researcher managed to develop these guidelines. The recommendations were made in quest for wholeness. The study was evaluated based on the limitations and contributions. The value of this study will be determined by the applicability of its findings to improve the support services for patients with chronic diseases and the nursing practice in general.
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ANNEXURE 1

LETTERS TO CONDUCT A STUDY

(i) Request for permission to conduct research study (District Health).
(ii) Request for permission to conduct a research (Clinics).
(iii) Request for consent from participants.
(iv) Permission to conduct a research study.
A copy of the research results will be made available to you on completion of the study for future reference and review of guidelines with regard to facilitation of support groups.

Hopefully this will be of great benefit to your region/district the PHC Nursing facilitator, facility manager as well as the patients with chronic diseases within support groups, as it will have addressed the concerns with regard to facilitation of support. It will also help in the rendering/delivering of effective, high quality support group services which is important for ensuring sustainability and cost effective chronic disease care.

Should you have any questions with regard to this study I will be available, and indeed pleased to answer them.

Thank you in anticipation

Yours faithfully

Ms BONGI P ADAMS
M. CUR. STUDENT: PROFESSIONAL NURSING MANAGEMENT

MARIE MULLER (PROF)
SUPERVISOR
THE FACILITY MANAGER  
Mofolo C.H.C

Dear Madam

REQUEST FOR PERMISSION TO CONDUCT A RESEARCH STUDY.

I hereby request permission to conduct a research study on “MANAGEMENT OF SUPPORT GROUPS FOR PATIENTS WITH CHRONIC DISEASES” as part of the requirement of the Masters degree in Professional Nursing Management at the Rand Afrikaans University.

A focus group interview on patients with chronic diseases actively participating in support groups of your health centre will be conducted. Patients will be asked to freely describe their experiences with regard to facilitation of support groups, and how their needs can be met through quality facilitation that will be provided by the Primary Health care Nurse facilitators. The interview will be conducted during their general meetings to avoid any disruption of services.

Should you have any questions with regard to this study I will be pleased to answer them.

Feel free to contact me at the following numbers:

(011) 623 – 2962 (H)  
(011) 936 – 5496 (W)  
082 829 7654 (Cell)

Yours faithfully,

Bongi P. Adams  
M. CUR (PROFESSIONAL NURSING MANAGEMENT) student.
Dear Participant

REQUEST FOR CONSENT FROM PARTICIPANTS

I intend conducting a research project/study on “MANAGEMENT OF SUPPORT GROUPS FOR PATIENTS WITH CHRONIC DISEASES” in Soweto Community Health Centres, as part of the master’s degree in professional nursing management under the guidance and supervision of Professor Marie Muller from the Rand Afrikaans University.

The overall goal of this study is to DEVELOP GUIDELINES FOR QUALITY MANAGEMENT OF SUPPORT GROUPS that can be utilised and followed by the Primary Health Care Nurse facilitator during facilitation of support group for patients with chronic diseases.

This study will be of great benefit to you directly as the guidelines will be used as a tool towards ensuring sustainability of support groups and attainment of cost effective chronic disease care, as well as providing with basis for planning and evaluation of support group activities. Also will be of help the Primary Health Care Nurse towards improving the facilitation skills which are important for successful efficient sustainable support groups.

The patients with chronic disease too will directly benefit from this study as quality facilitation will be provided towards quality support group service delivery in terms of how well their needs and expectations with regard to facilitation are met. Thus quality patient care and service delivery which is increasingly becoming important in health care delivery will be ensured.

To achieve this goal, I hereby request for your consent to participate in this study, and your permission will be highly appreciated. A focus group interview will be conducted for a period of 1-2 hours with a break in between, whereby your experiences with regard to facilitation will be explored and described.

A tape recorder will be used with your permission as a tool to collect information, store, verify and analyse the collected information. The recording will be kept under strict safety, and will be immediately destroyed after completion of study. Follow up interviews will be conducted where necessary to ascertain if the information collected was indeed described by you.

Precautionary measures will be taken during interview. Anonymity and confidentiality is guaranteed as no information will be linked to your name nor the name of your health centre. If you agree to participate in this study an informed
consent is necessary from you as an agreement to participate. A space will be provide below for you to attach your signature.

Your participation is voluntary, as you are not under any obligation to do so. You have the right to withdraw at any time of the research. Arrangements will be made available once permission has been granted by you, as to the venue, and time of research.

Research results will be made available to you on request. Should you have any questions with regard to this study feel free to contact me at the following numbers:

(011) 623 – 2962 (H)
(011) 936 – 5496 (W)
082 829 7654 (Cell)

PARTICIPANT/RESPONDENTS: SIGNATURE:
DATE:

Thanking you in anticipation.

Yours sincerely

Bongi P. Adams
STUDENT (Professional Nursing Management)
RE: PERMISSION TO CONDUCT A RESEARCH

This is to certify that permission to conduct a research on "MANAGEMENT OF SUPPORT GROUP FOR PATIENTS WITH CHRONIC DISEASE" by Mrs. B.P Adams in the facilities of C. W.W.R. has been granted.

The conducting of the research has been approved by the Rand Afrikaans University by the following formal structure of the university:

a) Nursing Science Committee.
b) Facility Council.
c) Research Ethical Committee.

It is hereby required of Mrs. B. P. Adams that on completion of the research project, she submits a research report to the Central Wits Health Region.

Southern District Health System Team (SDHST)
Chairperson : Dr. Olufemi
Assistant Director : Mrs. M.M. Thokoane
TO WHOM IT MAY CONCERN

I hereby confirm that the research proposal that was submitted by Mrs. B P Adams on the facilitation of support groups for patients with chronic diseases, has been approved by the following formal structures at the University:

   a) Nursing Science Committee.
   
   b) Faculty Council.
   
   c) Research Ethical Committee.

Sincerely

MARIE MULLER (PROF)
CHAIRPERSON: DEPARTMENT OF NURSING SCIENCE
ANNEXURE II

EXTRACTS FROM THE FOCUS GROUP INTERVIEWS

- Primary Health Care Nurse Facilitators.
- Facility Managers.
- Patients with Chronic Diseases
P8: Oh .. yes a lot. I am not happy about the way I am being treated. I feel so overworked, uncared for. I am not even consulted when changes or decisions are taken. My facility manager imposes or instruct me. She does not even care of how I feel. I also don’t even know what is exactly expected of me, this whole thing is confusing. It is even worse because of the rigid restrictive policies, which does not include any support group related activities. It becomes so unworkable, I mean there is nothing guiding us in the management of support groups.

R: Hmm.

P1: “My hands are tight, I cannot make decision, or do what I think is going to benefit the service. Really this is unfair, this is really putting me off, I am always told that this is not inline with the clinic policies. There is a lot of dissatisfaction when it comes to that. I also feel so much deprived of valuable support and guidance from the manager. She is always busy, has no time. Coming to clinic doctors, they are the worst, they look down upon nurses. Even the time allocated for the support groups session is insufficient, as a result I cant even cope and complete my work.”

P4: “While you are still taking about time, It is ridiculous that one is expected to sustain the support groups and yet given or allocated insufficient time. I feel two hours is not enough, I cannot finish all what is expected from me within two hours. Something needs to be done if we are gunning for the sustainability of support groups. Another pressing issue that is bothering me is the way I perform my work, I am like a robot a remote control, things are at all times prescribed for me. I mean working without any autonomy, I always depend and ... work under management prescriptions.”

R: “Is it so?”

P8: “It is really and quiet frustrating and tiresome to work under such conditions. We are not given feedback. Information is so little, you know it is so telegraphic, you cant even make up what it was all about. Policies that are put in place and guiding us are all outdated, nothing within these policies that outlines support group related activities.”

R: “Ok ... Thank you, is there anyone who would like to add to what she has just said?

P5: “Yes, for sure. There are no continuous education on facilitation and management of support groups, and yet we are expected to make things right. I want to be empowered so that I can empower patients effectively. It is unfortunate that no inservice training on support group related activities. Hey with me, feedback is sometimes delayed, censored or not given at all. You can just imagine, the conditions that one works under, poor or no feedback, lack of trained makes me feel insecure, I am never sure. I work haphazard there is no proper planning of those activities. There is inconsistence in the role that I do, I am also not happy
about time allocation for group session. I think we need more time. No quality time is spent with the group.

R: Is it so, anything else to add?

P2: “Ehm .. yes, the other thing that bothers me is eh ... unsafe unconducive environment that these support groups are managed. I mean things like the chronic shortage of drugs, patients are being sent from pillar to post. Clinic is not big enough, and cannot accommodate all members. We are also so short staffed and overworked.”

R: Mh ..”

P7: There is something good about managing support groups. Patients are now appreciating the service we are rendering as health providers. You know, their families too, are starting to be involved. They are so active in creation of awareness. They are always available at meetings. They are now more responsible. Another good thing is that this service keeps us on our toes at all times, we are forced to understand and apply the Batho Pele and patients right character principles into practice every day.

R: “Please tell me more about the good things.”

P6: “My colleague is very much correct to reveal the good about the support group. Yes there are both good and bad here. The bad are more than the good one. To count a few I have experience is the appreciation that is shown and displayed by patient. They actually verbalise and thank us. This is nice to be appreciated. The fact that the educational programmes offered empowered them to cope with their illness and its therapies, and are now less a burden to us. They are now self sufficient.”

P7: “There is a remarkable decrease of regular unnecessary clinic visits ... patients are no longer coming daily for nothing here, they now come per appointment, of which is a bonus to us who are so overworked. The service itself is who are so overworked. The service itself is just patient tailored, I mean everything here ... the system and procedures are tailored to favourable satisfy them. They enjoy programmes featuring active quite improved complain system and special clinic days. People within the community are now coming on board to appreciate these services. It is really encouraging to see patients shown the sense of belonging and ownership. They are so involved committed and they share responsibility and everyone has a role to play.”

R: “Thank you, very much for your time.”
EXTRACTS FROM THE TRANSCRIBED FOCUS GROUP INTERVIEWS WITH THE FACILITY MANAGERS.

R = RESEARCHER
P = PARTICIPANT

R: “Good afternoon ladies, without waste of time I would like you to kindly and freely answer the question that I am going to ask you. The question is: WHAT IS YOUR EXPERIENCES WITH REGARD TO THE MANAGEMENT OF SUPPORT GROUPS FOR PATIENT WITH CHRONIC DISEASES.”

P3: “Umm … I am not so much involved in support good related issues, but I have observed both good and bad about support groups. Starting with the good experiences, I must say I am impressed about the enthusiasm shown about these patients in taking control of their own lives. Patients are now actual driving and drivers of this process, they actually and know exactly that this service belong to them, they participate actually giving meaningful input, they take greater responsibility for their own needs, they are not dependent on whom or what, but now their participation can improve and sustain the group, that is the real cornerstone to this programme.

R: Hmm … Hmm …

P6: “It is so good that these groups has brought something good to the service .. What I have realised is that patients now value the service, share power and control of support groups, and work hand with the facilitator who now acts as the resource person and helps them in meeting their needs. However there are a lot of negative things I have witnessed that can badly affect the quality service delivery. Lack of training and develop with regard to skill development. Honestly speaking I also feel outdated not confident to deal with support groups … yes, we as managers need to trained and develop through formal or informal training as long as they can improve their skills. Some of the facilitator own these groups, as in the case with the facilitator in my clinic, she will not give you a feedback or information. The facilitator is very secretive, she withholds informations, there no transparency specially with information pertaining to support groups. She does things on her own.”

R: Yeah .. anything else. Yes mam

P4: I have not much to say, but the shortage of st is creating so much dissatisfaction among the PHC’s in general, and worse among facilitators. Some PHC’s no facilitating support groups are less interested in support groups, as some tell when asked for co-facilitation they just tell them it is not in their job description and were never trained in facilitation. Another issue that I am not comfortable with, and this is lack of inservice training on facilitation skills. Inservice training,
seminars conferences or any form of empowerment will help us a lot in gaining knowledge and skills that will empower us to grow and develop."
EXTRACTS FROM THE TRANSCRIBED FOCUS GROUP INTERVIEWS WITH PATIENTS WITH CHRONIC DISEASES

R = RESEARCHER
P = PARTICIPANT

R: “Good afternoon ladies and gentlemen. Thank you very much for honouring this invitation and agreed to participate in this study. Thank you once more. Kindly answer this question. What is your experiences with regard to management of support groups for patients with chronic diseases?”

P10: “Thank you for inviting us to come to this meeting. So that we can share with your our feelings on support groups. I have been a member of this group for almost three years now. Not a single day have I missed the group sessions. It is my second home I am happy, I like what I love every minute her every one is free to express his/her own opinion, without any fear from the above … there is freedom of speech. Our nurse, she is a real nurse in its true sense ha … uyadla wena .. the nightingale of the twenties. She is caring well disciplined, respectful and conducts herself in a professional manner. What I don’t like is the amount of time that we specify with her. We need the whole day .. 2 hours that is little.”

R: “Yeah .. it sounds like you, you are having the best of care and a good experience.”

P9: “That right. I’ve been well supported, guided towards understanding my condition, the nurse sister have really worked hard to put me where I am now.”

R: Ok anything else from anyone?

P2: “Yes, may you please tell your seniors (management) that we want drugs, equipment, more staff for us to enjoy and belong. Please tell them that floors are terrible.”

R: “Well if there’s nothing to add we have come to the end.”
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