

**THE IMPACT OF THE TRANSFORMATION PROCESS ON THE  
QUALITY OF SERVICE DELIVERY IN THE VHEMBE HEALTH  
DISTRICT, LIMPOPO PROVINCE**

by

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COMPLETED IN DECEMBER 2006

## **DEDICATION**

This research study is dedicated to my youngest daughter, Ampfarisaho Madzivhandila, to whom I am serving as an inspiration to follow in my footsteps.

## **DECLARATION**

I declare that the mini-dissertation hereby submitted to the University of Limpopo for the Master's degree in Public Administration has not previously been submitted for a degree at this or any other University, and that it is my own work in design and execution and that all references contained therein have been duly acknowledged.



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Dr. M W MADZIVHANDILA

**18 DECEMBER 2006**

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## LIST OF TERMINOLOGY

This section seeks to define certain core concepts which are used frequently throughout the mini-dissertation. There is a perception that the meaning of what is said is not expressed solely through its etymological usage, but is also a matter of individual comprehension because the same words may convey different meanings to different people. The following terms are described in the context of this mini-dissertation:

- **Transformation:** The concept 'transformator' is "... the process of a system that changes inputs into outputs; the movement from one position to another" (Fox & Meyer, 1995:130). It is concerned with positive changes in existing human society.
- **Development:** It is generally conceptualised as a process of direct change leading to political autonomy, economic growth and a broad basis of socio-economic reconstruction which includes principles such as the satisfaction of basic needs and a general process of community growth. According to Coetzee (1989:99) development is defined as "... an increase in goods, achievements, services or

reordering of distribution”, whereas community development is the process whereby the efforts of the people themselves are united with those of government authorities into the life of the nation, and they are enabled to contribute fully and optimally to the national progress.

- **Participation:** It is the fostering of dialogue between local people and the way services are to be delivered in respect of, for example, how certain projects are prepared, implemented and evaluated with a view to obtaining information on the local context and on social impact. According to Mikkelsen (1995:38), participation is a concept which refers to “... people-oriented development, empowerment, mobilization, participatory planning and evaluation, culture and traditions, contributions in cash and kind and affordability”. Participation enhances greater opportunity for self-reliance; it empowers local people to influence and understand the decision-making process and it fosters a sense of responsibility among the rural people themselves. It should also be borne in mind that participatory development creates opportunities for rural communities to take part in the planning and policy formulation, decision making, as well as in the allocation and distribution of resources especially to the needy people.
- **Target population:** It is the population of interest in the intended investigation. The population of interest is frequently too large to be subjected to any form of research; hence a sample is often used for empirical study.
- **Simple random sampling:** It is the process of selecting cases “... from a population in such a way that each and every distinct sample of a particular size, N, has an equal chance of being selected” (Huysamen, 1976:15). A sample should always be representative of the target population of interest.
- **Consultation:** It is one of the eight Batho-Pele principles and is regarded as the process through which the affected rural communities would be able to express their concerns and basic needs. The affected rural communities must be consulted

from the initial stages of decision-making, planning and organising to the implementation stage of whatever issues are being dealt with in the community.

## LIST OF ACRONYMS

It is also considered appropriate to indicate the acronyms since some concepts or acronyms are often used rather too loosely and sometimes interchangeably, without sufficient consideration for their respective underlying core meanings. The following are, therefore, some of the acronyms used in the mini-dissertation:

- ANC : African National Congress
- ANCYL: African National Congress Youth League
- APA : American Psychological Association
- Asymp Sig.: Asymptomatic Significance
- BTEP: Business Transformation Enablement Programme
- CL : Clients (patients or members of the communities)
- CBO : Community-based organisation
- COSATU: Congress of South African Trade Unions
- $\chi^2$  test: Chi-square test
- DBSA: Development Bank of South Africa
- df : Degree of freedom
- DHS: District Health System
- EMIS: Expenditure Management Information System
- FREQ: Frequency
- $H_0$ : Null hypothesis
- $H_1$ : Alternative hypothesis
- KM. : Kilometer
- N : Total number of responses (respondents)
- NHIS: National Health Information System
- NHS: National Health System

NGO:	Non-governmental organisation
PHC:	Primary Health Care
PS:	Public Servants
PERC:	Percentage
RDP:	Reconstruction and Development Programme
SACP:	South African Communist Party
SPSS:	Statistical Package for Social Services
SSD:	Significant Statistical Difference
Std	Standard
TITCAS:	Transformation Information Technology and Corporate and Administrative Services
TTSS:	Telecommunication Transformation: Strategic Services
VHD:	Vhembe Health District
WPPSTE:	White Paper on Public Service Training and Education
WPTPS:	White Paper on Transformation of the Public Service.
$\chi^2$ :	Chi- square Test
@:	Alpha

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## EXECUTIVE SUMMARY

The main purpose of this survey research was, first, to explore and gain a better comprehension of the extent to which the transformation process had impacted upon the quality of health-service delivery. Second, it was to determine the attitude of public servants towards the implementation of the processes and, third, to establish the extent of patients' knowledge about the processes.

The research questions for the survey research were as follows:

- What was the impact of the transformation process on the quality of health-service delivery?
- What were the perceptions and expectations of the rural communities about the process of transformation as it related to health-service delivery?
- What were the anticipated desired outcomes of the transformation process?
- What were the tangible benefits of the process of transformation in the remote rural communities?

The final survey research was undertaken in the fourteen (14) clinics save the Health Centre in Mutale sub-district in Vhembe Health District of Limpopo Province in the Republic of South Africa. Both the pilot sample and the main sample were randomly selected and the latter was also purposively constituted. The data was collected from one hundred and twenty-four (124) active respondents in the sub-district. In conducting this survey research, ethical considerations were taken into consideration.

The research methods used in the survey research were quantitative, qualitative and documentation and the derived data were presented in the form of frequencies, percentages, tables and graphs for easy interpretation and understanding. A chi-square

test (abbreviated as  $\Sigma^2$ ) was used to analyse the survey data in terms of the three specific hypotheses that were formulated.

Finally, the findings on the basis of the survey research led to the formulation and development of the recommendations to be implemented by the Department of Health and Social Development in Limpopo Province. Another recommendation for further investigation by any interested investigator for the benefit of all South African citizens was recommended for consideration in order to further contribute towards the body of knowledge in this field of study; and to generalise the findings, as the transformation process and service delivery were meant to be implemented in the entire country in terms of the legislation (National Health Act, Act No. 61 of 2003).

## **CHAPTER ONE**

### **INTRODUCTION TO THE SURVEY RESEARCH**

#### **1.1 INTRODUCTION**

The political environment of contemporary South Africa differs vastly from that which existed before the interim supreme authority, hereafter called the Constitution Act of 1993 ( Act No. 200 of 1993) came into being. The Act made provision for the Constitutional transformation of the Republic of South Africa to give, inter alia, all citizens the same freedom and rights. It was the first Constitution Act of this country in the new political dispensation which was later repealed in favour of the Constitution Act of South Africa of 1996 ( Act No. 108 of 1996).

Until the first democratic elections were held on 27 April 1994, South Africa was governed by the former apartheid regime, the apartheid government led by the white minority in the country. After the attainment of democracy in April 1994, it subsequently became clear that the Republic of South Africa should undergo a transformation process in order to eradicate the imbalances of the past which were characterised by disparity and by discrimination against the majority of the people of the country.

Since the government was committed to the eradication of all oppressive laws, it was considered necessary to implement the transformation process to improve the quality of service delivery in all three spheres of government, namely, national, provincial and local government. This was effective in rectifying the imbalances created by the former oppressive apartheid regime.

The South African government has already made some progress in the political transformation process. Transformation is usually inevitable wherever there is a transition from one government to another. The concept 'transformation' has been defined by Fox

and Meyer (1995:130) as "the process of a system that changes inputs into outputs; the movement from one position to another."

## **1.2 PROBLEM STATEMENT**

The problem to be investigated in the research was the impact of the transformation process on the quality of service delivery in the Vhembe Health District in Limpopo Province. The research sought to find out how the transformation process could best be managed, especially in rural communities, in order to yield the desired outcomes.

The significance of transformation and the impact it had on the quality of service delivery was also clearly stated in the White Paper on Transforming the Public Service (1997), section 1.1.2, in which it was pointed out that "the purpose of this White Paper is to provide a policy framework and a practical implementation strategy for the transformation of public service delivery." Eight principles which promoted service delivery were also spelt out in detail and which the researcher considered during the research process to establish whether they were being implemented and to ascertain whether they had any bearing on the quality of service delivery in the Republic of South Africa.

In view of the foregoing, the present situation poses a challenge to investigate the impact of the transformation process on service delivery, especially in those communities that are still predominantly rural in the Vhembe Health District of Limpopo Province in South Africa. This study was regarded as both urgent and necessary since the South African public service was directly and indirectly affected by globalisation and the inescapable changes and challenges due to technological innovation and development.

Although generally speaking pieces of legislation and papers on the transformation process and service delivery have been passed and published prominently since 1994 when the new democracy was attained, no publication has to date revealed that a study has been conducted pertaining to the impact of the transformation process on promoting,

facilitating and stimulating the quality of service delivery in terms of health issues, especially in the rural health districts within the Limpopo Province in South Africa because these are the areas that had been most grossly neglected and adversely affected during the repressive apartheid government.

In addition, the researcher personally observed that many people in the rural areas were complaining that there had been no real and practical delivery of basic health services, particularly in their respective areas, since the achievement of democracy in 1994. General comments of this nature from the public stimulated the researcher's interest and curiosity, and induced him to consider conducting research on the effectiveness of the transformation process and its impact on service delivery in the Limpopo Province. This decision was further encouraged because a number of pieces of legislation, papers and other relevant publications had been passed and published by the government of South Africa and also by other countries such as Canada, indicating the significance and indispensability of the process of transformation. South Africa and Canada found that the transformation process played a significant and beneficial role in promoting and facilitating service delivery. The consumers of such basic services, however, were apparently not satisfied as they perceived no difference in service delivery between their lifestyle prior to the attainment of democracy and that in the post-democratic period in South Africa.

The researcher was convinced by the untested findings obtained through observation and the perusal of publications that it was worthwhile conducting research on the topic to establish beyond any reasonable doubt whether the perceptions and expectations of the public and the researcher's unverified observations indeed gave a true reflection of what was transpiring in the rural areas in spite of the abundant availability of legislation and publications on the transformation process and its impact on the quality of service delivery. The findings of the investigation would first be made available to the Department of Health and Social Development in particular and Limpopo Province in general to enable the officials to address any gaps and shortcomings that were found to be prevailing so that people in the peripheral areas should enjoy the same benefits and privileges as those being offered to other people, such as those in the urban areas.



Second, the researcher also intended to make informed knowledge regarding the reality pertaining to service delivery available to service consumers in the entire Province and in particular to the consumers in the rural areas of Limpopo Province. Third, the researcher wished to demonstrate that the new government should carry out its mandates, activities and responsibilities in a transparent, effective and efficient manner to try to avoid any form of discriminatory practice which was the order of the day in the era of the repressive apartheid government.

It is also worth mentioning that the fundamental and ultimate objective of the investigation was to ascertain whether the enabling mandates from the national and provincial spheres of government were indeed being implemented, as was expected in the numerous pieces of relevant legislation already passed in Parliament, in order to improve the quality of service delivery especially in the rural areas which had been grossly neglected for many years by the previous apartheid regime. Such challenges could, therefore, only be addressed by ensuring that the transformation process took place on the periphery of the health sector as well, as the marginalisation had disadvantaged many black people who resided there. The transformation process was regarded as one of the best mechanisms whereby the quality of service delivery could be promoted and facilitated wherever and whenever there was a need to do so.

### **1.3 RESEARCH QUESTIONS**

The current investigation sought to examine a number of questions such as:

- What was the impact of the transformation process on the quality of service delivery?
- What were the perceptions and expectations of the rural communities about the process of transformation as it related to health service delivery?
- What were the anticipated desired outcomes of the transformation process?
- What were the tangible and intangible benefits of the process of transformation in the remote rural communities?

## **1.4 OBJECTIVES OF THE SURVEY STUDY**

Sections 1.4.1 and 1.4.2 below reflect the general and specific objectives of the investigation now under review.

### **1.4.1 General objective of the survey study**

The investigation focused on studying the transformation process as the mechanism that facilitated and promoted the quality of health-service delivery in the rural communities. The fundamental and ultimate objective of the research was, therefore, to enable South African people in general to be well equipped with the necessary information, expertise and skills that were essential for promoting the quality of service delivery as it related primarily to health services for the patients.

### **1.4.2 Specific objectives of the survey study**

The specific objectives which necessitated the present study were fourfold:

- to check the understanding and application of both the transformation process and service delivery in the rural communities;
- to investigate the effectiveness of the transformation process on the quality of service delivery;
- to make a contribution to the existing body of knowledge on the matter of transformation and service delivery; and
- to provide recommendations on how the transformation process should be resolving the quality of health-service delivery problems in the remote rural communities.

## **1.5 HYPOTHESIS**

The hypothesis for this mini-dissertation is: The public servants of the Vhembe Health District of the Department of Health and Social Development who have been exposed to the transformation process are more effective, efficient and productive in implementing and promoting the quality of health-service delivery than those who have not been subjected to the process of transformation; and that the local communities are not knowledgeable about the transformation process and its impact on the quality of health service delivery.

According to Mason and Bramble (1978:65), "The hypothesis is actually a guess at a solution to the problem" and its characteristic is that it should be verifiable and testable as it is a tentative declarative statement about the relationship between two or more variables.

## **1.6 SPECIFIC HYPOTHESES**

The following specific hypotheses were considered in this section and also in chapters four and five of the research study:

- 1.6.1** The public servants of Mutale sub-district lacked capacities and skills to implement the transformation process in order to promote and facilitate the quality of health-service delivery.
- 1.6.2** The transformation process promoted and facilitated the quality of health-service delivery in the peripheral communities.
- 1.6.3** Members of the communities were not altogether knowledgeable about the process of transformation and its impact on the quality of health-service delivery.



## **1.7 SIGNIFICANCE OF THE SURVEY RESEARCH**

As a psychologist, the researcher had very little theoretical knowledge of and interest in public administration and management until he registered for an MPA programme through the University of Limpopo in 2005. He subsequently developed an interest in the field of study following extensive guidance from dedicated and committed lecturers. After studying and having passed seven modules in the programme, the researcher's interest gradually developed to such an extent that he decided to investigate the impact of transformation on the quality of service delivery because he perceived the inadequate service delivery in the rural areas as a serious challenge, taking cognisance of the fact that the Republic of South Africa was in its eleventh year of democracy, since 1994.

The study is significant because it sought basically to explore the effectiveness of the transformation of the quality of service delivery in terms of health services in the periphery of this country; to increase and broaden the understanding of both the process of transformation and the quality of service delivery, as well as to make a scientific contribution to the existing body of knowledge in the matter pertaining to the transformation process and the quality of service delivery; and finally to develop recommendations which could assist and/or guide the implementation of the transformation process wherever gaps and further challenges had been identified.

## **1.8 SCOPE AND LIMITATION OF THE STUDY**

The survey research examined the process of transformation with special reference to its role and the impact it had had on the quality of service delivery in the communities based in Mutale sub-district in the Vhembe Health District in the Limpopo Province during the past eleven years.

The investigation was conducted among public servants (PS) of the Department of Health and Social Development and patients or members of the communities (CI) located in the Vhembe Health District in the Limpopo Province. The Directorate of Transformation and

Transversal Services in the Department of Health and Social Development entrusted with the task of ensuring that the transformation process was implemented also participated in the survey research by providing a comprehensive case study and other relevant documentation.

Taking into account that many black people in South Africa had been disadvantaged tremendously during the apartheid regime, which was neither development-oriented nor service delivery-oriented, this study was, of necessity, limited to focusing on the critical factors that played a significant role in the transformation process and how they impacted positively or negatively on service delivery in the Vhembe Health District of Limpopo province.

The study, therefore, addressed the mechanisms of the transformation process and how they helped promote service delivery in the rural communities. The focus of the research into the transformation process was limited to the period from 1995 to 2006 and mainly to two of the four sub-districts, namely Makhado and Mutale, which were randomly and purposively sampled in the Vhembe Health District in the Limpopo Province. The above-mentioned four sub-districts falling within the geo-political jurisdiction of the Vhembe Health District were Makhado, Musina, Mutale and Thulamela.

## **1.9 ETHICAL CONSIDERATIONS**

It is worth mentioning, even in this type of survey research, that in order to assist research professionals, especially psychological researchers when dealing with ethical issues, the American Psychological Association (APA) in 1992 adopted the Ethical Principles of Psychologists and Code of Conduct. The formulated and adopted principles govern the full range of a psychologist's behaviour and activities, including scientific and professional integrity, treatment of clients (respondents) in therapy, and the care of human and non-human subjects in their research. The principles regarding human subjects apply to any type of study (and not only to experiments) and can be summarised as follows (Heiman, 1995:159):

According to the APA, researchers must always abide by the ethical conditions while conducting research studies with human beings or non-human beings. They must not harm subjects or respondents either physically or emotionally, and they must respect their rights. Another condition is that subjects or respondents cannot be made alcoholic or simply be subjected to alcoholism, and besides all the ethical issues mentioned above, researchers must be practical, transparent and realistic, also accepting that they cannot devise a perfectly reliable and valid study from all perspectives by being unethical in their research studies (Heiman, 1995:157).

It is also worth mentioning that Elmes *et al.* (1999:445) reiterate that ethical considerations involve "Removing harmful consequences: Ethical researchers remove any harmful consequences that their participants may have incurred". It is, therefore, the sole responsibility of the researcher in the various disciplines always to identify both potential physical and psychological risks and effectively and efficiently manage them; that is, they must always find out if there is anything in the study that could physically and psychologically endanger or harm the subjects, as is sometimes the case in socio-psychological experiments (Elmes *et al.*, 1999:297).

As a way of maintaining and adhering to the ethical principles and considerations of conducting a research study, this researcher ensured that he was not in violation of any ethical considerations which needed to be strictly observed during and also after the completion of the investigation. Norms and standards as well as the guidelines set for conducting research were honoured, respected and regarded as confidential without any compromise. Non-disclosure was observed by the researcher and his trained enumerators because no information that emerged from the investigation would be made available to any interested institutions without the consent of the participants in particular and the University of Limpopo in general.

The assurance was also mentioned in the questionnaires given in writing to the respondents who had volunteered and accepted the invitations to participate in the study.



Confidentiality, therefore, was and will be protected under all circumstances by not disclosing, *inter alia*, their biographical information. The participants were requested to volunteer to take part in the investigation and were informed about the non-disclosure of the information so as to enable them to feel free to give as much information pertaining to this survey study as they could without any fear of victimisation or intimidation by any institution that might be affected by the outcome of the investigation.

## **1.10 LAYOUT OF THE CHAPTERS OF THE SURVEY STUDY**

The research study consists of five chapters which eventually constitute the mini-dissertation. Chapter 1 is an introduction presenting a discussion of the problem statement and justification for the study, the objectives, the hypotheses, the scope of the research, ethical considerations, definitions of terminology and acronyms of certain unusual terms, and ethical considerations. Chapter 2 focuses on the literature and legislative framework review as they relate to the impact of the transformation process on the improvement of the quality of service delivery.

Chapter 3 describes the pilot questionnaire, research design, research methods, research questions, random sampling, methodological shortcomings/limitations, and the format of the questionnaires. Chapter 4 addresses the method of data collection, data presentation, data analysis, and data description. In a nutshell, section 4.1 deals with the brief introduction of Chapter Four, while 4.2 of the chapter focuses on the presentation of the background in respect of Mutale sub-district. Tabular and graphic descriptions of the survey study, therefore, constitute the subject matter of section 4.3. Section 4.4 focuses on the case study pertaining to the impact of transformation process on the improvement of health service delivery and finally, section 4.5 is the conclusion. The purpose of Chapter 5 is to deal with the conclusions and recommendations.

## **1.11 CONCLUSION**

This chapter, Chapter One, focused attention on the introduction, presenting a discussion of the problem statement, justification for the survey study, research questions, the objectives, the hypotheses, significance of the survey research, the scope and limitation of the survey research, ethical considerations and the layout of chapters of the survey study. The following chapter, Chapter Two, deals with the literature and legislative framework pertaining to the transformation process and health service delivery.

## CHAPTER TWO

### LITERATURE AND LEGISLATIVE FRAMEWORK REVIEW

#### 2.1 INTRODUCTION

The chapter focuses on a literature and legislative framework review of the role and the impact of the transformation process on the quality of health-service delivery. The major purpose of the chapter was to review briefly some recent literature published to date as well as the pieces of legislation promulgated since 1995 to date and considered to be pertinent to the transformation process, with a view "... to ascertain whether there is availing evidence in the field that similar research has been done in the delimited geographical area" (Van der Wald: *et al.*, 2002:285. Another reason for the literature review was to enable the researcher to determine whether the problem to be investigated had not been researched before so as to avoid duplication of investigation. As the literature and legislative review under consideration focused on the relationship between the two important variables, namely, the transformation process and health-service delivery, Nedohe (2006:10) therefore defines the transformation as a process that means "to change an existing reality into another".

The fundamental priority of the government of South Africa was to ensure that there was improved service delivery in all the communities. South Africa, being a developing country, needed a public service that was committed to the execution of its responsibilities, one that was people-centered, had an array of skills and expertise and was always prepared to accept the dynamic challenges and opportunities posed by the new democracy. It was also imperative that for the public service to achieve the objective, it had to be transparent, honest, flexible, collaborative, innovative, creative, and also to work in partnership with all stakeholders of the country such as the CBOs, civil society organisations, NGOs, government departments, the private sector, traditional leaders, traditional healers and members of the community. The above-mentioned were some of the stakeholders that could play a significant role in bringing about transformation towards a high quality of service delivery.

The Republic of South Africa inherited a fragmented public service and, in the previous eleven post-apartheid years, saw the need to transform the public service. The main task confronting it was the challenge of amalgamating and integrating the ethnically and racially fragmented administrations into a unitary, powerful, non-racial administration that would be transparent, effective and efficient in the delivery of services in order to meet the numerous needs of the country. The inherited public service was characterised, among other things, by corruption, its monolithic, rule-bound nature, its inflexibility, poor quality of service delivery, low skills base, and little or no respect for the members of the communities it was supposed to serve with dignity, transparency and honesty. There was lack of commitment and dedication. Other serious challenges faced by the new government were the creation of a new democratic organisational ethos, establishment of a new work ethic and bringing services closer to the people at grass roots level, to create a shared vision in all spheres of government in the country, and so to bring about public service transformation. This was not the case under the former regime (<http://www.dpsa.gov.za/documents/service-delivery-review/launchedition/government>).

The transformation process of the new public service was to be guided and directed by the Constitutional principles the current government wanted to promote within the communities of the country. The government was determined that in its pursuit, practice and conduct it would ensure that it upheld, promoted and reflected the Constitutional principles of transparency, effectiveness, representativeness, efficiency, honesty and accountability, to mention but a few. It was the responsibility of the public service, on the one hand, to ensure that those fundamental principles were practised to the best benefit of the communities of South Africa. On the other hand, the government was also expected to recognise, reward and affirm those public servants who were responsible, dedicated and talented in the execution of their tasks and responsibilities. The same applied to those departments and directorates that were productive, creative and innovative in order to encourage and motivate them to sustain their standards and to improve the quality of service delivery. They needed to be publicly rewarded and recognised and not only in monetary terms as was sometimes preferred, but by praising or patting them on the back as a way of recognising their efforts.



All these factors would have an adverse impact on the quality of service delivery if not addressed properly. The involvement and participation of the members of the communities were of paramount importance. Hence, the new government which emerged from the democratic elections was aware that it should engage members of the communities in decision making and initiating the projects because some of them were innovative, creative, willing to experiment and to take risks for the communities. The government expected public servants to observe and comply with the ethical considerations underpinning service delivery and they had an obligation, too, to act in an appropriate way to avoid all forms of fraudulent and corrupt practices since such activities deprived members of the community of the services that were due to them (<http://www.dpsa.gov.za/documents/service-delivery/launch%20innovative%20s.atc> and <http://www.dpsa.gov.za/documents/service-delivery-review/vol2no3/towardsanintegrated-public-service-2003>).

The research study was primarily about the transformation process and its impact on the quality of service delivery. The concept 'transform' means a change in form, in outward appearance, in character and in disposition. Section 1 of the Constitution Act, 1996 of the Republic of South Africa (Act No. 108 of 1996) ensured that the composition of the state was transformed into one sovereign state. This significant transformation process from a fragmented apartheid-based state consisting of four so-called independent states and six self-governing areas into the current unitary type of state required that particular attention be devoted to, among other things, policy-making processes, organisational structures, human resources matters as well as managerial issues (Thornhill, 2005:578). The Constitution Act (Act No. 108 of 1996) either directly or indirectly ensured that the new entrants had to learn that the public service existed for the best benefit of society at large and not only for the sake of family members and friends as was the case in the past era. Transformation was required not only in the establishment or creation of public institutions, but also in the values underlying the administrative and managerial practices that were in place in the country. Transformation can be considered as a once-off phenomenon on the one hand, whereas on the other hand, reform should be viewed as a continuous process (Thornhill, 2005:579).



## **2.2 LITERATURE AND LEGISLATIVE FRAMEWORK: THE LOCAL PERSPECTIVE, THE NATIONAL PERSPECTIVE AND THE INTERNATIONAL PERSPECTIVE**

The Republic of South Africa entered a completely new era with the democratic elections held on 27 April 1994. The main purpose of democracy in South Africa was to promote and facilitate sustainable public service delivery.

The adoption of the Interim Republic of South Africa Constitution Act (Act No. 200 of 1993), superseded by the current Constitution Act of the Republic of South Africa (Act No. 108 of 1996), placed the South African public service before its greatest challenge. It was and still is the objective of the newly established government to reform the public service in an effort to provide the most effective and efficient service to the society it serves (Mubangizi, 2005:633; Thornhill, 2005:559). It should also be borne in mind that the past decade has witnessed unprecedented transformation and reform processes and related processes such as the rationalisation of thirteen different public services which were in existence in South Africa, which was a duplication of unproductive services (Clapper, 2005:182).

The transformation and restructuring processes were initially introduced and established within the provinces in order to facilitate the amalgamation of the former disintegrated homelands and the so-called independent homelands and the defunct provincial administrations within the Republic of South Africa. The subsequent formulation of the Transformation Plan was indispensable to the new political dispensation because its principles for directing and guiding the entire process of transformation and restructuring were basically to improve the internal processes through the Customer Services Improvement (CSI) programme to provide transparent, effective and efficient services with a view to improving the quality of productivity and delivering excellent services to all the communities in the country (Reddy, 2003:438–450).

The Constitution Act (Act No. 108 of 1996) together with the other pieces of legislation of the Republic of South Africa such as the Public Service Act of 1994, the National

Health Act of 2003 and the Labour Relations Act of 2002, to mention but a few, emphasised that the objective of their implementation of the process was to achieve satisfaction with service delivery. Fourie and de Jager (2005:229) indicate that low job satisfaction had a negative impact on the quality of service and might be a contributing factor associated with shortages of health-care providers in the Republic of South Africa. The African National Congress (ANC)-led government had, since being elected into government on 27 April 1994, engaged itself in collaboration with the other minority political parties in a process of transforming the public service into an efficient, effective, transparent, democratic, fully representative and development-oriented instrument of service delivery as laid down by the White Paper on the Transformation of the Public Service (1995) and the Constitution Act (Act No. 108 of 1996).

The transformation policy initiative which emanated from this White Paper, including being a new, more flexible regulatory framework, enhanced the management autonomy, transparency, effectiveness and accountability of the national and provincial departments with the devolution of decision making on matters regarding human resource management, work organisation and information management. Although service delivery was gradually improving, it was worth noting that severe backlogs in terms of delivery and management challenges existed and they, in turn, had an adverse impact on the quality of service delivery in the entire country and especially in the remote rural communities. The Batho-Pele approach to transforming service delivery had achieved some level of popularity and was to some extent a marketing success in the country, but had not yet resulted in a significant improvement in the quality of delivery, mainly because no real indicators to measure service improvements had so far been satisfactorily formulated or developed by the current government (Fourie & De Jager, 2005:230).

It is also worth mentioning in this section that South Africa had, since 1994, been insisting that there had to be comprehensive constitutional, political and socio-economic changes and transformation, but only political transformation had been accomplished and not socio-economic transformation because the wealth of the country was still being controlled and managed by the white minority. Black South Africans were still the poorest in the country, especially in the remote rural areas. The transformation process also necessitated the changes in the public policy which influenced the direction the

transformation process should take. It was considered essential since 1994 that public policies needed to be formulated effectively in order to ensure the survival and sustained productivity of the institutions, which meant in simple terms that there should be sufficient financial resources available to provide for the most-needed services. The institutions should, therefore, have the capacity to deliver the desired services and also to adapt themselves to ever-changing circumstances as well as technological developments.

Given the fact that the larger section of the population of South Africa was basically rural in nature and characterised by severe poverty and unemployment, the implementation of the transformation process was considered to be the right direction to take towards addressing such issues, including the backlog in terms of service delivery in the most peripheral areas of the country. The objectives of the policies such as the Constitution Act, 1996 (Act No. 108 of 1996) and other subsequent pieces of legislation formulated and promulgated since 1994, were to ensure that the transformation processes were cost-effective and implementable, and that they would eventually satisfy the basic needs of transformed communities in South Africa.

A key priority for the South African government was the accreditation of the transformation of the public service. The policy framework and guidelines that have been in place since 1995 to date have empowered public servants to innovatively improve quality and service delivery. Fourie and De Jager (2005:231) indicate that the President of South Africa, Thabo Mbeki, in his speech at the official opening of Parliament in July 1999, emphasised the importance of and the need to accelerate the delivery of services by all government departments. Mbeki is quoted by Fourie and De Jager (2005:231) as having suggested that there should be extensive exploration of new and innovative mechanisms by government departments to deliver effective, efficient and economic services to the citizens.

Kotler and Andreasen (1996:379-380) argue that effective service delivery is often sabotaged by unresponsive actions of frontline employees/public servants who provide services directly to the members of the various communities. These frontline public servants do not necessarily consider themselves to be responsible for meeting citizens'



needs, desires and demands first and not those of the public servants themselves. One of the tasks of the public institutions is to effectively train, develop and motivate those frontline public servants who have direct contact with members of civil society.

### **2.2.1 The local perspective**

Local government, within which the health districts operate, is the third and hierarchically lowest sphere of government in the Republic of South Africa. It is closest to the communities and should thus, together with the other two spheres of government, namely national government and provincial government, ensure the best service delivery of basic needs to citizens. Ever since the new government of the Republic of South Africa was established in terms of the Constitution Act (Act No. 108 of 1996), it was faced with enormous challenges and the task of transforming this country from the oppression of the apartheid regime to a democratic type of government. At that time there were huge backlogs in most municipalities and health districts in terms of health services which the government was addressing. Hence, transformation was considered to be one of the key mechanisms whereby those challenges, relating particularly to the lack of access to basic services, were addressed and redressed.

According to Ismail, Bayat and Meyer (1997:3), local government can be described as "... that level of government which is commonly defined as a decentralised representative institution with general and specific powers devolved to it by a higher tier of government within a geographical area". Section 40 (1) of the 1996 Constitution recognised local government as a distinct sphere of government and as such its powers were derived from the Constitution Act, 1996. Stated differently, local governments could be described as public organisations authorised to manage and govern the affairs of a given territory or area of jurisdiction.

The White Paper on local government indicates that local government is development-oriented and that its development, especially in the rural areas where the majority of the poor people were marginalised for a long time by the apartheid system, must not be a stumbling block or obstacle in the transformation process. Development must be there to

ensure that services are aimed at relieving the poor rural people of the economic stress that they might be experiencing; and also to ensure that basic needs such as water, shelter, sanitation, electricity, food and transport are made accessible and available to all citizens of this country. Local government is that machinery or instrument that must ensure that all people have access to the means of satisfying their basic needs without any form of disparity or discrimination, as was the case during the apartheid era.

The concepts 'local government' and 'community development' are closely intertwined and it is in this regard that Coetzee (1989:126) points out the importance of community development since it is the process through which the efforts of the community members themselves are united with those of government authorities, and which enables them to contribute optimally in order to achieve national progress. Subsequently, community participation has played an important role in the process of transformation, as it has empowered members of the communities to take part in the decision-making process regarding matters that concern them. Participation enables members of the community to identify their own needs and prioritise them. Any community that was denied participation in matters concerning their own interests and concerns was, indeed, being socially and historically disadvantaged and such a practice is completely undemocratic and unacceptable in the current South African culture (Myonjo & Theron, 2002:492-506).

The Local Government: Municipal Systems Act, 1998 (Act No. 117 of 1998) provides that whenever the municipalities carry out their responsibilities, they must ensure that there is community participation in the determination and prioritisation of the needs of the people. It further emphasises the involvement of rural people in particular, who know precisely what their needs were. The principle of consultation presented in this Act, which is also enshrined in the Constitution Act, 1996 (Act No. 108 of 1996) as well as in the Batho-Pele document, is the prime factor to be complied with by all spheres of government in the Republic of South Africa.

The main purpose of the Municipal Systems Act of 1998 is primarily to provide for social and economic upliftment or advancement, in particular of members of local communities. It furthermore ensures universal access to essential services that are affordable to all

citizens of this country and also to working in partnership with the municipality's political and administrative structures. The Act also provides for the participation of all relevant stakeholders; it empowers the poor people to take part in the process of decision-making and to monitor standard setting by other spheres of government in order to progressively change municipalities into efficient, frontline development agencies capable of integrating the activities of all spheres of government for the overall social and economic development of communities in harmony with their local natural environments.

The Municipal Structures Act, 2000 (Act No. 32 of 2000:2) indicates that the "...Constitution established local government as a distinctive sphere of government, interdependent, and interrelated with national and provincial spheres of government". It is, therefore, the responsibility of municipalities to fulfil their respective constitutional obligations by ensuring that there are sustainable, effective and efficient services in place, promoting social and economic development, and encouraging a safe and healthy environment by working with communities to create environments and human settlements in which all people continue to live dignified lives; and these requirements apply to the health districts as well, as they are also expected to deliver health services in the same way for the best benefit of the communities.

The ultimate goal that faced newly-established municipalities and health districts in South Africa was to deliver more cost-effective and efficient services to the members of the communities, within the context of limited financial and human resources. In order to meet such numerous and apparently insurmountable challenges, municipalities had to investigate alternative and creative means of delivering quality services to all the inhabitants of the Republic of South Africa. It was also argued that the commercialisation of certain basic services was regarded by the government of the day as an instrument towards achieving this goal. The Local Government Transition Act of 1993 made provision for the apartheid structures to be abolished in toto, followed by the establishment of transitional structures. The provinces were empowered to determine the powers and functions of the municipalities and prepare for the first democratic local government elections held in 1999.



Myonjo and Theron (2002:492). in their endeavour to address issues pertaining to social exclusion in the Blockombos case, argued that most challenges facing especially the local authorities in this country entailed the establishment of appropriate and relevant partnerships among the municipalities and their respective communities within their geopolitical jurisdictions. They indicated that the concept 'social exclusion' simply referred to a situation pertaining to social disadvantage and to which poor people were exposed as it related mostly to all forms of poverty, public participation, empowerment and sustainable development as well as capacity building. Hence, in this context, human needs were regarded as part of 'social exclusion'.

The government of South Africa had committed itself to the improvement of the skills levels of public servants and to establish a culture of learning in the public service. The need for skilled public servants was, indeed, of paramount importance in the municipalities as well as the health districts since they constituted the sphere of government closest to the people and directly responsible for service delivery to the inhabitants. The institutional capacity of the municipalities was not only hampered by the inadequate skills of the functionaries as it was often perceived, but also due to institutional and resource impediments. The lack of effective and efficient municipal service delivery might be as a result of inadequate institutional support for the managers. Sometimes one might find that the functionaries' educational background (qualifications), experience and the appropriateness of their qualifications might not be congruent with the requirements of their positions. To this extent the government of South Africa promulgated many comprehensive pieces of legislation and official policies in an effort to assist employees in municipalities with regard to their roles, functions and responsibilities towards socio-economic development and municipal service delivery (Marais & Kroukamp, 2005:122).

According to Section 152 (1) of the Constitution of 1996, the general objectives of local government in the Republic of South Africa are primarily to provide democratic and accountable government to municipal residents and to render services in a sustainable manner. According to Reddy et al (in Marais and Kroukamp; 2005:122-123), accountability is considered to be "... the cornerstone of the Constitution and therefore the maintenance of accountability, as well as the effective and efficient use of public



resources...” and it is “... imperative for the successful transformation of political and managerial systems in the local sphere of government”. Furthermore, section 152 (1) of the Constitution Act, 1996 (Act No. 108 of 1996) determines that the local government sphere should encourage municipal residents and their organisations to become involved in local government matters. Legislation and policies such as the White Paper on Local Government (1998), the Local Government: Municipal Finance Management Act, 2003 (Act No. 56 of 2003) and the Local Government Municipal Systems Act, 2000 (Act No. 32 of 2000) emphasise the principle of developmental local government and particularly emphasise public participation, community involvement, the delivery of quality municipal services and transparent administrative and management systems (Reedy, 2003:viii). These are some of the comprehensive objectives that required managerial skills, dedication and institutional capacity to materialise.

Although the rendering of essential services to the poor and historically disadvantaged is the complete responsibility of the municipalities, some municipalities still appear to be experiencing challenges with regard to the effective and efficient execution of their tasks, probably due to incapacity and lack of the essential resources. Unfortunately, in spite of clear constitutional provisions and local government legislation passed by Parliament for the restructuring of municipalities within a transformed democratic dispensation, municipalities in the majority of cases appeared to be unable to render basic services such as housing, education, health care, sanitation, electricity and water provision, especially in the poor and disadvantaged communities. These, together with the backlogs in municipal service delivery originating from the pre-1993/94 political dispensation of the Republic of South Africa, raised various concerns among local communities about government’s ability to implement the above-mentioned responsibilities as well as to formulate sound policies.

The fundamental governmental transformation that has taken place since 1993/94 has affected administratively and otherwise the current structure, composition and focus of local government in South Africa. In fact the Policy Framework of the African National Congress (ANC) as envisaged in the original Reconstruction and Development Programme (RDP) noted the critical importance of the municipalities, because it was the level of representative democracy closest to the communities. According to the African

National Congress (1994:2) the need for a Reconstruction and Development Plan in our country was that "Segregation in education, health, welfare, transport and employment left deep scars of inequality and economic inefficiency". The Policy Framework placed particular emphasis on the restoration, upgrading and maintenance of networks of services, as well as the eradication of the huge existing backlogs in municipal services. The vast service delivery backlogs that existed particularly in the previously neglected peripheral areas remained a challenge for the municipalities in South Africa. Eleven years after the establishment of a true democracy in South Africa, the rendering of essential services, particularly to the poor and historically disadvantaged people, appeared still to be a highly problematic challenge.

The Constitution Act, 1996 (Act No. 108 of 1996) of the Republic of South Africa paved the way for a truly democratic dispensation. The goal of a democratic country would be to ensure the spiritual and material welfare of all members of its communities. The government, therefore, had a social responsibility and obligation, and found its practical application in the municipalities and health districts. Section 40 (1) of the Constitution Act, 1996 (Act No. 108 of 1996) clearly indicates that the local government sphere consists of municipalities in South Africa. Each sphere is distinct, yet the spheres are interrelated and interdependent. Because of its position, local government was often regarded as a mirror reflection of the success and failures of national government. Local government as the government closest to the people existed primarily to bring government to grass roots level. The role that municipalities played in the Republic of South Africa was largely focused on the quality of the delivery of a variety of services.

According to section 152 of the Constitution Act, 1996 (Act No. 108 of 1996), the objectives of local government have been stipulated as follows:

- to provide democratic and accountable government for local communities;
- to ensure the provision of services to communities in a sustainable manner;
- to promote social and economic development;
- to promote a safe and healthy environment; and
- to encourage the involvement of communities and community organisations in matters of local government.

Being the government closest to the people, it was to be expected that a core function of municipalities and the health districts would be the rendering of a variety of basic but essential services to the communities within their jurisdictions. The provision of services by municipalities to the citizens was a constitutional obligation that it could hardly escape, including such services as the provision of water, electricity, sanitation, transport and shelter to mention just a few.

### **2.2.2 The national perspective**

The main objective in the transformation process was basically the improvement of the quality of service delivery. The gross negligence committed deliberately during the former apartheid regime, especially in the remote rural areas inhabited by black people, exacerbated the prevailing situation of excessive backlogs confronting the new government so that the government had no choice but to try to address the huge imbalances of the past through the process of transformation. The former government was characterised firstly by the duplication of inadequate service delivery in the whole country and, secondly, by the fact that the human and financial resources as well as the assets were utilised in a way that was discriminatory, inefficient and ineffective with gross disparities and lack of transparency. When the new democratic government came into power it was indeed faced with numerous challenges, including the huge backlogs in the provision of houses, clinics, power supply to the dwellings of poor people, sanitation, educational facilities, transport, employment and job opportunities (Reddy, 2003:455).

Subsequent to the process of transformation, a large number of predominantly peripheral areas were incorporated into the nine new provinces and about 284 municipalities in order to ensure that the huge backlogs were addressed as promptly as possible.

Kroukamp (2002:453) argues that the transformation process and reform were of the most significant and exciting challenges facing the Republic of South Africa, and which brought about profound changes and challenges to enhance the transformation process of



public service delivery. He indicates furthermore that in order to ensure the provision of quality of service delivery, the public service whether at national, provincial or local sphere of government, definitely needs relevant skills, knowledge and expertise in the implementation of the transformation and service delivery policies.

Since 1994 the government of South Africa introduced a variety of new policies that had to be implemented effectively, mostly by disoriented and inexperienced workforces, especially the black people who, during the apartheid government, were regarded as an inferior and poor-quality workforce. Kroukamp (2002:471) indicated that some of the most important types of policies introduced during the first eleven years of the African National Congress-led government were, inter alia, the Skills Development Act of 2001 and the Skills Levies Act of 2002, the main purpose of which was basically to develop appropriate and relevant skills in the public service of South Africa with a view to improving the quality of service delivery. Policies were indispensable and were meant to provide and regulate employment services as well as to improve the employment prospects of those people previously and historically disadvantaged and marginalised by the unfair discrimination of the apartheid system.

The transformation process, therefore, was one of the key and fundamental processes to be embarked upon in order to improve service delivery and to eradicate inequalities especially in South Africa with its fledgling democracy. Cameron (1999:81) pointed out that “The 1990s saw some major changes in the political landscape of South Africa”, and as a result of such developments it was imperative that politics and administration, among others, be transformed to cater for the needs of all South African citizens as the previous regime was neither development-oriented nor service delivery-oriented, hence there was poor service delivery in most rural areas inhabited by the majority of black people (White Paper on Reconstruction and Development, 1994 and Constitution of the Republic of South Africa, 1993a).

It is currently generally accepted that contemporary governments in the world are striving towards the realisation of predetermined goals. Such goals are, however, embodied in

specific objects as well as in concrete targets. Every government institution, regardless of the spheres of government it establishes, should pursue the identified objectives and targets as they are always reflected in their respective annual capital and operational budgets. It was found that all three spheres of government were, therefore, created with certain prescribed core functions or competencies and responsibilities to perform in order to fulfil the basic needs of the communities (Botes, 1994:217).

The vision for the public service, as captured in the White Paper on Public Service Training and Education, 1997, is primarily to develop a competent and capable workforce that is committed and dedicated to delivering services of a high quality to the public of South Africa. According to Mubangizi (2005:611) the WPTPSD defines the role being played by the public service in the country with an overall emphasis, among other things, on matters such as the following:

- it places more responsibility and relevance on the needs of the citizens;
- it emphasises more efficiency, transparency and effectiveness in the utilisation of public resources; and finally;
- it emphasises more representativeness of the diversity and the needs of all, especially the most historically marginalised and disadvantaged sectors of the communities.

It is worth mentioning at this point that a plethora of pieces of legislation have been introduced since the new government came into power in 1994, in an endeavour to shape the post-apartheid government dispensation in the Republic of South Africa. All possible efforts were made, taking due cognisance of, among others, the redistribution of resources, democracy, transparency, efficiency and effectiveness in service delivery in a new, redefined developmental context. The undemocratic and discriminatory pieces of legislation implemented by the former illegitimate government were repealed and the new core democratic pieces of legislation were passed in the National Parliament to start addressing all possible imbalances of the past that were identified by the time the new government came into power (Reddy, 2003:438-460).

The pieces of legislation passed since 1994 to promote and facilitate the process of transformation which have a bearing on service delivery were there and one wondered whether their effectiveness was appreciated by the public; hence there is now a need for this research study to verify the effectiveness of the transformation process in service delivery. The new government realised that public service delivery needed to be transformed so that even those people who were denied their right to access satisfactory service would be given an opportunity in this country. Transformation was essential for the improvement of service delivery which was neglected in this country prior to its achievement of democracy and independence from the oppressive white minority government. The statutory framework designed to transform the public service after the attainment of democracy in 1994 was focused on improving service delivery and was informed particularly by the mandates mentioned below:

The Constitution Act of 1996 (Act No. 108 of 1996) is a powerful authority in a democratic South Africa. It comprehensively defines the objectives, composition, powers and functions of Parliament, as well as each sphere of government, namely, the National Government, nine Provincial Governments and about 284 Local Governments. It determines what common affairs are and how the institutions should go about managing them economically, efficiently and effectively. The Constitution Act, 1996 (Act No. 108 of 1996) also determines the relationship between the spheres of government and intergovernmental relations among the constitutional institutions and government institutions (Constitution Act, Act No. 108 of 1996).

The Constitution Act, 1996 (Act No. 108 of 1996) is regarded as the supreme law of the Republic of South Africa and sets out the rules for governing the country. It protects the rights of its citizens. Many pieces of legislation have been passed in order to ensure that the basic provisions enshrined in the Constitution Act, 1996 (Act No. 108 of 1996) are effectively implemented. The democratic values and principles provided for in the Constitution Act are vital to the prosperity of the country. The observation of basic values and principles by all organs of state and public servants ensures that there will always be



good governance and transparent and effective utilisation of resources. Good governance and effective administration in each of the spheres of government are essential in facilitating the effective implementation of the transformation process.

The constitutional principles enshrined in chapter 10, Section 195 (1) of the Constitution Act, 1996 (Act No. 108 of 1996) form a sound basis for the transformation process and play a significant role in promoting and transforming service delivery and addressing the imbalances of the past which were based on discrimination against and the marginalisation of certain groups of people who were not getting satisfactory and adequate services from the former government.

The Public Service Act of 1994 (Act No. 103 of 1994) makes provision for the organisation and administration of the public service of this country by regulating the conditions of employment and all other related matters, including all the provisions in the Public Service Regulations of 2001 which are based on the Public Service Act of 1994.

The purpose of the Public Service Act of 1994 is to ensure that public servants become transparent, effective, efficient and economical in the utilisation of limited resources and that they must serve the public honestly and without involving themselves in any form of corruption and fraudulent activity. Hence, the transformation of the public service is basically intended to improve and promote service delivery which is the right of all people of this country and not the privilege of a few as was the case in the past. The Public Service Act of 1994 which regulates behaviour and actions within the public service is applicable to all public servants and any one found contravening the provisions of the Act and the Public Service Regulations of 2001 is subject to severe disciplinary measures (Public Service Act of the 1994 and Public Service Regulations of 2001).

Besides responsibility, effectiveness, accountability and efficiency as the key concepts for the improvement of the quality of service delivery, the training and development of the public service was of paramount importance. The training and development that black

people underwent during the apartheid era was not job-related or intended to empower them to be able to manage work-related issues competently or to improve service delivery or to make sound and objective decisions. The black education system that prevailed at the time was not meant to develop a black person to be self-reliant and take any initiative independently. People were not equipped with the appropriate skills and knowledge to facilitate their being effectively creative and innovative. Hence, when the democratic government came into power in 1994, one of its objectives was to ensure that most black people appointed in the managerial positions underwent appropriate training and development through attending workshops, conferences and job-related courses, and pursuing relevant academic degrees. In view of the fact that the new public service was comprised of people with different career paths and their own potential, the government then "...proposed an integrated approach to facilitate human resource development through the use of a performance management system, the main purpose of which was and still is to ensure that employees receive development and training because it has a bearing upon the promotion and facilitation of service delivery. Hence, the government is seriously taking cognisance of training and development (Kanyane, 2004:237 and Van Dijk & Thornhill, 2003:461).

The White Paper on Transforming Public Service Delivery (1997) which is in line with the provisions of principles enshrined in the Constitution Act, 1996 (Act No. 108 of 1996) called on all departments in the national and provincial spheres of government to ensure that service delivery was a priority. The Paper furthermore enabled departments in all spheres of government to develop service delivery strategies in order to promote continuous improvements in the quality, equity and quantity of service delivery in the entire country.

The major objective of the Batho-Pele White Paper is to provide a policy framework as well as the practical implementation strategy designed especially for the transformation of Public Service Delivery in particular. Batho-Pele principles ensure that there is a public service capable of meeting the challenges of improving the delivery of services to all the people of the Republic of South Africa. As access to decent and clean water was limited to a few during the era of the former discriminatory government, the current

government ensured that all people shared access to decent services as it was the rightful expectation of all people of this country, especially black people, women, the youth and people with disabilities, who had been marginalised and disadvantaged and were not given fair treatment.

Subsequent to the implementation of the Batho-Pele principles, the real guiding principles of public service transformation emerged which endeavoured to reform the services to be delivered to the people as one of the possible means of redressing the imbalances of the past (White Paper on Transforming Public Service Delivery of 1997: 4-5). The transformation process should enable the poor and other vulnerable people to see practical differences between their past lives before this country attained democracy in 1994 and their lives during the past eleven years of independence, since the Batho-Pele principles are aimed at ensuring that the basic needs of the people come first and are accomplished satisfactorily.

It is also worth mentioning that Thakhathi, while addressing employees of the Department of Correctional Services based in Polokwane in the Limpopo Province at a seminar on the transformation process held on 24 July 1998, strongly emphasised the significance of the process of transformation for service delivery. The emphasis of the address was on the White Paper on the transformation of the public service in the Republic of South Africa, transformation goals, strategies and methods of making transformation successful, the role of transformation units and responsibilities of transformation officers in their respective environments (Thakhathi, 1998:3). The research now envisaged would also take cognisance of some of these and many other factors pertaining to the role and impact of transformation on the quality of health-service delivery.

The assessment of the extent to which the transformation process had, indeed, taken place satisfactorily would be judged against the implementation of the eight national principles which had already been identified in the White Paper on Transforming Public Service Delivery (1997:7, 15 and 16 – 22), which follow below:

- consulting users of services: that is, citizens should be consulted about the level and quality of the public service they receive and, where possible, should be given choices about the services that are offered;
- setting service standards: citizens should be told what level and quality of public services they receive so that they are aware of what to expect.
- increasing access: all citizens should have equal access to the services to which they are entitled;
- ensuring courtesy: citizens should be treated with courtesy and consideration;
- providing more and better information: citizens should be given full and accurate information about the public services they are entitled to receive;
- increasing openness and transparency: citizens should be told how national and provincial offices are run, how much they cost, and who is in charge;
- remedying mistakes and failures: that is, to redress, if the promised standard is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy, and when complaints are made, citizens should receive a sympathetic, empathetic, positive and prompt response;
- getting the best possible value for money: public services should be provided economically and effectively in order to give citizens the best possible value for money (Mubangizi, 2005:641 and the White Paper on Transforming Public Service Delivery 1997: 7, 15 and 16-22).

Kroukamp (1999:642) pointed out that Batho-Pele had the potential to ensure that major changes that were achieved were as a result of the way public services were effectively and efficiently delivered. He cautioned that improving public service delivery was not a



once-off exercise or practice, but it was an ongoing and dynamic process because as standards were met, they had to be raised progressively and others could possibly emerge for consideration. The process necessitated a thorough understanding on the part of both the citizens and the public servants especially of the realities and dilemmas emanating from the phenomenon. There is no doubt that Batho Pele is a key policy to unlocking the backlogs of service delivery in the Republic of South Africa.

What should be remembered is that the former government was always characterised by inefficiency, ineffectiveness, corruption, a lack of transparency and openness and was uneconomical; hence service delivery was non-existent or of a very poor quality and inadequate for the majority of the people of South Africa. Subsequently, it was considered necessary and appropriate to transform the public service with a view to delivering services of a better and higher standard based upon the eight Batho-Pele principles. Although challenges were still prevalent at the time of the investigation, it was worth applauding the government of the day that significant improvements had already taken place in various remote rural parts of the country. However, more was still expected to be done in order to ensure that adequate services were accessible to all poor people who were in the peripheral rural areas (White Paper on Transforming Public Service Delivery, 1997).

Another important policy mandate promoting the transformation process was stipulated in The White Paper on the Transformation of the Health System of 1997. The primary objective of The White Paper on the Transformation of the Health System of 1997 was to present the citizens of South Africa with a set of policy objectives and principles upon which the unified National Health System (NHS) was based. The unified Health System was capable of delivering quality health care to the people of South Africa in an efficient way and in a caring environment.

The Paper furthermore presented various implementation strategies designed specifically to successfully meet the basic needs of all the inhabitants, despite the limited resources that were at their disposal. The importance of The White Paper on the Transformation of

the National Health System was that it provided the legislative framework and policy guidelines for health care in South Africa.

The paper dealt with how the South Africa public service became a learning organisation. With globalisation becoming a reality coupled with the technological developments that were inescapable, the people's demands for better quality of goods and services had led the public service to recognise the need to adopt a paradigm shift in learning. Binza (2005:105) argues that learning can be a source of competitive advantage to the degree that it motivates and enables the public service as an organisation and public servants to be more proactive, productive, transparent, efficient and effective in providing quality service in an ever-dynamic environment.

The increasing rate of change due to technological advancements necessitated that there should be a need for the public service to develop a learning culture in order to develop the capacity to redesign, reform, re-align and or re-engineer itself in order to respond effectively and transparently to future changes. The perception was that human resources development was of cardinal importance in government institutions in bringing efficiency, transparency and effectiveness to the delivery of quality in public goods and services.

According to Binza (2005:106) a learning organisation is an organisation in which employees acquire skills, expertise and knowledge through experience, practice or by being taught. A truly learning organisation is one that is able to effectively improve service quality and employee performance, as learning is performance-based.

The Oxford Advanced Learners' Dictionary (1995:671) describes learning as referring to the acquisition of skills and knowledge, in other words, it means to know why something happens or works in the environment. The public service must therefore enable its human resources to learn so as to acquire knowledge, expertise and skills. Performance and productivity can be improved when the public service adopts learning and becomes a learning organisation. Senge in Binza (2005:106) defines a learning organisation as an



"... organisation where people continuously expand their capacity to create the result they truly desire, where new and expansive patterns of thinking are nurtured, where collective aspiration is set free, and where people are continually learning how to learn together".

Marquardt (1999:76) argues that learning organisations have the capacity to collect and store knowledge, transform themselves, and are able to equip their human resources for a co-operative success in the delivery of services and further says that "...it empowers people within and outside the organisation and makes them to be proactive and innovative in shaping resources necessary for organisational growth and sustainability". Hence, it is important for the public service to develop a learning culture and to create a healthy atmosphere which is conducive to enabling public human resources to learn new operational and management skills, applications and techniques to optimise the productivity of the institutions.

Marquardt (1999:107) continues to argue that the failure of implementation occurs when managers, supervisors and subordinates identify challenges and problems in order to take steps to develop solutions, but do not implement those solutions, or implement them insufficiently and/or incorrectly. Failure to deliver services occurs when public servants at all organisational levels fail to recognise an opportunity to implement policies or good ideas; derailment occurs when public servants do not recognise good and noble ideas but lose direction in the implementation process because ideas were not fully developed and effectively implemented.

The Constitution of the Republic of South Africa, 1996 (Act No. 108 of 1996), and the Public Service Act of 1994 (Proclamation No. 103 of 1994), as amended, provide a legal framework in which the public service as a learning organisation can be developed to the extent of promoting the quality of service delivery. For example, Section 195 (1) (h) of the Constitution Act (1996) provides that public administration must "cultivate good human resource management and career development practices to maximise human potential ...". It is argued that political office bearers and public servants are responsible

for transforming the public service into an acceptable learning organisation which is flexible and adaptable and which is not rule-bound. It is in this context that the South African public administration is considered to be development-oriented so that it can adapt to dynamic changes and challenges emanating from the political, economic, social, technological and global environments.

The White Paper on Public Service Training and Education (WPPSTE, 1997:3) acknowledges and recognises the need for an investment in skills development to improve the capacity of public servants which will impact on the improvement of the performance, productivity, quality and cost-effectiveness of the public service. The vision of the WPPSTE provides for "the development of a dedicated, productive and people-oriented public service staffed by public servants whose performance is maximised and whose potential is fully developed via the comprehensive provision of appropriate and adequate training and education at all levels".

The national government is currently also faced with a legacy of inequitable distribution of resources as well as the corrupt and inefficient practices by those who were in authority during the past regime who still resist changes being brought about by the transformation process. So, in order to carry out its mandates and functions as prescribed by the Constitution of 1996 it is, therefore, the responsibility of the government to transform public sector delivery through the processes of transformation and restructuring. Restructuring is the process that the new government has embarked upon since it came into power after the first democratic general elections conducted in April, 1994. In order for all spheres of government in the Republic of South Africa to deliver services effectively and efficiently, and given the existing enormous problems and challenges, it is imperative that the government should strive towards sound principles for service delivery in order to attain certain specified standards. It is a fact that rural health authorities who do not change their mind-sets need to undergo a process of transformation in order to ensure that service delivery is achieved without any compromise. To facilitate the objective of transformation, it is of paramount importance that there must be coordinated efforts from all spheres of South African government in order to build the capacity of rural health authorities in particular for the sake of the communities they are serving.

Accountability, effectiveness, responsibility and efficiency are regarded as the cornerstone of the promotion of service delivery. According to Kuye and Ma'nisa (2003:26), "...internal accountability is a process which holds public service answerable to their line supervisors for their own actions and the actions of their subordinates" on the one hand, and on the other hand, "External accountability, by implication, holds public servants answerable to the public as well." It is, therefore, of paramount importance that if a high standard of service delivery is to be achieved, maintained and improved, public servants are expected to display honesty, transparency, internal and external accountability within their respective institutions and the general public respectively. Although public servants are directly accountable for their actions and activities, first, to their executive authority and administrative authorities in the Republic of South Africa, it is incumbent upon them to ensure that they are also accountable to the consumers of the services rendered by them, especially to the historically disadvantaged black people, women and people with disabilities who are in the peripheral areas of this country.

Although the intention of the government was good in urging the implementation of the transformation process on the improvement of service delivery, it should also be borne in mind that the current government had the serious challenge of inheriting a public service that was characterised by practicing, *inter alia*, corruption, fraud and nepotism during the apartheid era, and such practices could not be eradicated or eliminated immediately at the time when the new government came into power as similar practices still prevailed at the dawn of democracy in South Africa; hence Kanyane (2005:17) also reiterated by echoing more or less the same sentiment stating that, "Since 1994, transformation has also created opportunities for corruption" and other social ills that are currently depriving the South African citizens of their rightful basic services and benefits.

### **2.2.3 The international perspective**

Nsingo and Kuye (2005:744) argued that democratic participation as a fundamental concept for improving service delivery in rural local government in Zimbabwe was both intensively and extensively explored. They pointed out that it was vital to show commitment and dedication to the democratic process through implementation plans that



compelled the local authorities and councillors in Zimbabwe's rural district councils (RDCs) to actively involve communities in the service delivery process. The authors furthermore acknowledged that although Zimbabwe had arguably adopted commendable local government policies and guidelines and had established appropriate structures for democratic participation, the practice did not really justify the anticipated efforts displayed by members of the local communities. They noted that RDCs tended to minimise or underplay the role of the local communities in service delivery and this invariably led to uninformed communities and quasi-compliance. It was also noted that RDCs should sensitise local communities to the fundamental values of democratic participation and ensure that all council deliberations were premised on community input. It was also noted that councillors in Zimbabwe were compelled to provide intelligible and timely reports to communities to 'keep the latter informed of council's actions as a way of trying to comply with the important 'consultation principle' as it applied in Zimbabwe. In the Republic of South Africa, the principle of consultation is embodied in the *Batho-Pele* policy which has been developed and is currently being applied in South Africa to promote the quality of health-service delivery.

Haycock and Stone (2005:62) noted that the move towards contracting services as a way of improving the quality of service delivery originated in Britain during the 1980s, under the Conservative Party Government. For instance, municipal parks and recreation maintenance facilities were ideally suited to being commercialised in order to achieve the government's pre-determined objectives. Hence, the South African Government also promotes commercialisation as a tool towards systematically transferring services, like urban environmental maintenance, from the public to the private sector where services are regulated by market and price mechanisms. Unfortunately this initiative is not supported by the ANC alliance in South Africa, such as the South African Communist Party (SACP), Congress of South African Trade Unions (COSATU) and the African National Council Youth League (ANCYL), to mention but a few, because it is perceived to be related to the privatisation process, the concept of which was not approved by the said members of the alliance because it had negative connotations. It was apparently believed that it promoted, among many things, unemployment and poverty and

subsequently the rift in the alliance has become obvious. The ANC leadership has indicated that there was no crisis in the alliance, however.

Nsingo and Kuye (2005:745) mention that the fifty-seven Zimbabwean Regional District Councils (ZRDCs) are expected to provide services of a local nature and initiate and implement sustainable development projects for rural communities within their respective areas of jurisdiction. They ensure that the welfare of the rural people is improved to enjoy the good life which independent Zimbabwe should offer all Zimbabweans. It has also been noted that prior to Zimbabwe's independence, rural black people were denied access to fertile land, agricultural loans, and were subjected to socio-economic and political deprivation resulting from the colonial era, and were denied full entry into the money economy of their own country. They were also subjected to gross poverty. They were denied participation in politics, access to education and health services and given an inferior citizen status. Nsingo and Kuye (2005:750) further argue that the process of democratic participation implies active citizenship and ownership and is, furthermore, expected to benefit all the people of Zimbabwe who are engaged in local government, also inclusive of communities, councillors, local officials and ultimately the Central Government.

Regional District Councils (RDCs) of Zimbabwe are presently still regarded as the engine of local development and hence, the heart of democratic participation. Local development can only be meaningful to the local members of the communities if they are given the opportunity to actively participate in the determination and prioritisation of needs, programmes and projects initiated to contribute to their development (Nsingo and Kuye, 2005:757).

On the internet, the researcher found that the telecommunication industry had transformed the industry in services rendered from "A la Carte Services" to "Networking solutions", from "Best effort" to "Mission critical", from "Mobile Access" to "Ubiquitous wireless" and from "Service Provider" to "Business Partner". All those dynamic challenges and changes, following the implementation of the transformation



process, eventually improved service delivery and maximised the output and outcomes (<http://www.idc.com/getdoc.jsp?containerId=IDC-P9631>).

The government of Canada undertook a number of transformative initiatives to improve the quality of services to Canadians and to enhance the efficiency and value-for-money of government investments. The government indicated that its work was driven mostly by the needs and expectations of the Canadians. Community participation and involvement were recognised as keys to the promotion and facilitation of the quality of service delivery. Citizens and businesses were looking for convenient single-window, multi-channel access to government services, seamlessly integrated across programmes, departments and jurisdictions (<http://www.gol.ged.gc.ca/rpt2005/rpt09-c.asp>).

The following were, inter alia, the initiatives and supporting tools: the Enabling Government Transformation Expenditure Management Information System (EMIS), Business Transformation Enablement Program (BTEP), and Transformation Information Technology and Corporate and Administrative Services (TTCAS). The Canadian government strongly believes that programmes, activities and institutions need to be transformed when the need arises and especially whenever service delivery starts deteriorating. This implies that new missions and objectives on service delivery need to be reviewed periodically for the best benefit of the services' customers (<http://www.gol.ged.gc.ca/rpt2005/rpt09-c.asp>).

Telecommunication Transformation Strategies Services (TTSS) under the IDC Continuous Intelligence Services analysed the motivational and probable outcomes of the telecommunication industry's migration from a capital intensive and technology focus to a user-centric service delivery model. The TTSS evaluated successes and failures as service providers initiated new tactics for application-aware networking, managed solution selling, integrated wireless-wireline services, innovative channels and enhanced customer management (<http://www.idc.com/getdoc/getdoc.jsp?containerId=IDC-P9681>).

As part of transformation, the Ministry of Community Safety and Correctional Services of Ontario entered into a public-private partnership in the areas of correctional operations such as the supply of electronic appliances for Ontario's expanded electronic surveillance programme as well as treatment and forensic psychiatry services as part of the St. Lawrence Valley Correctional and Treatment Centre being developed in Brockville. Although the transformation focused on certain areas where service delivery was deteriorating, the government of Ontario still remained responsible for certain important facilities by setting and enforcing results-based performance standards. The performance standards which were realistic and measurable objectives were to be met by all operators and suppliers. It was the fundamental objective of the Ontario government to continue to explore options for improving safety and effective standards in prison transformation services as well. Transformation was regarded as the mechanism whereby service delivery would be promoted and facilitated in the government of Ontario (<http://solutions.gc.ca/oro-hgc/tool/profiles-profiles-profiles13e.asp>)

## **2.3 CONCLUSION**

Chapter Two dealt with the literature and legislative framework with regard to the role and the impact of the transformation process on the quality of the health-service delivery. The major purpose of the chapter was to review briefly some recent literature published to date as well as the pieces of legislation promulgated since 1995 to date and considered to be pertinent to the transformation process, with a view "... to ascertain whether there is availing evidence in the field that similar research has been done in the delimited geographical area" (Van der Waldt *et al.*, 2002:285). Another reason for the literature review was to enable the researcher to determine whether the problem to be investigated had not been researched before so as to avoid duplication of survey research. The researcher, during literature and legislative framework review looked at local, national and international perspectives dealing with the role the transformation process played in promoting and facilitating the quality of health-service delivery especially in Mutale sub-district of the Vhembe Health District of the Limpopo Province in South Africa.

The following chapter, Chapter Three, focuses on the empirical investigation into the impact of the transformation process on the promotion and facilitation of the quality of health-service delivery in Mutale sub-district in the Vhembe Health District.

## **CHAPTER THREE**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 INTRODUCTION**

This chapter focuses on the research methodology applied during the investigation. The chapter deals with the pilot study, research design, the target population, methods of data collection, data collection techniques, research analysis technique, random and purposive sampling, the sampling procedures, the format of the questionnaire, methodological shortcomings or limitations and intervention mechanisms for overcoming shortcomings.

#### **3.2 PILOT STUDY**

The concept "transformation process" has frequently been used in speeches by many executive authorities and senior public servants of this country in various places such as at meetings, workshops, conferences and seminars, as well as in much documentation ever since the new democratic government came into existence.

The survey study sought to determine the impact of the transformation process on the health-service delivery. The researcher found it necessary to develop questionnaires that would be appropriate to test the null hypothesis because there were no relevant measuring instruments on the market designed to test it at the time of conducting the current research study in the Vhembe Health District. It would only be possible to publish new instruments for this purpose after the researcher had developed them based upon the pilot surveys conducted among the relevant samples in particular or the population in general. Hence, at the outset, the researcher took a brief look at the definition, purpose, value and role of a pilot survey so that the readers of the investigation would have a common understanding of the concept as it was applied in this particular context.

Madzivhandila (1992:110) quotes Robinson as having defined a pilot survey as an investigation in which the researcher or the user of the data performs what could be referred to as a mini-experiment during which items are administered to a small group of

about four, five or six participants. According to McBurney (1994:185), the pilot study is the "... tentative, small study done to pretest and modify study design and procedures" and to "... find bugs in the procedures". A pilot survey is, therefore, a trial preceding the actual experiment that is performed on a small group of subjects from the same population from which the sample for the actual experiment will be drawn. In his definition pertaining to a pilot study, Leedy (1974:136) says that the "questionnaire should be pretested on a small population in what is often referred to as a pilot study".

The main purpose, role and value of the pilot survey is that it assists the researcher or the developer of the questionnaire to verify whether there are items constituting the questionnaire that might have been misconceived, miscommunicated, misconstrued or miscomprehended by the respondents. It is of paramount importance to consider the pilot study as a valid source of information concerning the credibility for a huge pool of items that provides the opportunity to the researcher to become closely acquainted with the prevailing circumstances (Leedy, 1974:136).

Madzivhandila (1992:111) furthermore mentions that Robinson is one of the prominent authors who emphasises the role played by a pilot study and indicates that one of the best methods for the novice researcher to develop better, reasonable, firm and vivid experimental research is first, to develop or construct a pilot survey that will yield the desired outcomes. Even Carlsmith *et al.* (1976:162) support the idea of conducting a pilot survey before the administration of the final version of questionnaires to the respondents when they argue that, "The most general technique for finding out just what an independent variable treatment is doing to people is to run some pilot tests", because questionnaires are always designed to fulfil a specific objective a researcher might have in mind. Hence, a pilot survey is regarded by some researchers as a mini-experiment that could assist to either eliminate vague and ambiguous items, or assist in adding the omitted ones that are relevant and important to the investigation.

Madzivhandila (1992:112) indicates that, "... items that might be found to be contributory to misunderstanding and ambiguities when performing the pilot study on a reasonably small group of subjects similar in character to those who would be participating in the study, can be dropped or modified; this procedure can be repeated



until the sensible and logical final set of questions forms a questionnaire that could be applied with confidence to the randomly-selected sample". According to the same author (1992:112-113), Van Niekerk is quoted as having said that a pilot survey is an important and indispensable measuring tool or instrument designed to pre-empt the mistakes that might feature predominantly in the final questionnaires of the research survey. He says that the pilot investigation helps especially the novice researcher to become conversant with and aware of the significant variables he/she might have overlooked or omitted while compiling provisional questionnaires from a huge pool of items.

According to Elmes *et al.* (1999:444), the pilot study is the "preliminary research undertaken to discover problems of method and design for a subsequent full-scale project"; whereas Mason and Bramble (1978:63) refer to a pilot study as "... a small-scale version of the proposed study, with a restricted sample of subjects".

It is also worth pointing out that Nisbet and Entwistle (1970:51) say that "... the provisional draft of the questionnaire is pre-tested on a pilot similar to the sample to whom the questionnaire will be given ... the pilot run will show up flaws and ambiguities, and it provides an invaluable check on the options in multiple-choice items and on the feasibility of the proposed procedure for coding responses". Hence, it is considered appropriate where there is no scientifically-tested, reliable and valid measuring tool, to embark upon a pilot investigation because it is essential when drafting a provisional questionnaire and can eliminate items that may appear vague, ambiguous, meaningless, or conflicting. It has been noted in the past by novice researchers that its role is that items characterised by irrelevant questions, ambiguous construction of sentences and incorrect phrasing or wording could be discarded completely so that only those items or questions that are appropriate and relevant to the investigation remain to constitute the final questionnaires suitable for administration on the respondents with a view to obtaining the correct results or outcomes.

The researcher, with the assistance of the medical professionals and nursing personnel in the Vhembe Health District, endeavoured to construct many items that were relevant to health issues that might have either a positive or a negative impact on service delivery in the rural communities if heeded or not heeded respectively. The provisional versions of

questions were reviewed after having been administered to the pilot group which was comprised of members of the communities and public servants based in the rural districts.

The preliminary study was conducted in order to afford the novice researcher in this field of study an opportunity to determine with precision the general content of the final questionnaires, their credibility, clarity, readability and duration. Questions of which the preliminary versions were comprised were all based on close-ended and open ended formats, as these were the formats proposed for the final questionnaires that would be responded to by the final participants. The researcher included open-ended types of questions since he had chosen the qualitative method for collection of data and this assisted him to interpret and consolidate the findings meaningfully and effectively. Hence, the final versions of the questionnaires were considered appropriate to yield the best and desired outcomes. The data collected, analysed and interpreted as well as the conclusions and recommendations appear in Chapters Three, Four and Five.

### **3.2.1 Constitution of the pilot sample**

Two sub-districts out of the four in Vhembe Health District, namely, Makhado and Mutale, were randomly selected and the latter was also purposively selected. The first sub-district, Makhado, was used for the purpose of the pilot research and the second one, Mutale, was randomly and purposively selected for data collection in the final investigation.

The pilot group was comprised of two sub-samples, namely, six health-care personnel in their own health-care facilities and six members of the communities who visited the health-care facilities; that is, six respondents from each sub-sample took part in the pilot study from 24 July to 14 August 2006. Numbers were assigned to each of the four sub-districts, namely, Makhado, Musina, Mutale and Thulamela. Code number 1 was assigned to Makhado as sole identification, followed by code number 2 to Musina, code number 3 to Mutale and code number 4 to Thulamela. Cards bearing the numbers of the four sub-districts were put in a container and shuffled several times and a ten-year-old child, unaware of what was taking place, was requested to take two cards out of the container, one after the other. The first two cards taken out of the container constituted

the pilot sample comprised of two sub-districts. The same procedure used for constituting the pilot sample was applied for the sampling of the health care facilities which are within the catchment area of Elim hospital in Makhado sub-district (Carlsmith *et al.* 1976:177). The health-care personnel who volunteered to participate in the pilot survey at the health-care facilities (clinics) were randomly selected in terms of the sampling procedures. Cards bearing their names were used, and were picked out of the container by the same ten-year-old child. The pilot sample comprised two sub-samples of six public servants and six patients or members of the communities respectively.

### **3.2.2 Results of the pilot investigation**

The pilot survey was conducted in the health-care facilities within the catchment area of Elim hospital in Makhado sub-district between 24 July and 14 August 2006 after the Health District Manager had verbally approved in principle that the survey could go ahead as planned. Out of the six public servants who received the pilot questionnaires, only four responded to the items and returned the questionnaires to the trained enumerator. The other two respondents did not return the questionnaires to the enumerator, whereas all six members of the communities who had received and responded to the questionnaires returned them to the enumerator. The original questionnaires for public servants were comprised of a pool of 29 items each; but after the pilot survey, the final version of the questionnaires was reduced to 25 different items each. The original questionnaires for the members of the communities consisted of 26 items each, but the final version consisted of only 20 different items each.

The pilot study revealed that there were vague and ambiguous items in both types of questionnaires in respect of the health care personnel and of the members of the communities. Those items were deleted so as not to form part of the final questionnaires, and all possibly irrelevant items were discarded or modified to suit the circumstances because some of the discarded items were quite misleading and vague in the context of this survey study. Relevant items that had been omitted due to oversight were included to be part of the final questionnaires that were administered to the actual respondents in Mutale sub-district. The composition of the initial pilot questionnaires and those of the

final questionnaires were significantly different from each other, which showed that the pilot survey played an important role in the constitution of the final questionnaires.

### **3.3 RESEARCH DESIGN**

The research methods used in the research were quantitative and qualitative. As the research was descriptive and documentative in nature, the information collected was presented in the form of frequencies, percentages, tables, graphs and figures in chapter 4. The method was three-fold: First, a literature and legislative framework survey was undertaken to consider the new statutory framework on the process of transformation; second, an empirical study was conducted to discern the real role played by the transformation process and the impact it had on the quality of health-service delivery in the public service; and third, an analysis was done by means of a chi-square test, based on the data collected from various sources. This was followed by making appropriate conclusions and recommendations in Chapter 5 wherever gaps existed due to, inter alia, inadequacies in the implementation of legislation dealing with the transformation process on promoting and facilitating the quality of health-service delivery.

### **3.4 TARGET POPULATION**

The target population of interest in this mini-dissertation included public servants working in the Vhembe Health District and particularly those in the sub-districts of Makhado and Mutale, and members of the communities who visited the primary health-care facilities for consultation at the time of conducting the surveys in the respective sub-districts. To draw a random sample and a purposive sample of respondents, letters were written to the Research Committee under the Directorate: Transformation and Transversal Services in the Department of Health and Social Development in the Limpopo Province, seeking permission to conduct surveys in its health-care facilities. After approval had been obtained, a decision was taken on the method and technique of sampling and selecting the participants. The respondents consisted of public servants (PS) and patients or members of the communities (CL) in the already sampled sub-districts within the Vhembe Health District.



### **3.5 THE NEED FOR AND IMPLEMENTATION OF SAMPLING METHODS AND PROCEDURES**

The researcher considered using stratified sampling procedures because there were two distinct sub-samples, public servants and members of the communities in the sub-districts, which groups were represented in the final survey sample. According to Brynard and Harekom (1997:44), the sample drawn from strata "... improves the reliability of the results of the research. Under-representation of the strata in a sample or the non response of elements in the sample could result in bias in the conclusions reached by the researcher." Random and purposive sampling were chosen as appropriate and unbiased methods of assembling samples of respondents in the context of this type of survey research. Huysamen (1976:15) recommends random sampling as the process of selecting cases "... from a population in such a way that each and every distinct sample of a particular size, N, has an equal chance of being selected".

Random sampling was necessary for this survey study because the envisaged population in the Vhembe Health District was too large for all its subjects to be observed or subjected to any level of treatment. Such a situation required that a representative and manageable group of respondents be randomly selected for any scientific study. Vockell (1983:104) mentions that "The manner in which a sample is drawn is an extremely important factor in determining how useful the sample is for making judgements about the population from which it is drawn". This ensures that the sample should be representative of the target population of interest.

In random sampling no favouritism in the selection of subjects is entertained. Instead, one finds that every member of the population about which the study would like to generalise, has an equal opportunity of being sampled for participation in the research study. This method, therefore, ensured that all respondents in this mini-dissertation had an equal opportunity to participate in the research survey and to be represented by the survey sample.

The final sample of the investigation was comprised of a total of one hundred and fifty (150) participants, that is, one sub-sample, namely, public servants, consisted of seventy-



five (75) respondents and the other seventy-five (75) was comprised of members of the communities in the Vhembe Health District in the Limpopo Province, the details of which data are presented and analysed in Chapter 4. Given the fact that there were only fourteen clinics and one Health Centre in Mutale sub-district the researcher, by virtue of the limited number of health-care facilities in the sub-district, decided that the participants be purposively selected in Mutale sub-district and furthermore ensured that the respondents of the two sub-samples were randomly selected from each health-care facility for this particular purpose.

On the basis of the lists of the personnel made available to the researcher by the health-care facilities through the District Manager, the names of health-care workers for each health care facility were written on cards as the first option of sampling. In randomly selecting five (5) respondents per health-care facility, the names of the health-care personnel per clinic were assigned numbers on the cards and the cards were put into a container or basket. The cards were mixed and thoroughly shuffled to avoid taking them out in the same sequence as they were put into the container. The same ten-year-old child who was unaware of what was being done was once again requested by the researcher to pick one card after another out of the basket until the required number of respondents or public servants per clinic had been obtained for the final investigation. The same procedure of randomly selecting five (5) members of the communities visiting a particular health-care facility on the day of the survey were repeated until a total number of one hundred and fifty (150) respondents were obtained after consulting within the health-care facilities in Mutale sub-district. As a second option to the previous procedure of random sampling which was not considered for this survey, the researcher could have considered using tables to constitute a representative sample (Brynard & Hanekom, 1997:45), but did not do so because the first one was appropriate for the research study being undertaken.

A purposive sample is one that is selected non-randomly for some particular reason. According to McBurney (1994:449), a purposive sample is frequently preferable to a random sample. The researcher surveyed the population that had identifiable sub-groups, namely, public servants or internal clients (PS) and members of the communities or external clients (CL) that were likely to differ in their responses, and on the basis of that

prevalence accuracy could only be improved by selecting a stratified random sample, the procedures of which he adhered to in the survey research under consideration. The population was comprised of public servants and members of the communities who visited the primary health-care facilities for consultation. The researcher had reason to believe that they might respond differently on the dependent measures or variables. The researcher's point of argument is supported by McBurney (1994: 207).

### **3.6 METHODS OF DATA COLLECTION**

The research methods used in this survey were, first, the quantitative method because statistics generated due to the close ended type of questionnaires necessitated that the data be collected in this manner and, second, the qualitative method was used because open-ended questions were used in the collection of data, and third, the documentation method was considered in which a case study was used. The documentation method was considered necessary because it used phenomenon analysis, concept analysis and contextual analysis of the collected data (McNeill, 1990:7 and Van der Walci, 1999). The survey results elicited by all three methods which were analysed statistically and also in terms of tabular-graphic descriptions, were reflected in terms of frequencies, percentages, tables, figures and graphs and eventually presented in chapter 4. This was followed by appropriate chapter descriptions, conclusions and recommendations in Chapter 5.

### **3.7 DATA COLLECTION TECHNIQUES**

Subsequent to the fact that the researcher decided to use the quantitative, qualitative and documentation methods as the methods of collecting data in this survey research, it is appropriate to mention that close-ended questionnaires, open-ended questionnaires and documentation were the relevant research techniques used to generate the relevant survey data. The researcher administered structured or close ended questionnaires and unstructured or open-ended questionnaires to the pilot and final respondents in Makhado and Mutale sub-districts and a case study received from the Department of Health and Social Development was used in the final investigation to check against the findings yielded by quantitative, qualitative and documentation techniques (Van der Walci *et al.* 2002:290).

In view of the fact that open-ended questionnaires had comparatively more shortcomings than the close-ended questionnaires, the researcher decided to use very few open-ended items as compared to the close-ended items for the collection of data due to the fact that the latter were easy to codify, analyse and interpret. The distribution of the questionnaires among the respondents and collection was done within one month by the three trained enumerators whose responsibilities were the distribution, completion and return of questionnaires to the researcher so as to eventually enable him to systematically compile data to be processed with the assistance of the technicians and statisticians.

### 3.8 RESEARCH ANALYSIS TECHNIQUE

The non-parametric statistical test selected and used by the researcher in the survey research was the Chi-square test (abbreviated  $\chi^2$  test). The researcher considered the appropriateness of the Chi-square test because the dependent variables were measured on a nominal scale resulting in the obtained data's being in frequencies. The purpose of using the Chi-square test in this context was to establish whether a significant statistical difference (SSD) existed between the actual, observed frequencies (A) and the expected or theoretical frequencies (E) (Behr, 1983:80; Huysamen, 1976:89). The formula that was employed in the quantification of the survey data by means of the Chi-square test was as follows:

Figure 1: Chi-square formula

$$\chi^2 = \left[ \frac{(A - E)^2}{E} \right]$$

where A represents actual or observed frequencies of occurrence and E represents the expected or theoretical frequencies of occurrence.

The statistical method used in analysing the data in this case was a one-tailed test due to the fact that the alternative hypotheses were directional, that is, they were symbolised by < or >, that is, less or more than the critical or table value. It should be borne in mind that whenever the Chi-square test was administered, justification for rejecting the null hypothesis was based on the fact that the computerised values were less or more than the appropriate critical values as reflected in the tables (Behr, 1983:79; Mason & Bramble, 1978:206-210 and 246). Both the presentations and analyses of data and testing of hypotheses were performed by the computer of the University of Limpopo, making use of the SPSS, that is, the Statistical Package for Social Services.

### **3.9 METHODOLOGICAL LIMITATIONS AND MECHANISMS FOR OVERCOMING SHORTCOMINGS**

A few possible limitations anticipated by the researcher in this investigation need to be pointed out as well as the respective mechanisms for overcoming them so that the survey research process would be meaningful and successful.

#### **3.9.1 Limitations**

- the display of negative attitudes and possible lack of co-operation from the department and institutional authorities and their respective respondents;
- anticipated financial constraints to cover travel and accommodation costs, questionnaires and production costs;
- resource capacity problems such as unavailability of documents, faxes, computers and photocopiers, to mention but a few; and
- the inaccessibility of indispensable documents, especially those which have been classified, but which would be very relevant to the survey research, and the validity and reliability of the questionnaires.



### 3.9.2 Mechanisms for overcoming shortcomings

- The researcher and the Acting MPA Programme Manager applied to the Research Committee of the Department of Health and Social Development for permission to conduct the survey in the Vhembe Health District, with special reference to Mutale sub-district. The researcher also indicated the purpose of the survey study and how the findings of the study would benefit the department and members of the communities with regard to the improvement of the quality of health-service delivery in the Limpopo Province. It was imperative for the researcher to make appointments with the health-care supervisors of Mutale and Tshipise local areas and the Health Care Centre in advance regarding the visits to the health-care facilities and the surveys to be conducted with the randomly and purposively selected respondents.
- The researcher made use of trained enumerators to assist in the distribution and completion of the questionnaires. He used statisticians and technicians for the analysis and interpretation of the survey data.
- The researcher or trained enumerators assembled the respondents in one place, for example, an office or a hall, and demonstrated to the respondents how to answer the questionnaires by writing, explaining and/or making use of flip-charts.
- Fund-raising through the identification of potential sponsors within the communities was also considered as a contingency plan should there be any need for incurring financial expenditure beyond the researcher's means.
- The researcher assured confidentiality in writing with regard to classified or any information provided from whatever sources and also reassured those who were responsible for the custody of documents that they were only

meant for survey purposes and would not be made available to any other people or institutions without their consent.

- A pilot study was conducted by the researcher to restructure and modify irrelevant items in the questionnaires and to delete ambiguous items. It was through the pilot survey that other relevant items or questions which had unintentionally been omitted due to oversight became part of the final questionnaires.

### **3.10 CONCLUSION**

This chapter, Chapter Three, paid attention to the research methodology applied during the investigation. The chapter dealt with the pilot study, research design, method of research, the target population, methods of data collection, data collection techniques, research analysis technique, random and purposive sampling, the sampling procedures, the format of the questionnaires, methodological shortcomings or limitations and intervention mechanisms for overcoming such challenges.

The research methods used in the research were quantitative and qualitative. As the research was descriptive and documentative in nature, the information collected was presented in frequencies, percentages, tabular and graphic forms in Chapter 4.

The researcher considered using stratified sampling procedures because there were two different sub-samples comprised of public servants (PS) and members of the communities (CL) in the sub-districts. Those two sub-samples were represented in the final survey sample. According to Brynard and Hanekom (1997:44) the sample drawn from strata also "... improves the reliability of the results of the research".

The non-parametric statistical test selected and used by the researcher in the survey research was the Chi-square test (abbreviated  $\chi^2$  test). The researcher considered the Chi-square test to be appropriate because the dependent variables were measured on a nominal scale resulting in the obtained data being represented in frequencies.

In view of the fact that the researcher decided to use the quantitative, qualitative and documentation methods as the relevant methods of collecting data in this survey, close-ended questionnaires, open-ended questionnaires and a case study were the relevant survey techniques that generated the relevant survey data. The researcher administered structured or close-ended questionnaires and unstructured or open-ended questionnaires to the pilot group and final respondents in Makhado and Mutale sub-districts; and a case study from the Department of Health and Social Development was used against which to check the findings yielded by both quantitative and qualitative methods. The following chapter, Chapter Four, will reflect the findings of the survey data in the tabular and graphic descriptions.

## **CHAPTER FOUR**

### **THE FINDINGS OF THE SURVEY RESEARCH**

#### **4.1 INTRODUCTION**

The focus of Chapter Three above was mainly on the pilot survey, the development of the measuring instruments, sampling methods and data collection in the Makhado and Mutale sub-districts in the Vhembe Health District in the Limpopo Province of South Africa. The district, like the other four health districts in the province as well as in the entire Republic of South Africa, was established in terms of the National Health Act, 2003 (National Health Act, 2003: Act No. 61 of 2003).

The current chapter deals specifically with data collection, analysis, tabular and graphic presentations, interpretation and discussions of the data. Two different sets of close-ended and open-ended questionnaires were administered to the respondents comprised of two sub-samples, one of public servants (PS) and the other of members of the communities (CL) in the randomly and purposively sampled sub-districts and respondents.

#### **4.2 BACKGROUND IN RESPECT OF MUTALE SUB-DISTRICT**

The Vhembe Health District, in which Mutale sub-district is located, has a total population of one million two hundred and eighty-one thousand eight hundred and twenty-two (1 281 822) people (Appendix E), whereas Mutale sub-district is known to have a population of eighty-three thousand two hundred and seven (83 207) people (Appendix E). The topography of Mutale sub-district is mountainous, that is, it is a mountainous sub-district in which most communities are not easily accessible to one another and it is now in the process of gradual socio-economic development. Many users of the health-care facilities had to travel long distances to access the health-care facilities, whereas the legislation provides that all health care facilities must be within 5 km's reach by members of the communities.



Before the Republic of South Africa attained democracy in 1994, there were only fourteen (14) primary health-care institutions and one Health-Care Centre based at Tshilamba Township. According to Appendix E, the survey research conducted revealed that during the past eleven years of democracy no additional clinics had been built or established as a way of addressing the backlogs left by the previous apartheid regime in spite of the fact that the Head of the department said that "... we have increased our fixed clinics to 392 ..." in the Limpopo Province (Annual Report: 2005/2006 Financial Year: 1), whereas, on the other hand, the survey revealed that no clinic was built in Mutale sub-district since 1995 (Appendix E). The non-erection and non-establishment of new health-care facilities in Mutale sub-district signified a drastic drawback in this part of Limpopo Province which was regarded as the poorest of the nine provinces of the Republic of South Africa.

The survey study revealed that the transformation process that the sub-district had longed for during the past eleven years had not been effectively implemented by the authorities of the district in particular and the provincial government in general on the one hand, while on the other hand, the new government ensured the improvement in the quality and standard of health-care services especially in the grossly neglected, disadvantaged and marginalised areas of the entire Limpopo Province, let alone the Republic of South Africa. The survey data collected also revealed that the average distance between the clinics within Mutale local area was seventeen comma one kilometres (17,1km) whereas in terms of the National Health Act, 2003 ( Act No 61 of 2003), the clinics should be within 5 kilometres walking distance or reach by the patients or clients. Seventeen comma one kilometres posed a serious challenge to the patients or prospective clients of the clinics in the said local area. The average distance between clinics located in Tshipise local area was nineteen comma eight kilometres (19,8 km). The average distance between the health care institutions within the entire Mutale sub-district was seventeen comma five kilometres (17,5 km).

Mutale local area had fifty-three percent (80) of the randomly and purposively selected respondents in its primary health-care institutions while Tshipise local area had forty percent (60) of its respondents identified for the survey and Mutale Health Centre had seven percent (10) of the entire sample, giving a total of one hundred and fifty (150)

respondents randomly and purposively selected for the survey research in Mutale sub-district.

### **4.3 TABULAR AND GRAPHIC DESCRIPTIONS OF SURVEY DATA**

This section presents the data of the investigation that was conducted in the Mutale sub-district in the Vhembe Health District which is regarded as one of the poorest and deepest rural districts in the Limpopo Province of South Africa. Two sets of questionnaires which differed in content, one for public servants (Appendix H) and the other for members of the communities (Appendix I), were administered by the researcher through the three trained enumerators based in Mutale sub-district. The developed and modified sets of questionnaires were indispensable in the survey study due to the fact that they afforded the researcher the opportunity to comprehend the effect and impact the transformation process had on the quality and standard of health-service delivery in the remote rural areas, that was historically grossly disadvantaged by the discriminatory apartheid regime of the white minority.

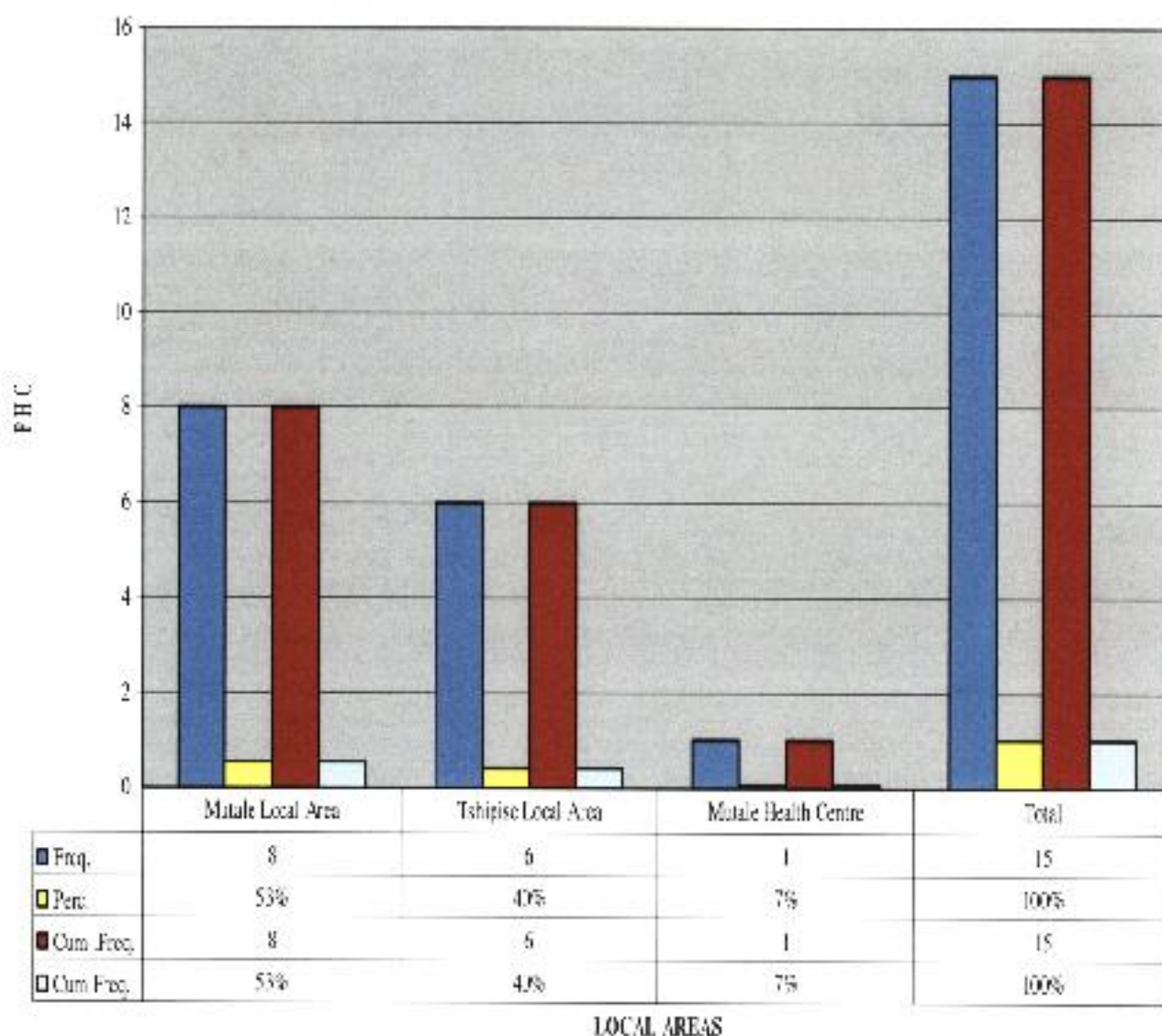
Although Mutale sub-district is geographically a vast area, the researcher decided to use all the health-care facilities in both local areas because there were few of them and they were manageable as far as the distribution and collection of questionnaires were concerned. The sub-district was divided into local areas, each with a responsible and dedicated supervisor. It was possible for each supervisor to distribute the questionnaires and also assist in their completion, although, comparatively speaking, the questionnaires had many items or questions. This was done deliberately in order to tap into more data since the issue of the transformation process and its role and impact on the quality of health-service delivery were complex and also a new phenomenon during the past eleven years of democracy in the Republic of South Africa. The researcher was interested in collecting abundant data so that he could arrive at informed conclusions and recommendations about the survey findings in Mutale sub-district within the Vhembe Health District in Limpopo Province. The entire district in particular and the province in general were regarded as the most deeply rural one in nature, and which had suffered much marginalisation before democracy was attained in 1994.

The final investigation was conducted in Mutale sub-district in October 2006 after approval to make use of the health-care workers of the health-care facilities and members of the local communities who were patients during their visits to the health-care facilities had been obtained from the Head of the Department of Health and Social Development (Appendix C). A request was also directed to the District Manager by the researcher for a list of health-care facilities, the Health-Care Centre, including the total number of health-care personnel in respect of each local area in Mutale sub-district which was furnished by the Vhembe Health District in Limpopo Province (Appendix D).

Below follow tabular and graphic descriptions of the survey study for easy understanding and in which the data or variances have been reflected in terms of frequencies, cumulative frequencies, percentages and cumulative percentages which have been elicited from the responses provided by the public servants and members of the communities of Mutale sub-district in Vhembe Health District for each of the items in the questionnaires. The presentation of each tabular-graphic description will be followed by a description of the responses in terms of the frequencies and associative percentages.



TABLE 1: Distribution of frequencies of Mutale sub-district local areas



It is observed from the data shown above in Table 1 that Mutale sub-district is comprised of three local areas, namely, Mutale Local Area, Tshipise Local Area and Mutale Health Centre. The latter is based at Tshilamba Township. Mutale Local Area consists of fifty-three percent (8 clinics) in terms of the health-care facilities. Forty percent (6 clinics) of the health-care institutions or clinics are based in Tshipise local Area and finally seven percent (1) represents a Health Centre, all of which are based in Mutale sub-district. The total number of health care institutions that were randomly and purposively selected for the purpose of the survey was fourteen (14) and a Health Centre (1) giving a total of



fifteen (15) health-care institutions. The above tabular and graphic descriptions depict the distribution of the frequencies and percentages in respect of the health-care institutions within Mutale sub-district in the Vhembe District of Limpopo Province.

**TABLE 2: Distribution of responses in terms of the PHC facilities**

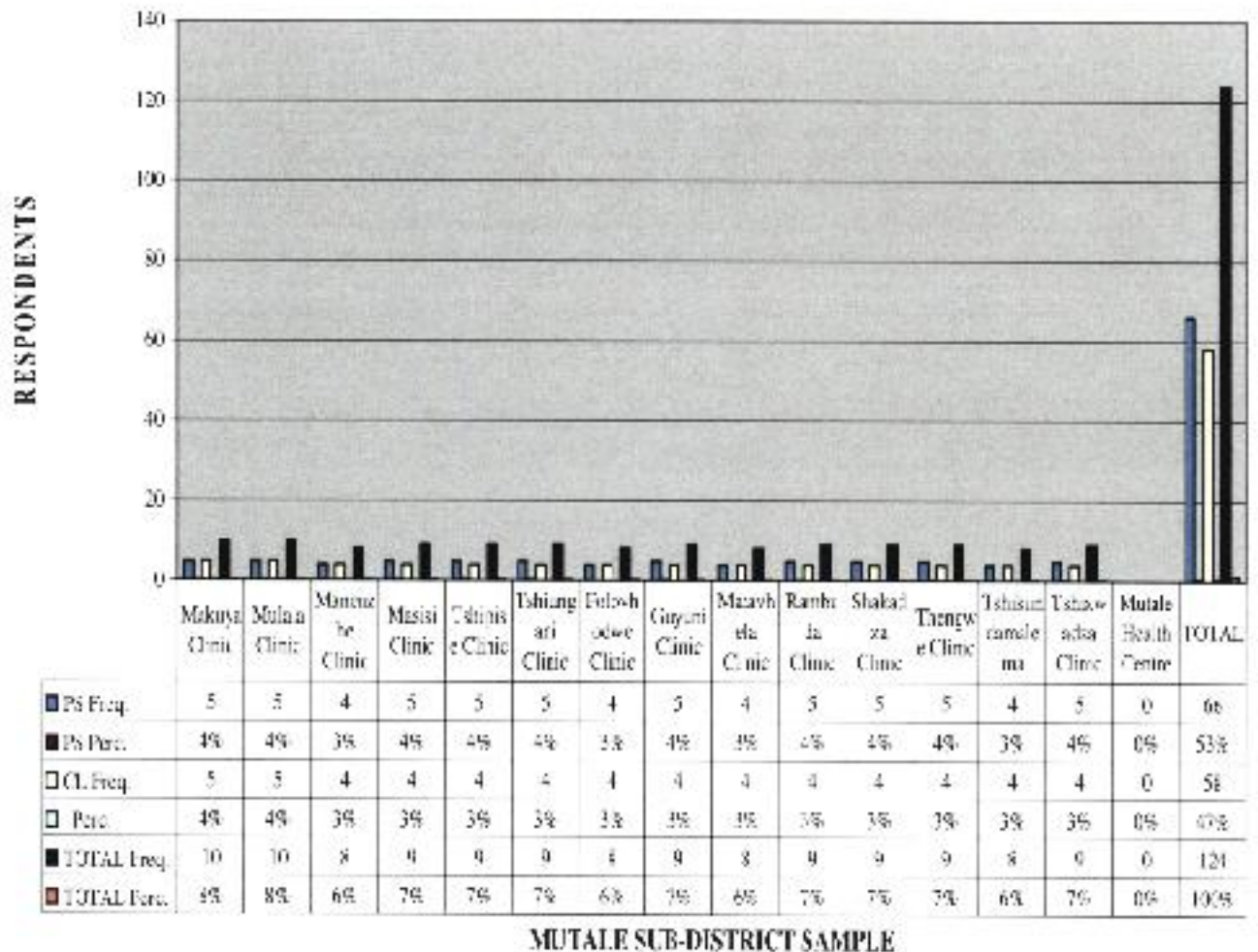


Table 2 and the graphic description indicate the distribution of the frequencies and percentages of all health-care institutions (PHC) or clinics at which the survey research was conducted in Mutale sub-district. The first six institutions (40%), viz., Makuya Clinic, Mulala Clinic, Munenzhe Clinic, Masisi Clinic, Tshipisc Clinic and Tshipungari Clinic represented Tshipisc Local Area while the next eight (53%) health-care institutions, namely, Fovohodwe Clinic, Guyuni Clinic, Matavhela Clinic, Rambuda Clinic, Shakadza Clinic, Thengwe Clinic, Tshikundamalema Clinic and Tshixwadza Clinic constituted Mutale Local Area and, finally Mutale Health Centre (7%). The data

reflected in Table 2 above and the graphic descriptions clearly show that there were ten respondents in some of the clinics and eight as well as nine participants in other institutions who actively participated in the survey study, that is, there were five (5) public servants or internal clients and five (5) clients, patients or external clients who received the distributed questionnaires for this survey study and were expected to complete them. Both the graph and Table 2 reflected above indicate that there were, in fact, one hundred and twenty-four (124) respondents who actively participated in the final survey research.

**TABLE 3 : Distribution of frequencies of respondents in terms of the sub-samples**

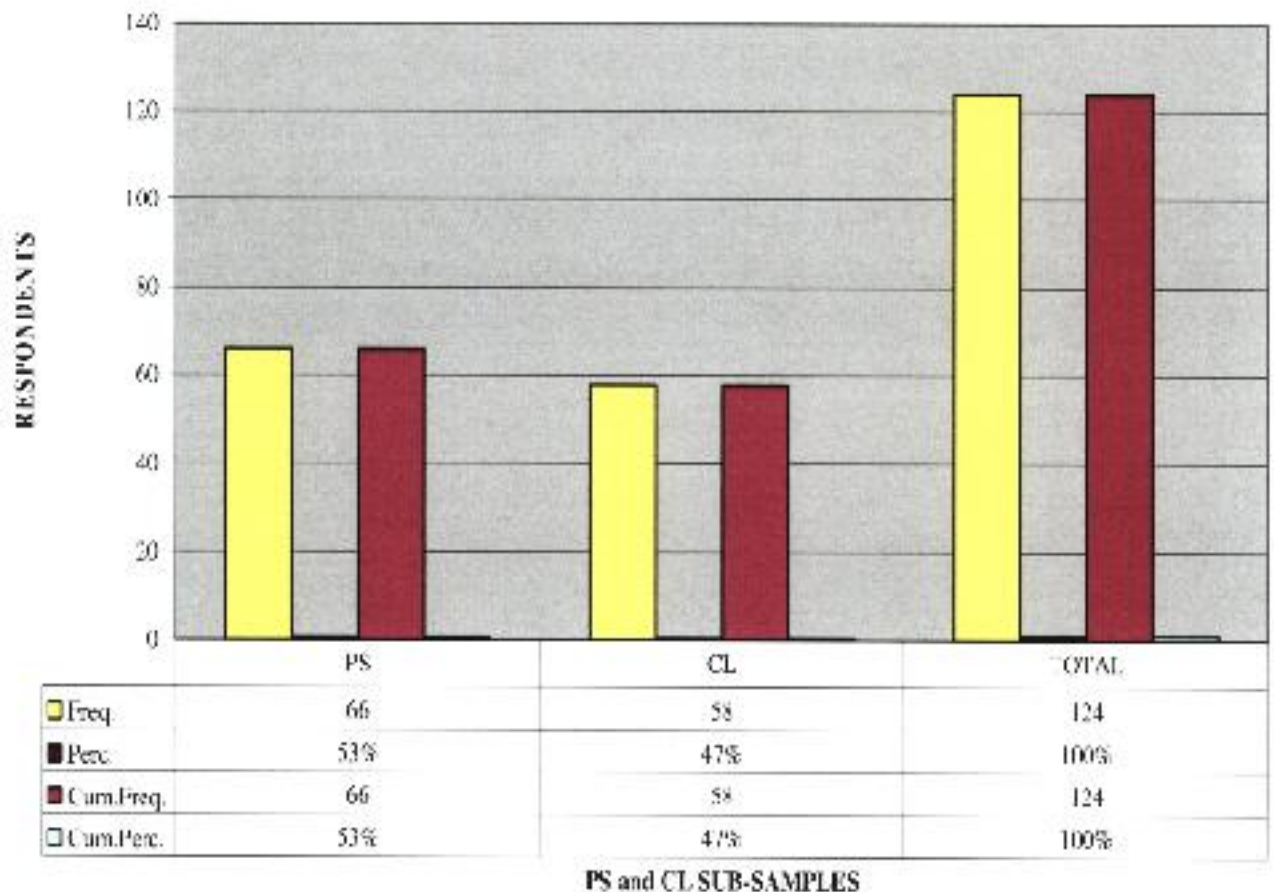


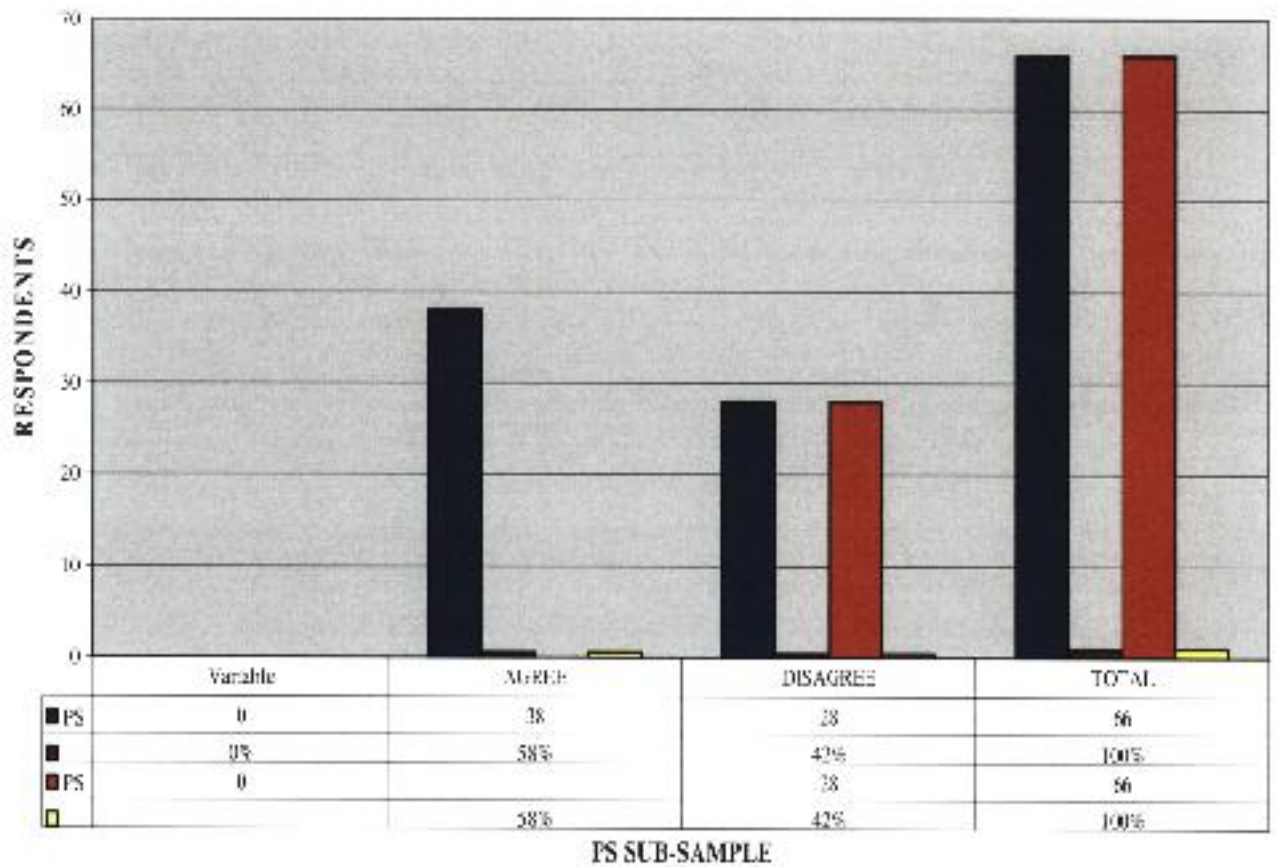
Table 3 and the graphic description shown above indicate the distribution of the frequencies and percentages in respect of the survey sample which was comprised of two sub-samples, namely, public servants represented by (PS) and clients denoted by (CL). There were fifty-three percent (66) public servants and forty-seven percent (58) clients, giving a total of one hundred and twenty-four (124) respondents who actively took part in

the investigation. All the respondents who received the questionnaires from the enumerator who was the supervisor of Mutale Health Centre failed to return the questionnaires for reasons unknown to the researcher, in spite of the fact that they were all expected to have returned the questionnaires on 14 October 2006 and also regardless of the fact that the final date for the submission was extended to 18 October 2006; hence the respondents were excluded as active participants in the final survey research.

## SURVEY DATA DESCRIPTIONS IN RESPECT OF PUBLIC SERVANTS IN MUTALE SUB-DISTRICT

### Item 1

**TABLE 4: Distribution of responses in terms of which Mutale public servants lacked capacities and skills to promote and facilitate health service delivery**



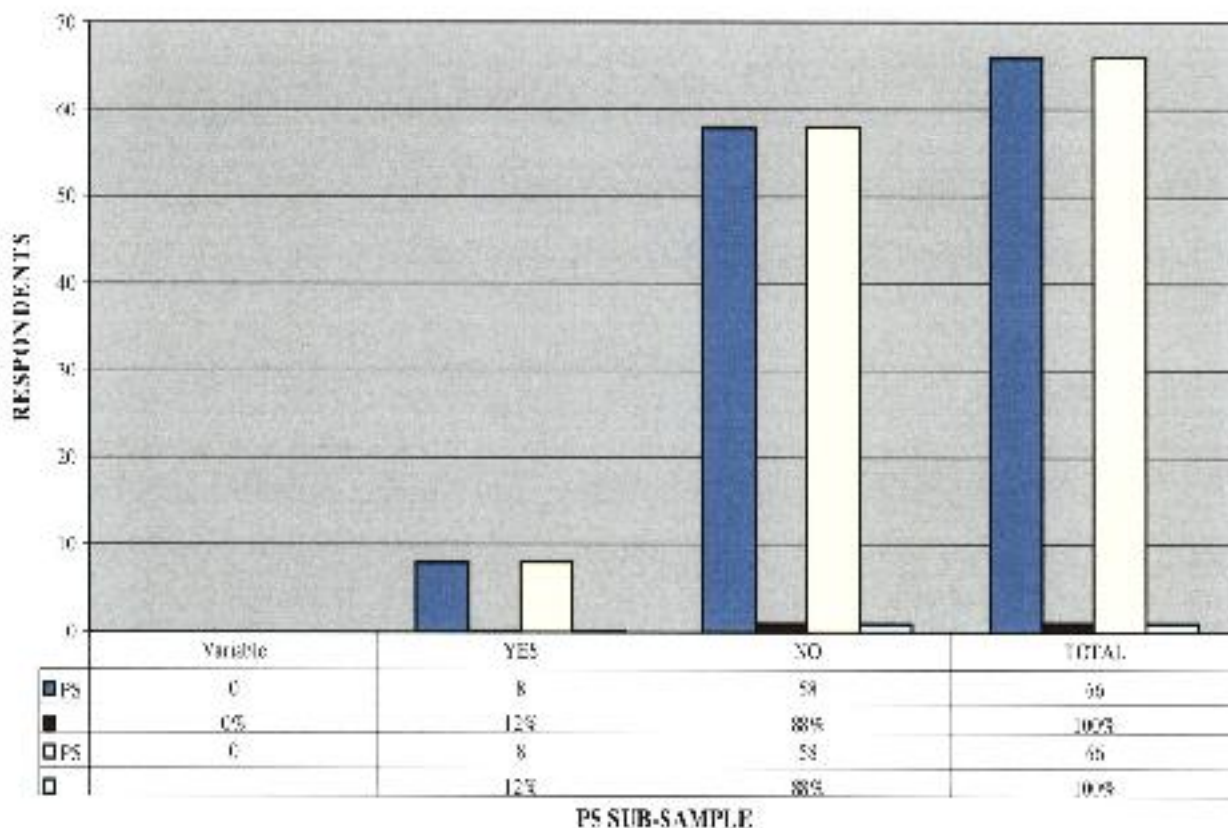
It was observed from the data shown above in Item 1 in Table 4 that fifty-eight percent (38) of the survey respondents said that they agreed that public servants of Mutale sub-district lacked capacities and skills to implement the transformation process in order to promote and facilitate the quality of health service delivery; whereas forty-two percent (28) out of sixty-six respondents of the sub-sample denoted by PS indicated that they disagreed that the public servants lacked capacities and skills to promote and facilitate the transformation process in order to improve the quality of service delivery at Mutale sub-district in the Vhembe District. The latter respondents implied that the public servants



had the necessary capacities and skills which were essential for the promotion and facilitation of the quality of health-service delivery in Mutale sub-district.

## Item 2

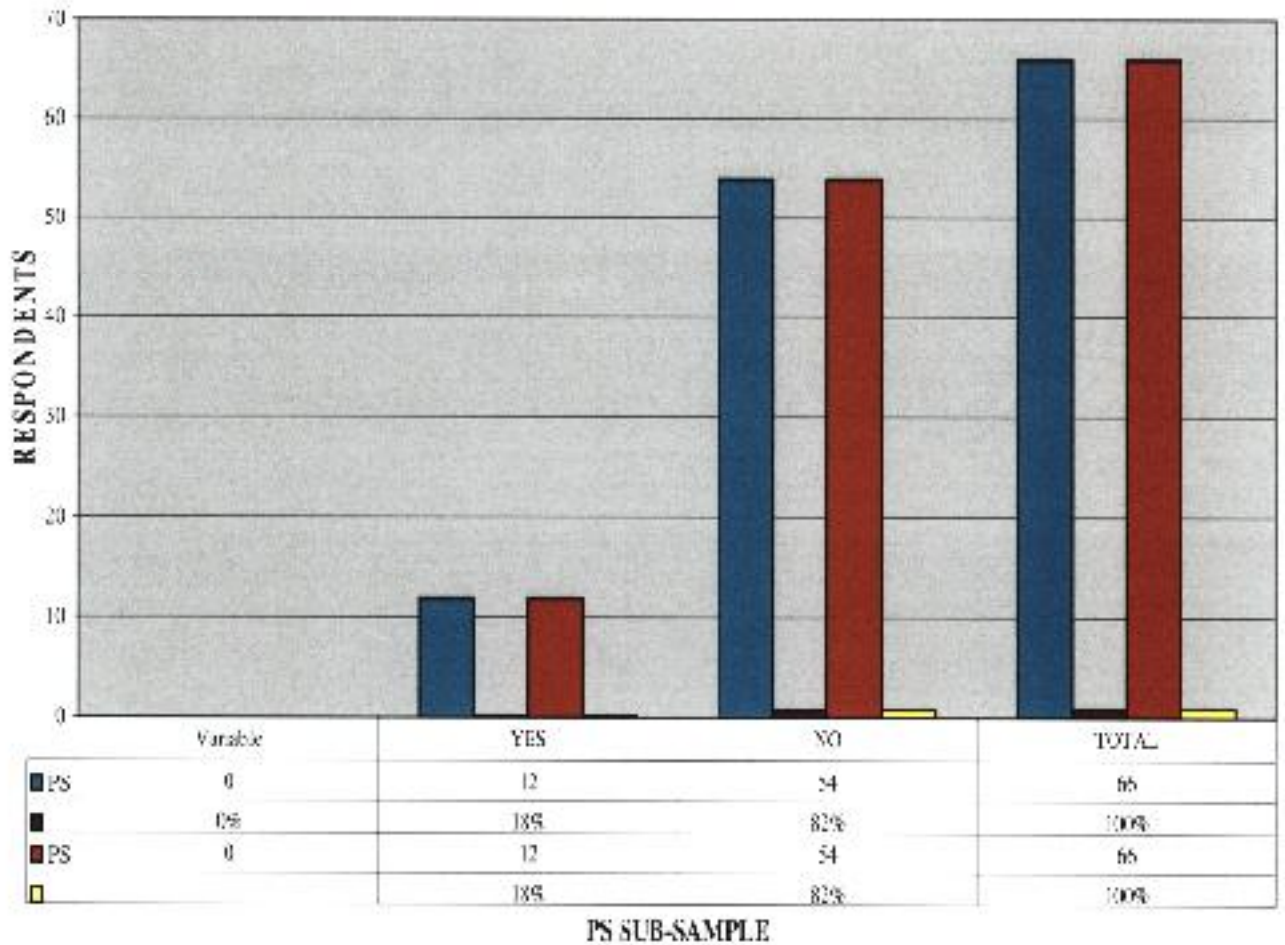
TABLE 5: Distribution of responses in terms of which public servants disliked to implement the transformation process



Item 2 in Table 5 above reflects the responses in terms of which public servants disliked implementing the transformation process as required and expected by the current government. According to the survey data twelve percent (8) of the participants answered in the affirmative, indicating that Mutale public servants disliked implementing the transformation process which was designed, of course, to relieve the poor and unemployed people of Mutale sub-district, whereas eighty-eight percent (58) argued that the public officials did not dislike implementing the transformation system or process which was intended to address and redress all imbalances of the past regime, that is, they liked to implement the transformation process as the legislation and some policies required them to do that.

**Item 3**

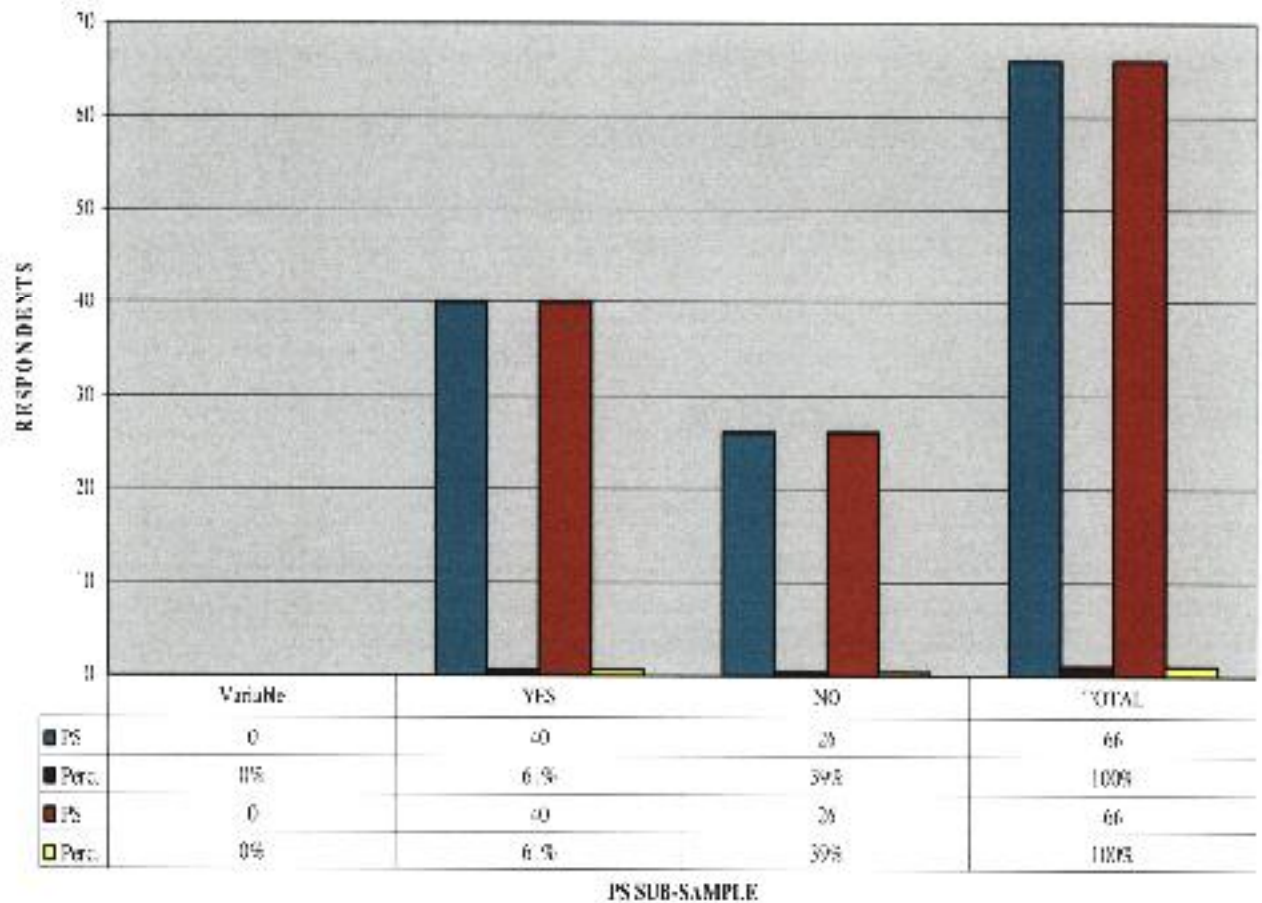
**TABLE 6: Distribution of responses in terms of which the transformation process is designed to benefit only the public servants**



According to Item 3 above in Table 6, eighteen percent (12) of the survey participants responded in the affirmative, according to which the transformation process benefited only the public servants; but the remaining eighty-two percent (54) mentioned that the process did not benefit only the public servants as it was designed to benefit all South African citizens and especially the poor, women, the youth, people with disabilities and the unemployed categories of people who were in dire need of a better standard of living. The eighty-two percent (54) of the survey sub-sample (PS) mentioned that they disagreed that the process was designed to benefit only the public servants but supported the objective of the transformation process that it was designed to help all South African citizens

#### Item 4

**TABLE 7: Distribution of responses in terms of which Mutale public servants lacked relevant resources to enable them to promote and facilitate health-service delivery**

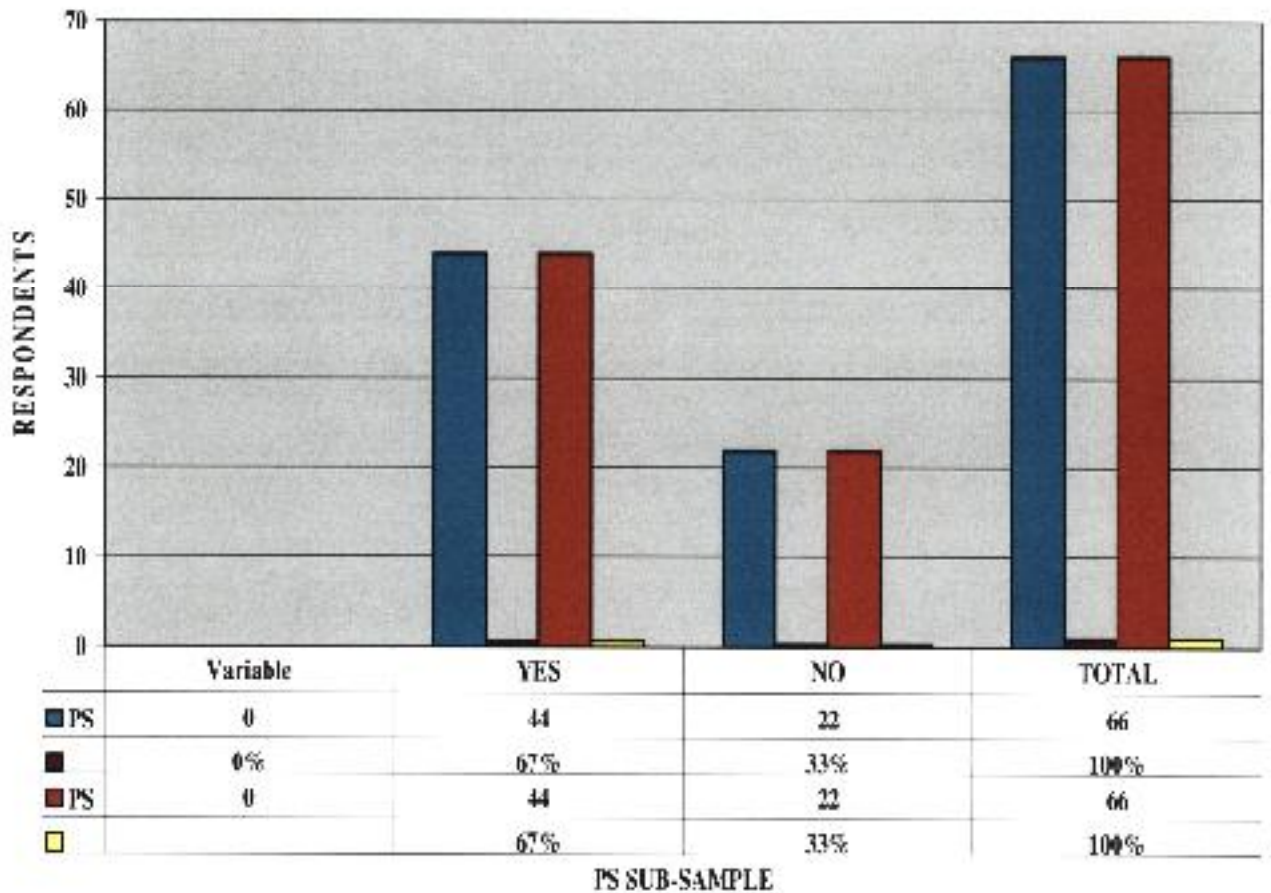


The data in Item 4 in Table 7 shows that sixty-one percent (40) of the survey participants responded in the affirmative indicating that their work environments lacked relevant resources to enable them to promote and facilitate the transformation process; whereas thirty-nine percent (26) indicated that the places where they worked did not lack relevant facilities to enable them to promote and facilitate the transformation process, that was, the resources were available. The latter cited health-care facilities such as the primary health-care institutions, health-care centres, reception, offices and gardening and resources such as human, infrastructure and financial as examples, taking into account the fact of the existence of constraints. Two of the sixty-six respondents indicated transport as an example, and that clearly indicated that the item was not properly comprehended by some respondents.



**Item 5**

**TABLE 8: Distribution of responses pertaining to non-recognising transparency as part of transformation process**

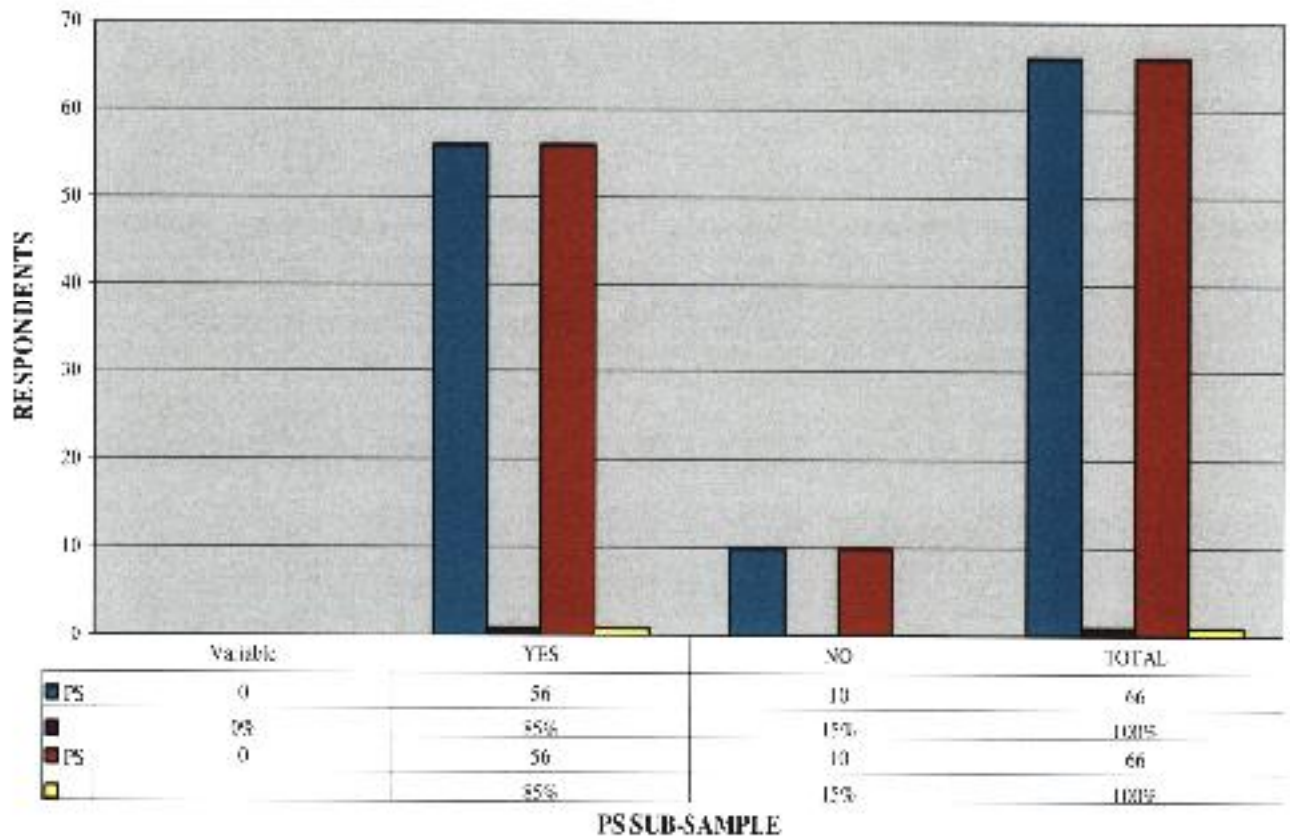


The data reflected in Item 5 in Table 8 revealed that sixty-seven percent (44) of the survey members responded in the affirmative, thereby implying that they did not recognise transparency as part of the transformation process, which also implied that the transformation process was not the cornerstone of the improvement of the quality of service delivery and the standard of living of everybody in any community; whereas thirty-three percent (22) of the public servants argued that they recognised transparency as part of the transformation process. The current government was urging all public servants to be transparent in the responsibilities that they were discharging since the government was completely against any form of disregarding the implementation of the transformation process which benefited all South African people regardless of their colour or creed.



**Item 6**

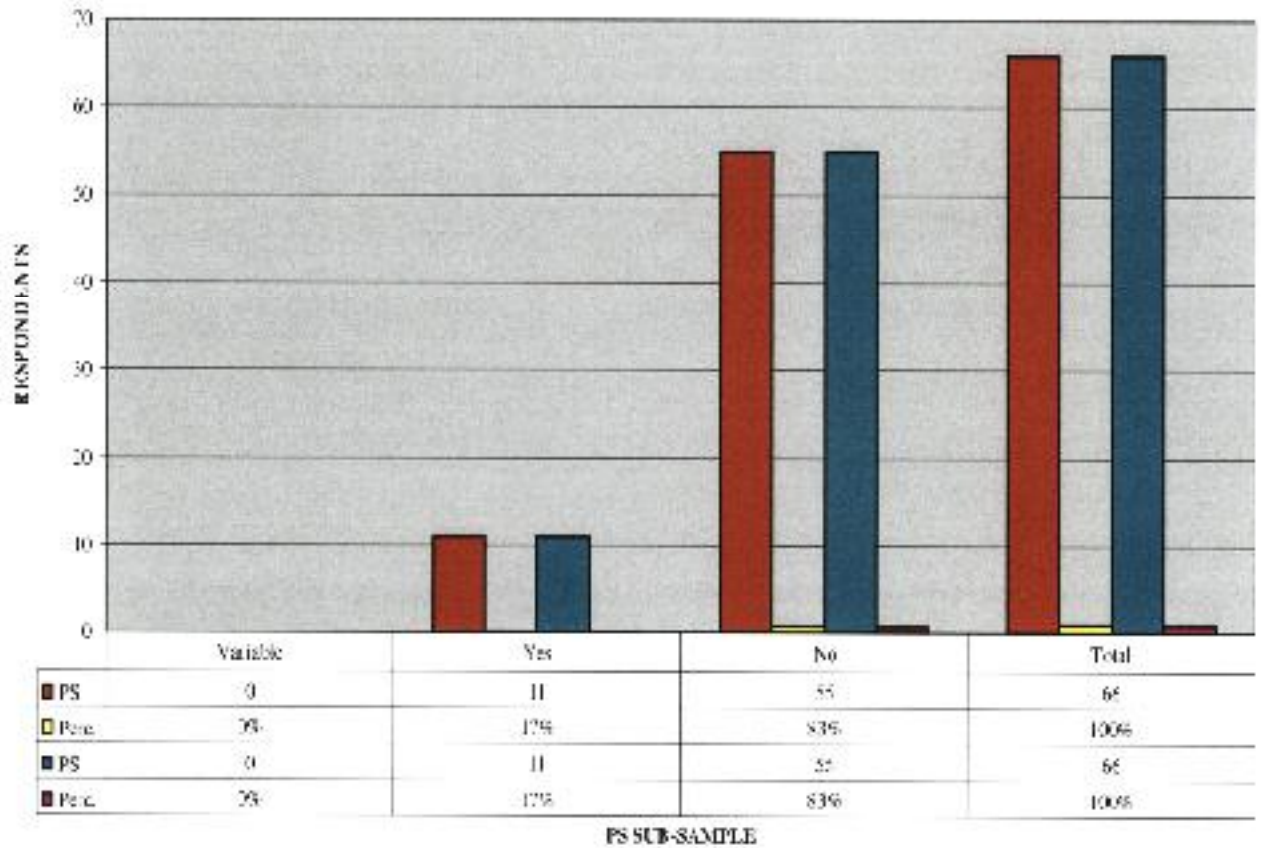
**TABLE 9: Distribution of responses in terms of which public servants regarded health service delivery as a priority to the public**



Item 6 in Table 9 above required respondents to indicate as public servants that service delivery to the public was their priority; and in response to that, eighty-five percent (56) indicated that delivering service to the communities was their priority and these responses were in alignment with the requirement of the current democratic government policy as a way of trying to address and redress the backlogs created by the defunct former government which was dominated by the minority of white people who, together with very few black people, was characterised by inefficiency, ineffectiveness, lack of transparency and lack of accountability to the public. Fifteen percent (10) of the remaining PS sub-sample mentioned that they did not regard health-service delivery to the public as a priority and this was the category of the public servants who deliberately delayed or retarded the implementation of the transformation process due to their negative attitude towards the transformation process.

**Item 7**

**TABLE 10: Distribution of responses reflecting the unavailability of legislation that enforced transformation process in the Republic of South Africa**

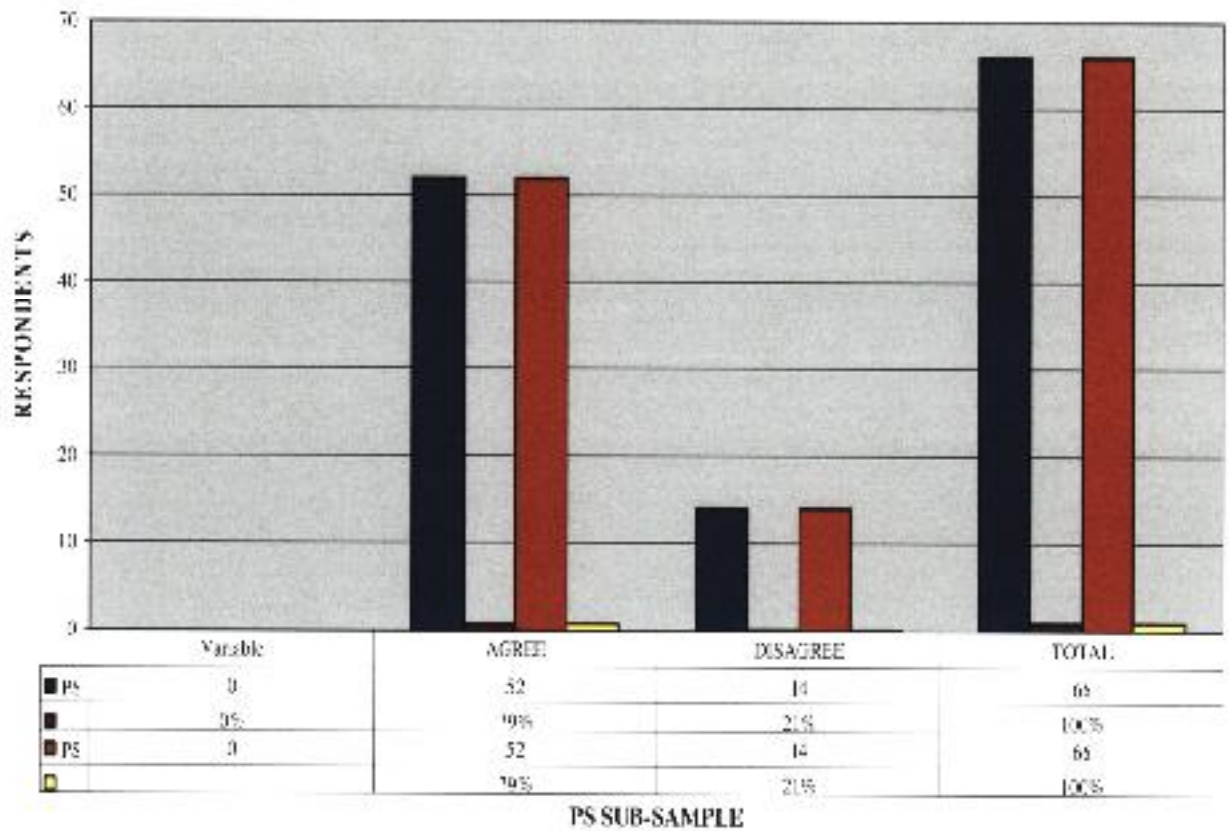


In response to Item 7 in Table 10, seventeen percent (11) of the participants in the survey mentioned that there were no pieces of legislation that enforced the implementation of the transformation process; whereas eighty-three percent (55) responded that there were pieces of legislation enforcing the implementation of the transformation process in the Republic of South Africa. The responses provided by the respondents represented by seventeen percent (11) revealed that they were not altogether conversant with the pieces of legislation passed by Parliament ever since the new government came into power in 1994 which were designed to promote and facilitate the transformation process and to improve the lives of the marginalised black people of this country. All repressive apartheid laws which were uncessirable due to their discriminatory nature and the fact that they promoted disparity among the citizens of South Africa were repealed in toto and pieces of democratic legislation and especially those free of all forms of discrimination were passed to address and redress all the imbalances of the past in terms of health-

service delivery in Mutale sub-district. The remaining members of the sample (55) represented by eighty-three percent appeared to be aware of the existence of the new pieces of the legislation and policies that ensured that the implementation of the transformation process was enforced, and they mentioned legislation such as the Constitution Act, 1996, Public Service Act, 1994, the Public Service Regulations, 2001, the White Paper on Transforming Public Service, 1997 and The White Paper on Reconstruction and Development, 1994 and Labour Relations Act of 2002 to mention just a few, that were in place to promote and facilitate the transformation process and service delivery.

**Item 8**

**TABLE 11: Distribution of responses which indicated that the transformation process promoted and facilitated health service delivery in the peripheral communities**

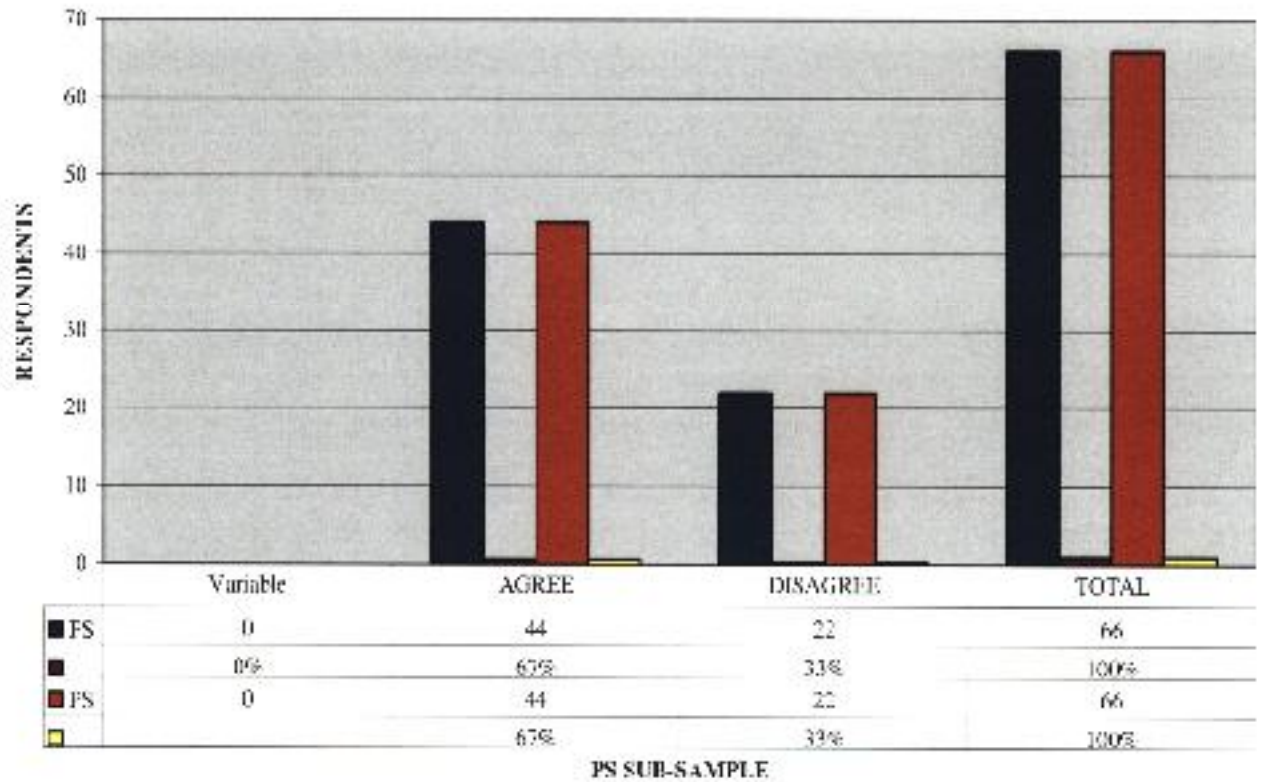


It is observed from the data shown in Item 8 in Table 11 above that seventy-nine percent (52) of the survey respondents agreed that the transformation process promoted and facilitated health service delivery in the remote peripheral communities of Mutale sub-district in South Africa; whereas twenty-one percent (14) disagreed that the process promoted and facilitated health- service delivery in the remote rural communities because there was no improvement in their lifestyles since 1994 to date.



**Item 9**

**TABLE 12: Distribution of responses which indicated that members of the communities were not knowledgeable about transformation process and its impact on the quality of health service delivery**



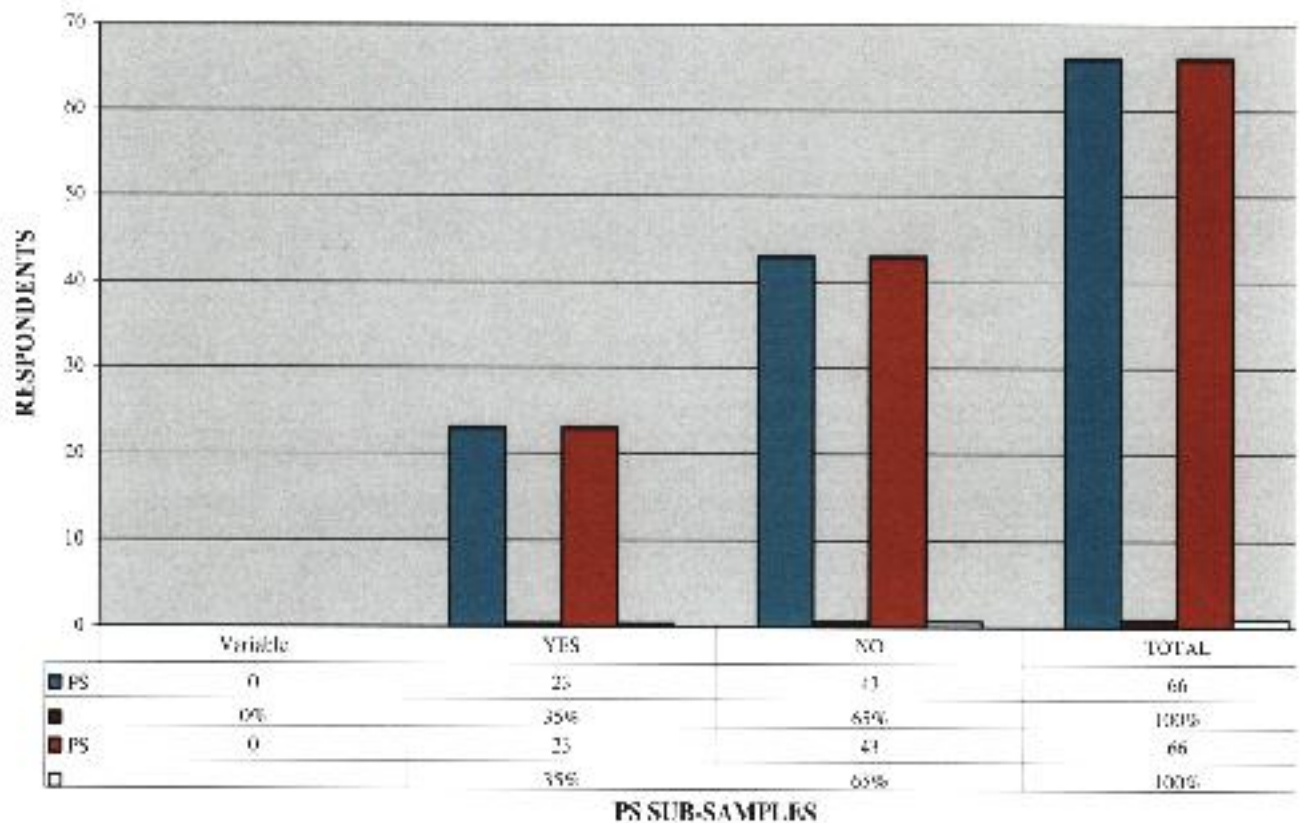
It is observed from the data shown in Item 9 in Table 12 above that sixty-seven percent (44) of the survey respondents said, at the time of conducting the survey research, that members of the communities in Mutale sub-district were not knowledgeable about the transformation process and the impact it had on the improvement of the quality of service delivery; whereas thirty-three percent (22) mentioned that members of the public were knowledgeable about the transformation process and its impact on the quality of health-service delivery.

Improvement in the lifestyles and standard of living had since the attainment of democracy in 1994 changed from bad to somewhat better as far as black people were concerned, following the implementation of the transformation process and that the responses represented by sixty-seven percent (44) was proper and acceptable acknowledgement of the public servants that members of the communities, although the transformation process had long been implemented, were not altogether knowledgeable

about the process and its impact on the health service delivery; hence they needed to be informed about it and encouraged to be actively involved in the management of their affairs.

### Item 10

**TABLE 13: Distribution of responses reflecting that the current government disregarded the implementation of the transformation process**

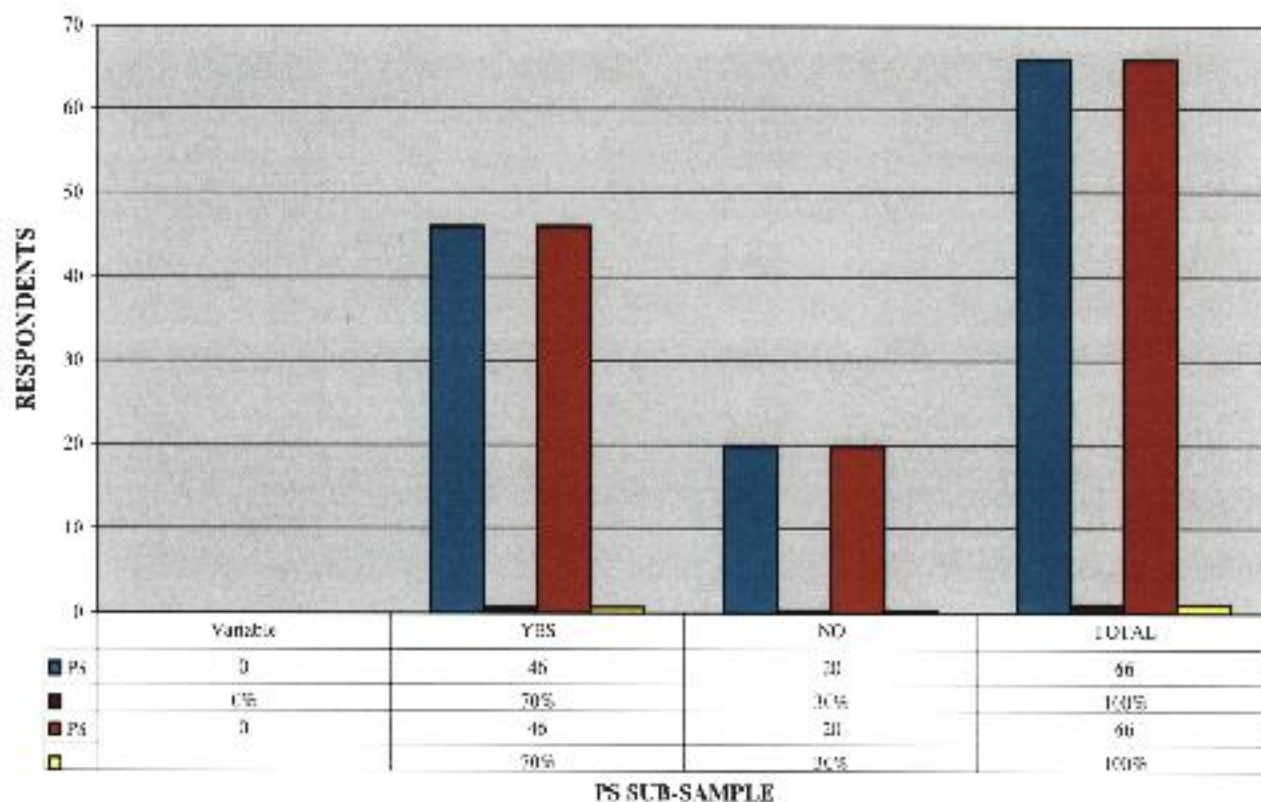


The results of the survey conducted among the PS sub-sample revealed that thirty-five percent (23) in Item 10 in Table 13 indicated that the South African democratic government disregarded the implementation of the transformation process as a priority, even the transformation of the public service. Sixty-five percent (43) mentioned that the current democratic government regarded the implementation of the transformation process as a priority, even the transformation of the public service; hence the Public Service Act of 1994, the Public Service Regulations of 2001, the White Paper on Public Service Training and Education of 1997, the White Paper on Transforming Public Service of 1997, the White Paper on Affirmative Action of 1998 and the Employment

Equity Act of 1998, to mention but a few, were formulated and passed by the Parliament of South Africa in determination that the transformation process of the public service would be enforced without compromising the quality of health-service delivery.

### Item 11

**TABLE 14: Distribution of responses in terms of which public servants lacked the necessary skills and knowledge to clearly and perfectly render adequate service delivery**

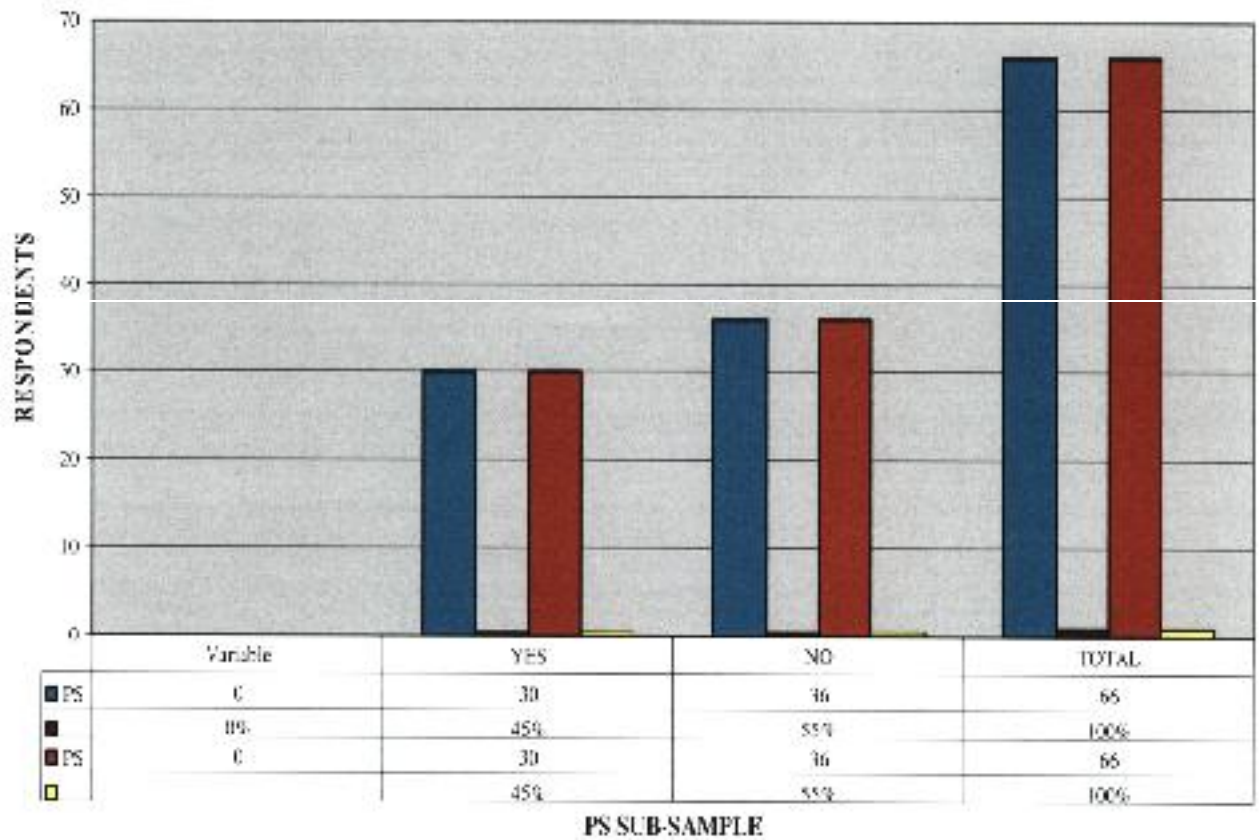


In response to Item 11 in Table 14, seventy percent (46) of the respondents indicated that some public servants lacked the necessary skills and knowledge to render adequate health services; whereas thirty percent (20) of the participants mentioned that some public servants possessed skills and knowledge to render adequate health services to the communities. Members of the sample who responded in the affirmative indicated that public servants required certain basic and fundamental skills such as communication skills, listening skills, administrative skills, technical skills, counselling skills, professional skills, basic training, computer skills and literacy skills in order to facilitate the transformation process which had a bearing on the quality of health service delivery.



**Item 12**

**TABLE 15: Distribution of responses according to which very poor people had access to all health-related basic needs in Mutale sub-district**

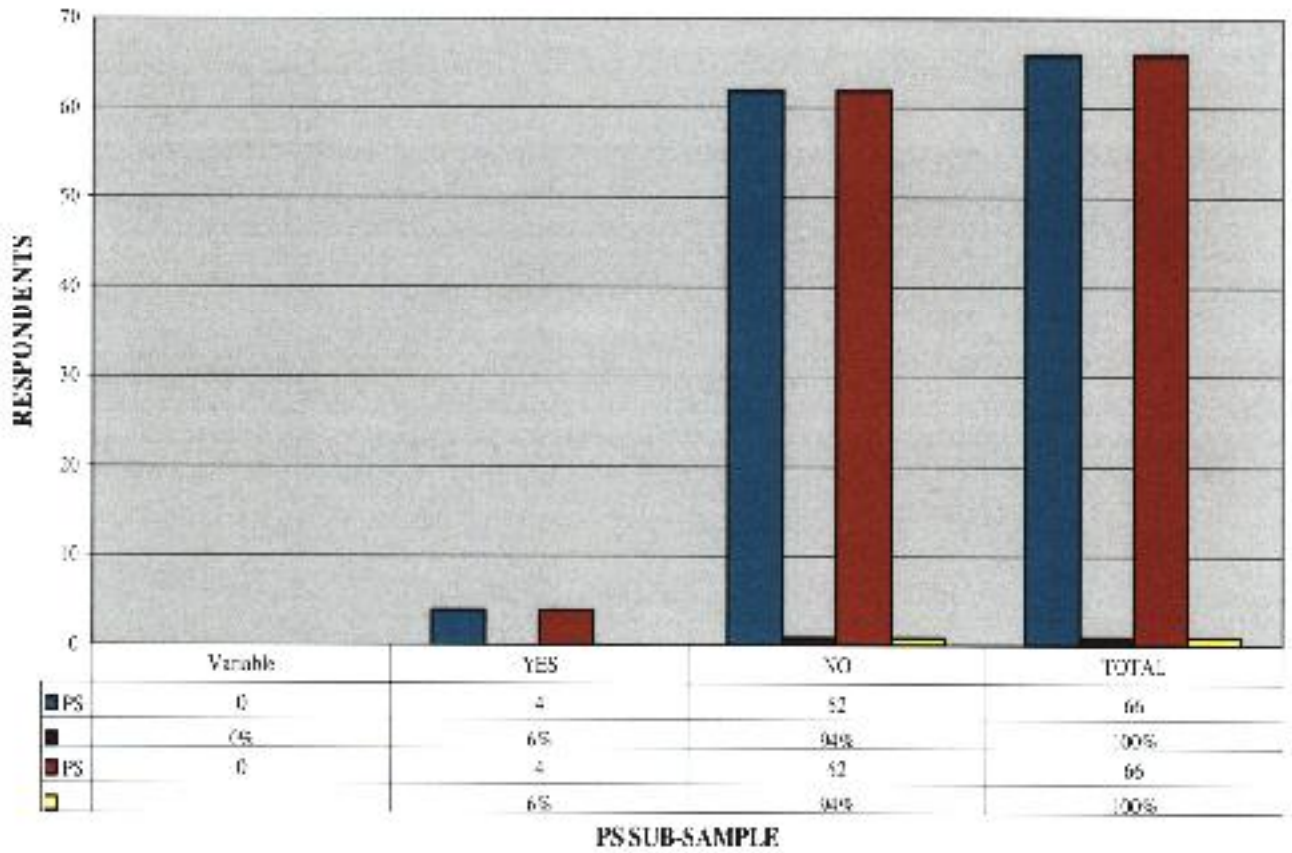


It is observed from the data in Item 12 in Table 15 that forty-five percent (30) of the participants mentioned that all health-related basic needs were easily available to the very poor people residing in Mutale sub-district; whereas fifty-five percent (36) claimed that not all basic health-related needs were easily available to the very poor and unemployed people residing in Mutale sub-district by the nature of its remoteness from the urbanised areas of the district since democracy was attained in 1994. Local communities were still in dire need of water, sanitation, health services, transport and housing facilities. The new government was already in power for eleven years but since then no new clinics had been built let alone adequate provision made for medication in the clinics in the sub-district.



**Item 13**

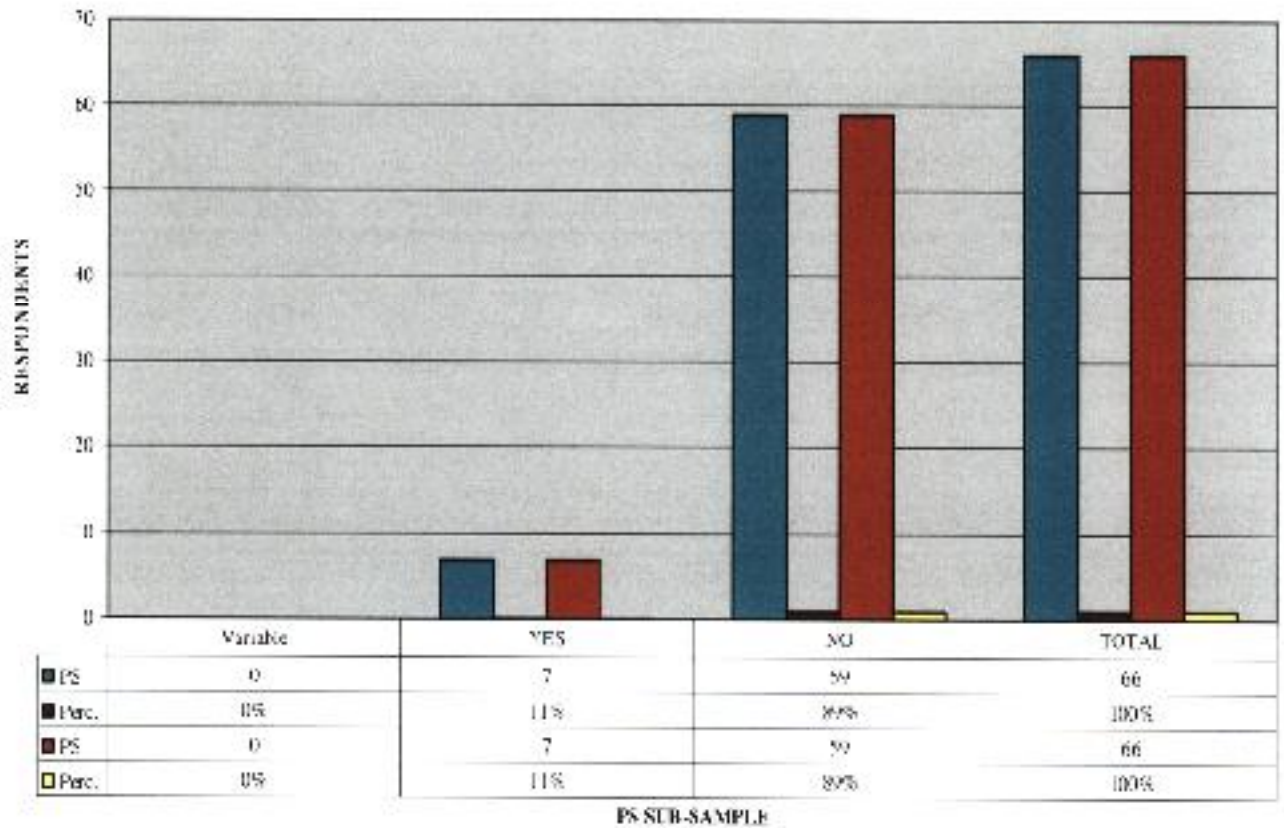
**TABLE 16: Distribution of responses in terms of which public servants rendered services in an unacceptable manner**



According to Item 13 in Table 16, six percent (4) of the subjects who participated in the survey claimed that public servants rendered services in a manner that was completely unacceptable to the communities; whereas ninety-four percent (62) responded that public servants rendered health services in an acceptable manner to the communities of Mutale sub-district. Those who responded in the affirmative did not advance reasons for having said so whereas the item required them to substantiate their answers with examples to support their arguments.

**Item 14**

**TABLE 17: Distribution of responses in terms of which government was keen to ensure that transformation took place in terms of legislation , but public servants dragged their feet**

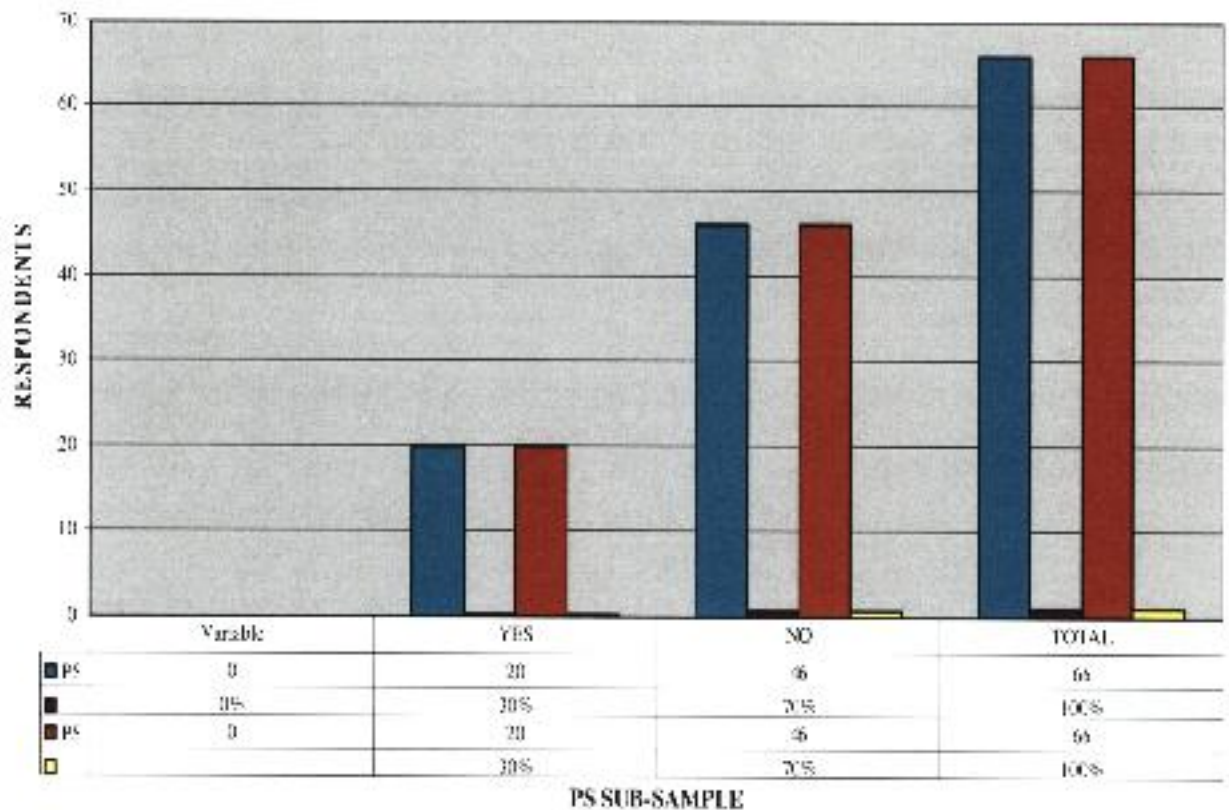


The responses provided in accordance with Item 14 in Table 17 of the survey research reflected that eleven percent (7) of the subjects pointed out that the government was keen to ensure that the transformation process took place in terms of the legislation, but public servants were said to be retarding the progress, due to the fact that they were dragging their feet; but eighty-nine percent (59) indicated that the government was not at all keen to ensure that the transformation process was implemented, while shifting the blame to the public servants who were said to be dragging their feet. Some respondents mentioned that as most public officials had served the previous discriminatory regime, they were still resisting the political and transformation changes as their mind-sets were still those of the past. Others went on to indicate that they dragged their feet because they did not understand the objectives of the transformation process in particular and of the government in general. These public servants who at one stage had served the defunct apartheid government were not conversant with the legislation pertaining to the

implementation of the transformation process and its impact on the quality of health service delivery. Although the participants were expected to substantiate their views, the majority did not indicate the reasons for having commented that way.

### Item 15

**TABLE 18:** Distribution of responses reflecting the negative attitude by some public servants towards the transformation process and service delivery



In terms of Item 15 in Table 18, thirty percent (20) of the survey respondents who answered in the affirmative mentioned that some public servants displayed negative attitudes towards the transformation process and health-service delivery in particular whereas in accordance with prescriptions of the pieces of legislation passed by the democratic South African Parliament they were all expected to ensure that the process was promoted for the benefit of the poor and unemployed black people; whereas the remaining seventy percent (46) argued that the public servants did not display any negative attitude towards the transformation process and health-service delivery in Mutale sub-district of the Vhembe District. Although the majority of the survey respondents did not advance reasons, those who did, mentioned that such public servants



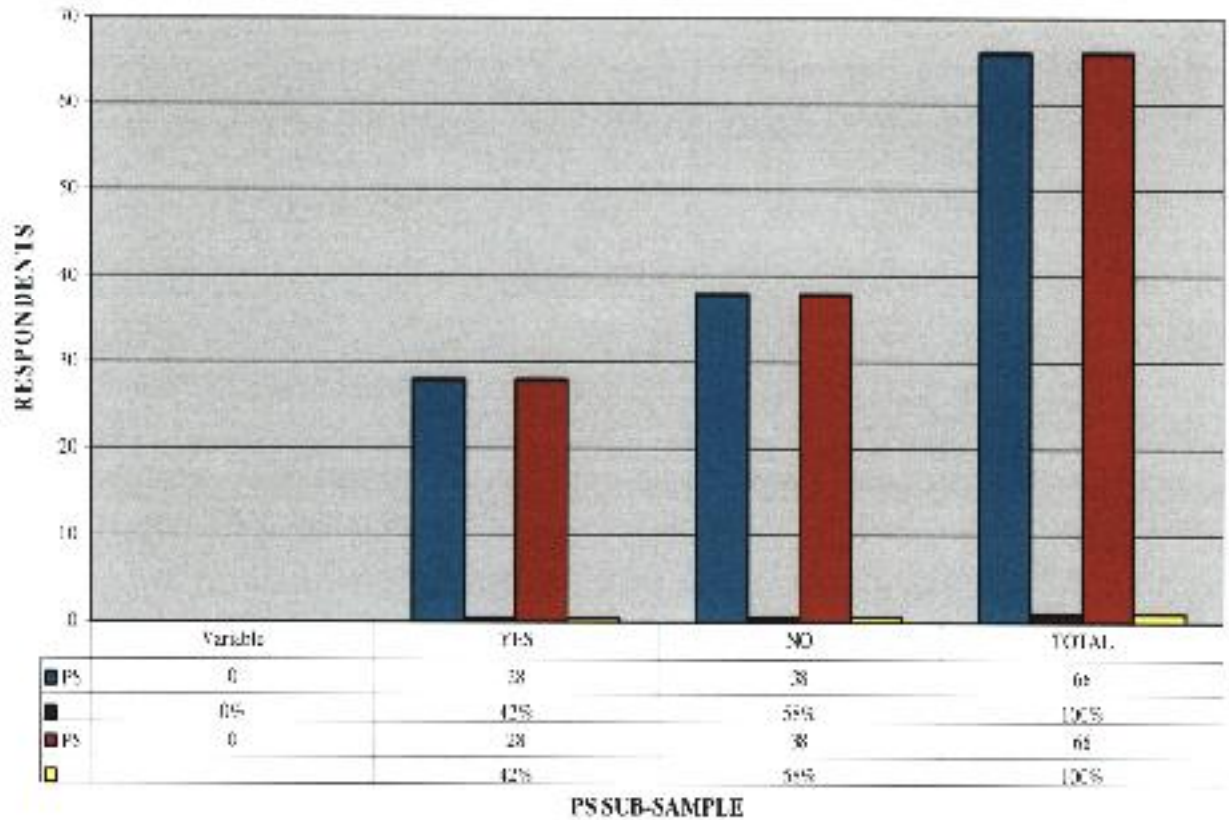
adopted negative attitudes towards the transformation process because they were afraid that they might lose their positions in the new administration of the current government. They perceived the transformation process to be a threat because they found it difficult to comprehend and lacked the ability to implement it.

The public servants who once served the defunct government were labeled as "deadwood" by the new public service entrants; hence those from the former administration adopted a negative attitude towards transformation and found it very hard to comply with the modern changes and challenges. They resisted change; hence it was very difficult for them to adjust to the challenges coupled with the requirements of the new democratic government. They mentioned that the government was a threat to them as it targeted transforming even the public service to ensure that it was efficient and transparent in the execution of its responsibilities. They felt threatened as they were not well informed about the objectives of the new government pertaining to the implementation of the process and the positive effect it had on health service delivery. Others adopted a negative attitude towards the transformation process because they were not adequately and properly educated to be able to clearly understand the positive implications for the lives of the majority of the people who had been disadvantaged for many years during the apartheid regime. The majority of the respondents did not comment and the above remarks were made by very few participants.



**Item 16**

**TABLE 19: Distribution of responses in terms of which public servants should be disciplined for failing to promote and facilitate transformation**

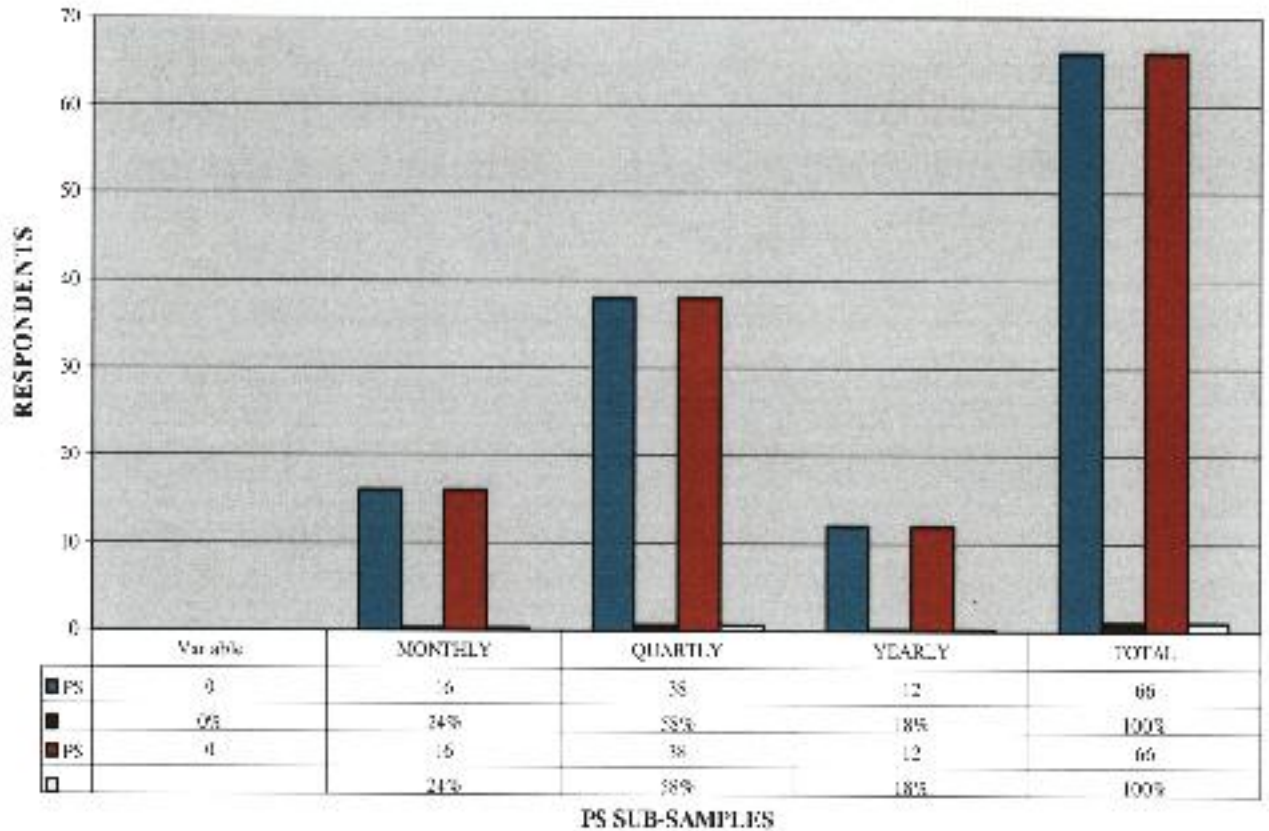


The responses furnished in Item 16 reflected in Table 19 showed that forty-two percent (28) of the subjects supported the notion that public servants who did not promote the transformation processes as required by the legislation and related policies and also as a way of promoting health-service delivery should be disciplined for their unlawful practices; but fifty-eight percent (38) indicated that public servants who did not facilitate the transformation process should not be disciplined because such behaviour could not be regarded as unlawful practices, the reason being that some were not conversant with relevant legislation and policies of the government currently in power, and hence it was imperative for them to be given the opportunity to attend workshops for the purpose of becoming conversant, and those who were still found to be failing deliberately and desparately after being exposed to extensive and comprehensive induction and orientation, could thereafter be charged with misconduct and should face the might of the law. Others further argued that those who completely failed should forfeit their salaries

and any other financial incentives as a disciplinary or corrective action against them. These actions should not be considered as punitive, but as a way of trying to motivate and encourage employees and persuade them to see the significance of the objectives of the government towards the implementation of the noble and good idea of transforming this country socio-economically, as political liberation had already been achieved in 1994. No further comments were made by the respondents.

### Item 17

TABLE 20: Distribution of responses in terms of which government monitored and evaluated the transformation process

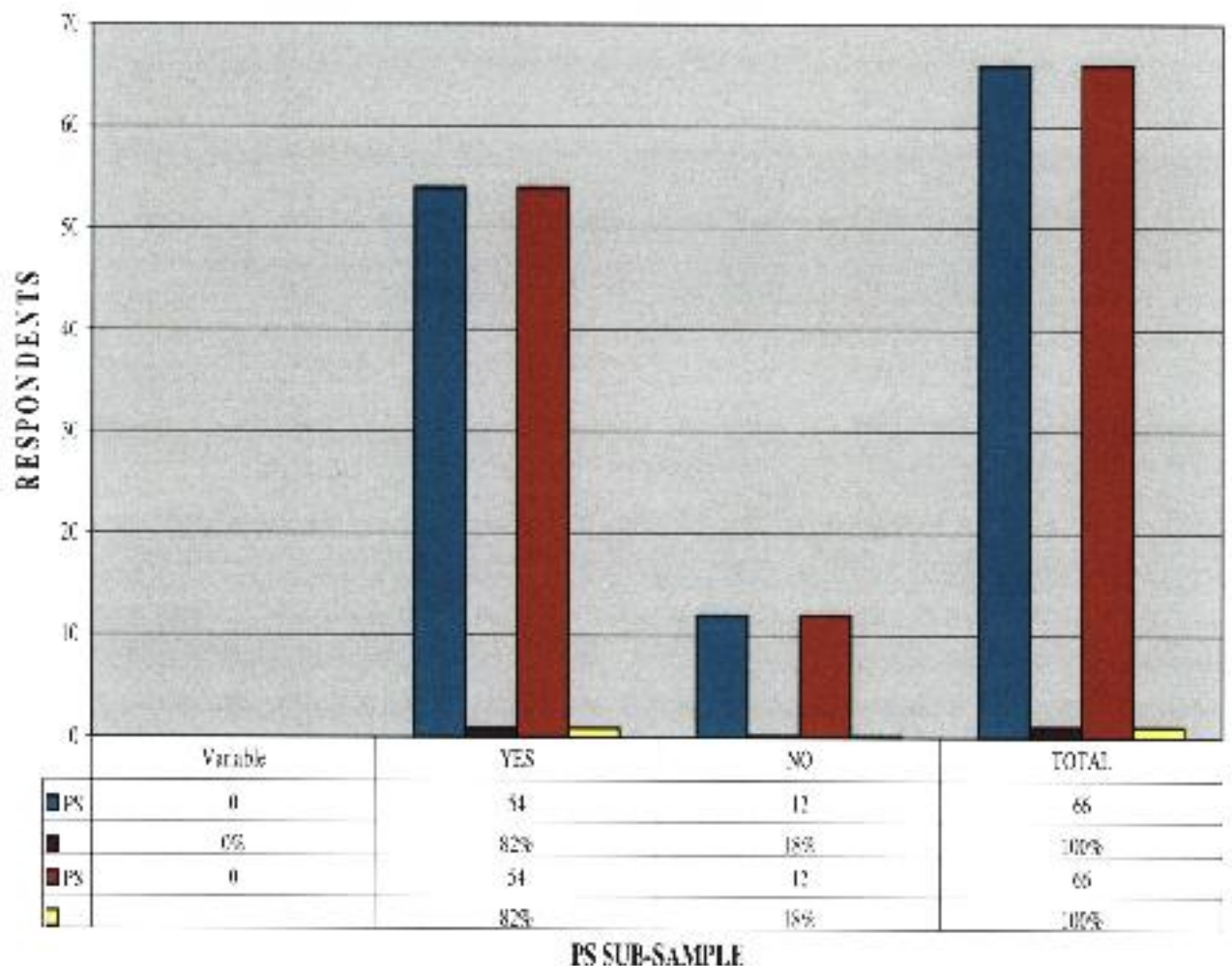


The data reflected in Item 17 of Table 20 of the survey research indicated that twenty-four percent (16) of the participants pointed out that the transformation process needed to be monitored and evaluated by the government on a monthly basis; and fifty eight percent (38) of the respondents mentioned that the transformation process needed to be monitored and evaluated quarterly. Eighteen percent (12) of the responses recorded by the members of the remaining sub-sample to the monitoring and evaluation of the

transformation process indicated that such processes should be done on a yearly basis to ensure that there was, indeed, not only lip-service towards the implementation of the transformation and health-service delivery but that real health-service delivery should be seen to be done by the public servants in the remote rural communities.

**Item 18**

**TABLE 21: Distribution of responses in terms of which transformation process should be regulated to ensure that targets were met**



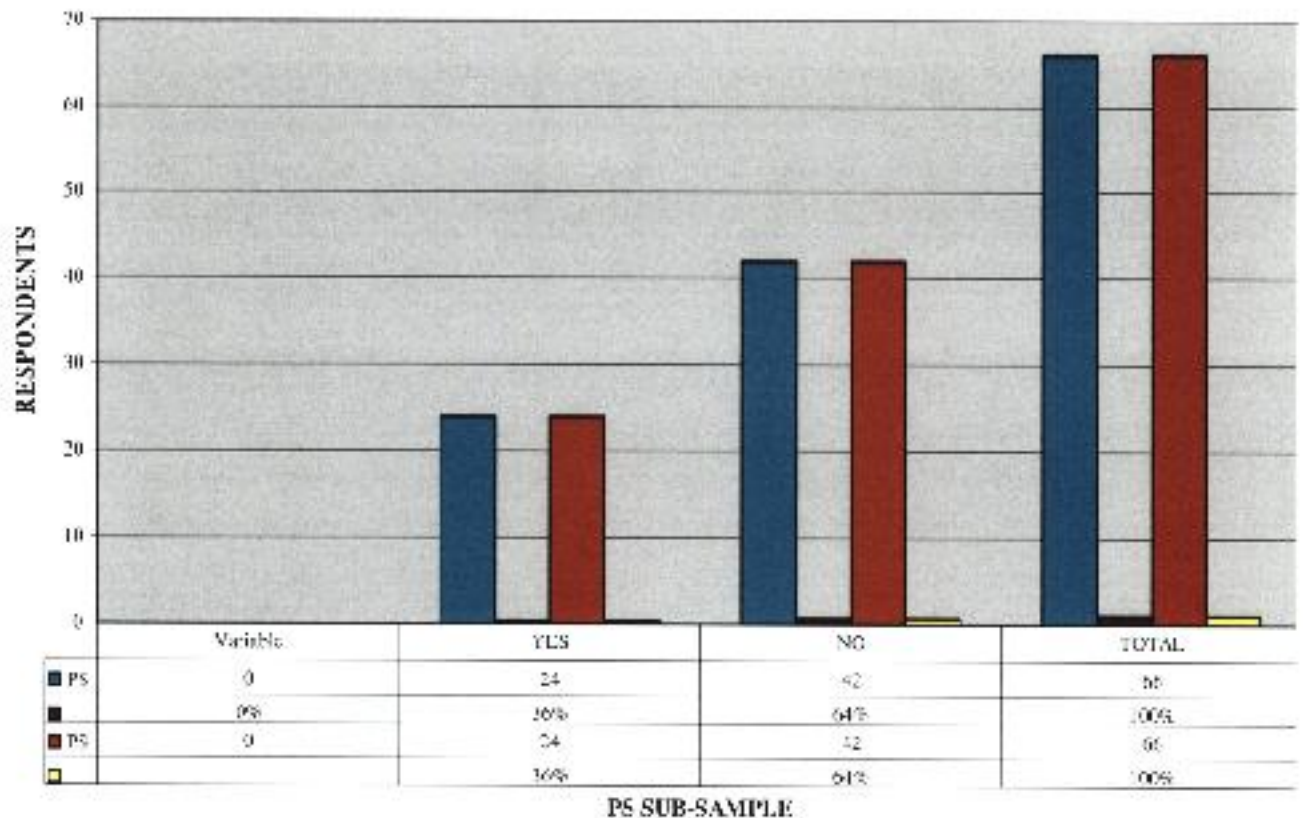
The data shown in Item 18 in Table 21 of the survey study indicated that eighty-two percent (54) of the participants pointed out that the transformation process needed to be regulated within the set timeframes to ensure that targets were met as scheduled; whereas eighteen percent (12) of the subjects of the same sub-sample mentioned that the transformation process did not need to be regulated within the set timeframes to ensure



that targets were met as scheduled as they saw no benefit in its implementation especially in their rural sub-district.

**Item 19**

**TABLE 22: Distribution of responses reflecting unpleasant attitude by medical and nursing personnel towards patients**



The survey results reflected in Item 19 in Table 22 above showed that thirty-six percent (24) of the survey sub-sample argued that the attitude of medical doctors and the nursing personnel in their clinics towards patients was unpleasant, whereas sixty four percent (42) of the same sub-sample indicated that the attitude of some frontline public servants, especially medical doctors and nursing personnel towards patients, was satisfactory, pleasant and beyond any complaint because they were performing a vital and indispensable task of ensuring that their lives were safe and prolonged for a reasonable period of time before death befell them. They complimented the professionals in all different categories on what they were doing and urged them to maintain their standard of performance.

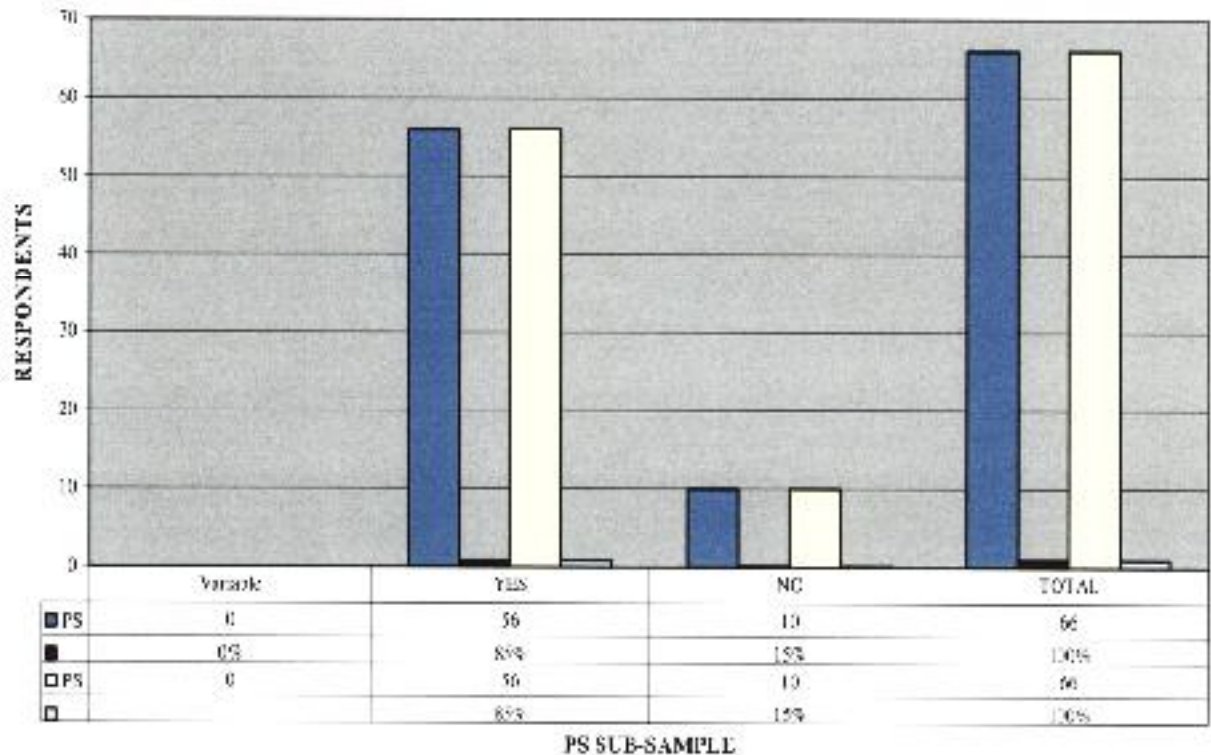


Those who responded in the affirmative furthermore indicated that what prompted the medical officers and nursing personnel to adopt that particular negative attitude according to the perception of the public was because of the pressure of work they were subjected to because they represented the scarce skills in the entire workforce in the district; and the reality was that even during odd hours they would be found carrying out their tasks due to shortage of staff. In addition to that people should realise that besides what had been said, the majority of the professionals were subjected to a stressful environment that was full of challenges.

Others who commented unfavourably about their attitudes towards the patients went to the extent of mentioning that those professionals did not practice the Batho-Pele policy and other relevant legislation pertaining to the promotion and facilitation of the transformation process which had an impact on the improvement of the quality of service delivery. They needed to be workshopped on legislation and procedure manuals that were designed to promote the high standard and quality of health service delivery in South Africa so that they too would come on board with the rest of the public service.

## Item 20

**TABLE 23:** Distribution of responses revealing that some outpatients were impossible towards the doctors and nursing personnel and such attitude impeded their performance in their respective institution

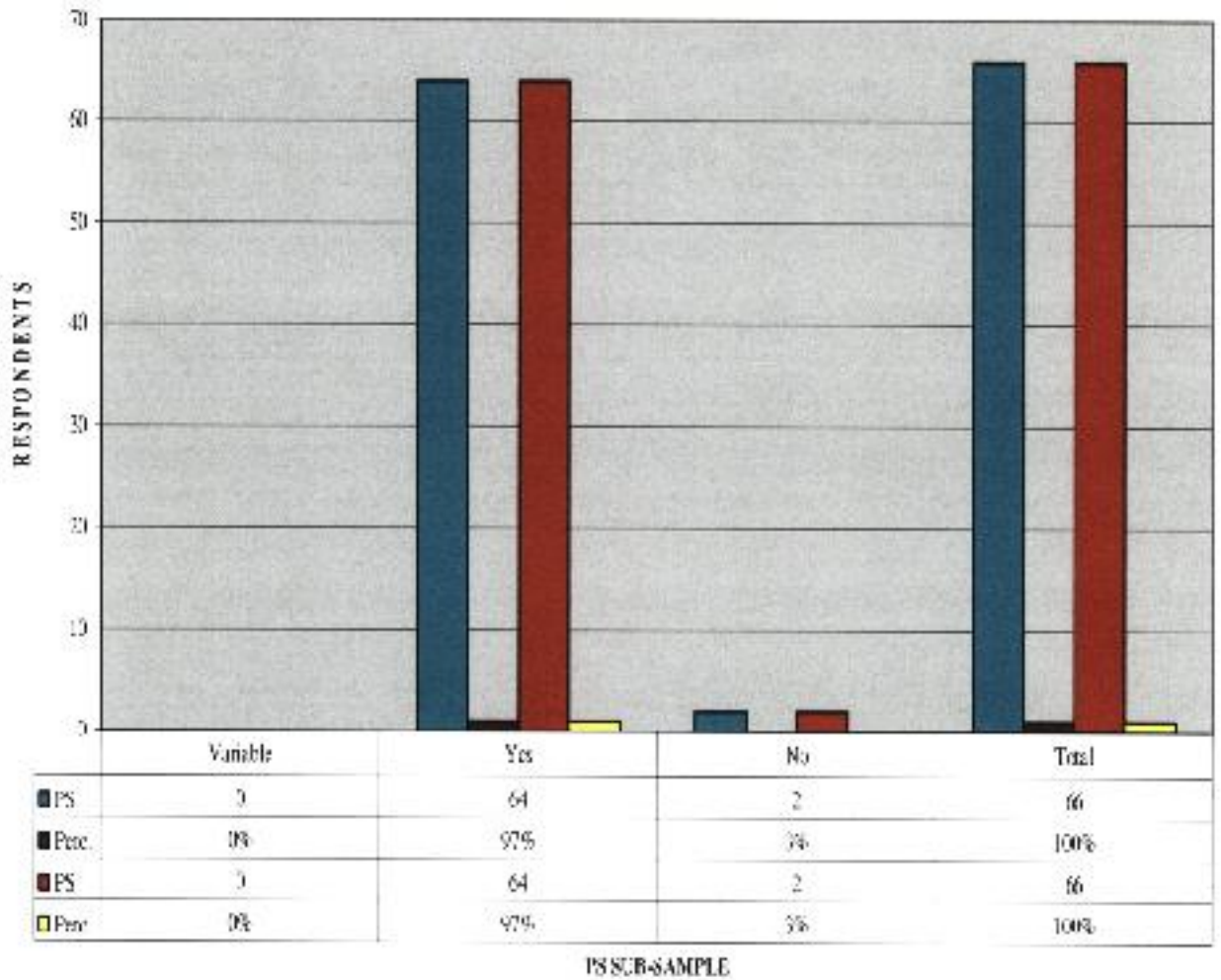


In response to the question in Item 20 in Table 23 as to what the attitude of outpatients was towards the medical officers and the nursing personnel, the respondents represented by eighty-five percent (56) answered in the affirmative that some outpatients, due to their improper behaviour, made it impossible for the medical officers and the nursing personnel to perform their duties well in their respective institutions, whereas fifteen percent (10) of the same sub-sample mentioned that some outpatients did not deliberately make it impossible for the medical doctors and the nursing personnel to perform their tasks well in their respective institutions; but what they understood was that their rights enshrined in the Constitution Act, 1996 were undermined and they wanted to know that the Constitution of the country as the supreme law and other relevant and related legislation and policies were observed and properly implemented by all health professionals because they were not treated well or fairly during the apartheid regime; hence they were demanding that the medical doctors and nursing personnel under the democratic government should change their mindsets; and should have their negative

attitude transformed. They demanded to be treated like any human being as they disliked being discriminated against.

**Item 21**

**TABLE 24: Distribution of responses reflecting whether public servants told patients about the level and quality of service they received so that they became aware of what to expect**



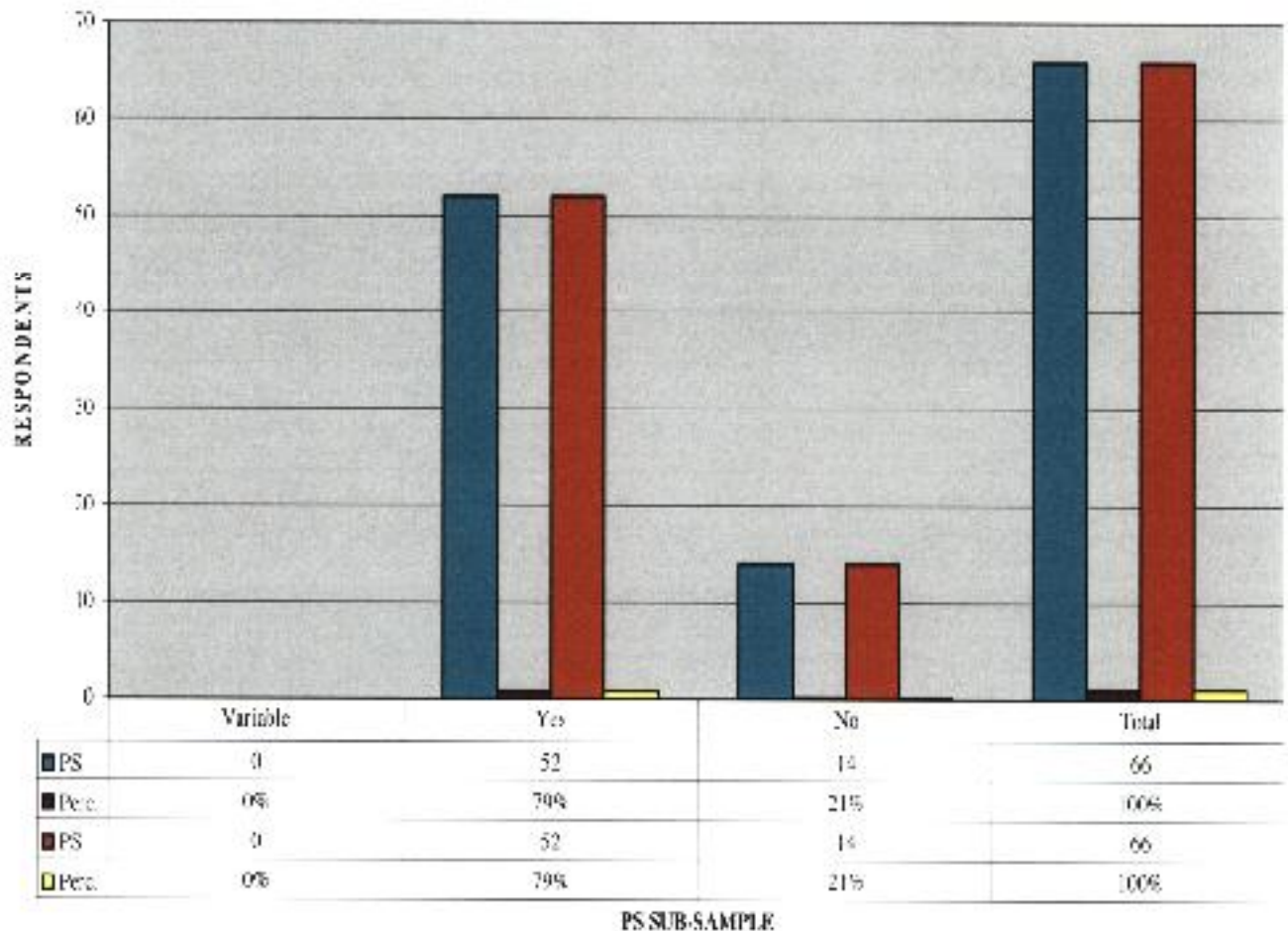
Item 21 in Table 24 above required the survey sub-sample to indicate whether patients were told about the level and quality of health service they received so that they were aware of what to expect. Ninety-seven percent (64) of the sub-sample claimed that they had informed patients so as to empower them to know their rights and what they should expect regarding the level and quality of health service delivery being offered by the health-care facilities. Three percent (2) of the same sub-sample mentioned that they did not tell patients about the level and quality of health-services they received so that they

became aware of what to expect from the public servants during the process of delivering services to them. No further reasons for such responses were given to justify such behaviour, as they were contrary to the provisions of Batho-Pele policy and other many pieces of legislation and the policies of the country. It was imperative that public servants, especially those who were in constant contact with the patients, had to have a thorough knowledge of Batho-Pele and other relevant legislation and policies pertaining to the transformation process as it related to health-service delivery. Ignorance in this respect was unacceptable to the current ANC-led government.



**Item 22**

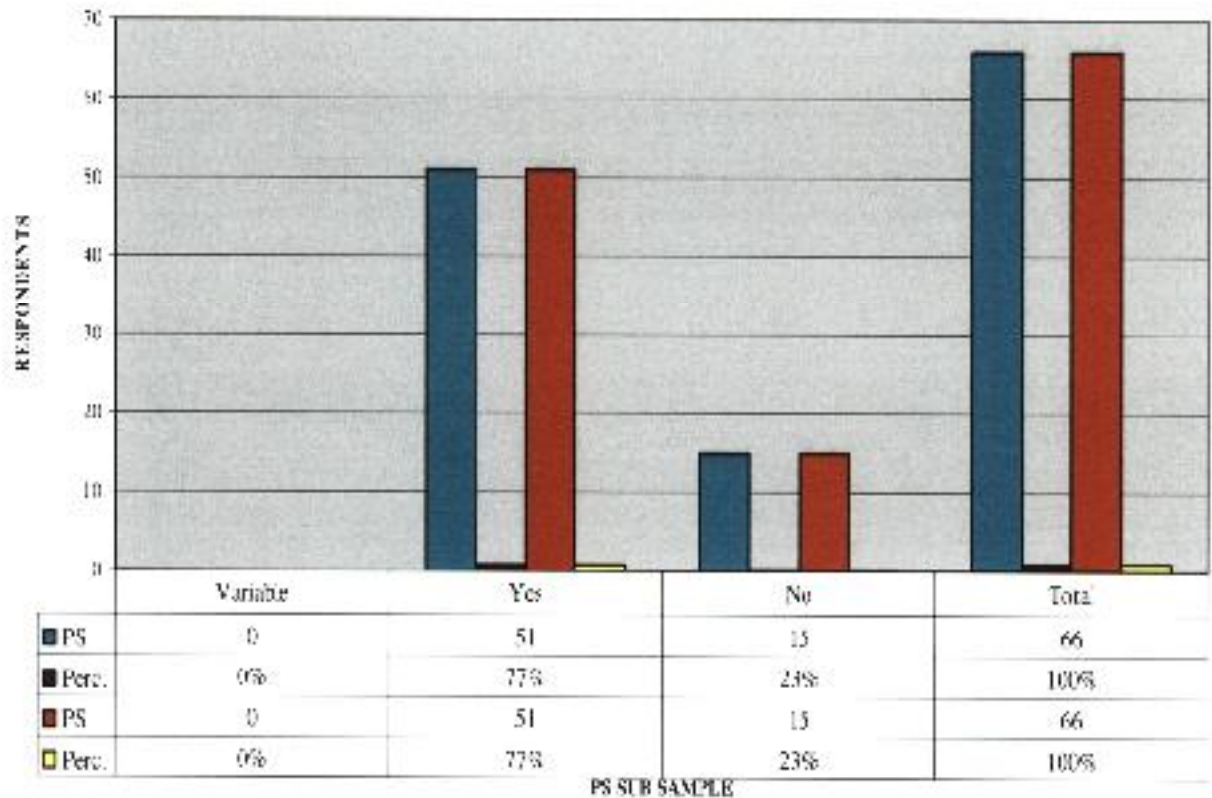
**TABLE 25: Distribution of responses indicating whether public servants treated patients with courtesy and consideration**



In Item 22 in Table 25 the respondents were required to indicate whether public servants treated patients with courtesy and consideration and seventy-nine percent (52) of the survey sub-sample responded in the affirmative, that they treated patients with courtesy and consideration, whilst twenty-one percent (14) indicated that they did not treat patients with courtesy or with consideration. As the latter responses were in contradiction to the principles contained in the Batho-Pele policies as well as those enshrined in the Constitution, Act of 1996 of the Republic of South Africa, it showed that the attitude of the latter towards the patients was incomplete violation of the charter of the patients' rights and they needed to transform their behaviour, as the policies of the government required all health professionals to show respect, courtesy and consideration towards their patients at all times.

**Item 23**

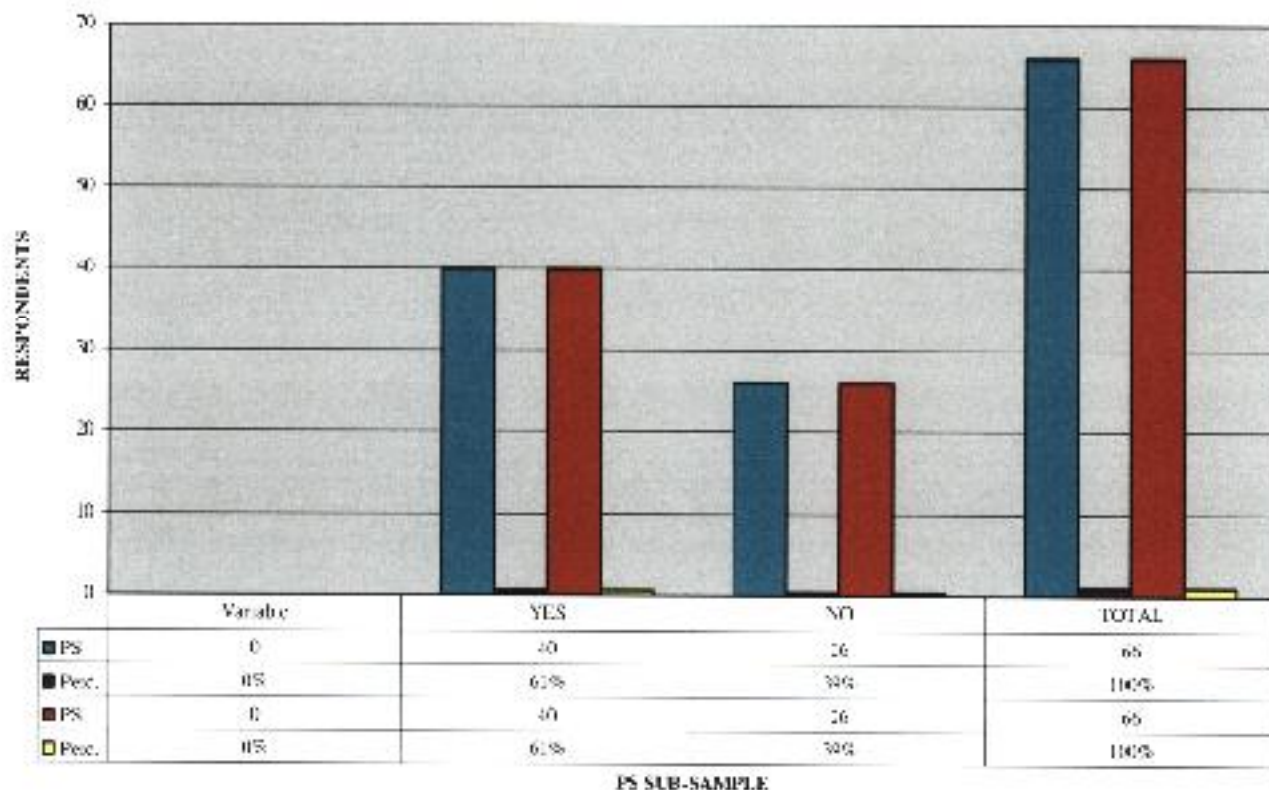
**TABLE 26: Distribution of responses reflecting whether public servants provided full and better information to the patients about the public service they were entitled to receive**



Item 23 in Table 26 above reflected responses pertaining to whether public servants should provide full and better information to patients about the public service they were entitled to. In response to that enquiry, seventy-seven percent (51) of the sub-sample responded in the affirmative, confirming that they did provide the necessary and relevant information to the patients about the public service they were entitled to in the clinics; whereas twenty-three percent (15) indicated that public servants did not provide full and better information to the patients about the public service they were entitled to receive; hence many patients had their lawful rights overridden and undermined by the health professionals because they lacked the essential knowledge and information pertaining to their rights as patients.

## Item 24

**TABLE 27: Distribution of responses indicating that public servants offered apologies to the patients and full, speedy explanation and effective remedies whenever complaints were lodged**



Item 24 in Table 27 above indicates that sixty-one percent (40) of the respondents mentioned that they offered apologies to the patients, and full, speedy explanations and effective remedies whenever complaints were lodged; whereas thirty-nine percent (26) said that they did not offer apologies to the patients and full, speedy explanations and effective remedies whenever complaints were raised by the patients. Although the latter explanation sounded negative which might be reflecting the reality of the prevailing circumstances, the Batho-Pele principles are completely opposed to such health professionals' attitude towards their patients, since patients have rights to be observed by the health professionals in all health-care institutions.



**Item 25 Distribution of responses by public servants pertaining to the general comments on the transformation process and service delivery in the department**

In the general comments advanced by the public servants about the relationship between the two variables, namely, the transformation process and its impact on the quality of health service delivery, some public officials indicated that they were not reluctant to implement the transformation process because they were not given sufficient exposure to the legislation and other relevant policies that dealt with transformation, as this was a new concept for the new government. Their main concern on the issue of the exposure to the transformation process was that although they were desirous of implementing the processes, their authorities, especially their immediate supervisors, were denying them the opportunity to attend workshops, relevant meetings and conferences, to mention but a few, during which they would be acquainted with the prescriptions of the legislation and policies that were about the promotion and facilitation of the processes.

There were proposals that as the transformation process was here to stay in this country and to ensure that the political and socio-economic situation in South Africa changed for the better, they would like to see that tertiary courses on the processes were introduced at post-matric level, as many young people were still furthering their academic studies and that would equip them with the relevant knowledge and skills before they entered the labour market.

They expressed fear that the implementation of the processes would be delayed especially by those from the defunct administrations of apartheid system as they had resisted change since 1994. Such people should be requested to leave the public service before it was too late. The public servants from the defunct administration had also caused a lot of damage to the current public service, and should always be prepared to change their mindsets in order to ensure that the process of the transformation of health-service delivery was facilitated and promoted without any further delay. Such negative attitudes did not benefit the majority of the black people residing in the remote peripheral areas of the sub-district.

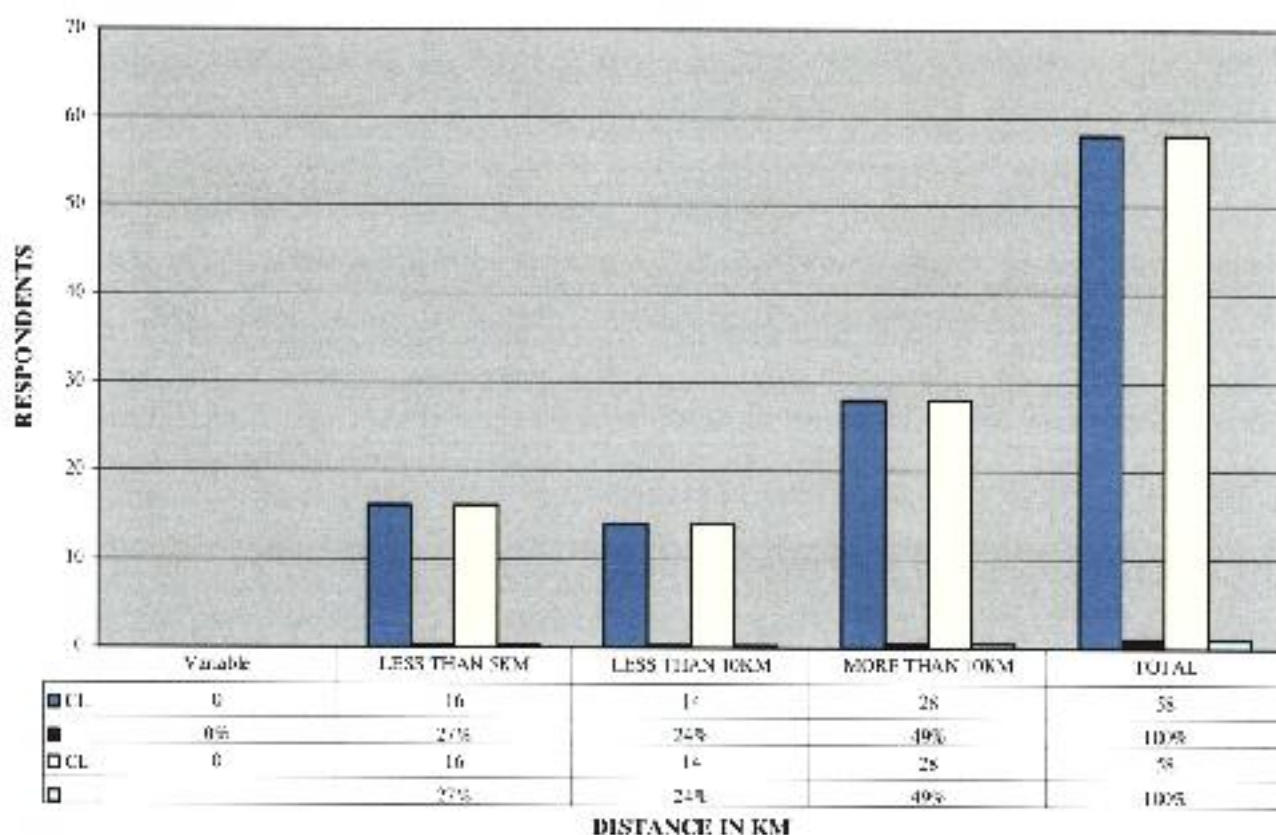


The respondents furthermore recommended that corrupt officials should be uprooted from the public service since the practice of such behaviour delayed the process from getting off the ground, and thereby continued to disadvantage the poor black people. Laziness, absenteeism, abscondment, faking illness, theft, staying away from work, nepotism, drunkenness on duty, drug abuse, to mention but a few, were regarded as the social ills that were the enemies of the process since such activities had a negative impact on the improvement of the quality of health service delivery. The authorities and supervisors were expected to capacitate their junior co-workers by ensuring that they were equipped with the relevant knowledge and skills related to the transformation process and service delivery so as to ensure that improvement in terms of service delivery was attained.

## SURVEY DATA DESCRIPTION IN RESPECT OF THE CLIENTS IN MUTALE SUB-DISTRICT

### Item 1

TABLE 28: Distribution of responses reflecting the distances between patients' homes and PHC

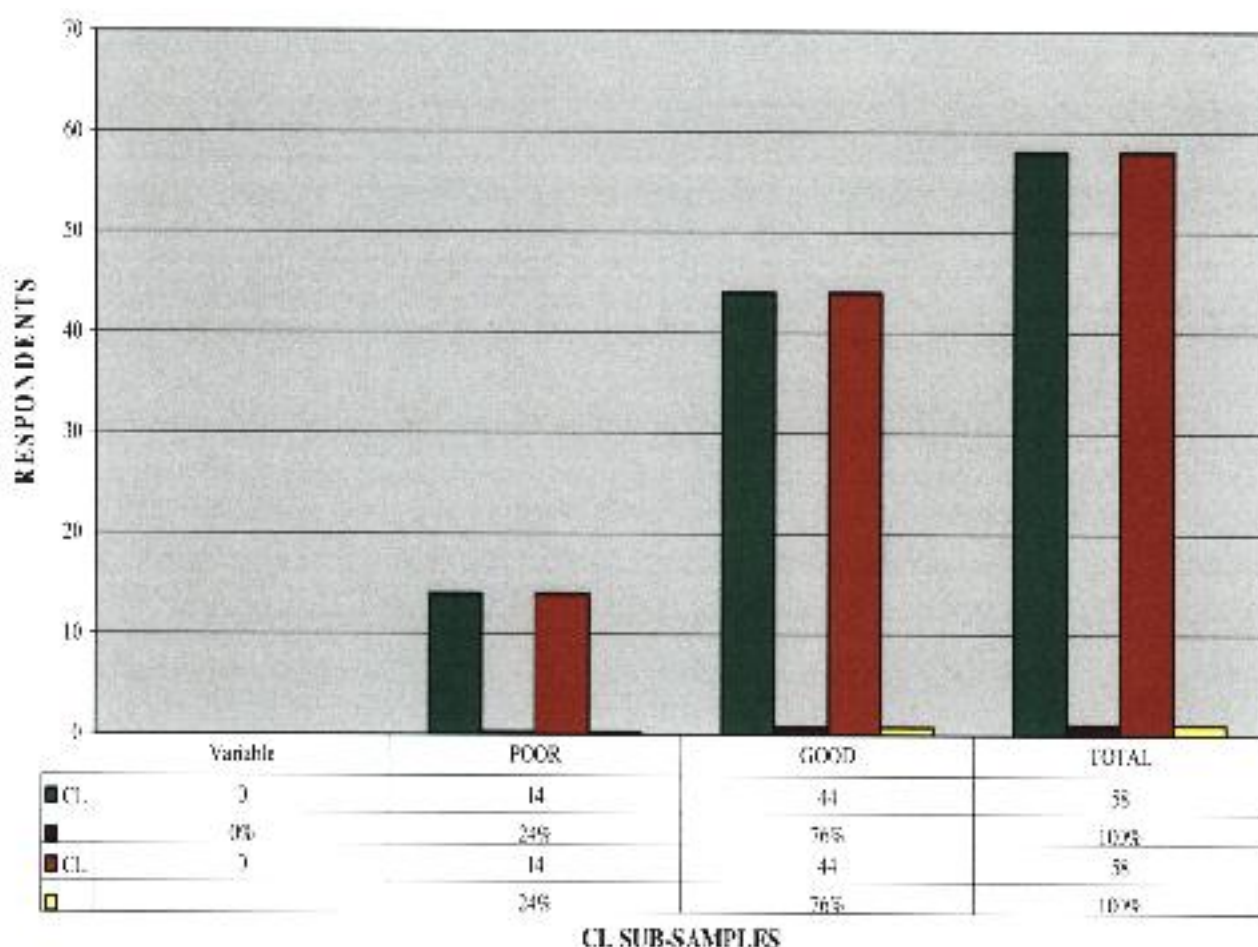


It was observed from the above data in Item 1 in Table 28, that twenty-seven percent (16) of the survey respondents said that they traveled less than 5 km from their homes to the health-care facilities, whereas twenty-four percent (14) mentioned that the health-care facilities were less than 10 km from where they stayed. The last group of respondents comprised of forty-nine percent (28) said that they travelled more than ten (10) kilometres to reach their nearest primary health-care facility. The current government is busy erecting clinics in the rural communities in such a way that members of the communities must be within five kilometres' reach rather than travelling such long distances. Although it was and still is the policy of the current government to ensure that an adequate number of clinics are built, the public officials from the Vhembe Health District, especially from the Information office, revealed that according to the information they had in their

records, no clinics, especially at Mutale sub-district, had been built since democracy was achieved in 1994. That means that the processes of transformation and health-service delivery were not being seen to be implemented to benefit the poor black people. The situation was still appalling, especially for the members of the communities who had expected changes in terms of health service delivery since 1994.

## Item 2

TABLE 29: Distribution of responses in terms of the services provided by PHC

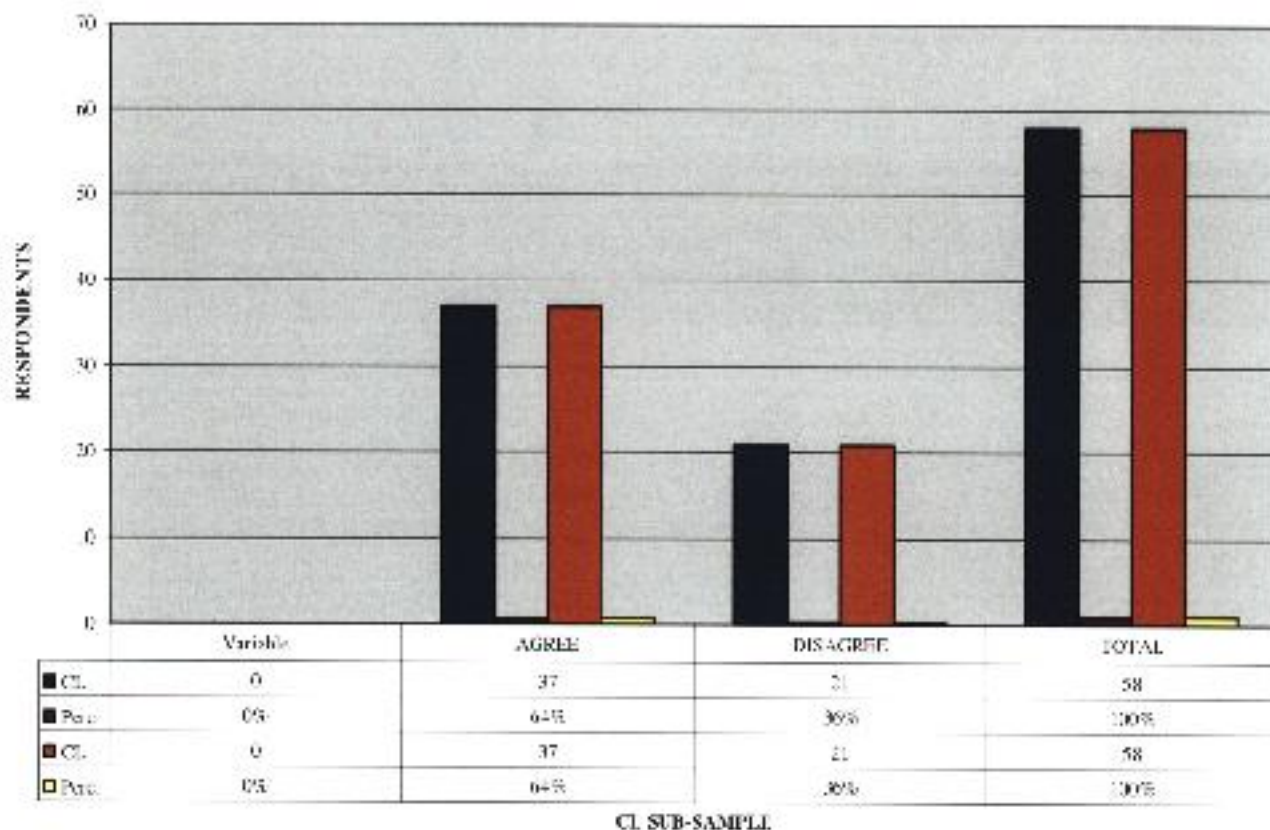


In response to Item 2 in Table 29 above, twenty-four percent (14) of the respondents indicated that the quality of the health services provided by the health-care personnel at the clinics was poor while the remaining respondents representing seventy-six percent (44) in the same sub-sample mentioned that the services provided in all the primary health-care institutions in the Mutale sub-district at the time the survey was conducted were good; but not in terms of the provision of the new clinics in order to achieve the

national norm that indicated that the clinics must be within 5 kilometres' reach by the patients in their respective rural communities.

### Item 3

TABLE 30 : Distribution of responses in terms of which Mutale public servants lacked capacities and skills to promote and facilitate health- service delivery



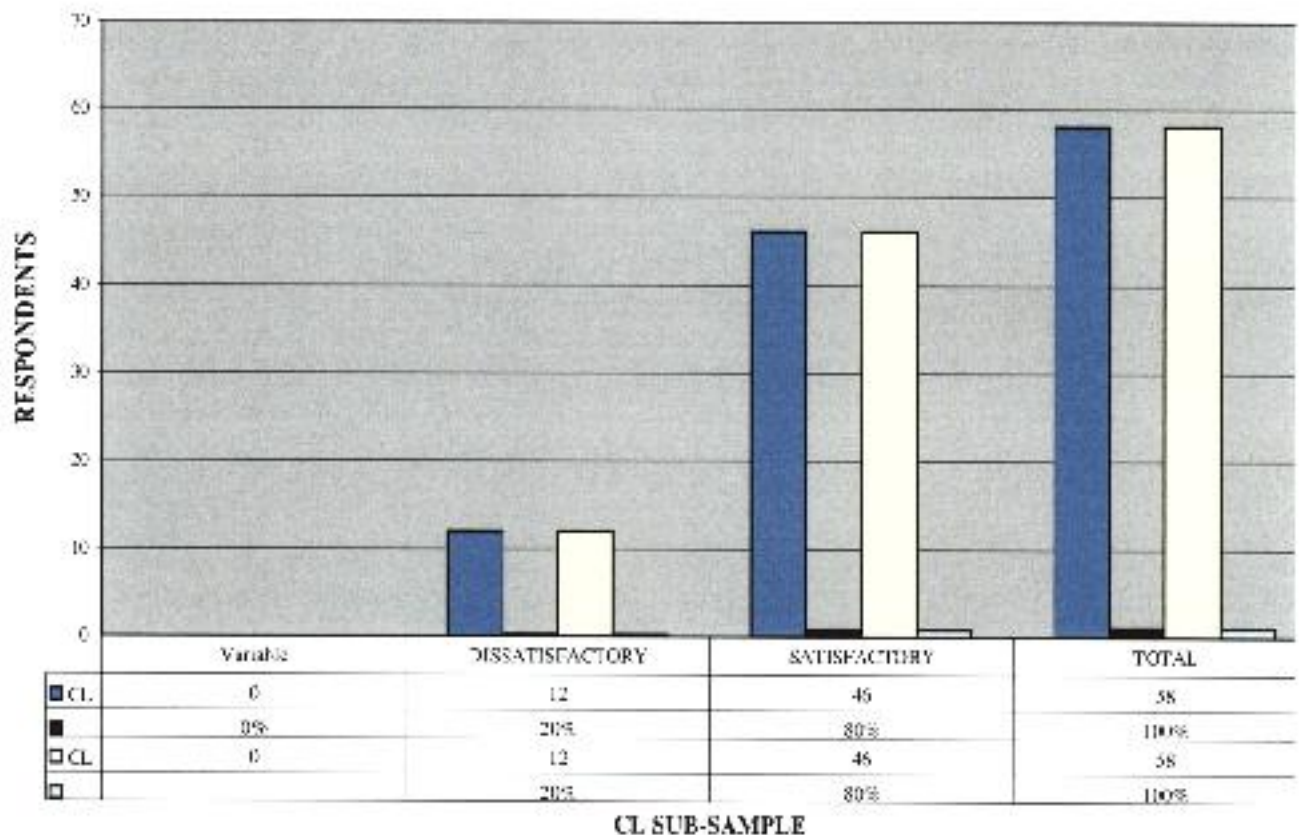
It was observed from the above data shown in Item 3 in Table 30 that sixty-four percent (37) of the survey respondents indicated that they agreed that public servants in the Mutale sub-district lacked the capacities and skills to implement the transformation process to promote the quality of health-service delivery; hence there was no adequate and satisfactory health service delivery, whereas thirty-six percent (21) of the respondents said that they disagreed that the public servants in the sub-district lacked the capacities and skills which were indispensable for the facilitation of the improvement of health-service delivery. Members of the communities argued that public servants had the adequate capacities and skills to promote and facilitate health-service delivery in their communities because they attended workshops, conferences and meetings during which



they were equipped and capacitated with skills and knowledge as to how they should implement their knowledge and skills to benefit the public. They had to dispel the negative attitude they have towards the processes.

#### Item 4

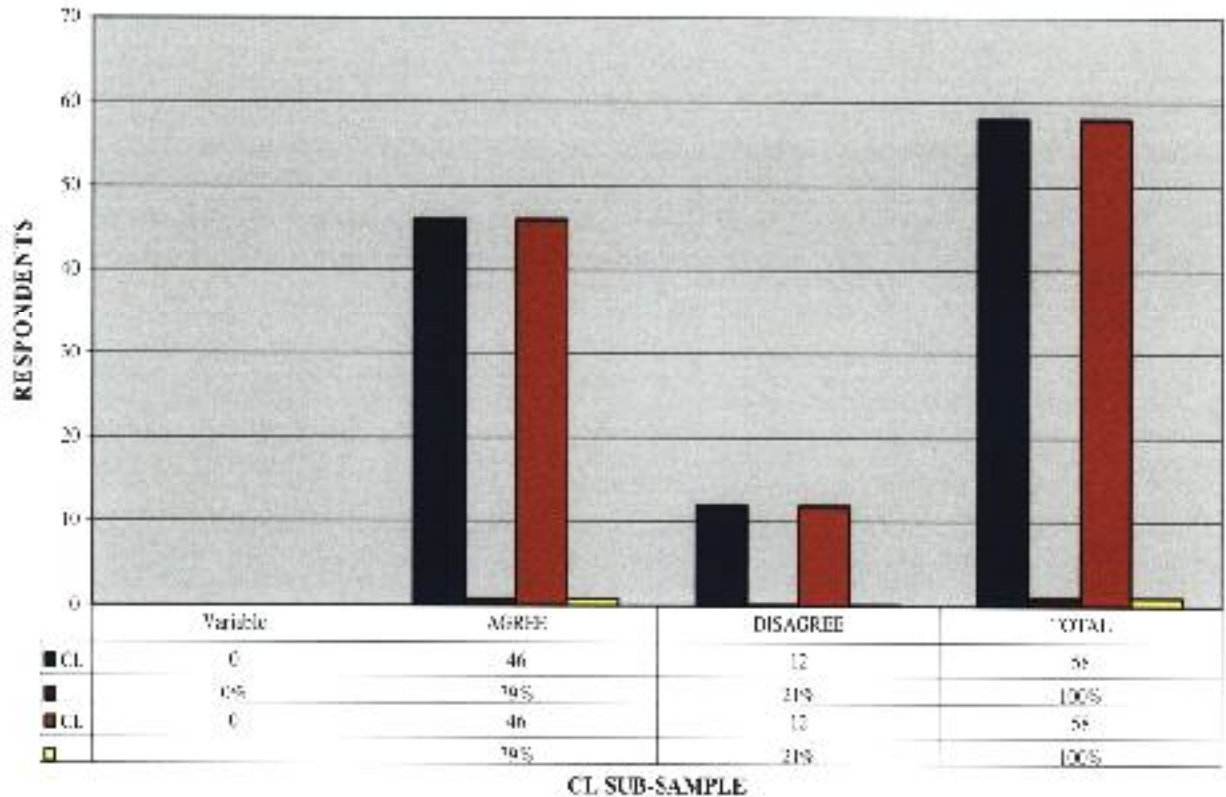
**TABLE 31: Distribution of responses in terms of the attitude to health care personnel towards the patients at the PHC**



The data in Item 4 in Table 31 above shows that twenty percent (12) of the survey participants indicated that the attitude of the health-care personnel at the health-care institutions in Mutale sub-district was dissatisfactory; while eighty percent (46) of the remaining members of the sub-sample argued that they perceived the attitude of the health-care personnel towards the patients as satisfactory in the Mutale sub-district clinics.

**Item 5**

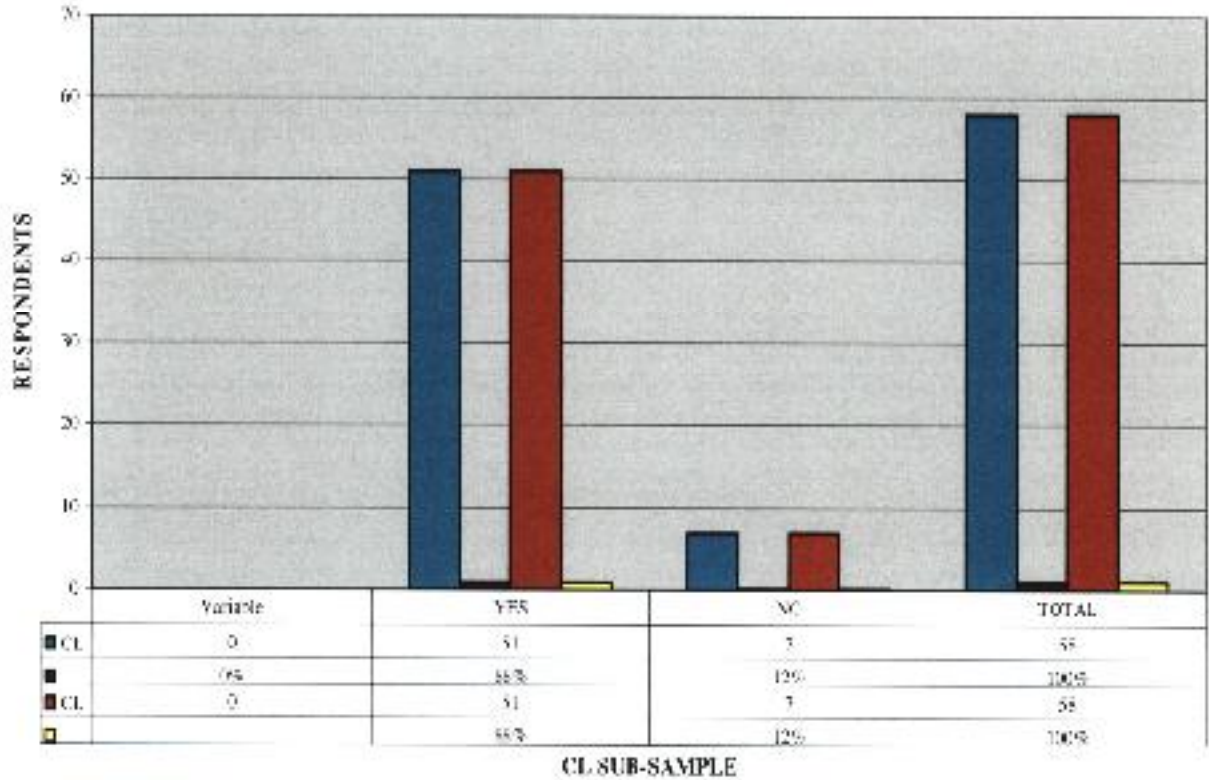
**TABLE 32: Distribution of responses reflecting that the transformation process promoted and facilitated service delivery in the peripheral communities**



Item 5 in Table 32 above shows that seventy-nine percent (44) of the CL sub-sample mentioned that they agreed that the transformation process promoted and facilitated health-service delivery in the peripheral communities, and twenty one percent (12) disagreed that the transformation process had a positive influence to the extent that the health-service delivery could be promoted and facilitated especially in the most rural areas of the Vhembe Health District. The impact of the transformation process was not being seen to be implemented and taking place in the rural areas.

**Item 6**

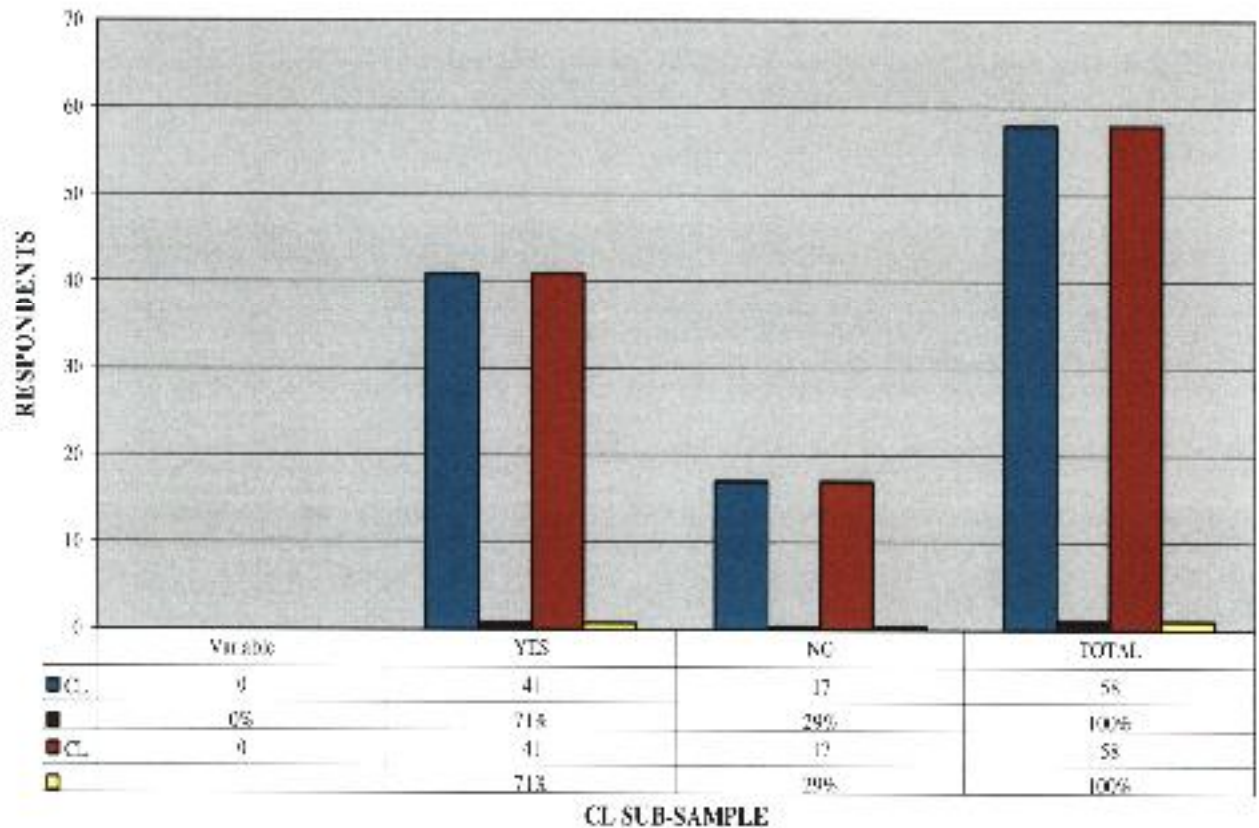
**TABLE 33: Distribution of responses indicating that health care personnel showed respect towards patients when they sought consultation**



The data in Item 6 in Table 33 above shows that the responses given by survey respondents indicated that eighty-eight percent (51) of the health-care personnel showed respect towards patients when they sought consultation at the clinics in the Mutale sub-district; and only twelve percent (7) indicated that according to their observation the health-care personnel, indeed, did not display any respect towards the patients when they sought consultation.

**Item 7**

**TABLE 34: Distribution of responses reflecting that the PHC personnel met patients' expectations when they visited the health care institution**

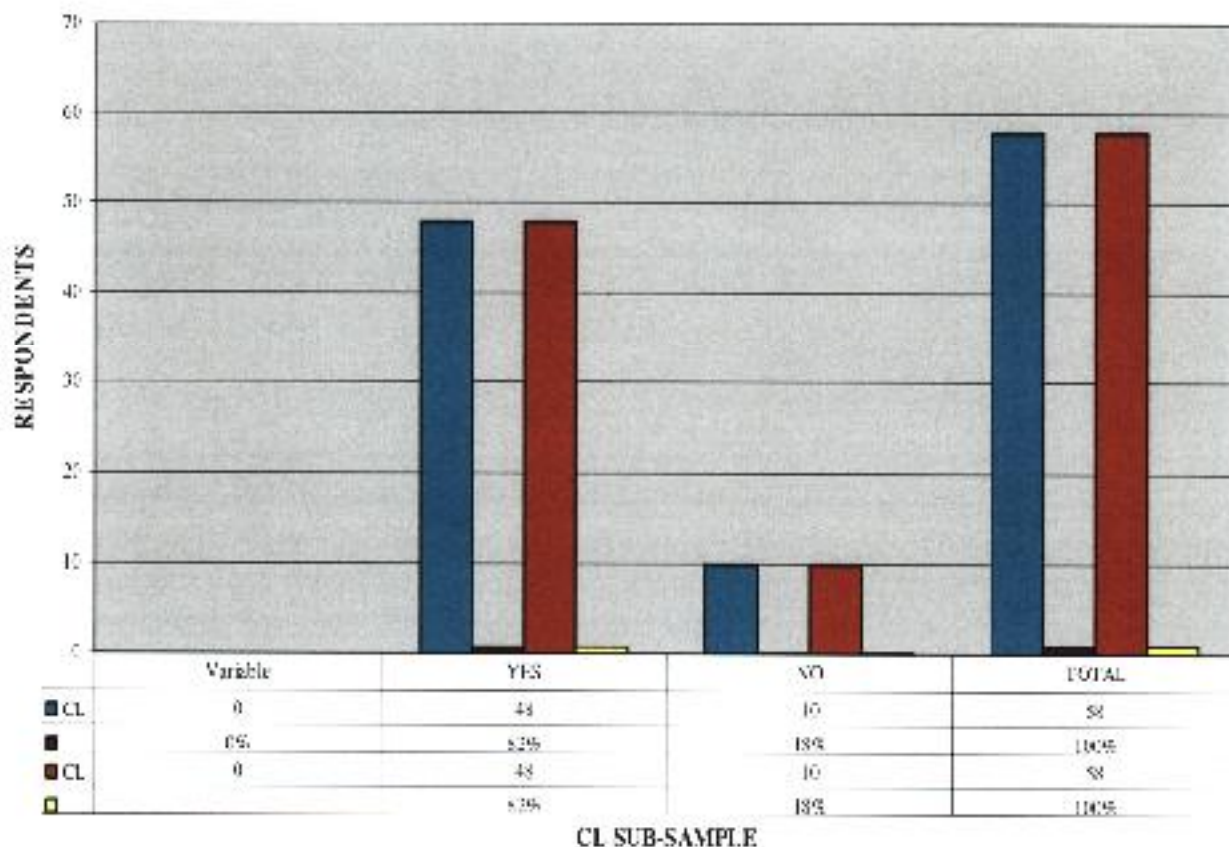


In response to the enquiry in Item 7 in Table 34 above, seventy-one percent (41) of the sub-sample indicated that the primary health-care personnel met patients' expectations when they visited the health-care institutions and the remaining twenty-nine percent (17) indicated that the health-care personnel did not meet the patients' expectations when they visited their health-care institutions in the Mutale sub-district. The latter responses displayed that the objectives of the processes were being defeated by the behaviours of some public servants at the health-care institutions. The department should ensure that the processes are implemented without any compromise.



## Item 8

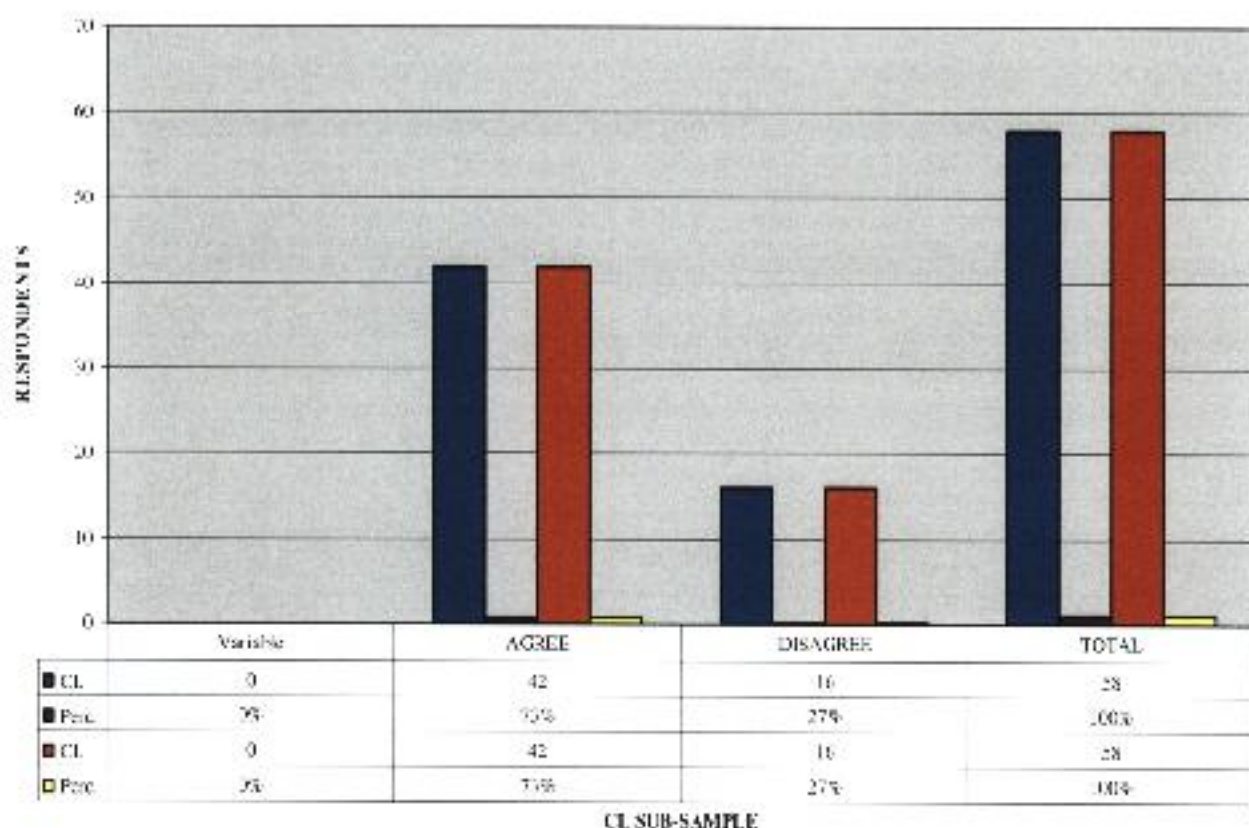
TABLE 35: Distribution of responses indicating the possibility of accessing the health care facilities



In response to the enquiry in Item 8 in Table 35 above, whether there was a possibility of accessing the health-care facilities in the sub district, eighty two percent (48) responded in the affirmative, indicating that the possibility was there to access the health-care facilities, while eighteen percent (10) disputed that point of view by stating that there was no possibility of accessing the health-care facilities within Mutale sub-district, probably due to the vast distances between the clinics in the sub-district still being unacceptable as no new clinics had been built since 1994 as a way of trying to ensure that health-care institutions were within the national norm of being within 5 km of all patients' respective homes. Especially those staying in the remote peripheral areas are still daunted by inadequate provision of public transport which should enable them to reach clinics with little or no difficulty at all.

**Item 9**

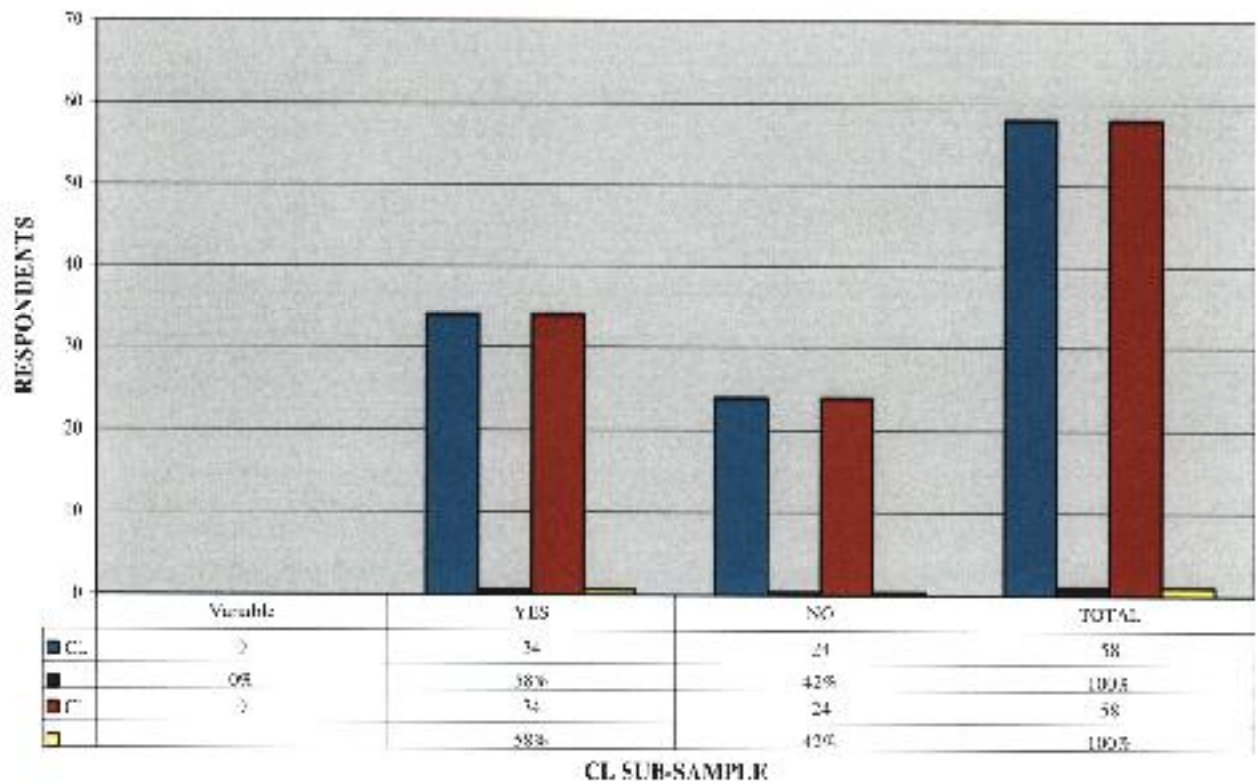
**TABLE 36: Distribution of responses which indicated that members of the communities were not knowledgeable about transformation process and its impact on the quality of health-service delivery**



It was observed from the above Item 9 in Table 36 that seventy-three percent (42) of the survey respondents agreed that as members of the communities in Mutale sub-district, they were not knowledgeable about the process of transformation or its impact on the quality of health-service delivery because the concept was quite new and they were not familiar with it and the impact it had upon the quality of health-service delivery was a new phenomenon. Twenty-seven percent (16) of the same CL sub-sample disagreed that as members of the communities in the same locality they were knowledgeable about the transformation process and its impact on the quality of health-service delivery, but it was the sole responsibility of public officials to ensure that it was implemented for their benefit. Unfortunately circumstances were not unfolding as they expected, apparently for reasons beyond their comprehension.

**Item 10**

**TABLE 37: Distribution of responses in terms of which health care personnel provided prompt support to the patients during emergency calls**

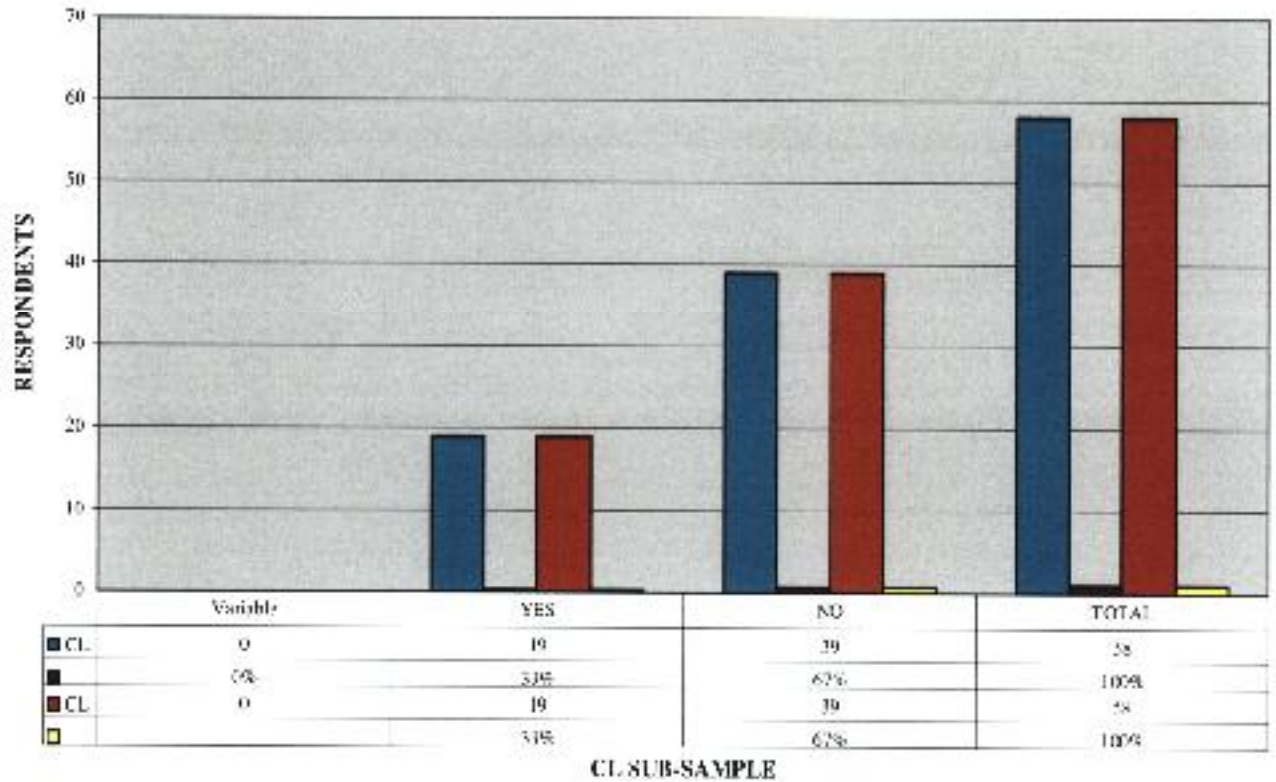


The data reflected in Item 10 in Table 37 above revealed that fifty-eight percent (34) of the responses showed that health-care personnel provided prompt support to the patients during emergency calls, but forty-two percent (24) indicated that their experiences in this regard showed that the health-care personnel did not provide prompt support to the patients during emergency calls. Complaints had been lodged with the health authorities through making use of the suggestion boxes at the clinics for their attention and consideration indicating that the situation left much to be desired, and demanding that the situation to be transformed to benefit them.



**Item 11**

**TABLE 38: Distribution of responses reflecting some of health care personnel who shouted at the patients when they asked for assistance**

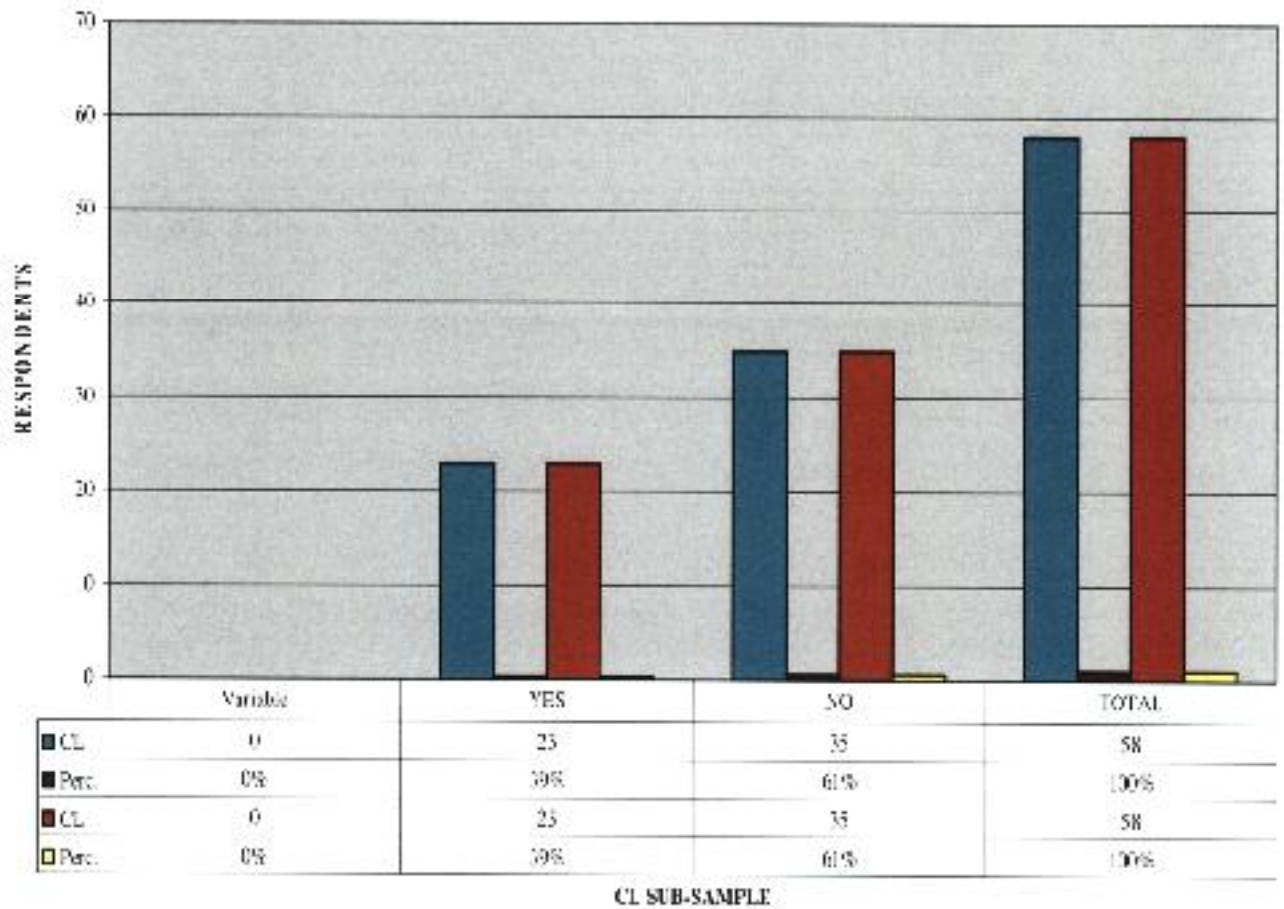


Item 11 in Table 38 above required respondents to indicate whether public servants shouted at them when they asked for assistance, or not. In response to the enquiry, thirty-three percent (19) responded in the affirmative indicating that, indeed, they shouted at them when they asked for assistance at the clinics, while sixty-seven percent (39) indicated that health-care personnel did not shout at the patients when they asked for assistance as they were employed to serve them with respect and dedication. Batho-Pele Policy and the Patients’ Charter required the public servants to be respectful to the patients.



**Item 12**

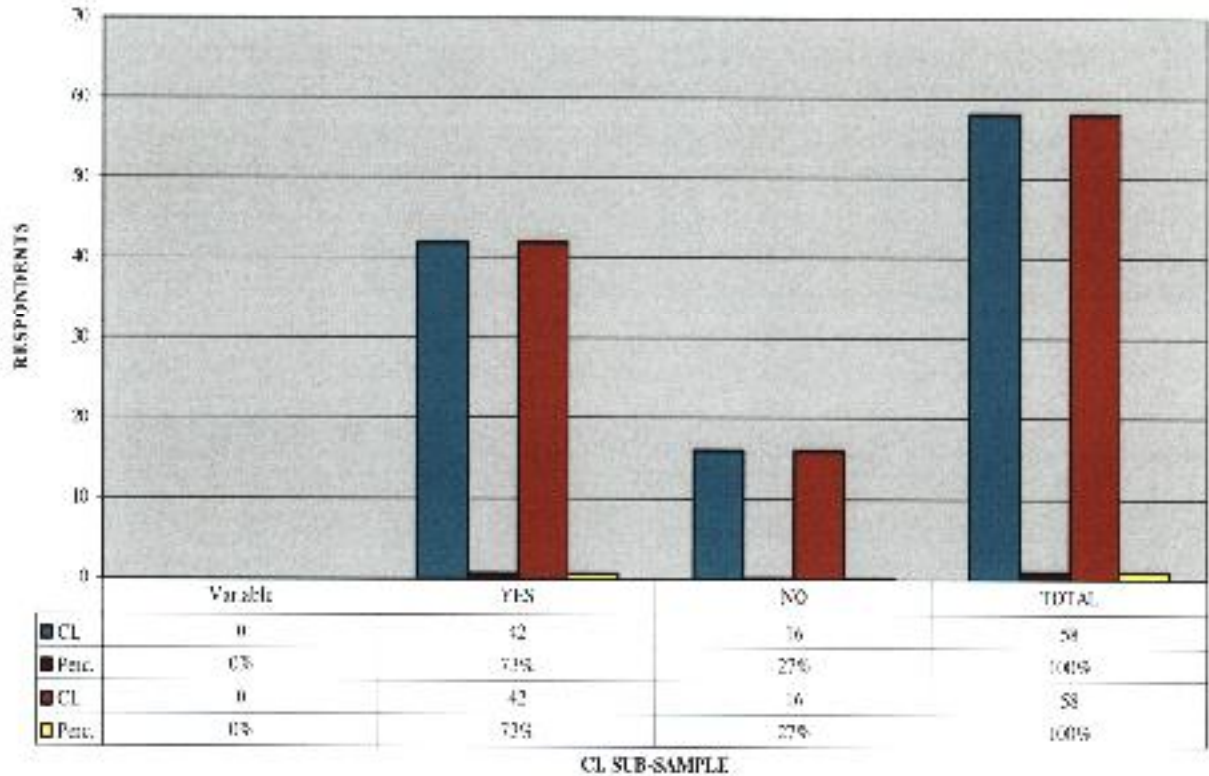
**TABLE 39: Distribution of responses in terms of which patients were turned down at the health care institutions**



According to item 12 in Table 39 above, thirty-nine percent (23) of the survey participants responded in the affirmative, indicating that they were turned down by the health-care personnel in the health-care institutions when they needed health care, whereas sixty-one percent (35) mentioned that they were not turned down at the health-care institutions by the health-care personnel. Patients were treated fairly well by the health professionals working at the clinics. The responses reflected that patients were treated differently by different health-care personnel.

### Item 13

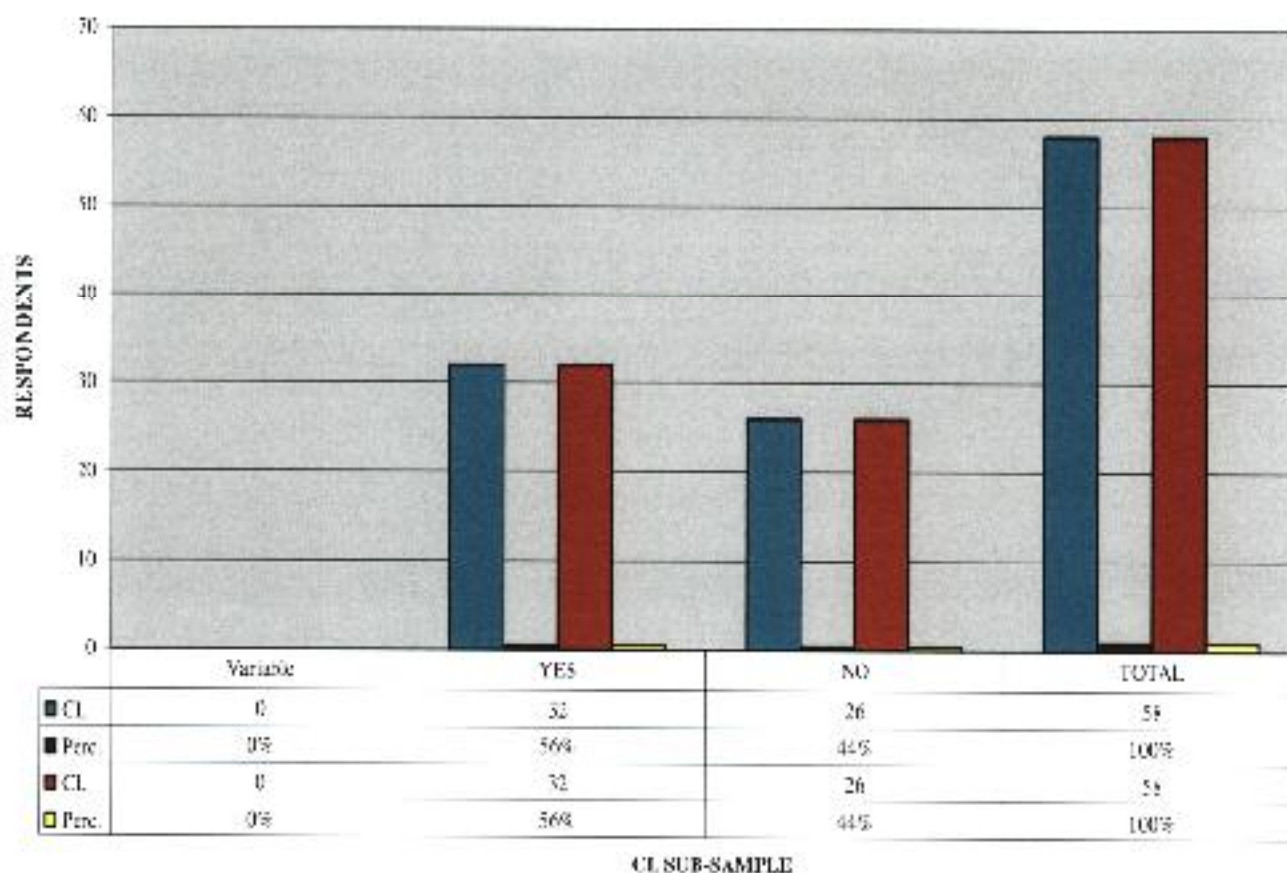
TABLE 40: Distribution of responses pertaining to the ready availability of drugs for the patients' illness after diagnoses



In response to Item 13 in Table 40 above, seventy-three percent (42) answered in the affirmative, indicating that drugs were readily available to the patients for their illnesses after diagnoses, but twenty-seven percent (16) of the sub-sample indicated that drugs were not readily available to them after their illnesses had been diagnosed, especially common drugs prescribed for their common illnesses. The prevailing situation, indeed, left much to be desired especially for fragile and vulnerable patients in the remote rural areas where there were no alternatives in terms of other health-care facilities. The patients demanded all clinics to have adequate stock of medication at all the health-care institutions in the Mutale sub-district including also in all the clinics in the Limpopo Province, because the provision of medical drugs was their rights not a privilege.

## Item 14

**TABLE 41: Distribution of responses reflecting whether the hospital services were within reach of the patients**



According to Item 14 in Table 41 above, fifty-six percent (32) of the respondents as members of the communities indicated that the hospital services in their localities were within reach of the patients, whereas forty-four percent (26) mentioned that the hospital services were not within their reach if one takes cognisance of the fact that the current government wanted health services to be within reach of every patient and the national norm of 5 km was expected to be complied with if the transformation process was to be seen to be taking place and not only lip-service which the public was not interested in.

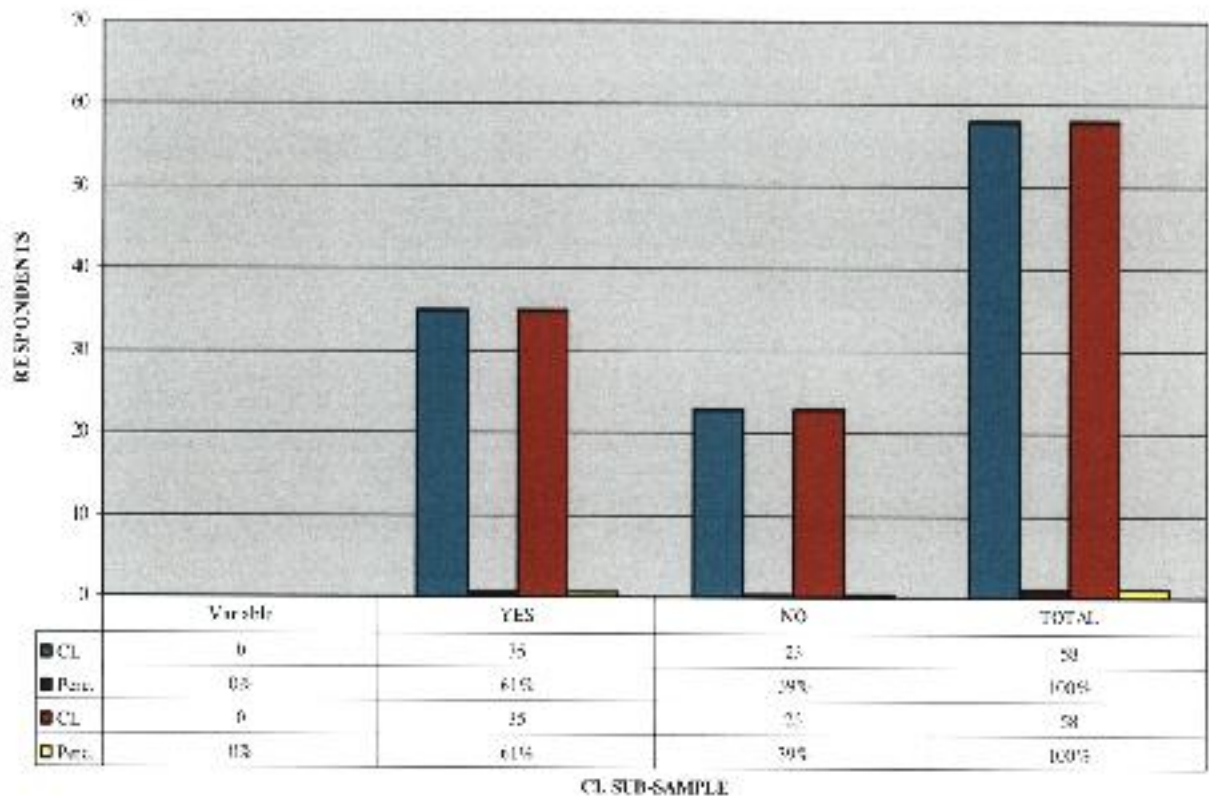
The reason for the latter responses was based, perhaps, on the fact that no additional health-care facilities had been built to address and redress the backlogs of the past since 1994. So, in spite of the current government's emphasis on the fact that transformation should be implemented throughout the whole country, such a situation was not prevailing



in the Mutale sub-district; hence the provincial government was expected to ensure that new clinics should be built in the sub-district within the next few years in order to prove beyond any reasonable doubt that, indeed, the government was upholding its policy of implementing the transformation process to ensure the improvement of health service delivery in the rural communities in the entire province..

### Item 15

TABLE 42: Distribution of responses reflecting that the female health care personnel provided better services at the clinics than the male health care personnel

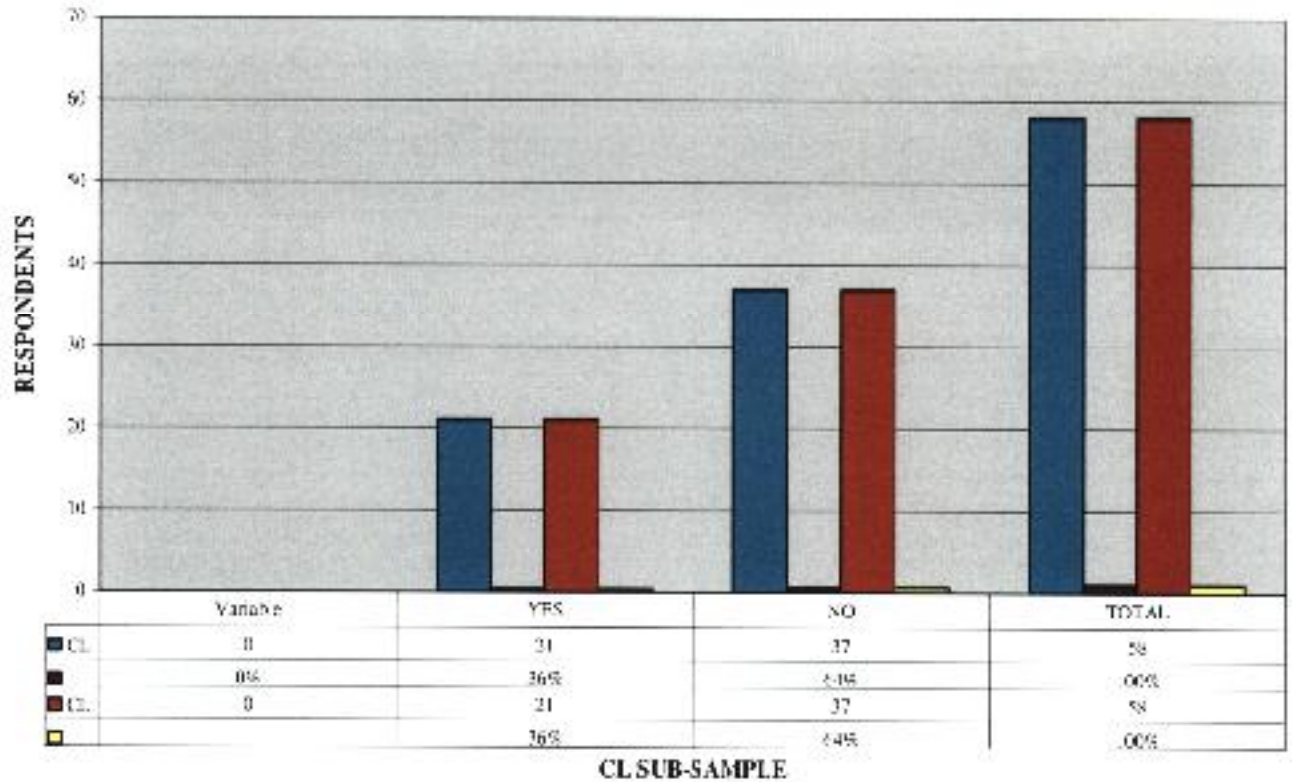


In response to the enquiry in Item 15 in Table 42 above, sixty-one percent (35) of the respondents indicated that the female health personnel provided better service at the clinics than the male health-care personnel, whereas thirty-nine percent (23) indicated that the female health-care personnel did not provide better services at the clinics than the male health-care personnel, the reason being that both categories of health-care personnel performed equally well for the benefit of all the patients in the sub-district of Vhembe district. Gender was not, in fact, a major contributory factor in the determination of the quality of health-service delivery



**Item 16**

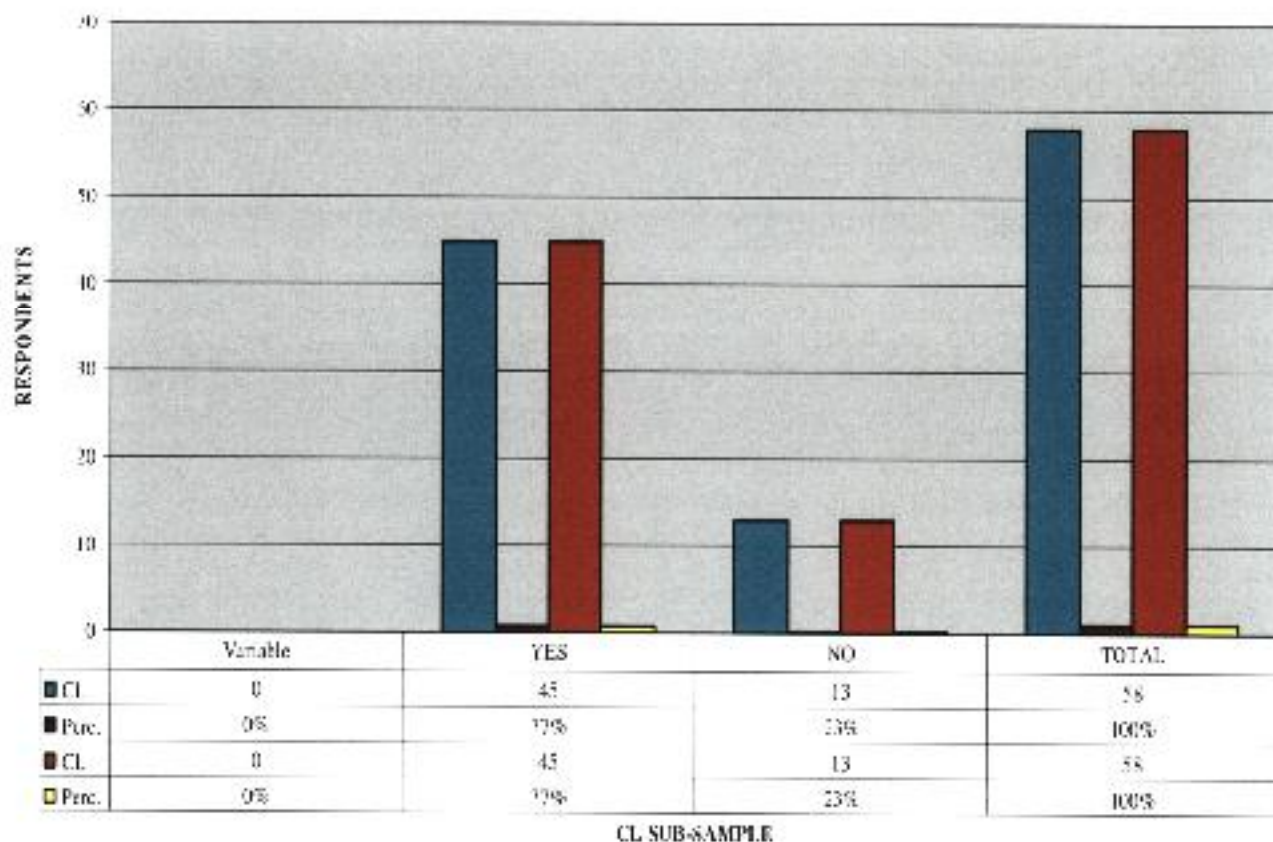
**TABLE 43: Distribution of responses reflecting that the aged patients paid health care levies for the services rendered to them by clinics**



Thirty-six percent (21) of the participants in Item 16 in Table 43 responded in the affirmative, indicating that the aged patients paid health-care levies for services rendered to them by clinics, whereas sixty-four percent (37) disputed that point of view, but argued that the aged patients did not pay health-care levies for services rendered to them by clinics, as this would be contrary to the provisions of the legislation in South Africa which stipulated that pensioners were exempted from paying health-care levies when they visited clinics for consultation. They were entitled to free services provided at the clinics and also at the public hospitals in terms of the legislation.

**Item 17**

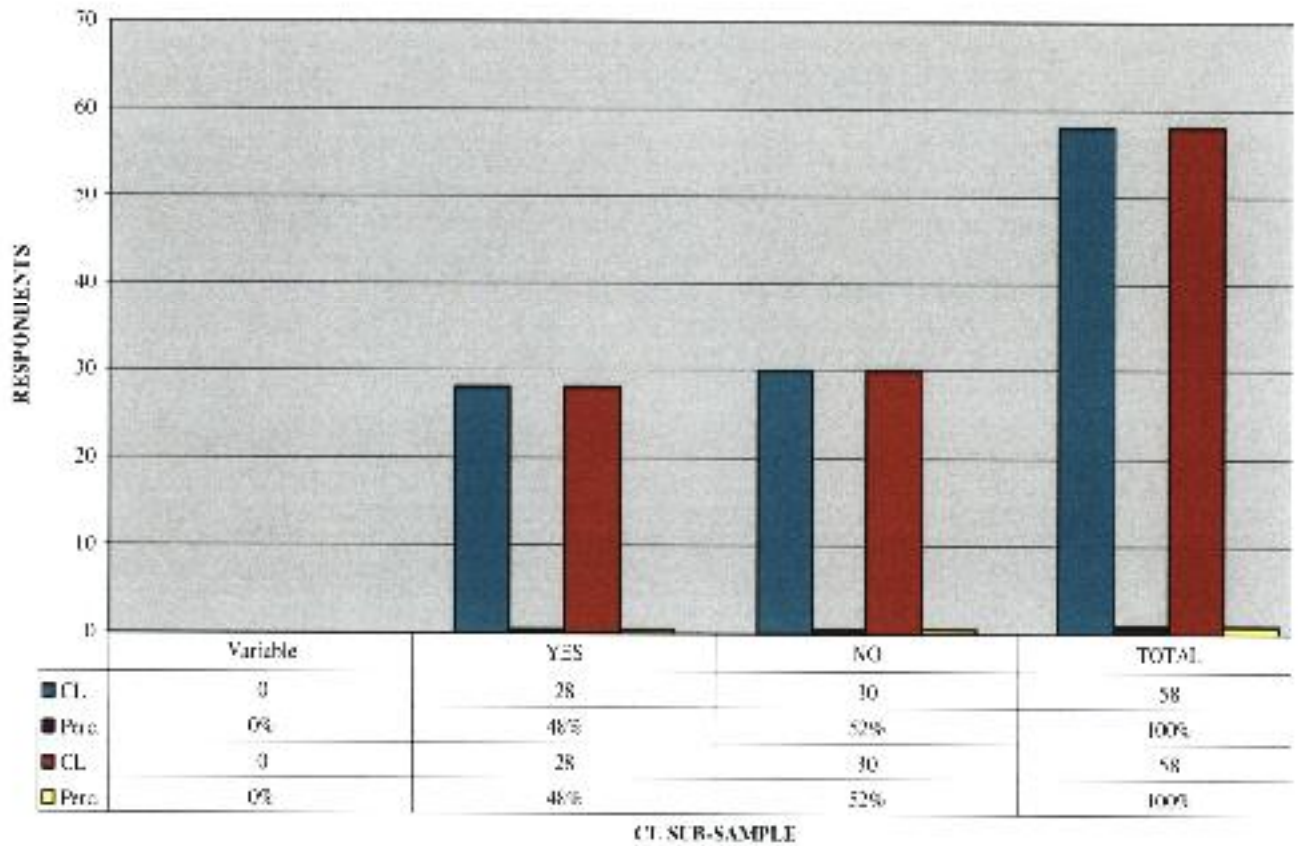
**TABLE 44: Distribution of responses in terms of which patients were told to come back the following day to collect drugs whenever they were out of stock**



In response to Item 17 in Table 44, seventy-seven percent (45) of the respondents indicated that patients were told to come back the following day to collect drugs wherever they were out of stock, but twenty-three percent (13) argued that patients were not told to come back the following day to collect drugs whenever they were out of stock. There was no indication of how the problem of unavailability of drugs at the clinics was addressed as the patients needed to take drugs home with them for use. Complaints had been received in the suggestion boxes pertaining to the unavailability of medication at the clinics. It was the responsibility of the clinic management or authorities to ensure that there was adequate provision of drugs at the clinics to avoid complete depletion of drugs.

**Item 18**

**TABLE 45: Distribution of responses in terms of which patients were advised to buy drugs from the private pharmacy or chemist whenever they were out of stock at the clinics**

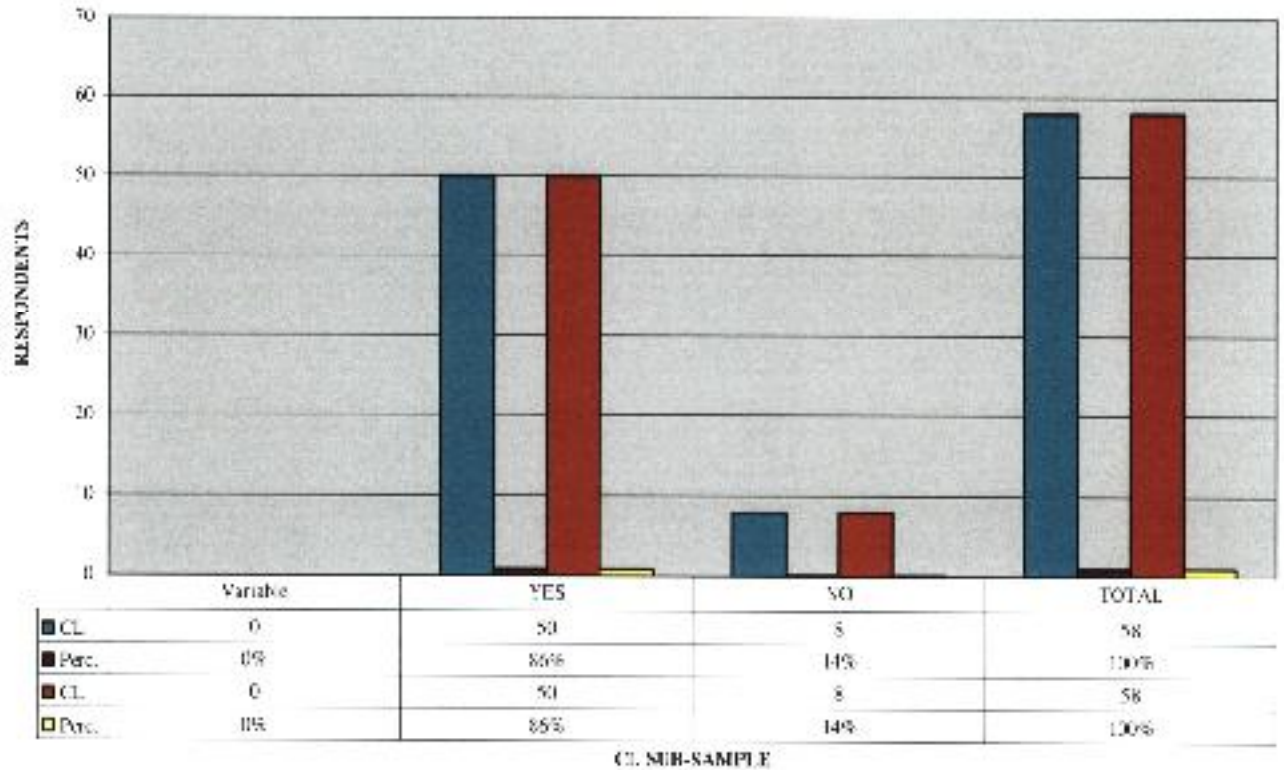


In the light of the responses furnished in Item 18 in Table 45, forty-eight percent (28) of the survey participants pointed out that patients were advised to buy drugs from private pharmacies or chemists whenever they were out of stock at the clinics; but fifty-two percent (30) argued that no health-care personnel, especially not medical officers and nursing personnel, advised patients to go to private pharmacies or chemists for the purchase of drugs prescribed at the health care institutions. No mention was made of how the health professionals addressed the challenge pertaining to the medication that was frequently out of stock as alleged by the patients who visited the clinics.



**Item 19**

**TABLE 46: Distribution of responses according to which patients enjoyed support provided for by the health care personnel at the clinics**



It is observed from the data in Item 19 in Table 46 above that eighty-six percent (50) of the participants mentioned that they, as patients, enjoyed the support provided by the health-care personnel at the clinics, whereas fourteen percent (8) indicated that they did not enjoy the support provided by the health-care personnel at the time of their visits to the clinics in their respective localities.

**Item 20 Reflection of responses by members of the communities pertaining to the general comments on the transformation process and service delivery in the department**

Twenty (34,5%) out of fifty-eight respondents did not answer Item 20. The responses of the other thirty-eight (65,5%) participants were as follows: 'Nurses should explain to us when to wait for drugs.' It was said that clinics did not provide good service because most of them closed at 16h30. Some patients did not like the way they were treated by the



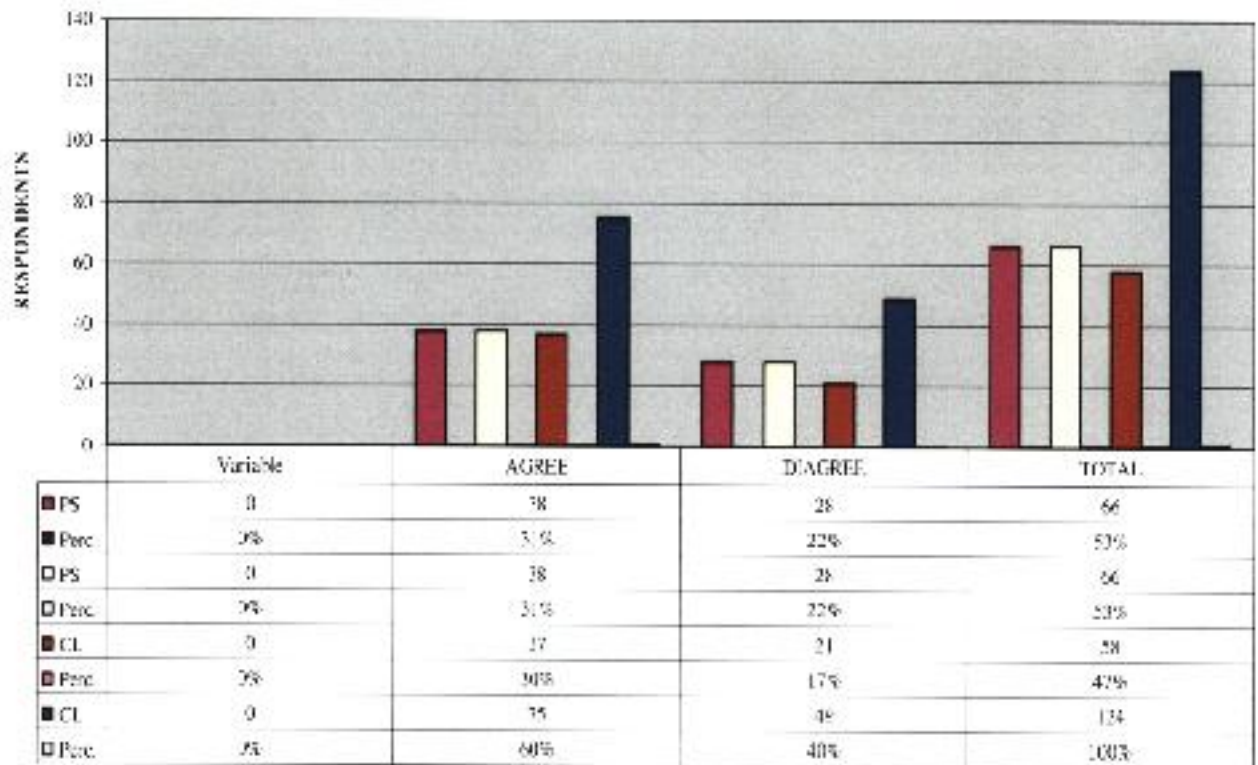
health-care professionals because they underestimated the integrity of the patients and did not show respect for them. The patients pointed out that when they needed help from the health-care professionals, they were often told to wait for a long time and there was no explanation for the delays. The health professionals were working at a slow pace and that was unacceptable to the patients as it was disturbing and irritating for a person who was in acute agony. They reiterated that satisfying their needs in respect of medication was unsatisfactory because most clinics at the time of the survey research were said to be unable to provide essential drugs to them as they were often told that clinics were still waiting for the deliveries by the department from wherever they came from and that was very frustrating.

The above-mentioned comments were negative although they were reflecting the situation prevailing at the clinics. The positive perceptions and observations of the other patients were that they regarded health-care professionals as very important since they were performing vital and indispensable services. The health professionals were very cooperative as they were dealing with some extremely difficult patients such as those rehabilitated from psychiatric institutions or wards. The patients appealed for urgent attention and consideration when they visited the clinics. All the health-care professionals were commended for their unconditional diligence, commitment, dedication and sacrifice they displayed towards the fragile and vulnerable patients and were requested to maintain the current standard of health-care services provided in the entire Mutale sub-district. The above-mentioned valuable comments were advanced by very few respondents as the majority did not bother to make any general observations.

**TABLE 47**

**Table reflecting frequencies in respect of the consolidated Tables 4 and 30**

**TABLE 47: Distribution of responses in terms of which Mutale sub-district public servants lacked capacities and skills to implement the transformation to promote and facilitate the quality of health-service delivery in the health care facilities**



**MUTALE SUB-DISTRICT SAMPLE**

**Hypothesis 1.6.1:** The public servants of Mutale sub-district lacked the capacities and resources to implement the transformation process in order to promote and facilitate the quality of health-service delivery.

It is observed from the above data indicated in Table 47 that sixty percent (75) of the survey respondents said that they agreed that the public servants of Mutale sub-district lacked capacities and resources to implement the transformation process to promote and facilitate the quality of health-service delivery; whereas forty percent (49) out of one hundred and twenty-four (124) respondents of the survey sample indicated that they disagreed that the public servants lacked capacities and resources to promote and

facilitate the transformation process in order to improve the quality of health-service delivery at Mutale sub-district in the Vhembe District. In other words, the latter members of the sample agreed that they had capacities and resources to implement the transformation process in order to promote and facilitate the quality of service delivery.

**Figure 2: Chi-square formula for Table 47**

$$\chi^2 = \left[ \frac{(A - E)^2}{E} \right]$$

The application of the above indicated Chi-square test in the analysis of the survey data yielded the calculated value of 5.452. Therefore because  $5.452 > 3.841$  the following prevailed: the null hypothesis was rejected in favour of the alternative hypothesis, which stated that the Mutale public servants, indeed, lacked capacities and resources for the transformation process which had an impact on service delivery in terms of health services.

The significant level was set for the test at an  $\alpha = 0.05$ , the critical value of 3.841 was the value which fell at the 95<sup>th</sup> percentile of the  $\chi^2$  distribution with 1 degree of freedom. This table value was 3.841. A one-tailed test was used. Since the calculated value of 5.452 was more than the critical value of the statistic, 3.841, the null hypothesis under review that stated that Mutale public servants lacked capacities and resources was unrelated to the achievement of the quality of service delivery, was rejected in favour of the alternative hypothesis, which was that the lack of capacities and resources was related to the attainment of health service delivery.

The following statistics in Tables 48 and 49 are the output which resulted from the analysis of the data in terms of the Chi-square test after the application of the SPSS programme.

**TABLE 48**

**FREQUENCIES IN RESPECT OF THE OBSERVED AND EXPECTED RESPONSES**

The public servants of Mutale sub-district lacked the capacities and resources to implement the transformation process in order to promote and facilitate the quality of health-service delivery.

Response	Observed N	Expected N	Residual
Agree	75	62.0	13.0
Disagree	49	62.0	-13.0
Total	124	124.0	

The minimum expected cell frequency is 62.0.

Table 48 shown above reflects the frequencies in terms of those participants who responded in the affirmative (75) and also those who expressed disagreement (49) out of one hundred and twenty four (124) respondents. The minimum expected cell frequency is 62.0 for both types of responses.



**TABLE 49**

**DESCRIPTIVE STATISTICS AND TEST STATISTICS**

DESCRIPTIVE STATISTICS						TEST STATISTICS		
Hypothesis	N	Mean	Std. Deviation	Minimum	Maximum	$\chi^2_{(a)}$	df	Asymp.Sig.
The public servants of Mutale sub-district lacked the capacities and resources to implement the transformation process in order to promote and facilitate the quality of health-service delivery.	124	1.40	.491	1	2	5.452	1	.020

(a) 0 cells (.0%) has expected frequencies less than 5.

Table 49 shows both descriptive statistics and test statistics generated from the application of the Chi-square test. The total sample size was one hundred and twenty four (124) participants whilst the analysis of data in terms of the same test generated the mean of 1.40, the standard deviation of .491, with the minimum of 1 and the maximum of 2 under the descriptive statistics. Under the test statistics there is a calculated value of 5.452 with 1 degree of freedom (df), whereas the level of significance is .020. The calculated statistics shows that it is very significant.

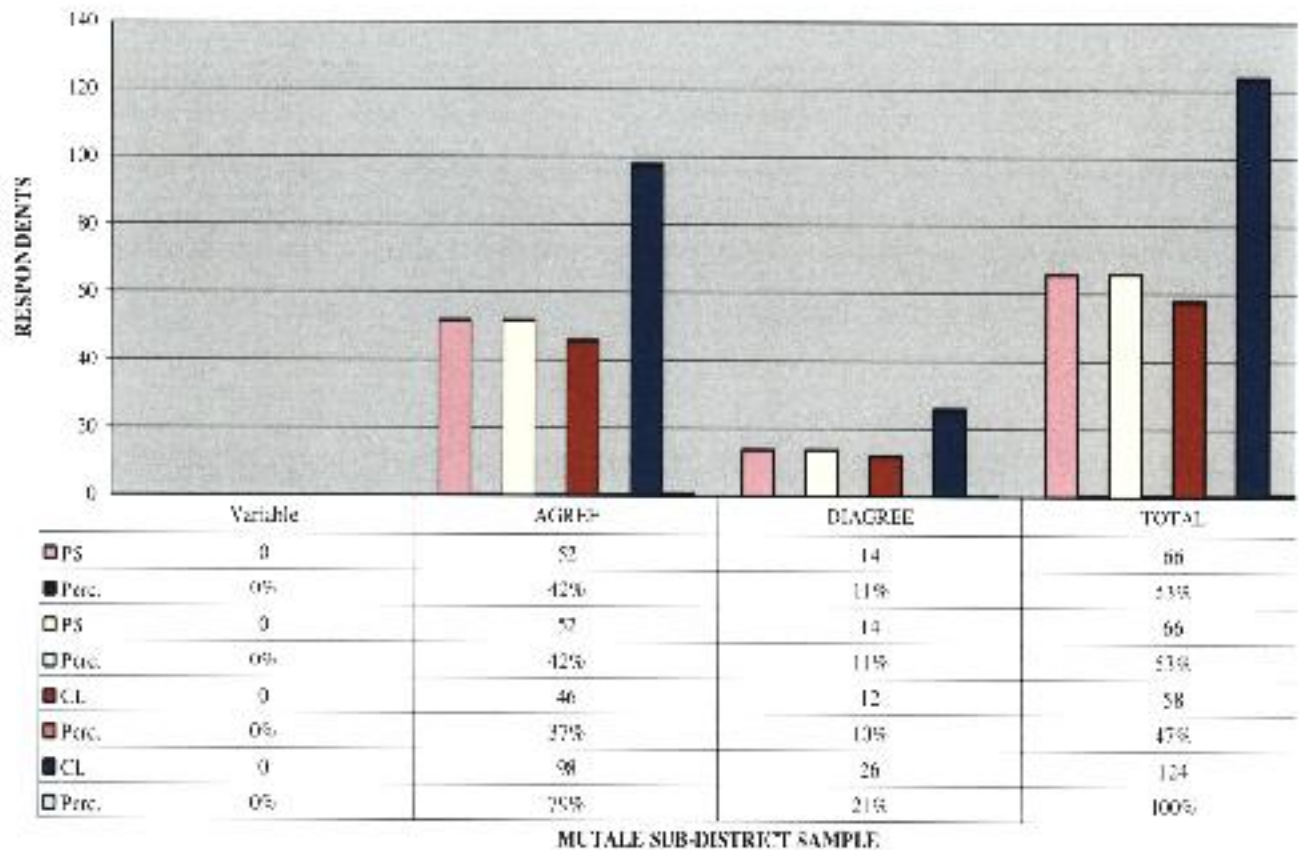
In conclusion and on the basis of the survey findings, therefore, the null hypothesis was rejected because  $5.452 > 3.841$ , and the alternative hypothesis that stated that Mutale public servants lacked capacities and resources that were essential for the improvement of the quality of health-service delivery was accepted. The significance level of .020 indicates that the relationship between lack of capacities as well as the resources and the

quality of health-service delivery is very significant at the 5% level. The above survey findings are similarly interpreted in Chapter Five, under the section that deals with interpretation of the responses.

**TABLE 50**

**Table reflecting frequencies in respect of the consolidated Tables 11 and 32**

**TABLE 50 : Distribution of responses reflecting that the transformation process promoted and facilitated health-service delivery in the peripheral communities**



**Hypothesis 1.6.2:** The transformation process promoted and facilitated the quality of health-service delivery in the peripheral communities.

It is observed from the data shown in Table 50 above that seventy-nine percent (98) of the survey respondents agreed that the transformation process promoted and facilitated

health-service delivery in the remote peripheral communities in the said sub-district in South Africa, but twenty-one percent (26) thereof disagreed that it promoted and facilitated health-service delivery in the remote rural communities.

**Figure: 3 Chi-square formula for Table 50**

$$\chi^2 = \left[ \frac{(A - E)^2}{E} \right]$$

The Chi-square test shown above yielded the calculated value of 41.806 (Ref. to Table 52). Therefore because  $41.806 > 3.841$  the null hypothesis was rejected in favour of the alternative hypothesis. In a nutshell, the null hypothesis that stated that the transformation process was unrelated to the promotion and facilitation of the quality of health-service delivery in the peripheral communities was rejected, but the alternative hypothesis that stated that the transformation process was related to the quality of health-service delivery in the peripheral communities was accepted; no wonder the government introduced the process and passed numerous pieces of legislation, directives and policies to ensure that it was implemented in order to achieve its desired goal.

The significant level was set for the test at an  $\alpha = 0.05$ , the critical value of 41.806 was the value which fell at the 95<sup>th</sup> percentile of the  $\chi^2$  distribution with 1 degree of freedom. This table value was 3.841. A one-tailed test was used. Since the calculated value of 41.806 was more than the statistical value of 3.841, the null hypothesis now under review was rejected in favour of the alternative hypothesis because the hypothesis stated that the process of transformation was unrelated to the promotion and facilitation of health-service delivery in the peripheral communities whereas the alternative hypothesis stated that the transformation process was related to the promotion and facilitation of the quality of health-service delivery in the peripheral communities.

The following statistics in Tables 51 and 52 are the output which resulted from the analysis of the data in terms of the Chi-square test after the application of the SPSS programme.

**TABLE 51**

**FREQUENCIES IN RESPECT OF THE OBSERVED AND EXPECTED RESPONSES**

The transformation process promoted and facilitated the quality of health-service delivery in the peripheral communities.

Response	Observed N	Expected N	Residual
Agree	98	62.0	36.0
Disagree	26	62.0	-36.0
Total	124	124.0	

The minimum expected cell frequency is 62.0.

Table 51 shown above reflects the frequencies in terms of those participants who responded in the affirmative (98) and also those who expressed disagreement (26) out of one hundred and twenty four (124) respondents. The minimum expected cell frequency is 62.0 for both types of responses.



**TABLE 52**

**DESCRIPTIVE STATISTICS AND TEST STATISTICS**

DESCRIPTIVE STATISTICS						TEST STATISTICS		
Hypothesis	N	Mean	Std. Deviation	Minimum	Maximum	$\chi^2_{(1)}$	df	Asymp. Sig.
The transformation process promoted and facilitated the quality of health-service delivery in the peripheral communities	124	1.21	.409	1	2	41.806	1	.000

(a). 0 cells (.0%) have expected frequencies less than 5.

Table 52 shows both descriptive statistic and test statistics generated from the application of the Chi-square test. The total sample size is one hundred and twenty four (124) participants whilst the analysis of data in terms of the same test generated the mean of 1.21, the standard deviation of .409, with the minimum of 1 and the maximum of 2 under the descriptive statistics. Under the test statistics there is a calculated value of 41.806 with 1 degree of freedom (df), whereas the level of significance is .000. The calculated statistics shows that it is very significant.

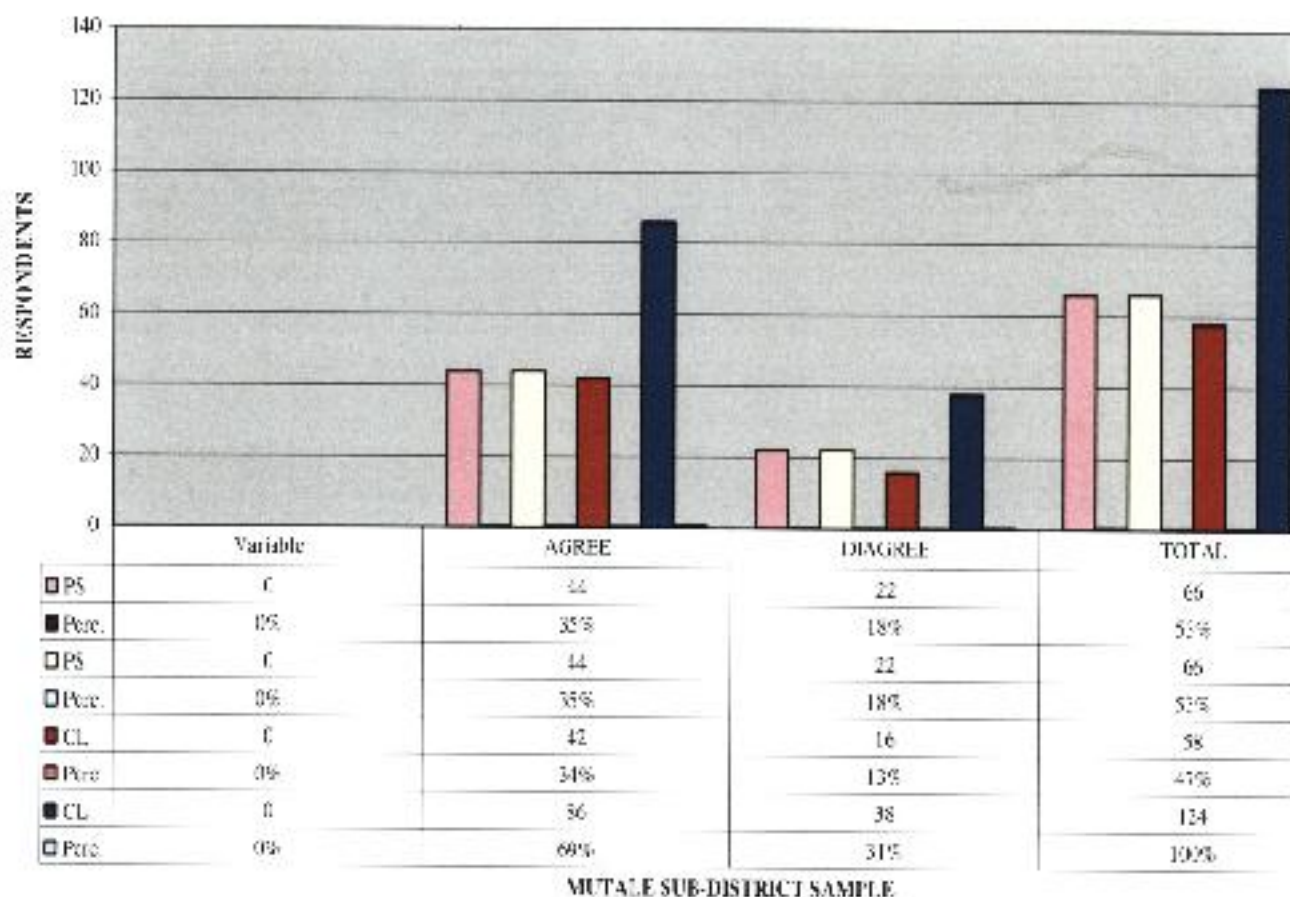
In conclusion and on the basis of the survey findings, therefore, the null hypothesis was rejected because  $41.806 > 3.841$ , and the alternative hypothesis that stated that the transformation process promoted and facilitated the quality of health-service delivery was accepted, hence the government constantly urged the public servants in the entire country to be fully capacitated with adequate knowledge and expertise that would enable them to implement the process for the benefit of the poor people and those who were unemployed in the rural areas. The significance level of .000 indicates that the relationship between the transformation process and the quality of health-service delivery is very significant at the 5% level. The above survey findings are interpreted more or less in the same way in

the following chapter, Chapter Five, under the section that deals with interpretation of the responses

**TABLE 53**

**Table reflecting frequencies in respect of the consolidated Tables 12 and 36**

**TABLE 53 : Distribution of responses which indicated that members of the communities were not knowledgeable about transformation process and its impact on the quality of health service delivery**



**Hypothesis 1.6.3:** Members of the communities were not altogether knowledgeable about the process of transformation and its impact on the quality of health-service delivery.

The responses in Table 53 indicated that sixty-nine percent (86) of the survey respondents agreed that members of the communities in Mutale sub-district were not knowledgeable about the process of transformation as well as the impact it has on the quality of health service delivery. Thirty-one percent (38) of the survey sample disagreed that members of the communities in the same locality were not knowledgeable about the transformation process and its impact on the quality of health-service delivery. In other words, they agreed that members of the communities had knowledge of the processes. In other words, the latter's responses indicated that members of the communities were knowledgeable about the process of transformation and its impact on the quality of health-service delivery.

**Figure 4: Chi-square formula for Table 53**

$$\chi^2 = \left[ \frac{(A - E)^2}{E} \right]$$

The following statistics in Tables 54 and 55 are the output which resulted from the analysis of the data in terms of the Chi-square test after the application of the SPSS programme

**TABLE 54**

**FREQUENCIES IN RESPECT OF THE ONSERVED AND EXPECTED RESPONSES**

Members of the communities were not altogether knowledgeable about the the process of transformation and its impact on the quality of health-service delivery.

Response	Observed N	Expected N	Residual
Agree	86	62.0	24.0
Disagree	38	62.0	-24.0
Total	124	124.0	

The minimum expected cell frequency is 62.0.

Table 54 shown above reflects the frequencies in terms of the participants who responded in the affirmative (86) and also those who expressed disagreement (38) out of one hundred and twenty four (124) respondents. The minimum expected cell frequency is 62.0 for both types of responses.

**TABLE 55**

**DESCRIPTIVE STATISTICS AND TEST STATISTICS**

DESCRIPTIVE STATISTICS						TEST STATISTICS		
Hypothesis	N	Mean	Std. Deviation	Minimum	Maximum	$\chi^2_{(a)}$	df	Asymp.Sig.
Members of the communities were not altogether knowledgeable about the the process of transformation and its impact on the quality of health-service delivery.	124	1.31	.466	1	2	17.065	1	.000

(a) 0 cells (.0%) has expected frequencies less than 5.

Table 55 shows both descriptive statistic and test statistics generated from the application of the Chi-square test. The total sample size is one hundred and twenty four (124) participants. The analysis of data in terms of the same test generated the mean of 1.31, the standard deviation of .466, with the minimum of 1 and the maximum of 2 under the descriptive statistics. Under the test statistics there is a calculated value of 17.065 with 1 degree of freedom (df), whereas the level of significance is .000. The calculated statistics shows that it is very significant.



The significant level was set for the test at an  $\alpha = 0.05$ . The critical value of 3.841 was the value which fell at the 95<sup>th</sup> percentile of the  $\chi^2$  distribution with 1 degree of freedom. This value was 3.841 and a one-tailed test was used. Since the calculated value of 17.065 was more than the critical value of the statistic, 3.841, the null hypothesis, which stated that the lack of knowledge by the members of the communities about the transformation was unrelated to the quality of service delivery was rejected in favour of the alternative hypothesis that stated that the lack of knowledge by the members of the communities about the transformation process was related to the attainment of the quality of health-service delivery. Therefore, the null hypothesis was rejected because  $17.065 > 3.841$ , and the alternative hypothesis, which stated that members of the communities were not altogether knowledgeable about the process of transformation and its impact on the quality of health-service delivery, was accepted. The significance level of .000 indicates that the relationship between lack of knowledge about the process of transformation and the quality of health-service delivery is very significant at the 5% level. The above survey findings are also interpreted in Chapter Five, under the section that deals with interpretation of the responses.

#### **4.4 CASE STUDY PERTAINING TO THE IMPACT OF TRANSFORMATION ON HEALTH SERVICE DELIVERY**

Responses that emerged from the case study, that were related to the transformation process and service delivery, receive attention in this section. The primary objective of the transformation process in the public service is to meet the needs of the people by making sure that their needs are responded to through various government legislation, policies, directives and programmes.

Although the department has mentioned that transformation has enabled many of the South African citizens who had not been benefiting from government's programmes to benefit, giving as example the following: the building of new clinics and the provision of essential drugs in the public hospitals; access to health care; access to old-age pension; that the department was accountable to the citizens during department service standards summits that citizens attended; that complaints were responded to within the specified

national norms; that the political office-bearers went to the citizens through Imbizos, Road shows and Exco and met the people; and that all these showed that there was vast transformation of service delivery compared to the system and process during the past apartheid administration the survey findings, therefore, revealed that no clinics were built in Mutale sub-district since 1994 and that was probably due to financial constraints but the matter will receive due consideration and that some clinics were still not accessible in terms of distances since the national norm that patients should be within 5 km's reach of the health care facilities had not been complied with in this district of Limpopo Province. The issues pertaining to old-age pension and Imbizos were not part of the survey research; hence the researcher was unable to indicate findings in this regard.

The department indicated that some of the challenges that needed to be resolved were the provision for equitable resources for service delivery; making sure that the citizens were equipped with information to enable them to use government services responsibly and with care; building citizen ownership of the property, assets and other resources that government and/or the department was providing in their community; ensuring that there was an accountability framework among political leadership, citizens and the department as the instrument of service delivery to reduce corruption, duplication and misuse of services by the citizens.

According to the department there were indications that the department was improving the quality of services, both in terms of quality and quantity. It could not be denied that the department was reaching the most remote areas which had not been considered during the previous administration, but the survey results indicated that the transformation process was not being focused upon Mutale sub-district in terms of the provision of adequate health-care services and many more needs to be provided by the department.

The department indicated that there was no need for additional years for achieving the effective implementation of the transformation process as, whenever new challenges arose, new ways of resolving those challenges would be required. Transformation was the process that was often accomplished by designing new structures of governance that brought community and government together to account for government service delivery, for example, government structures such as hospital boards and institutional committees.



New policies had transformed the militaristic bureaucracy of the past to people-centred or focused policies. Information was given to citizens, accurately and more timely than in the past where citizens had no chance of getting accurate, reliable and timely information. Challenges were addressed as an on-going transformation process, by making sure that services addressed the needs of the community. Communities and citizens were to be represented by community elected people, who become watchdogs on their behalf. Some of these were the establishment of the following governance structures such as the District Hospital Boards, Regional Hospital Boards, Regional Mental Health Review Boards, District Health Council, Provincial Health Council, Pension/Paypoint Committees, Clinic Committees, Health Centres Committees, District Consultative Forums to mention just a few. All these governance structures were represented by members of the community who challenged the government/department if service delivery was not taking place. This was a huge step towards transformation where the department was completely accountable to the citizens, through these bodies.

To ensure that the transformation process had an affect on service delivery in the Province, the department ensured that the following structures were established:

- Transformation Task Teams, which were formed in various institutions to guide the process;
- Quality Assurance Teams which were established in various institutions to measure the level of service delivery in all the institutions;
- CEOs that had been appointed to hospitals to guide the governance of the institutions;
- Service Delivery Optimisation processes that were started in 2005 to fix challenges and track service delivery;
- Service Standards Manuals containing improvements of levels of services that were developed;
- Citizens Reports Manuals which were developed at each District and Provincial level showing citizens the achievements of the department for that particular financial year.

- Service Delivery Improvement Plans Manuals per institution and District that had been started in 2003 and continued to date, indicating what each institution and district would be doing to improve service for the coming financial year;
- Service Excellence Awards conducted by each District for best public servants; Provincial Service Excellence Awards which took place each year from 2003 to reward public servants who performed beyond the call of duty.

The other principal stakeholders who were driving the transformation process and service delivery within the Department of Health and Social Development were the Member of the Executive Council (MEC), Head of the Department, Senior General Managers, General Managers, Senior Managers and those who held equivalent ranks: managers, personnel, members of the communities, governance structures, the National Department of Health, the private sector, traditional leaders, traditional healers, and service providers in the department, to cite just a few.

The following is a concise list of the principal legislation and mandates that were a driving force in the implementation of the transformation process and service delivery in the department:

1. The Constitution Act, of 1996 (RSA: Chapters 3 and 10);
2. National Health Act, Act No. 61 of 2003
3. Public Service Act of 1994
4. Public Service Regulations of 2001;
5. White Paper on the Transformation of the Public Service of 1995;
6. White Paper on Transforming Service Delivery of 1997 (Batho-Pele Principles);
7. Public Service Staff Code.
8. PFMA, Act No. 1 of 1999 as amended by Act No 29 of 1999.
9. Treasury Regulations of 2002
10. Labour Relations Act, Act No. 12 of 2002.
11. Employment Equity Act, Act No. 55 of 1998.
12. Skills Development Act, Act No. 97 of 1998.
13. Basic Conditions of Employment Act, Act No. 75 of 1997



## 4.5 CONCLUSION

The current chapter, Chapter Four, deal specifically with data analysis, tabular and graphic descriptions, interpretation, and discussions of the survey data. It presented basically a discussion of the examination of a number of questions such as: What was the impact of the transformation process on the quality of service delivery? What were the perceptions and expectations of the rural communities about the process of transformation as it related to service delivery? What were the anticipated desired outcomes of the transformation process? What were the tangible benefits of the process of transformation in the remote rural communities?

Before the Republic of South Africa attained democracy in 1994, there were only fourteen (14) primary health-care institutions and one Health-Care Centre based at Tshilamba Township in Mutale sub-district. According to Appendix E, the survey research conducted revealed that during the past eleven years of democracy no additional clinics had been built or established as a way of addressing the backlogs left by the previous apartheid regime in spite of the fact that the Head of the department said that "... we have increased our fixed clinics to 392 ..." in the Limpopo Province (Annual Report: 2005/2006 Financial Year: 1), whereas, on the other hand, the survey revealed that no clinic was built in Mutale sub-district since 1995 (Appendix E). The non-erection and non-establishment of new health-care facilities in Mutale sub-district signified a drastic drawback in this part of Limpopo Province which was regarded as the poorest of the nine provinces of the Republic of South Africa.

The survey study revealed that the transformation process that the district had longed for during the past eleven years had not been effectively implemented by the authorities of the district in particular and the provincial government in general on the one hand, while on the other hand, the new government ensured the improvement in the quality and standard of health-care services especially in the grossly neglected, disadvantaged and marginalised areas of the entire Limpopo Province, let alone the Republic of South Africa. The survey data collected also revealed that the average distance between the clinics within Mutale local area was seventeen comma one kilometres (17,1km) whereas in terms of the National Health Act, 2003 ( Act No 61 of 2003), the clinics should be

within 5 kilometres walking distance or reach by the patients or clients. Seventeen comma one kilometres posed a serious challenge to the patients or prospective clients of the clinics in the said local area. The average distance between clinics located in Tshipise local area was nineteen comma eight kilometres (19,8 km). The average distance between the health care institutions within the entire Mutale sub-district was seventeen comma five kilometres (17,5 km)

The next chapter, Chapter: Five, will focus on the discussion of conclusions and recommendations.

## CHAPTER FIVE

### CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 INTRODUCTION

One of the main reasons for launching this study was that, as far as could be ascertained, few research studies had been conducted in these vital areas of transformation and service delivery. The survey findings revealed that little had been investigated on the subject matter, especially in Mutale sub-district of Vhembe Health District; hence the researcher saw the need to launch this research for the optimal benefit of respondents and selected members of the communities. It is, therefore, the researcher's firm conviction that a valid need exists for embarking upon a further survey study of this nature. The main purpose of the chapter, therefore, is basically to present the conclusions and recommendations of the survey findings, and to arrive at a better comprehension of the impact that the process of transformation has on the quality of service delivery in Vhembe Health District, especially in Mutale sub-district.

#### 5.2 DESCRIPTION OF THE CHAPTERS

**Chapter One** focused attention on the presentation and a brief discussion of each of the five chapters of which the mini-dissertation was comprised. Hence, Chapter One was about the introduction, presenting a discussion of the problem statement and justification for the survey study, research questions, the objectives, the hypotheses, significance of the survey research, the scope and limitations of the survey research and ethical considerations.

In **Chapter Two**, special consideration was given to a review of the literature and legislative framework. This included the legislative framework with regard to the role and the impact of the transformation process on the quality of health-service delivery. The major purpose of the chapter was to review briefly some recent literature published as well as the pieces of legislation promulgated since 1995 and considered to be pertinent

to the transformation process and health-service delivery. Another reason for the literature review was to enable the researcher to determine whether the problem to be investigated had not been researched before so as to avoid duplication of survey research in the same sub-district. The researcher, during the literature and legislative framework review, looked at local, national and international perspectives dealing with the role that the transformation process played in promoting and facilitating the quality of health-service delivery.

**Chapter Three** paid attention to the research methodology applied during the investigation. The chapter dealt with the pilot study, research design, method of research, the target population, sampling techniques, the sampling procedures, the format of the questionnaires and methodological shortcomings. The research methods used in the collection of data in the research survey were both quantitative and qualitative.

The researcher considered using stratified sampling procedures because there were two sub-samples comprised of public servants and members of the communities in the sub-districts. Those groups were represented in the final survey sample results of the research. The non-parametric statistical test selected and used by the researcher in the survey research was the Chi-square test (abbreviated  $\Sigma^2$  test). The researcher considered the appropriateness of the Chi-square test because the dependent variables were measured on a nominal scale, subsequently resulting in the obtained data being in frequencies.

**Chapter Four** dealt specifically with the presentation of the analyses of the survey data in terms of the frequencies, percentages, tables and graphs for easy interpretation of the survey results. The three hypotheses were analysed in terms of the Chi-square test and the interpretations of the findings are made followed by the presentation of the conclusions and recommendations in this chapter.



### **5.3 INTERPRETATION OF SPECIFIC HYPOTHESES**

#### **Hypothesis 1.6.1:**

The Chi-square test yielded the value of 5.452. Since the calculated value of 5.452 was more than the critical value of the statistic, 3.841, the null hypothesis under review that stated that Mutale public servants lacked capacities and skills was unrelated to the achievement of the quality of service delivery was rejected. The alternative hypothesis that stated that lack of capacities and skills by Mutale public servants was related to the attainment of the quality of service delivery was subsequently accepted.

#### **Hypothesis 1.6.2:**

Since in this hypothesis the calculated value was 41.806 and therefore, because 41.806 is greater than 3.841, the null hypothesis was rejected in favour of the alternative hypothesis. In a nutshell, the null hypothesis that stated that the transformation process was unrelated to the promotion and facilitation of the quality of service delivery in the peripheral communities was rejected, and the alternative hypothesis that stated that the transformation process was related to the promotion and facilitation of the quality of service delivery in the peripheral communities was accepted. No wonder the government introduced the transformation process and passed numerous pieces of legislation and policies to ensure that they were implemented to achieve the desired goal in the rural communities.

#### **Hypothesis 1.6.3:**

The analysis of the survey data in terms of the Chi-square test resulted in the value of 17.065. Since the calculated value of 17.065 was more than the critical value of the statistic, 3.841, the null hypothesis which stated that the lack of knowledge by the members of the communities about the transformation process was unrelated to the quality of health service delivery was therefore subsequently rejected in favour of the alternative hypothesis that stated that the lack of the possession of knowledge about the

transformation process by the members of the communities was related to the attainment of the quality of health-service delivery.

#### **5.4 RECOMMENDATIONS FOR IMPLEMENTATION BY THE PROVINCE**

Based on the critical transformation issues raised, the following recommendations are made for the attention of the Department of Health and Social Development in Limpopo Province:

##### **Recommendation A:**

According to the survey findings it appears that the present transformation process in terms of the availability of additional new clinics in the sub-district was sadly deficient, first, largely due to the revelation that no clinics were built in Mutale sub-district whereas 392 clinics were built in the province since 1994 (Annual Report for 2005/2006 Financial Year: 1) and, second, the majority of the patients in the rural communities were still travelling a distance of at least an average of seventeen comma five (17,5) kilometres before they reached the nearest clinic. Hence, the attention of the department is drawn to the fact that the current situation is defeating the objectives of the transformation process, and despite constraints in terms of resources, it should ensure that during the following financial years cognisance be taken of the importance of building new clinics in order to address the challenges of reducing distances between clinics and also between clinics and the homes of the patients. It is therefore strongly recommended that funding in terms of long-term loans be secured from the Development Bank of South Africa (DBSA) or alternatively from the World Bank: since the provision of the clinics should receive a priority and serious attention to ensure that proper health-care services are made available to the poorest communities residing in those peripheral areas.

##### **Recommendation B:**

The survey findings revealed lack of capacities and skills that were indispensable for the implementation of the transformation process to improve health-service delivery in the

deep rural areas. It is therefore strongly recommended that long-term training programmes encompassing transformation-related legislation and policies such as the Constitution Act of 1996 (RSA: Chapters 3 and 10); National Health Act of 2003; Public Service Act of 1994; Public Service Regulations of 2001; White Paper on the Transformation of the Public Service of 1995; Skills Development Act of 1998; Labour Relations Act of 2002; Basic Conditions of Employment Act of 1997; PFMA of 1999; White Paper on Transforming Service Delivery of 1997 (Batho-Peetse Principles); Public Service Staff Code, to cite but a few, be initiated by the Department of Health and Social Development in Limpopo Province. Such programmes should preferably be conducted by the local universities within reach as they have the expertise.

### **Recommendation C:**

The survey findings furthermore revealed that there were constant shortages of medication at the clinics and that was supported by the general comments from the patients that there should be abundant medication at all times. Because of the inadequate provision of medicine at the clinics, it is therefore strongly recommended that the stock level of drugs be monitored and regulated on a regular basis, for example, weekly or monthly, to ensure that all different essential drugs were readily available to the patients; and also to introduce and implement management interventions where the stock levels tended to dwindle to an unacceptable level that was contrary to the national norms and standards. Deviation from the national norms and standards was viewed in a serious light and had an adverse impact and effect on health-service delivery and had to be avoided at all costs, through monitoring and evaluation instruments.

## **5.5 RECOMMENDATION FOR FUTURE SURVEY RESEARCH**

In view of the fact that the research was limited to Mutale sub-district while the Vhembe Health District was comprised of four sub-districts at the time of conducting the survey, it is strongly recommended that another investigation in this regard be conducted in the other three sub-districts for the purpose of obtaining additional knowledge about the effectiveness and impact of the transformation process on health-service delivery. The district is still regarded as one of the poorest districts in Limpopo Province; and the

necessity to do so is because the findings of this survey research on the effectiveness and impact on health-service delivery were not conclusive and, therefore, could not be generalised to the entire district in particular or the province in general, let alone the Republic of South Africa, as the situation that prevailed at the time of the investigation was of great concern to this survey study.



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## APPENDIX A

P.O. Box 444  
SHAYANDIMA,  
0945  
25 August 2006.

The HOD  
Department of Health and Social Development  
Private Box 9302  
POLOKWANE  
0700

ATTENTION: Research Committee/Senior Manager:  
Directorate: Transformation and Transversal  
Services.

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A SURVEY IN MAKHADO AND  
MUTALE SUB-DISTRICTS DURING AUGUST AND SEPTEMBER 2006.

1. The above mentioned subject has reference.
2. Kindly be informed that I have successfully completed the Course-work for the Master's degree in Public Administration at Turfloop Graduate School of Leadership under the auspices of the University of Limpopo. I have now progressed to a stage during which I am now ready to commence with the empirical research study in two of Vhembe Health sub-districts, namely, Makhado and Mutale which have randomly been sampled for the purpose. I now wish to embark upon the empirical study under the supervision of Dr MH Kanyane.

3. The theme of my mini-dissertation is: "THE IMPACT OF THE TRANSFORMATION PROCESS ON THE QUALITY OF SERVICE DELIVERY IN THE VHEMBE HEALTH DISTRICT, LIMPOPO PROVINCE", with special reference to Vhembe Health District in the Limpopo Province in South Africa. The survey findings will not only benefit the Vhembe Health District, but other districts within and outside the Limpopo Province.
4. Subsequent to the brief explanation pertaining to the intention of my investigation, kindly be informed that Vhembe Health District has randomly been selected out of the five districts of the Limpopo Province and you are hereby humbly requested to grant me permission to conduct my survey study in the health-care facilities in which the Supervisors of the respective local areas and the Health Centre in Mutale sub-district will serve as the enumerators in this regard if approval is granted.
5. Finally, the District Manager is hereby requested through your department, if my request is acceded to, to provide me with the following information relevant to the research study:
  - 5.1 The full names of the supervisors/heads of each of the two local areas and the Health Centre and their respective direct contact numbers for easy communication with the researcher;
  - 5.2 The names of the clinics being supervised by each head, as well as the population of each local area, particularly and only in Mutale sub-district;
  - 5.3 Will you please provide me with an aerial map of Mutale sub-district which reflects the location of each clinic. I shall appreciate it if distances between the clinics could also be made available to me for this purpose;
  - 5.4 The entire population of Vhembe Health District will be appreciated.
  - 5.5 The legislation in terms of which the district as well as the local areas were established and other documents pertaining to the statistics of patients who

visited each clinic during the previous financial year:

- 5.6 The total number of all health-care personnel in each ; and finally
- 5.7 The total number of new clinics built from 1994 to 2006.
6. You are hereby assured that all information, in accordance with the ethical conditions for research study, and also for this empirical investigation, will be held and kept strictly confidential and **shall not** in any way be disclosed to any other people and institutions without the consent of the respondents and all who would have contributed in the final findings of the study.
7. I shall highly appreciate it if permission to conduct the survey study in the two sub-districts mentioned above could be granted as well as the provision of all data sought under sub-sections 5.1. to 5.7. The duration of the empirical survey study is August and September, 2006 and your cooperation is, indeed, indispensable for this survey study to be successfully completed.
8. Attached hereto, kindly receive copies of my initial request forwarded to the District Manager. Thanking you, the District Manager and all the Supervisors of the two local areas and a Health Centre in advance.

Yours faithfully



Dr M.W. Madzivhandila.

APPENDIX B



**UNIVERSITY OF LIMPOPO**  
**TURFLOOP GRADUATE SCHOOL OF LEADERSHIP**

PO Box 756, Fauna Park, 0767

Tel: 015 290 2842

Fax: 015 290 2842

E-mail: [kanyane@yahoo.com](mailto:kanyane@yahoo.com)

[mpa@edupark.ac.za](mailto:mpa@edupark.ac.za)



DATE : 08 September 2006


HOD  
DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT  
PRIVATE BAG X 9302  
POLOKWANE  
0700

Dear Sir/Madam

**REQUEST TO CONDUCT RESEARCH BY THE CANDIDATE DR MADZIVHANDILA M.W.**  
**STUDENT NO: 1559**

1. The candidate Dr Madzivhandila M W is our registered student for the Programme Masters in Public Administration at the Turfloop Graduate School of Leadership.
2. In terms of our requirements for the Masters programme he is supposed to conduct research on 'The impact of the Transformation process on quality of Service Delivery in the Vhembe Health District, Limpopo Province' for him to complete his studies under my supervision. His research proposal was approved by Senior Degree Committee of the University.
3. We will appreciate it if the candidate could be permitted to conduct the research in your Health Institution.
4. As a supervisor for the candidate: Dr M H Kanyane, I hope that this research will benefit your Hospital in pertinent issues on transformation process towards effective Service Delivery.

Regards

  
Dr M H Kanyane

Acting Programme Manager: MPA





DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT

Enquiries: Malomane EL

Ref: 4/2/2

18 September, 2006

DR Madzihhancila M.W  
University of Limpopo

Dear Dr Madzihhandila

**The Impact of Transformation process on quality of service delivery in Vhembe Health District, Limpopo Province**

- Permission is hereby granted **provisional permission** to **Dr Madzihhandila MW** to conduct the study as mentioned above in Vhembe district in Limpopo Province
- The final permission will be given subject to a submission of the ethics clearance letter
- The Department of Health and Social Development will expect a copy of the completed research for its own resource centre after completion of the study.
- The Researchers should be prepared to assist in interpretation and implementation of the recommendations where possible
- The Institution management where the study is being conducted should be made aware of this,
- A copy of the permission letter can be forwarded to Management of the Institutions concerned

HEAD OF DEPARTMENT

HEALTH AND SOCIAL DEVELOPMENT  
LIMPOPO PROVINCE

Date:


Cc Dr Buthelezi V

Mr. Tshikovhi N

2. The reason he is asking for provisional permission is that his ethics clearance letter is not yet available and he has dead lines to meet for the research and have been instructed to submit ethics clearance letters as soon as they are submitted.

Compiled by:

Malomane EL


 Malomane EL  
Manager Quality Assurance

Seen by




Mr. Tshkovhi N  
General Manager Corporate

Seen by the university ethics review committee by approval the proposal including ethical considerations this office finds the project will add value

 26/9/06

Dr V Buthefazi  
Acting Senior General Manager

Approved:

 26/09/2006

Dr J Dlamini  
Head of Department Health and Social Development

## APPENDIX D

### REQUEST FOR THE DATA PERTAINING TO MUTALE SUB-DISTRICT

P.O. Box 444  
SHAYANDIMA.  
0915  
21 July, 2006.

The District Manager  
Vhembe Health District  
Private Bag X  
THOHOYANDOU  
0950

ATTENTION: The Information Manager:  
Mr. Netshiswinzhe

Dear Sir

REQUEST FOR THE PROVISION OF THE SURVEY DATA IN RESPECT OF  
MUTALE SUB-DISTRICT.

1. The above mentioned subject has reference.
2. Kindly be informed that I have successfully completed the Course-work for the Master's degree in Public Administration at Turfloop Graduate School of Leadership under the auspices of the University of Limpopo. I have now progressed to a stage during which I have already commenced with the empirical research study in two of Vhembe Health sub-districts, namely, Mashado and Mutale which had randomly been sampled for the purpose. I have already embarked upon the empirical study under the supervision of Dr MH Kanyane.

3. The theme of my mini-dissertation is: "THE IMPACT OF THE TRANSFORMATION PROCESS ON THE QUALITY OF SERVICE DELIVERY IN THE VHEMBE HEALTH DISTRICT, LIMPOPO PROVINCE" with special reference to Vhembe Health District in the Limpopo Province in South Africa. The survey findings will not only benefit the Vhembe Health District; but other districts within and outside the Limpopo province.
4. Subsequent to the brief explanation pertaining to the intention of my investigation, kindly be informed that Vhembe Health District has randomly been selected out of the five districts of the Limpopo Province and you are hereby humbly requested to provide me with data pertaining to, among other things, the names of the Supervisors of the respective local areas and the Health Centre in Mutale sub-district who are serving as the enumerators in this regard since the approval has already been granted.
5. Finally, the Information Manager of the said district is hereby requested, to provide me with the following information relevant to the research study:
  - 5.1. The full names of the supervisors/heads of each of the two local areas and the Health Centre and their respective direct contacts numbers for easy communication with the researcher.
  - 5.2. The names of the clinics being supervised by each head, as well as the population of each local area, particularly and only in Mutale sub-district;
  - 5.3. Will you please provide me with the **electronic aerial map** of Mutale sub-district which reflects the location of each clinic in Vhembe Health District but should reflect the location of the clinics. I shall appreciate it if distances between the clinics could also be made available to me for this purpose;
  - 5.4. The entire population of Vhembe Health District as well as that of Mutale sub-district in particular will be appreciated.



- 5.5. The legislation in terms of which the district as well as the local areas were established and other documents pertaining to the patient's statistics who visited each clinic during the previous financial year;
  - 5.6. The total number of all health-care personnel in each clinic; and finally
  - 5.7. The total number of clinics built in Mutale Sub-district from 1994 to 2006.
6. You are hereby assured that all information, in accordance with the ethical conditions for research study, and also for this empirical investigation will be upheld and kept strictly confidential and **shall not** in any way be disclosed to any other people and institutions without the consent of the respondents and all who would have contributed in the final findings of the study.
  7. I shall highly appreciate it if the provision of all data sought, inter alia, under subsections 5.1. to 5.7. could be made available before 18<sup>th</sup> August, 2006. The duration for the empirical survey study is August and September, 2006 and your cooperation is, indeed, needed and is necessary and indispensable for this survey study to be successfully completed. Attached hereto, kindly receive copy of the approval from the Head of the Department of Health and Social Development.
  8. Thanking you, the District Manager and all the Supervisors of the two local areas and the Health Centre, in advance.

Yours faithfully

  
Dr. M.W. Madzivhandila.

## APPENDIX E

### RESPONSE TO THE REQUEST FOR SURVEY DATA IN MUTALE SUB-DISTRICT

Private Bag X5009  
Thohoyandou  
0950  
23 October 2006

The Chief Executive Officer  
Elim Hospital  
Private Bag X312  
Elim  
0960

ATTENTION: The Chief Executive Officer  
Dr M.W Madzivhandila

#### SURVEY DATA IN RESPECT OF MUTALE SUB-DISTRICT

5.1. The full names of the supervisors/heads of each of the two local areas and the Health Centre and their respective direct contacts numbers for easy communication with the researcher:

- o Mutale Local Area supervisor  
Name of CCLO: Mrs. Maumela J.K  
Tel : 072 593 2722
- o Tshipise Local Area supervisor  
Name of CCLO: Mrs. Medal R.M  
Tel : 084 916 2493
- o Mutale Community Health Center supervisor  
Name: Nemahehi M.H  
Tel : 015 967 2016

\*CCLO – Chief Community Liaison Officer

5.2 The names of the clinics being supervised by each head, as well as the population of each local area, particularly and only in Mutale sub-district;

**Mutale Local Area – Maumela JK: Local Area Supervisor.**

- o Population mid year 2005 = 58 346

- o Clinics in Mutale Local Area:

1. Folovhodwe Clinic
2. Guyuni Clinic
3. Matavhela Clinic
4. Mutale CHC
5. Rambuda Clinic
6. Shakadza Clinic
7. Thengwe Clinic
8. Tshikundamalema Clinic
9. Tshixwadza Clinic

### **Tshipise Local Area – Mudau RM: Local Area Supervisor**

- o Population mid year 2005 = 24 861

- o Clinics in Tshipise Local Area:

1. Makuya Clinic
2. Manenzhe Clinic
3. Masisi Clinic
4. Mulala Clinic
5. Tshipise Clinic
6. Tshungani Clinic

5.3. Kindly provide the electronic map of Mutale sub-district which reflects the location of each clinic or Vhembe Health District but should reflect the location of the clinics. Also provide distances between the clinics;

#### **NOTE:**

(a) The District office does not have a map of each of the sub-district BUT that of the district as a whole. I hope you will be able to find what you need from the district map provided below.

(b) Distances between the clinics:

- o Mutale Local area

Folovhodwe Clinic = 16km from Rambuda

Rambuda Clinic = 12km from Mutale CHC

Thengwe Clinic = 17km from Tshikundamalema clinic

Tshikundamalema clinic = 19km from Mathavhela Clinic

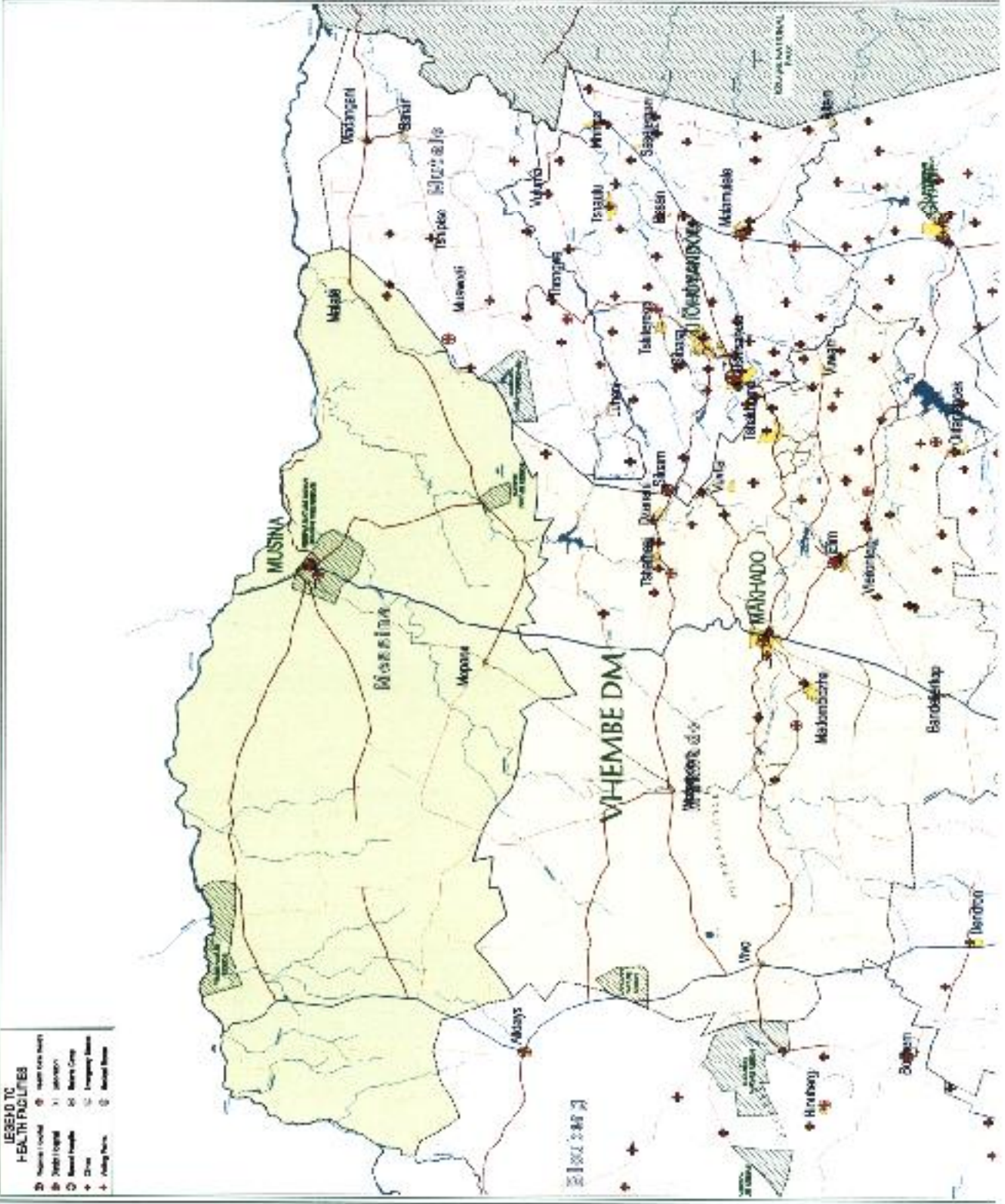




**VHEMBE DISTRICT MUNICIPALITY**

- LEGEND**
- BOUNDARIES**
- National Boundary
  - Provincial Boundary
  - Entity / Local Authority Boundary
  - Water Body
  - City / Town Boundary
  - Local Council Boundary
- INFRASTRUCTURE**
- Major Road
  - Minor Road
  - Natural Dam
  - Water Dam
  - Water Lift
  - Power Line
  - Airfield

- REFERENCE**
- Water Pump
  - Water Tank
  - Public Mains
  - Post Office
  - Urban Area / Village
  - Urban Reserve
- Scale: 1:50,000  
 0 1 2 3 4 5 6 7 8 9 10  
 Kilometers  
 0 1 2 3 4 5 6 7 8 9 10  
 Meters



- LEGEND TO HEALTH FACILITIES**
- Regional Hospital
  - Special Hospital
  - Local Hospital
  - Chronic
  - Primary Care
  - Specialist Centre
  - Water Pump
  - Water Tank
  - Public Mains
  - Post Office
  - Urban Area / Village
  - Urban Reserve

Matavhela Clinic = 12km from Guyuni Clinic  
Matavhela Clinic = 18km from Shakadza Clinic  
Shakadza Clinic = 18km from Polovhodwe Clinic  
Tshixwadza Clinic = 25km from Guyuni Clinic

o Tshipise Local Area:

The closest facility to the Department of Health & Social Development (Thohoyandou) district office is Mutale CHC which is 38km from Thohoyandou

Makuya clinic = 39km from Mutale CHC  
Mulala clinic = 22km from Makuya clinic  
Tshipise Clinic = 24km from Mulala clinic  
Manenzhe Clinic = 10km from Tshipise Clinic  
Tshiungani Clinic = 14km from Tshipise clinic  
Muisi Clinic = 10km from Tshiungani Clinic

o Mutale CHC = 6km from Thengwe Clinic

5.4. The entire population of Vhembe Health District as well as that of Mutale Sub-district in particular;

o Vhembe District = 1 281 822

o Mutale Sub district = 83 207 (\*Data excludes Mutale & Tshipise Mobile Clinics)

5.5. The legislation in terms of which the district as well as the local areas were established

o Health Act

5.6. The total number of clinics built in Mutale Sub-district since 1994 to 2005

o No clinic has been build since 1994 to date

**Compiled by: Nthabiseng Hlatshwayo**

Vhembe district Office: Information Office

## APPENDIX F

### REQUEST FOR A CASE STUDY PERTAINING TO TRANSFORMATION

P.O. Box 44  
SHAYANDIMA.  
0945  
21 July 2006.

The HOD  
Department of Health and Social Development  
Private Bag X 9302  
POLOKWANE  
0700

ATTENTION: Senior Manager  
Directorate: Transformation and Transversal Services.

Dear Sir/Madam

#### REQUEST FOR A CASE STUDY PERTAINING TO THE IMPACT THE TRANSFORMATION PROCESS HAS ON SERVICE DELIVERY

1. The above mentioned theme has reference.
2. You are hereby informed that I am studying the Master's degree in Public Administration at Turf loop Graduate School of Leadership under the auspices of the University of Limpopo. I have now commenced with the empirical research under the supervision of Dr M. H. Kanyane.

3. The theme of my mini-dissertation is: "THE IMPACT OF THE TRANSFORMATION PROCESS ON THE QUALITY OF SERVICE DELIVERY.", with special reference to Vhembe Health District in the Limpopo Province in South Africa. The survey findings will not only benefit the Vhembe Health District; but other districts within and outside the Limpopo province.
- 4 If my request is acceded to, I shall highly appreciate it if the Case Study is developed or built up based, among other things, upon the following [as a way of guidance, but you are at liberty to furnish me as much details as you possibly can in order to make my survey more meaningful]:
- 4.1 What are the objectives of the transformation process?
- 4.2 Have the objectives been attained so far?
- 4.3 If not as yet, what could be the possible challenges?
- 4.4. Are those challenges within your management and intervention?
- 4.5. As our democracy is eleven years old now, and if your response to 4.3. is in the affirmative, do you still need another additional ten years to can guarantee that, indeed, transformation has successfully been implemented to achieve the set objectives?.
- 4.6. How do you consider addressing such challenges? When was the transformation process implemented in the Department of Health and Social Development?
- 4.7. When was the transformation process implemented in the Department of Health and Social Development?
- 4.8. Who are the stakeholders who are responsible for driving the whole process within the department in order to achieve the pre-set objectives?



- 4.9. List all the available principal pieces of legislation and political mandates that are a driving force for the possible implementation of the process of transformation.
- 4.10. Are the current pieces of legislation designed to meet the purpose sufficient; and if not, does it mean that the department is encountering some challenges that would, perhaps, warrant additional legislation?. If yes, may you please briefly, indicate as to how could such a legislation be formulated which could ensure that the process is implemented to best benefit the historically disadvantaged population of the Province in particular or South Africa in general?
- 4.11. May you please add any information which you believe is relevant to the successful implementation of the process and the impact it would have on the quality of health-service delivery in the Department of Health and Social Development.
5. According to my work schedule, I am expected to submit the first draft of the findings of the survey to my Supervisor mid-September 2006; and this will only be realized and become possible if I receive your support within the next few weeks. Thanking you in anticipation.

Yours faithfully



Dr M.W. Madzivhandila.

## APPENDIX G

### **RESPONSE FROM THE DEPARTMENT PERTAINING TO THE CASE STUDY**

#### **TRANSFORMATION PROCESS ON THE HEALTH SERVICE DELIVERY IN THE DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT**

The primary objective of the transformation process in the public service is to meet the needs of the people by making sure that their needs are responded to through various government legislation, policies, directives and programmes.

Transformation process is not an event, but a process, fortunately, the department and government in general have enabled many of the South African citizens who had not been benefiting from government's programmes to benefit by building new clinics, making sure that there are drugs in the public hospitals, that there is access to health care, access to old age pension, that the department is accountable to the citizens during department service standards summits that citizens attend. Complaints are responded to within the specified national norms; that the political office-bearers go to the citizens through Imbizo, Road shows and Exco meet the people. All these show that there is vast transformation of service delivery compared to the system and process during the past apartheid administration.

Even when there is vast transformation challenges will always be there as others are solved. Some of the challenges that need to be resolved is equitable resources for service delivery; making sure that the citizens are equipped with information to enable them to use government services responsibly and with care; to build Citizen Ownership of the property, assets and other resources that government and/or department is providing in their community, to build formidable accountability framework between political, citizens and department as the instrument of service delivery to reduce corruption, duplication and misuse of services by the citizens.

The challenges are both from our society and the management and each needs to build their capacity for intervention. Communities and/or societies need to take government

services as their own services and protect both service providers and be responsible for their use of services on the one hand. On the other hand, the government needs to improve quality of services based on the resources that are there for the financial year. Each year, there is indication that the department is improving the quality of services, both in terms of quality and quantity. The department is reaching the most remote areas which had not been considered during the previous administration.

There is no need for additional years for the effective implementation of transformation process as new challenges arise; new ways of resolving those challenges will be required. Transformation is the process, the government has moved substantially by (1) redesigning new structures of governance that bring community and government together to account for government service delivery, for example, government structures such as the hospital boards, institutional committees to mention just a few. (2) new policies have transformed militaristic bureaucracy of the past to people-centred or focused policies, (3) information is given to citizens, accurately, timely than in the past where citizens had no chances to get accurate, reliable and timely information.

Challenges are addressed as an on-going transformation process, by making sure that services address the needs of the community. Communities and citizens are to be represented by community elected people, who become watchdogs on their behalf, for example, the establishment of the following governance structures: (a) District hospital Boards, (b) Regional hospital Boards, (c) Regional Mental Health Review Boards, (d) District Health Council, (e) Provincial Health Council, (f) Pension/Paypoint Committees, (g) Clinic Committees, (h) Health Centres Committees, (i) District Consultative Forums to mention just a few. All these governance structures are represented by members of the community who challenge government/department if service delivery is not taking place. This is a huge step towards transformation where department is completely, through these bodies, accountable to the citizens.

The process of transformation started immediately after the passing of the White Paper on Transforming Service Delivery, 1997. In 2003, the department started developing a

framework for consultative programme in terms of the following Batho-Pele taking the following into account:

- Transformation Task Teams were formed in various institutions to guide the process;
- Quality Assurance Teams established in various institutions to measure the level of service delivery in all the institutions;
- CEOs have been appointed to hospitals to guide the governance of the institutions;
- Service Delivery Optimization process was started in 2005 to fix challenges and track Service Delivery;
- Service Standards Manuals developed containing improvements of levels of services.
- Citizens Reports Manuals developed at each District and Provincial level that give citizens and the department the opportunity to express achievement for that particular financial year.
- Service Delivery Improvement Plans Manuals per institution and District have been started in 2003 to date, indicating what each institution and district will be doing to improve service for the coming financial year;
- Each District conducts Service Excellence Award for best public servants in each district.
- Provincial service Excellence Award takes place each year from 2003 to reward public servants who performed beyond the call of duty.

The department also assists national department to give National Awards from 2003, in the following categories:

- Cecilia Makiwane Awards (For nurses)
- Alfred Nzo Environmental Awards
- District Health System Awards
- Impumelelo Awards
- Community Builder of the year Award.



The other principal stakeholders who are driving the transformation process and service delivery within the Department of Health and Social Development are the Member of the Executive Council (MEC), Head of the department, Senior General Managers, General Managers, Senior Managers and those who hold equivalent ranks, Managers, personnel, members of the communities, Governance structures, National Department of Health, private sectors, traditional leaders, traditional healers, service providers in the department to cite just a few.

The following is a concise list of the principal legislation and mandates that are a driving force for the implementation of the transformation process and service delivery in the department:

- The Constitution Act, of 1996 (RSA: Chapters 3 and 10);
- Public Service Act of 1994
- Public Service Regulations of 2001;
- White Paper on the Transformation of the Public Service of 1995;
- White Paper on Transforming Service Delivery of 1997 (Batho-Pele Principles);
- Public Service Staff Code.

The pieces of legislation are to meet the challenges. We do not need additional legislation, we need to change the attitude of public servants and refocus them to service delivery. There is need for intergovernmental planning process between spheres of government.

**Case study compiled by: Senior Manager: Mr. A.C. Mutheiwana.**

Directorate: Transformation and Transversal Services  
Department of Health and Social Development.  
Private Bag X 9302  
POLOKWANE.  
0700.

## APPENDIX H

### UNIVERSITY OF LIMPOPO

#### TURFLOOP GRADUATE SCHOOL OF LEADERSHIP

P.O.BOX 756

Fauna Park.

0787

29<sup>th</sup> September 2006.

Dear Respondent

#### THE IMPACT OF THE TRANSFORMATION PROCESS ON THE QUALITY OF SERVICE DELIVERY (PS)

With special reference to the above-mentioned subject, kindly be informed that I am at present conducting a scientific research study for my Master's degree in Public Administration [MPA] through Turfloop Graduate School of Leadership under the auspices of the University of Limpopo. I am greatly desirous of your assistance for this sole purpose. Let us help each other in this endeavor so that both of us can benefit each other and the society at large. I am currently enrolled for the MPA Programme at the University of Limpopo, Turf loop Graduate School of Leadership and am conducting this investigation under the supervision of Dr M. H. Kanyane.

This research study is basically aimed at searching for information about the impact transformation process has on the quality of service delivery especially at Vhembe Health District but within the geographical jurisdiction of Mutale municipality within which the health sub-district falls. I foresee that with the information sought now from you and the others which I can obtain from researches, the literature and pieces of legislation published since 1995 to date would enable me to make informed, suitable and appropriate

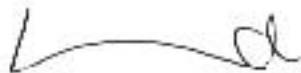
recommendations to help the present and the future generations of the Republic of South Africa.

You will concur with me that in the research study one really needs honest and transparent information for this purpose in particular. Therefore, do not fear to disclose your candid **ideas** and **opinions** asked for in the questionnaire to the best of your ability and knowledge. The investigation is undertaken on an anonymous basis. Hence, you are not required to furnish your name or identity number. Furthermore, confidentiality will be upheld in the entire research study and you will be the only person as the respondent who will know what your specific answers are.

Please feel absolutely free to actively participate in this research study. Hopefully your assistance will furthermore help the communities which have been historically marginalized and disadvantaged for decades which are currently in dire need of scientific information about the role and the impact of the transformation process on the quality of service delivery throughout the whole country of South Africa.

It will be highly appreciated if you complete the attached questionnaire and return it to the researcher or his enumerators by not later 18<sup>th</sup> October 2006. Thanking you in anticipation.

Yours faithfully



Dr. M.W. MADZIVHANDILA.

MPA STUDENT [UNIVERSITY OF LIMPOPO].

**SURVEY QUESTIONNAIRE FOR PUBLIC SERVANTS [PS]**

**YOU ARE HEREBY REQUESTED TO ANSWER THE FOLLOWING QUESTIONS OR ITEMS OF THE QUESTIONNAIRE RELEVANT TO YOU WITHOUT SEEKING ANY GUIDANCE OR ASSISTANCE FROM ANY OTHER PERSON. CONFIRM YOUR RESPONSE BY WRITING AN X WHERE IT APPLIES HEREUNDER:**

1. The public servants of Mutale sub-district lack capacities and skills to implement the transformation process in order to promote and facilitate the quality of service delivery:  AGREE  DISAGREE

2. I do not like to implement the transformation process: YES  NO

3. The transformation process benefits only the public servants: YES  NO

4. The place where I am working lacks relevant resources to enable me to promote and facilitate the transformation process: YES  NO

If YES, which health-care resources?: .....

5. I do not recognise transparency as part of the transformation: YES  NO

6. Service delivery to the public is my priority as a public servant: YES  NO

7. There are no pieces of legislation that enforce the implementation of the transformation process in the Republic of South Africa: YES  NO

If YES, give three examples: .....

.....

.....



8. The transformation process promotes and facilitates the quality of service delivery in the peripheral communities:  AGREE  DISAGREE
9. Members of the communities are not altogether knowledgeable about the process of transformation and its impact on the quality of service delivery:  AGREE  DISAGREE
10. The current government disregards the implementation of the transformation process as a priority even the transformation of the public service: YES  NO
11. Some public servants lack the necessary skills and knowledge to clearly and perfectly render adequate services: YES  NO

If YES, what type of skills?: .....

.....

.....

12. All health-related basic needs are easily made available to the very poor people residing in Mutale sub-district: YES  NO
13. Public servants render services in a manner that is completely unacceptable to the public: YES  NO

If YES, WHY?: .....

.....

.....

14. The government is keen to ensure that the transformation process takes place in terms of the legislation, but public servants are dragging their feet: YES  NO

If YES, why?: .....  
.....  
.....

15. Some public servants display negative attitude towards the transformation process and service delivery: YES  NO

If YES, why?: .....  
.....  
.....  
.....

16. Public servants who do not promote and facilitate the transformation process should be disciplined for their unlawful practices: YES  NO

If YES, what type of discipline?: .....  
.....  
.....

17. Transformation is a process which needs to be monitored and evaluated by the government:  MONTHLY  QUARTERLY  YEARLY

18. Transformation process needs to be regulated with the set timeframes to ensure that targets are met as scheduled: YES  NO
19. The attitude of some frontline public servants, especially medical doctors and nursing personnel towards patients is unpleasant: YES  NO   
If YES, why?: .....  
.....  
.....
20. Some outpatients are just deliberately impossible for the doctors and the nursing personnel to perform well in their respective institutions: YES  NO
21. Do you tell the patients the level and quality of service they receive so that they are aware of what to expect?: YES  NO
22. Do you treat patients with courtesy and consideration?: YES  NO
23. Do you provide more, full and better information to the patients about the public service they are entitled to receive?: YES  NO
24. Do you offer an apology to the patient, and a full, speedy explanation and effective remedy whenever complaints are lodged?: YES  NO

25. Generally comment on the transformation process and service delivery in the Department of Health and Social Development in the Limpopo province: .....

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**APPENDIX I**

**UNIVERSITY OF LIMPOPO**

**TURFLOOP GRADUATE SCHOOL OF LEADERSHIP**

P.O.BOX 756

Fauna Park,

0787

29<sup>th</sup> September 2006.

Dear Respondent

**THE IMPACT OF THE TRANSFORMATION PROCESS ON THE QUALITY OF SERVICE DELIVERY (CL)**

With special reference to the above-mentioned subject, kindly be informed that I am at present conducting a scientific research study for my Master's degree in Public Administration [MPA] through Turfloop Graduate School of Leadership under the auspices of the University of Limpopo. I am greatly desirous of your assistance for this sole purpose. Let us help each other in this endeavor so that both of us can benefit each other and the society at large. I am currently enrolled for the MPA Programme at the University of Limpopo, Turfloop Graduate School of Leadership and am conducting this investigation under the supervision of Dr M. H. Kanyane.

This research study is basically aimed at searching for information about the impact transformation process has on the quality of service delivery especially at Vhembe Health District but within the geographical jurisdiction of Mutale municipality within which the health sub-district falls. I foresee that with the information sought now from you and the others which I can obtain from researches, the literature and pieces of legislation published since 1995 to date would enable me to make informed, suitable and appropriate

recommendations to help the present and the future generations of the Republic of South Africa.

You will concur with me that in the research study one really needs honest and transparent information for this purpose in particular. Therefore, do not fear to disclose your candid **ideas** and **opinions** asked for in the questionnaire to the best of your ability and knowledge. The investigation is undertaken on an anonymous basis. Hence, you are not required to furnish your name or identity number. Furthermore, confidentiality will be upheld in the entire research study and you will be the only person as the respondent who will know what your specific answers are.

Please feel absolutely free to actively participate in this research study. Hopefully your assistance will furthermore help the communities which have been historically marginalized and disadvantaged for decades which are currently in dire need of scientific information about the role and the impact of the transformation process on the quality of service delivery throughout the whole country of South Africa.

It will be highly appreciated if you complete the attached questionnaire and return it to the researcher or his enumerators by not later 18<sup>th</sup> October 2006. Thanking you in anticipation.

Yours faithfully



Dr M W MADZIVHANDILA.

MPA STUDENT [UNIVERSITY OF LIMPOPO].

## SURVEY QUESTIONNAIRE FOR THE CLIENTS [CL]

**YOU ARE HEREBY REQUESTED TO ANSWER THE FOLLOWING QUESTIONS OR ITEMS OF THE QUESTIONNAIRE RELEVANT TO YOU WITHOUT SEEKING ANY GUIDANCE OR ASSISTANCE FROM ANY OTHER PERSON. CONFIRM YOUR RESPONSE BY WRITING AN X WHERE IT APPLIES HEREUNDER:**

1. How far is your nearest primary health care facility and Health Center)?:

LESS THAN 5KM

LESS THAN 10KM

MORE THAN 10KM

2. How is the quality of the services provided by the health-care personnel?:

POOR

GOOD

3. The public servants of Mutale sub-district lack capacities and skills to implement the transformation process in order to promote and facilitate the quality of service delivery:

AGREE

DISAGREE

4. What is the attitude of the health care personnel towards you at the clinics?:

DISSATISFACTORY

SATISFACTORY

5. The transformation process promotes and facilitates the quality of service delivery in the peripheral communities:

AGREE

DISAGREE

6. Do the health care personnel show you any respect when you seek consultation?:

YES  NO

7. Do the primary health care personnel meet your expectations whenever you visit the clinic?:

YES  NO

8. Do you find accessibility to the primary health care facility possible?: YES  NO

9. Members of the communities are not altogether knowledgeable about the process of transformation and its impact on the quality of service delivery:

AGREE

DISAGREE

10. Do the health care personnel respond promptly to your request for support during emergency calls? YES  NO

11. Are there some health care personnel who shout at you when you ask for assistance?: YES  NO

12. Are you turned down at the primary health care facility when you need health care?: YES  NO

13. Are drugs prescribed for you readily available for your illness after diagnosis?: YES  NO

14. Are the hospital services within your reach?: YES  NO

15. Do female health care personnel provide better services at the clinic than male health care personnel? YES  NO

16. As the aged patient do you pay health care levies for the services rendered to you by the clinic?: YES  NO

17. Whenever the prescribed drugs are out of stock, as a patient are you told to come back the following day for drug collection?: YES  NO

18. Whenever drugs are out of stock at the clinic, as a patient are you advised to buy same from the local private pharmacy or chemist?: YES  NO



19. Do you enjoy full support provided by the health care personnel at your clinic?:

YES  NO

20. Generally comment on the transformation process and service delivery in the Department of Health and Social Development in the Limpopo Province: .....

.....

.....

.....

.....

.....

.....

**APPENDIX J**

**CONFIRMATION BY DR LARAINÉ O'CONNELL FOR HAVING EDITED  
THE MINI-DISSERTATION**

**DR LARAINÉ C O'CONNELL  
LANGUAGE PRACTITIONER**

**TEL: 015-3072088  
CELL: 083 2289 801  
FAX: 015-3072088  
E-MAIL: [laraine@lantic.net](mailto:laraine@lantic.net)**

**PO BOX 4166  
0850 TZANEEN  
28 December 2006**

**TO WHOM IT MAY CONCERN**

I, DR LARAINÉ C O'CONNELL, hereby declare that I am an editor/translator and a registered member of SATI (South African Translators' Institute), Registration number 1001497.

I further declare that I have edited the following dissertation:

**THE IMPACT OF THE TRANSFORMATION PROCESS  
ON THE QUALITY OF SERVICE DELIVERY IN THE  
VHEMBE HEALTH DISTRICT, LIMPOPO PROVINCE**

prepared by **DR M W MADZIVHANDILA**

submitted to the Turfloop Graduate School of Leadership, University of Limpopo, Polokwane, in partial fulfilment of the requirements for the Master's Degree in Public Administration.

**DR L. C. O'CONNELL**