CHAPTER ONE

INTRODUCTION AND BACKGROUND TO THE STUDY

1.1 INTRODUCTORY BACKGROUND AND THE RATIONALE FOR THE STUDY


The 1994 first general election liberated South Africa from the apartheid system and its subsequent primary objective was “… to transform South Africa into a non-racial and democratic society” (http://www.anc.org.za/show.php?doc=ancdocs/speeches/1994/sp941217.html:2). The new democratic government now looks politically different from the racist regime because the current government since 1994 has been, and to date still is, a truly and broadly representative of the South African citizens and also a transparent one, whereas the defunct apartheid government was characterized primarily by, among other things, the violation of human rights, denying black South Africans of any rights of basic services, no rights of owning property or land, no freedom of association and speeches and firmly practised discrimination which was detrimental to the majority of the black population groups in this country (http://www.anc.org.za/show.php?doc=ancdocs/ngcouncils/docs2000/discuss2.html:1; http://www.anc.org.za/show.php?doc=ancdocs/policy/foreign.html:1).

According to the then President Nelson Mandela whilst addressing the ANC masses that were commemorating the eighty-third (83rd) anniversary of the African National Congress on the 8th January 1995, democracy entails “… a thorough-going process of transformation, of overcoming the political, social and economic legacy of apartheid colonialism, of racism, sexism and class oppression.” The government is still grappling with the challenge of ensuring
a better life for all the citizens of this country (http://www.anc.org.za/show.php?doc=ancdocs/history/jan8-95html:1).

In order to eradicate the critical problems caused by apartheid, it follows that South Africa needs a government with the political will to meet all challenges brought about by the implementation of the apartheid system; a government that has a better comprehension of the needs of the future generations and which understands the neglect and division of the past. The current situation needs a government that will put ‘people first’ over anything else as it is clearly stated in the Batho-Pele principles. When the African National Congress set out its vision for a non-racial society on 8th January 1912, nobody knew how long it would take to achieve political liberation. The African National Congress, together with the other liberation organizations, had led the freedom struggle for several decades in order to bring about a country or home that belongs to all the people of different population groups because it is, indeed, for all South Africans (http:www.anc.org.za/show.php?doc=ancdocs/policy/manifesto.html:1).

The dawn of democracy in the Republic of South Africa, which was the result of the first democratic election held on 27th April 1994 did not just come without some enormous challenges taking place in terms of health-service delivery. The country adopted a new Constitution at the end of apartheid system in 1994 and has since been hailed world-wide as one of the most liberal countries in the world, prohibiting all forms of discriminatory practices, whilst simultaneously facilitating, stipulating and promoting equal rights for all people irrespective of race, culture, creed and sex. The implementation of apartheid was completely a violation of universal human rights and was an indication of moral disintegration and degeneration in the country. The Freedom Charter that was adopted and accepted as the policy document at the Congress of the People held at Kliptown near Johannesburg in Gauteng Province in South Africa on 26th June 1955 became a powerful force that united the people of all racial origins in the struggle that eventually culminated in the elimination of racist apartheid regime, which, as a result of the first democratic general elections held on 27th April 1994, was completely replaced by a non-racial democratic government (http:www./209.85.229.132/customer?q=cache:XGrITldImxcJ: http://www.anc.org.za/ancdocs/history/c:1; The Constitution of the Republic of South Africa, 1996:6).
When the new democratic government of South Africa came into power after the first general elections, it ultimately “… inherited a society marked by deep social and economic inequalities, as well as by serious racial political and social divisions” (Thompson, 2000:184-189). On the basis of such serious social ills, the new government considered it important and necessary that the process of transformation should be implemented in this country in order to redress such political and socio-economic imbalances. The time-frame decided upon in terms of the Reconstruction and Development Programme was that it should completely be addressed within a period of three to four years from 1994 for both political and socio-economic challenges inherited from the former apartheid regime (African National Congress, 1994:16; White Paper on the Transforming Public Service delivery, 1977; Batho-Pele ‘People First’ 1995:2). Such transformation challenges are deemed necessary and essential due to the fact that they are as a result of the then public service that was basically characterized by lack of consultation with regards to the needs of the communities, inefficiency, lack of accountability, lack of commitment, lack of relevant skills and inadequate provision of better high quality of health-services in the rural black communities.

Inadequacy and impartiality in the provision of service delivery, especially health-care services, during the former apartheid government was a dilemma that faced South Africa in 1994. The current study is, therefore, being conducted following the recommendation made by Madzivhandila (2006:135-136) in Mutale subdistrict, emphasizing the need for the expansion and extension for further research, the scope of which was limited to the said subdistrict within the geographical area of Vhembe Health District located in Limpopo province in South Africa. The lack of implementation of the transformation process in South Africa on, among other things, health-care service delivery in particular was a serious challenge during the apartheid regime, because the regime oppressed the other population groups, denying them their rights to have access to basic services (The Constitution of the Republic of South Africa, 1996:111; WPTPS of 1995, Notice 1227 of 1995). Hence, it adopted the new supreme law called the Constitution in 1996.

It was, however, the first supreme law in the new political dispensation of the Republic of South Africa which was later repealed in favour of the Constitution of the Republic of South Africa in 1996, to reinforce the process of transformation. The Constitution, being the supreme
law of the country, prevails over all other pieces of legislation, policies and directives, that is, all the said legislation, policies and directives are subordinate to the Constitution of 1996. The formulation and passage of the 1966 Constitution of the Republic of South Africa by the National Parliament rendered all the then apartheid pieces of legislation null and void, that is, they were repealed to give way for the new political dispensation to provide the best services ever to all the people of this country. The transformation process was necessary and indispensable in South Africa due to the fact that there were great imbalances in terms of the manner in which services were delivered; hence due to this historical background, the South African public service needed to be transformed to redress all past imbalances such as the discrimination in terms of, inter alia, the provision of health-care among the different population groups especially the black people, which were reinforced by the previous discriminatory apartheid regime.

The concept “transformation’ has been clearly defined in the White Paper on the Transformation of Public Service (WPTPS of 1995:2) as a dramatic, focused and relatively short-term process that was designated to fundamentally reshape the public service for its appointed role in the new dispensation in South Africa. President Nelson Mandela, in his opening address during the forty-ninth (49th) National Conference held in Durban on 17th December 1994, said that transformation refers to “… visible change” and that “… visible change will need to be the prime feature of the government operations next year” (1995). “To succeed, we must transform the state itself into a more effective driving force of change.” “Restructuring of the state also means, more than anything else, transforming the public service into a representative, equitable and efficient arm of the government.” He further said that “The need for such change (transformation) is acknowledged by all and sundry” in “… addressing the blockages to the process of transformation.” (http://www.anc.org.za/show.php?doc=ancdocs?speechs/1994/sp941217.html:15).

Transformation has been defined as “… the process of altering the way in which an organisation does business… (it) provides a roadmap for a measured, goal-orientated response to marketplace events, or to the need to improve performance… (it) is the execution of an integrated, business-wide programme aimed at ensuring an improved future” (http://www.orprenewal.co.za/business%20transformation..Asp:1). Transformation is a process which cannot
be completed by the government overnight. The government will continue to implement it whenever and wherever service delivery-related challenges emerge.

The process of transformation is a key and indispensable concept in the practice of logical democracy world-wide especially in a very young, developing and fledging country like the Republic of South Africa where democracy was not observed, respected and practised for decades by the former racist regime. The concept ‘transformation’ has, therefore, been defined by Nedohe (2006:10) as a process that means “to change an existing reality into another.” Fox and Meyer (1995:130) define it as “the process of a system that changes inputs into outputs; the movement from one position to another.” It is interesting to note that Hellriegel et al (2001:381) define the transformation process as the organizational change in the design or functioning of an organization. Transformation is, therefore, referred to as the process which is not necessarily negative, destructive or threatening, but should be seen as a condition of renewal and progress in terms of service delivery to benefit the majority of the historically disadvantaged people of South Africa. (The Constitution of the Republic of South Africa, 1996:195(1)(d):111).

The challenges that prevailed during the pre-transformation period, that is, the period prior 1994, such as poverty, socio-economic, unemployment, political discrimination and discriminatory health-care service delivery could, therefore, only be addressed by ensuring that the transformation process takes place as speedily as possible especially on the periphery of the health-care sector in particular. The current researcher, therefore, regards transformation process as one of the possible mechanisms whereby the quality on health-care service delivery could be improved, promoted and facilitated wherever there is the most need to do so in the Limpopo province under study.

The concept of ‘service’ is intangible; hence, it is different from a ‘good’ because it is not touchable. If the patient, for example, consults the psychologist because he or she has a serious problem, and after the counselling sessions, the patient feels relieved from the stress and tensions he or she had been going through before the counselling sessions, one would say that the patient received a service from the psychologist because time was spent trying to put the client at ease and in comfort. There are two main types of services, namely, there are
government services, that is, those that are provided by the government to the communities, and those that are provided by private individuals or companies. Government services include everything that is done by the general assistants through to that which is done by heads of institutions. Hence, within the broad category of services rendered by the government there is a specific type of service called health-care service. Besides the fact that the government provides health-care services to the patients or clients, there are also some professionals that do the same to the members of the communities, for example, medical officers who are in private practice and private institutions approved by the government that also provide similar services to the patients or members of the community.

The World Health Organization (WHO) defines health as “a state of complete physical, mental or infinity “. This state of good health could be attributed to, for instance, good health-care facilities, enough qualified health-care workers and the availability of required resources such as the availability of the necessary funds and expertise to provide adequate health-care facilities and services. Mkasi (2006:9) identifies disease as poor quality of water, unhygienic living conditions, inadequate nutrition, poverty and stress as the main factors affecting health-care since lack of clean water, unhygienic living conditions and inadequate nutrition can be related to poverty. On the basis of what has been said above one could say that poverty is one of the major contributors to the poor state of health-care in developing countries and South Africa is no an exception in that regard.

The former President Mokgae Motlanthe in his State of the Nation Address delivered on 6th February 2009 in the Parliament in Cape Town (2009:9-10) commented that although “Evidence of the social wage is also seen in massive improvements in access to primary health facilities, 95% of South Africans now live within 5 kilometres of a health facility; and we are informed that all clinics now have access to potable water. Children immunization coverage has steadily increased to about 85%; and malaria cases have massively declined” (2009:6). However, much more needs to be done to improve the service culture and orientation of some public servants, especially those at the coal-face of direct interaction with the public”. Motlanthe emphasized that there should be a change of mind-set on the part of public servants because they are always in the forefront and are expected to render services in a transparent, honest, respectful and dedicated manner. It is through the process of transformation that an improvement on the quality of health-care service delivery should be brought about.
Since the South African government was effectively committed to the eradication of all oppressive policies and legislation, it was then considered very important and necessary to enforce the implementation of the transformation process in order to completely eradicate, among other things, the socio-economic and political imbalances of the past, which were underlined by extreme poverty, unemployment, inequalities, racial discrimination and complete lack of transparency, honesty and accountability as well as the lack of participation by blacks in the socio-political and economic matters of the country. The main purpose of implementing the transformation process was, therefore, to address all such imbalances in order to ensure that there is improvement on the quality of health-care service delivery in the national, provincial and local spheres of government. This was effective in rectifying the imbalances created by the former oppressive apartheid regime.

The democratic government expects the public service to drive as speedily as possible the transformation process in terms of the provisions of the Constitution of 1996 of the Republic of South Africa as reflected explicitly in Chapter 10, Section 195 (i) which states, inter alia, that the “Public must be broadly representative of the South African people… “. Nethengwe (2009:21) has quoted Hanekom et al (1987:207) who mentioned that the current government and administration are faced with a growing imbalance between the great demand for more and better services in the country, but the resources of overcoming or resolving the problem are very limited. Therefore, the public institutions should pro-actively strive for the efficient and effective use of their human resources. The White Paper on a New Employment Policy for the Public Service (1997:2) further indicates that it is important to transform “… the Public service into an instrument capable of fulfilling its role in bringing about the new South Africa …. (which) depends on the commitment and effectiveness of its public servants, which in turn depends on the way in which those public servants are managed”

The implementation of and compliance with the afore-mentioned constitutional values and principles play significant and supportive roles in terms of promoting, facilitating and improving the delivery of services and especially in this context, health-care services in those areas that were completely neglected, disadvantaged and marginalized by the defunct apartheid government. The current Constitution of 1996, as the supreme law of South Africa, strongly
supports the process of the transformation as one of the mechanisms whereby the quality of health-care service delivery could be improved for the benefit of all South African citizens (Constitution of 1996:111).

The ANC-led government, in complete contrast with the apartheid regime the policies of which were basically discriminatory, was highly committed to the reconstruction and development of the public service and the improvement of life of all the people of this country regardless of race, creed and the colour of the skin; hence it placed more emphasis on the implementation of the transformation of the public service for the best benefit of all communities, especially the Black South Africans in particular. In terms of the Reconstruction and Development Programme (RDP), the first major priority as currently outlined in the RDP included, among others, water and sanitation, housing and services, nutrition, land reform, employment, energy and electrification, transport, clean environment, transport, tele-communications, food, health-care, education, and welfare, including the implementation of the basic values and principles governing public administration (African National Congress, 1994:111; Sangweni and Balia, 1999:29, 34 and 64).

The elimination of disparities in the provision of services in general and health-care services in particular was to ensure that people’s needs are unconditionally met. Such basic needs in particular urgently prompted the new democratic government to devise and seek strategies for addressing the effects and consequences of the apartheid policies. When the new government came into being in 1994, it found gross fragmentation of administrations, services, inefficiency, ineffectiveness, lack of accountability, fraud, corruption that was pandemic, disparity of health-care services, discrimination in the treatment of patients as well as policies which promoted and enforced the apartheid system to benefit the minority White community in South Africa (Kanyane, 2005:x; Sangweni and Balia, 1999:29, 34 and 64).

on Transforming Public Service of 1997, Labour Relations Act of 2002 as amended, the White Paper on Public Service Training and Education 1997, the White Paper on Local Government of 1998 and the White Paper on Transforming Service Delivery of 1997 are some of the most important pieces of legislation and policies that are an endeavour made by the democratic government in approaching the way this country could be liberated from the apartheid ideology and system. These and many other pieces of legislation, policies and directives are, indeed, the bases on which the transformation process is anchored and established. The success or failure of the transformation process in terms of improving the quality of health-care in South Africa will depend upon whether they were effectively implemented and enforced or not by the public servants.

One of the government policies on which transformation anchors, which is also implemented in order to fundamentally transform the health-care delivery system, is the White Paper on the Transformation of Health System in the Republic of South Africa. In view of the fact that the majority of the people of the Republic of South Africa have inadequate access to basic services such as clean water, basic sanitation, health-care and adequate transportation, the implementation of the transformation process is necessary to ensure that all basic services are easily accessible by all inhabitants of this country through their direct participation. The White Paper on Transforming Public Service (1997:5) stipulates that “It is essential to obtain the active participation and involvement of all sectors of South African society in health-care and health-related activities, sections of the community, all members of the households and families and individuals should be actively involved, in order to achieve the health-care consciousness and commitment necessary for the attainment of goals at the various levels.” Hence, the objective of the White Paper is to promote equity and accessibility, improve access to comprehensive health-care services and utilization of health-care services in the entire country without discrimination on the basis of race, colour, creed and religion to cite just a few (White Paper for the Transformation of the Health System in South Africa, 1997:6 and 7).

To this end, this study aims to explore and assess the effects of the transformation process on the health service in Limpopo Provincial government of South Africa, especially in the remaining three subdistricts (save Mutale subdistrict) of Vhembe Health District in Limpopo
Province since South Africa now already has a democratic government that is fifteen years old. The study would further establish if there are any challenges in terms of the effectiveness of the pieces of legislation and other policies on transforming health-care in the health-care facilities; whether the public servants have any gaps, lack of skills, interests and knowledge as far as the implementation of the various legislation to promote and facilitate the transformation process is concerned as the process of transformation of services is dynamic.

The first primary purpose of the current study is that it is being conducted following the recommendation made by Madzivhandila (2006:135-136) in Mutale subdistrict, emphasizing the need for the expansion and extension for further research, the scope of which was limited to the said subdistrict within the geographical area of Vhembe Health District located in Limpopo Province in South Africa and another primary purpose for undertaking the study is the fact that the findings of the survey conducted in Mutale subdistrict could not be generalized to the rest of Vhembe Health District, let alone the entire Limpopo Province and South Africa at large. Hence, the present researcher is furthering the research survey with a view to determining the extent to which the transformation process has to date benefited members of the rural communities, especially those who were historically marginalized, disadvantaged and discriminated against from accessing the basic services, especially the health-care services. Subsequent to huge backlogs, the current researcher is interested in exploring the effects of transformation process on the high quality of health-care service delivery in the remaining three subdistricts of Vhembe Health District of Limpopo Province in South Africa.
The current researcher also observed more or less similar inadequate health-care service delivery in the rural areas as serious challenges, being cognizant of the fact that the Republic of South Africa was at the time of the study in its fifteenth year of democracy. Such challenges were and still are apparently retarding the improvement and promotion of the high quality of health-care service delivery.
1.2 THE STATEMENT OF THE PROBLEM

The study raises concerns about the effects of the transformation process on the quality of health-care service delivery especially in the three judgmentally or purposively sampled subdistricts of South Africa under study, namely, Makhado, Musina and Thulamela, by virtue of their being too deep rural.

The introduction and implementation of the 1995 White Paper on the Transformation of the Public Service and the 1997 White Paper on Transforming Public Service Delivery both brought about a new era in the South African public service as means of redressing the past imbalances of the apartheid regime. The implementation of the two White Papers was an endeavour by the democratic government to transform the public service, which would ensure that there is also transformation of health-care service delivery in the country. Numerous pieces of legislation were developed and passed by the National Parliament with a view to ensuring that there is an improvement on the quality of health-care service delivery for all the citizens.

The research findings of the study made by Madzivhandila (2006) revealed that many people in the rural areas expressed dissatisfaction that there has been no transparent and practical delivery of basic needs such as shelter, food, education or health-care services, particularly in their respective peripheral areas in Limpopo Province, since democracy was achieved in 1994.

1.3 RESEARCH OBJECTIVES OF THE STUDY

The research objectives of the present study are two-fold, namely, general and specific, and are outlined below:
1.3.1 **General objectives of the scientific survey study**

First, the study focuses on studying the transformation process as one of the major mechanisms that facilitates, promotes and improves the quality of health-care service delivery in the deep peripheral communities of Limpopo Province in South Africa. The fundamental and ultimate objective of the research is, therefore, to enable the people of South Africa in general to be well equipped with the necessary information, expertise and skills that are essential for promoting and facilitating the quality of service delivery as it relates primarily to the health-care service delivery for the patients. Second, the study pays thorough attention to the health-care service delivery on the basis of the available limited skills and knowledge of the public servants in the three identified subdistricts of Limpopo Province in South Africa.

This study, furthermore, seeks to explore respondents’ understanding, knowledge, attitudes and beliefs towards transformation and health-care service delivery processes. Few studies to date have been done in South Africa regarding attitudes and beliefs towards the transformation process and its effects on health-care service delivery; having said that, no similar study has been conducted in the Vhembe Health District save at Mutale subdistrict. Hence, this study is deemed necessary and indispensable in the situation in which the country finds itself now having been a democratic country for 15 years.

1.3.2 **Specific objectives of the scientific study**

The specific objectives which necessitate the present study are five-fold:

1.3.2.1 to assess whether the public servants and members of the community of Vhembe Health District of Limpopo Province in South Africa lack the capacity and skills to implement the transformation process in order to promote and facilitate the needed health-care services;

1.3.2.2 to evaluate the effectiveness of the transformation process against the high quality of health-care service delivery in the peripheral community;
1.3.2.3 to determine the extent within which the government complies with the norm of the range of 5km reach;

1.3.2.4 to establish whether the public servants and members of the community of Vhembe Health District of Limpopo Province in South Africa are knowledgeable about the transformation process and its effects on the high quality of health-care service delivery; hence there have been massive service delivery problems;

1.3.2.5 to provide recommendations on how the transformation process should be resolving the high quality of health-care service delivery problems and challenges in the remote rural communities under study.

1.4 RESEARCH QUESTIONS

The following five questions received attention in this study:

1.4.1. Do the public servants and members of the community of Vhembe Health District of Limpopo Province in South Africa lack the capacity and skills to implement the transformation process in order to promote and facilitate the needed health-care services?

1.4.2 What are the effects of the transformation process on the high quality of health-care service delivery in the peripheral community?

1.4.3 Do members of the community (patients) of Vhembe Health District of Limpopo Province in South Africa stay within the government norm of the range of 5km reach?

1.4.4 Are the public servants and members of the community of Vhembe Health District of Limpopo Province in South Africa knowledgeable about the transformation process and its effects on the high quality of health-care service delivery?
1.4.5 What is the possible way of resolving transformation and health-care service delivery problems and challenges in the remote and rural communities under study?

1.5 HYPOTHESES

The hypotheses that have been formulated and developed in this thesis are to be tested through the application of the chi-square test for this study. The alternative hypotheses of the study are postulated as follows:

- **Hypothesis 1.5.1:** The public servants and members of the communities of Vhembe Health District of Limpopo Province in South Africa lack the capacity and skills to implement the transformation process in order to promote and facilitate the needed health-care services;

- **Hypothesis 1.5.2:** The transformation process promotes and facilitates the high quality of health-care services in the peripheral community;

- **Hypothesis 1.5.3:** Members of the communities (patients) in Vhembe Health District of Limpopo Province in South Africa stay within the government norm of the range of 5km reach;

- **Hypothesis 1.5.4:** The public servants and members of the community in the Vhembe Health District in South Africa are not knowledgeable about the transformation process and its effects on the high quality of health-care service delivery; hence, there have been massive service delivery problems.
1.6 SIGNIFICANCE OF THE STUDY

The significance of the present study is to demonstrate the importance of ‘transformation process’ and its effects on the quality of health-care service delivery. There are various reasons for carrying out the study. One of the reasons for this study is the inability of the Department of Health and Social Development or health-districts to provide adequate health-care facilities; the majority of the patients in the peripheral areas were still travelling more than 5 kilometers to reach their clinics and health-care services were not delivered in an effective and efficient way as revealed in the findings by Madzivhandila (2006:135-136), whereas the mission of the department is to provide and maintain adequate health-care services in the entire Limpopo Province in the manner that would benefit all the South African citizens.

What is worth mentioning is that during the apartheid era, the defunct government was not at all concerned about the aspirations, political and socio-economic liberation or emancipation of African people in particular; rather the focus was mainly on the practices of discriminatory systems and procedures by means of which the interests of whites were promoted and protected. The practices were not directed towards the determination and establishment of the needs or improvement of the lifestyles of the communities, especially the historically disadvantaged black South Africans.

The current study is, furthermore, being conducted following the recommendation made by Madzivhandila (2006:135-136), emphasizing the need for the expansion and extension for further research on his mini-dissertation, the scope of which was limited to Mutale subdistrict within the geographical area of Vhembe Health District located in Limpopo Province in South Africa. The current researcher also noticed the inadequate health-care service delivery in the rural areas of South Africa as a serious challenge, taking cognizance of the fact that the Republic of South Africa is now in its 15th year of democracy since it attained it in 1994. Another reason for further conducting the present study is the fact that the findings of the research survey conducted in Mutale subdistrict could not be generalized to the rest of Vhembe Health District, let alone the entire Limpopo Province and South Africa.
This study, therefore, seeks to make a contribution in the field of Health and Vhembe District Health management in general and to Provincial Management linked to the Provincial Department of Health and social Development in the provision of health-care services. The importance of the study centres on the promotion of effective and efficient health-care service delivery by the Department of Health and Social Development.

The following are the anticipated contributions to be made by the current study because they are significant and necessary as they seek basically:

- to explore and evaluate the effectiveness of the transformation process on improving the high quality service delivery in terms of health-care services in the poorest provinces of this country,

- to increase and broaden the understanding of both the processes of transformation and the high quality of health-care service delivery,

- to make a scientific contribution to the existing body of knowledge in the field of Public Administration,

- to furthermore contribute to the general understanding of the correlation between the transformation and health-care service delivery processes, construction of social theories and identification and management of some challenges.

1.7 DELIMITATIONS OF THE STUDY

With regards to the limitations of this study, it should be noted that the study was conducted in Vhembe Health District and could not extend to the other four districts within Limpopo Province in South Africa. It focused mainly on the correlation between the transformation and health-care service delivery processes.

The study examines the process of transformation with special reference to its effects it will have on the improvement, promotion and facilitation of the high quality of health-care service delivery in the poorest communities based in South Africa, especially in the remaining three
subdistricts of Vhembe Health District in the Limpopo Province, namely, Makhado, Musina and Thulamela. Madzivhandila (2006:135-136), in the findings of his survey study conducted in Mutale subdistrict in Vhembe Health District, recommended that a further study be conducted as the survey results in the said subdistrict could not be generalized to the entire district and let alone to the Limpopo province. Hence, the current study which has increased scope.

The research is conducted among public servants (PS) of the Department of Health and Social Development and out-patients or members of the communities (MC) residing in the Vhembe Health District of the Limpopo Province in South Africa at the time of conducting the current study.

The literature is reviewed in accordance with the topic and the aim of the present study. Primary data are collected from questionnaires administered to the respondents; secondary data are collected from various available sources either in the form of professional journals, electronic and print media, books, articles, government gazettes, legislation and acts to mention just a few.

The main focus of the study into the transformation and health-care service delivery processes is, therefore, limited to the period from 1994 to 2009 of the fifteen years of democracy in the three afore-mentioned remaining subdistricts, which are all judgmentally or purposively sampled in the Vhembe Health District of the Limpopo Province in South Africa.

1.8 ETHICAL CONSIDERATIONS

The Professional Code of Ethics in any discipline is of fundamental significance in all research studies. In order to assist research professionals, especially the public administration practitioners and other researchers in this context, when dealing with ethical issues, the Code of Ethics of American Sociological Association (ASA, 1982) indicates the ethical considerations that should always govern all the activities associated with any research projects
(Leedy, 1997:116). The principles or ethical issues regarding human subjects apply to any type of study and not only to experiments.

The present researcher adopted the professional code of ethical issues as reflected in Leedy (1997:116): for instance, the researcher must maintain scientific objectivity; he or she should recognize the limitations of his or her competence and not attempt to engage in the study beyond such competence; every person is entitled to the right of privacy and dignity of treatment; all research studies should avoid causing personal injury or harm to the respondents used in the research studies; confidential information provided by a research respondent must be held in strict confidentiality by the researcher and all research findings should be presented honestly without distortions. According to the APA (the American Psychological Association, 1992), researchers:

- must always abide by the ethical conditions while conducting investigations with human beings or non-human beings.
- they must not harm subjects or respondents either physically or psychologically,
- 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 investigation from all perspectives by being unethical in their research studies (Heiman, 1995:157).

Elmes et al (1999:445) reiterate that ethical considerations involve researchers removing “… any harmful consequences that their participants may have incurred”. It is, therefore, the sole responsibility of the researcher in the various disciplines to always identify both potential physical and emotional risks and effectively and efficiently manage them; that is, he or she must always find out if there is anything in the study that could physically and psychologically endanger or harm the respondents, as is sometimes the case in socio-psychological research studies.
As a way of maintaining and adhering to the ethical principles and considerations of conducting a study, the current researcher always 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 study. 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 present study was made available to any interested professionals, organizations, people and institutions without the consent of the respondents in particular and the University of Fort Hare in general.

Ramalamula (2007:11) has quoted De Vos as having said that in conducting research, the researcher undertakes to consider all ethical values throughout the study, which are values and principles that quench the study from the beginning to its end and hereunder follow some of such principles for consideration in any study:

- The researcher’s competency.
- Informed consent.
- No harm of respondents.
- No deception of respondents.
- No violation of privacy.
- Co-operation with other researchers.
- Release of findings and restoration of respondents.

1.9 OUTLINE OF THE CHAPTERS OF THE STUDY

The study consists of seven chapters which eventually constitute the thesis. Chapter one is an introduction and background presenting a statement of the problem for the study, the research objectives of the study, the research questions, the hypotheses, the significance of the study, the delimitation of the study, ethical considerations and the outline of the chapters of the study.
Chapter two discusses the historical and political developments between 1910 and 2009 as catalysts for the development of a democratic government and focuses on the determination and demarcation of boundaries of Limpopo Province as well as the Vhembe Health District respectively. The first section of this chapter is an introduction pertaining to the demarcation of boundaries after 1994 prior to the local government elections of 1996, followed by exploration of its geographical topology reflecting its accessibility to all the health-care facilities. It also looks into the socio-economic viability within the entire district and the effects of its health-care services on other health-care facilities adjacent to the Vhembe Health District.

Chapter three deals with the establishment of both Limpopo Province and Vhembe Health District following the attainment of a democratic government in 1994. Chapter four focuses on the scientific study, theoretical perspective, the review of the relevant related literature and legislative frameworks reflecting how the transformation process effects the improvement, promotion and facilitation of the high quality of health-care service delivery in the Limpopo Province in South Africa. In chapter five, the research methodology in general which is inclusive of research design, research methods, research format, research techniques, target population, sampling procedures, sampling type, sampling techniques, methodological limitations, and the formats of the questionnaires, is outlined in context.

Chapter six gives explicit analysis of the research data and it addresses the methods of data collection, data presentation, data analyses, and research data descriptions. The analyzed and interpreted research data determine views expressed by the public servants and members of the communities on the effects of transformation process on the quality of health-care service delivery in Limpopo Province in South Africa. Lastly, the purpose of chapter seven deals specifically with the conclusion and recommendations of the current study.

1.10 CONCLUSION

It is worth mentioning that since 1994, the South African government has undertaken significant political transformation, as well as sought to clearly define most of the polices and directives that were considered as the fundamental determinants of the activities of the state in the management of social relations. It is very interesting to note that some of the considered
strong pillars of apartheid policies and directives, which were designed to exclude completely the majority of the black people from full and active participation in the various aspects of activities of the South African communities, had already begun to collapse and crumble by the late 1980’s (South Africa: Millennium Development Goal Country Report, 2005:9). Since the current government came into being in 1994, however, it made a point to deliberately set out systematically strong mechanisms to aggressively dismantle apartheid social relations. Furthermore, it created a democratic country based on the principles of equality, non-racialism and non-sexism as a way of eradicating the policies of the discriminatory government or phasing out completely the apartheid system which denied many black people of the health-care service delivery they deserved.

The public servants have been tasked with the responsibility of ensuring that all transformation-related pieces of legislation, policies and directives are implemented in order to improve the standard of life of the citizens of South Africa. The transformation process is one of the best processes whereby the high quality of health-care service delivery could be improved, promoted and facilitated depending also on the availability of skills and the resources.

Numerous pieces of legislation have been well-developed to date by the National Parliament of the ANC-led government to ensure that the challenges pertaining to health-care service delivery are properly addressed as speedily as possible since many black people in particular have been disadvantaged and marginalized for decades by the apartheid regime. It is through the effective implementation of the transformation process by the public service that challenges such as a lack of accountability, the prevalence of nepotism and corruption, discrimination, lack of openness and transparency, lack of honesty, control and domination, all of which were prevalent during the apartheid era, must be addressed in order to ensure that all people of this country have equal access to the delivery of health-care services especially the communities residing in the peripheral areas of Limpopo Province in South Africa. The transformation process is a serious challenge that is being undertaken, ensured, enforced and strengthened by the implementation of the legislative frameworks to improve the lives of all South Africans.
Adequate and satisfactory service delivery serves a vital role especially for alleviating social ills such as poverty, hunger and unemployment in South Africa. Therefore, the purpose of this study is to conduct an assessment between the success and failures of the post-transformation period since 1994 with regards to the attainment of a better health-care service delivery in the Vhembe Health District of Limpopo Province in South Africa.

The 1994 general democratic elections have heralded the end of the racist apartheid system and brought about a new era of democratic governance. The minority regime was characterized during the pre-transformation period by, among other things, denying the majority black population groups of basic services, which, according to the Freedom Charter which is in harmony with the Universal Declaration of Human Rights, proclaimed by the United Nations on 10th December, 1948, reflected the essence of the Freedom Charter. It states: “… that South Africa belongs to all the people who live in it, that the people should enjoy equal rights and opportunities and all apartheid laws and practices which discriminate on the grounds of race, colour or belief shall be set aside and repealed, including the right to vote, and be elected to legislative bodies, in a democratic State without distinction of colour, race, sex or creed” (The Freedom Charter, 1955:1-3).

The Prime Minister of the People’s Republic of China, Chou En-lai commented in a telegram to the African National Congress of South Africa during the struggle for liberation that “The Asian-African conference has solemnly condemned colonialism and racial discrimination. The Chinese people, together with the peoples of other Asian and African countries and the people of the whole world, will continue to support the just struggle waged by the people of South Africa” (The Freedom Charter, 1955:6). The objective of the Freedom Charter of 1955 is that it expressed “… the democratic and humanist aspirations of the oppressed people of South Africa; the struggle which the United Nations General Assembly has recognized as legitimate and as deserving international support” (The Freedom Charter, 1955:8).

The current situation in South Africa is that the transformation process should be implemented in all spheres of life because it is inevitable in the new democratic South Africa. The country cannot uphold apartheid principles which were dehumanizing, detrimental to, and degrading of the socio-economic status of the majority black population groups. Hence, the present democratic government has good plans in place for people in this country regardless of colour,
race, religion and creed, that is, to better and improve the lifestyles of all inhabitants in this country. Black population groups played a pivotal role in the political and socio-economic status of South Africa during the apartheid era though their contributions were not publicly recognized, acknowledged and commended. The current political transformation was achieved as a result of the first 1994 general elections and during which the African National Congress had an overwhelming victory of 63,0%, whereas the economic transformation is still a challenge since the economy is still being controlled by the minority white population. Hence, there is a great need for the implementation of the transformation process in all spheres of life in this country (http://www.elections.org.za/elections2004stastic.asp; (http://www.elections.org.za/results/natpersparty.asp)).

It is of great significance that there must be a political and administrative will if politicians and public servants of this country respectively are committed to ensure that effective transformation process in terms of health-care service delivery in particular must be brought about for the optimal benefit of all South African citizens. The current government must seek tangible solutions to the service delivery challenges created by and left unresolved for many decades by the defunct apartheid regime. It is, therefore, now the responsibility of the current government and the private sector to collectively ensure, inter alia, that there is a provision of the high standard of health-care services as the first priority in the entire country, followed by the creation of adequate job opportunities for all and alleviation of poverty and hunger, to mention just a few. Diversity has also been another important challenge the present government is faced with since it is a multi-cultural society and it should be resolved to the benefit of all South Africans. Hence, in terms of this study, transformation is regarded as one of the best mechanisms for redressing and addressing the past imbalances which were the legacy of the apartheid regime.
CHAPTER TWO

THE HISTORICAL AND POLITICAL DEVELOPMENTS BETWEEN 1910 AND 1994 AS CATALYSTS FOR THE DEVELOPMENT OF A DEMOCRATIC GOVERNMENT

2.1 INTRODUCTION AND RATIONALE

Chapter two provides a general overview of the history of the Republic of South Africa reflecting the main historical and political developments since the declaration of the Union of South Africa in 1910, through to the attainment of a democratic government following the general elections in 1994. The major part of chapter two attempts to illustrate the historical and political transformation that took place between 1910 and 1994, that is, the focus is over a period of 84 years under the British government and the apartheid regime. The lesser part of it deals specifically with the historical and political developments subsequent to the emergence of the 15-year-old democratic government from 1994 to 2009.

It is imperative to reflect on the historical and political developments of South Africa since the occupation of the country by the minority white regime. The objective of chapter two is, therefore, to present a clear outline of the history of South Africa in the light of the recent political transformation of this country. The most important single theme is the historical explanation of the creation of the peculiar system of systematic racial exploitation, discrimination, marginalization and repression known as the apartheid policy, which appeared in the early nineties to be on the threshold of disintegration.

The current researcher considered it to be appropriate and of great significance to have an extensive knowledge and better comprehension of the historical and political developments prior to the attainment of democracy in 1994 if the implementation of the transformation process on the basis of the legislative frameworks of the country was to be reinforced with little resistance or without encountering any resistance from the public servants and members of the communities in South Africa. The focus on the conquest and elimination of the imposed colonialism and imperialism, especially by the French government, the Dutch East India Company and the British government in Southern Africa and the practice of the notorious apartheid policy in South Africa from 1910 to 1994 was imperative to understand the need for
the introduction and implementation of an effective transformation process in this country since 1994.

The now defunct South African government, while in power in the mid-1970s, was rocked by the liberation of the former Portuguese colonies, namely Angola and Mozambique, which on attaining democracy, posed a great threat of cross-border raids by freedom fighters (also called terrorists by the apartheid regime) with the South African liberation movements. Similar democracies, which were attained by the freedom fighters in Rhodesia (now called Zimbabwe) as well as in South Africa, met with greater resistance from the colonialists and imperialists but, nevertheless, freedom, emancipation and liberation for the indigenous inhabitants of South Africa were inevitable as they were eventually attained (The Reader’s Digest: South Africa, 1995:368). The implementation of the apartheid policy by the South African regime was strongly opposed for several decades by the indigenous black people of this country and the international community. More dissidents were arrested and their organizations banned in 1960 and 1961, but similar actions in 1976 and 1977 failed to have the same effects. Black resistance became more pronounced and formidable than before (Thompson, 1995:228 and 256).

In the context of South Africa, the concept ‘apartheid’ meant ‘apartness’, which referred to the separation of the racial groups into which the apartheid regime classified black communities and which distinguished them from white communities. The apartheid policy was regarded as an ideology as well as a political system. The term ‘ideology’ in this context of the South African circumstances referred to a set of ideas such as Christianity, sexism, Islam and nationalism. The apartheid policy as an ideology meant during the apartheid era that the racial groups were separated as far as possible in every aspect of life, that is, socially, politically, economically and geographically. In terms of the apartheid policies, the white population occupied high political positions of power in this country in relation to the other population groups such as the black people, Coloureds and Indians and often took decisions about their future without consultation. The Afrikaner people were characteristically racist because they held the view that one race was superior to another race and subsequently imposed domination and oppression on the already oppressed black majority (Pape et al, 2007:306).

The implementation of the apartheid policy severely affected the black people in various ways in this country. Most white people were privileged and their security was more readily
available in contrast to the majority of black South Africans for whom ‘apartheid’ meant increased and unbearable hardships, oppression and a ‘curse’. The dawn of 1990, subsequent to the lifting of the ban on political organizations, release of political prisoners and unconditional release of prominent freedom fighters, was considered an interesting, challenging and critical period preceding the political transformation in South Africa when the apartheid government was substituted by a democratic government. This process represented the emergence of democracy, the realization of the implementation of the transformation process and also the latter’s effect on health-care service delivery particularly in the peripheral areas of this country (Pape et al, 2007:311).

The former Nigerian President, Olusegun Obasanjo, while leading a monitoring team in the recent national and provincial general elections held in South Africa, expressed his optimism and confidence on 21st April 2009 on SABC Channel 2, that both national and provincial elections would be conducted in a democratic atmosphere since democracy “is not a destination in itself or an end in itself but a process and a means to an end and has to be upheld and sustained”. According to him, ‘democracy’ is about making or expressing one’s choice, voice or selecting a government of one’s choice. The knowledge of both the historiography and political developments in the period between 1910 and 1994 is deemed indispensable to enable the people of this country to understand the reason and the necessity for the implementation of the transformation process and its effects on health-care service delivery.

During the era of apartheid it was very important for the people to realize and experience an irresistible urge to push forward by reflecting on the past because the past was the one constant factor for the people transforming the world in order to come to terms with their political and socio-economic developments. The periods of radical transformation in South Africa, namely, 1910, 1994. 2005 to 2009 are significant and it is necessary to reflect on these historical and political developments.

In brief, Chapter two focuses on the historical and political developments which took place during the pre-transformation eras, mainly during the coloniziation of South Africa by the British government and the apartheid regime between 1910 and 1994; the disengagement of South Africa from Britain and the declaration of the Union of South Africa in 1910; the fragmentation of the Republic of South Africa; the establishment of ‘homelands’ and
‘territories’ in South Africa; the creation of the Coloured Persons’ Representative Council (CPRC) in 1975; the empowerment of urban black people in the ‘white areas’; the international sanctions and political violence; the setting up of the tri-cameral parliament; the negotiations towards the establishment of a democratic government; and the dissolution of the Government of National Unity (GNU). During the transformation process the focus was mainly on the 1994 general elections in the Republic of South Africa, the defragmentation of South Africa into a unitary democratic government, the establishment of provincial and local governments, the creation of institutional structures such as the Parliament, Provincial Legislatures and Municipal Councils, the establishment of the Limpopo Provincial local government, the establishment of Vhembe Health District, the establishment of a single Public Service and finally the post-transformation period between 2005 to 2009.

2.2 THE TRANSFORMATION PERIODS IN SOUTH AFRICA

The transformation process is a fundamental element of democracy in this country. It is important that on the basis of what has been alluded to in section 2.1 above, attention is paid to the different eras of transformation. South Africa went through a long pre-transformation period, which lasted from 1910 until 1994. The transformation era commenced in 1994 and ended in 2004 and South Africa is now in the post-transformation phase, which commenced in 2005. Although the political transformation has already been accomplished to a certain extent, the socio-economic transformation is still far from being realized since the lifestyles of the majority black people have not been significantly improved due to, for instance, the high rate of unemployment, poverty, social ills, and the economy, which is still mostly under the control of white people. More efforts have to be exerted to ensure that there is transformation from a socio-economic perspective (Thompson, 1995:254).

The transition from the apartheid era to the democratic period signified that the process of transformation was a serious challenge since it did not take place gently, suddenly and smoothly. In South Africa this transitional phase in the context of the present study was represented by three phases, namely, the pre-transformation era - between 1910 and 1994, transformation era - between 1994 and 2004 in the Republic of South Africa and the post-transformation period – between 2005 and 2009.
2.2.1 The pre-transformation period between 1910 and 1994

This section, which provides an overview of the South African historical situation from 1910 to 1994, deals specifically with historical and political developments which conclude the apartheid historiography in 1994. The apartheid era was followed by the historical political developments after the achievement of democracy in 1994. It would be noticed that the period during which South Africa was occupied by the racist regime was comparatively much longer than the period since the attainment of democracy. This is the period during which the democratic government was expected to have provided equal and non-discriminatory health-care services in particular and other basic services in general to all the citizens of this country.

2.2.1.1 The disengagement from Britain and the declaration of the Union of South Africa in 1910

Section 2.2.1.1 deals mainly with the disengagement of South Africa from the British government with the ultimate view to managing her own political and socio-economic affairs without the intervention of the British government and further attention is given to the declaration made by South Africa to consolidate and unify the four former British colonies or republics. After the end of the Second World War the National Party, with its ideology of apartheid that brought about an even more rigorous authoritarian approach than the segregationist policies of previous governments, won the general election in 1948 (South African Yearbook 2007/08:35). The British administration in Southern Africa was extended from 31st May 1902 beyond the self-governing colonies of the Cape, Natal, the High Commission territories of Lesotho, Botswana, Swaziland and the countries under the administration of the British South Africa Company, Southern Rhodesia now called Zimbabwe and Northern Rhodesia, now called Zambia. The two former Boer republics, designated as the Orange River Colony and Transvaal, became British colonies. The four South African territories became British Colonies on 31st May 1902. The Cape Colony had had responsible government since 1872; the Natal Colony had been a self-governing member of the British Empire since 1893 (Liebenberg and Spies, 1993:20 and 30).

The delegation of the Union of South Africa in 1910 did not motivate or stimulate black people to take any active part in the political and socio-economic affairs of the country because of the
sustainability of the apartheid policy. Therefore, according to Hertzog, the solution to the so-called ‘native problem’ was to be realized primarily in a policy of segregation. He believed that the white people and their civilization were doomed unless there were territorial and political segregation in South Africa. He acknowledged that there could be no absolute segregation since African labour was indispensable to the economy of this country. Subsequently, Hertzog embarked upon a campaign to assert South Africa’s right to control her hard-won international destiny in 1912. The South African government was no longer interested in being under the control of Great Britain. It, therefore, took a resolution in 1961 by means of which it transformed this country into a republic and it effectively quit the Commonwealth so as to effectively assume independence from Great Britain (Davenport and Saunders, 2000:269, Pape et al, 2007:266; Thompson, 2000:182 and 183).

2.2.1.2 The declaration of the Union of South Africa in 1910

2.2.1.2.1 The disengagement of South Africa from Great Britain

The declaration of the Union in 1910 by the apartheid regime prompted a number of political influences such as the initial victory in the 1948 election by the National Party, empowering it to consolidate its political power as the United Party was defeated in that election and it eventually used its mandate to fulfil Afrikaner ethnic and white racial goals. The establishment of the Union of South Africa rapidly turned into dissatisfaction especially among the Indians, African republics, the White mineworkers and the black people of this country because they strongly opposed and objected to the policy of the regime (Liebenberg and Spies, 1993:51; Muller, 1993:585; Thompson, 1995:190).

The South African Party led by Louis Botha and Jan Smuts came into power in the Transvaal in 1907 and some semi-skilled work was reserved solely for white people as they imposed and enforced racial discrimination against the black inhabitants to ensure that the Afrikaner people got work at the expense of the indigenous people of South Africa. After Hertzog and Smuts had formed the coalition government in March 1933 and subsequently formed the United Party in 1934, the United Party, in terms of the Status of the Union Act (1934) reinforced the Statute of Westminster, declaring that the Acts of the British parliament would no longer be
recognized and enforced as valid in South Africa unless they were also enacted by the South African parliament (South Africa Yearbook, 2007/08:37; Thompson, 2000:153 and 157).

The Afrikaner people consolidated their control over South Africa in 1948, strengthened their political position by overcoming the black population and eventually eliminated the British government’s control over the affairs of South African inhabitants. The people of British origin virtually monopolized the entrepreneurial, managerial and skilled positions in every sector of the economy and politics in this country except in agriculture. This resulted in Afrikaner settlers being driven off the land as agriculture became extensively capitalized. The Afrikaner people found it difficult at the time to adapt to the urban economy except as unskilled workers and as such they were liable to encounter competition from among the black people. The industrial development gradually reduced the magnitude of the state aid, pervasive colour bars and poverty and subsequently some Afrikaner people were appointed in top positions throughout the country in 1948 without recognizing the available potential skills and abilities of the black people. The black people who were regarded as subordinate to the white people did manual work in the white households, worked in the factories and mines, and also on the arable land, however feeble they were. The income of the white people per capita in South Africa was ten times more than that of the black people, reflecting the prevalence of economic discrimination. At that time the white people were better paid while the black inhabitants were poorly paid, earning very low wages and causing the widening of the wage gap between white employees and black labourers. The black people were dissatisfied with the prevailing unfavourable economic conditions to which they were subjected in the country (South Africa Yearbook, 2007/08:37; Thompson, 2000:150 and 151-182).

The Union of South Africa that was richly endowed with minerals was founded in 1910 and the unification brought considerable economic advantages to this country. The evidence of the availability of iron, gold, coal, copper and tin mining in the Cape and Transvaal in pre-historic times was a true reflection of the prevailing favourable economic situation. Job opportunities were available but the challenge that prevailed was that the policy protected the white labourers while offering preferential treatment to them over the indigenous black labourers. In terms of the government’s policy of labour reservation or ‘civilized labour’ as it was sometimes called, certain job opportunities were reserved for people who measured up to certain standards of being ‘civilized’ as perceived from the white perspective. ‘Uncivilized
labour’ meant a specific type of work which was done by people whose purpose was simply to acquire the most basic necessities of life as was the case with the so-called ‘barbarians’ or ‘undeveloped’ people in this country. In practice, this meant preference was given to the employment of white people and Coloureds above the black people in government departments and municipalities against the afore-mentioned background of unfavourable agricultural conditions and subsequently it was understandable that there was some resistance against the labour reservation policy which disadvantaged, undermined and marginalized the black people (Liebenberg and Spies, 1993:23 and 180).

During the period under review the economy of the country improved tremendously due to the gold-mining industry, which made a major contribution to the national budget and provided enough foreign exchange for essential imports such as fuel and heavy machinery. The white farmers also received huge state subsidies while manufacturing expanded prodigiously after 1933. The country produced a lot of coal but unfortunately there was no oil and in order to sustain its economic growth, it needed large inputs of foreign capital and technology. By 1948 the economy of the country was nearly self-sufficient. During this period the British government was greatly involved in the transformation of those republics and successive British administrations also tried to prevent rivals such as Germany and France from encroaching on the territories dominated by the British government because British politicians and business people had vested interests in the mineral wealth of this country as a matter of national importance and prosperity.

When Verwoerd became the Prime Minister in 1958, he quickly terminated all political ties with the British government following the favourable outcome of the 1960 election in which the white people expressed themselves in favour of the proposal that South Africa should declare its independence from the British government so that she could effectively manage her affairs without the political intervention of Great Britain (Pape et al, 2007:337).

After achieving a major ethnic objective in 1961, the government transformed South Africa into a republic, thereby completing the process of disengagement from Great Britain. South Africa came increasingly under the control of the white people, especially the Afrikaners. The government raised the standard of living of white South Africans of all classes, especially the Afrikaners, and they subsequently became the principal beneficiaries while the standard of
living of the black people significantly declined and deteriorated as they were excluded from taking any meaningful and active participation in the socio-political and economic matters affecting themselves as South African citizens. The South African government decided to sever political and economic ties with the British government in order not to sustain interdependence and interrelations with Great Britain so that she would be able to practice the apartheid policy without the objection and opposition of Great Britain and other international communities in the world (Liebenberg and Spies, 1993:297; Thompson, 1995:190).

In terms of the segregation policy that was included in the South Africa Act, only white male adults over the age of 21 years were permitted to vote and become members of parliament. But in the Cape Colony a few black male voters with certain economic and education qualification were allowed to remain on the voters’ roll for a certain limited period. Cape Town subsequently became the legislative capital, where Parliament conducted its legislative activities, while Bloemfontein became the judicial capital and Pretoria was identified as the administrative capital of this country (Cloete, 1986:29; Muller, 1993:385).

The white people conquered the indigenous inhabitants of South Africa in 1910, the people whom the white people classified as the coloured people who scarcely owned any land and property but surprisingly at that time many black farmers were still able to practise very limited agricultural farming called subsistence farming. Thompson (2000:170) quotes one of the founders of African National Congress, Pixley ka Isaka Seme as having said that “… in the land of their birth, Africans are treated as hewers of wood and drawers of water” … The white people of this country have formed what is known as the Union of South Africa – a union in which we have no voice in the making of the laws and no part in their administration. We have called you therefore to this Conference so that we can together devise ways and means of forming our national union for the purpose of creating national unity and defending our rights and privileges”. The apartheid government enacted a crucial law called The Natives Land Act (1936) without consulting and involving any of the black people. This Act prohibited the indigenous inhabitants from purchasing or leasing land outside the reserves from those who were not black people. This discriminatory practice was intensified after the inauguration of the Union of South Africa in 1910. Those areas set aside for the black people, constituting 11.7% of South Africa, were destined to be treated as the ‘homelands’ of all the black
inhabitants of South Africa in the apartheid era and were scattered throughout the eastern half of the country.

The draft South Africa Act, which was taken to Britain by a delegation from South Africa, was signed as the South Africa Act. It came into force on 31st May 1910, that is, eight years after the Vereening Peace Treaty was signed. The four provincial authorities were established on 31st May 1910 when the colonies of the Cape of Good Hope, Natal, the Orange Free State and the Transvaal integrated to form the Union of South Africa after long deliberations at a National Convention between British and South African representatives (Pape et al, 2007:228). Although the Constitution of 1910 integrated four provinces of South Africa under a single government, it is interesting to note that those provinces did not make South Africa in all respects a sovereign independent state but there were reasons why unification or federation of the four provinces appealed to many white South African leaders and their followers. Their belief in their being Afrikaners was that it could strengthen Afrikaner nationalism and solidarity (Davenport and Saunders, 2000:268; Liebenberg and Spies, 1993:45).

The establishment of the Union of South Africa in 1910 was one of the most significant political developments in the history of this country. General Louis Botha became the first Prime Minister of the Union of South Africa. The Union was expected to expand and incorporate Rhodesia (now called Zimbabwe) and the three British Protectorates (now called Botswana, Lesotho and Swaziland). During that period the Union of South Africa had a government but there was no Parliament. General Louis Botha wished to form a new comprehensive party that would embrace both the Afrikaners and the British settlers in order to eliminate white racialism while making a success of the Union and encouraging real solidarity of Afrikaner people in this country (Cloete, 1986:29; Liebenberg and Spies, 1993:85; Muller, 1981:385; Van Jaarsveld, 1975:228 and 229).

The period 1910 to 1939 was characterized by successive South African administrations which consolidated white power in the Union of South Africa. The Afrikaner people were aggrieved by the participation of South Africa in the First World War. The declaration of the Union of South Africa constituted the last phase of the pre-transformation period from 1910 and ended with the general democratic elections held in 1994. The Constitution under which the four South African colonies were integrated in 1910 to form the Union of South Africa gave the
white government the monopoly of political representation. The Union of South Africa, which later became the Republic of South Africa, comprised of four provinces, namely, the Cape of Good Hope, the Natal, the Orange Free State and the Transvaal (Cloete, 1986:29; Omer-Cooper, 1994:155; 158 and 159; Thompson, 2000:150).

In 1961, the National Party government under Prime Minister HF. Verwoerd declared South Africa a republic after winning a whites-only referendum on the issue. South Africa had to apply for continued membership of the Commonwealth after becoming a republic. In view of the continuous demands for an end to the apartheid policy, the South African government eventually withdrew its application to be a member of the Commonwealth and subsequently a figurehead president replaced the British Governor-General as head of state (South African Yearbook 2007/08:37).

The National government policy in the Union of South Africa did not only develop in isolation, but against the backdrop of black political initiatives due to the fact that both segregation and apartheid policies assumed their shape in part as a white response to increasing African participation in the country’s socio-economic life and their assertion of political rights (South African Yearbook 2007/08:35).

2.2.1.3 The fragmentation of the Republic of South Africa

The establishment of the Union of South Africa on 31st May 1910 ushered in a new period in the history of South Africa and the Union brought to an end the political strife, which had lasted for more than 50 years and integrated the four colonies, namely, the two former Afrikaner republics and the two British colonies, into one unified country. When the Union of South Africa came into being on 31st May 1910, the government of the new state had already been designated, but there was no Parliament and the existing political trends grew in scope, tempo and force. Debates about the homelands were central to critiques of apartheid policy. The very word ‘homeland’ stimulated unease and tension especially among the black inhabitants because it seemed to lend legitimacy to the state’s policy of balkanization and exclusion. The opposition forces preferred to retain the word ‘reserves’ or use the word ‘Bantustan’ as designated territories to be occupied by the indigenous people only of this country. Black communities were forcefully dislodged displaced and scattered in the barren
land; recreational and health facilities as well as the employment were minimal (Beinart, 1994:203; Cloete, 1986:29; Liebenberg and Spies, 1993:345; Muller, 1981:385).

In spite of South Africa’s becoming a Union in 1910, the South African government was still keen to continue promoting the policy of segregation that saw many black people forcefully displaced and removed to barren areas of land where there were no basic services. It is often mentioned that 87% of the land was reserved for the white people and only 13% of South Africa was designated for the use of the indigenous black people in terms of the Natives Land Act of 1913. This was the manner in which the majority of the indigenous inhabitants of this country were treated by the white minority government (Liebenberg and Spies, 1993:346 and 347 and Thompson, 2000:170).

Dr HF. Verwoerd, the architect of the policy of separate development, who was appointed Minister of Native Affairs on 18th October 1950, strongly believed in the ideal of total segregation of the South African black population. To justify his argument he indicated that the black people might develop to the highest level of self-government and self-determination through segregation and local self-government, which, according to him, was an ideal situation by means of which he then set about reshaping and transforming the whole political structure as it affected particularly the black people. Verwoerd was perceived by the black people as trying to effect a turning point in political perspective for the black people by taking unilateral decisions on their behalf without any consultation, and segregating them from the white people. His political elevation together with that of the Secretary of the Department of Native Affairs, WM. Eislen, marked the significant promotion and intensification of the apartheid ideology over the more pragmatic administrators of the previous years. In order to strengthen his policy of segregation, Verwoerd ultimately gave less educated traditional leaders, namely, the black chiefs and headmen, the opportunity to participate actively in their own political affairs, marginalizing and excluding the direct participation of the well-educated ordinary black people in this country as he was afraid of their political influence among the black communities (Liebenberg and Spies, 1993:346 and 347).

South Africa had been a fragmented country since time immemorial because the entire country had been occupied by different tribes such as the Khoikhoi, the Zulus, Xhosa, Venda, Pedi, and Tsonga even before the arrival of Jan Van Riebeeck in 1652, and thereafter by English-
speaking people and lastly Afrikaners, who, after the establishment of the Union of South Africa, aggravated the fragmentation of the country by promoting the partitioning of South Africa into poor, uneconomic and unsustainable ‘homelands’ and ‘self-governing’ territories. The fragmentation of the Republic of South Africa was strongly reinforced and strengthened, among others, by the establishment of ‘homelands’ and ‘territories’, the creation of the Coloured Persons Representative Council (CPRC) in 1975 and the empowerment of the black people residing in the so-called urban ‘white areas’ (Cloete, 1986:28). These three factors receive brief attention under items 2.2.1.3.1, 2.2.1.3.2 and 2.2.1.3.3 respectively below.

2.2.1.3.1 The creation of ‘homelands’ and ‘territories’ in South Africa

The Verwoerd era commenced with two major changes in the political arena of South Africa since the illusions of Dr Verwoerd were shattered and no international government recognized the independence of all ‘homelands’ and ‘territories’. The first one was the firm commitment of the government to a policy of some kind of independence for the territories occupied by black people and the second one was the decision of the government to declare this country a Republic, which eventually led to South Africa’s departure from the Commonwealth. Black resistance became more formidable than before due to Soweto uprising when all black people became involved in efforts to liberate South Africa from the apartheid regime. Both these developments reached a climax in the Sharpeville massacre in March 1960. Verwoerd committed himself to independence for the reserves, always limiting his promises to self-government of the black populations under the firm control of and uncompromising administration by the government of South Africa (Davenport and Saunders, 2000:407; Thompson, 2000:215 and 222).

The transformation developments revealed themselves in many ways and also to the extent that even Verwoerd conceded that the apartheid policy could lead to the creation of a number of ‘independent’ black territories within South Africa, which would naturally entail the eventual fragmentation of South Africa. The granting of greater powers to the black authorities in the ‘homelands’ was carried a step further with the Promotion of Bantu Self-government Act of 1959, which abolished parliamentary representation for black people. The afore-mentioned Act classified the black people in South Africa into 8 “Bantu ethnic units”, namely, the North Sotho, South Sotho, Swazi, Tswana, Xhosa, Zulu, Tsonga and Venda. Each of these ethnic
groups had its own ‘homeland’ and the Xhosa even had two separate ‘homelands’, namely, the Transkei and the Ciskei. The black people who did not wish to live in the ‘homelands’, but worked in the so-called ‘white areas’, were also assigned to a particular ‘homeland’ for political reasons and were regarded as ‘homeland’ citizens who had a right to vote in those respective ‘homelands’ and ‘territories’, against their will, and all such decisions were taken on their behalf without any consultation by the apartheid government (Muller, 1993:489 and 490).

The policy of separate development was supported, among others, by the 1953 Bantu Education Act, the purpose of which was to prevent black learners from being given a high standard of education similar to that of white learners because the perception of the apartheid regime was that it would lead them to aspire to better positions which they would not be allowed to hold particularly in the white communities in this country (Omer-Cooper, 1994:201).

It merits mentioning that the unilateral territorial partitioning of South Africa had its origin in the Land Act of 1913 and in the political segregation effected by the Representation of Natives Act of 1936. The National Party evolved and developed its apartheid policy of unilateral partition. The result was that the four independent territories of Transkei, Bophuthatswana, Venda and Ciskei (TBVC) came into existence and consequently the citizens of these independent territories were deprived of their South African citizenship. The grand apartheid policy resulted in a manifestly inequitable distribution of land and property among the majority (black people) and the minority (white people) and the consequent flagrant social and economic inequality. During the period of ‘baaskap’ the South African government paid no more than lip service to the idea of developing the reserves for the black people. The system of government that was agreed upon after the lifting of the ban on liberation movements, political prisoners and political leaders in 1990 was totally different from any of the previous systems that operated in South Africa from 1910 to 1990 (Omer-Cooper, 1994:213 and 14; Thompson, 2000:186).

From its inception, the policy of apartheid accorded great discrimination against the black people in the ‘homelands’. Those ‘homelands’ and territories eventually and automatically became the national homes of all black inhabitants of South Africa, including those who were residents in the ‘white areas’. The first ‘homeland’ to opt for the apartheid system was
Witsieshoek, now called Qwaqwa, which was situated near Harrismith. Subsequently, several other ‘homelands’ in the Transvaal followed the Qwaqwa territory, but the most important ‘homeland’ of all, the Transkei, continued to demand a greater degree of representation in the white Parliament. Kaizer Matanzima succeeded in persuading the Bunga Authority to accept the system of black authorities; hence the Transkei became the first ‘homeland’ to receive a territorial authority, the third level of ‘self-government’ in the system of black authorities in May 1957 (Muller, 1981:486).

The first major step towards the constitutional development of the homelands in South Africa came in 1963 when the Transkei was granted a considerable measure of self-government. The formulated Constitution Act of 1963 of Transkei became law in March 1963, giving the Transkei territory its own Legislative Assembly, which consisted of a total number of 109 members, that is, 64 chiefs and 45 legislative seats that were held by the elected members. Its statutes were subjected to the approval of the South African government before implementation since its political and economic activities were constantly and strictly under the scrutiny of the apartheid regime. Furthermore, it clearly signified that Transkei was not independent in the real sense of the concept and that although the Transkei territory had been given a large degree of so-called ‘self-government’ in 1963 within South Africa; the key portfolios remained strictly under the control of the South African national government. The Transkeian Cabinet controlled all portfolios save defence, internal security, postal services, railways, immigration, money and banking, and customs and excise, as these remained solely under the control of the South African government. Subsequent to the acceptance of the concept of ‘separate development’, the Transkei eventually forfeited South African citizenship and acquired its own and all the Xhosa people living within and outside the territory were declared Transkeian citizens whether they preferred it or not since they had no chance to retain the South African citizenship after 1993 (Liebenberg and Spies, 1993:433; Muller, 1981:522 and 1993, 522). The Transkei, under the leadership of Kaizer Matanzima, was the pioneer of those to be coerced into accepting the imposed self-governing status which benefited none of the inhabitants of the Transkei.

Subsequent to such political developments, Dr HF. Verwoerd instructed Kaizer Matanzima, when he opted for independence, to ensure that the Constitution for Transkei remained within the concept or framework of separate development and that it “… will be no multiracial
Transkei as far as its government is concerned”. This showed that the South African regime continued to have much political and economic control over Transkei in spite of her intended ‘independence’, the reason being that all the white people still remained full-fledged citizens of the Republic of South Africa in spite of the fact that they were living and working within the respective ‘homelands’ and ‘territories’ (Liebenberg and Spies, 1993:433; Muller, 1981:522).

The Transkei was the first homeland of the black people to obtain Territorial Authority. The partial self-government, which the Transkei obtained in December 1963, paved the way for similar constitutional developments in the other remaining ‘homelands’. Other black territories in this country followed the path of the Transkei despite the fragmented nature of all the ‘homelands’. Bophuthatswana, the Ciskei and Lebowa became partially self-governing in 1972 and Gazankulu and Venda followed suit in 1973. During the following year, 1974, the Basotho Qwaqwa territory also obtained partial ‘self-government’. In spite of the fact that in March 1970 Vorster had already announced that any ‘homeland’ was at liberty to ask for complete ‘independence’, the KwaZulu territorial authority turned down the political offer of ‘independence’ since the territory was still an integral part of South Africa (Liebenberg and Spies, 1993:434; Omer-Cooper, 1994:213 and 214).

The emancipation of the first homeland of the black people and the establishment of self-government in the Transkei was a great political event in the history of South Africa. The Prime Minister, Mr. John Vorster, promised independence in 1973 to the black homelands and in 1974 he promised Transkei full sovereign independence. The marginalized black inhabitants who then constituted sixty-nine percent (69%) of the total population of the Union of South Africa continued to live in the poverty-stricken ‘homelands’ or ‘territories’ and villages, still acknowledging the political authority of their respective chiefs and headmen to whom they were subjected (Thompson, 2000:215).

In terms of its Constitution, the Transkei, instead of incorporating the apartheid ideology as envisaged by Verwoerd, became a multiracial state in which all citizens including both the black people and white people of Transkei and South Africa had the same franchise. No other country except South Africa recognized the ‘independence’ of the Transkei. In spite of the attitude adopted by the rest of the international communities towards the Transkei, its non-recognition did not prevent Bophuthatswana from following the same course already taken by
the Transkei. Bophuthatswana, which became ‘independent’ on 6th December 1977, consisted of six (6) enclaves or small separate territories; this made sustainability in terms of coordination and administration very difficult and almost impossible. The four so-called “independent states” eventually established by the racist government within South Africa were the Transkei, Bophuthatswana, Venda and Ciskei (TBVC). A further six so-called ‘self-governing territories’ established in an endeavour to promote the policy of separate development for the various indigenous people were the now defunct Gazankulu, KaNgwane, KwaNdebele, KwaZulu-Natal, Lebowa and Qwaqwa and the racist regime deliberately fragmented and partitioned the entire afore-mentioned ‘homelands’ and ‘territories’ of the Republic of South Africa (Cloete, 1986:28; Davenport and Saunders, 2000:478; Thompson, 2000:90).

The other 2 territories, which became partially ‘self-governing’ within the Republic of South Africa, namely, Swazi and Ndebele, did not have their own Legislative Assemblies. Since the political crisis of power-sharing had no obvious reference to the black people as full-fledged citizens of South Africa, most black people began to react negatively to the denationalization of the people in the ‘homelands’ and ‘independent’ territories since the Transkei and Bophuthatswana obtained their independence in 1976 and 1977 respectively and Venda acquired it on 13th September 1979 and Ciskei in 1981. The government intended that as each ‘homeland’ acquired full sovereign status from South Africa, its citizens would automatically lose their South African citizenship and retain that of the ‘homeland’ only, even if they continued to live and work in the Republic of South Africa (Liebenberg and Spies, 1993:434-435; Davenport and Saunders, 2000:478).

The ‘separate development’ policy divided the African population into artificial ethnic ‘nations’, each with its own ‘homeland or ‘territory’ and the prospect of ‘independence’, supposedly in keeping with trends elsewhere on the continent, as the methodology of trying to vigorously implement the apartheid system. This divide-and-rule strategy was designed by the apartheid regime to disguise the racial basis of official policy making by the substitution of the language of ethnicity. The truth was that the rural reserves were by this time thoroughly degraded by overpopulation and soil erosion. This, however, did not prevent four of the ‘homeland’ structures, namely, Transkei, Bophuthatswana, Venda and Ciskei, being declared ‘independent’, the political status of which the vast majority of black South Africans and also
the international community declined to recognize. The forced removals from ‘white’ areas affected some 3.5 million people and vast rural slums were created in the ‘homelands’, which were used as dumping grounds. The pass laws and influx control were extended and harshly enforced upon the black people.

THE APARTHEID ERA: 1948 - 1978

Figure 2.1: The African ‘Homelands’ of South Africa: [www.sahistory.org.za](http://www.sahistory.org.za)

The reserves (‘homelands’) as they were subsequently called eventually comprised about 13% of South Africa’s land surface (South African Yearbook 2007/08:37 and 38).
2.2.1.3.2 The creation of the Coloured Persons Representative Council in 1975 in South Africa

While the black South African communities were granted ‘self-governing’ and ‘independent’ political status by the government of South Africa, the vision of how the political aspirations and ambitions of the Coloured people in this country were to be realized and accomplished was not quite clear to Prime Minister Verwoerd, as he was strongly opposed to the socio-political integration of the white people and coloureds as well as the black people. He was not altogether satisfied that coloureds were still represented in the House of Assembly by 4 white members as he also wanted whites and coloured people to develop separately from the white community, like the black people. In December 1961, he mooted the possibility of a parliament for coloureds and a cabinet with limited legislative power. The Coloured Persons Representative Council (CPRC) was constituted during the era of Prime Minister BJ Vorster in March 1975 for the coloured people in particular as they were no longer allowed to be represented by the white members in the white Parliament. This was one of the mechanisms by means of which the apartheid policy was implemented, enforced and justified among the Coloured people in this country (Liebenberg and Spies, 1993:436-437).

2.2.1.3.3 The empowerment of black people in the ‘white areas’ in South Africa

The major premise of the racial policy in South Africa since the declaration of the Union was that the urban black inhabitants were temporary sojourners and were encouraged to “develop along their own lines”, preferably in the reserves. The apartheid government considered the urban black residents as directly linked to their respective territorial authorities through their tribal representatives appointed by the new political structures. In spite of remaining in the so-called ‘white areas’ such black people were never given any opportunity in terms of permanent residence (Liebenberg and Spies, 1993:345 and 357).

The pass laws were applied by the apartheid government to prevent the black people domiciled in the ‘homelands’ from staying permanently in the cities. They were allowed to be migrant workers on temporary contracts only subject to renewal between the white employers and the black labourers. Many black people went to the cities because their ‘homelands’ could not provide them with adequate and satisfactory job opportunities. Their economic and educational
background could not sustain a decent livelihood. The Natives Land Act of 1936 was imposed upon black people to ensure that they were confined to their ‘independent homelands’, which included the Transkei, Bophuthatswana, Venda, the Ciskei (TBVC) and other territories such as Gazankulu, KaNgwane, KwaNdebele, KwaZulu, Lebowa and Qwaqwa as they were regarded as aliens in this country of their birth in terms of the apartheid policy. To compound that undesirable labour practice, the white employers were not allowed to employ black labourers without obtaining special official permission from the apartheid government of South Africa (Thompson, 2000:186).

During Verwoerd’s leadership era, the National Party government implemented the apartheid system in a plethora of laws and executive actions. In practising the apartheid policy, the white people were the only entitled population group and had absolute control over the management and administration of the government system. The interests of the white people prevailed over those of the black people since the government was not obliged in any way to provide equal facilities, goods and basic services for the subordinate races, namely, the black inhabitants of South Africa. The white racial group formed a strong single nation while black people were divided in terms of ethnic, political and geographical perspectives, thereby separated from one another into enclaves or smaller ethnic groups and eventually into ten ethnic groups, thereby making the population of the white nation presumably the largest in the country (Thompson, 2000:184).

As another way of promoting the apartheid system and also as part of its attempt to meet the challenge of 1976, municipal councils under the authority of the Bantu Affairs Administration Boards (BAABs) were established, which governed and implemented the policy of the government on forced removals and displacement of about 3.5 million black people. As a reflection of other attempts to bring about transformation and devolution of power to the urban residents they similarly extended their rights as the black people residing outside the homelands since they could not exercise control over matters such as housing, rent and services as it was considered to be a provincial competency. The main objective of the enforcement of the apartheid policy was that it required that the existing legislation deny black people their birthright, permanent residence and property ownership outside the reserves and furthermore required the extensive and close control of the influx of black people into urban
areas as unwanted people other than to provide labour (Beinart, 1994:237; Omer-Cooper, 1994:196; South Africa Yearbook, 2007/08:38).

The position of the chiefs and headmen installed under the Bantu Authorities Act was often an invidious one since Dr Veword’s system of Bantu Authorities reflected his strong belief that there was no place for the participation of the black inhabitants in the white political system. His resuscitation of tribalism was clearly intended to revive and strengthen the political and geographical barriers between white people and black people. According to Verwoerd’s premise, the black people in the urban areas in South Africa were regarded as temporary visitors and he regarded all the black people whether born in the urban areas or not as belonging to the reserves, homelands or ‘territories’, the same as the black inhabitants who had never departed from them (Liebenberg and Spies, 1993:297).

The problem was that 54% of black people did not live in their self-governing ‘homelands’, namely, Gazankulu, KaNgwane, Kwandebele, KwaZulu Lebowa and Qwaqwa, but outside their respective ‘homelands’ and ‘territories’ in the so-called ‘white areas’. They were not interested in being under the political control of their respective ‘homelands’ that were located hundreds of kilometers away and some of whom had never been in those ‘homelands’ and ‘territories’ or ever seen them. The apartheid government gradually began to realize from the numerous demands of urban black people living outside the ‘homelands’ that they, too, should be granted political power in the areas where they lived since politically, socially and economically they could not be ignored indefinitely and it was then opportune for the apartheid government to bring about some immediate transformation due to the prevailing unfavourable socio-political conditions brought about by the economic sanctions imposed upon South Africa by the international community (Liebenberg and Spies, 1993:434).

2.2.1.4  International sanctions and political violence in South Africa

This section identifies and presents some sanctions imposed by the international community upon the Republic of South Africa and the political violence the country severely went through, which was inflamed and exacerbated by the furious actions of some local members of the communities and political organizations as the determining factors that forced this country to gradually and reluctantly yield to the transformation process with a view to attaining
democracy and, subsequently, move away from its undesirable apartheid policy so that South Africa could be declared a country that belongs to all its citizens regardless of colour, gender, race and creed.

2.2.1.4.1 External pressure

The following were some of the most important factors that significantly contributed to the collapse of white power and the supremacy of the National Party government in South Africa since September 1985 when the American Congress imposed a number of sanctions against South Africa (Liebenberg and Spies, 1993:509).

The Republic of South Africa experienced international isolation for a long period of time as a result of the country’s apartheid policy, and at home, too, uncertainty took its toll in many spheres of life. The economic growth of South Africa was inhibited owing to a lack of internal business confidence, the imposition of sanctions and disinvestment by international corporations. The public officials, elected representatives and citizens of the country clearly experienced uncertainty in their various functional spheres (Pape et al, 2007:352).

Economic sanctions imposed upon South Africa by the United Nations (UN), some of the western countries and internal politically-motivated violence were regarded as the major factors that contributed towards the emancipation of black people from persistent domination by the white minority government that had been in power for several decades and consistently denied the inhabitants of this country the opportunity to actively participate in the socio-economic and political issues that directly affected their lives. The UN declared the apartheid policy a ‘crime against humanity’ and called upon all its member countries to effectively impose economic sanctions or to stop any form of trading with South Africa (Pape et al, 2007:352).

The combined pressure of the external and internal influences left the apartheid government with no choice other than to abandon or relinquish the apartheid policy in the 1990s, paving the way for the internationally recognized democratic governance system to prevail in South Africa. The refusal of the international community to recognize the independence of the Transkei, Bophuthatswana, Venda and Ciskei signified that South Africa’s policy of separate
development, of which Transkei was the first product, was completely repugnant to them. The black people of South Africa were completely opposed to the implementation of the apartheid policy as it discriminated against them politically, socially and economically (Pape et al, 2007:354).

The Republic of South Africa sustained her political ties with the Portuguese government that had been established on the Mozambique coast for more than 50 years during the period between 1840 and 1890. After the Second World War both South Africa and Portugal were subjected to pressures from the Black African states and from the United Nations because there was close co-operation between the two neighbouring countries in practising the apartheid policy at the expense of the black majority population groups. The defeat of Mozambique by the freedom fighters for African nationalism, however, presented a serious threat to the government of South Africa. When the freedom fighters (then called the terrorists) finally made swift inroads into and conquered the government of Mozambique, following the defeat also of the Portuguese government in Angola, the Republic of South Africa realized how important the holding actions of the Portuguese were at that time (Muller, 1981:554 and 555).

In 1958, Prime Minister Verwoerd presented a proposal to the Commonwealth that South Africa would remain as a member of the Commonwealth as an independent republic; but other countries like India and the newly independent Ghana strongly objected to South Africa’s proposal of being independent, arguing that the country could not become a republic while still practising the apartheid system. Prime Minister Verwoerd went ahead and declared South Africa a republic on 31st May 1961, choosing to operate outside the political and economic jurisdiction of the Commonwealth. This was one of the first steps taken by members of the international community towards imposing strict isolation on the Republic of South Africa. It is worth noting that South Africa was one of the founding members of the United Nations (UN), which drew up the Charter. Moreover, she supported unreservedly the objectives of the UN, which were designed to maintain international peace and stability. The political developments in South Africa in 1961 were characterized by her declaration of independence, ending her political ties with the British government in order for this country to become a republic that was discriminatory against the black people. The United Nations adopted an even more critical stance against the South African government for imposing the apartheid policy (Pape et al, 2007:337).
General Antonio de Spinola, a veteran of recent campaigns in Africa, headed a coup leading a group of the young freedom fighters who eventually overthrew the Portuguese government on 25th April 1974 and furthermore ended the military and political co-operation between South Africa and the Portuguese governments as well as the decolonization of Angola by the Portuguese. After the defeat, the Portuguese Colonies, namely, Mozambique and Angola were taken over by the left wing called the Frelimo organization on 25th June 1975 and 11th November 1975 respectively when the Portuguese government finally collapsed in both colonies. The Portuguese settlers in both territories, while still bewildered at the manner in which the political transformation took place in Mozambique, were apprehensive of their future under the new political leaders. They began to abandon their farms, homesteads and businesses in a general exodus by land, sea and air. The dissolution of the Portuguese colonial empire subsequently gave South Africa little hope and confidence, and no choice but to adjust and increase her relationship with Rhodesia (now called Zimbabwe) under the leadership of the Prime Minister Ian Smith. By 1976, the problems of southern Africa had already reached such proportions that the US Secretary intervened personally (Muller, 1981:554, 564 and 568).

There were growing demands from foreign countries that South Africa should relinquish its policy of apartheid and permit black people to participate actively in the government. As a way of intensifying the opposition against the apartheid policy, anti-apartheid demonstrations were set in motion in November 1984 outside the South African embassy in Washington DC and, as a result, the American Congress was no longer prepared to oppose the imposition of sanctions against South Africa. The Swedish government intensified its existing ban on economic investment in this country in February 1985 followed by Denmark in May 1985. Moreover, the French government forbade further economic investment in South Africa while the American Chase Manhattan Bank announced that it would not “roll over” its loans to South Africa. The continued suspension of foreign loans, the withdrawal of foreign capital and the imposition of harsh trade sanctions against South Africa had suddenly become realities for the political future of South Africa (Liebenberg and Spies, 1993:509).

Other foreign banks operating in South Africa immediately followed Chase Manhattan’s example and demanded the immediate repayment of their loans and consequently the attitude of these overseas banks led to a crisis of confidence in the South African economy. It further led to foreign investors’ beginning to sell their South African shares and the Johannesburg
Stock Exchange unexpectedly closed for three days as a reaction to the financial crisis. Subsequent to these harsh foreign economic transformations the South African government indicated that reforms might be forthcoming in this country which was inclusive of the participation of the black people (Liebenberg and Spies, 1993:509).

The South African government was at the crossroads when the announcements were made that Mozambique and Angola were due to become independent states in June 1975 and in November 1975 respectively. The withdrawal from those colonies by the Portuguese government caused uncertainty in South Africa because the prospective new black governments would be unsympathetic towards the South African government due to her apartheid policy. The uncertainty and fear were based on the assumptions of the possibility that the new black government of Mozambique would give support to the African National Congress (ANC) in its armed struggle against the South African regime while on the other hand the Angolan government would also permit the Swapo Organization to invade and attack South West Africa (now called Namibia) from that country subsequent to the ascension to power of those former Portuguese colonies (Liebenberg and Spies, 1993:443).

Subsequent to the political confrontation that developed between South Africa and the international world during the premierships of both the Prime Ministers Verwoerd and Vorster, an international political threat of economic confrontation or sanctions emerged, as part of an international bid to force South Africa to abandon her discriminatory policies. The foreign countries, which strongly opposed the apartheid policy of South Africa, promoted and encouraged the implementation of disinvestment, that is, the sale of companies and shares and various forms of sanctions such as the arms embargo. Some companies in the western countries, which traded directly with South Africa, exerted more trading pressure by making expatriate firms in the Republic of South Africa eventually take the initiative in the elimination of the apartheid policy by means of laying down codes for employment and persuading business organizations to adopt them, but those firms resented the intrusion as interference into their own privacy. The codes, however, did not resolve the problem of employment since they did not resolve the real difficulties of the black workers as they did not help promote the integration of facilities and the opening up of new employment avenues for black people in the workplace in a number of instances. The codes were not effective enough because they did not
remove the apartheid policy as had been anticipated (Davenport and Saunders, 2000:533 and 534).

The imposition of trade sanctions intensified into a campaign at the United Nations during the 1970s when the Republic of South Africa refused to support the boycott of the now defunct Rhodesia (now called Zimbabwe) because it undermined the effectiveness of that campaign by relying on the vetoing of resolutions demanding sanctions by one or more of the trading partners with permanent seats on the security Council, namely, the United States, Britain and France. The disinvestment by foreign firms took place on a considerable scale as an option to try and force South Africa to abandon her apartheid policy (Davenport and Saunders, 2000:535 and 537).

The issue pertaining to sanctions was particularly intensely debated by the international community because of South Africa’s strategic position since she was the guardian of the Cape route and also on account of this country’s position with enormous reserves of minerals which were vital to the weapons system of the West. Western strategists were divided over the importance of the Cape route and the calculation was hard to make after the Soviet navy had acquired facilities in the Indian Ocean for the first time. Rhodesia’s Unilateral Declaration of Independence (RUDI) by the Prime Minister Ian Smith in 1965 increased South Africa’s difficulties regarding the imposition of sanctions by the international community (Davenport and Saunders, 2000:530 and 540).

The South African economy at that time was extremely attractive to American and European business and defence interests. The British government, which was the former colonial power in South Africa, had by far the largest foreign stake in the economy of this country, but what transpired during the boom years of the 1960s and early 1970s was that the American and continental European trade and investments grew spectacularly and by 1978 the United States had already surpassed Britain as South Africa’s principal trading partner. Furthermore, Japanese as well as the Europeans were trading with South Africa on a magnificently increasing scale. The decrease of British commercial trading subsequent to the departure of South Africa from the Commonwealth eventually led the British government to terminate her trade ties with South Africa, even after 1961, when South Africa had become a republic and quit the Commonwealth. The trade relations between South Africa and the United States
became more important as British power ebbed due to the fact that the South African economy was more skewed and oriented toward Britain and far less to the United States of America. The Kennedy and Johnson administrations became more critical of the discriminatory policy and committed the United States to effecting a decisive arms embargo, stopping the selling of arms to South Africa, but they continued to reject economic sanctions. The Vice-President of the United States of America, Walter Mondale, told Prime Minister John Vorster that America only supported the principle of majority government with universal suffrage on the basis of the ANC formula, which emphasized the principle of one person one vote and strongly requested Vorster to consider removing the apartheid policy since it was a violation of human dignity and the Bill of Rights in the world (Thompson, 2000:211-213).

Subsequent to the introduction of the apartheid policy, the South African government had to face a transformed world order because it became an isolated anomaly due to the fact that in 1977 the United Nations passed a mandatory embargo on the sale of arms to South Africa. The United States was completely against the undesirable apartheid policy as this policy had already been outlawed in the United States of America. The economic success of South Africa was eroding the Afrikaner people to an extent that Afrikaners subsequently discussed transforming the apartheid system carefully while crafting changes simply to appease foreign and domestic critics while on the other hand strengthening white supremacy by creating further division among the African people, because the Afrikaner people feared the consequences of extending political and economic rights to the black people of South Africa.

The South African government was characterized by her transformation from ‘baasskap’ apartheid to separate development. Ever since 1948 South Africa had been the target of continuous international criticism and economic sanctions. The South African government, by openly embodying racism in law, increasing inequality by government action and removing rights that had been previously enjoyed by all South African inhabitants, was moving in exactly the opposite direction to the logical demands of the international community, condemning the harsh practices of the apartheid policy which undermined human dignity, respect and interaction free from racial discrimination and appropriate self-development (Omer-Cooper, 1994:211).
It is worth pointing out that in the 1960s and the first years of the 1970s the system of white domination and oppression in the whole of the southern and central African continent came under increasing attack and severe scrutiny by the international community. The process began with the triumph of African nationalism in the white-dominated Central African Federation of Southern Rhodesia (now called Zimbabwe), Northern Rhodesia (now called Zambia) and Nyasaland (now called Malawi). Subsequent to this development or scenario the federation was dissolved in 1964. Nyasaland became independent as Malawi in 1964 and Northern Rhodesia attained independence as Zambia later in 1964. In 1965, Ian Smith unilaterally proclaimed the independence of Rhodesia in spite of British insistence that independence must have the support of the majority of the black population groups of Rhodesia and must rest on the four principles, including unimpeded progress towards a black majority government. Smith’s unilateral declaration of independence (UDI) eventually placed the South African government in an awkward political and economic position (Omer-Cooper, 1994:214 and 221).

During the mid-1970s, the white apartheid government was cushioned by a circle of settler and colonial states around it. In the Portuguese colonies of Angola and Mozambique, the metropolitan government itself, rather than settlers, had underwritten the large military effort in controlling an increasingly hostile black population. In the 1960s and 1970s when a coup in Portugal displaced the Fascist government, it was followed by rapid decolonization. The prime Minister of Rhodesia, Ian Smith and his settlers, made their Unilateral Declaration of Independence from Britain in 1965 and fought their own campaign against the black Zimbabwean liberation movements. The black Zimbabwean liberation movement called the Zimbabwe African National Union (ZANU) under Robert Gabriel Mugabe was elected and ascended into power in 1980 and subsequently the South African government increasingly perceived itself to be the object of a total ‘onslaught’ from the north and the hinterland. The South West Africa People’s Organization (SWAPO) was able to mount an increasingly effective challenge from bases in Angola. The ANC founded military bases from which to launch its own armed struggle against the South African government. Because of its proximity and its socialist government, Mozambique was seen as a major potential threat to the Republic of South Africa. Prime Minister Vorster tried to develop diplomatic and economic relationships with some African countries in order to counteract regional isolation and armed attacks by freedom fighters (Beinart, 1994:225 and 226).
Although there was strong opposition by the black people against the apartheid system in South Africa, Van Jaarsveld (1975:398 and 401) confirms that not every person in South Africa supported the policy of separate development, neither did the OAU nor UN and since 1946 international pressure had been imposed upon South Africa to abandon the apartheid policy for which she had been strongly criticized and condemned by the international community. He said that up to World War II South Africa had been a country of relative international isolation due to her apartheid policy.

2.2.1.4.2 Internal pressure

During the period between 1948 and 1984 the system of apartheid developed through three definable phases. The first phase was characterized by the classic apartheid or ‘baasskap’ phase, which referred to white supremacy. During this period the National Party government put its original ideas into legislative form, frustrating almost all black people. During this period South Africa was transformed into an Afrikaner-ruled republic by re-organizing the South African society in accordance with Afrikaner nationalist ideas. The second phase was characterized by separate development and continued until 1974. The pressure of transformation in South Africa in particular and Africa as a whole led to the third phase. The third phase was characterized predominantly by the economic transformation. The changed strategic situation followed the revolution in Portugal and the liberation of Mozambique and Angola, the massive violent protests by black people within the townships, and the beginning of African nationalist guerrilla activity on a significant scale within the Republic of South Africa. The third phase, called the multiracial co-option, also involved greater transformation at the political level whereas the previous two phases in 1984 witnessed the promulgation of a new multiracial constitution in South Africa. The policy of separate development was driven especially hard down the long and tortuous route to disenfranchisement (Liebenberg and Spies, 1993:443-445).

In the labour market the apartheid planners of the now defunct apartheid regime saw it fit to protect white workers from competition, to control the movements of migrant black people to towns and cities and also to regulate their position in the labour market situation, which was exacerbated by establishing black townships such as Soweto situated many kilometres away from the city of Johannesburg of Gauteng Province in South Africa, while on the other hand
the white people were allowed to stay and own properties in the city and also in the suburbs adjacent to the city of Johannesburg without any restrictions (Beinart, 1994: 149; Omer-Cooper, 1994:197 and 217).

The release of Mandela and the other political prisoners on 2\textsuperscript{nd} February 1990, together with the lifting of the ban on the ANC and other black political movements in South Africa later on, started a new phase in politics which remained unresolved for a considerable period of time. This development was considered to be a final recognition on the part of the apartheid government that it no longer hoped to win and sustain the legitimacy of the apartheid system by relying on black allies outside the ANC and other democratic movements. This was also an admission that a political settlement was inevitable, imminent and a requirement for negotiations with popular movements since the violence had already impacted upon and scarred the South Africa government. The renaissance of black opposition to the apartheid system in the 1970s paved the way for both political and economic transformation. The insurrection in the period between 1984 and 1986 made the process very difficult to reverse. The white minority government partially collapsed during the 1980s and early 1990s due to internal pressures such as the political violence coupled with the loss of the lives of many black people. The Afrikaners were reluctant to share the political and economic power with the other population groups for several decades but a decade of political mobilization lay behind the insurrection of the mid-1980s and its intensity was fuelled and aggravated by economic recession and intricacies of managing the black urban population (Pape et al, 2007:347,353, 355: South Africa Yearbook, 2007/08:38 and 40).

There were several factors that forced the apartheid government to transform its apartheid policy into a democratic policy in South Africa. The political violence that erupted in 1980 was one of the major contributing factors that increased internal pressure on this country. The stay away of 1984 in the Transvaal reached new heights in this country. There were growing demands from foreign countries that South Africa should relinquish its policy of apartheid and give the black majority equal opportunity to participate in the government; it was as a result of such demands that the black people became aggressive, impatient, violent and resistant towards the apartheid policy. The uncontrolled and unavoidable emergence of massive opposition to the apartheid policy in the 1970s commenced with the politically motivated worker strikes in 1973 and subsequently the Soweto uprisings of 1976 necessitated that negotiations be
commenced with a view to attaining the progressive process of democracy in South Africa in order to avoid more loss of life particularly of black people. The political violence and resistance among black people, especially the youth, were intensified in the 1980s and indirectly by the international community. The apartheid government was eventually forced to negotiate itself out of power (Pape et al, 2007:355).

While the coloured people and the Indian people were given voting rights by the apartheid regime, the black people were denied that privilege but instead were given ‘independence’ that was imposed upon them in their respective ‘homelands’ and ‘territories’. By 1981, the Transkei, Bophuthatswana, Venda and Ciskei governments had already been granted full ‘independence’ within the Republic of South Africa. The granting of this independence exacerbated forced removals to areas not well and adequately serviced in terms of the provision of basic needs such as clean water, electricity, housing, health-care and sanitation to mention but a few. Hundreds of black people who were living in so-called ‘white areas’ of South Africa were forcibly relocated to their so-called ‘homelands’ and ‘territories’. Although the ‘homelands’ policy stipulated the provision of ‘independence’, this so-called ‘independence’ was in reality not recognized internationally, either by the United Nations (UN) or by the vast majority of the international community. The mass movements in many of the ‘homelands’ arose to protest against undemocratic government and imposed independence because both ‘homelands’ and ‘territories’ in the context of the regime of South Africa were designed as places to dump all undesirable or unwanted black people in the so-called ‘white areas’ or exclusive South Africa for white people. The ‘homelands’ policy was complex, complicated and aggravated by the situation in KwaZulu. Its leader, Chief Mangosuthu Buthelezi who led the Zulu-based Inkatha movement, had a history of resisting the apartheid system because of its negative effects on the lives of black people. Buthelezi refused the independence offered by the National Party-led government. In 1963, the Transkei under the leadership of Kaizer Matanzima was granted ‘self-government’ by the South African regime. The Transkei constitution was drawn up in Pretoria and not in Mthatha (formerly called Umtata) and Verwoerd had a great deal to do with it. Its implementation was constantly and regularly monitored by the regime (Davenport and Saunders, 2000:418; Pape et al, 2007:354).

The political violence in South Africa was also exacerbated by various situations including, among others, that the government fed into an autocratic and increasingly militarized pattern of
authority subsequent to the declaration in July 1985 of a state of emergency by Prime Minister Botha. This gave the security forces extraordinary powers, more than the government possessed at that time since the Cabinet was rendered dysfunctional, incompetent and hopeless because of the critical political situation then prevailing in South Africa that was beyond the effective control of the government (Beinart, 1994:244).

The political situation in this country became worse when the National Party was tainted by scandal when it was revealed that in 1978 the government had misappropriated public funds intended for secret propaganda campaigns. Notably, the scandal affected senior Cabinet Ministers, including the Prime Minister John Vorster. The political scandal broke on white self-image because Vorster’s security chief and information supreme misappropriated public funds intended for a campaign to persuade the world of the government’s credentials. This spelt the end of Vorster, already a sick man who subsequently resigned and was succeeded by PW Botha who claimed that the international community was waging a ‘total onslaught’ against this country and as a result of this development, the military was empowered by the government to have the most influence over the management and administration. The State Security Council comprised of the Minister for Defence, the five other Cabinet Ministers and the heads of Defence, the Police, and the Intelligence Services became more powerful than the Cabinet itself; and with white confidence shaken by the Soweto violence in 1976, harder questions began to be asked about the feasibility of grand apartheid, the viability and sustainability of the homelands and the consequences of mass forced removals to other areas of this country which promoted suffering among the black inhabitants of South Africa (Beinart, 1994:225; Thompson, 2000: 217).

The apartheid government of South Africa was oppressing the political organizations that sought peaceful political solutions and stability and banned them for their resistance and fight for democratic rights, freedom, moral decay and emancipation from the bondage of the apartheid system. The ANC and PAC military wings or military offshoots, Umkonto we Sizwe (Spear of the Nation) and Poqo respectively, initially went underground reluctantly, operating from outside and also from within the country to overthrow the regime of South Africa by violence. Umkonto we Sizwe, the armed wing of the ANC, concentrated upon the formation of cells to sabotage identified government strategic installations. All these were attempts by the African National Congress (ANC) to jolt the government into recognizing the need and
demand for a negotiation process in order to have a democratic government. Quite a number of sabotage campaigns were launched in this country with great success by freedom fighters despite the causalities suffered by the armed liberation forces (Liebenberg and Spies, 1993:396; 404-405; Muller, 1993:528; Pape et al, 2007:354).

The decision of the government to ban, for example, the African National Congress (ANC) and the Pan African Congress (PAC) resulted in those two and many other political organizations going underground in April 1960 and shortly thereafter, deciding to use violence in their ultimate efforts to achieve more political power for the black people in particular in this country. The resurgence of mass resistance in this country led to an increase in guerrilla activities. The apartheid government had been facing major crises even during and after the 1976 Soweto uprisings. The pressure from the internal democratic movements, the armed liberation forces and international quarters forced the apartheid government to make several attempts in terms of political transformation (Muller, 1981: 528; Pape et al, 2007:352 and 353).

The South African apartheid government was in trouble in 1978 because the country’s economic boom of the 1960s and early 1970s had been followed by a sharp recession. The administration of the complex discriminatory laws which were superfluous proved to be extremely costly to the government and was compounded by inflation that was running at over 10 percent. The economic situation was further aggravated by an increase in the gross domestic product that was scarcely keeping up with the increase in the population, with the result that many white people became poorer. A skilled labour force was direly needed at that time to manage private industries. Skilled bureaucrats became scarce. On the one hand, the shortage of labour was accentuated by the fact that in 1977 there was a white emigration of largely professional men and women with much needed managerial and industrial skills and experience from South Africa, while on the other hand, the black population was increasing at a far greater rate than the white population with the result that all the illusions of the Prime Minister Verwoerd were eroded and completely shattered (Thompson, 2000:215).

Omer-Cooper (1994:210) pointed out that in 1961; ex-members of the ANC under the leadership of Nelson Mandela made one last attempt to persuade the apartheid government of the need for radical transformation to take place by peaceful means. However, the government
rejected the demand of the majority of the black people out of hand and subsequently the strike gained greater momentum and support. It was after most ANC leaders had given up confidence and hope of achieving any significant political transformation in South Africa by peaceful means that Mandela and other ANC prominent members saw it fit to go underground and a militant wing of the ANC, called Umkhonto we Sizwe (the Spear of the Nation), was formed to undertake an extensive campaign of sabotage of public installations in the hope of forcing the National Party-led regime to recognize the need for transformation in South Africa. The black population was always committed to non-violence to avoid loss of human life but the ANC had no choice other than to embark upon campaigns of sabotaging the apartheid regime and especially at its strategic installations, although soft targets (human beings) were not directly aimed at, in order to achieve negotiations.

The resistance displayed by the black people in South Africa against racial segregation was impeded not only by black people’s lack of access to firearms at the time but also by their cultural and historical differences that were in existence because, for instance, Indians and Coloured people shared very little if anything in common with one another, let alone with the black people and were themselves disunited on, among other important things, cultural values, materials and principles (Thompson, 2000:166).

The regime of South Africa showed signs of vulnerability from the late 1970s after three decades of being in power and that was due to an increase of political opposition on a number of fronts. For instance, the Natal strikes of 1973 and the Soweto protests and uprisings of 1976 were considered as turning points in the political history of South Africa. The year 1976 witnessed massive numbers of deaths of black people in Soweto in particular, but also country-wide and especially in the ‘homelands’ and ‘territories’ inhabited by black people as they were the victims of circumstances in that era (Pape et al, 2007:347).

The untimely political violence that erupted unexpectedly in South Africa in September 1984 was one of the major factors that increased internal pressure on this county. The ANC called for ungovernability of South Africa. What was of great concern to the indigenous people of this country was that they were labelled in a derogatory manner and sometimes they were called names such as the ‘Natives’, ‘non-Europeans’, ‘non-whites’ and ‘nie-blanke’. No nation in the world is the direct opposite of another one as each group of people has its own
unique natural identity. Certain public areas were declared ‘no-go’ areas as reflected by signs such as ‘Europeans only’, ‘Slegs vir blankes’, denying black people access to or the opportunity to make use of certain amenities such as toilets, certain train coaches, public railway platforms and other transport facilities, soccer stadiums, educational and health facilities and resources (Beinart, 1994:212 and 216).

In 1985, western financial institutions expected Botha to increase the pace of political transformation. As the National Party-led government dragged its feet in resolving the political chaos through negotiation, the ANC called for ungovernability in this country and the youth, in response to the call, swiftly frustrated the apartheid government by making it ungovernable through strike, violence and protests which affected the entire country both politically and economically. The school system had already collapsed as learners and educators had abandoned classes and there was a need to liberate education from the Bantu Education System. Learners and educators stayed away from their classes completely. They were no longer keen to attend them since the political solution was top priority (Beinart, 1994:242).

The extension of the use of the Dutch language (Afrikaans) as the medium of instruction in all black schools and enforced full bilingualism in the civil service by JBM. Hertzog frustrated the black people, especially the black learners. His insistence on language equality was aimed mainly at facilitating and promoting Afrikaner access to the expanding structures of the country and this exacerbated the anger the black learners had already harboured for several decades against the imposition of a foreign language upon them as a medium of instruction instead of English or their mother tongue. The prevailing situation led to the Soweto uprising or strike, which arose out of dissatisfaction with the use of Afrikaans as the medium of instruction in schools. The dissatisfaction expressed by the black learners, educators and their parents regarding the regulation that half of the school subjects selected in high schools had to be taught through the medium of Afrikaans instead of English manifested itself frequently during the first half of 1976. The Meadowlands Tswana School Board requested that all school subjects must be taught through the medium of English and in spite of the refusal of the regional inspector to accede to that request, the Board insisted and instructed all the principals within its jurisdiction that the medium of instruction should in future be English. The government’s indifference to the dissatisfaction expressed by the Black members of the community contributed significantly to the outburst on 16th June 1976 and this, in addition to
the general feelings of dissatisfaction among the urban black inhabitants about their political powerlessness, poor economic situation, backwardness and social insecurity, were regarded as the immediate cause of Soweto riots or political violence (Beinart, 1994:76; Muller, 1993:532).

The oppression of the indigenous black people by white people was done in various ways and one of them was that they were prohibited from possessing fire-arms as they were not privileged like the white people during the apartheid era. The black inhabitants were also forced in terms of the oppressive laws imposed in the Republic of South Africa to carry ‘passes’ (Identity documents) because in terms of the apartheid policy “… the Bantu are only temporary resident(s) in the European areas of the Republic for as long as they offer their labour there” and also preventing those in the ‘homelands’ and ‘territories’ from staying in the so-called white areas wherever they travelled due to the apartheid system. Similar requirements were not conditions for white South Africans (Thompson, 2000:188 and 187).

When the National Party came into power in 1948, resistance had already been overtly expressed for a considerable time among educated black people about the number of discriminatory laws that were in practice at the time which kept them in positions subordinate to the white people in South Africa. The implementation of the policy of apartheid caused an increase in the pressure being applied to the government to transform the existing legislation. The various black organizations such as the African National Congress (ANC), the All African Convention, the Indian Congress and the Coloured African People’s Organization began increasingly to clamour for a transformation process in South Africa for the benefit of all its citizens (Pape et al, 2007:305-306).

The domestic political movements in the early 1980s, whose members were mostly in exile, proved to be of great importance and the use of the concept ‘black’ was in itself a serious insult and a challenge to apartheid’s ethnic and racial terminology and an alternative to the negative terms ‘non-white’ (nie-blanke) or ‘non-European’ (Beinart, 1994:212 and 216). The economic challenges of the urban government were compounded by the longevity of the economic downturn. The gold price declined in 1983, expensive imports and debt repayments became a financial drain on the country, and South Africa’s manufacturing industries stagnated, especially when Europe began to climb out of its recession in the early 1980s. Furthermore, the high unemployment rate, being part of the economic problem, helped to fuel political turmoil.
in the mid-1980s, which in turn exacerbated economic challenges. The period between 1973 and 1984 marked the political transition from the policy of separate development to a new approach of multiracial co-option. With the advance of technology it became obvious that the needs of the industry were beginning to change. Subsequent to technological developments the utilization of new equipment required less unskilled labour and a larger skilled workforce. The number of white workers was inadequate to fill those positions. Their numbers were further depleted as whites took advantage of the expanding economy to move from manual work to clerical and administrative posts. The employers thus had to rely increasingly upon black and coloured workers to perform the more skilled operations the new machinery demanded. The Soweto school revolt of 1976 forced reconsideration of urban black living conditions because the black people wanted real socio-economic and political transformation in South Africa and real transformed initiatives so that their lifestyles could be equal or similar to those of the white people in this country (Beinart, 1994: 240; Omer-Cooper, 1994:223).

It is worth noting that the internal political upheavals in South Africa were a significant factor which contributed to the downfall of the apartheid regime. The key feature of the transitional period was that the government had to transform in three main areas, namely, politically, economically and administratively. The introduction of apartheid policies coincided with the adoption by the ANC in 1949 of its effective programme of action clearly expressing the renewed militancy of the 1940s, which embodied the rejection of white domination and oppression and called for effective action in the form of protest, strikes and demonstrations in South Africa (Pape et al, 2007:317-320).

In response to the rising tide of protests, defiance and resistance against the apartheid regime, the international community strengthened its support for the anti-apartheid cause. Sanctions and boycotts were instituted and intensified both by communities across the world and through the United Nations (UN). FW de Klerk, who replaced PW Botha as the State President of the Republic of South Africa in 1989, announced at the opening of Parliament on 2\textsuperscript{nd} February 1990, the unbanning of the liberation movements and the release of political prisoners and political leaders among whom was Nelson Mandela (South African Yearbook 2007/08:38 and 40).
The conflict between the South African army and the freedom fighters (terrorists) raged for quite a long period. The purpose of the conflict was to attain democracy in which the black people would be afforded the opportunity to participate actively in the governance of this country. All of the afore-mentioned factors were the determinants that forced the apartheid regime to agree to the process of negotiation, which eventually led to the attainment of a democratic government in 1994.

2.2.1.5 The setting up of the Tri-Cameral Parliament

The Republic of South Africa Constitution of 1983 was adopted in 1983 but was formally implemented in 1984. The Republic of South Africa Constitution of 1983 provided for the establishment of a tri-cameral system of government. The political scenario of South Africa continued its gradual transformation of the Republic of South Africa in terms of the Constitution of 1983, which further brought about some other form of political transformation by means of which provision was made for the existence of three Houses of Parliament and each House of Parliament dealt specifically with matters relating to the local authority for the specific population group entrusted to it (Cloete, 1986:26; Pape et al., 2007:353).

Although the Constitution of 1983 was adroitly marked as one that extended democracy to the formerly excluded black populations, different population groups were afforded the opportunity to participate as members of statutory defined groups in terms of the Population Registration Act of 1950, which promoted and emphasized the Segregation and Separation Act of 1950. The Constitution of 1983 made, inter alia, provision for the appointment of the Cabinet and three Ministers’ Councils. The appointment of the three Ministers’ Councils was no deviation from the apartheid policy and instead it strengthened it. It made further provision for a three-chamber parliament consisting of a House of Assembly for the white people, a House of Delegates for the coloureds and a House of Representatives for the Indians. Subsequent to those political developments and transformation, Prime Minister Vorster applied Verwoerd’s principles of the apartheid policy very tactfully and less rigidly and strictly (Liebenberg and Spies, 1993:477–478 and 488-493).

It was through the setting up of the tri-cameral parliament and carrying out the political transformation that the apartheid regime hoped to win more supporters and thereby undermine
the resistance displayed by the black freedom forces. The most important political transformation that took place was the setting up of the tri-cameral parliament to counteract the opposition by the majority black people through the passing of a new Constitution of 1983. The protest against the inauguration of the tri-cameral parliament in September 1984 subsequent to the passing of the Constitution of 1983 and the increase of rent ended in battles between black people, especially the youth, and the South African police. Consequently, some Councillors in Sebokeng, which is situated south of Johannesburg on the Vereniging road in Gauteng Province, were fatally wounded (Beinart, 1994:239).

The Constitution of 1983 also provided for, besides those three parliaments, the election of local governments in areas where black people resided. Those local governments were referred to as ‘Black Local Authorities (or BLAs). Both the tri-cameral parliament and BLAs prompted widespread opposition, criticism and resistance from the black people. The parliamentary structures were still based on racial separation and included no national voice for the majority black population. The Coloured and Indian Houses of Parliament could not actually pass legislation on their own since any measure they adopted could possibly be vetoed, rejected, amended or over-ruled by the parliament dominated by white members which was the supreme constitutional statutory body in this country (Pape et al, 2007:353).

The black people of this country were excluded from politically participating in the tri-cameral government and as a way of enforcing the policy of separate development, the exclusion and marginalization of the black people were intensified in terms of the Bantu Homelands Citizenship Act of 1970, which attached the citizenship of all the black people still working and residing in the republic to one or other of the ‘homelands’, even if they had never lived outside the ‘white area’. The Bantu Homelands Constitution of 1971 was an enabling piece of legislation, which empowered the state president to confer self-government on any of the eight Territorial Authorities in terms of the proclamation as had happened, for instance, in the Transkei where Matanzima had negotiated for independence within the Republic of South Africa. This took effect from October 1976 but in practice the Transkeian government did not acquire real political and socio-economic independence as it remained completely economically dependent on the Republic of South Africa. In terms of legislation, the Ciskei territory became self-governing on 28th July 1972, while KwaZulu became self-governing on 30th March 1972 though it still remained a fragmented territory. The sprawling territory of
Bophuthatswana, which became self-governing in May 1972, stretched across eight main territorial enclaves north-east of Pretoria. Lebowa followed suit in September 1972. During the enforcement of the apartheid policy the ‘homelands’ and the ‘territories’ were not regarded as integral parts of the Republic of South Africa. It was considered appropriate and relevant during that period to establish a tri-cameral system as a way of trying to address the concerns and aspirations of Coloured and the Indian people who owned neither their own ‘homeland’ nor a territory in South Africa (Davenport and Saunders, 2000:432 and 434).

2.2.1.6 The negotiations towards a democratic government in South Africa

The period between 1948 and 1994 marked the practical existence of the apartheid government and that happened during the pre-transformation period. Apartheid was the system or instrument the government used that was characterized mainly by racial division and discrimination, general confusion among the marginalized black people and defective service delivery policies. The black inhabitants were treated in an inhuman manner, forcibly removed from their regions of birth to barren areas which were not serviced at all. For instance, the Tsonga people were forcibly evicted from Venda to barren areas currently in Mopani municipality without the provision of facilities such as clean water, sanitation, electricity, shelter, food, educational or health-care facilities. Many black people in South Africa were the greatest opponents of the apartheid system in the 1950s and 1960s and some academics in the 1970s also perceived the maintenance of the migrant labour system as undesirable, disgusting and abhorrent as it was used as the mainstay of the apartheid policy in South Africa (Beinart, 1994:150).

Cameron and Stone (1997:7) indicated that the Republic of South Africa established the Government of National Unity (GNU), which consisted of representatives of three different political parties and operated on the basis of consensus. The parliament in the national sphere of government was the highest rule-making constitutional body and its responsibility was to pass bills into pieces of legislation, to regulate the lives of all the people of this country regardless of sex, religion, race and creed. Davenport and Saunders (2000:494) reiterated that the country-wide uprising of 1976 was one of the major contributory factors which led to the process of negotiation and the achievement of democratic government.
The Convention for a Democratic South Africa (CODESA) popularly known as the” strategic shift” was the political forum that was established on 20th December, 1991 in the World Trade Centre near the then Jan Smuts Airport (currently called the O.R. Tambo International Airport) in order to ensure that negotiations were conducted in order to realize the establishment of a democratic government in this country. Different task teams, committees or groups were appointed to work hard to come up with tangible recommendations, which led to the establishment of the Government of National Unity (GNU). All CODESA’s task teams under the GNU worked hard as they were expected to, inter alia, make recommendations in terms of whether the new Constitution should be unitary or federal, to indicate precisely where transitional legislative power should be vested, to show how Parliament and executive authority should be structured and also to define the provincial boundaries. The greatest breakthrough and achievement by CODESA was that it recommended the adoption of the constitution by the National Assembly (NA) with a view to bringing about the elections that culminated in the substitution of the apartheid government by a democratic government (Davenport and Saunders, 2000:561; Liebenberg and Spies, 1993:532; Pape et al, 2007:361; http://www.anc.org.za/show.php?doc= ancdocs/speeches/1994/sp941217.html:4).

The racist National Party of South Africa had no justification to continue to pursue the implementation of the apartheid policy as it had been rejected by the indigenous people of this country and also by the members of the international community since it was grossly discriminatory against the black majority. The Restoration of South African Citizenship Act of 1996, which gave South African citizenship back to the people of the Transkei, Bophuthatswana, Venda and Ciskei (TBVC) countries, was a great political stride taken in terms of transforming South Africa from the policy of separate development to a democratic system recognized world-wide. The loss of citizenship by the inhabitants of the TBVC ‘homelands’ and the six ‘territories’ in this country had caused great dissatisfaction especially among those black people who were required to vote in their ‘homelands’ and ‘territories’ and owe their allegiance to one of the former TBVC territories despite the fact that they had been born in this country and lived here all their lives. The Botha government realized after several decades of white oppression, domination and discrimination against the black people that the latter had not been given a fair deal and agreed to rectify the inhuman attitude towards the black population of South Africa. The Constitution of 1983 gave a measure of political power to Coloureds and Indian people but excluded the black communities from the political exercise.
In order to address the exclusion of the black majority, the government of South Africa had justified the decision taken by indicating that the black people already had political power in their respective so-called ‘homelands’ and ‘territories’. Hertzog began to address the broader position of the reserves for black people and their political rights in spite of the previous negative attitude against them by means of which the regime protected white people in the labour market, established control over the movements of the black inhabitants, unbanning of the political organizations and restoring chieftaincy in this country. About 1.7 million TBVC citizens reclaimed South African citizenship due to the democratic transformation process (Cloete, 1986:37; Thompson, 1995:186).

The political revolt by black people after the implementation of the 1983 Constitution in September 1984 rendered the apartheid government incapable of governing without the effective implementation of a country-wide state of emergency, as the government had already lost its grip on stability and peace in South Africa. Since political transformation in South Africa was unavoidable as reflected by the political and economic developments towards the end of the 1980s, it was not unexpected when, at the opening of the parliamentary session on 2nd February 1990, President FW de Klerk announced the lifting of the ban on prominent political freedom fighters and political organizations such as the ANC, the PAC and SACP, that all political prisoners, including Nelson Mandela, would be freed and that other organizations such as COSATU, National Education Crisis Committee (NECC) and the United Democratic Front (UDF) could once more resume their political activities in South Africa without harassment, intimidation or arrests by the South African police. President De Klerk’s speech was considered the most important turning point in the South Africa political situation since the implementation of the apartheid policy. The unbanning of the ANC and the setting of political goals such as the drafting of a new democratic constitution, the granting of universal franchise to all the inhabitants of this country and the termination of white domination over black people were the beginning of the process of transformation. President De Klerk then realized that the new constitution had to be negotiated no matter what prevailed in the political scenario and that the political aspirations of the black people could no longer be ignored and delayed unnecessarily (Liebenberg and Spies, 1993:525; Omer-Cooper, 1994:242 and South Africa Yearbook, 2007/08:38-40).
The international pressure was becoming so acute that De Klerk had little or no option than to completely abandon the apartheid policy. In order to ease the political tension that South Africa was going through, President De Klerk announced in Parliament the unbanning of ANC, the PAC and Communist Party and that all political freedom fighters were freed and he seriously engaged with the ANC, especially Nelson Mandela and other comrades in a number of negotiations in order to bring about a peaceful transition from the apartheid regime to a democratic government of South Africa. Unlike in Zimbabwe, Angola and Mozambique, South Africa was characterized by the attainment of a democratic government without bloodshed and massive loss of human life since it was achieved peacefully through extensive negotiations (Liebenberg and Spies, 1993:525; Omer-Cooper, 1994:242).

The political situation further changed when Nelson Mandela emerged from 27 years of imprisonment on 2nd February 1990. This was an obvious step towards the attainment of democracy. While President De Klerk frequently met with Nelson Mandela in an effort to negotiate the transition of government, he insisted that the formal negotiations, which took shape at the Convention for a Democratic South Africa (code named CODESA) on 20 December, 1991, should include representatives from a wide range of political groups including homeland governments and ethnic political parties. The South African government also urged that some form of power-sharing would be an ideal option as it would be most conducive to political stability and peace in this country (Beinart, 1994:252-255; Omer-Cooper, 1994:248).

Subsequent to all the unfavourable political developments, the South African government started to prepare for the systematic repealing of all remaining segregationist and discriminatory laws to such an extent and such good effect that it was possible to call together a Convention for a Democratic South Africa (CODESA) at the World Trade Centre in Kempton Park, near Johannesburg on 20th and 21st December 1990 since apartheid was regarded as a “monster” that had to be effectively eradicated by democratic mechanisms. CODESA played a significant role in laying the foundation for multi-racial discussions. The political situation necessitated that CODESA’s decisions be adopted as speedily as possible since they were vital for the implementation of the transformation process as they were pragmatic and provided good direction towards the attainment of democracy in South Africa. Democracy was the culmination of great efforts initiated by CODESA. The strengthening of
CODESA’s peace-keeping structures was crucial and indispensable for the success of any political solution as the success of the general election of 1994 depended much upon the setting up of a National Peace Accord in April 1994 (Davenport and Saunders, 2000:560; http://www.sahistory.org.za/pages/governance-projects/constitution/codesa.htm.:3).

After a long negotiation process that was sustained despite much opportunistic violence from the right wing and its supporters, South Africa’s first democratic election was held in April 1994 under the interim Constitution of 1993. The Constitution of 1993 provided a mandate for the division of South Africa into 9 provinces in the place of the previous 4 provinces, 4 ‘homelands’ and 6 ‘territories’, and provided for the Government of National Unity (GNU) to be constituted by all political parties with at least 20 seats in the National Assembly. The African National Congress (ANC) emerged victorious from the election with a 62.0% majority. The main opposition came from the National Party (NP), which gained 20% of the total votes nationally but secured a majority in the Western Cape. The Inkhatha Freedom Party (IFP) received 10% of the total votes, mainly from its KwaZulu-Natal base. The NP and IFP eventually formed part of the Government of National Unity until 1996 together with the principal party, namely, the ANC, when the NP withdrew from the coalition government. Despite the withdrawal from a coalition government by the NP, the ANC-led government embarked upon an effective programme to promote and facilitate the reconciliation and development programme of the country and its institutions (South African Yearbook 2007/08:41).

The national, provincial and local governments were established as a result of the success of the long negotiations, which eventually led to the formulation and development of the democratic interim Constitution of 1993 in terms of which a unitary state was established. For the first time black people were accepted in the white residential areas of South Africa as permanent residents and were permitted to decide on their own affairs up to the highest sphere of government in terms of the interim Constitution of 1993. The leader of the opposition party, Dr F Van Zyl Slabbert, supported President PW Botha’s decision to accept the majority black people as full-fledged residents of the Republic of South Africa as the first step in the right direction. This was regarded as a radical deviation from the National Party’s historical and fundamental policy of apartheid. After the President’s declaration that the black inhabitants should be given greater political freedom and rights in South Africa, the apartheid government
proceeded to implement the new policy, which accommodated all South African people regardless of their colour, gender, religion or creed. A measure of political power was given to the black people in the third sphere of government, called the local government, and in the second sphere of government called the provincial government, but this political power was limited since the white people remained in control of the country (Liesberg and Spies, 1993:494).

Van der Waldt and Helmbold (1995:xvii) indicate that the Constitution of the Republic of South Africa, 1993 was a product of extensive negotiations. Hence, due to dynamic change, transformation is fundamentally significant and indispensable in addressing the inherited backlogs from the past apartheid regime.

2.2.1.7 The dissolution of the Government of National Unity (GNU)

The release of Nelson Mandela, following President De Klerk’s speech of 2nd February 1990, set in motion a chain of events in South Africa which few white people had anticipated in their life-time. The National Party government had initially shown little desire to continue participating actively in the talks initiated in the conferences held at Morogoro in Tanzania in 1969 and at Kabwe in Zambia in 1985, but at a meeting with President De Klerk at the Tuynhuys on 13th December 1989, Mandela proposed that talks should take place in order to create a conducive climate for peaceful negotiations that should precede the real negotiations. An agreement between the racist government and the ANC on 4th May 1990, known as the Groote Schuur Minute, laid down pre-conditions for the safe return of exiles from abroad and neighbouring states who had left South Africa illegally or merely belonged to the then unlawful organizations, or whose return would help to end or contain the political violence in the country or promote peaceful negotiations. De Klerk began to release political prisoners accordingly, and readmitted exiled freedom fighters (formerly called terrorists by the apartheid regime) and leaders in South Africa under the promise of safe conduct. President De Klerk lifted the remaining restrictions under the five-year state of emergency period in October 1990 after Mandela had announced a unilateral ending of the armed struggle in August 1990, although he did not commit himself to disbanding the military wing of the ANC called the MK as would have been expected of him by the apartheid regime. In January 1991, Mandela renewed his call for an all-party congress to tackle the first phase of the negotiations, the
acceptance of which the apartheid government rightly hailed on 2\textsuperscript{nd} February 1990 as both regarded this as a political breakthrough and the introduction of the implementation of the transformation process in South Africa (Davenport and Saunders, 2000:559 and 560).

After President De Klerk’s speech on 2\textsuperscript{nd} February 1990, all political organisations operated freely and legally in this country. De Klerk’s speech began the process of negotiating a transition to a democratically-elected government. Several organizations and individuals that had not interacted politically with one another for several decades of apartheid domination made use of the opportunity to commence discussions regarding how to transform the white minority government into a black majority government. The transition process from 2\textsuperscript{nd} February 1990 to the country’s democratic elections held on 27\textsuperscript{th} April 1994 was not without political challenges since the political violence and protests did not immediately end. Some political organizations were dissatisfied with the manner in which the negotiation processes were conducted. The masses demanded an immediate end to the abhorrent system of domestic service as practised in South Africa such as the long working hours (from 05:00 to 20:00) and starvation wages for black labourers in particular, from about twenty rand (R20,00) to sixty rand (R60,00) per month per person (Pape \textit{et al}, 2007:358).

President De Klerk gradually dismantled racial legislation. He revoked the Reservation of Separate Amenities Act in June 1990, followed by the Native’s Land Act of 1913, which deprived the black people of the right to access to land and property, the Group Areas Act of 1950 that separated white from black people and prevented them from sharing this country equally, and the Population Registration Act of 1950 in 1991. Under the old Constitution of 1983 the rights of the majority of South African people were not guaranteed. When the 1994 elections were held, the parties agreed upon an interim Constitution of 1993, which remained in force until 1999. During the first 5 years after democracy was achieved, the new Government of National Unity (GNU) had the responsibility of putting a new and permanent Constitution in place, which would be agreed upon by all different political parties. A Constitutional Assembly (CA) was established in order to carry out such vital and indispensable tasks. The CA, led by the then ANC General-Secretary, Cyril Ramaphosa, spent almost two years making major inputs towards the finalization the Constitution. The CA attempted to provide opportunities for all South African citizens to take part in the constitution-making process in order to put together a new and permanent constitution by all political
parities. After the conclusion of those lengthy and extensive processes the democratic Constitution was finally accepted by the CA on 8th May 1996. The Constitutional Court translated the document into law in December 1996, hence the emergence of the Constitution of 1996, the implementation of which culminated in the dissolution of the Government of National Unity (Beinart, 1994:254; Pape et al, 2007:360-361; Thompson; 1995:247).

Maharaj and Kathrada (2006:261) indicate that during the negotiations held in Johannesburg’s World Trade Centre “… all was not well on the political front … (since) … CODESA 2 started and deadlocked almost immediately” in spite of the schedule which made provision that the negotiations would last for three days while preparing and paving the way for a conducive atmosphere for the major negotiations. The reason that they were tough was because the trust Nelson Mandela had in President de Klerk was betrayed by the delaying tactics displayed by the representatives of the white minority government. Although the negotiations were tough and suffered a serious setback, Nelson Mandela and other prominent political organizations did not give up but worked hard to achieve the political goals of the Government of National Unity.

The country’s first non-racial elections saw the African National Congress (ANC) achieving great success with 62,0% of the total votes, becoming the majority party in the Government of National Unity (GNU). The political success of the ANC in 1994 was considered as a massive victory obtained by the freedom liberation organization, which fought for democracy and defended the independence of this country against the apartheid system. The country’s political transformation from an apartheid-driven society to a non-racial and non-sexist democratic government was undoubtedly one of the major, if not the major, global news items in 1994 when it became the first democratic government in South Africa to replace the apartheid regime with confidence and the full mandate of the voters (Davenport and Saunders, 2000:568-569; Pape et al, 2007:360; South Africa Yearbook, 2007/08:41).

The Republic of South Africa Constitution of 1983 prevailed during the apartheid era and the institutions that were created as a result of it were simply to further oppress and dominate black people, denying them their democratic right to participate in the decision-making process of their political and democratic affairs in this country while at the same time promoting and advancing the policy of separate development. The four former provinces in South Africa were
abolished. Nine (9) new provinces with different names were established in this country of which the province of Northern Transvaal (now called Limpopo) is one of afore-mentioned provinces which came into being during the term of office of the Government of National Unity (GNU) (Cloete, 1998:8; The Constitution of the Republic of South Africa, 1996:6).

The significant role played by the new Government of National Unity (GNU) was that it brought all different political parties together by following the policy of the interim Government of National Unity (GNU). The GNU ensured that all major parties were represented in the new government with a view to paving the way towards fundamental democracy. Since the ANC had achieved an overwhelming victory in the 1994 general elections (62.0%) in order to bring about the reconciliation process among the different political parties, it ensured that it appointed a significant number of Cabinet Ministers from the National Party and it was for the purpose of reconciliation that the former President FW de Klerk was appointed as one of the two deputy presidents in the new democratic government in South Africa. There were two positions of deputy president in the ANC-led democratic government, the other position being occupied by Thabo Mbeki before he was appointed to the position of the President of the Republic of South Africa succeeding the former and first President of the democratic government of the Republic of South Africa, President Nelson Mandela. The new Government of National Unity (GNU) began to dismantle all the political structures set up by the National Party regime in order to cater for the interests and aspirations of the black people, Indians and Coloured people as well as those of the White people. The Government of National Unity served as a compromise when the apartheid government agreed to share political power with all other people. A freely-elected government was a major step toward the transformation of South African society as a way of building a new South Africa. (Davenport and Saunders, 2000:379; Pape et al, 2007:360).

The Government of National Unity dissolved immediately after the passage of the Constitution Bill in May 1996 following which the Deputy President de Klerk announced that the NP would leave the Government of National Unity (GNU) to take up the unfamiliar role of opposition party to the ANC-led government. The National Party, which had participated in the GNU, later left the government to continue to serve as the opposition party within the government of South Africa (Davenport and Saunders, 2000:583).
2.2.2  *The transformation period between 1994 and 2004 in the Republic of South Africa*

The political interaction between the white people and the black people has been harmonious and sound ever since the attainment of a democratic government in 1994. Both white people and black people acknowledged and accepted the existence of each other as equal partners in this country in terms of the new democratic Constitution of 1996. The South African government became a non-racial democracy after the 1994 elections governed by a code of entrenched fundamental rights, and structured levels of legislature comprising a dominant National Assembly (NA) and a specialized National Council of Provinces (NCOP). The 9 provinces were established in terms of the interim Constitution of 1993 (200 of 1993). Each of the under-mentioned provinces has its own legislature and is retained collectively as constituting a second sphere of government, while a new system of local government was created as the third sphere of government by ordinary legislation as outlined in the new Constitution of 1996.
The provinces with their own distinctive landscapes, vegetation and climate, are the Western Cape, the Eastern Cape, KwaZulu-Natal, the Northern Cape, Free State, North West, Gauteng, Mpumalanga and Limpopo (South African Yearbook 2007/08:7). Proportional representation in the Parliament, the Provincial Legislature and the Municipal Councils was introduced in the national, provincial and local spheres of government of the Republic of South Africa respectively (Davenport and Saunders, 2000:572).
2.2.2.1 The 1994 general elections in the Republic of South Africa

The armed struggle against the apartheid policy of the South African regime and the process of negotiation leading to the first general election on 27th April 1994 prompted many black and white people to think positively about the future of the South African government. The 1994 general election results showed that the African National Congress (ANC) scooped 63.0% or 12 237 655 votes of the total number of votes, followed by the National Party (NP), which obtained 20% or 3 983 690 votes. The Inkatha Freedom Party (IFP) scored 11% or 2 058 294 votes, while the Freedom Front (FF) obtained only 2% or 424 555 votes of the total votes. The Democratic Party (DA) won 2% or 338 426 votes and finally, the Pan African Congress (PAC) won 1% or 243 476 votes of the total votes. The 1994 general election results indicated that the ANC had absolute control over 7 of the 9 provinces in this country, but fractionally less than the parliamentary two-thirds majority that it would have needed to write the next constitution of this country on its own. In the first National Assembly of the democratic South Africa, the African National Congress/South African Communist Party (ANC/SACP) had collectively won 252 seats, followed by the National Party (NP) which had won 82 seats. The Inkatha freedom Party (IFP) had won 43 seats, the FF had won 9 seats, the Democratic Party (DP) had won 7 seats, the Pan African Congress (PAC) had won 5 seats, and the African Christian Democratic Party (ACDP) had won 2 seats. In the provincial election held on the same day together with the national election, the ANC won the Eastern Transvaal Province (later renamed Mpumalanga), the North West province, the Northern Province (later renamed Limpopo), the Free State Province, and the Eastern Cape Province with sweeping majorities. The ANC gained a two-thirds majority in Gauteng as well and a narrow win in the Northern Cape. It polled 63.0% of the total votes across all 9 provinces. The NP won the Western Cape with an outright majority over the ANC, and the DP polled 20% of the total votes. The Inkatha Freedom Party won KwaZulu-Natal with a narrow margin over the ANC, with the NP and the DP together polling 50.35% of the total votes, but only 10.5% across all the parties. The interim Constitution of 1993 laid down conditions according to which the country should be governed by a President, elected by the National Assembly (NA), who would also be the head of state during the term of office of the Government of National Unity (GNU) composed of members of various political parties which had obtained 20 or more seats in the National Assembly and that process was to be accomplished in proportion to their political strength.

The Republic of South Africa held national and provincial elections to elect a new National Assembly as well as a provincial legislature in each of the 9 provinces on 22\textsuperscript{nd} April 2009. The current National Assembly consists of 400 members elected by proportional representation with a closed list approach. The 200 members are elected from national party lists while the remaining 200 are elected from provincial party lists in each of the nine provinces of this country. The President of the Republic of South Africa is elected by the National Assembly after each election whereas the Premiers of each province are selected by the winning majority party in each provincial legislature (http://www.limpopo.gov.za).

The Republic of South Africa uses a multi-member constituency proportional system to allocate the 400 seats in the National Assembly. There are 10 constituencies altogether, namely, one provincial constituency corresponding to each of the nine provinces and one national constituency. The parties participate in the Constitution of the National Assembly by providing lists of names in respect of each constituency. If all parties provide national lists, then 200 seats are allocated from national lists and 200 from provincial lists. The provincial seat allocation was as follows (http://www.Limpopo.gov.za).

The National Council of Provinces (NCOP), which is the other constitutional component of the parliament, comprises 90 members with ten (10) members being elected by each provincial legislature. The ninety (90) members of the NCOP have to be elected in proportion to the party membership of the provincial legislature (http://www.limpopo.gov.za).

The seats in each Provincial Legislature or Provincial Parliament in this country are allocated in terms of the proportional representation from a single constituency and it is only those political parties that have won seats in the general elections that qualify to constitute the National Council of Provinces (http://www.limpopo.gov.za).
Subsequent to the general elections held on 22nd April 2009 the following are the results of the first few political parties that won no fewer than 4 seats in the National Assembly. The African National Congress (ANC) won 11 650 748 or 65.90% votes, and obtained 264 seats, followed by the Democratic Alliance (DA) which won 2 945 829 or 16.66% votes, and obtained 67 seats. The Congress of the People (COPE) won 1 311 027 or 7.42% votes and secured thirty 30 seats while the Inkatha Freedom Party (IFP) won 804 260 or 4.55% votes with 18 seats. The Independent Democrats (ID) won 162 915 or 0.92% votes with 4 seats while the United Democratic Movement (UDM) won 149 680 or 0.85% votes with 4 seats. The Freedom Front Plus (VF+) won 146 796 or 0.83% votes with 4 seats and the African Christian Democratic Party (ACDP) won 142 658 or 0.81% votes with 4 seats in the National Assembly. The remaining political parties obtained less than 4% of the total votes cast during the 2009 national and provincial general elections.

The African National Congress, which has been in power since 1994, obtained 65.90% of the total votes cast in the 2009 national ballot, and just missed obtaining the two-thirds majority required in order to be able to change the South African Constitution. It is still the ruling party in Parliament following the attainment of the overwhelming, magnificent and a huge successful victory in the 2009 general election. The Democratic Alliance Party took control of the Western Cape provincial government in the 2009 provincial election. It also consolidated its position as the official opposition party increasing its seats in the National Assembly from

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http://www.limpopo.gov.za
2.2.2.2 The defragmentation of South Africa into a unitary democratic government

The Republic of South Africa was fragmented before 1994 into 4 TBVC ‘homelands’, 6 ‘territories’ designed for occupation by black people only and the 4 provincial administrations of the Cape Province, Orange Free State Province, Natal Province and Transvaal Province (Liebenberg and Spies, 1993:434).

The population of the Republic of South Africa consists of black, white, coloured and Indian/Asian groups of people. According to the second census released on 10 October 2001, there were altogether 44 819 778 people in this country. 79% of the 44 819 778 people were Africans, 9.6% were Whites, 8.9% were Coloureds and 2.5% were Indians/Asians. The black people were in the majority because altogether 35.4 million people of the total South African population were black. The entire population was estimated at 47.9 million people mid-2007 (South African Yearbook 2007/08:2).

2.2.2.3 The establishment of provincial and local governments

The Republic of South Africa underwent enormous geographical transformation due to the implementation of the apartheid policy. The major challenges of concern to the citizens of this country are primarily to have effective, transparent, open, loyal and efficient local governance.

In order to understand the need for the implementation of a transformation process, especially after the 1994 democratic elections, it is essential to realize that South Africa did not have recognized fixed and legalized boundaries during its colonization by Dutch and British governments (Van Aswegen, 1990:vii).

2.2.2.4 The establishment of Parliament, Legislatures and Councils

Section 40 (1) of the Constitution of 1996 provides that the Republic of South Africa as a sovereign state is the government which “… is constituted as national, provincial and local
spheres of government which are distinctive, interdependent and interrelated” and all spheres of government and organs of state within each sphere must comply with all principles stipulated in Section 41(1) of the same Constitution. The following sections focus upon the composition and function of the parliament, provincial legislatures and local government Councils.

2.2.2.4.1 The Parliament

The interim Constitution of 1993 was the first legal framework in the Republic of South Africa that brought the democracy into being. It authorized the democratic constitutional transformation and eventually gave all the people regardless of their colour, creed or race the same rights and freedoms. It was the first supreme Constitution of the country which prevailed over all previous pieces of oppressive and discriminatory apartheid legislation and was eventually repealed in 1996 by another supreme Constitution of 1996 of South Africa.

Roux et al. (1997:41) comment that the Constitution of the Republic of South Africa of 1993, in contrast with the Constitution of 1983, makes provision for a central Parliament consisting of a National Assembly and the National Council of Provinces (NCOP). It is worth noting that the Senate was replaced by the Council of Provinces (NCOP) when the interim Constitution of 1993 was replaced with the Constitution of the Republic of South Africa of 1996.

The current National Assembly of the Republic of South Africa comprises 400 members that are divided between 200 seats for the National list and 200 seats reserved for regional seats. In terms of Section 60(1) of The Constitution of the Republic of South Africa, 1996, “The National Council of Provinces is composed of a single delegation from each province consisting of ten delegates.” There are presently 90 delegates, 10 delegates from each of the 9 provinces, which constitute the National Council of Provinces in the Parliament of South Africa. The members of NCOP are indirectly elected by the respective nine Provincial Legislatures, also on the basis of proportional representation. Any bill has to be approved by both Houses of the National Assembly and the National Council of Provinces (NCOP) as a joint venture and especially by the majority of members present if it is to be signed by the President to be accorded the status of legislation. The NCOP must have a mandate from the provinces before it can make certain decisions. It cannot initiate a bill concerning finances
since this is a competency and prerogative of the Minister of Finance (South African Yearbook 2007/08:281). The National Assembly is established in terms of Section 46(1) of The Constitution of the Republic of South Africa, 1996. It is comprised of 90 members renamed ‘delegates’ to emphasize the different role of the NCOP from that of the previous upper House. The NCOP consists of 54 permanent members and 36 special delegates and is to represent provincial interests in the national sphere of government. The 9 provinces defined in the interim Constitution of the Republic of South Africa 1993 remained intact in the Constitution of the Republic of South Africa of 1996 which defines their territorial form of government and powers (Davenport and Saunders, 2000:575 and 576; IEC, 2009:1).

The parliament is the highest legislative authority or law-making institution of the Republic of South Africa and has the power to make legislation for the country in accordance with the Constitution. The National Assembly is presided over by the Speaker, assisted by the Deputy Speaker. It is elected to represent the people and to ensure democratic governance as required by the Constitution of 1996.

The National Assembly is elected on the basis of proportional representation, which means that the number of seats the party receives in parliament is in direct proportion to the number of votes gained during the general election. According to constitutional provisions, 200 members of the National Assembly are elected on a national list and the remaining 200 members on the basis of the provincial lists submitted to Parliament by various qualifying political parties. Section 49(1) of the Constitution of 1996 provides that “The National Assembly is elected for a term of five years only” and as such the provision applies to the term of office of the NCOP, that is, the term of office of the Parliament since the National Assembly and the National Council of Provinces are components thereof, and its term of office is, therefore, also 5 years.

One of the most important responsibilities of Parliament is, among others, to pass and amend legislation in accordance with Section 44(1)(a)(b)) with regard to a matter falling within a functional area listed in Schedule 5, whenever it is deemed necessary; and Section 44(2) furthermore lists all the functions that fall within its jurisdiction and mandate such as maintaining national security, economic unity, essential national standards and establishing minimum standards required for service delivery.
The prime objective of every legislature is to pass legislation on the matters entrusted to it by the Constitution of 1996. The Republic of South Africa is a unitary state with the legislative powers vested only in parliament, which is constitutionally empowered to pass legislation for the country even on those matters that are delegated to subordinate legislatures such as the provincial legislatures and local government councils. Parliament is vested with powers which prevail over those of the Provincial Legislatures and the Local Government Councils. That means that it has a full mandate to overrule and veto those mandates of the Provincial or Local Governments if they are inconsistent with the Constitution of 1996 or any of the pieces of legislation that were developed within the framework and parameters of the Constitution of 1996. The South African Parliament, unlike the previous 1983 Parliament, is democratic in nature since democracy is demonstrated by the observation of, inter alia, human rights, respect, freedom and transparency as enshrined in the Constitution of 1996 as well as in other pieces of legislation and the Bill of Rights. All the people are equal before the law in this country and failure to observe democratic principles and values is unconstitutional since no one is above the law. The current machinery of government is organized in a manner that allows transparent, frank and honest deliberation, consultation and the exercise of discipline. The objective of democracy is, therefore, to create conditions under which each individual is able to achieve the greatest well-being in this country conducive to the promotion and improvement of service delivery (Cloete, 1998:42).

The Constitution of 1996 is the supreme law of the Republic of South Africa and no other piece of legislation or government action can supersede the provisions of the Constitution of 1996. There is an acknowledgement that the Constitution of 1996 of South Africa is one of the most progressive Constitutions in the world and enjoys high acclaim internationally. According to Chapter One of the Constitution, South Africa is a sovereign and democratic state founded on values enshrined in it and its spheres of government are distinctive, interdependent and interrelated (South African Yearbook 2007/08:296; The Constitution of the Republic of South Africa, 1996:3).

2.2.2.4.2 The provincial legislatures

Section 104(1) of the Constitution of 1996 makes provision for the establishment of provincial legislatures by stating that “The legislative authority of a province is vested in its provincial
legislature …” which is responsible for, inter alia, passing and amending a Constitution for its own province. The legislature of each province in South Africa was established as provided for in terms of section 103(1) of the Constitution of the Republic of South Africa, 1996.

The Limpopo Province legislature, which was also established in terms of the same Act, consists of 49 legislative members from various political parties. 10 members of the legislature are redeployed to the National Parliament in terms of the Constitution of 1996 to constitute the NCOP and of the remaining members of the provincial legislature there are 10 Members of the Executive Council (MECs) including the Premier, who is the political head of the province, to constitute the Executive Council. The provisions for proportional representation are necessary to accommodate the heterogeneity of the South African population and to ensure checks and balances to represent specific political parties, population groups or provinces from gaining excessive powers and becoming oppressive, abusive, dominant and exploitative as was the case during the apartheid era. During the apartheid era political power was concentrated in the white people. The current Constitution of 1996 was formulated in such a manner that power is neither vested in the President nor the Cabinet, but rather in the parliament as the entire authority is concentrated in the supreme law, that is, the Constitution of 1996 (Cloete, 1998:12).

2.2.2.4.3 The Local Governments and the Councils

Section 151(1)(2) of the Constitution of 1996 makes provision for the establishment of local government, which consists of various Municipalities in this province. The executive and legislative authority of municipalities is vested in its Municipal Council as set out in Section 156 of the current Constitution of 1996 of this country. The District Municipalities that constitute the Limpopo Province are now only 5, namely, Capricorn District Municipality, Mopani District Municipality, Sekhukhune District Municipality, Vhembe District Municipality and Waterberg District Municipality as Bohlabela District Municipality was incorporated into Mpumalanga Province in 2006 (The Constitution of 1996:84-85).

There are altogether 282 municipalities in the Republic of South Africa that are focused particularly on growing local economies and providing infrastructure and services. They are responsible for growing and sustaining local economies and providing infrastructure and basic

2.3 CONCLUSION

Chapter two focused on the effects of the colonization of South Africa by the British government and the occupation of the country by the apartheid regime until 1994 when the democratic government was elevated to political power by election by secret ballot. The various policies that were apartheid-related, which had been implemented since and before 1910, denied the indigenous people, particularly the black population groups, their South African birthright when the white people took over the control of this country.

The period from 1910 to 1994 was dominated by all possible efforts and endeavours by the different apartheid regimes to try to transform the country socio-economically and politically to justify the existence of the apartheid system as genuine and acceptable practice in South Africa. Such efforts, which were believed would be everlasting, were short-lived as they were overtaken by democracy in 1994. Since 27th April 1994 the country has witnessed, among other things, the abolition of the Tri-cameral parliament, the establishment of the Government of National Unity (GNU), the granting of the franchise to all citizens of the country regardless of colour and creed and the change in government structures and their respective functions. This is a clear indication of the need to have the transformation process implemented in the entire country to address all past imbalances in order to benefit all the citizens. It is through the process of transformation that South Africa is trying to position herself to eradicate discrimination on the basis of colour, race, alleviation of poverty, reduction of the high rate of unemployment and improving the life styles of all the citizens of this country especially those in the peripheral areas of South Africa. All those imbalances in terms of service delivery were inherited by the new government when it ascended to power in 1994.

The apartheid system was based on several principles, the most important of which were the concentration of all power in the white people only, racial classification laws, racial sex laws,
the designation of group areas for each racial community, segregated schools and universities, the elimination of integrated public facilities and sport, protection of whites in the labour market, a system of influx control that stemmed the movement of blacks to the cities, and designated ‘homelands’ and ‘territories’ for the black people as the basis for preventing them from demanding rights in the common area.

The release of the prominent political leader Mr. Nelson Mandela on 2\textsuperscript{nd} February 1990, the lifting of the ban on liberation movements and the abolition of all apartheid laws were strong signals in the speech of the former President FW. de Klerk that the government was prepared and willing to dismantle or to completely do away with the apartheid policy. The implementation of the Constitution of 1983 commenced the process of transformation in South Africa, but it delayed the attainment of democracy by a period of about ten (10) years (Liebenberg and Spies, 1993:488). Subsequent to the peaceful achievement of democracy in 1994, it is opportune now to consider implementing vigorously, decisively and effectively the transformation process in this country (Liebenberg and Spies, 1993:526; 404-405; Pape \textit{et al}, 2007:357-358).

The negotiations that took place under the auspices of the Convention for a Democratic South Africa, ‘CODESA’, at the Trade Centre in Johannesburg in Gauteng Province during the 1990s, paved the way for the attainment of democracy. After the 1994 general elections, the Republic of South Africa emerged from the apartheid era which was characterized primarily by exploitation, oppression, marginalization, hatred, lack of transparency, ineffectiveness, inefficiency, corruption and discrimination by the minority white people over the majority black people of this country. The black people who led a miserable and unpleasant life under the apartheid system eventually embarked upon politically motivated unrest, protests and political violence, which were regarded as the catalysts for peace and democracy. Ever since the attainment of democracy in 1994, the Republic of South Africa has been a country of freedom and democracy which are accompanied by peace and political stability. The black people can now take positions of leadership in the communities and both the former Presidents, namely, Nelson Mandela and Thabo Mbeki, including the current President Jacob Zuma, are examples of internationally recognized leaders and South Africa is proud of their exemplary leadership. The perception that black people were not capable of delivering services and lacked leadership was a myth since there were prominent leaders who demonstrated practically and
had international recognition bestowed upon them by various communities in the world even after leaving the political arena (Liebenberg and Spies, 1993:532).

All these and many other historical and political developments culminated in the need to implement the transformation process to redress all the past imbalances that disadvantaged and marginalized the majority black people who were also the full-fledged citizens of the Republic of South Africa. The transformation process has been identified as one of the most effective and valuable mechanisms by means of which the quality of health-care service delivery could be improved so that the majority of the black people, who were excluded from all types of excellent basic services, could also become the beneficiaries after several decades of domination and discrimination by the now defunct apartheid regime.

The following chapter focuses mainly on the establishment of Limpopo Province and the five health districts and also the extent to which transformation affects the quality of services, that is, the extent to which the process promotes, improves and facilitates health-care service delivery in Vhembe Health District in particular and also in Limpopo Province in general.
CHAPTER THREE

THE ESTABLISHMENT OF LIMPOPO PROVINCE AND VHEMBE HEALTH DISTRICT IN 1994

3.1 INTRODUCTION

The Republic of South Africa is a country that has her own unique history of being illegally divided into smaller territories since 1652 by the white people without proper consultation with the indigenous people and the same scenario repeated itself when several traditional ‘homelands’ also known as ‘Bantustans’, independent states, four provinces were divided by the apartheid regime according to race. Hence, a brief scenario of Limpopo Province is necessary to ensure a better comprehension of why there is a need to implement the process of transformation for the equal benefit of all South African citizens regardless of their race, religion and colour. The Republic of South Africa has since 1994 changed geographical boundaries as well as representation. All these political and geographical transformations created a great challenge for the new South African government. Geographically, South Africa is situated on the dividing line between the Indian Ocean and the Atlantic Ocean and Limpopo Province is part of the Republic of South Africa (The Constitution of 1996:61).

Limpopo province lies in the northernmost part of Republic of South Africa within the great elbow of the Limpopo River. Limpopo Province was named after the beautiful river called the Limpopo that serves as the border between this country and Zimbabwe in the north. This province was renamed from the northern region of the former Transvaal province and came into being after the democratic general elections in 1994. Initially it was named the Northern Transvaal in 1994. In the following year (1995) the province was renamed Northern Province as a form of transformation in order to get an appropriate name for the province. The name was retained until 11th June 2003 when the name of the province was formally changed again and was called Limpopo Province after its most important river (South African Yearbook, 2008/09:23).

Limpopo Province is situated in the northernmost part of the Republic of South Africa and shares its international borders in the far north with the Republic of Zimbabwe especially the
Matabeleland South Province and Masvingo Province to the north and north-east respectively and in the east with the Republic of Mozambique. Limpopo Province shares international borders with districts and provinces of three neighbouring countries, namely, the Central and Kgatleng districts of the Republic of Botswana to the west and north-west respectively, the Gaza Province in the Republic of Mozambique to the east, Mpumalanga Province in the south-east and Gauteng Province in the south. Limpopo province’s border with Gauteng province includes the Johannesburg-Pretoria axis and North West province in the south-west. Limpopo Province forms the international link between the Republic of South Africa and other countries further afield in sub-Saharan Africa. The province offers a mosaic of exceptional scenic landscapes, a fascinating cultural heritage, and abundance of wildlife species and many nature-based tourism opportunities (http://www.golimpopo.com/towns29.htm).

There are four languages most commonly spoken in the province, namely, Northern Sotho (Sepedi), which makes up the largest number, being nearly 57%. The Tsonga (Shangaan) speakers comprise 23% while the Venda speakers make up 12%. The Afrikaans speakers make up 2.6% while English-speaking whites are less than a 0.5%. The population of Limpopo Province consists of several ethnic groups distinguished by culture, language and race. The composition of the people in the province is reflected as follows: 97.3% comprises the black people, 2.4% comprises the white people, 0.2% consists of Coloured people and 0.1% comprises Asian people (http://www.limpopo.gov.za).

3.2 LIMPOPO PROVINCE

Limpopo is one of the 9 provinces of this country and it serves as the best attraction for tourism by local and foreign tourists from within and from the neighbouring provinces and international communities in the world. The Department of Health and Social Development, as one of the governmental institutions that must be promptly and positively responsive to the challenges of providing adequate health-care services to the public, remains the custodian that ensures that patient health-care is always effectively promoted and facilitated. The main objective of the provincial department in terms of service delivery is to provide an acceptable health-care service at an affordable and appropriate price. In this regard the Batho-Pele principles are important bases on which the department’s vision and mission are based and developed. Those principles and values enshrined in the Constitution of 1996 are observed by
all health-care providers at all health-care facilities in the province. It is imperative to direct efforts that should be initiated towards the improvement of the performance of the Department of Health and Social Development especially the health-care facilities in the application of the Batho-Pele principles in all its endeavours (http://www.golimpopo.com/towns29.html).

The following departments comprise the administrative structure for Limpopo Province:

- Office of the Premier
- Department of Agriculture
- Department of Education
- Department of Health and Social Development
- Department of Safety, Security and Liaison
- Department of Treasury
- Department of Economic Affairs and Environment
- Department of Roads and Transport
- Department of Public Works
- Department of Local Government and Housing and

3.3 THE COMPOSITION AND FUNCTIONS OF THE PROVINCIAL LEGISLATURE

The Legislature of Limpopo Province, like the Parliament in the national sphere of government, is the highest law-making body in this province. The political Head of Limpopo Provincial Executive Council is the Premier, who is supported in the governance of the province by the other 9 Members of the Executive Council (MECs). Section 108(1) of the Constitution of 1996 provides that “A provincial legislature is elected for a term of five years. The powers of the Provincial Legislature are in terms of Section 114(1)(a)(b) stipulated, inter alia, to “…. consider, pass, amend or reject any Bills before the legislature;… (and to) initiate or prepare legislation, except money Bills.” before the Provincial Legislature (The Constitution of 1996:66).
3.4 THE ROLES OF THE MEMBERS OF THE EXECUTIVE COUNCIL (MEC’s)

According to the White Paper on Local Government, the Executive Council of a province consists of the Premier and Members of the Executive Council (also commonly referred to as MECs). All the provincial Premiers are, in terms of the provisions of the Constitution of 1996, appointed by the President of the country (The Constitution of the Republic of South Africa, 1996:61).

The MECs are the political heads of the provincial departments and their duties are, among others, to provide political direction and leadership in the province as directed by the Premier. Each MEC submits the bills of his/her department in the legislature for consideration and approval. He/she tables before the legislature any budget-related issues of the provincial department.

3.5 THE SOCIO-ECONOMIC PROSPERITY OF LIMPOPO PROVINCE

It is the responsibility of Limpopo Province to stimulate the economy in such a way that it creates job opportunities and wealth for its citizens, which is a vital condition towards the anticipated sustainability of development in the province. The importance of the creation of job opportunities and wealth has a direct bearing on the standard of living of its entire people and affords a better quality of life, self-reliance, distribution of resources and empowerment in the province. Most black people were economically excluded from the means of production and disadvantaged during the apartheid regime, but ever since the attainment of a democratic government in 1994, the provincial environment is affording its citizens the opportunity to actively participate in the economy to improve their lives.

This historical overview has highlighted how colonialism, imperialism and apartheid overshadowed the freedom and liberation direly longed for by all South Africans, especially the black people. During the apartheid era Limpopo Province also was racially demarcated into the former Gazankulu territory, Lebowa territory, Transvaal Administration and Venda ‘homeland’, which were not economically viable as they always depended upon the Republic of South Africa for their socio-economic survival Cloete, 1986:28-29).
Limpopo Province, from an economic perspective, is strategically situated at the northern-most tip of South Africa. It is ideally positioned for easy access to African markets. Its proximity to Zimbabwe, Mozambique and Botswana provides the investor confidence with a powerful platform from which to access the Southern African region and to contribute to as well as to benefit from the New Partnership for the Development of Africa (Pape et al, 2007:340-341).

According to the Community Survey conducted in 2007 the population of Limpopo Province is more than 5,2 million people in a geographical territory of about one hundred and twenty-three thousand nine hundred and ten square kilometers (123 910 km²) of land. It is geographically characterized by a primeval indigenous forests, latter-day plantations, unspoilt wilderness areas, and patchworks of farming land. In brief, the province is a mountainous province with mixed grassland and trees. Its popularity is also enhanced by being a mountainous province with indigenous forests, plantations, wilderness areas and farming land (http://www.limpopo.gov.za; South African Yearbook, 1999:23 and 24).

The province is strategically located for business and tourism and lies within the great elbow of the Limpopo Province. It is characterized by true bushveld country and majestic mountains, primeval indigenous forests, plantations, wilderness areas and farming land. It is basically a rural and poor province with its strategic growth centres addressing infrastructure backlogs created during the apartheid era such as unemployment, the alleviation of poverty and social development. Limpopo Province is considered the gateway to the rest of the African continent. It has excellent road, rail, and air links. The well-designed N1 route from Johannesburg goes through the province, and it is the busiest overland route on the African continent in terms of cross-border trade in raw materials and manufactured goods and services. The N1 interconnects a series of well-known towns. Further north there is Modimolle (formerly called Nylstroom) with its table grape industry and beautiful Waterberg mountain range, and Musina, far north and the last town before the border with Zimbabwe with its thick-set baobab trees was renamed Musina and Dendron was renamed Mogwadi. Crossing into Zimbabwe one reaches the well-known Beitbridge. The names of the cities have now been changed and are as follows: Warmbaths was renamed Bela-Bela with its popular mineral spa near the southern border of the province; Pietersburg was renamed Polokwane - the capital city, situated strategically in the centre of the province; Potgietersrus was renamed Mokopane; Naboomspruit was renamed Mookgopong; while Soekmekaar became Morebeng, Nylstroom was renamed Modimolle,
Ellisras is called Lephalale. There is also Makhado (formerly called Louis Trichardt) at the foot of the Soutpansberg Mountain range. All these changes were effected following the government’s initiative of implementing transformation in the whole country, the primary objective of which is to redress all imbalances of the past era. The port of Durban is served directly by the province as are the ports of Richards Bay and Maputo, and the Polokwane International Airport is strategically situated in Polokwane, the capital of Limpopo Province (http://www.limpopo.gov.za; http://www.golimpopo.com/owns29.html.; South African Yearbook, 1999:15 and 16).

The province is also favourably situated for economic cooperation with the other parts of southern Africa. It is also linked to the Maputo Development Corridors through the Phalaborwa SDI, which is basically a network of rail and road corridors connecting it to the major seaports in the east and has the prospect of opening up the province for trade and investments. This is complemented by the presence of smaller airports in Phalaborwa and Musina, as well as the Gateway International Airport in Polokwane. The Statistics South Africa figures reveal that the economy of Limpopo Province grew from 4.2% in 2005 to 4.6% in 2006. Limpopo Province is also beginning to observe a gradual decline in its unemployment rate from 35.6% in March 2006 to 27.6% in September 2007. In spite of the bleak picture painted of a province with a high unemployment rate, it is commendable that marketing efforts since the attainment of democracy in 1994 have increased fruit production and this is being effectively displayed and demonstrated by an increasing number of tourists visiting the province thereby boosting the economic output and creating chances of more job opportunities for the black inhabitants of the province in particular (Provincial Overview, 2003:16).

The bushveld in Limpopo Province is suitable for cattle farming. The province is the largest producer of various crops in the agricultural market such as sunflower, cotton, maize and peanuts, which are cultivated in the Bela-Bela and Modimolle municipalities. Tropical fruit such as bananas, litchis, pineapple, mangoes and pawpaws, as well as a variety of nuts, are grown abundantly in the Tzaneen and Makhado areas in this province. It is subtropical with hot, humid summers, mild winters and mostly frost-free. Its climatic conditions ultimately translate the province into becoming the national food basket since it produces about 60% of
the country’s tomatoes, 75% of its mangoes, 65% of its papaya, 33% of its oranges, 36% of its tea, 25% of its citrus, bananas and litchis and 60% of its avocados. It exports some of its fresh produce to foreign countries such as the People’s Republic of China (South African Yearbook 2007/08:6, 7 and 23-24). About 80% of South Africa's hunting industry is found in Limpopo Province. Modimolle is also known for producing table grapes. Tzaneen and Thathe-vondo in Venda are also known for the extensive tea and coffee plantations (http://www.limpopo.gov.za).

The other impressive feature of Limpopo Province is that it is a typical developing country rich in minerals. Limpopo Province’s rich mineral deposits include, inter alia, platinum group metals, iron ore, chromium, high and middle-grade coking coal, asbestos, diamonds, antimony, phosphate and copper, as well as mineral reserves like gold, emeralds, scheelite, magnetite, vermiculite, silicon and mica. Basic commodities such as black granite, corundum and feldspar are also found abundantly in the province. Mining is therefore a significant economic activity in this province and contributes to over one fifth of the provincial economic output (http://www.limpopo.gov.za; South African Yearbook 2007/08:24). The minerals are currently extracted and transported to other local markets such as Gauteng Province and abroad for further processing without much benefit to the local communities. The province exports raw products as it does not have the capacity, expertise or capability to process them locally and it imports manufactured goods and services for the benefit of its own communities.

The economy of this province is stimulated because both local and foreign investors are attracted here due to the fact that it is comparatively well-known as the province with the greatest political stability in the entire Republic of South Africa, and possibly in Africa. The greater part of the province is rural in nature, offering a wealth of cultural diversity for tourism. The province has high potential and capacity for appropriate economic development and is an attractive location for local and foreign investors (South African Yearbook 2007/08:24).

Prior to the attainment of democracy in 1994, the province had the reputation of being one of the largest producers of agricultural products such as most of the tomatoes in the entire country, with the largest bulk being produced on the farm called ‘ZZ2’ which is situated between Tzaneen and Makhado (formerly called Louis Trichardt). The province has a high
potential and capacity with the right kind of economic development, which is, of course, a strategic advantage for investors. Other important economic-oriented towns within the Limpopo province include the major mining centres of Phalaborwa and Thabazimbi, and Tzaneen, a major producer of tea, forestry products and tropical fruit. It is, therefore, clear that the province is placed at the centre of the regional, national, and international developing markets in the continent of Africa. It contains much of the Waterberg Biosphere, which is a UNESCO designated Biosphere Reserve. The Waterberg Biosphere that is approximately 15,000 km² is the first region in the northern part of South Africa to be named as a Biosphere Reserve by UNESCO. Geographically, the Waterberg district ecosystem within which there are archaeological finds dating to the Stone Age with early evolutionary finds related to the origin of humans is a dry deciduous forest or Bushveld (Waterberg District Municipality:en.wikipedia.org/wiki; http://www.Limpopo.gov.za).

3.6 THE ESTABLISHMENT OF LIMPOPO HEALTH DISTRICTS (DISTRICT MUNICIPALITIES)

Section 103(2) of the Constitution the Republic of South Africa of 1996 makes provision for the demarcation of geographical boundaries of the provinces that came into existence when the interim Constitution of 1993 as amended by the Constitution of 1996 of this country took effect. The Limpopo Province comprises five (previously six) district municipalities save the last one in the following list:

- Mopani District Municipality (DC33)
- Vhembe District Municipality (DC34)
Each of the above-mentioned districts consists of a certain number of municipalities and the number varies from one district to the other. The health-care subdistricts have been named.
after the current municipal areas. One of the five districts of Limpopo Province, hereafter also called the Vhembe Health District, consists of municipalities, namely, Makhado, Musina, Mutale and Thulamela (Vhembe District Municipality://en.wikipedia.org/wiki/Vhembe-DistrictMunicipality:1).

Both the vision and the mission of the Provincial Department of Health and Social Development were developed during a strategic planning workshop held at Bela-Bela in Waterberg District Municipality from 3rd to 6th August 2009, which are in operation during the current five-year term starting from 2009/2010 to 2011/2014 of the new provincial government that came into power immediately after the April 2009 general elections. The vision of the Department of Health and Social Development has been developed as follows: “A health-promoting and developmental service to the people of Limpopo”. This vision, which reflects a peaceful, vibrant, dynamic and self-sustaining province, serves to provide adequate and reliable health-care services in the entire Limpopo Province. The mission of the Department has been phrased as follows: “The Department is committed to providing sustainable health and developmental services of high quality through a comprehensive and integrated system”. Therefore, the mission is designed to provide health-care services in the entire province. The vision of the Department is closely linked to the Batho-Pele Principles as set out in provincial documentation (http://www.northernprovince.gov.za/docs/batho-pele.html; http://www.northernprovince.gov.za/docs/batho-pelehtml:1; The Constitution of 1996: Section 40–41).

The Department of Health and Social development in Limpopo Province is responsible for, among others, the provision and management of comprehensive health-care services at all levels of care, formulating and implementing provincial health policies, standards and pieces of legislation which are consistent with the Constitution of 1996 and the National Health Act of 2003, planning and managing a provincial health information system. The National Health Act of 2003 provides a framework for a single health system for the Republic of South Africa and furthermore highlights the rights and responsibilities of health-care providers and health-care users and ensures that there is broad community participation in health-care service delivery from health-care facility level up to the national level in the entire country (National Health Act of 2003:2).
3.6.1 Background of Vhembe Health District

Settlement of the Vhembe territory by the Boers began in the late 18th century and gradually continued throughout the 19th century. By the turn of the century, the Soutpansberg had been taken over from the Venda rulers by the Boers, making it one of the last areas in the future Republic of South Africa to come under white control. During the apartheid era, the Bantustan of Venda that was declared independent on 13th September 1979 was established in the eastern part of the Vhembe area and was reintegrated into the country at the end of white minority rule in 1994. The former Bantustan capital, Thohoyandou, which was named after the chief that had led the expansion of the Venda Empire in the 18th century, is the current capital of both Vhembe Health District and Thulamela Municipality (Vhembe District Municipality://en.wikipedia.org/wiki/Vhembe-DistrictMunicipality:1; http://www.limpopo.gov.za).

3.6.2 Demarcation of Health Districts (Municipal Districts)

The Constitution of the Republic of South Africa, 1996 Section 151(1) stipulates that the whole of South Africa must be demarcated into municipalities. This is done in terms of the Local Government: Municipal Demarcation, 1998, Section 21. The municipalities have been demarcated into categories and established in terms of Section 155(1) of the Constitution of 1996 of the Republic of South Africa and also according to the Local Government: Municipal Structures Act of 1998 in terms of Sections 2 and 3.

When the Constitution of 1996 came into effect, South Africa had a fairly well-developed system of municipal authorities and as a result the Health Districts eventually adopted the District Municipal geographical boundaries. The Health District authorities were established to perform their functions in terms of the provisions of the relevant pieces of legislation of Parliament and provincial ordinances. Both the Parliament and the Provincial Legislature as well as the Municipal Council are the law-making institutions and are subject to the provisions of the Constitution of 1996 (Cloete, 1998:34).

The Municipal Demarcation Act of 1998, which provides for the establishment of the Board ensures that one of its main functions is to determine municipal boundaries in accordance with the Act and other related pieces of legislation and to advise on demarcation matters. It is also
tasked with delimiting wards into manageable metropolitan and local municipalities. The Constitution of 1996 provides for the establishment of three categories of municipalities and as directed by it, the Local Government: Municipal Structures of 1998 contains criteria for determining when an area must have a category A, B or C municipality. For instance, Category A refers to the Metropolitan Municipality that has exclusive municipal executive and legislative authority, and when it falls into Category B it is a Local Municipality that shares municipal executive and legislative authority in its area with Category C municipality within whose area it falls and category C refers to the District Municipality that has municipal executive and legislative authority in an area that includes more than one municipality (South African Yearbook, 2007/08:302 & 303). It is in terms of these categories that Vhembe Health District is established within or has adopted the boundaries of Vhembe District Municipality and its respective municipalities, namely, Makhado, Musina, Mutale and Thulamela. Vhembe District Municipality is a category C Municipality. The subdistricts have adopted the boundaries of the municipalities (http://www.Vhembe District Municipality.wikipedia.org.wikipedia/vhembeDistrictMunicipality:2; http://www.thedplg.gov.za/subwebsites/wpaper/wp4.htm:1).

The Health District authorities within each district municipality are presently still independent of the municipal administrative jurisdiction, and are currently subject to the directives and control exercised by the National and Provincial Department of Health and Social Development. One of the most important objectives of the Department of Health and Social Development in the Limpopo Province is, therefore, to promote a safe and healthy environment (National Health Act of 2003:2; Vhembe District Municipality://en.wikipedia.org/wiki/Vhembe-DistrictMunicipality:2).

The Vhembe Health District comprises a vast area of the former Venda Administration and part of the former Transvaal Provincial Administration. The Department of Health and Social Development in Limpopo Province has successfully integrated all the various health-care facilities such as the hospitals, primary health-care facilities (PHC’s) and human resources of the former apartheid government into a unitary manageable health-care system.
3.6.3 Vhembe Health District (vision and mission)

Thohoyandou, which means "head of the elephant" in the Venda language, is the current legislative and administrative capital of the Vhembe District Municipality and Thulamela Municipality in the Limpopo Province in South Africa. The capital is also a bustling centre of commerce that is well served with shopping complexes, an interesting museum and a hotel and casino of international standard.

Thohoyandou is situated in the south of Vhembe District Municipality and it is the lush agricultural centre of the district, with its banana plantations, acres of sub-tropical fruit, tobacco and maize lands. It is the main development node in the Thulamela Local Municipal area with a total of approximately 80 000 residents within the proclaimed boundaries of the town. It is further surrounded by numerous rural settlements situated on the outskirts of the proclaimed area (Vhembe District Municipality://en.wikipedia.org/wiki/Vhembe-DistrictMunicipality:1; http://www.golimpopo.com/towns29.html).

The vision of Vhembe District in Limpopo Province has been developed as follows: “A health-promoting and developmental service to the people of Vhembe District”. The vision is to provide adequate, affordable and reliable health-care services in Limpopo Province, while the mission of Vhembe District has been phrased as follows: “The Department is committed to providing sustainable health and developmental services of high quality through a comprehensive and integrated system”. The mission is therefore designed to provide health-care services to the entire province. The vision adopted by the district from the department is closely linked to the Batho-Pele Principles as set out in the provincial documentation (http://www.northernprovince.gov.za/docs/batho-pele.html) as well as in the Constitution of 1996, Section 40–41.

This study deals with the Vhembe Health District as determined by the Provincial Department of Health and Social Development, which corresponds with that of the Vhembe District Municipality as determined by the Local Government: Municipal Demarcation Act, 1998 (in terms of Section 21).
3.6.4 Vhembe District Health-Care Facilities

There are four categories of health-care facilities providing health-care services to clients in the Vhembe Health District. There is one provincial hospital called Tshilidzini, one specialized hospital called Hayani, 6 district hospitals, namely, Donald Fraser, Elim, Malamulele, Louis Trichardt Memorial, Siloam and Messina; and 8 Community Health Centres, namely, 4 in Makhado Municipality, namely, Bhungeni, Tiyani, Tshilwavhusiku, Makhado and 3 in Thulamela subdistrict, namely, Mphambo, Thohoyandou and William Eadie, and Mutale based at Mutale subdistrict or municipality. There is no Community Health Centre in Musina subdistrict. There are a total of 120 primary health-care facilities or clinics including ‘Gateway’ clinics (PHC’s) within Vhembe Health District.

The main geographic feature of Vhembe Health District is the beautiful range of Soutpansberg Mountains. The district is surround by the Republic of Zimbabwe to the north, Capricorn (DC35) to the South-west, Mopani district (DC33) to the east, and Waterberg (DC36) to the west and Sekhukhune (DC37) within the Limpopo Province. Vhembe Health District (DC34) covers a vast area of over 21 000 km². The Vhembe District Municipality is basically a rural and mountainous area where extensive use is made of its mobile clinic network system so that health-care services are accessible to those patients who do not stay within 5 walking kilometres from their homes in Vhembe district (Madzivhandila, 2006:129-130; Vhembe District Municipality://en.wikipedia.org/wiki/Vhembe-District-Municipality:2).

The population of Thulamela municipality is 584 568 or 48,71% of the people while that of Makhado Municipality is 497 093 or 41,43%. The population of Mutale Municipality is 78 917 or 6,58% and Musina Municipality has a population of 39 308 or 3,28% people. The total population of Vhembe Health District which is 1 199 886 or 100% is served by the above-mentioned 8 hospitals and 8 community health-care centers (Vhembe District Municipality://en.wikipedia.org/wiki/Vhembe-District-Municipality:1).
TABLE 3.1

The local municipalities out of which Vhembe Health District consists

<table>
<thead>
<tr>
<th>Local municipality</th>
<th>Population</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Thulamela</td>
<td>584 568</td>
<td>48.71%</td>
</tr>
<tr>
<td>Makhado</td>
<td>497 093</td>
<td>41.43%</td>
</tr>
<tr>
<td>[Mutale]</td>
<td>78 917</td>
<td>6.58%</td>
</tr>
<tr>
<td>Musina</td>
<td>39 308</td>
<td>3.28%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1 199 886</td>
<td>100%</td>
</tr>
</tbody>
</table>


The recently established Vhembe District Municipality was originally settled by now-expired tribes of Khoisan people. It was later settled by the Venda people recently migrated from what is now called Matabeleland South in Zimbabwe, who constitute the majority of the population of Vhembe today. The Dzata ruins in Thulamela local municipality once served as the main settlement and capital of the former Venda Empire which had dominated the area during the 18th century (Vhembe District Municipality://en.wikipedia.org/wiki/Vhembe-DistrictMunicipality:1; http://www.limpopo.gov.za).

The Boer settlement of Vhembe territory commenced in the late 18th century and gradually continued throughout the 19th century. By the turn of the century, the Soutpansberg had already been invaded and taken over from the Venda inhabitants by the Boers, making it one of the last areas in the future Republic of South Africa to come under the control of the white people. It
was in 1973 during the apartheid regime in South Africa that the Venda territory was declared self-governing and on 13th September 1979 it became independent and was established in the eastern part of the current Vhembe Health District. It was later reintegrated into South Africa at the end of the white minority government when the new democratic government came into power in 1994. The former capital of the ‘homeland’ of Venda, Thohoyandou, named after the chief that had led the expansion of the Venda Empire in the 18th century, is the current capital of both Thulamela Municipality and Vhembe District Municipality (Vhembe District Municipality://en.wikipedia.org/wiki/Vhembe-DistrictMunicipality:1).

The Venda people were the indigenous people of Vhembe District previously called Venda territory before the arrival of the white farmers during the late 18th century. The political and socio-economic destiny of the Venda people was under the control of the white people until 1994. Vhembe is one of the 5 health-care districts comprising the Limpopo Province in South Africa. It is the most northerly district of the province and shares its northern border with Beitbridge district in Matabeleland South of Zimbabwe. According to the 2001 census, the majority of 1 199 886 are Venda-speaking people (2001 Census). The district code is DC34. Vhembe District covers a vast land area of over 21 000 km² with a total population of 1 199 886 people. The Vhembe Health District is, therefore, the main focus of this study and consists of the following (subdistricts) municipalities (Vhembe DistrictMunicipality://en.wikipedia.org/wiki/Vhembe-DistrictMunicipality:2).

- Makhado
- Musina
- Mutale and
- Thulamela (Republic of South Africa: Division of Revenue Act, 2003 (Schedule).

Makhado municipality is in the south-west of Vhembe Health District while the Musina Municipality is situated in the far north of the district. Mutale Municipality is located in the north-east of the district while the Thulamela Municipality is in the south-east of Vhembe Health District. Figure 3.2 below reflects the geographical locations of the four health
subdistricts of Vhembe Health District as adopted from Vhembe District Municipality together with its four municipalities.


Figure 3.2: Vhembe Health District

3.7 The establishment of a single public service in South Africa

The government structure of South Africa consists of three spheres of government. The first sphere is the national government for the country as a whole. The second sphere of government consists of the 9 provincial governments, with each one being responsible for the delivery of certain designated services to their respective communities. The third sphere of government consists of the local governments, which are responsible for delivering basic services to their respective local communities. Each sphere of government is responsible for a specific type of services to deliver to the members of the communities. The executive institutions and functionaries at all spheres of government have been divided into two groups, namely, the
political executive institutions and functionaries, which are referred to as political office-bearers, and the administrative executive and functionaries also called public servants (Cloete, 1998:18; Van der Waldt and du Toit, 2001:90 and 91). The administrative institutions in the national sphere of government are state departments functioning under the control of Ministers who are members of the Cabinet and the same institutions in the provincial sphere of government are under the control of the Members of the Executive Councils (MECs) of the provinces. Finally, the district municipalities and municipalities are under the management and control of the Executive Mayors and municipal Mayors respectively as a way of enforcing and implementing effective and efficient governance in the province and particularly transformation (Cloete, 1986:28-30).

Subsequent to CODESA deliberations in 1991, GNU was eventually established to pave way for the democratic government. The public service inherited in 1994 was immensely fragmented. South Africa was characterized by a high level of fragmentation in terms of structures and health-care services. There is now a single public service in place, the activities of which are regulated by the Public Service Commission, which was established as one of the state organs in terms of the Constitution of 1996. The most urgent priorities of the new administration were the consolidation and centralization of the civil service to administer the various departments. The assets and liabilities of the four former provinces, the four former ‘homelands’ and six former ‘territories’ were taken over by the new democratic Government of National Unity (GNU) and provision was made to relocate and redistribute the existing assets to the 9 provinces of the Republic of South Africa (Liebenberg and Spies, 1993:532; The Constitution Act of 1996:112; Thompson, 1995:251).

The Limpopo Provincial government, like other provinces in South Africa, underwent both transitional and transformational processes in terms of the November 1995 White Paper on Transformation of the Public Service, as it applies to other Provinces. The focus of the present study was on the exploration of transformation process in terms of the provision of health-care services as there was inequality in this regard during apartheid era in the provision of such services between black and white population groups. Political transformation was attained in 1994 but economic transformation is presently still questionable since the economy of this country is still controlled by the white minority population group and very few elite black people. Subsequent to the successful completion of the rationalization process, which was to
integrate all systems since 1994 (Marule, 2000:44), Limpopo Province deserves to be commended on the successful integration and amalgamation of the Venda ‘homeland’, the ‘self-governing’ territories of Gazankulu and Lebowa, and the Transvaal Provincial Administration (TPA) into a unitary Limpopo Province. Polokwane was eventually declared the capital city of Limpopo Province and all the most senior government officials from the former ‘homeland’ of Venda, Transvaal Provincial Administration (TPA) and the six ‘self-governing’ territories of Gazankulu, Lebowa and Qwaqwa were redeployed to the capital city of Polokwane for the purpose of harmonizing management and the performance of the provincial government under a single Public Service of the Republic of South Africa.

When the GNU came into power it witnessed that administrative transformation in this country was necessary because it “… inherited a society marked by deep social and economic inequalities as well as by serious racial, political and social divisions” and the government identified the public service as one of the institutional transformation and reform agencies to ensure that there is an establishment of a single public service to monitor and manage the activities of all public servants. The Public Service Act of 1994 (Proclamation No. 103/1994) makes provision on the basis of the integration and amalgamation of the already-created fragmented systems of state administration inherited from the apartheid government for transformation into a single unified national public service (Constitution Act of 1996:115 and WPTPS, 1995:2).

3.8 THE POST-TRANSFORMATION PERIOD BETWEEN 2005 AND 2009

The post-transformation period in the context of this study was the period that extended from 2005 to 2009. This transformational period ranging from 2005 to 2009 disregarded the period of service delivery achieved by the African National Congress-led government since the term of office of the Government of National Unity (GNU) came to an end immediately after the 2004 general elections in spite of the fact that the elections gave the ANC a clear mandate to constitute its own government. The first President of the first democratic government, Nelson Mandela, who led the GNU, served only one term instead of the two terms of office provided for in terms of the Constitution of 1996. He was succeeded by Thabo Mbeki who served the country for two terms as the President of this country until he witnessed the post-transformation era although he did not complete the full second term as he was recalled by the
ANC due to certain internal and insurmountable political challenges within the organisation itself. The first period of 5 years after the achievement of democracy was primarily devoted to the repeal of all oppressive and discriminatory pieces of legislation that were inconsistent with the provisions of the current supreme law, the Constitution of 1996, which also contains the Bill of Rights.

The Constitution of 1996 is the supreme law on which all other pieces of legislation which are consistent with it are based. The fragmented departments, institutions, state organs and services were all integrated into single relevant departments and services including the creation of a single Department of Health responsible for the provision of the health-care services, including the establishment of the 9 provincial health departments but still under one Department of Health. This eliminated the fragmentation of various health-care departments that were in existence in the now defunct South African public administrations, the former ‘homelands’ and the former ‘self-governing’ territories.

3.9 CONCLUSION

Chapter three focused attention mainly on the establishment of Limpopo Province and the five health districts and also the extent to which transformation affects the quality of services, that is, the extent to which the process promotes, improves and facilitates health-care service delivery in Venda Health District in particular and also in Limpopo Province in general.

The Department of Health and Social development in Limpopo Province is responsible for, among others, the provision and management of comprehensive health-care services at all levels of care, formulating and implementing provincial health policies, standards and pieces of legislation which are consistent with the Constitution of 1996 and the National Health Act of 2003, planning and managing a provincial health information system. The National Health Act of 2003 provides a framework for a single health system for the Republic of South Africa and furthermore highlights the rights and responsibilities of health-care providers and health-care users and ensures that there is broad community participation in health-care service delivery from health-care facility level up to the national level in the entire country (National Health Act of 2003:2).
CHAPTER FOUR

LITERATURE REVIEW

4.1 INTRODUCTION AND BACKGROUND

The purpose of Chapter four is to focus mainly on the core concepts, namely, democracy, transformation, health-care services, legislation, the health-care system in South Africa and the Department of Health and Social Development. The main objective of the present study was on the exploration of transformation process in terms of the provision of health-care service as there was inequality in this regard during the apartheid era in the provision of such services between black and white population groups. Political transformation was attained in 1994 but economic transformation is presently still questionable since the economy is do date still controlled by the white minority people and very few black elite.

The knowledge and understanding pertaining to the concepts such as ‘democracy’, ‘transformation’ and ‘service delivery’ are very essential and important to understand the logic and need for this research study. The concept ‘democracy’ had its origin from the Greek concept ‘demokratia’. This concept was derived from the two Greek words, namely, ‘demos’ and ‘kratos’. In simple terms, ‘demos’ refers to the masses of people and ‘kratos’ to the authority. In other words, this means that democratic government is rule of the people by the people themselves. So, the term ‘democracy’, therefore, literally means the government of the people by the people. The system of democratic government in which the ruling authority of any country is legally vested, is not based in any particular population group, ethnic group or class, but solely in all the citizens of the country (Botes et al, 1996:11; Cloete, 1993:3).

The concept ‘democracy’ could also be understood as “… a form of government where the wishes, (aspirations) and interests of the people are paramount. A broader view suggests that democracy is a philosophy of life not only limited to governmental activity, but that guides humans and their relationship with others in the social, economic and political realms of life”. Democracy is expected to promote rationality, morality, equality and liberty (Nsingo & Kuye, 2005:747). According to Ramney (1971:76) democracy refers to “(1) popular sovereignty, (2) political equality (3) popular consultation, and (4) majority rule”.

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Democracy, as a social process, is viewed as the tendency of a political system to continuously promote, improve and facilitate equal access to fundamental human rights and liberties such as the freedom and right to engage in self-determining endeavours that raise one’s consciousness to remake his or her own world while acting within the confines of social parameters. According to Ntalaja (1997:7), “Democracy becomes that social process through which people strive to expand these rights within a given political order and seek to promote and defend them effectively, in line with notions of the social contract of humans”. Nsingo & Kuye (2005:748) indicated that there was no effective democracy without participation by community members. Since the public servants often perform their respective duties in a political milieu it is, therefore, of necessity that their activities and duties should be monitored continuously. They should have a thorough understanding of and an insight into the functioning of ‘democracy’ in this country. In that way they can direct their actions and efforts fruitfully and accordingly in order to improve service delivery in the health-care sector wherever it would be needed in the peripheral communities in particular.

One of the most profound challenges facing the Republic of South Africa during the past decade and half since the inception of democracy (1994–2009) was the anticipated display of accountability by both public and private sectors in respect of the implementation of the transformation process which has, inter alia, the direct bearing on the improvement of the lives of all the people of the country as well as the alleviation and reduction of poverty and unemployment respectively, especially among the historically disadvantaged black South Africans (HDBSA). Hence, the current researcher has developed a keen interest and curiosity in this field of study especially in public administration in general to explore the effectiveness of the transformation process on the high quality of service-delivery with special reference to health-care of patients in Limpopo Province in particular and this country in general.

The Republic of South Africa is a new democratic country confronted with several political and socio-economic challenges, which need to be promptly addressed for the benefit of all her inhabitants. If the principles of ‘democracy’ are undermined, compromised and ignored, the state can quickly degenerate into a dictatorship or to the detriment or disadvantage of the citizens of this country.
Cloete (1993:6) contends that democracy means that each country encompasses a process by means of which a head of government and other political office-bearers are elected by the majority of the people through a system of universal suffrage and periodic general elections. ‘Democracy’ is, therefore, basically characterized by one or a combination of the following concepts, namely, representative democracy, participatory democracy, social democracy, liberal democracy, people’s democracy, direct democracy, pluralist democracy and consociational democracy. The latter is the type of democracy often found in communities characterized by ethnic and/or cultural divisions usually referred to as plural societies (Gildenhuys and Knipe, 2000:18). Fox and Meyer (1995:26) comment that consociation is “a democracy within a society characterized by cleavages. The basis of the system is that cooperation exists between the leaders of the various groups in order to interact the inherent conflict and disintegration of most of such societies.”

Although there is no universally-accepted governmental system that has yet been developed to give effect to its value concepts at this stage, it is necessary to indicate that the concept ‘democracy’ refers to the manifestation of values such as the following:

- tolerance and recognition of the views, needs and expectations of opponents,
- respect for equal rights and freedom for all,
- rejection of violence as a means of resolving differences,
- the right of free expression and criticism,
- rule of law,
- accepting responsibility for the welfare, and
- acceptance of the requirement that the people must peacefully choose and change their leaders for the maintenance and the promotion of the general welfare (Cloete, 1993:5).

The term ‘transformation’ has well and comprehensively been defined in section 2.2 of chapter two and the understanding of the term still applies in chapter four. Hence, the repetition of the concept is considered no longer valid and necessary.

Another concept that is complementary to ‘democracy’ during the current democratic era is ‘service delivery’. Whenever one talks about democracy one thinks about the prevalence of
service delivery in order to ease people from social ills such as hunger, unemployment, lack of shelter and electricity, inadequate transport services, lack of security services, lack of purified water and sanitation to mention just a few. Service delivery is closely associated with the notion of providing services that would bring about a better life for all the people of South Africa. According to Fox and Meyer (1995:118), service delivery refers basically to “the provision of public activities, benefits or satisfactions. Services relate to both the provision of tangible public goods and to intangible services themselves.” The concept ‘service delivery’ is a systematic arrangement for satisfactory fulfilling the various demands for service by undertaking purposeful activities with optimum use of limited resources for delivering effective, economic and efficient services that result in measurable and acceptable benefits to the members of the communities of this country (Roux et al, 2002/1997:2).

4.2 LEGISLATIVE AND POLICY FRAMEWORKS ON ORGANIZATIONAL TRANSFORMATION

Cameron (1999:1) indicates that one of the most momentous political developments of the 1990’s was the political transformation process in South Africa, which ended when the first non-racial elections held on 27th April 1994 in this country witnessed the overwhelming victory when the African National Congress (ANC) won 62.0% of the votes thereby becoming the majority party in the Government of the National Unity (GNU).

The Parliament of the Republic of South Africa spent the first period of about 5 years repealing all the discriminatory pieces of legislation and during the same period passing numerous laws that were consistent to the democratic Constitution of the Republic of South Africa of 1993 as amended by 1996. The Constitution of the Republic of South Africa of 1996 is considered as the first supreme law of the country to effect and support the transformation process by means of which the citizens were expected to see improvement in their life-styles and the tangible provision of basic services such as clean water, electricity, housing, adequate transport, adequate security and sanitation to mention just a few. The following are some of the principal pieces of legislation and mandates that were driving forces in the implementation of and support to the transformation process and service delivery in the Department of Health and Social Development (DoHSD) in Limpopo Province in South Africa and they assisted, inter alia, in the promotion and facilitation of health-care service delivery.
The constitution of any country is a reflection of a people’s history, fears, concerns, aspirations, vision and mission of that specific nation and it should equally well take into consideration the aspirations and concerns of minorities. It must provide a common framework within which people of diverse or even opposed views, beliefs and cultures interact freely without having to embark upon violence or possibly a force of arms. What is perhaps more important is that the constitution that has been formulated and developed on democratic principles and values does not limit the government’s ability to pass any piece of legislation that in any way compromises the basic rights of the ordinary people or citizens in particular. At its very core and in simple terms, the constitution is nothing more than a set of rules by means of which a country is governed. More directly, a constitution embraces the overall authority or power to be wielded and also as to who is wielding it, and over whom it is being wielded in the governance of a particular country.

The Republic of South Africa has, on the basis of transformation process, the constitution that has the embodiment of hope, vision and security and its coming into being in 1994 resulted in the restoration of dignity, respect and citizenship that were stripped off the inhabitants of this country as they were victims of racial discrimination for several decades. The Constitution of the Republic of South Africa, 1996 is a reflection of the liberation of women and children from physical and psychological abuse and humiliation, which were the order of the day in the recent past decades of the apartheid system. The Constitution restored dignity, respect, ownership of the land, abolishing of the job reservation for white population group only and security which were denied the majority of the black population by the white minority. The inhabitants of this country were reduced to the status of neither being objects rather than human beings as they could neither participate in debates about the political and socio-economic issues nor partake in any decision-making (The Constitution of the Republic of South Africa, 1996:6-24).

The Constitution of the Republic of South Africa of 1996 is the only supreme law in this country since the new democratic government came into power after the 1994 general elections and it sets out rules and regulations governing this country without any form of discrimination; and it is on the basis of such supremacy that it prevails over all national, provincial pieces of legislation and by-laws promulgated by the Municipal Councils. The parliament of this country is the legislative authority and has the power to make laws in accordance with the Constitution
of 1996. The primary objective of the transformation process, which is primarily informed by the Constitution of 1996 and other many relevant pieces of legislation as well as the White Papers and government policies is to improve the quality of service delivery especially among those citizens still residing in the poor remote areas of South Africa (The Constitution of the Republic of South Africa, 1996:3; Van der Waldt and du Toit, 1999:143).

The objective of the White Paper on the Transforming of the Public Service, 1995 and the White Paper on Transforming Public Service, 1997 was basically to transform the South African public service in its entirety thereby including transformation of service delivery in the whole country. Thakhathi (1998:3) in addressing the public servants in the Department of Correctional Services in Limpopo Province in South Africa on the transformation process strongly reiterated the significance, the need and the effects of the process of transformation in order to achieve the high quality of service delivery. The emphasis of the address was specifically 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 the responsibilities of the public servants responsible for the implementation of the transformation process in their respective work environments.

The White Paper on Transformation of Public Service released in October 1997 indicates that Batho-Pele policy is the Sotho concept given to the government’s initiative to improve the delivery of public services since improving service delivery is one of the government’s eight priorities. The concept ‘Batho-Pele’ is a Sesotho word which refers to ‘People First’. The purpose of the policy implies that the outcomes of public administration are aimed at the most important aspect of service delivery and improvement of the general welfare of all the people, to alleviate poverty particularly among the previously historically disadvantaged individuals (HDI) as well as to redress past discriminatory apartheid laws and to empower South African people with skills relevant to their fast changing country because of the attainment of democracy (Gildenhuys and Knipe, 2000:130).

The Constitution of the Republic of South Africa, 1996 and the White Paper on Transforming Public Service Delivery of 1997 made an important contribution towards the adoption of a new positive attitude amongst the public servants and members of the communities regarding
service delivery. The policy documents ushered in a five-year period of democratic government were to instil an attitude of Batho-Pele policy, namely, “people first”, to the public servants.

The primary objective in terms of Section 1.1.2. of the White Paper on Transforming Public Service Delivery (1997:16-22) is to improve efficiency, transparency and effectiveness in the manner in which services are delivered in the rural communities in particular. Specifically, it sets out the principles which could be used to promote, facilitate efficiency, transparency and effectiveness in the public service. In terms of such principles citizens of a democratic South Africa should:

- be consulted about the level and quality of public services they receive and, where possible, be given a choice about the services that are offered;
- be told what level and quality of public services they will receive so that they know what to expect;
- have equal access to the services to which they are entitled;
- be treated with courtesy and consideration;
- be given full and accurate information about the public services they are entitled to;
- be told how national and provincial departments are run;
- be offered an apology, full explanation and speedy and effective remedy when the promised standard of service is not delivered; and receive public services that are rendered economically and efficiently in order to give them the best possible value for money (Batho-Pele White Paper of 1997, Notice No. 1459 of 1997:16-22).

The Batho-Pele principles or guidelines empower people to demand services of a high quality from the government institutions and also engrave the idea of ‘people first’ in the minds of public servants. It should also be realized that Batho-Pele policy is not an end in itself, but rather a means to an end ensuring an impeccable implementation of the White paper within the Department of Health and Social Development in Limpopo Province in this country.

The Batho-Pele policy was introduced in order to encourage public service employees to perform efficiently, productively and effectively and also to embark upon self-development, dedication and commitment. The process of developing people means to continue educating
and training them for the purpose of gaining satisfactory experience and skills as well as the development of a positive attitude, to be able to hold even the highest managerial position. Batho-Pele as a policy of quality improvement can address the deteriorating service standards and assist in improving these standards as well as sustaining them. Through the Batho-Pele policy standards are set, performance evaluated against these standards and remedial actions taken to maintain or improve existing performance and output (Batho-Pele White Paper of 1997, Notice No. 1459 of 1997:8-10).

Ever since South Africa attained democracy in 1994, the current government made several significant endeavours to transform the socio-political perspective of this country to ensure that there is a better life for all the people through the publication of White Papers basically on service delivery for the community that the process of transformation be in place. The White Paper on the Transformation of the Health System published in 1997 is one of the important mandates developed by the democratic government to ensure that the implementation of the transformation process is promoted and facilitated in an efficient and effective manner in order to address the imbalances created by the former apartheid regime. A further objective of the White Paper on the Transformation of the Health System is to present the people of South Africa with a set of policy objectives and principles on which the National Health System (NHS) is based. The NHS is a system that is capable of delivering health-care services in an efficient, economical, transparent and effective manner and in a caring environment that is of high quality to all the people of this country regardless of colour, race and gender. It was on the basis of this White Paper that important various strategies to meet and address the basic needs of the marginalized black people of this country with the available limited resources were successfully presented.

The current democratic public service of this country, which emerged from the amalgamation of several defunct apartheid public services, was established in terms of the provisions of the Constitution of the Republic of South Africa, 1996 and the Public Service Act of 1994 (103 of 1994). Both pieces of legislation and the Public Service Regulations of 2001 regulate the conditions of employment of all the employees appointed in terms of the Public Service Act and other human resource-related issues without discrimination. The working conditions of the current Public Service Act of 1994 and its subsequent Public Service Regulations of 2001 provide for better working conditions and for all citizens unlike the previous Act of the
apartheid system, the practices of which were discriminatory in terms of race and gender. The transformation of the public service was basically aimed at improving, promoting and facilitating service delivery among all South African people the majority of whom were, for several decades in the history of this country, marginalized and disadvantaged. Both the Public Service Act of 1994 and the Public Service Regulations of 2001 require all the employees to comply and strictly adhere to their provisions with a view to improving and promoting the high standards of service delivery to all members of the communities. The disciplinary actions are often taken against any display of insubordination and non-compliance by public servants if the provisions outlined in those government policies and directives are undermined, ignored and not complied with since no one is above the law.

The White Paper on Transforming Public Service Delivery of 1997, also referred to as the ‘Batho-Pele’ policy, is one of the cornerstones of the transformation process in ensuring that service delivery is made available to all the people at the appropriate time without any racial discrimination as was the case during the apartheid era. The apartheid government in pursuit of its apartheid policy was basically characterized by having a public service that was fragmented, disintegrated and full of duplication of services particularly in the former four provincial administrations, ‘homelands’ and ‘self-governing’ territories of this country. The former apartheid public services were ineffective, corrupt, and inefficient in the execution of their responsibilities. The former Speaker of Parliament of the Republic of South Africa, Ginwala, F. in her presentation of the paper on the role of parliament during the Public Sector Anti-Corruption Conference held on 10th-11th November 1998 in Parliament in Cape Town, commented that “Corruption flourishes in the context of a society in which there is no accountability of public servants, government officials and institutions (Sangweni and Balia, 1999:29). Nhlapo indicated in Sangweni and Balia (1999:64) that “If corruption is to be understood as the abuse of power for illegitimate and illegal gain or profit, then corruption in the public sector is pervasive and includes almost all areas of public activity, including semi-public institutions such as learning institutions”, whilst Grobler mentioned that “corruption occurs when an employee forsakes his or her duty for benefit.” That is, “corruption occurs when any form of unearned compensation or benefit is given to a person for any act or omission related to his duty for which he receives a salary.” (Sangweni and Balia, 1999:34). They lacked accountability, transparency and openness and were also uneconomical in terms of the provision of services; hence the entire service delivery was of a poor quality and was
rendered in a racially discriminatory way. The significant of the White Paper was to bring about some transformation in the public service in order to ensure that services were provided in a better and improved manner to benefit all the people of this country instead of channelling services of high standard to the minority white population group only at the expense of the majority black inhabitants of the Republic of South Africa.

A former Minister for Public Service and Administration introduced the White Paper on Transforming Public Service Delivery in 1997 with the intention of transforming public service in this country, that is, to make service delivery customer-friendly, user-friendly and to meet the basic needs of all South Africans. The White Paper introduced eight principles known as the Batho-Pele principles, which means ‘the people first’ and they are as follows: Consultation, Service standards, Access, Courtesy, Information, Openness and Transparency, Redress and Value for money. The White Paper on the Transformation of the Public Service (WPTPS) published on 24th November 1995, sets out eight transformation priorities, amongst which transforming Service Delivery is the key. This is because a transformed South African public service will be judged by one criterion such as effectiveness in delivering services which meet the basic needs of all South African citizens. Improving service delivery is, therefore, the ultimate goal of the public service transformation programme.

Van der Waldt and du Toit (1999:107) comment that this country has a central civil service which has been structured in terms of the Public Service Act of 1994 to provide effective and efficient public administration. They mention that the philosophy of the White Paper is that the government institutions are always under obligation to ensure that efficient, effective and economic services are being delivered to the members of the public as they are also entitled to legitimate right with a view to receiving efficient, cost-effective and economic services. They have legitimate right to demand access to the quality services whenever it comes to their attention and knowledge that there is deterioration in the sustainability of standards.

The National Health Act of 2003 (61 of 2003) is one of the key pieces of legislation passed by parliament in order to regulate all health-care services. The main objective of the National Health Act of 2003 is “To provide a framework for a structured uniform system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local governments with regard to health services; and to provide
for matters connected herewith”. When the current government came into power in 1994, it found that there was a huge fragmentation of health-care services throughout the country established on the basis of promoting and sustaining the apartheid policy. Each homeland and self-governing territory, for example, had its own health-care services, which were characterized by lack of adequate human and financial resources, lack of infrastructure and poor provision of health-care services to the patients. The Act recognized the prevailing socio-economic injustices, imbalances and inequalities of health-care services of the past, and it acknowledged that there was a need to address and heal the racial divisions created by the former government and furthermore to establish a society primarily based on democratic values, principles and fundamental human rights as enshrined in the Constitution of the Republic of South Africa, 1996. Last but not least, it shows that there is a need to improve, facilitate and promote the standard and high quality of life of all South African inhabitants regardless of colour, race and creed and to free the potential of each citizen of the country. It was in terms of the provisions of the Constitution of the Republic of South Africa, 1996 and this Act in particular that the fragmented and disintegrated health-care services were amalgamated and integrated into a single service in order to be managed by one single National Department of Health instead of the various defunct independent departments of the homelands and self-governing states of the apartheid system (National Health Act of 2003:2).

The objective of the Act is to ensure that health-care services are accessible by clients within 5 kilometres walking distance or within possible reach by the patients from their places of residence, especially those who are residing in the remote rural areas as patients had to walk long distance, in the past for several decades in order to access health-care services. That endeavour is in the process of being implemented by erecting many health-care facilities or clinics for all members of the communities especially in the remote rural areas (National Health Act of 2003).

The National Health Act of 2003 ensured that there be a system of co-operative governance and management of health-care services, within national guidelines, norms and standards, and in which each provincial government, municipality and health district must address questions related to health-care policy and directives and also the delivery of high quality of health-care services in the entire country. It furthermore provides that a health-care system based on decentralized management, principles of equity, sound governance, internationally recognized standards of research, a spirit of enquiry and advocacy that encourage participation by all
people, efficiency and effectiveness are established for the benefit all South African citizens. The Act promotes, improves and facilitates a spirit of co-operation and enables that there be a shared responsibility among public and private health professionals, service providers and other relevant sectors within the context of national, provincial and district health plans. The objective of the Act is, furthermore, to ensure that health-care services are accessible by clients within 5 kilometres walking distance or within possible reach by the patients from their places of residence, especially those who are residing in the remote rural areas (National Health Act of 2003).

The Health Professions Act 56 of 1974 makes provisions for the guidelines for good practice in the health-care professions by stipulating, inter alia, the ethical and professional rules as well as the rights of the clients. The practice as a health-care professional is based primarily upon a sound relationship of mutual trust between the clients and health-care practitioners. In order to become a dedicated and good health-care practitioner, it requires of him or her compliances to the ethical considerations or practices and a life-long commitment to sound professional and ethical practices, and respect for the clients in terms of maintaining confidentiality; hence the Act requires all health-care practitioners to subscribe without any compromise to the rules of practice and also uphold the National Patients’ Rights Charter (The Health Professions Act 56 of 1974 and HPCSA: Guidelines For Good Practice In The Health Care Professions: National Patients’ Rights Charter. Booklet:3).

The Act provides that the professionals should serve and protect the public in matters involving the rendering of health-care services, to exercise their powers and discharge their responsibilities in the best interest of the public and also in accordance with the national policy determined by the government, to uphold and maintain professional and ethical standards within the health-care professions. It ensures that persons registered in terms of the Act behave towards the clients in a manner that respects their constitutional rights to human dignity, bodily and psychological integrity and equality. Disciplinary action should be taken against the people with disability who fail to act accordingly (The Health Professions Act 56 of 1974:8).

The Mental Health Act 17 of 2002 is one of the legislative frameworks that ensures that there is transformation in terms of regulating the health-care service in a manner that makes the best possible mental health-care. It, furthermore, ensures that treatment and rehabilitation services
are available to the population groups equitably, efficiently and also in the best possible interest of mental health-care users within the limits of the available resources. It co-ordinates access to mental health-care, treatment and rehabilitation services to various categories of mental health-care users. It clarifies the rights and obligations of mental health-care providers and regulates the manner in which the property of persons with mental illness and persons with severe or profound intellectual disability may be dealt with by a court of law, to mention just a few objectives (Mental Health Act 17 of 2002:12 and 14).

The Dental Technicians Amendment Act of 2004 provides for the restricted registration of informally trained persons as dental technicians. It makes direct billing by a dental technicians contractor discretionary and restricts the performance of certain acts by members of certain juristic persons, and further makes provision for the publication of draft regulations for comment (Dental Technicians Amendment Act 24 of 2004).

The Traditional Health Practitioners Act of 2004 provides for the establishment of the Interim Traditional Health Practitioners Council of South Africa the function of which is to ensure that there is a regulatory framework to ensure the efficacy, safety and quality of traditional health-care services. It provides for the management and control over the registration, training and specified categories in the traditional health-care practitioners profession (The Traditional Health Practitioners Act of 2004:2).

Some of the important objectives of the Act are, inter alia, to promote public health-care awareness. It ensures the quality of health-care services within the traditional health-care practices. It protects and serves the interests of members of the public who use or are affected by the service of traditional health-care practitioners. It promotes and maintains appropriate ethical and professional standards required from traditional health-care practitioners and also ensures that traditional health-care practice complies with universally accepted health-care norms and values (The Traditional Health Practitioners Act of 2004:8).

Another significant legal framework developed to promote and facilitate transformation is Occupational Health and Safety (OHS) Act of 1993 the objective of which is to provide for the health-care and safety of people at workplaces and for the health-care protection of people in connection with the use of a plant and machinery at their respective workplaces, as well as the
protection of persons other than persons at work against other hazards to health-care and safety arising out of or in connection with the activities of the persons at the workplaces because all workers are expected to be free from illnesses or injuries attributable to occupational causes. The Act takes the safe life of all workers and other people into account since human life is a precious gift from God and needs to be nurtured at all cost (Occupational Health and Safety Act, 85 of 1993; Van der Waldt et al, 2001:50).

The Sterilisation Act of 1998 provides, among other things, for the right to sterilisation, to determine the circumstances under which sterilisation may be performed on persons incompetent to consent due to mental disability. It provides for the restoration, protection and promotion of the human dignity of persons, in particular, those who are mentally disabled by ensuring that decisions about sterilisation are made in a manner that is responsible and considerate. It also provides that no person is prohibited for having sterilisation performed on him or her if he or she is capable of consenting and is also 18 years and above and the provisions of section 3(1)(a) and (20) applies as well for the promotion of good health of the patients (Sterilisation Act of 1998:2 and 4).

The Medicines and related substances control Amendment Act of 1997 provides for the regulation of the purchase and sale of medicines by wholesalers, to increase the jurisdiction of the magistrates’ court in respect of penalties in terms of this Act, to provide for the rationalisation of certain laws relating to medicines and related substances that have remained in force in various territories of the national territory of the Republic by virtue of section 229 of the Constitution of the Republic of South Africa. It provides for the establishment of a pricing committee. It prohibits bonusing and sampling of medicines. It regulates certain persons to compound, disperse or manufacture medicines. It provides for generic substitution of medicines. It provides for procedures that will expedite the registration of essential medicines, and for the re-evaluation of all medicines after five years. It provides measures for the supply of more affordable medicines in certain circumstances and to require for the labels to be approved by the council to mention just a few objectives of the Act (Medicines and related substances control Amendment Act of 1997:2).

The Disability Rights Charter of South Africa is one of the important legal frameworks that ensures that there shall be no discrimination against the people with disability regardless of
their colour and race and they shall enjoy equal opportunities in all spheres of life. They shall be protected in terms of the Constitution of this country and this charter against any exploitation and all treatment of abusive or degrading nature. The majority of the people with disability have been excluded from the mainstream of society and subsequently have been prevented from accessing fundamental Socio-political and economic rights. The people with disability shall be entitled to represent themselves on all matters affecting them. The resources shall be made available to them to enable them to fulfil their roles in life. The charter ensures that that health-care and rehabilitation services shall be cost-effective, accessible and affordable to all people with physical and mental challenges in this country and they shall have the right to appropriate assistive technology (The Disability Rights Charter of South Africa and White Paper on South Africa: Integrated National Disability Strategy: 1997:9).

4.3 THE HEALTHCARE SYSTEM IN SOUTH AFRICA

4.3.1 Introduction

The healthcare system is designed to meet the health-care needs of the target population. There is a wide variety of health-care systems around the world. In some countries, health-care system planning is distributed among members and participants, that is to say, it is decentralized, whereas in others planning is done more centrally among the government, trade unions, charities, religious, or other coordinated bodies to deliver planned health-care services targeted at the populations they serve. However, health-care planning has often been evolutionary rather than revolutionary. The lives of vast numbers of people in the world lie in the hands of deliverers of health-care systems, from the safe delivery of a healthy baby to the care with dignity of the frail elderly. Health-care systems have a vital and continuing responsibility to people throughout their life span (Gutierrez et al, 2003: 939; WHO, 2000).

Casebeer and Hannah (2008/11/20) comment that health-care reform is a worldwide phenomenon which is in the process a transformation and it is everywhere including the Republic of South Africa. Governments everywhere in the world are now busy transforming their health-care systems in order to provide the necessary and required quality of health-care to their respective citizens (http:www.meraldinsight.com/.2008.Insight/ViewContentsServlet?Filename=Published/Emena---2008/11/20).
4.3.2 The National Health Insurance (NHI) in South Africa

The main objective of the health-care system of any country in the world is, therefore, to save the lives of many people in each country. A good health-care system, besides saving the lives of the people, reduces the frequency of diseases and combats them, prolongs the life expectancy and sustains the healthy lifestyles of the people. In the present study, the focus is primarily on highlighting briefly the health-care system in South Africa. The United States of America and South Africa have very different situations regarding the structure, financing and function of their health-care systems. The two rich and industrialized countries, namely, the United States of America and Japan, have a dissimilar performance regarding their health-care policies. The Japanese health-care insurance guarantees universal coverage of all the people, while the USA public medical security system does not cover all the citizens universally. This inequality has yielded different health-care outcomes throughout the USA, depending on race, origin and incomes of people (Gutierrez et al, 2003:937). The health-care is a universal challenge. Those that pay for health-care can hardly cope with the rising health-care costs and especially those that cannot afford it and need it most are not getting enough access to it (Gutierrez et al, 2003:937).

4.3.3 The proposed National Health Insurance (NHI) in South Africa

At the launch of Free Primary Health Care Services in Gauteng on 1st April, 1996, Dr Olive Shisana, Director-General of the Department of Health commented that the objectives of the National Health System for Universal Primary Health Care were to provide basic health-care as a fundamental right, which should be enjoyed by all South Africans and not reserved for only those who could afford to pay. Free services would be provided at public primary health-care facilities, for example, clinics, community health care centres and local authority clinics as they would be phased in. At the present time free health-care for pregnant women and children under 6 years, continues. Medicines on the Essential Drug List (EDL) for Primary Care are also available free of charge in the public sector (Department of Health; http://www.doh.gov.za).

The Health Sector Strategic Framework, 1999–2004, which was popularly called the ‘Ten Point Plan’ because it had ten priority areas, was launched in 1999. The priorities were
programmes related to the goal of ensuring that all South African people had access to health-care, irrespective of their social status and geographical location (Department of Health; http://www.doh.gov.za). The major achievements by the department in the past 10 years have been in relation to vaccine-preventable illnesses, better management of malaria, improved reproductive health-care services, a more focused approach to disability, reducing tobacco use and the gradual achievement of a truly comprehensive response to HIV and AIDS. During the same period more than 1 300 new clinics in under-served areas of this country were built. There are 5 functioning health-care districts right across the country. 966 hospital rehabilitation projects were implemented and the erection of 18 entirely new hospitals was undertaken. A Patients' Rights Charter was introduced and saw provinces gradually initiate complaint systems, help desks and incentives for good service (Department of Health; http://www.doh.gov.za). The reform of the medical aid legislation has resulted in a stabilization of the financial situation of the medical-aid schemes, to the extent that there have been no bankruptcies in the past 2007/08 and 2008/09 financial years (Department of Health; http://www.doh.gov.za).

The National Health System for 2004 - 2009 highlighted, inter alia, first, the new vision and mission for the national health system. Second, a situation analysis highlighted the achievements and challenges. The last part of the Strategic Priorities for the National Health System for 2004 – 2009 is the list of priority areas with targets and health-care indicators, which are used to monitor progress in the health-care facilities of the Department of Health, particularly in the 9 provinces of this country (Department of Health; http://www.doh.gov.za).

The new vision is “An accessible, caring and high quality health system” and the department wishes to achieve this through working hard and in a transparent manner to ensure that every health-care worker, whether they are in the public or private health-care sector, managers or frontline health-care workers, whether academics or researchers, embody this vision as they perform their daily activities. The new mission, which is basically about achieving this vision, is “To improve health status through prevention of disease and promotion of healthy lifestyles and to consistently improve the health care delivery system by focusing on access, equity, efficiency, quality and sustainability” (Department of Health; http://www.doh.gov.za).

While there has been quite significant progress in almost every programme embarked upon, the area of concern was around the inability of the department to meet the targets on managing
tuberculosis. It merits pointing out that despite such challenges, significant progress through the Partnership Against AIDS has been made and this partnership approach should assist the department in dealing decisively and effectively with TB as well. The department is intensifying the partnership approach as it works towards meeting its targets with regard to the Comprehensive Plan for Management, Care and Treatment of HIV and AIDS (Department of Health; http://www.doh.gov.za).

The department is increasing service points to all districts where a series of interventions aimed at prolonging the progression from HIV infection to development of AIDS-defining conditions can be provided to ensure optimal health-care for people living with HIV and AIDS. These include nutritional support, traditional medicine, treatment of opportunistic infections and antiretroviral therapy. The department expects the finalization of the long-term tender for the supply of antiretroviral drugs as soon as possible (Department of Health; http://www.doh.gov.za).

The department has a prioritized healthy lifestyle amongst the people of this country because the burden of diseases from unhealthy lifestyles is growing very rapidly. The department sees this challenge often manifested in non-natural causes of death as well as diseases of lifestyle like diabetes, hypertension and obesity. The department will accelerate the health-care promotion campaigns in order to strengthen its interventions in this area as well as combining the management of communicable diseases and non-communicable illnesses. Together with promoting healthy lifestyles, this priority constitutes the core business of the national health-care system (Department of Health; http://www.doh.gov.za).

4.3.4 Initiating the National Health Insurance Model (NHIM) in South Africa.

The current health-care system needs to be addressed even before considering a model like the National Health Insurance. The process for rolling out a National Health-Care model is a noble idea as it will benefit the poor and unemployed people of this country since very few people can afford to pay for private health-care coverage insurance out of their own pocket. It is not quite clear at the present moment whether the model (NHI) is sustainable since its sustainability depends entirely upon the availability of adequate resources of funding, besides the contributions of the members of the medical-aid schemes. Substantial government subsidization of the model is a key solution especially to the poor and many unemployed
people of South Africa. A massive health-care model like NHI requires strong support of the politicians and the government at large in order to maintain the sustainability to assist the citizens, the majority of whom cannot afford the private medical-aid scheme on their own (Department of Health; http://www.doh.gov.za).

It has been indicated in the World Health Organization (WHO) that once another new drug or treatment, or a further advance in medicine and health technology is announced, it often results in increasing demands and pressures on health-care systems, including both their public and private sectors in all countries in the world, rich or poor. Constraints often exist, depending on what governments can finance and on the capacity of what services they can deliver. The National Health-Care Systems (NHS), if not planned properly and wisely, might require huge amounts of money. Poorly structured, badly led, inefficiently organized and inadequately funded health-care systems can do more harm than good to the people. These challenges often result in large numbers of preventable deaths and disabilities, unnecessary suffering, injustice, inequality and denial of the basic rights of individuals in each country (WHO, 2000).

Duarte (2009:1) defended the ANC policy in the ANC statement on National Health Insurance (NHI) that “In line with the resolutions of the ANC 52nd National Conference, the NHI Task Team was carrying out the mandate to address numerous challenges to improve service delivery of health-care services to all South Africans; and that the implementation of the NHI would strengthen the public health-care, hence the current government will continue to transform health-care in South Africa (ANC Statement on National Health Insurance: http://www.anc.org.za/show.php?include=docs/pr/2009/Pro608.html:1)

Since one of the priorities of the “Ten Point Plan” is the implementation of the National Health Insurance (NHI), it is considered appropriate to look briefly at the model as it applies in South Africa. Finance Minister, Pravin Gordhan pointed out that the government was absolutely committed to developing a health-care system that was designed to serve about 50 million South Africans and it is ready to implement the National Health Insurance (NHI). The scheme might not necessarily mean higher taxes, but mentioned that over the period of the next 14 years the NHI would be a relentless and systematic approach to ensure that the health-care insurance coverage was implemented in this country. With regards to funding of the model, the Minister indicated that at present nobody quite knew how much NHI would cost since the
government was still busy working the key issues such as to how it would stop the wastage in the health-care system and how it would stop provinces from diverting funds that are meant for health-care to the other projects. The government did not have any immediate plans to raise taxes to fund the proposed national health-care insurance (NHI) but emphasized the government’s commitment to introducing the NHI. According to him, it would be “unfair to South Africans” to increase their taxes before the government had worked out what it would cost. The policy statement tabled in Parliament by the Minister of Finance detailed an increase in the 2010/2011 financial year's health budget to R101.9 billion (Department of Health; http://www.doh.gov.za; http://www.mg.co.za/article/2010-10-27-relevantless-approach-to-implenting-nhi).

Minister of Finance (National treasury), Pravin Jamnadas Gordhan, comments that "In view of South Africa's rising disease burden these ratios are likely to increase somewhat, and arrangements for bringing private-sector capacity into a common health funding framework are being explored." He indicates that some provision for funding the NHI may come from the R21.1 billion of unallocated funds being put aside as a contingency reserve. This was likely to go to education and health as spending plans were finalized (http://www.busrep.co.za/index.php?fSectionId=552&fArticleId=5705166).

The South African Health Minister, Dr. Aaron Motsoaledi, suggested that in order to ensure that hospitals complied with the accreditation requirements set out under the proposed National Health-care Insurance (NHI) system, to be eligible as suitable health-care facilities, there were plans in place to institute a regulatory body that would ensure such compliance. In the system envisioned by him, the hospitals were required to pass a series of tests before being accredited as ready to provide health-care services under the National Health-care Insurance (NHI) system. The responsibility of the regulatory body would be to monitor compliance in all hospitals with all the criteria required to obtain NHI approval and subsequent to that compliance, the department could start the process of developing an Act of parliament to establish the office of standards and accreditation (http://www.info.gov.za/speech/DynamicAction?Pageid=461&sid=13375&tid=20716).

The second meeting of the Ministerial Advisory Committee (MAC) on National Health Insurance (NHI) was held in Johannesburg on 12 to 13 February, 2010 to discuss further work relating to the implementation of the National Health Insurance scheme in South Africa. The
Ministerial Advisory Committee was established in 2009 by the Minister of Health, Dr Aaron Motsoaledi, to advise him on how best to implement the National Health Insurance (NHI) scheme. The MAC consists of experts in various fields drawn from South Africa and internationally. The proposed transitional from the current health-care set-up to NHI were discussed. The discussions revolved around the timing of key policy and process steps, completeness of activities and feasibility. The meeting also developed plans aimed at ensuring that the public would remain informed at all times in detail about the various costing models for the NHI, based on the inputs by a number organisations on the matter. The MAC noted with concern the latest report of Econex indicating the potential cost of the scheme. The Minister warned that at this stage it was impossible and pre-mature to accurately project the NHI costs outside a policy framework and with the research still underway. The cost details of the NHI could only be determined and made public only once details on the scheme have been extensively researched and finalized (http://www.info.gov.za/speech/DynamicAction?Pageid=461&sid=13375&tid=20716).

In his address on the occasion of the 53rd Anniversary of the Women's March to the Union Buildings at Vryheid, on National Women's Day on 9th August 2009, His Excellency President of the Republic of South Africa Mr JG Zuma, was concerned about the shortage of professionals, poor management of health-care institutions, poor financial management and inadequate funding, and deteriorating infrastructure. He pointed out that some hospitals and clinics needed refurbishments and while others were still in good shape, the only challenge was that they were run by incompetent, ineffective and inefficient managers who had no commitment and dedication to the health-care of the patients. Another challenge facing the public health-care sector is the unavailability of medicines at health-care facilities, especially HIV and AIDS drugs, and the ability of the department to access medicines at lower prices (Department of Health; http://www.theprecide ncy.gov.za).

The President of the Republic of South Africa, Mr Zuma indicated that a key solution and the first priority would be the introduction of a National Health Insurance (NHI) scheme in this country. The broad objective of the National Health-care Insurance was to put in place the necessary funding and health-care service delivery mechanisms. With regard to the cost of the model, he indicated that the intention was that the contribution should be less than members
and their employers currently paid to medical aid schemes. The advantage of the scheme was that it would expand health-care coverage to all South Africans, regardless of their economic or social status and as such there would be no financial barrier to access health-care, and National Health-care Insurance would be free to all the people of this country. He also mentioned that there would be no upfront payment required from the patients by the doctor or hospital after the implementation of the National Health Insurance (http://www.thepresidency.gov.za).

It has also been considered that certain categories of workers due to their low-income status will be exempted from the contribution towards the NHI. The NHI fund or scheme will be implemented in a phased manner to allow for consultation, policy making and legislation review and before implementation of the model the government will consult extensively with all affected stakeholders, especially the workers, employers, the organized labour, health-care providers, suppliers and health-care funders and finally it is commendable that the Department of Health has succeeded in reducing the prices of medicines and to ensure that those professionals who dispense medicine have the necessary competencies. The South African government is furthermore commended for the initiative taken to introduce the National health Insurance (NHI) to benefit those people who previously found it difficult to access health-care services without a medical-aid scheme such as the poor and unemployed people (Department of Health; http://www.doh.gov.za; http://www.theprecidency.gov.za).

4.4 THE DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

The restructuring of the governmental institutions was effected immediately after the April general elections in 1994 and it was a process during which period 9 provinces were established in terms of the provisions of the Constitution of 1996 and the same Act established both the national and provincial departments that have been mandated to implement the transformation process; hence the creation of the Department of Health and Social Development, which is one of the 10 Limpopo provincial departments. The establishment of the Department of Health and Social Development comprises subsystems or branches, directorates, divisions and sections. Its core or line function that it provides is health-care to the patients on the basis of numerous support functions for other support directorates for the sustainability of the line function. In rendering its functions the department is expected to
implement the ‘Batho-Pele’ policy to its entirety. Breitenbach (2006:53 and 58) indicates that transparency and accountability always call for openness with reference to organizational structures and methods of functioning. Both transparency and accountability consequently require that public servants be answerable for their behaviour and actions towards service delivery in the organization. One of the principles of Batho-Pele actually refers to redress and the citizen’s right to complain and as a result thereof to be provided an explanation. In his State of the Nation Address the President of the Republic of South Africa, the former President Mbeki was quoted in the Budget Speech of the Minister of Public Service and Administration as having encouraged citizens to be more vigilant by emphatically stating that: “We must be impatient with those in the public service who see themselves as pen pushers and guardians of the rubber stamp … bureaucrats who think they have the right to ignore the vision of Batho-Pele … “ and highlighted the importance of transparency and accountability to be displayed by public servants towards the customers who in this instance are called patients or clients for the Department of Health and Social Development. It also advocates that public servants be directly accountable to all the taxpayers for the execution of their specific functions and responsibilities. Hence, as a rational system of organization, the department naturally demands public servants to be held accountable for all their actions and inactions. It should also be borne in mind that the lines of communication including delegation of responsibility and division of labour all enhance transparency, responsibility, respect, dedication and accountability. This accountability is ensured through the existence of structures and systems that result in the public servants having to explain and clarify their behaviours and actions. Accountability is necessary if a high standard of public service ethics is to be realized and sustained in the organization. Public servants need to maintain ethical values and morals in the employ of the public service and that the employee’s values, perceptions and beliefs should be compatible with those of the organization if improvement and facilitation in terms of service delivery are to be optimally realized (Breitenbach, 2006:54).

It should be acknowledged that the new appointees in the public service naturally enter organizations with different value systems, beliefs and perceptions. It remains a serious challenge for the organization to realize that there should be some congruence and compatibility between the value of the public servant and that of the organization he or she has been employed to serve. This understanding is influenced by two phenomena, namely, that the satisfaction of the individual’s needs, wants, aspirations, desires, the individual’s contribution
of skills, expertise, experiences and knowledge towards achieving organizational goals and objectives should play a meaningful role. Some professionals such as psychologists, medical doctors, social workers, nurses, dentists, dieticians and physiotherapists always display a desire to serve to the best of their abilities their own organization and have a passion to help the patients and to share their experiences with their health co-workers. Public servants are performing functions that are often valued by members of the communities because these are to serve societal interests. As such, they are getting paid for performing particular functions and are afforded ample opportunity to exhibit key traits, skills and competencies in exercising their duties and hereby satisfying both extrinsic and intrinsic needs in terms of the theory of motivation. Public servants are appointed to serve efficiently, honestly, transparently and effectively members of the communities without any racial discrimination as it were the practice during the apartheid era (Breitenbach, 2006:54).

According to Breitenbach (2006:57), the principle of ‘People First’ in terms of Batho-Pele policy requires some dedicated attitude of commitment to the basic values and principles governing public servants. Such commitments are often influenced by a number of factors, namely, first, the public servant should be happy within the organization. Secondly, that he or she should be motivated, supported and valued by the organization, and finally, that the employer should create an atmosphere that is conducive to and promote service delivery that enhances and effectively contribute towards a person-environment fit.

Cloete (1998:303) comments that in every community there is a diversity of public institutions that provide health-care services, for example, the state departments of health, hospitals, CHCs, clinics, pharmacies and health-care departments of local authorities and NPO’s. The establishment of hospitals and the provision of other buildings for the purpose of rendering of a variety of health-care services and the availability of medical equipment or buildings require collective contributions from a diversity of professional and other employees for the benefit of all patients of this country.
4.5 CONCLUSION

Chapter three, dealt with the establishment of Limpopo Province and Vhembe Health District. The present chapter, therefore, paid attention on the understanding of the core concepts namely, democracy, transformation and service delivery; the definitions and explanations of certain concepts of which were presented in the current chapter followed by the description of the general objectives of literature review, the literature and legislative reviews within which the focuses were mainly on the books, White Papers, articles and pieces of legislation as the main sources that informed the need and necessity for the implementation of the processes of transformation and service delivery especially in the peripheral areas of Limpopo Province. It thereafter paid attention to the implementation of the health-care system in South Africa and transformation and service delivery in South Africa. The knowledge and understanding pertaining to the concepts such as ‘democracy’, ‘transformation’ and ‘service delivery’ are also very crucial, essential and important to understand the logic and need for this research study.

The Republic of South Africa is a new democratic country confronted with several political and socio-economic challenges which needed to be promptly addressed for the benefit of all her inhabitants. If the principles of ‘democracy’ and ‘transformation’ are undermined, compromised and ignored, the state can quickly degenerate into a dictatorship or eventually placed on a commercial basis to the detriment or disadvantage of the inhabitants of the Republic of South Africa.

One of the most profound challenges facing the Republic of South Africa during the past decade and half since the inception of democracy (1994–2009) was the anticipated display of accountability by both public and private sectors in respect of the implementation of the transformation process which has the direct bearing on the improvement of the lives of all the people of the country as well as the alleviation and reduction of poverty and unemployment respectively, especially among the historically disadvantaged black South Africans. Hence, the current researcher has developed a keen interest and curiosity in this field of study especially in the public administration in general to explore the effectiveness of the transformation process on the high quality of service-delivery with special reference to health-care of patients in this country in particular.
The National Health Insurance (NHI) is one of ten key priorities of the health sector Programme of Action in South Africa. It is to be implemented in phases from 2012 over a fourteen year period. Its objective is to put in place the necessary funding and health-care service delivery mechanisms that will enable the creation of an efficient, equitable and sustainable health system in South Africa. NHI is one of the most ambitious reforms that the government of South Africa has introduced and preparatory work for the implementation of the NHI requires a comprehensive and systematic approach. The NHI is founded on the constitutional principle of the right to quality health-care by all South African citizens. The successful implementation of the NHI is, therefore, dependent upon the realization of a quality of care in the health-care facilities. The public health-care facilities in this country will be required to conform to agreed-upon quality standards that have been approved by the National Health Council (NHC) if they are to be accredited to deliver and render health-care service within an NHI. As the NHI is one of the most ambitious reforms that South Africa has introduced, all the health-care facilities and the public should support the initiative of the Department of Health (Department of Health (http://www.doh.gov.za).

The Republic of South Africa will learn from this process how health-care services can be delivered, based on principles of honesty, transparency and respect, and how it can promote the culture of safety, quality, openness, accountability and collaborative teamwork that can promote responsiveness to patient's needs. This will furthermore require good leadership, competency and skills. The government can also learn from National Health Service (NHS) how they introduced appropriate standards, enhanced safety of patients, and promoted public participation, in addition to having established entities such as the National Institute for Clinical Excellence (now the National Institute for Health and Clinical Excellence) (NIHCE), the Quality Care Commission (QCC) and the National Patient Safety Agency (NPSA). South Africa as a developing country is commended for taking this giant stride to initiate the implementation of the National Health Insurance (NHI) scheme so that all South African people, rich or poor, and employed and unemployed, should have access to health-care system that will be most affordable to all its citizens.
CHAPTER FIVE

RESEARCH DESIGN AND METHODOLOGY

5.1. INTRODUCTION AND BACKGROUND

The main objective of chapter five is to provide the objectives of the study, the research design, research methodology, data collection techniques and procedures, methods of data collection and data analysis. For better understanding of social phenomena especially in the human sciences such as the public administration, psychology, sociology, social work and anthropology to mention just a few, the researcher has to bear in mind that there is a wide range of alternative approaches, criteria and methodologies whilst conducting an empirical study.

The present study sets out to explore the opinions of public servants and members of the communities with regard to their understanding of the correlation between the transformation and health-care service delivery processes and to determine the extent to which health-care service delivery has been improved since 1994 to 2009 as well as determining the adequate efficiency of the public servants that has been made effective and sustainable for the continued survival of the public service. The current study raises concerns especially about the effects of the transformation process on the quality of health-care service delivery in the three subdistricts of Vhembe District, namely, Makhado, Musina and Thulamela, save Mutale subdistrict, by virtue of their comparatively being too deep rural in nature and that they were some of those which were immensely neglected before the attainment of a democratic government.

The study also sought to explore the effects of transformation on the quality of service provided to the recipients of health-care services with special reference to health-care of the patients in the health institution, namely, hospitals, Community Health Centres (CHC) or Primary Health Care (PHC) facilities. The current researcher has been motivated by a previous study which was conducted in the subdistrict of Mutale instead of the entire Vhembe Health district in Limpopo Province at the time South Africa had already attained democracy. Vhembe Health District is one of the 5 districts in Limpopo Province which was considered to be one of
the poorest and neglected provinces in the Republic of South Africa. The researcher wanted to assess the extent to which transformation impacted on service delivery and to measure the extent of its effectiveness since 1994. The implementation of the transformation process in certain countries like Canada in America proved to be very effective and successful in the sense that it brought about some improvement in service delivery as well as alleviating poverty and reducing the high rate of unemployment. It improved the standard of life especially of the poor and destitute people who stayed in the deep rural areas in South Africa (http://www.gol.gc.ca/rpt2005.rpt09-e.asp).

5.2 THE OBJECTIVES OF THE SCIENTIFIC STUDY

This section briefly examined the main objectives of social research that helped to define the type of research study being undertaken and subsequently the unit of analysis was considered with special reference to what or whom the researcher wanted to study. The rationale of the research is clarified if the research commences with the objective of the research. The logic of the research objectives was to explain the intention, focus and motivation of the research. In formulating the objectives, the attention should be paid to, for instance, the research subject, the relevance of the research for the discipline such as Public Administration, the relevance of the problem and solution for society. The research objectives could be explorative, descriptive, explanatory or a combination of the three in nature. With special reference to exploration as the objective, the researcher hopes to explore a relatively unknown field as his or her point of departure as it is presently applying to transformation and service delivery processes being undertaken. The word ‘description’ should be understood as a term that describes accurately and exactly that which prevails in the research situation while explanatory study demonstrates the prevalence of causality or correlation between two or more variables in the phenomenon and it is subsequently related to prediction and evaluation. Science is distinguished from pseudoscience by its objectivity, logic and theoretical agreement to mention just a few (McBurney, 1994:28-32; Van der Waldt et al, 2001:53).

There were various ways and means of determining the attainment of the objectives. The determination may be achieved through assessing the progress made in respect of transformation in the public service in particular and the government in general and in this instance the focus of the process of transformation was delimited to the services provided by
the Department of Health and Social Development (DoHSD) in Limpopo Province in South Africa. The assessment included identifying the weaknesses, needs, objectives, successes and failures of the relevant pieces of legislation and policies of the current government since their inception or publication in 1994. This research study was important as it hoped to achieve and bring clarity on the issues pertaining to the correlation between the transformation and service delivery processes and also to provide recommendations on how to improve health-care service delivery since the attainment of democracy in 1994. Health-care reform was vital and fundamental towards the sustainability of economic and social development of this country; hence this study was exploratory, descriptive, explanatory and evaluative in nature in terms of transformation in the public service of South Africa. The main objective of this research study was, therefore, to review and assess the extent to which the current government (since 1994 to 2009) had achieved the implementation of the set objectives and especially with regards to transformation-related policy objectives of, inter alia, Batho-Pele and transformation of service delivery in the past decade and half in the public service.

5.3 THE TYPES OF RESEARCH APPROACHES

The research usually involves more than one approach and the current research study could usually be described as primarily exploratory, descriptive and explanatory research in nature. Besides those three already mentioned by Babbie (2001, 91 and 92), other such researches are evaluation research, participatory research, unobstructive research and action research to mention just a few. It merits indicating that some of the research studies can simultaneously apply more than one of the above mentioned purposes whereas others can be used separately depending on the fact that each has different implications for other aspects of research design in a specific research situation. It is worth noting that some of the social science researches are conducted for the purpose of exploring the research problem or to familiarize the social researcher especially with the research problem or solving problems under study (Fox and Bayat, 2007:30)

Although it was useful to distinguish the four major objectives of research, it bared saying that most studies shared certain common elements of all three. Suppose, for example, that the researcher had set out to assess the effectiveness of the transformation process on the service delivery, the research study would, therefore, have exploratory aspect, as the researcher
explores possibly relevant variables and maps out the effects of the transformation process on the attainment of service delivery and the project needs to be occasionally evaluated to detect if there are challenges encountered in the process even before the project is completed and the researcher would undoubtedly seek to explain why the transformation process worked better where it has been implemented especially in the remote rural communities that have been neglected in terms of provision of inadequate, inappropriate and unsatisfactory service delivery for several decades of the apartheid era (Babbie, 2001:91 and 93).

A research project usually includes elements of two or all three of these main approaches. The social research serves many purposes and the choice of the type of research, whether experiment, descriptive, correlational or explanatory cannot be arbitrary. Three of the most common and useful purposes are description, exploratory and explanation. A major purpose of many social scientific studies is to describe situations, phenomena and events and it also depends on the factors such as the object of research, the objective of the research and the formats of the data to be collected (Babbie, 1995:84-86; Babbie, 2001:91 and 94). Bless et al (1995:41) point out that the nature of the research problem under study is that the initial level of knowledge, that is, epistemology, the properties of the variables as well as the purpose of the research study determine whether the research is descriptive, correlational, or explanatory. In any research study, the research problem to be solved requires a suitable and appropriate type of research. The research design may also be classified in terms of respondent’s respective purposes. Below are some of the common forms of research approaches used on the basis of their broad purpose, namely, exploratory research, descriptive research, explanatory research and evaluation research; but the present study focused particularly on the last four mentioned types of social research. The present study gave a brief discussion of some of the identified few research approaches that are relevant and logical to it in the following subsections. The current researcher observed and then described the prevailing phenomena as they occur and, hence, the attention of such approaches was given in exploratory, descriptive and explanatory and evaluative researches under 5.3.1, 5.3.2, 5.3.3 and 5.3.4 respectively of subsection 5.3 hereunder:
5.3.1 Exploratory research

The exploratory research is the first general purpose of social scientific research to be considered in the present study. The purpose of exploratory research is to gain a broad comprehension of the research situation, phenomenon, community or an individual. The need for such a study could arise from a lack of basic information in a new research area of interest. It is, therefore, very important for the social researcher to become aware and more familiar with that specific research situation in order to formulate a research problem or develop a research hypothesis. In essence, there are two alternatives for the design of exploratory and descriptive researches, namely, the case study and the survey (Bless et al, 2006:47 and 48).

This research design or format involves developing strategies for executing scientific inquiry. It also involves specifying precisely what the social researcher wants to find out and determining the most efficient and effective strategies for doing so. The appropriate research format enables the social researcher to make appropriate observations and interpret the research findings. The social researcher has at his or her disposal one or more of the following approaches as goals for their research, namely, exploration, description and explanation (Bless et al, 1995:48).

An exploratory research and descriptive research both serve an important role in the research design but differ in many respects, for instance, they have different objectives, they arise from different levels of understanding of the area of interest and they also require different degrees of precision in the research data. Both, however, rely on particular common forms of data collection, namely, observation, questionnaires and interviews (Bless et al, 1995:43).

The first general study is to explore the events, phenomena or things, hence the exploratory research could be considered as the first stage in a sequence of the study because a social researcher may need to conduct an exploratory study in order to explore a new research problem, topic or issue in which very little is known about it. If very little is known about the phenomenon, then the research questions become more general and exploratory in nature. When no extensive and intensive research has been done on the specific area being studied, then there is likelihood that the social researcher will have to explore more from what other researchers have already laid a foundation. Subsequently, the curiosity and inquisitiveness of
the researcher would be to develop or formulate more precise scientific research questions that any research studies to be conducted in future should be able to answer with ease. The exploratory research addresses the “what” scientific question and as a result thereof the exploratory researcher finds it extremely difficult to conduct the exploratory research because there are few or no guidelines at all to follow or dependent upon whilst conducting this type of a research study (Babbie, 1998:90 and 91; Babbie, 2001:91 and 92).

The exploratory research focuses mainly on the exploration of a relatively unknown area of study. Some of the objectives and research methods pertaining to this approach are, inter alia, to obtain new insights into the phenomenon; to determine priorities for further research study; to conduct a preliminary research study as a precursor to a more structured study; to explicate central concepts and constructs; and to formulate or develop new research hypotheses about the existing phenomenon, hence, Bless et al, (1995:43) emphasize the fact that it is often very useful to evaluate the feasibility of a research project, the correctness of some concepts, the practical possibilities to carry it out, the adequacy of the method and instrument of measurement by doing a pilot study. In all these cases, the exploratory research can best serve as an initial phase before the actual study is embarked upon and subsequently, the topic of the research study may not be precisely determined but left open for adjustment (Ary et al, 1985, 287).

The significance of the exploratory research is that it could assist the social researcher in the identification of research data collected. It is significant and also appropriate for those specific phenomena which occur persistently since they can lead to bringing about changes in what is being studied. Babbie (2001:92) further reiterates that this type of study is quite valuable in social sciences and it is typically conducted to fulfil three purposes, namely, to satisfy the researcher’s inquisitiveness and curiosity and desire for better understanding of what is happening in the social world; to formulate and develop the research methods to be adopted and applied in any future research study and to test the feasibility of undertaking a more extensive and comprehensive research.

The exploratory study requires the use of either qualitative or quantitative measurement. For the purposes of this study both the quantitative and qualitative measurements were used because the current researcher was looking for broader understanding of the phenomena with
regards to the relationship between transformation and service delivery processes. A quantitative measurement is one which focuses on a larger number of responses. The suggested method of collecting research data for a quantitative study included the application of questionnaires, study documents and surveys. For the purposes of this study questionnaires were used as a method of data collection and were selected by the current researcher in order to enable him to reach large number of respondents in the vast geographical area of Vhembe Health District of Limpopo Province in South Africa to get a broader understanding of the phenomenon.

The need for such an exploratory study could arise out of a lack of basic information on a new area of interest. The research methods used in the exploratory research include, among others, to review the existing relevant literature; to conduct survey researches among the respondents who have vast experience of the research problem; and to analyze examples that promote understanding of the nature of the problem or phenomenon. The main purpose of exploratory research is, therefore, to gain insight into a situation, phenomenon, community or person (Ary et al, 1985:287).

One of the strengths of an exploratory research is that a large proportion of scientific management research is conducted to provide a basic awareness of the theme while, furthermore, exploratory research is carried out for the purpose of obtaining at least an estimated answer for the question. It yields new insights into the theme particularly for research and it is also regarded as the appropriate source of grounded theory. It is worth pointing out that it seldom provides satisfactory solutions to the research questions, though it can suggest which research methods could provide definitive solutions. The exploratory research is seldom definitive in itself in that it has to do with representativeness, that is, the respondents the social researcher studies in his or her exploratory research may not be typical of the larger target population that interests him or her as such (Fox and Bayat, 2007:30).

The exploratory study being the first type of research to receive attention in this study is primarily concerned with finding out what is happening and discovering new insights about the effect of transformation and democracy on the health-care service delivery and as a result thereof the researcher can begin to integrate details about the real nature of transformation and that portrays the significance of exploratory research in the present study. The study gathered
data from the respondents considered in this study relating to the effects of the process on health-care service delivery.

The research design used for the current study was the sampling of research respondents, health-care facilities from the target populations in the district as reflected in this paragraph and the relevant research technique employed was the questionnaire which generated quantitative and qualitative data. As the present research study was an extension of the survey research conducted by Madzivhandila (2006:61) in which he initially randomly selected 15 health-care institutions each with 10 respondents in the Mutale subdistrict, the same procedures of selecting samples were applied in the three subdistricts which were selected both randomly and judgmentally. All the respondents and the health-care institutions were randomly selected while the subdistricts of Vhembe Health District and the PHC’s of Musina subdistrict were judgmentally sampled. The random sampling was preferred over others because the population of 1 199 886 people was too huge for observation and the judgmental technique was also preferred because the research study was conducted in all the remaining three subdistricts of Vhembe Health District including also all three clinics at Musina subdistrict, hence it was being applied because it was relevant in the current study. The lists of all health-care facilities, public servants and well-identified members of the communities were compiled and the researcher randomly selected the required number of respondents. In each health-care facility, 5 public servants (PS) and also 5 members of the communities (MC) were randomly selected with informed concern from the authorities of the institutions and the respondents in the present study. 326 respondents were selected to constitute the sample. To be more specific and practical, the main sample of the research study comprised of a total number of 326 respondents, that is, one subsample, namely, public servants, consisted of the total of 161 public servants and the other subsample comprising of out-patients or members of the communities consisted of the total of 165 in all the 3 subdistricts; that is, each subdistrict was represented by a research sample comprising specific members of the sample, namely, Makhado’s subsample consisted of 148 respondents, Musina’s subsample comprised of 28 respondents and Thulamela’s subsample consisted of 150 respondents both the PS and MC respondents inclusive.
5.3.2 Descriptive research

The descriptive research is the second general purpose of social scientific research study. Descriptive research describes situations and events. Leedy (1997:190) refers to the descriptive survey study as the method of research that gives insight into the nature of the method and also as one that looks with intense accuracy at the phenomenon and describes precisely what the social researcher observes in the research situation because the research has to do with the description of data. The concept ‘descriptive’ is derived from the prefix ‘de-’, meaning ‘from’ and ‘scribere’ meaning to ‘write’. The term, therefore, describes the essential character of the research method. What the social researcher does in the application of this approach is that first, researchers “… observe with close scrutiny the population bounded by the research parameters; second, they make a careful record of what they observe so that when the aggregate record is made, the social researchers can then return to the record to study observations described above.” The descriptive study basically concerns itself with what the researcher observes and sees, with what can be described numerically or statistically (quantitative data) and in words (qualitative data). The descriptive approach is always suitable for situations where social researchers realize that the data (information) at their disposal do not adequately exist in order to solve the prevailing problem. One of the responsibilities of researchers is to observe and describe situations, phenomena and events. This study under review subsequently complies with this prerequisite since the research format is relevant to this type of the research study (Fox and Bayat, 2007:8 and 30).

The descriptive approach is the study designed especially to describe human behaviour patterns, the social environment within which it occurs, or the research respondents exhibiting it; whereas a correlational design is a descriptive procedure used to test a research hypothesis which shows that a correlation exists between two or more variables. Outside of these contexts, however, the term descriptive approach often conveys the intention by the social researcher to observe and describe respondents’ actual or their behaviour patterns, usually in natural settings where the social researcher does not manipulate or control any variable. The descriptive study might describe certain patterns of behaviour of the specific type of the respondent. In descriptive research the social researcher must endeavour to plan and structure the research in such the manner that valid research findings can be generated. The main objective of the
Descriptive approach is simply to describe the events or phenomena which exist as accurately and clearly as possible in the research situation. The examples of the descriptive research include, inter alia, an in-depth description of a specific individual or group; a description of the frequency with which a certain characteristic occurs in a sample; statistical summary, which entails systematic classification of variables; and correlational studies, which demonstrate relationships between variables (Ary et al, 1985:287; Heiman, 1995:352).

Descriptive approach answers questions related to the ‘what’, ‘which’ and ‘how’ because its objective is to collect data that describes and reports the frequency of occurrences of some events and there is no cause-effect relationship that is sought in such a project, but it simply presents the information as it is being observed (Robinson, 1976:145). Bless et al, (2006:48) point out that the descriptive approach is also to test factual hypotheses, or statements that do not relate two variables but express facts about the social world. The examples of factual research hypotheses are, for instance, ‘The client is smiling at the psychologist’ and ‘Loskop dam is an artificial dam built in Umpumalanga Province in South Africa’ In these instances the social researcher has only to observe directly whether the client is smiling, or not or the researcher consulted some geographical documents that have a bearing about the construction of Loskop dam. What the researcher is merely interested in is describing a phenomenon as it prevails, hence the research is often referred to as descriptive research. When the research question requires an understanding of the relationship between variables, namely, the independent variable (IV) and the dependent variable (DV), the research is called correlational research, hence Bless et al (2006:46) mention that when the social researcher is able to state a hypothesis, expressing the relationship between at least two variables, the results obtained provide more than just a description of reality.

The main goal of the research study tends to be the careful mapping out set of events or developments. What is of great concern to the social researcher is that he or she would like to know why something happens and how what happens is related to other events or variables. The first step in the acquisition of knowledge about the interaction between people and the social world is the description of the object, respective relationship and also the situation. The acquisition of knowledge through objective observation of phenomena is called the descriptive method (Bless et al, 2006:3). If, for example, the researcher is interested in the study of transformation process, he or she will, therefore, would like to know how the achievement in
terms of service delivery has been attained as the result of the implementation of the transformation process in the specific community. The descriptive exploration of this study is often called descriptive study because it attempts to describe phenomenon in detail as it describes what happened behaviourally or generally attempts to explain a social phenomenon by specifying who, why or how it happened in contrast to explanatory research (Bailey, 1994:40; Rosnow and Rosenthal, 1996:15).

Leedy (1997:191) indicates that the descriptive survey method is basically distinguished by the following salient characteristics, namely, it “1. … deals with a situation that demands the technique of observation as the principal means of collecting data. 2. The population for the study must be carefully chosen, clearly defined, and specifically delimited to set precise parameters for ensuring discreteness to the population. 3. Data in descriptive survey research are particularly susceptible to distortion through the introduction of bias into the research design. Particular attention should be given to safeguarding the data from the influence of bias (and) 4. Although the descriptive survey method relies on observation for the acquisition of the data, those data must then be organized and presented systematically so that valid and accurate conclusions can be drawn from them.” whereas Heiman (1995:48) indicates that with a descriptive research design the social researcher does not manipulate or change the factors or variables of interests; but rather the researcher would only observe behaviour patterns and relationships so that he or she may describe and explain them without attempting in any way to influence such human behaviour patterns or to cause a relationship happen. This type of the descriptive design meets the social scientific goal of predicting behaviour patterns in the current research study. This research method format is being considered due to the nature of the present study in order to gain insight into a situation, phenomenon, community or person, hence, the present study is also basically descriptive in nature.

The second general objective of the study describes the phenomena or the events. The descriptive approach, therefore, presents specific details of the prevailing research situation. In this case, a researcher commences with a well-defined challenge or issue and conducts study to describe it accurately and appropriately. The current research study used a descriptive study to describe the problem accurately because there were highly developed ideas about transformation and service delivery processes in the new public service in the Republic of
South Africa in 1994. The transformation process as a topic under consideration was accurately defined and discussed extensively in section 2.2 of Chapter two of the present study, presenting basic background information so as to get a detailed picture of the topic (Babbie, 1998:91 and 92).

Many social scientific studies are descriptive in nature, that is, they always describe the phenomena, situations and events or developments as they prevail in the research situation. The responsibility of the social researcher is, therefore, to observe, then describe and explain what was observed in the social research situation. The scientific descriptions are typically more accurate and precise than are casual or correlational ones. Babbie (2001,93) mentions that some qualitative studies are primarily descriptive in nature because a social researcher is keen to describe and then describes what was observed and to examine why the observed patterns of behaviour of some respondents in that particular way exist and what these patterns of behaviour subsequently imply. Such descriptive studies answer questions of what, where, when and how, for instance, reporting the extent the transformation process has been implemented since 1994 in different remote rural areas of this country and its effects on the quality and standard of health-care and this type of research is conducted to be an appropriate example of description. Bless et al, (1995:42) comment that before searching for an explanation related to some attributes, a certain amount of background information, namely, a description of the ‘object of research’, must be gathered. In such a case the type of research will be exploratory, which is a particular type of descriptive study. Under certain circumstances, a description of the new situation is required.

The descriptive approach, however, being the second type of research, describes the attributes of an existing phenomenon and it seeks to discover answers to questions relating to the fundamental characteristics that define the research subject. The main objective of descriptive study is that it is often conducted to advance the broad objectives of science; it is performed mostly to develop knowledge on which the problems and explanations of subsequent research are based and it also often goes beyond a mere description of the phenomenon as it prevails in the research situation.
5.3.3 **Explanatory research**

The exploratory research is the third general objective of social scientific study in the context of this research. According to Bless et al (2006:43 and 50) it indicates sequentially that once the data have been collected through the descriptive method, the social researcher should proceed with an explanation or statement pertaining to the relationship between the described facts that need to be expressed in terms of the law wherever it is deemed necessary and the stated explanation should permit a prediction of further events under well-defined conditions. Such an explanation should allow prediction of the next events under the well-defined or controlled circumstances in order for explanatory approach to afford the social researcher the ample opportunity to foretell the occurrences of some events and the eventual correctness of an explanation must be tested to explain some phenomena or things and, therefore, to show causality if possible between two or more variables, phenomena or events. It is also useful to engage explanatory research to explain the need for transformation in the public service in South Africa even if one wants to go beyond focusing on transformation process as a subject. This will advance knowledge especially about an underlying process suggested to transform the public service and service delivery with a view to improving the standard of life of all South African citizens (Bless et al, 2006:43; 46; 48-51).

The present researcher’s intent in the explanatory study is to observe, describe and explain some segments or units of social reality. It merits pointing out that the explanatory study is undertaken especially to identify possible causal variables of a given social phenomenon and thereby contributing to the understanding of the research data as they relate to the correlation between transformation and service delivery processes (Bless et al, 1995:48).

The explanatory study being the third type of research approach always seeks to explain things or the relationship between variables and to identify the connectedness or relationship between the variables or the components of a phenomenon. The basic objective in this type of study is to closely study the research problem, collect data on the respective phenomenon through an analytic and deductive process often entailing statistical analyses, to explain the relationship among variables and to demonstrate causality between two or more variables or events. This means that correlational studies are taken a step further and the direction of the relationship is also indicated. The exploratory approach facilitates the selection of a suitable method or
methods and when an explanation is sought for the relationship between variables, one is, therefore, dealing with explanatory research. More new knowledge is acquired by using an explanatory research than using either correlational or descriptive research. When the research question demands that the social researcher explains the relationship between variables and demonstrates that change in one variable subsequently causes change in another variable, such the method of collecting data is called explanatory research (Ary et al, 1985:287, Babbie, 2001:131 and 132; Bless et al, 2006:43; 46; 48-51).

Fox and Bayat (2007:31) comment that the significance of scientific research is to explain the phenomena or things and further indicate that the intentions of, for example, the voters in an election campaign are to describe them, but reporting why some voters are planning and intending to vote for their respective candidates of their choices and interests becomes an explanatory activity of the social setting.

5.3.4 Evaluative research

According to Mason and Bramble (1978:45) evaluative research refers to “… the process of determining the usefulness and adequacy of a product, objective, approach, function, or functionality.”

The evaluative research basically aims at testing social interventions to see how effective they are and therefore represents an important means of linking action and research in a constructive manner and this type of study may be used, for example, to identify neglected areas especially of need, target groups and problems within organizations, projects and programmes. The evaluative research can be used to assess the implementation and usefulness of social interventions, for example, the Reconstruction and Development Programme - initiated initially by African National Congress but later on was adopted as the government policy of GNU - and the transformation process. One of the central concerns of social research is action. Any attempt to change the conditions under which people live and no matter how simple it is or who is responsible for such conditions can be regarded as a social intervention in a particular community (Bless et al, 2006:57 and 58).
As there were objectives to be accomplished by the current government in the present study, the following issues were considered to be of paramount importance. First, the evaluation research to help to identify the developmental needs of the marginalized community in terms of health-care service delivery. The main objective of assessment was not to pass or fail a particular research endeavour or initiative made by the current government but simply to identify weaknesses and furthermore to suggest how they could possibly be remedied and also to inform the DoHSD and rural communities about the developments that have so far been successfully accomplished since 1994. Second, the present government needed to be informed on whether its policies and mandates were being effectively implemented by the relevant stakeholders especially the public servants, and other statutory organs of state and private sectors inclusive. So, one of the purposes of evaluation research in this regard was to ascertain how much progress to date has been made in achieving targets and priorities the government had already set for the DoHSD of Limpopo Province in South Africa.

Bless et al (1995:489) identified certain benefits of evaluation research, first, a diagnostic tool that can help the people in the community to implement a social intervention, to identify neglected areas of need, neglected target groups, and problems within organizations and projects or programmes as already mentioned above. There are three different roles that evaluation research can play in social interventions, namely, diagnostic evaluation, formative evaluation and summative research that are designed to inform the social researchers and project managers about the present situations within communities and the organizations and also highlighting current problems, trends, forces and resources, as well as the possible consequences of various types of such social interventions (Bless et al, 1995:47, 49 and 58). Second, that a comparison of a project’s progress with its original purposes serves as other functions of evaluation research since this may also serve to adjust the project or programme to the particular needs and resources of the organizations or communities within which it is situated. This type of evaluation is, therefore, called formative evaluation since it is designed to promote and facilitate the effectiveness of the identified project or programme and relates particularly to the development and implementation of it. Formative evaluation furthermore aims at shaping the project so that it will eventually have the greatest beneficial effect upon the target population. Many projects use formative evaluation to ensure that the social intervention adapts to changes in social reality and as a result thereof continues to have the greatest possible
effect. It improves the organizational and community programmes or projects (Bless et al, 1995:489; Bless et al, 2006:57-64).

The other type of the evaluation research, namely, summative research, may provide tangible evidence of the usefulness of a project or programme and subsequently the project may gain credibility from the able funding organizations as well as from the community within which it is operating. Bless et al (1995:51) mentioned that summative evaluation is one of the three types of evaluations and its broad objective is to determine the degree to which a project or programme meets its specified purposes within the particular environmental setting. The information acquired through summative evaluation is also used to gain credibility with various groups of people particularly potential funders; and target communities and people are likely to be more enthusiastic about the programme or project that has positive effects on their lives; and although summative evaluation ought always to happen at the end of a project, it is often carried out at regular intervals during the life of long project as well. It merits pointing out that the afore-mentioned three types of evaluation, namely, diagnostic, formative and summative are all interrelated, interdependent and occur side by side in the course of ongoing social interventions (Bless et al, 1995:48, 52 and 53).

The diagnostic evaluation, for example, is another type of a technique for the collection of data which is crucial in the planning especially of a new project or programme. It is of paramount importance that the community is always made aware that something in accordance with the development of the project is or has been implemented and is in progress. This type of evaluation can help especially the communities, organizations and societies undergoing rapid transformation like South Africa, but does not fully conceptualize how these changes will affect them (Bless et al, 1995:47, 49 and 58). Although such roles of the various types of evaluation research are different their respective goals are, nevertheless, complementary to each other and most assessors are expected to simultaneously implement them.

5.4 RESEARCH DESIGN

According to Huysamen (1987:91) a research design is “… the preconceived plan, according to which data are to be collected and in terms of which inferential-statistical methods are to be applied.”
Since the objective of the research design is to plan and structure the project, the present study employed the quantitative and qualitative descriptive design in which the former makes use of the questionnaires as the research technique for data collection. The data collected from the respondents were presented in the form of frequencies, tables and figures in chapter six. The quantitative method is the appropriate research design for the current study because this method is the most predominantly and the frequently used research methodology in the collection of data in many social science studies. A study that studies phenomena and looks at broader comprehension of such particular phenomena and attribute measures in numbers or statistics is often referred to as the quantitative research methodology. The quantitative research methodology often relies upon measurement and uses various scales in the research analysis. Numbers form a coding system by which different cases and different variables are represented for easy comparison purpose (Babbie, 2001:10 and 36; Bless et al, 2006:43 and 44). The quantitative research methodology focuses primarily on the description of attitudes and opinions whilst measuring the effect of one event or variable upon another variable or event. The researcher investigating the kind of data needed in the present study is dealing with quantitative and qualitative research since some of the items in the questionnaires generated responses that are quantitative in nature on the one hand and on the other hand others generated responses that are qualitative in nature (See Appendices E and F). The present study is designed in such a way as to provide either supporting or refuting evidence for the hypotheses outlined in chapter one. As this study is the extension of the previous research done in Mutale subdistrict by Madzivhandila (2006:42-47) who also conducted the pilot study, the present study adopted the set of questionnaires that emanated from its findings.

Every scientific research study requires a research design that is carefully tailored to eventually meet the exact identified needs of the communities, the envisaged requirements as well as the research problem identified by the social researcher. The current researcher, therefore, chose to include in the research design aspects such as the class of design for data collection, target population, survey sample and sample size, methods and procedures of sampling and also research sampling techniques. The design of a study, therefore, demands a full grasp of research philosophy, research paradigms, research processes and research strategies and in addition, the researcher needs to have a full comprehension of the theoretical and practical processes relating to sampling procedures, data collection and data analysis.
Bless et al (1995:63) define the research design “…as the planning of any scientific research from the first to the last step … it is a programme to guide the researcher in collecting, analysing and interpreting observed facts… it relates directly to the testing of hypothesis”. Mouton (2001:55) mentions that “A research design is a plan or blueprint of how you intend conducting the research.”, that is, how it structures a given research project or programme in such a manner that the eventual validity of the research findings is maximized. A good research design is essential and indispensable to the social researcher because it, therefore, gives direction to the envisaged research project.

The research design is the plan which specifies how research respondents will be sampled from the target population and what is going to be done to them with a view to reaching conclusions about the research problem, research hypothesis or research questions. It is the visualization of the data and the problems associated with the employment of those data in the whole research project and it also involves analytic thinking and imagining. The research design has to specify clearly the number of respondents that should be used in the study and whether the respondents are to be drawn randomly from the target population involved or whether the respondents should be drawn judgmentally, assigned randomly to the samples and also what exactly should be done to them as each design is, therefore, expected to serve a specific purpose. The research in social and behavioural sciences is often undertaken with a view to studying the causal relationships. The research design is indispensable and necessary for the management of the entire research endeavour since it requires specifically planning, organizing, leading, controlling including imagining, thinking, visualization of the data and the problems associated with the employment of those data in the entire research project (Huysamen, 1994:20; Leedy, 1997:93). Kweit and Kweit (1981:357) have been quoted by Leedy (1997:93) as having defined the word research design as “… the strategy, the plan, and the structure of conducting a research project”

According to Heiman (1995:9) the design “…is the specific manner in which the study will be conducted. A design includes many components, such as the characteristics of our subjects, the specific situation or sequence of situations under which we will study subjects, the way we will examine their behaviour, and the components of the situation and behaviour we will consider”.

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The research design relates directly to the testing of hypotheses. It is a specification of the most adequate operations to be performed in order to test a specific research hypothesis under a given condition. The important questions facing the researcher are the steps that should be taken in order to demonstrate that a particular research hypothesis is, indeed, true and that all other possible hypotheses must be rejected, and in order to achieve the set objectives of research, the researcher requires a carefully and critically thought out research strategy. These challenges relate directly to the focus, the unit of analysis and the time dimension of the problem at hand. The research can, therefore, be used to explore almost any theme of the social world.

The focus of research may be understood in terms of three different categories, namely, conditions, orientation and actions. The conditions are, therefore, studied whenever the researcher wishes to explore the current state of the respondents in the research situation, for example, a researcher who measures the transformation process in South Africa is interested in the current condition of the effects of transformation on the quality of service delivery while the orientations are concerned with the respondents’ attitudes, opinions and beliefs they harbour towards the transformation process in general. The researcher interested in political and religious views would, for example, be interested in orientations and actions that are also very often the focus of research. These actions may be observed directly or may be reported by the actor or others who observed the actor, hence in the collection of data the primary and secondary sources of data play a significant role in the present study. These three different categories in most cases are not mutually exclusive of one another and the social researcher must simultaneously be sensitive to all of them while carrying out a research.

The second important factor that the researcher must consider when planning an appropriate and logical research design is that of the unit of analysis. The unit of analysis is either the person or object from whom the researcher collects data. The individuals are the most common to constitute the unit of analysis in the study. In this case the social researcher studies the conditions, orientations or actions of a group of individual people. The groups of people are also sometimes studied as units of analysis. Where an entire group is studied, for example, health workers, professionals, marital relationships and members of the community, each of them constitutes one unit and can be compared to another group or another unit. The
organizations with formal structures are often a particular kind of group that is often used as the unit of analysis in social research studies (Bless et al, 2006:71 and 73).

Babbie (1995:80-83 and 2001:91) indicates that scientific research is a process for achieving generalized understanding through observation and that the scientific design addresses the planning of scientific inquiry, which is designing a strategy for finding out something in the research situation. First, the researcher specifies precisely what he or she wants to find out. Second, the researcher must determine the best way to do that. Before the researcher can observe and analyze he or she needs to plan, that is, planning precedes organizing, leading, monitoring and evaluation to mention just a few. The researcher needs to determine what he or she is going to observe and analyze in terms of why and how. That is briefly what research design entails or is all most about.

5.4.1 The class of design for data collection

The primary task of a research theory in any study is to explain change that takes place in the research situation. The researcher in the social sciences and whose objective is to identify and explain change has a choice of three main classes of design for data collection, namely, the longitudinal study, the cross-sectional study and sequential study (Breakwell et al, 1995:12; Creswell, 2003:16). The other observations may be made more or less at one time or they may be deliberately stretched over a certain long period, for example, a sequential study. The research design is a process for deciding what aspects the researcher should observe, of whom, and for what specific purpose (Babbie, 1995:95; Bless et al, 1995:49). There are three types of study in any research endeavour being undertaken, namely, the longitudinal, cross-sectional and sequential studies, hence the following subsections of the present research design focused mainly on the class of design for data collection such as cross-sectional study followed by target population, sample size, sampling types, sampling methods and sampling procedures and sampling research techniques.

5.4.1.1 Cross-sectional study

A cross-sectional method takes a large sample of the population of various ages at one time and testing them in contrast with the longitudinal method. The cross-sectional study is said to
be the study in which a certain phenomenon is observed or studied at a given specific moment. A cross-sectional design involves eliciting information from the respondents in a number of different conditions expected to be significant to the change at a single time and often this means studying respondents in different occasions and this design applies well to the current study in which the effects of the transformation process are deemed to be a major determinant of change upon the quality of service delivery in this country (Babbie, 2001:101; Elmes et al, 1999:440; McBurney, 1994:314). Elmes et al (1999:440) point out that a cross-sectional method takes a large sample of the target population of various ages at one time and testing them in contrast with the longitudinal method.

In cross-sectional studies many research projects are designed to study some phenomenon by taking a cross-section of the target population at one time and analyzing that cross-section carefully. The exploratory and descriptive studies are often cross-sectional in nature. A single South African census, for instance, is a study the objective of which is to describe the South African population at a given time and this is regarded as cross-sectional study (Babbie, 1995:95: Babbie, 2001:101). In view of the fact that the present research is both exploratory and descriptive in nature, it boils down to the fact that it is also a cross-sectional study in which the study is exploring and describing the correlation between the transformation and service delivery processes in Vhembe Health District of Limpopo Province in South Africa because the research data were collected from the respondents in the health-care facilities at the same time from various health-care facilities (PHC’s or clinics) during the course of 2009.

According to Bailey (1994:36) a “… cross-sectional study is one that studies a cross-section of the population (or universe) at a single point in time.” It is worth noting that the primary strength of cross-sectional research study is that it studies a cross-section of the target population at a single point of time and that data can be collected from a huge number of respondents and such data are comparable since they are not affected by any changes over time (Bailey, 1994:36). Heiman (1995:350) mentions that respondents are observed at different ages or at different points in a temporal sequence while Bless et al (2006:182) define the cross-section as “… A research design where all data are collected at the same time.”

The third fundamental aspect of any research is the manner in which it deals with time. The observations may all take place at a particular time or may deliberately be stretched over a long
period. When all data are collected at the same time, the research design is cross-sectional in nature. The social researcher uses this type of design or format as an attempt to understand a phenomenon by collecting a cross-section of information relevant to that specific topic. The inherent weakness with cross-sectional design is that, because it does not allow the researcher to measure change over time since all the data are collected at once, it is, therefore, very difficult to demonstrate causality. Nevertheless, according to Bless et al (2006:74) the immediate nature of cross-sectional design as well as the relative ease of data collection, makes this design the most common choice for social scientists or researchers since data are collected from the respondents at the same time. A questionnaire to survey opinions of the respondents on a certain issue at a specific moment is an example of what the cross-sectional study is all about and opinion polls conducted before an election fall within this category of the cross-sectional study.

5.4.2 The target population

A target population consists of the total collection of all units of analysis (the members or elements of a population) about which a social researcher requires to reach distinct conclusions, that is to say, the population or universe in the research situation is the object of study and often consists of individuals, groups, human products, events, organizations or the conditions to which they are exposed. The population is, therefore, the full set of, inter alia, individuals, groups, organizations, human products, events and cases from which samples are drawn and in research setting such cases need not necessarily be human beings (Fox and Bayat, 2007:30, 51-52). The study of the target population received attention under the research design and is nothing else other than just the aggregation of elements or units from which the research sample is actually drawn. A theoretically specified aggregation of study units is, therefore, a target population. A sampling frame is the actual listing of sampling units from which the sample is collected and usually corresponds to the population being studied in the one hand, although many sampling frames fail to include all the elements in a study of a target population while on the other hand, the concept ‘population’ is regarded as the total set of potential observations from which a sample is drawn or an aggregation of study of elements (Babbie, 1995:193; Bless et al, 1995:115; Elmes et al, 1999:444). According to Babbie (2001:185) a population “… is that aggregation of elements from which the sample is actually
Huysamen (1998:2) defines a population “… as the total collection of individuals who are potentially available for observation and who have the attribute(s) in common to which the research hypothesis refers.” While Bless et al (1995:85) define the population (or universe) as the “… entire set of objects and events or group of people which is the object of research and about which the researcher wants to determine some characteristics…. “; and Rosnow & Rosenthal (1996:411) indicate that the concept ‘population’ refers to the universe of elements or units from which the research sample elements are drawn, or the universe comprised of elements to which the researcher wants to generalize. Brynard and Hanekom (1997:43) describe the concept, ‘population’ as referring especially to “… all the objects, subjects, events, phenomena, activities or cases which the researcher wishes to study in order to establish new knowledge”. All the definitions made by the afore-mentioned authors, in brief, indicate that the word ‘population’ refers to the total collection of units or elements from which the sample elements are constituted or drawn.

The population unit, therefore, is the single unit of the sample on which measurement and observations are made by the social researcher. The general population is a full set of units from which a sample is constituted. If the researcher, for example, wishes to examine the administrative effectiveness of the transformation process on the quality of services delivery in Vhembe Health District of Limpopo Province in the Republic of South Africa, then the population from which he or she would draw the sample would be health-care workers and the members of the communities and each respondent would be an element in the population. The target population is, therefore, the full group of respondents to whom the researcher wants to generalize the findings of the study. In contrast, the universe refers to all possible elements or cases of a certain kind. The general target population is the portion of the universe that the researcher has identified and has possible access. The target population used in the current study was the health-care personnel, particularly the nursing staff and members of the community in the district.
The survey sample and sample size

The goal of surveying in general is to find out how every respondent identified in the target population of interests feels about a topic under study. Bless et al, (2006:100) define the research sample as “… a subset of the population, … and … must have properties which make it representative of the whole.” Frequently, because of practicalities, the researcher cannot interview every available respondent or the entire population and instead he or she needs to draw from such a large number of people to find out how some of them feel like in that particular situation and the sample is preferable to the study due to the magnitude of the target population. The researcher is usually forced to limit his or her observations or study to a part of the general population which is a sample. It is both practically and physically impossible as well as difficult to obtain information from the entire target population of interest for the purpose of study unless the identified general target population is immensely too small and in such a way that the respondents of which are very few and are easily accessible for consideration, hence such respondents are said to constitute the sample which is the representative of the target population in its entirety. Any group of individuals or objects that shares a common attributes or characteristics and represents the whole or sum total of units involved in a study is called the target population or the universum; hence the separate individuals or objects belonging to the population of interest are called the elements or units of the population. The researcher or the scientist is sometimes not able to study all the members of the general population that interest him or her, that is, in virtually every case, it is imperative, therefore, that the researcher must sample certain respondents randomly or purposively for specific study since the goal of sampling is to collect data from a representative group of people in order to generalize the results back to the target population of interest (Babbie, 1995:103, Bless et al, 2006:100; Van der Waldt et al, 2001:291 and 302-303).

The size of the research sample is affected or depends mostly upon a variety of practical considerations such as the size of the relevant target population, research problem, the availability of respondents and instrumentation and method of sampling to mention just a few (Fox and Bayat, 2007:61). A sample is a representative of the target population from which it is selected or withdrawn if the aggregate attributes of the sample closely approximate those same aggregate attributes in the general population. The sample needs to be a representative in all respects; representativeness is limited to those attributes that are relevant to the substantive
interests of the study (Babbie, 1995:193 and 194). Huysamen (1998:2) points out that “A sample is a relatively small subgroup of cases from the population.” The researcher has to rely upon the research data obtained for an appropriate selected sample from the entire population. In any random sampling one finds that every member or unit of the target population about which the research study would like to generalize, has an equal opportunity of being sampled for participation in the study. This research method, therefore, ensured that all respondents identified for this study have an equal opportunity to participate in it and to be represented in the research sample. Heiman (1995:34) mentions that a sample “… is a relatively small subset of a population that is selected to represent or to stand for the population.” The basic research technique for selecting a sample is, therefore, random sampling which includes random, systematic and stratified samplings.

It is possible in any research endeavour for the researcher to choose a relatively small sample of respondents from the entire target population in such a manner that their responses can safely be taken to represent the intentions and interests of the target population across Vhembe Health District of Limpopo Province in the Republic of South Africa. The research sample is a special subset of a target population observed for purposes of making inferences about the attributes of the total population itself (Babbie, 1995:193). The sampling frame is a list of all units from which the sample is to be drawn and it is selected at random from a list of the population also referred to as the sampling frame.

The application of the findings and generalization of a study to the general population and the universe is only permissible when the research sample can be considered to be representative of the target population and the universe. According to Leedy (1997:210), the basic rule is that the larger the sample, the better for the objective of survey research. But such a generalized rule is not too helpful to a researcher who has a practical decision to make with respect to a specific research situation. It is imperative that somewhat more definite guidelines should be formulated. The constitution of the appropriate sample size depends largely on the degree to which the research sample approximates the qualities and attributes of the general population. If, for instance, the target population is markedly heterogeneous, the social researcher must ensure that a larger sample will be drawn than if the total population is homogeneous.
According to Bailey (1994:83) a research sample is “… a subsection or portion of the total population and should be viewed as part of the whole population.” The correct research sample size is dependent primarily upon the nature of the target population and also the objective of the research study. Some research studies deal adequately with small general population. The size of any envisaged research sample in any research situation depends also upon the size of the general population to be sampled; but many researchers regard 30 respondents as the required minimum for the research study (Bailey, 1994:97; Champion, 1970:89). Another contributory factor to the determination of the sample size is a question which demands a thorough thought before it is answered and this may subsequently also be left unanswered due to its complexity. Other questions might have been phrased in a vague and ambiguous manner or have unclear answer categories, causing some respondents to refuse to answer them in order to avoid providing or furnishing meaningless responses. Rosnow and Rosenthal (1996:413) mention in brief that a sample is nothing else but simply “A subset of the population”.

Bless et al (1995:96) advised that the very important issue in ‘sampling procedure’ is to determine the most adequate size of the sample. A large sample is, therefore, the most appropriate and representative but very costly on the one hand, whereas a small sample, on the other hand, is much less accurate but more convenient to the researcher or the social scientist. The major criterion to use when deciding upon the sample size is the extent to which the research sample is representative of the total target population or universe. This extent can be expressed in terms of probability; one usually expects to have a ninety-five percent (95%) chance that the sample is distributed in the same way as the general population. One can at least note that the more heterogeneous the target population is, the larger the sample size must be to cover sufficiently and correctly the attributes of the entire target population. Fox and Bayat (2007:54) define a research sample as “… any subset of the elements of the population that is obtained (by some process) for the purpose of being studied. The process by which elements are drawn from the population is known as sampling.”

In some instances, the researcher may wish to study a small subset of a larger population in which many members of the subset are easily identified, but the enumeration of all of them would be nearly impossible. If it is intentionally a qualitative study, then relatively small purposive samples, would typically be used, and there is no ‘rule’ that determines sample size. The sample builds and evolves as data gather, and it is the quality, rather than the quantity of
the sample that is the researcher’s prime concern. If, in contrast, the study is intentionally a quantitative and experimental in design, then the sample size necessary can be calculated mathematically and will be determined (Fox and Bayat, 2007:7).

A sample of individuals from a target population, if it is to provide any useful and meaningful descriptions of the total general population, must contain essentially the same variations that exist in the target population. An element or unit should be understood as that unit about which information is collected and provides the basis of analysis. Typically, in the survey research units are people or certain types of people or respondents, for example, families, social clubs and co-operations, to mention just a few. The elements or units of analysis that are often the same in a given study refer to data analysis (Babbie, 1995:86-88; Babbie, 2001:94 and 95).

The size of research sample is also often determined by various factors such as the type of the research, research hypotheses, financial constraints, importance or results, number of variables studied, method of data collection and the degree of accuracy needed. From the huge pool of respondents the researcher may randomly select few representatives so as to shorten the scope, minimizing time as well as the financial cost, but for the purpose of the current research study the following respondents were used, namely, the public servants (PS) also called the nursing personnel and members of the communities (MC) also referred to as the patients or health-care consumers and both subsets were sampled as reflected hereunder.

On the basis of the lists of the personnel made available to the researcher by the health-care facilities through the District Executive Manager, the names of health-care workers for each health-care facility were written on the cards as the first option of random sampling since there were various types of sampling. In randomly selecting 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 thereafter put into a closed container, for instance, in this case, it was a hand-made basket (mufaro) that could be closed at the top in such a way that no one could see the numbers appearing on the cards being taken out one after another to constitute the research sample. The cards were mixed and thoroughly shuffled to avoid taking them out in the same sequence as they were inserted into the bag. The member of the community who was unaware about what was being done was requested by the current researcher to pick up one card after another out of the basket until the required number of 161 respondents or public servants (PS) in the district
has been obtained for the study. The same procedure of randomly selecting 5 out-patients or members of the communities (MC) visiting certain particular health-care facilities on the day of the study was repeated until a total number of 165 respondents was obtained after consulting within the health-care facilities in the identified subdistricts. As a second option the current researcher could have considered or implemented as against the previous procedure of, for example, roulette, computer and random sampling tables to constitute a representative sample, but did not do so because the first one was appropriate for the current research study being undertaken as it prevailed significantly over other types of sampling procedures (Brynard and Hanekom, 1997:45).

As the present research study was an extension of the survey research conducted by Madzivhandila (2006:61) in which he initially randomly selected 15 health-care institutions each with 10 respondents in the Mutale subdistrict, the same procedures of selecting samples were applied in the three subdistricts which were selected both randomly and judgmentally. All the respondents and the health-care institutions were randomly selected while the subdistricts of Vhembe Health District and the PHC’s of Musina subdistrict were judgmentally sampled. The random sampling was preferred over others because the population of 1 199 886 people was too huge for observation and the judgmental technique was also preferred because the research study was conducted in all the remaining three subdistricts of Vhembe Health District including also all three clinics at Musina subdistrict, hence it was being applied because it was relevant in the current study. The lists of all health-care facilities, public servants and well-identified members of the communities were compiled and the researcher randomly selected the required number of respondents. In each health-care facility, 5 public servants (PS) and also 5 members of the communities (MC) were randomly selected with informed concern from the authorities of the institutions and the respondents in the present study. Out of 1 199 886 people, 326 respondents were selected to constitute the sample. To be more specific and practical, the main sample of the research study comprised of a total number of 326 respondents, that is, one subsample, namely, public servants, consisted of the total of 161 public servants and the other subsample comprising of out-patients or members of the communities consisted of the total of 165 in all the three subdistricts; that is, each subdistrict was represented by a research sample comprising specific members of the sample, namely, Makhado’s subsample consisted of 148 respondents, Musina’s subsample comprised of 28
respondents and Thulamela’s subsample consisted of 150 respondents both the PS and MC respondents inclusive.

5.4.4 The types, methods and procedures of sampling employed

The method employed in the present study was three-fold: First, a literature and legislative framework survey was conducted to consider the new statutory framework on the transformation process; second, an empirical study was undertaken to discern the real role played by the process and the effects it had on the health-care service delivery in the public service; and third, an analysis was done by means of a chi-square test, based upon the data collected from the respondents. One of the fundamental elements in social research study that is not always important in physical sciences concerns how the social researcher selects from among the infinite observations the appropriate representative of the target population he or she might make. The logic of sampling is at the disposal of the researcher at the same time since he or she cannot observe almost every phenomenon that is taking place in any research situation. It is significantly important for the researcher to focus on sampling or picking up what he or she observes in the research situation. The logic of research sampling is that having identified and specified what is to be studied, the next step in the research process would, therefore, be to choose a research sample. The process of research sampling affords the social scientist the capacity to describe a larger population based on only a selected portion of that particular target population (Babbie, 1995:5; 226 and 227; Bless et al, 1995:114).

Some of the things the social researcher needs to do before he or she decides on a sample is to think about the attributes of the target population that will be important to him or her, so that when drawing the sample, he or she should be sure that, indeed, the sample represents a particular population appropriately. To this end, however, the researcher needs to draw a sample from the target population in such a manner that the research sample resembles more or less the general population of interest, or is absolutely representative of it (Moser and Kalton, 1977:156). The goal of sampling therefore is to collect research data from a representative group of people in order to generalize the research findings back to the target population of interest.
This section indicates what the concepts ‘sampling method’ and ‘sampling procedure’ imply. The definitions of these concepts are very important in the research study of this nature so that the readers should have same common understanding of what is being implied or conveyed by such concepts in this particular context, since the same word might have different meanings in different circumstances and also to different people, hence, the definitions of each concept is necessary, indispensable and important. It should also be borne in mind that in the types, methods and procedures of sampling not all research data lend themselves to sampling. The process of sampling is appropriate wherever huge target populations that have an outward semblance of homogeneity are to be studied. Leedy (1989:152) points out that “The sample should be so carefully chosen that through it the researcher is able to see all the characteristics of the total population in the same relationship that they would be seen where the researcher in fact inspects the whole population.” Leedy (1997:210) further mentions that the size of the research sample is dependent largely upon the extent to which sample approximates the qualities and characteristics of the target population, for example, if the target or general population is markedly heterogeneous, a larger sample will, therefore, be needed than if the target population is more homogeneous while Bless et al, (1995:88) indicate that the “… sample is the subset of the population and should be representative of the whole. An adequate sampling frame should exclude no element of the target population. All elements of the population have the same chance of being drawn into the sample.”

A sampling frame is the actual list of sampling units or elements from which the sample, or some sage of the sample, is selected, for example, in the context of the present study a sample comprised of public servants and members of the communities in Vhembe Health District of Limpopo Province in South Africa was selected; the Vhembe District became the sampling frame. According to Babbie (1995:194 and 195; Babbie, 2001:176 and 194) the ultimate purpose of sampling is to select a set of elements or units from the target population in such a way that descriptions of those elements or statistics accurately portray the parameters or attributes of the entire target population from which the units or elements are chosen. The probability sampling, therefore, enhances the likelihood of accomplishing this research objective and also provides methods for estimating the degree of probable success.
In simple terms, ‘sampling method’ is understood as the process in any scientific research study whereby the study is restricted to a small but well-selected group of respondents or objects, that is, the sample represents a much wider group, namely, the universe or the total target population. It is the process whereby a target population of interest is designated and studied. Bailey (1994:83) defines a research sample “… as a subset or portion of the total population.” which is regarded as an approximation of the whole rather than as a whole in itself. The researcher thereafter attempts to select a subset of some predetermined size from the target population of interests. The subset should, therefore, appropriately and adequately represent the entire population so that the information gathered from the subset ideally will be just as accurate, adequate, appropriate and representative as the data the researcher could collect from the total target population of interest (Bailey, 1994:83).

According to Heiman (1995:201), the respondents are randomly selected so that every respondent in the defined target population or universe has exactly the same opportunity of being chosen in the study. By choosing the respondents in an unbiased and unselective manner, the researcher allows the diverse attributes of the target population to occur in the sample as often, and to the same degree, as they occur in the total target population and, therefore, the respondents in the study should be representative of the identified target population for the specific study. Another challenge often facing the social researcher is that he or she is unable to contact all identifiable respondents comprising the entire general population; hence sampling is an ideal process to embark upon in any social research project. Usually, in certain situations, the research sample is limited to those people living in a particular environment. The main objective of sampling, therefore, is to identify whom to ask questions so that the researcher can infer what everyone else thinks constitutes the phenomena. The reality of the matter is that the researcher wants to know how the population feels about the particular phenomenon or event, hence he or she is only expecting to have a subset of the total population since the entire target population cannot be studied due to its vastness and magnitude in size.

It is very rare for the social researcher to study all the people who would be appropriate respondents for a given research project. The process of choosing a fractional part of the whole relevant group or target population is referred to as sampling. The basic idea is that by selecting randomly some units in the target population and focusing research attention on this finite group, the research may apply the findings of the study to the whole population of
interest. Leedy (1997:210) comments that once the social researcher has looked very carefully at the nature of the characteristics of the population and the quality of the research data he or she can proceed to select wisely and intelligently the proper methodology for the treatment of those research data. The sampling procedure is appropriate wherever large populations that have an outward semblance of homogeneity are to be studied.

The sampling procedure looks at the issues of who should be part in the research study and why the researcher uses some respondents and not the other respondents. The procedures used to select respondents were probability and nonprobability samplings and a simple random sampling, stratified sampling, systematic sampling and judgmental sampling were commonly and predominantly used in the current study. The target population in this research was identified and well-known, hence both the PS and MC had the opportunity to participate in the study.

5.4.4.1 Types of sampling methods

There are two main types of methods of sampling, namely, the probability sampling and nonprobability sampling and the former remains today being the main primary method of selecting research samples for social science researches that receives preference and attention. In order to appreciate the logic of probability sampling, it is considered useful to distinguish it from the latter type of sampling. The probability sampling is currently the most respected, popular and useful method of a sampling procedure in the social settings. These two broad types of sampling methods received attention in this subsection (Babbie, 1995:190-227; Bless et al, 1995:115).

It is fundamentally significant to distinguish probability sampling from nonprobability sampling by indicating that the former refers to random sampling that occurs when the probability of including each element or units of the universe or total population could be determined in advance (Bless et al, 1995:88-89).
5.4.4.1.1 Probability sampling

The most survey studies in social sciences obtain their respondents in such a manner that the researcher knows the probability that any given respondent will appear in the sample and as such they rely mostly on random selection (McBurney, 1994:203). Rosnow and Rosenthal (1996:192) point out that there is only one way to find out whether there is prevalence of biasedness in a survey sample or not and that is only possible through by means of examining every member, element or unit of the target population and the sample at the same time the sampling process is conducted. If the pattern of replies in the research sample matches exactly the pattern of replies in the target population the researcher may, therefore, conclude for certain that, indeed, there is no biasedness in the survey sample and he or she would have no need to constitute a sample if he or she knew in advance the responses of everyone in the target population, but instead and because of the uncertainties, the researcher uses a selection process involving probability sampling of which the basic prototype is called simple random sampling.

Although philosophers tend to disagree on the answer to what probability is, Kerlinger (1986:90) indicates that if the concept is approached from a posteriori, frequency or scientific point of view, ” … probability is the ratio of the number of times an event occurs to the total number of trials.” and subsequent to this definition, the researcher performs a series of tests, counting the number of times a certain kind of event happens, and thereafter calculates the ratio and the result of the calculation is the probability of certain kind of event.

The main feature of probability sampling is that the likelihood of any one member or unit of the target population being selected is well-known. The probability sample is thus frequently used in social sciences such as public administration, psychology, health sciences, social work, sociology and anthropology to mention just a few. They say that the most common sampling procedure is probability sampling which includes, on the one hand, simple random sampling, interval or systematic sampling, stratified sampling and cluster or multi-stage sampling (Bless et al, 1995:88-89; Bless et al, 2006:100).

The probability sampling is based on the concept of random selection which, in other words, is a selection procedure that ensures that each unit of the target population is given an opportunity of being selected. Probability sampling avoids conscious or unconscious biases in
element selection on the part of the researcher. If all units in the general population have an equal or unequal and subsequently weighted chance of selection, then there is an excellent opportunity that the sample so selected would closely represent the target population of all units and also in all respects. The probability sampling allows estimates of sampling error. The features of the probability sampling are that the sample obtained should be representative of the general target population from which it is drawn; the sample must be selected randomly from the general population. Every unit or a member in the target population has an equal probability of being chosen once it is included in the sampling frame. It is possible to generalize or infer the findings from the sample to the target population. The probability sampling, therefore, exists within the positivist or quantitative paradigm as it is based on scientific assumptions of developing generalized knowledge about the aspects of reality and not about the individual.

The logic of probability sampling is that if all members of the target population are identical in all respects such as it affects demographic characteristics, opinions, attitudes, experiences and behaviour patterns to mention just a few, the social researcher does not see any reason, logic or need for careful sampling procedures (Babbie, 1995:190-195). The probability sampling, therefore, is the most important method that makes it possible for the social researcher to estimate the amount of sampling error that should be expected in any given research sample. With regards to the sampling frame one would say that it is a list or quasi-list of the members or units of a general population. It is the appropriate resource used in the selection of the research sample. Careful probability sampling provides a group of respondents whose attributes may be taken to reflect those of the larger target population. The basic principle of probability sampling is that a sample will be representative of the target population from which it has been selected if all the members of the population have an equal opportunity of being selected in the sample. The samples that have this quality are often called EPSEM SAMPLES (that is, equal probability of selection method) meaning that “… a sample will be representative of the population from which it is selected if all members (elements) of the population have an equal chance of being selected in the sample” (Babbie, 1995:190-193 and 226).
A probability sample is one in which each unit or element in the population has a known and not-zero probability or chance of being included in the research sample and hence, a researcher draws the research samples to calculate population parameters such as means (averages), variances, standard deviations and proportions to mention just a few (Fox and Bayat, 2007:54).

Leedy (1997:205) comments that in probability sampling, the researcher can specify in advance that each segment of the target population will be represented in the research sample. The elements are drawn from a larger general population in such a manner that the probability of choosing each subject (respondent) of the target population is known, though probabilities are not necessary equal to each other.” In probability sampling each element or a unit of the target population has a known opportunity of being drawn as an element of the research sample. This is the distinguishing characteristic that sets it apart from nonprobability sampling. The composition of the sample is derived by selecting units from those of a much larger target population. In survey studies, for example, the manner in which the sample units are selected is fundamentally significant. Generally, the components of the sample are elected from the larger population of interest by a process known as randomization. Such a sample constituted through randomization is known as a random research sample. The process of ‘randomization’ means selecting a sample from the whole target population in such a manner that the attributes of each unit of the sample approximate the attributes of the entire population (Leedy, 1997:205 and 211).

Bless et al (1995:115) indicate that the significance of the probability sampling is that it reduces biases, enhances the representativeness of the research sample and allows a statistical estimate of the accuracy or representativeness of the research sample. An element or segment is considered as that unit about which data is gathered, and it is typically the unit of analysis of the study. The human beings who comprise the real target population in this regard are quite heterogeneous. The probability sampling, therefore, provides an efficient method for selecting a sample that should adequately reflect variations that may exist in the target population. The two special strengths offered by probability sampling are typically more representative than other types of samples because biases are avoided. There is, therefore, a greater likelihood that the probability sample will be representative of the target population from which it is drawn than that of a nonprobability sample will be (Babbie, 1995:193).
Most importantly worth pointing out is that the probability theory permits the researchers to estimate the accuracy or representativeness of the research sample. In probability sampling each element or a unit of the target population has a known opportunity of being drawn as an element of the research sample. The following are the types of the probability sampling procedures, all of which were also considered in the present study, namely, simple random sampling, stratified random sampling, systematic random sampling. The suggested method or sampling procedure for the present study was probability method.

5.4.4.1.1.1 Simple random sampling

Random sampling, according to McBurney (1994:205) may require some considerable ingenuity and thorough thought. In simple random sampling, the sample is selected from an entire target population in such a manner that every member of the population has an equal and independent opportunity of been chosen in a single research sample. Sampling according to Kerlinger (1986:110) is a process of “… taking any portion of a population or universe as representative of that population or universe”, that is, the researcher takes the portion of the population and considers it to be representative. The simple random sampling is one of the three main types of the probability sampling that received attention in the present study. Randomization or random assignment is one of the most important tools used by researchers or experimenters for ruling out the dangers of systematic error. The goal of the researcher is to ensure that there is none of the myriad of extraneous variables (EV), influences or factors which might affect a respondent’s behaviour pattern in the research situation. Randomization is, therefore, essential for eliminating systematic error. The simple random sampling is the least sophisticated of all the research sampling procedures in any research study. Random sampling is the method of selecting or drawing a portion or sample of a population or universe so that each member of the population has an equal opportunity of being chosen and that all samples of fixed size ‘N’ have the same probability of being selected. From the target population whose texture is either homogeneous or heterogeneously conglomerate, the research sample is, therefore, derived by means of a simple randomization process. The word ‘randomization’ which is a technique for assigning experimental subjects (respondents) to experimental and control groups randomly; simply means choosing a sample from the whole target population in such a manner that the attributes of each member or unit of the sample

The random sampling informs the sample to be chosen by a process that gives each sampling unit or a member in the general population the same opportunity of being selected pertaining to the constitution of a sample. A sample is drawn from the population in the manner that each unit of the population has the equal opportunity of being selected during the first and successive draw of respondents or elements. In the case of simple random sampling, a further requirement is that the researcher has a list of the units in the general population called sampling frame. The idea is to draw respondents one at a time until the researcher has as large a sample as he or she requires in terms of the type of study of the predetermined sample size. The actual research method of respondent selection might, inter alia, consist of throwing dice, using a random lottery or a table of random digits, or even spinning a roulette wheel or drawing capsules from an urn and this procedure from using an urn provides the least complex approach, the computer method, but they are not without potential challenges or weakness. The roulette wheel method, for instance, is preferable over others because if the total population is small, for example, and is about 100 or fewer then each respondent may be assigned a number in some orderly sequence, for instance, alphabetically by surname, by birth date ranging from the youngest to the oldest respondent or vice versa, by weight or by any other preferable systematic arrangement. The corresponding numbers are on a roulette wheel and a spin of the wheel and its fortuitous stopping at a particular number eventually selects the respondent assigned to that particular number who in this instance becomes a unit of the research sample (Fox and Bayat, 2007:52-54; Rosnow and Rosenthal, 1996:192).

The sampling methods refer to the units of the total population selected for the purpose of the research study. Bless et al (1995:89) mention that simple random sampling ‘… is a sampling procedure which provides equal opportunity of selection for each element in the general population. There are various techniques of selecting randomly and the most common are the lottery techniques wherein a symbol for each unit of the target population is placed in a container, mixed well and then the “lucky number” drawn constitutes the sample. The symbol for each unit of the population can be names of respondents, and the most used and more sophisticated method is the use of the random number tables which are mathematically prepared so that numbers are written in a random way.” The randomization procedure in which
research is often used is a research technique that is used to ensure that as few differences as possible exist between different respondents or units of the samples by giving every respondent an equal opportunity of being assigned to each of the experimental conditions. The mechanics of this procedure is simplified by the use of random numbers. Other methods of attaining random allocation to groups can be used such as tossing a coin by the researcher.

The simple random sampling and systematic sampling both ensure a greater degree of representativeness and allow an estimate of the error present. A large sample produces a small sampling error than a small sample and a homogeneous target population produces samples with smaller errors than do heterogeneous populations. The researcher rather than selecting the sample from the entire population at large, he or she ensures that appropriate numbers of elements are drawn from homogeneous subsets of that population. A sampling frame is the list or quasi-list of elements from which a probability sample is selected. The properly drawn sample provides information appropriate for describing the target population of interest or the element comprising the sampling frame, that is, nothing more as each element has an equal opportunity of being selected independently of any other event in the sampling process (Babbie, 1995:194; 204 and 210: Babbie, 2001:194; Bless et al, 1995:116).

The simple random sampling is, therefore, a process that generally assumes in probability applications. This strategy involves assigning a number to each unit or segment of the target population and the basic sampling method generally assumed in the statistical computations of social researches. The researcher should assign a single number to each element in the list, not skipping any number in the whole process. The appropriate procedure is that the social researcher assigns arbitrary numbers to each respondent and literally pulls out these numbers from a container or a bag the latter of which was well-designed for the purpose. The total number that has been pulled out of the bag constitutes the research sample. A table of random numbers could also be used to select elements or units of random numbers and it is also used to select elements for the sample. If his or her sampling frame-list is in a machine-readable form, for example, a computer disk or magnetic tape, a simple random sample can be selected automatically by a computer, in effect, the computer programme numbers the units in the sampling frame and thereafter generates its own series of random numbers, and prints out the list of elements selected as it would be expected by the researcher. But simple random
sampling is seldom used because it is not generally feasible and it may not be the most accurate method in research studies (Babbie, 1995:190; Bless et al, 1995:116).

Leedy (1997:211) indicates that the researcher does not just go out to sample, but carefully takes into consideration the importance of the entire general population and its attributes. The descriptive survey method demands that the social researcher should select from the target population a research sample that will both be logically and statistically defensible. In simple random sampling the researcher selects elements or subjects from the target population so that all subjects (respondents) or elements of the population have the same probability of being selected. The first step in choosing any design is to analyze carefully the integral attributes of the most appropriate for the population type. The survey sampling is, therefore, the process of selecting, from a much huge population, a group about which the researcher wishes to make generalized statements so that the selected units will represent the total target population being studied. The basic principle of probability sampling is that “a sample will be representative of the population from which it is selected if all members of the target population have an equal opportunity of being selected in the sample.” and that a sample must be carefully chosen so that it will faithfully represent the particular group of interest being studied (Leedy, 1989:53 and 212).

Rosnow and Rosenthal (1996:413) refer to a sampling plan as a design or procedure that specifies the way the respondents are selected individually in a survey study especially on the basis of a randomized procedure, for example, a table of random digits may serve the purpose whereas Brynard and Hanekom (1997:45) indicate that “… selecting an element from a population is called random selection when each element has the same chance to be selected for the sample.” The random sampling tables are normally used for the random selection of elements to constitute the research sample. A random sampling table is used to determine the times at which observations should be made, or which subject, object, or activity should be studied.

Brynard and Hanekom (1997:43) mention the strengths for sampling procedure because according to them a sample derived from the target population is used because it is easier to study a representative sample of a general population than to study the entire population, it
saves time because studying an entire population could be time-consuming especially if the
target population is too large, or distributed over a large geographical area, it reduces costs
because the questionnaires are given to the sample instead of the entire population to collect
research data from every member or respondent of the entire general. In simple random
sampling procedure each unit or a member in the target population has an equal and
independent opportunity of being selected as part of the research sample. The strengths of the
sample is that there is no bias or predetermination in the selection process. If the researcher
were to select every tenth unit in the sampling frame which is the actual list of units from
which sample is actually drawn, ideally which is the complete and correct list of population
members only, and then there would be no need of independent randomness in the selection
process. The other strengths of the simple random sampling are that it is easy to implement
with automatic dialling and with computerized voice response systems and the weaknesses are
that it requires a listing of population units, it takes more time to implement, uses larger sample
sizes, produces larger errors and is expensive. The simple random sampling is not often
practical as it requires a complete population list which is difficult and something not always
possible.

Bailey (1994:89) indicates that “… In a random sample each person in the universe has an
equal probability of being chosen for the sample, and every collection of persons of the same
sample size has an equal probability of becoming the actual sample. The actual procedure in
random sampling is to assign a number to each person or sampling unit in the sampling frame
so that one cannot be bias by labels, names or other identifying criteria. The strength of random
sampling is that it cancels out bias (Bless et al, 1995:91). The simple random sampling is
logically the most fundamental technique in probability sampling though it is seldom used in
practice; hence it was considered in the selection of the sample in the present study in respect
of the public servants, members of the communities and health-care facilities (Babbie,

5.4.4.1.1.2 Stratified random sampling

The second probability sampling procedure in the present study is the stratification. The
principle of stratified random sampling is to divide the target population into different small
groups called ‘strata’ so that each respondent from the target population belongs to one and
only one stratum. In this type of sampling, a random sample is the one in which two or more subsamples are represented according to some predetermined proportion, generally in the same proportion as they exist in the general target population or universe (Babbie, 2001:201; Bless et al, 2006:102-103; Kerlinger, 1986:120; McBurney, 1994:207). The stratification is a procedure that requires the general population to be divided into homogeneous groups or units with each research sample having similar population attributes and this procedure is followed by the simple random sampling which is carried out within the identified and established strata. The strengths of the research sample drawn from strata are that they improve 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.

Bailey (1994:92) quoted Mendell, Otto and Scheaffer (1971, p.53) as having mentioned that “… a stratified sample is obtained by separating the (target) population elements into nonoverlapping groups, called strata, and then selecting a simple random sample from within each stratum. In other words, the stratification is the process of grouping the members or units of the target population into relatively homogeneous strata before random sampling is done. Stratified sampling is an alternative to a random sample in which the target population is divided into units or segments and random sampling is done from such particular units or elements. This practice has the effect of improving representativeness of a sample by reducing the degree of sampling error. The stratified sampling is, therefore, a method for obtaining a greater degree of representativeness subsequently decreasing the probable of sampling error. The stratification of samples may be used with both these strategies in place and it increases representativeness by first organizing the sampling frame into homogeneous groups reflecting variables or factors that may be revealed to the variables under study (Babbie, 1995:210-212, Babbie, 2001:201: Bless, 1995:91 and 116, Brynard and Hanekom 1997:44; Elmes et al, 1999:446).

In stratified random sampling, a separate research sample is randomly selected from each homogeneous stratum (or “layer”) of the identified target population and those strata are then statistically weighted to form a combined estimate for the entire population. In a survey research of health-care workers and members of the community expressing their opinions, for example, it might be useful to stratify the target population according to the personnel rendering health-care services, consumers of health-care services, types of the subdistrict and
other meaningful categories related to the provision of services. In stratified random sampling, the researcher commences by dividing the target population into a number of units and the researcher frequently uses another approach of probability sampling, namely, randomly selecting sampling units, for example, public servants or members of the community from several subpopulation termed strata or clusters into which the target population is divided. This is a very efficient manner of probability sampling, although it requires knowing something about the attributes of the entire population. The procedure is to divide the target population into subclasses or homogeneous strata or clusters and then to constitute sample in such a manner so as to ensure that each subclass or sample is proportionally represented (Rosnow and Rosenthal, 1996:195 and 196).

Leedy (1995:213) comments that in stratified random sampling instead of the simple random sampling (homogeneous mass), the target population is composed of layers (strata) of discretely different types of individual units or segments. This is a stratified general population which consists of layers which are somewhat equal to one another. The researcher may attempt to get, for example, three subpopulations of approximately the same size more especially in the equalization process on the one hand while on the other hand Babbie (1995:210) argues that stratification is not an alternative method to simple random sampling and systematic sampling, but it represents a possible modification in their application in the research situation. The ultimate function of stratification, therefore, is to organize the general population into homogeneous subsets or strata with heterogeneity between subsets and to select the appropriate number of elements from each. The choice of stratification variables typically depends on what variables are available.

In stratified random sampling the population that is dissimilar or heterogeneous in certain attributes regarding the phenomenon being studied is first divided into strata or a number of natural and non-overlapping groups that are more or less homogeneous pertaining to the phenomenon being studied at the time (Fox and Bayat, 2007:55).

In various studies, it is desirable to select a sample to assure that all subgroups in the total population are represented in proportion itself. The stratified random sampling assures that the profile of the sample matches the profile of the general population. The strengths of the stratified random sampling are that the researcher controls sample size in strata, increases
statistical efficiency, provides data to represent and analyze subsamples. The stratified random sample is likely to be most informative as it would allow a comparison of the attributes of various types of districts and could, if necessary, be further stratified in terms of subdistricts, health-care facilities or groups. This is the reason for the researcher that the method has been selected in this research study over other sampling types. The weaknesses are that, for example, there is an increased error that results if subsamples are selected at different rates and it is expensive especially if strata on the target population have to be created.

5.4.4.1.3 Systematic random sampling

The third type of probability sampling which is as important and valuable as the other previous two, namely, simple random sampling and stratified random sampling, is the systematic sampling. In terms of this type of sampling the researcher assembles his or her sampling frame and then systematically pulls names from it using a ratio of the target population for the desired research sample size. The key to systematic sampling is that the researcher needs to make sure that the sampling frame-list is not ordered to commence with or that there is no naturally reoccurring pattern in the target population. A systematic sample is a probability sample and not a random sample in the sense that it is not randomly selected (Babbie, 2001:197; Bailey, 1994:90; Bless et al, 2006:102; McBurney, 1994:205).

The systematic random sampling is that method of sampling characterized by its simplicity and involves drawing a number from a list of items arranged in sequences on some predetermined basis and it requires less time and costs less than simple random sampling and it is more practical in nature (Fox and Bayat, 2007:56-57; Kerlinger, 1986:120).

The systematic sampling involves the selection of every n\textsuperscript{th} member from a sampling frame. The systematic sampling is generally preferred over simple random sampling because of its simplicity. Once the sampling ratio or the proportion of the target population is finally determined, the researcher simply selects the elements or units corresponding to the sampling interval which is the distance between units selected with the first unit selected with a table of random numbers. In systematic random sampling every n\textsuperscript{th} name is selected from the list in order to constitute a research sample (Babbie, 1995:207; Babbie, 2001:197; Bless et al, 1995:116).
The simple random sampling is seldom used in practice and it is not usually the most efficient method since it is laborious if done correctly so manually whereas the systematic random sampling the acronym of which is also known as ‘SRS’ typically requires a list of units or elements. When such a list is available, the researcher usually employs a systematic sampling rather than simple random sampling. In systematic sampling procedure, every \( n^{th} \) unit in the total sampling frame list is selected systematically for inclusion in the research sample. If the list, for example, contains 100,000 units and the researcher wants a sample of 100, he or she selects every 1,000\(^{th} \) unit for the research sample. The researcher should select the first element at random in order to ensure against only possible human bias in using this method. Accordingly, the researcher would commence by selecting a random number between one and thousandth. The element having that number is included in the sample, plus every thousandth element following it. This method is technically referred to as a systematic sample with a random start. Two terms frequently used in connection with systematic sampling are, namely, the sampling interval which is the standard distance between elements selected in the sample; thousand in the preceding sample and the sampling ratio is the proportion of elements in the target population that are selected (1/1000) in the sample. In practice, systematic sampling is virtually identical to simple random sampling (Babbie, 1995:207 and 208).

In conclusion, one would point out that the systematic sampling is one statistically valid alternative to simple random sampling. In this approach every nth element in the target population is sampled, beginning with a random start of the unit in the range commencing from 1 to n. The systematic sampling is easier than simple random sampling though it may not be as precise as simple random sampling is in the randomness and independence of the selection process. An element is selected out of the general population at the beginning with a random sample. The systematic sample might be more reliable than the multistage sampling or clustering sampling.

The present researcher used effectively both the stratified random sampling and systematic random sampling procedures in the present study because there are two distinct subsamples, namely, public servants (PS) and out-patients or members of the communities (MC) in the identified three subdistricts of Limpopo Province in South Africa and the latter of which have been judgmentally sampled and all the members of the sample and the clinics in Makhado and Thulamela subdistricts were selected in terms of simple random sampling procedures.
5.4.4.1.2. Nonprobability sampling

In spite of the afore-mentioned comments, it is sometimes not possible to use standard probability sampling methods as it would be expected and sometimes it is not even appropriate to do so. In such instances, nonprobability sampling is preferable over probability sampling (Babbie, 1995:224: Babbie, 2001:178-181).

In nonprobability sampling, in contrast to the probability sampling, the exact number of units in the target population is unknown with the result that the likelihood of choosing any respondent, member or unit of the total target population is also not known. The nonprobability sampling is characterized by subjectivity since the researcher may select the sample not in accordance to criteria associated with randomness. The objective of the scientific research is to select the research sample in accordance with the design that allows the researcher to capture a wide range of facets or units from the target population as they are not selected randomly but in a deliberate, consciously controlled way with the result that every member or unit of the general population does not have an equal opportunity of being selected from the sampling frame. This type of sampling does not have generalization beyond the sample as a critical purpose. It only exists in the phenomenological or qualitative paradigm because of its concentration on specific cases and in-depth analysis of the specific. Sometimes units of analysis have no chance of being included in the research sample and they do not each have equal opportunity to be part of the sample (Fox and Bayat, 2007:58).

The probability sampling bias and subjectivity are reduced or eliminated through the random selection of units. There can, therefore, be a relatively high level of confidence that the sample is representative of the target population from which it has been drawn whereas in nonprobability sampling, with the greater scope allowed to the researcher’s subjectivity in the constitution of the sample, there is greater opportunity for the researcher bias to affect the sampling procedure and it also distorts the findings of the study. The nonprobability sampling is often the chosen route when the researcher is undertaking, for example, an exploratory, qualitative study and does not have the objective of generalizing the findings to the target population from which the sample was drawn. Other variables such as financial cost and time may also influence the selection of respondents due to nonprobability sampling as probability
sampling requires careful planning and comprehensive effort in defining the general population and also establishing the sampling frame. Nonprobability sampling may sometimes be the only practical option available in the study as the total population may not be available or easy to identify.

There are certain research situations in which it would be either impossible or unfeasible to choose the kinds of probability samples for the study purpose. There are times when probability sampling would not be appropriate or possible in certain research situations and as such one finds that in many such situations, nonprobability sampling procedures are more preferable over probability sampling and, hence, Babbie (1995:224) mentions that the nonprobability sampling can be divided into four types, namely, purposive or judgmental sampling, convenience sampling, availability or accidental sampling, snowball sampling and quota sampling. The quota sampling is a procedure that assigns a quota to be interviewed (Bless et al 1995:88 and 89; Leedy, 1997:204; Rosnow and Rosenthal, 1996:412). One of the afore-mentioned four types of nonprobability sampling, namely, judgemental or purposive sampling, received brief discussions hereunder:

5.4.4.1.2.1 Judgmental or purposive sampling

The judgmental sampling is nothing else but another type of nonprobability sampling similar to purposive sampling. The purposive sampling, in turn, is a generic term that is used to describe any sample which is deliberately selected by the researcher in accordance with the predetermined nonprobability criteria. In a study of determining the effects of the transformation process on the quality of service delivery, for example, the researcher may want to interview only those respondents with fairly wide experience in the understanding and implementation of transformation-related pieces of legislation, other government policies and mandates that are considered effective in improving health-care service delivery and its strength is that when used in the early stages of an exploratory or descriptive study, a judgmental sampling is an effective and time-efficient method. Researcher selects respondents particularly on the basis that they meet some particular requirements or criteria the researcher is familiar with (Babbie 1995:225; Babbie, 2001:179; McBurney, 1994:203).
Bless et al (1995:94 and 95) comment that the purposive or judgmental sampling is the method “… based on the judgment of a researcher regarding the characteristics of a representative sample. A sample is chosen on the basis of what the researcher thinks to be an average person. The strategy is to select units that are judged to be typical of the population under investigation.” The great weakness in this type of sampling is that the research method relies more heavily upon the subjective considerations of the researcher than on scientific determinants or criteria. This type of a sampling technique, unless it is used or applied by the researcher who is already an expert in the research field or conversant with scientific research often leads to uncontrollable bias and unreliable research findings.

The social researcher bases the selection of the units or elements of analysis on his or her own expert opinion of the target population and the selected units are regarded as being typical of the population. Purposive sampling is the most important method of nonprobability sampling since the researcher relies upon his or her ingenuity, opinion, experience and previous research experience of the population and findings to obtain units of analysis so as to have a sample that is representative of the target population (Babbie, 2001:179; Fox and Bayat, 2007:59).

The purposive sampling is a type of nonprobability sampling method in which the researcher uses his or her own judgment in the selection of the sample units or members. The nonprobability sampling occurs when certain members or units of the target population are chosen on the basis of the judgment of the researcher or scientist pertaining to the attributes of the target population and also on the basis of the needs of the survey research. With regards to purposive or judgmental sampling, sometimes it may be appropriate for the researcher to choose his or her sample on the basis of his or her own knowledge of the general population, its units, and the nature of the objectives of the research, in short, this is the situation where the researcher’s judgment is applied in such a study (Babbie, 1995:225; Van der Waldt et al, 2001:292).

The sampling of selected precincts for political polls, for example, is a somewhat refined or good example in respect of the purposive sampling. On the basis of previous voting results in a given area, city, nation, the authorities in charge of elections purposively select a group of voting precincts that, in combination, produces research findings similar to those of the entire target population (Babbie, 1995:225). The strength of purposive sampling is that the researcher
can use his or her judgement, research skills, expertise and prior knowledge to select such respondents and he or she selects only those who best meet the objective of the research study (Bailey, 1994:96).

A judgmental or purposive sampling is that procedure in which the research sample is selected non-randomly for some particular research objective (Kerlinger, 1986:120). According to Bless et al (2006:106) a judgmental sample which is frequently preferable over the random sample in certain unique research situations is the sampling method in which a sample is selected on the basis of what the social researcher considers to be typical units or elements. Given the fact that there will only be three identified subdistricts in Vhembe Health District in Limpopo Province participating in the present study, the current researcher, by virtue of the limited number of health-care institutions to be considered in each of the three subdistricts, including the health-care facilities of Musina subdistrict subsequently decided that the subdistricts and those PHC’s in Musina subdistrict be judgmentally selected or sampled and furthermore to ensure that the respondents of the two subsamples, namely, PS and MC, were excluded as the health-care facilities in Makhado and Thulamela subdistricts were randomly selected from each health-care institution for this particular objective.

5.5 RESEARCH METHODOLOGY

The core concept underlying all social science studies is its research methodologies. It is not enough to follow the research procedures without an intimate comprehension that research methodology directs the whole research endeavour especially in areas where critical decisions are often taken and where the processes of planning and directing the whole project occur. The selection of research methodologies involves, inter alia, decisions about the research paradigm, research approach and research method. The term scientific methodology involves method of analysis based on four assumptions, namely, empiricism, determinism, parsimony and testability (Robinson, 1976:31-32)

Leedy (1997:5) describes the term ‘research’ as “… the systematic process of collecting and analysing information (data) in order to increase our understanding of the phenomenon with which we are concerned or interested.” And it is a process through which we attempt to achieve systematically and with the support of data the answer to a question, the resolution of a
problem, or a greater understanding of the phenomena”. This process which is frequently called research methodology is characterized by eight distinct characteristics such as the fact that it originates with a research question or research problem, it requires a clear articulation of the formulated goal, it follows a specific plan of procedures, it divides the principal problem into more manageable and affordable subproblems, it is guided by the specific research problem, research question, or research hypothesis, it accepts certain critical assumptions, it requires the collection and interpretation of data in an endeavour to resolve the problem that initiated the research study and finally it is cynical or more exactly helical in nature.

An intimate understanding of research methodologies in any discipline is very important, necessary, indispensable and essential since it is basic in all types of research studies. The main objective of research methodologies is, therefore, to direct and control the whole scientific research endeavour. They dictate and corral the data after acquisition; they extract meaningfulness from the raw data and also arrange them in systematic and acceptable logical relationships. They set up a means of refining the raw data, contrive an approach so that the meanings that lie below the surface of those research data become clearly manifest and finally they issue conclusion or series of conclusions that lead to an expansion of scientific knowledge (SOURCE). The research methodologies extract meaningfulness from research data and this was supported by Leedy (1997:9) who comments that research methodology “… controls the study, dictates the acquisition of the data, arranges them in logical relationships, sets up a means of refining the raw data, contrives an approach so that the meaning that lie below the surface of those data become manifest, and finally issues a conclusion or series of conclusions that lead to an explanation of knowledge.” It is merely an operational framework within which the data are placed so that their meaning may be seen more clearly and extracts meaningfulness from them.

Brynard and Hanekom (1997:28) contend that the concept ‘research methodology’ in this context refers to “… planning, structuring and execution of the research in order to comply with the demands of truth, objectivity and validity”. This includes the assumptions and values that serve as a rationale for research and the standards or criteria the researcher uses for interpreting data and reaching conclusions”. The research methodology further plays a significant role in the selection of the research techniques and methods, in the design of research project or programme, on the decisions the research methodology needs to be taken
as the research study progresses as well as how the research methods and techniques for both data collection and data analysis respectively should be selected.

The term ‘research methodology’ simply refers to the overall approach evident in the research process from the theoretical foundation to the strategies that are used in the collection and analysis of the data. The methods, in contrast, refer to the specific means by which data are collected and analyzed (Hussey and Hussey, 1997:54). In terms of the current study, the questionnaires were distributed to the public servants and members of the communities on behalf of the researcher by two appointed enumerators in the three subdistricts of Vhembe Health District, namely, Makhado, Musina and Thulamela.

Bailey (1994:34) defines the research method as “…the research technique or tool used to gather data.”, in other words, the research methods are the instruments or tools such as the questionnaires and interviews to mention just a few that are often used by the researcher in the collection of research data. As the combination of the quantitative and qualitative research methods is administered to the respondents, it becomes necessary to indicate at the outset that the data collected in terms of the former method is numerical or expressed in terms of the statistics, frequencies or numbers whereas in the case of the latter method, as it could not be quantified, the data collected are expressed in terms of, for example, written words or physical gestures which had to be used to describe and explain the prevailing phenomena in the research situation.

The present researcher regarded the application of scientific research methodologies used in this study as relevant, necessary and very important due to the fact that this study was not based only on theory per se since the researcher had to administer the questionnaires on the respondents through the enumerators with a view to collecting the envisaged research data. The research findings were obtained through the application of well-designed pool of questionnaires. The empirical research studies which included, inter alia, the exploratory research, descriptive research, explanatory research and the evaluation which often started with statements of intent in which both the research problem to be studied and the field to be covered were clearly and thoroughly explored, explained, described and evaluated; hence the researcher categorized this research study as both basic and applied research because besides
being based upon empirical study it generated knowledge and research hypotheses, solved research problems as well as predicted outcomes in the real life situations. Subsequent to what have been reflected in this study and also the fact that scientific research methods were used, it was, therefore, clear that this study complied with the requirements of a scientific study as mentioned above and furthermore that the empirical research was relevant and indispensable in this study in order to achieve the pre-determined or set research objectives. The research is a process through which the researcher attempts to achieve systematically and with the support of the research data to answer any possible research questions, the resolutions of research problems, or a greater understanding of phenomena. The data which are based on the facts can also be classified into two types, namely, the quantitative and the qualitative; hence in terms of this research methodology this research study is both quantitative and qualitative in nature and both methodologies are very important in the present study. In view of the fact that this research study is by nature scientific, it is also categorized as both basic and applied study.

The research methods can be differentiated in terms of whether the research data are submitted to a qualitative or quantitative treatment. A qualitative treatment, therefore, describes what processes are occurring and unpacks the details in terms of differences in the character of these processes over time. A quantitative treatment indicates what processes are, how often they occur, namely, the frequencies, and what differences in their magnitude can be measured over time. It should also determine whether theory-building is at an inductive or deductive phase. A broader range of data types, elicitation techniques with lower control, cross-sectional designs and qualitative treatment of data may be the most appropriate in the early inductive phase of the study. The deductive phase leading to testable propositions is likely to be linked to the narrowing of the research data types, direct and control data elicitation; it leads to a mixture of change monitoring designs and the qualitative treatment of data. The research methods can be differentiated in terms of whether data are submitted to a qualitative or quantitative treatment and are often used in the explanation and description of the processes such as, in this instance, the transformation and the quality of health-service delivery processes. The research theories essentially specify the principles or rules which predict the relationship between the aforementioned two variables (Breakwell et al, 1995:13). The present research study used both the quantitative and qualitative approaches in terms of the research methodology. For the purpose of the present study both qualitative and quantitative methods of collecting data were used. Both quantitative and qualitative methods were preferable and used by the researcher in this
study as they provided the best possible means of the interpretation, verification, description, explanation and evaluation of the study and particularly the quantitative methods which the bulk consists of questions of which were closed-ended type because the study included both structured and very few unstructured questions.

Brynard and Hanekom (1997:27-30) stressed the vital role of the concept ‘research method’ by indicating that it refers to the research tool or research technique used to gather research data. The type of research data collected are the primary determinant factors with regard to whether the research study should be regarded as quantitative or qualitative in nature. The following two research methodologies, namely, quantitative method and qualitative method received a brief discussion in the subsections hereunder:

5.5.1 The quantitative method

The quantitative method is the most predominantly and the frequently used research methodology in the collection of data in many social science studies. A study that studies phenomena and looks at broader comprehension of such particular phenomena and attribute measures in numbers or statistics is often referred to as the quantitative research methodology. The quantitative research methodology often relies upon measurement and uses various scales in the research analysis. Numbers form a coding system by which different cases and different variables are represented for easy comparison purpose (Babbie, 2001:10 and 36; Bless et al, 2006:43 and 44). The quantitative research methodology focuses primarily on the description of attitudes and opinions whilst measuring the effect of one event or variable upon another variable or event.

The research that basically aims at testing theories, determining facts, statistical analysis, demonstrating relationships between variables and prediction is referred to as the quantitative research. The explanatory principles embodied in a theory make it possible to predict the occurrences of phenomena some as yet unobserved and studied. The theory stimulates the generation of new knowledge by providing clues for further research study (Ary et al, 1985, 282).
Leedy (1997:243) comments that “By the expressiveness of numbers, we can express what is inexpressible, describe what is indescribable, predict what is reasonable to expect, or infer a logical conclusion to a series of events. Statistics is a language that can speak where other tongues are mute. Words cannot express concepts that have been reserved for the eloquence and expressiveness of statistics alone”. He went on to clarify that in the quantitative study, the researcher analyzes data statistically or numerically so that he or she may discern certain dynamic and potential forces that may be clues to certain areas that warrant further research study. The quantitative method is different from the qualitative method because even its data are different since the former is expressed numerically or statistically and the latter is expressed in terms of words and sentences that is in qualitative and historical studies, the data are verbal and elicited through verbally oriented means such as the questionnaires, interviews, written records, and observational reports. This is not to imply that calculations are not used in the qualitative methodology. They are, but they are not the major form in which the research data exist. The researcher regards the data of qualitative study as non-numerical or verbal data and the data for quantitative studies as numerical data.

Mouton (1983:128) has been quoted in Brynard and Hanekom (1997:29) as having indicated that “…quantitative methodology is associated with analytical research, and its purpose is to arrive at a universal statement. In this type of methodology the researcher assigns numbers to observations.” The quantitative methodology requires the method to have the research techniques which include observation, pilot studies, quantitative analysis and questionnaires which describe and explain the phenomena. It merits pointing out that the numerical data to be generated in the present study formed part of the bulk of the research data gathered in terms of the quantitative method. The present research method also made use of the structured or closed-ended type of questions. This type of scientific approach is called quantitative research because it collected numerical or statistical data, hence the quantitative approach received greater attention in terms of the nature of the current study since it is quantitative study. The quantitative research relies on measurement to compare and analyze different variables.
5.5.2 The qualitative method

The qualitative method is the second research methodology that plays a significant role in the collection of the research data. Bless et al (2006:43 and 44) point out that there are some kinds of information that can hardly be adequately recorded using quantitative methodology. In some cases language is the preferable medium that provides a far more meaningful way of recording human behaviour patterns and experiences. In such cases, one often finds that words and sentences are used to qualify and record information about the phenomena as they prevail in the social world, hence this method of collecting research data is called the qualitative research since, unlike the quantitative approach, it does not use statistics or numbers to represent raw data.

Ary et al (1985, 284) indicate that in qualitative research the researcher’s position as outsider shifts to an inter-subjective position of insider and this ideal is basic to the qualitative approach of respondent involvement. Rosnow and Rosenthal (1996:412) confirmed that the qualitative method refers to “An observational method in which the raw data exist in a nonnumerical form, for example, reports of conversations”. Comparatively, the quantitative method is an observational method in which the raw data exist in a numerical or statistical form and according to Brynard and Hanekom (1997:29) qualitative methodology, therefore, “… refers to research which produces descriptive data – generally people’s own written or spoken words. Usually no numbers or counts are assigned to the observations.” The fundamental theme of qualitative research is a phenomenological one and it focuses upon the real-life experience of people.”

It is important for the researcher to know more about the purpose of the study so as to enable him or her to choose the appropriate method. With regards to the qualitative research, the researcher finds that the research methods in any research endeavour are always designed to explain phenomenon, events and matters associated with them scientifically and as such do not depend upon any numerical data; although this does not exclude the usage of the quantitative methods and their respective research techniques. Some typical examples of the types of the qualitative research are, namely, case studies and ethnography, that is, the scientific description of the different human races and also grounded theory, which is, building theory from the
ground up. The primary goal of research study using the qualitative approach is defined as describing and understanding rather than explaining the research data. The main concern is to understand social action in terms of its specific content rather than attempting to generalize to some theoretical population. In the qualitative method which explores opinions, attitudes, behaviour patterns and experiences of the respondents the present researcher or his trained enumerators distributed unstructured, open-ended questionnaires or free-response to the respondents for completion (Babbie, 1998:36; Babbie, 2001:36-37; Fox and Bayat, 2007:91).

Ary et al (1985:283) indicate that as qualitative research gained momentum and prominence, some social researchers have the tendency of considering quantitative research as dehumanizing. Since there is no a single method that is absolutely correct in terms of discovering the truth in the social world, it should also be borne in mind that the type or nature of the research problem is the core and a suitable determining factor of the specific approach. In quantitative research a clearly formulated research hypothesis is usually stated beforehand while the operationalization techniques feature prominently and that in the structuring of the research data categories are done beforehand, the researcher knows in advance, on the basis of the theory, the type of the research data to collect and what the eventual data or information will look like, that is, it is of paramount importance that the researcher who follows a qualitative approach will have to familiarize himself or herself thoroughly with the requirements coupled with the research hypotheses, conceptualization and operationalization, statistical analysis, research techniques and also with the general requirements pertaining to the validity and reliability of the methods and techniques applied in that particular study.

Although the main objective of this research methodology aims at formulating the theories, that is, grounded theory, another objective of the qualitative research is to promote better self-understanding and increase insight into the condition of the target population. Ary et al (1985, 283 and 284) argue that, unlike quantitative researcher, the qualitative researcher does not regard himself and herself as the collector of “facts” about the behaviour patterns of the respondents that would, therefore, lead to verification, the extension of theories and enable the researchers to determine causes of and predict human behaviour pattern. The emphasis in qualitative research is primarily on improved understanding of human behaviour and experience. The qualitative researcher, therefore, makes an endeavour to understand the ways in which different individuals make sense out of their own lives and describe those meanings.
to benefit themselves and also other people. The qualitative methodology, therefore, includes direct observation, an overview of different documents and artefacts, respondent observation and open-ended, unstructured interviewing.

A prospective qualitative researcher should familiarize himself or herself with the following, namely, the phenomenological approach whereby the researcher often strives to understand the meaning of events and social interactions to ordinary respondents in specific research situations; the symbolic interaction which is based on the assumption that people, objects, events and situations do not have inherent meaning, that is, the meaning is merely attributed to them. This process involves the ethnography the emphasis of which is on the task of describing a particular culture and the aspects of culture and it simply refers to the study of how an individual creates and understands his or her daily life; and finally the cultural study that is embedded in conceptual framework such as neo-Marxism, feminist materialism and feminist post-structuralism, and which is opposed to the idea that the world is ‘directly knowable’. The researchers working within this conceptual framework of reference insist that all social relations are influenced by power relations, which must be taken into account when analyzing interviewees’ interpretations of their own situations (Ary et al, 1985:283 and 284; Bailey, 1994:248; Fox and Bayat, 2007:70-71).

There are strengths and weaknesses to both quantitative and qualitative research methodologies. The skilled social researcher carefully selects the most appropriate and suitable approach to a particular research problem although in such cases the distinction between quantitative and qualitative methods is somewhat blurred. It merits pointing out that the qualitative method is preferred over the quantitative method especially in cases where research is conducted on topics that are immature, that is, when the phenomena under study have not as yet been adequately described and studied (Bless et al, 2006:43 and 44).

The researcher must ensure that his or her preferences and preconceptions are not imposed on the data. The phenomenological researchers, in contrast, argue that the world is socially and psychologically constructed and that science is driven by human interests and the researcher, as a subjective entity, is part of the social world he or she is observing. The element of objectivity is not always possible and present in the research situation. The strengths of this qualitative, interpretative orientation in research are that the findings often have greater validity and less
artificiality as the process of observing phenomena in natural, real-life settings often allows researchers to develop a more accurate understanding of those phenomena. The good qualitative research often reveals depth of understanding and richness of detail. It is worth mentioning that the research driven by phenomenological philosophy is sometimes undermined by the subjectivity of the social researcher and the poor reliability of the findings in that the two researchers may arrive at different conclusions based on their observations of the same phenomena at the same time.

The combination of quantitative and qualitative research design is relevant in this research study because both methodologies constitute the research design by means of which two different types of research data are generated, namely, numerical data and non-numerical data or narrative data respectively. It indicates a procedure by means of which the co-variance of a stable time-order can be proved. The research method was applied in this type of the study because it assisted in the planning and structuring processes in the manner that the research findings were maximized and this is confirmed by Mouton and Marais (1988:33) when they indicate that the objective “… of a research design is to plan and structure a given research project or programme in such a manner that the eventual validity of the research findings is highly maximized”, hence, a good research design is primarily characterized by giving direction to the envisaged research programme or project in any research endeavour. In contrast, qualitative research uses qualifying words or descriptions to record aspects of the social world. Although numerical data was collected during the present research study in terms of the quantitative research method, non-numerical data was also collected in order to complement the quantitative data. In fact, it is worth mentioning that non-numerical data did not form the bulk of the research data collected. The research approach that was used in gathering the non-numerical data is called the qualitative research which dealt specifically with qualitative data in the form of words rather than numbers as it was always the case with quantitative methodology and in this instance very few open-ended or unstructured questions were developed and administered to the respondents. The qualitative approach like the quantitative one was more suitable to the present research study for the purpose of eliciting the anticipated non-numerical or non-statistical responses or behaviour patterns of the respondents (Babbie, 1998:236).
There are many different ways of gathering research data. The present researcher used self-administered questionnaires as the method for collecting data. Several data collection research methods are often and commonly used in social sciences and they include, inter alia, interviews, questionnaires and documentation. Some research methods are objective, reliable and valid while others are subjective, less reliable and valid. So, once the researcher has selected the DV, he or she then decides on an acceptable way of measuring it. The interview methods of data collection require the researcher to set up his or her questions and interview appropriately. Structured and unstructured interviews with fixed or open-ended types of items respectively can be used to elicit responses from the respondents (Kerlinger, 1973:412-414: Robinson, 1976:122 and 146).

In order for the current researcher to obtain the required and necessary data for this research, both primary and secondary sources in the collection of data were consulted in this research study. The primary sources included the bulk of the closed-ended questions and few open-ended questions on the same questionnaires. There were two sources of data elicitation, namely, the primary source and secondary source of research data and hereunder follows a brief discussion of each of such sources.

5.6.1 Primary data

The primary data is considered as one of the important and indispensable sources of research information. According to Fox and Bayat (2007:37) the primary data “… are first hand sources, entailing the direct reporting of research and experience.” Bless et al, (2000:97) describe primary data as that specific research data collected personally by the researcher for the purpose of a specific research study being undertaken. This could be the research data collected or derived from primary sources. The primary sources are defined as the first publication of a piece of work.

The primary data refer to the process whereby the researcher collects his or her own research data. The questionnaires are simply the research instruments or tools comprised of printed lists of questions answered by the respondents and from which primary research data are elicited or
generated. The questionnaires constitute lists of pre-written questions and sometimes include scales (Brynard and Hanekom, 1997:28). The questionnaires applied in the present study consisted of both closed-ended and open-ended types of questions; and it merits pointing out that closed-ended questions were prominent in the questionnaires used for this study for both structured and unstructured questions and open-ended type of questions were very few because the researcher observed that their weaknesses outweighed the strengths and as a result thereof the objective of the present study would not have been realized to a significant extent and that previous experience revealed that many respondents were scarred and felt very much intimidated by such type of open-ended questions. Some respondents provided vague and ambiguous responses. In as far as the primary data are concerned; information is retrieved directly from the original sources. Some of the primary research data sources used by the present researcher in this research study were, for example, doctoral theses, master’s dissertations, annual reports issued by the Public service Commission and the Department of Health and Social Development, the newspapers and questionnaires (Bless and Higson-Smith, 2000:97).

5.6.2 Secondary data

The secondary research data in the context of this study refer to the research data which the researcher uses that were collected previously by researchers other than the actual researcher who is conducting the research study.

These are usually data collected by social researchers or other researchers from other fields of study in connection with other studies but are of more or less similar research problems, or as part of the usual collection of social data. They also refer to data published by others in some form that they are fairly readily accessible (Bless and Higson-Smith, 2000:97).

Finally, it is worth pointing out that the generation of both primary and secondary data was, indeed, indispensable, vital, fundamental and necessary in the current study. As the questionnaires were basically the primary research techniques preferred over others, for instance, interviews and the focus groups, they were, therefore, regarded as the relevant and
appropriate research techniques which were capable in this study of eliciting the primary data in the one hand, whilst on the other hand, books, articles, electronic and print media to mention just a few, elicited the secondary research data. In order to further obtain a comprehensive data, the secondary sources were consulted such as, inter alia, published books, newspapers and journals, papers and documents delivered by experts at the meetings, congresses, conferences and seminars regarding transformation and service delivery as they were implemented in Vhembe Health District of Limpopo Province in South Africa. The present researcher used secondary data as well for this study as a second hand report or record.

5.7 DATA COLLECTION TECHNIQUES

The questionnaires, observation and interviews are the most widely used research techniques in the survey studies, the objectives of which are descriptive and exploratory in nature and are also important and commonly use primary and secondary data collection methods. They can also be effectively used in studies with experiment and case study strategies. The questionnaires and the interviews are data collection instruments that enable the social researcher to pose questions to the respondents in his or her search for answers to the research questions. Both these instruments, however, have distinct features that have a bearing on the correct and appropriate use of each of the specific data collection objectives.

The essential part of the study is the continuous recording of adequate and appropriate data, which is inclusive of protocols and predetermined form in which data are collected during observing and interview (Fox and Bayat, 2007:74). When general plans of research are to be implemented, it is imperative that methods of data collection must be used. Research problems on the one hand dictate the type of methods to be considered whilst on the other hand the availability, feasibility and relevance of the methods to be used do influence the type of the problem to be studied. Both the interview and the questionnaire are used as tools of scientific research. The former is always a face-to-face interpersonal role situation in which the interviewer asks or interrogates the interviewee or respondent questions designed specifically to probe or obtain certain responses pertinent to the research problem (Kerlinger, 1986:440-441). Interviews and questionnaires also called schedules are easily available in the research market for use by researchers. The most significant data collection techniques used in the present study were the questionnaires and observations and both contributed significantly
equally well in this study. Babbie (1995:8) mentions that the most common research method used in the social sciences nowadays involves the administration of questionnaires either by using interviews or questionnaires through the mail or hand delivery to a sample of respondents (Babbie, 2001:239 and 258; Bless et al, 2006:114-116).

The social researcher is expected to have the data analysis plan established before commencing with the data collection process. The format of the research instruments and the identification of appropriate statistical techniques were used in the analysis of each phase of the research instruments and that the researcher should familiarize himself or herself with the research procedures and interpretation of the relevant statistics, data analysis and data presentation. It is the responsibility of the researcher to identify the use of various primary and secondary data collection strategies since the entire research planning, design and literature review processes all converge on the data collection stage. The data gathering procedure must be designed to facilitate positive and informed interaction with the research respondents.

Since Leeds (1997:191) indicates that the research data are sometimes buried quite deep within the subconscious minds, opinions, attitudes, feelings, or reactions of the respondents. It is considered essential that tools or instruments to probe below the surface must be devised or developed; hence the most common instruments or tools for observing data beyond the respondent’s physical reach are, namely, the questionnaires, observations and interviews. This section states the specific activities the researcher undertakes to fulfil the objective of the study. It provided step-by-step explanation of how the data is collected and the same procedures were followed by the present researcher in the Vhembe Health District. The following is, therefore, a concise discussion of one of the major data collection methods that received attention to assist the readers of the present study to have a better understanding of the data collection technique selected for this study.

5.7.1 Questionnaires

Since there is no one universal definition of what a questionnaire is, the current researcher regards it as measuring instrument or a tool in any study that enables the respondents in particular to elicit or answer questions relating to, amongst others, their frame of reference particularly their attributes and their social world. The questionnaires are the measuring
instruments or tools which elicit responses directly from the respondents during research studies. The survey often uses self-administered questionnaires which are generally executed by mail although sometimes they are administered directly to a group of respondents and at other times the questionnaires are delivered to and picked up from the respondents at a later stage either by the researcher or the appointed enumerators from the respondents to either the researcher or the enumerators (Babbie, 2001:239-258).

Vockell (1983:78) defines a questionnaire as “… any data-collecting instrument, other than an achievement or ability test, where the respondent directly supplies answers to a set of questions” A questionnaire is, therefore, a list of planned written questions relating to a particular topic, usually intended to gather descriptive information from a number of selected respondents.

There is no one perfect methodology to use to conduct all survey studies but rather, all the different methods have their strengths and weaknesses. What is worth noting is that what worked well for the social researcher in one research situation, will not automatically necessarily work well in the next research environment even for the same or another social researcher. The following criteria should, therefore, be looked at in the process of data collection, namely, cost and time, that is, the researcher should determine in advance the cost as per survey study and the implementation time, that is, the time the researcher takes to get his or her data or it is a time sensitive issue or not.

The first problem is to develop or devise a tool to probe below the surface. The common instruments for obtaining data beyond the physical reach of the observer are, inter alia, the questionnaires. Questionnaires are totally impersonal probes. With regards to the self-administered questionnaires and interviews each of them has its own strengths and weaknesses, for example, questionnaires are comparatively and generally cheaper, quicker and are also more appropriate in dealing with more sensitive issues than the interviews they can observe data beyond the physical reach of the researcher and they can be sent to the respondents thousands of kilometres away, whom the social researcher may never physically see or meet (Bless et al, 1995:545; Leedy, 1995:191).
Saunders et al (2003:280) maintain that it is generally good practice not to rely on questionnaire data but to use the questionnaire in conjunction with at least one other data collection instrument. It is advisable that the social researcher should avoid many opened-ended questions because of their weaknesses. The present questionnaires make bulk or greater use of closed-ended questions as well as the few open-ended questions, associated more typically with qualitative, phenomenological-oriented research, make use of small, deliberately selected purposive samples and give a large and potentially unlimited information yield. A questionnaire comprises a list of questions about a specific topic being studied and to which answers and information are required by researchers from the respondents (Babbie, 2001:239 and 258; Fox and Bayat, 2007:88).

The methods of data collection, namely, the questionnaires, interviews, documentation and observation to mention just a few need to be identified and properly described. Van der Waldt et al (2001:290) comment that through the application of the questionnaires the social researcher can ask questions about behaviour patterns, opinions, knowledge, biographical information and demographics such as age and education. The two types of questions in the questionnaires that can be differentiated are the open-ended and the closed-ended type of questions depending on the type of responses they are expected to elicit. The strength of using the questionnaires is that it may be sent to respondents who are many kilometers away from the researcher and whom he or she may never have seen or met in the past. The researcher or scientist does not have to see or meet physically the sources from which data originate; hence it is imperative that in the development of such questionnaires as tools in survey research, the researcher should firstly ensure that the language must be unmistakably clear, simple and free from vagueness and ambiguity to all the respondents and secondly that questions should be designed to fulfil specific research objectives (Leeds, 1997:195-199).

Babbie (1995:264) indicates that the interview is an alternative method to a questionnaire of collecting survey data. The respondents are often expected to read questionnaires thoroughly with a view to entering in the provided appropriate spaces the responses which are applicable to them being assisted by neither any researcher nor by the appointed enumerators or whosoever. Some institutions such as the universities and the Human Sciences Research Council (HSRC) in South Africa make use of the standardized questionnaires that have been developed to measure certain attributes of the respondents, but in the current research study,
the researcher found that there was no such an instrument or similar tool that has been developed to measure the effects of transformation process on the improvement and promotion of the quality of health-care services in any academic institution, including the HSRC, except those developed by Madzivhandila (2006:168-177) for the same purpose in this country.

According to Brynard and Hanekom (1997:29, 38 and 39) the most frequently used research techniques for data collection within quantitative and qualitative research methodologies are the scrutiny or review of relevant literature, experiments and surveys in terms of interviews, questionnaires and observations. According to these authors the questionnaires are needed and necessary to supply the respondents with standardized instructions on how to complete the questionnaires and to explain what is expected from them. The questionnaires are regarded as some of the best measuring research techniques in many disciplines such as Anthropology, Psychology, Sociology, Public Administration and Social Work to mention just a few, hence they are preferable over other methods of data collection. As both open-ended and closed-ended type of questions were used, it is appropriate that the latter were preferable over the former in this research study in view of the fact that open-ended questionnaires have comparatively more limitations than the closed-ended questionnaires with regards to their analyses and interpretations. They were applied in the present research study because of their significance and relevance to it, hence Bailey (1994:118-122) comparatively mentions that each and every research technique has its own strengths and weaknesses but one would find that closed-ended questionnaires outweigh over the open-ended questionnaires in terms of those. Another weakness of the open-ended questionnaires is that they sometimes elicit vague responses.

It is, therefore, important to know and understand that the strengths of a self-administered questionnaire over an interview survey study are that they are easily standardized, low drain on time and finances and they require very little training of prospective researchers as far as its administration upon respondents is concerned. In the open-ended type of questions there are options that are provided for the respondents to answer the questions. They are not expected to think of their own responses and describe them in their own words, since responses are provided. The strength is that if the respondents have taken the time to reflect on answers to the questions, the researcher can, therefore, get more meaningful information than from mere
closed-ended type of questions. The other strengths of using the questionnaires as measuring instruments for data collection, in contrast to the interviews, are that, first, the respondents have been given a latitude to think about their answers as they relate to the questions in the questionnaires and second, a large number of questionnaires can be distributed to the respondents residing and located over a large geographical area such as, for example, Vhembe Health District of Limpopo Province in South Africa and they can easily be accessed. The closed-ended type of questions as compared to the open-ended questions for the collection of data are easy to codify, analyze and interpret, they lack interview bias, there is possibility of anonymity, privacy, they are economical and could be completed within a reasonable period of time to encourage more candid responses on sensitive issues and the amount of data that can be collected is comparatively abundant; but the weaknesses of this type of data collection are that the social researcher or the trained enumerators will not physically be present to explain all the uncertainties to the respondents that may emerge in the interview session should such uncertainties arise, which may result, too, in serious biased or distorted answers by the respondents, using questionnaires could sometimes be quite costly especially where a huge number of respondents have to be reached in order to minimize the percentage error in the results obtained and, therefore, cognizance should be taken of the fact that the social researcher will have to supply the respondents with the franked envelopes with the correct postages affixed to them. Other weaknesses of open-ended questionnaires are that it is difficult to interpret respondents’ responses; it is difficult to check that respondents, indeed, understand the questions and it is also characterized by low response rate and response bias.

The other valid reason for the application of the questionnaires as research techniques was that they were capable of generating both frequencies or statistical data and words or produce quantitative and qualitative data respectively (Bailey, 1994:118-122). .

With regards to the closed-ended type of questionnaires the respondents are given a set of alternative choices from which they can select to answer the questions, that is, they are required to select, for example, either ‘Yes’, or ‘No’ or ‘Agree’ or Disagree’ in such a multiple choice of questions. The strengths of the closed-ended type of questions is that they are economical, that is, they can be answered quickly, allowing the researcher to get a lot of information quickly, while the weakness is that the respondents may rush through the questions and not take enough time to think about their answers carefully. The selection of the responses
by respondents may not include the answers the researchers prefer and anticipate (McNeill, 1990:167).

The current researcher used the questionnaires as the relevant research tools or instruments for collecting both the primary and secondary research data over others due to the type of the present study being undertaken. The estimated period of distribution of the questionnaires among the respondents and collection in this research study was a period of 4 months by the 2 trained enumerators. One enumerator was assigned to the two subdistricts, namely, Makhado and Musina to distribute and collect questionnaires from the respondents and the other one was assigned to Thulamela subdistrict and whose responsibilities were the distribution and return of the completed questionnaires to the researcher so as to eventually enable him to systematically compile data to be processed with the assistance of the statisticians and technicians of the University of Limpopo in Limpopo Province for the analysis of data. But the researcher experienced unexpected challenges that very few questionnaires were returned even after the set time-frame particularly from only 2 subdistricts, namely, Makhado and Thulamela, and surprisingly no questionnaires were returned at all from the only 3 health-care facilities (PHC’s) under Musina subdistrict; and as the return rate was too low. The present researcher considered extending by a period of 3 weeks so as to enable and allow the other PHC’s that had not returned the questionnaires to comply with the extended time-frame.

When the researcher realized that the selected research test does not in any way satisfy the assumptions related to the normal distribution of data, that is to say that the scores are normally distributed or that the distribution of hypothetical sample means is normally distributed, he or she should use the nonparametric test as an alternative to the parametric test, hence the current researcher preferred to use nonparametric test over parametric test by employing the chi-square test as is often the most commonly used test in the research study (Breakwell et al, 1995:352).

The current researcher selected a set of the questionnaires as the most appropriate and useable measuring instruments due to their focus on a larger target population of nursing and administrative personnel as compared to an interview the focus of which is upon very few identified respondents. The strengths of the questionnaires is, inter alia, that it encourages openness as it is self-administered, it is administered only once rather than many times with different respondents, it increases anonymity, confidentiality. Its weaknesses, for example, are
that it is expensive, time consuming and the respondents often feel intimidated and would just tolerate to provide responses to such a longer mail survey rather than in-person interview telephone or computer-based questionnaire. The presence of an interview in the research study especially on the telephone or in person may influence responses to a sensitive question and provide less than accurate data (Bailey, 1994:174-176).

In order to minimize or avoid bias and insufficient collection of data, it is the responsibility of the social researcher to use a combination of methodologies, for example, a questionnaire in order to quickly collect a great deal of information from many people, the interviews to get more in-depth information from certain limited number of respondents and the case study that could be used for more in-depth analysis of unique and notable cases.

The questionnaires and the interviews as well as the documentation are important and indispensable research instruments or tools in any scientific research conducted in social sciences with a view to collecting research data but the questionnaire was preferred over others because it was a relevant research technique for data collection in the current research study or thesis.

**5.8 DATA ANALYSIS**

The scientific research study in any field of study does not merely end with the collection of research data only since raw data as they are collected are very meaningless and are of no significance to any social researcher or scientist, hence there is a dire need for and necessity to analyze research data so that the researcher can translate them and derive appropriate logic and meaningfulness out of them and this prompted, in brief, Brink (1996:170) to indicate that research data analyses “entail categorising, ordering, manipulating, and summarising the data and describing them in meaningful terms”. Data analysis is the process of making sense out of the research data collected by the social researcher and while on the other hand Mouton (2001:108) in support of such views commented that data “Analysis involves “breaking up” the data into manageable themes, patterns, trends and relationships”. So, research data are either directly or indirectly the source of truth, that is, they are a reflection of truths.
Once the social researcher has decided upon the research design that suits the project under study, he or she has to select the relevant and appropriate procedure to analyze the data that he or she would eventually have gathered in the research situation and such a choice needs to be made before the researcher commences collecting data. Analyzing data simply means making sense by clarifying and refixing the terms, concepts and statement of what the researcher has collected so that the gained data lead to the knowledge that he or she has set out to gain (Fox & Bayat, 2007:104-106). It is sometimes possible to analyze research data and to draw inferences about relationships between variables without involving statistics in the case where data are so obvious that statistical test is even not really necessary. The statistical test is only superfluous where the scores of the experimental group are greater or less than those of a control group. Parametric and nonparametric statistics are used in both natural and social sciences. Whenever parametric and nonparametric tests are used, certain assumptions are also made. Nonparametric tests are free of assumptions about characteristics or form of distributions of the populations of research samples; hence, they are also called distribution-free tests. Siegel has been quoted by Kerlinger (1973:286) as having said that “A nonparametric statistical test is a test whose model does not specify conditions about the parameters of the population from which the sample was drawn”. The assumption behind the use of many parametric statistics is the assumption of normal distribution or normality.

It is the responsibility of the researcher to analyze data, translate the raw data into some meaningful information, communicating the research results in the form of charts, tables and graphical representation as a way of displaying findings (Fox and Bayat, 2007:104). The prerequisites in the data collection is that the researcher is expected to formulate research hypotheses, research questions and research objectives, deciding on the type of data method, and selecting the data collection and research data analysis strategies. The researcher should develop the research instrument(s) that may be required in the analysis of the data and decide on the tables and diagrams that might be appropriate for examining the patterns and regularities in the data. It is also considered very significant to conduct a pilot study to identify some areas that may require revision and correction, to refine both the instruments and data analysis procedures, to better achieve the research objectives, and to review the choice of statistical tools and computer programmes and as well as the sub-programmes whenever the need arises. The researcher needs to be guided in analyzing the data by the objectives of the study.
Kerlinger (1986:266) indicates that “A nonparametric or distribution-free statistical test depends on no assumptions as to the form of the sample population or the value of the population parameters.” It does “… not depend on the assumption of normality of the population scores.” as it is the case in the parametric statistical test.

After the research data have been collected from whatever sources, it is of necessity that it must be analyzed to form supporting statements for the conclusions or inferences of the research study. This analysis of data can be carried out in a quantitative or statistical or qualitative manner in terms of the concept analysis, textual analysis and the phenomenon analysis. It is worth mentioning that the quantitative data refer to all that can be reduced to numerical or statistical values, ranging from the numerical frequency of occurrences of phenomenon to the complex presentation of research data in terms of charts and graphs. The determinants of the research study, the objective of specific research, the research strategy, and the type of data once again influence the choice of either parametric test or nonparametric test.

Elmes et al (1999:443 and 447) indicate that the chi-square test for independence is the research tool or test that is often used to determine the statistical significance of the correlation between variables in a contingency table and nonparametric statistics, that is, in nonparametric statistics the statistical test that does not make any assumptions about the underlying distribution of scores; ordinarily require just ordinal-level research data. The null hypothesis states that the independent variable will have no effect on the dependent variable whereas according to the parametric statistics, the statistical test makes assumptions about the distribution of scores, for example, the scores are normally distributed and require interval or ratio data.

Although parametric test provides a powerful test in respect of the statistical hypothesis than do other tests, the nonparametric test was preferred over others in the present study due the fact that it generated quantitative, statistical or numerical research data and also the application of frequencies which were associated with or in terms of which they were analyzed by the chi-square test. The nonparametric assumption of the test distribution related particularly to the research test that was not normally distributed; hence the application of the chi-square test was
relevant in the analysis of the quantitative data in this particular data analysis. Both the presentations and analyzes of data as well as testing of research hypotheses were performed by the computer of the Department of Statistics of the University of Limpopo, making use of the SPSS, that is, the Statistical Package for the Social Services (Fox and Bayat, 2007:105).

The raw data had to be converted to numerical codes in order to perform quantitative analysis. The codes bearing specific numbers were assigned either as part of the observation process as in content analysis or after the data have been collected. The task of coding involved specifying an appropriate number of attributes for a given variable (Bless et al, 1995:222). During the research study, one often will have amassed a volume of observations which inform that probably is not easily interpretable. In the case of a survey study, the “raw’ observations are typically in the form of questionnaires. The data processing phase for a survey research typically involves the clarification or coding of written answers and the transformation of all information to some computer format, for instance, on magnetic diskettes or computer hard disks (Babbie, 1995:104). Finally, the researcher manipulated in terms of analysis the collected data for the purpose of drawing conclusions that reflected on the interests, ideas and theories that initiated the inquiry.

Self-mailing questionnaires do not require return envelops and thereby making it easier to return the instruments. The questionnaires can be sent via first-class postage or bulk rate and returned via postage stamps or business-reply permits depending on the vastness of the geographical areas where the respondents are located for the purpose of the distribution of questionnaires. The period when each option would be used is determined largely by the budget and the expected return rate of questionnaires. The most common research techniques used in many survey studies are, namely, questionnaires, observation, documentation and interviews (Ary et al, 1985, 283; Babbie, 1995:257, 258 and G6; Babbie, 2001:245 and 258).

5.9 CONCLUSION

Chapter five focused mainly of the discussion of the research design and methodology in particular with special reference to the issues pertaining to the objectives of the study, the types of research approaches, research design, research methodology, methods of data collection, data collection techniques and data analysis.
The probability sampling was applied in this study because the current researcher wanted to ensure that the sample selected was an ideal representative of the target population under consideration. The implementation of probability sampling and nonprobability sampling was also appropriate and relevant due to the type of the present research study in Vhembe Health District of Limpopo Province in South Africa. The random sampling and judgmental sampling were applied in the present study because in the case of the former the target population was too large that it could not be subjected to any treatment or observation, hence the sample comprised 326 respondents and as a result a sample was necessary and vital especially for the purpose of sampling in respect of the remaining three subdistricts of Vhembe Health District in South Africa which all participated in the study and both types of samplings were relevant in this study.

The researcher always ensured that all the respondents of the universe or population, namely, the health-care workers and members of the communities were selected in such a manner that representativeness was accomplished in accordance with the recommendation made by Leedy (1989:53). The random and judgmental samplings are chosen as appropriate and unbiased methods of constituting samples of respondents and subdistricts respectively in the context of this type of research study.

The simple random sampling procedure was also applied to this research study because there were three systems in Vhembe District which participated in the research study, namely, the public servants and members of the communities and health-care facilities. The researcher also considered using stratified sampling procedures because there were two distinct subsamples, namely, public servants (PS) and out-patients or members of the communities (MC) in the identified subdistricts of Limpopo Province in South Africa. Then, within each stratum, random sampling was performed using either the simple or the internal sampling method.

A sample of 326 respondents with two sub-samples, namely, the public servants (PS) and members of the community (MC) with 161 and 165 respondents respectively was constituted. The nonparametric tests, namely, the chi-squire-test was preferred over many other parametric tests because of its relevancy and appropriateness in the current study.
The two research methodologies, namely, the quantitative and qualitative were identified as significant and relevant as well as the documentation in this study since they played a significant role for the collection of data whilst on the other hand the methods used in this study for the collection of data were the primary and secondary sources. The most important research techniques with regards to data collection were the questionnaires and documentation and although interviews were very important, they were not considered due to the magnitude of the sample size of 326 respondents.

The present study was considered significant and relevant against the background of the history this country is coming from, which was characterized by severe backlogs in terms of service delivery in all aspects of life due to discriminatory practices by the former defunct regime. So, when the current government came into power in 1994, the serious challenges that it was faced with were, namely, to ensure that there were political, socio-economic and health-care transformations to benefit all South African citizens and not one minority population group at the expense of other population groups. All pieces of discriminatory legislation were abolished in toto immediately the GNU took over the administration of the country and different pieces of legislation were promulgated as a way and means of speeding up the process of redressing such imbalances of the past. The current legislation ensures that all people are treated equally well and should receive more or less adequate services including health-care services.

Both descriptive research and explanatory research as well as the explanatory research were applied in the present research study because the envisaged research data or phenomena were descriptive and explanatory in nature since the generated responses were statistically analyzed, described, explained and interpreted into meaningful information emerging directly from the research data and on the other hand, the qualitative method was characterized basically by narration on the elicited responses, hence the two major types of research format, namely, exploratory and descriptive researches including explanation were also applied and were also considered relevant to this research study.

The former Premier of Limpopo Province in South Africa, Mr Ramathlodi commented that since 1997, there has been a major shift in the focus of the current South African Public Service towards transformation process (Ramathlodi, (2004:6). A significant number of pieces
of legislation, namely, the White Papers as well as collective agreements have been passed to ensure this focus is not lost in the daily bustle and hustle commonly associated with huge bureaucracies like government departments. The most notable of these pieces of legislative framework affecting organizational and individual performance are, inter alia, The White Paper on Public Service Transformation, Affirmative Action and Human Resources Management, The Public Service Act; Labour Relations Act of 1995 (LRA) as amended, New Public Service, SAQA, Employment Equity and Skills Development and Public Service Regulations (as amended) and PSCBC to mention just a few and other relevant resolutions adopted by the current government and since the focus had been on the transformation-related legislative framework, that meant that all three spheres of government have had to direct their energies and focus in developing policies, systems and practices that seek to put delivery of service to the customer first, in terms of Batho-Pele principles. In order to ensure that all government departments are proactive and find effective and efficient ways of turning around the focus of each individual employee in the public service, the Limpopo Provincial Government agreed to have a uniform PMS based on an adapted balanced scorecard approach for all its ten departments so as to ensure that all members of the communities receive the best service delivery ever.

The transformation process has been identified as one of the effective mechanisms by means of which the quality of health-care service delivery in South Africa could be improved so that the majority of the black people who were excluded from all types of the excellent services now become the beneficiaries after several decades of the domination, oppression, marginalization and discrimination by the defunct apartheid regime.

In the next chapter the employees of the health-care facilities (nursing and administrative personnel) and the members of the communities who visited the health-care facilities for consultation, had questionnaires distributed to them in an attempt to obtain their views, attitudes, opinions and understanding on the effects of the transformation process on the quality of health-care service delivery in the three remaining subdistricts of the Vhembe Health District of Limpopo Province in South Africa. The purpose of conducting the research study was, therefore, to determine the extent of their knowledge and comprehension of what transformation process was all about, the magnitude of its effect on the quality of health-care service delivery and also to understand the manner in which the government implemented its
policies that were transformation-related and service delivery-related for the benefit of its citizens.
CHAPTER SIX

DATA PRESENTATION, ANALYSIS AND DESCRIPTION OF SURVEY RESULTS

6.1 INTRODUCTION

The previous chapter described the research design and research methodologies, focusing mainly upon the objectives of the study, types of research method, research approaches, methods for sampling and data collection techniques and procedures. Data analysis, results and discussions also constitute the subject matter of the present chapter. Included in the present chapter is the presentation of the empirical data in terms of frequencies and percentiles in tabular and graphic representations. The data were obtained by administering two sets of questionnaires, differing in content, to the respondents who participated in the study.

The study was cross-sectional in nature because the target population was studied at a single time. Both probability and non-probability sampling procedures were applied in the collection of data. The methodology applied also included both quantitative and qualitative methods because the bulk of the questions were quantitative. Some of them required the respondents to produce qualitative responses such as Items 3, 6, 10, 12, 13, 14, 15 and 18 to mention just few designed for public servants (PS) who were expected to be at liberty to express their own views on the correlation between the transformation and health-care service delivery processes without being limited to the options or alternatives on the questionnaire. The main objective of the next subsection, 6.2 is to present the findings of the study conducted in Vhembe Health District or Vhembe Municipality of Limpopo Province in South Africa at the sampled primary health-care institutions during the last six months of 2009. In chapter six the reflected responses elicited by PS and MC respondents are presented in the form of tables, figures and graphs. The public servants in this context refer to the nurses working at the clinics in Vhembe Health District and members of the community refer to the patients who, at the time of conducting the research, visited the clinics for consultation. The graphs, tables and figures are some of the most useful and powerful instruments or tools of data analysis because they highlight the main results, both positive and negative. The graph is a two-dimensional representation of a relation between variables. It exhibits graphically sets of ordered pairs in a manner that no other method could do. It is worth noting that a graph shows clearly its nature,
whether positive, negative, linear and quadratic and any other data. A histogram is a horizontal bar graph that graphically displays the time relationships between the different tasks in a study or identified project. It is a technique or tool that was developed in 1917 by Henry L. Gantt, an American engineer, for the purpose of planning a particular project and its advantages include, inter alia, a clear and comprehensive representation of the project as well as the reflection of milestones that can be graphically highlighted when the need arises. In the present study the questionnaires were administered to the respondents of both subsamples requiring the respondents to provide information pertaining to how much they knew about the processes, that is, to disclose their knowledge and understanding of transformation and service delivery processes as well as of transformation-related legislation, directives, mandates, policies and the Constitution of 1996 that brought the current Republic of South Africa into existence and also came into being in 1994 as constituted particularly in terms of the provisions of section 40 of the Constitution (Constitution of 1996:25; Kerlinger, 1973:143; Mouton, 2001:69 and 124).
The initial research sample reflected above in Figure 6.1 consisted of two sub-samples, the respondents of which were 163 public servants (PS) and 165 members of the communities or patients (MC) who were randomly selected giving a total of 328 respondents, but the actual sample consisting of the same subsamples which participated in the final study consisted instead of fewer respondents due to attrition that emanated either from some respondents failing to avail themselves to participate in the study or were unable to return the questionnaires to the appointed enumerators or the researcher resulting in their numbers being 145 in respect of the public servants (PS) and 148 in respect of the members of the communities or patients (MC) giving the actual number of respondents being 293 who eventually participated in the survey study; while the three subdistricts, namely, Makhado, Musina and Thulamela and all 3 clinics falling under Musina subdistrict were purposively selected for the reasons already advanced previously in chapters four and five of the present study. In short, this chapter focuses attention mainly on the issues pertaining particularly to data presentations, analyses and descriptions of the research results of the study.
Figure 6.2: Distribution of respondents in the actual sample in Vhembe Health District

The above data in Figure 6.2 indicate the graphic and tabular representations pertaining to the distribution of the frequencies and percentiles of the two subsamples of the main research sample, namely, PS which comprised 145 respondents and MC consisting of 148 respondents giving a total of 293, whereas the initial randomly selected sample consisted of 330 respondents from 33 clinics, each with 10 respondents during the research survey conducted in 2009 in Vhembe Health District.

It was also observed from Figure 6.2 above that although 330 questionnaires were distributed, only 293 were returned to the researcher by the respondents through the enumerators and the remaining 37 which represented 11.2% of the total number of questionnaires handed over to the respondents were not returned, nor were the uncompleted questionnaires returned. The researcher had initially decided that all the respondents would assemble at the same time at a common venue like a big conference hall to complete the questionnaires, but it was not practical because of the size and vastness of the district and also because the clinics were dispersed throughout the district. It was then considered to be best to have all the questionnaires distributed to the respondents by enumerators and the latter would, in due
course, return the completed questionnaires to the researcher for the purpose of analysis and interpretation of the results. In spite of the adequate time allowed for the respondents to complete the questionnaires, not all were completed and returned.

31 clinics were randomly sampled, 15 clinics at Makhado subdistrict and 15 clinics at Thulamela subdistrict but 13 clinics from Thulamela subdistrict were actively committed and returned the questionnaire and 3 at Musina, giving a total of 31 clinics. 10 respondents were sampled at each clinic, that is, 5 PS and 5 MC per primary health-care facility. Figures 6.3, 6.4 and 6.5 display the names of those clinics which were initially sampled before the distribution of the questionnaires to the respondents. The responses were returned to the researcher through the authorities at the clinics and also through the two appointed enumerators. The 2 clinics in Thulamela subdistrict were considered not to have participated in the research survey by virtue of their not having returned the questionnaires in spite of the extension of the pre-determined period. 31 clinics participated in the study with 328 respondents actively participating in the study. After the administration and analysis of the data the responses were captured in the manner reflected in Figures 6.6 through to 6.85. As stated in chapter five, the chi-square test was used with a chosen probability of Type I error that is equal to 0,05 (Behr, 1983:82; Breakwell et al, 1998:346; Fox and Bayat, 2007:127; Huysamen, 1976:83; Kerlinger, 1973:166-171). The following are the presentations and analyses of data according to the method prescribed in chapter five.
Figure 6.3: Distribution of responses in terms of the PHCs in Musina subdistrict

The above graphic and tabular representations of the responses in figure 6.3 reflect the distribution of frequencies and percentiles of each primary health-care (PHC) facility within Musina subdistrict. The three purposively-sampled clinics that participated actively in the present study were Madimbo clinic, Messina clinic and Lancefield clinic. The frequencies and percentiles of each clinic were calculated based on the sample that comprised of 328 respondents in Vhembe Health District. A total number of 30 respondents, that is, both PS (15) and MC (15) from the three judgmentally-sampled clinics participated in the present study in this subdistrict and the responses elicited were reflected in Figures 6.6 through to Figure 6.45.
Figure 6.4: Distribution of responses in terms of the PHC’s in Makhado subdistrict

Figure 6.4 above indicates the distribution of the 15 clinics with the data representation in terms of frequencies and percentiles. The clinics that participated in the study were De Hoop clinic, Nkhensani clinic, Kurhuleni clinic, Valdezia clinic, Vyeboom clinic, Rumani clinic, Beacons Field clinic, Phadzima clinic, Tshikuwi clinic, Helderwater clinic, Mashamba clinic, Louis Trichardt clinic, Manyima clinic, Mbokota clinic and Muila clinic. The graphic representation shows 10 respondents in each clinic in Makhado subdistrict, 73 public servants (and the 2 sampled did not participate) and 75 members of the community, giving a total of 148 respondents that eventually participated in the survey study in Makhado subdistrict.
The graphic and tabular representations in Figure 6.5 above show the number of clinics that volunteered to participate in the current study including the two clinics that did not return all the questionnaires to the researcher, namely, Vhurivhuri clinic and Sambandou clinic. The data pertaining to the number of clinics are 15 clinics as reflected in Figure 6.5. They were initially 75 public servants (PS) and 75 members of the communities (MC), but after the study was conducted, the responses received from the respondents in the present study revealed that 65 PS and 65 MC, giving a total of 130 respondents eventually participated in the research due to the two clinics that did not return the questionnaires and were subsequently considered no longer part of the survey study whereas initially a total of 150 respondents were randomly sampled for the present study.
**Figure 6.6:** Distribution of responses reflecting that the public servants of Vhembe Health District of Limpopo Province in South Africa lack capacities and skills to implement the transformation process in order to promote and facilitate the needed health-care services.

![Graph showing distribution of responses](image)

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Agree (%)</th>
<th>Disagree (%)</th>
<th>No Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>33.3</td>
<td>66.7</td>
<td>7.1</td>
</tr>
<tr>
<td>Makhado</td>
<td>22.9</td>
<td>70</td>
<td>3.3</td>
</tr>
<tr>
<td>Thulamela</td>
<td>40</td>
<td>56.7</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Item 1 of the questionnaire in Figure 6.6 required the respondents to indicate whether they lacked capacities and skills to implement the transformation process with a view to promoting and facilitating the quality of service delivery. In response, 33.3%, 22.9% and 40.0% of all the respondents agreed that the public servants of Vhembe Health District lacked the capacities and skills to implement the transformation process in order to promote and facilitate the quality of service delivery, whereas 66.7%, 70.0% and 56.7% of the total respondents in each of Musina, Makhado and Thulamela subdistricts respectively disagreed that the public servants of Vhembe Health District lacked the capacities and skills to implement the transformation process in order to promote and facilitate the quality of service delivery in their respective subdistricts. In spite of the fact that the public servants who responded in the affirmative were in the minority, if such a situation prevailed, then there was a dire need for the government to embark upon the development of a programme designed especially to develop and train such employees in order to capacitate and equip them with the necessary skills and knowledge so
that they would be able to expedite the delivery of health-care services particularly in the rural communities of South Africa.

**Figure 6.7:** Distribution of responses reflecting that the transformation process benefits only the public servants

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>15.7</td>
<td>100</td>
<td>2.9</td>
</tr>
<tr>
<td>Makhado</td>
<td>13.3</td>
<td>81.4</td>
<td>1.7</td>
</tr>
<tr>
<td>Thulamela</td>
<td>85</td>
<td>85</td>
<td>1.7</td>
</tr>
</tbody>
</table>

In the light of the responses elicited in terms of Item 3 in Figure 6.7 above, it was revealed that 15.7% and 13.3% of the public servants from Makhado and Thulamela subdistricts respectively confirmed that only public servants benefited from the transformation process but 100%, 81.4% and 85% of the public servants from the same subdistricts mentioned that public servants did not benefit from the transformation process, the reason perhaps being that the process was not designed by the government specifically to benefit the officials per se, but all the citizens of this country who were denied the privilege of satisfactory and adequate services for several decades prior to the attainment of democracy in 1994. The objective of implementing the transformation process was that it was one of the best available mechanisms in 1994 to address the huge backlogs in terms of service delivery that were created and left by the apartheid system.
**Figure 6.8:** Distribution of responses reflecting that the places where the public servants work lack relevant resources to enable them to promote and facilitate the transformation process.

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>86.7</td>
<td>6.7</td>
<td>6.7</td>
</tr>
<tr>
<td>Makhado</td>
<td>34.3</td>
<td>64.3</td>
<td>1.4</td>
</tr>
<tr>
<td>Thulamela</td>
<td>50</td>
<td>46.7</td>
<td>3.3</td>
</tr>
</tbody>
</table>

With regard to the responses to Item 4 on the questionnaire in Figure 6.8, 86.7%, 34.3% and 50.0% of the public servants from Musina, Makhado and Thulamela subdistricts respectively responded in the affirmative, indicating that the places where they worked lacked the relevant resources to enable them to promote and facilitate the transformation process, but 6.7%, 64.3% and 46.7% of the respondents respectively from the same subdistricts mentioned that the places where they worked did not lack the relevant resources to enable them to promote and facilitate the transformation process. In other words, the latter group of respondents indicated that the resources at the places they worked were available to enable them to expedite the execution of the transformation process which had a bearing on the quality of service delivery. 6.7%), 1.4% and 3.3% of the total number of respondents from Musina, Makhado and Thulamela subdistricts respectively did not express their opinions on Item 4 of the questionnaire.
**Figure 6.9:** Distribution of responses reflecting that the public servants do not recognize transparency as part of the transformation

![Bar chart showing the distribution of responses across different municipalities.]

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>20</td>
<td>80</td>
<td>2.9</td>
</tr>
<tr>
<td>Makhado</td>
<td>18.6</td>
<td>78.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Thulamela</td>
<td>16.7</td>
<td>80</td>
<td>3.3</td>
</tr>
</tbody>
</table>

Item 5 required the respondents to indicate whether the public servants did not recognize transparency as part of the transformation process. In response to the question, 20.0%, 18.6% and 16.7% of the respondents at Musina, Makhado and Thulamela subdistricts respectively responded in the affirmative, indicating that public servants did not recognize transparency as part of the transformation, but 80.0%, 78.6% and 80.0% of the respondents from the above-mentioned subdistricts respectively indicated that public servants recognized transparency as part of the transformation. 2.9% and 3.3% of the public servants in Makhado and Thulamela subdistricts respectively did not respond to Item 5. The White Paper on Transforming the Public Service of 1997 requires public servants in terms of the Batho-Pele policy to recognize transparency as part of the transformation process because the present democratic government has enhanced transparency as one of the core values and standards to promote, improve and facilitate service delivery.
In Item 6 in Figure 6.10 above, 100.0%, 85.7% and 95.0% of the respondents from Musina, Makhado and Thulamela subdistricts respectively argued that service delivery was a priority to them, whereas only 11.4% and 5.0% from Makhado and Thulamela subdistricts respectively argued that service delivery to the public was not a priority to them. 2.9% of the public servants in Makhado subdistrict did not express their views on it. Although some responses revealed that there were certain public servants who did not regard the attainment of service delivery as a priority, the current government has made it clear that it has committed itself to ensuring that there is satisfactory delivery of services to all the people of this country regardless of race and colour since there were huge backlogs in terms of service delivery particularly regarding health-care services in the rural areas where most black people lived. The present government will not compromise in any way as far as service delivery is concerned because it does not want the lifestyle of the already historically disadvantaged black people (HDBP) to continue deteriorating without any political intervention.
Figure 6.11: Distribution of responses reflecting that there are no pieces of legislation that enforce the implementation of the transformation process in the Republic of South Africa

![Bar chart showing distribution of responses](chart.png)

It is observed from the data in Item 7 reflected in Figure 6.11 above that 4.3% and 10.0% of the respondents from Makhado and Thulamela subdistricts respectively responded in the affirmative, pointing out that there were no pieces of legislation that enforced the implementation of transformation in the Republic of South Africa. On the other hand, 93.3% from Musina, 90.0% from Makhado and 85.0% from Thulamela subdistricts confirmed that there were pieces of legislation in place that enforced the implementation of the transformation in this country. 6.7%, 5.7% and 5.0% of the respondents from Musina, Makhado and Thulamela subdistricts respectively did not answer this item. All discriminatory and oppressive laws that were in place during the apartheid period were outlawed or repealed in toto and only legislation of which the intention was to promote, advance and facilitate peace, stability and to promote and facilitate high quality service delivery has been promulgated by the present government since 1994, based on the principles of democracy. Hence the majority of respondents in Vhembe Health District disagreed with the question which stated that there were no pieces of legislation that enforced the implementation of the transformation process in
this country since some of the transformation-related legislation and policies such as National health Act of 2003 (61 of 2003:18), the Labour Relations Act of 1995 as amended, the RDP policy (1994:7, 42-51) and the White Paper on Transforming the Public Service of 1997, were put in place to address the imbalances of the past.

**Figure 6.12:** Distribution of responses reflecting that the transformation process promotes and facilitates the quality of service delivery in the peripheral communities

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Agree</th>
<th>Disagree</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>100</td>
<td>7.1</td>
<td>5.7</td>
</tr>
<tr>
<td>Makhado</td>
<td>87.1</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Thulamela</td>
<td>90</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In the light of the responses advanced to Item 8 given in Figure 6.12 above, it was revealed that 100,0% of respondents from Musina subdistrict, 87,1% from Makhado subdistrict and 90,0% from Thulamela subdistrict agreed that the transformation process promoted and facilitated the quality of service delivery in the peripheral communities whereas 7,1% and 10,0% of the respondents from Makhado and Thulamela subdistricts respectively disagreed that the transformation process promoted and facilitated the quality of service delivery in the peripheral communities. There are abundant provisions in terms of the National Health Act of 2003 (61 of 2003), the Batho-Pele policy of 1997 and the RDP policy of 1994 to ensure the promotion and facilitation of a high quality of service delivery in the rural communities. Through the process of transformation significant changes have been brought about in terms of service delivery in
the peripheral areas where houses have been built for those who are very poor and cannot afford to build for themselves. Roads and bridges have been constructed; clinics have been built and are still in the process of being built in the rural areas. Most of them were more than 5 kilometres away from the majority of the patients especially from the black people. Community Health Centres (CHC) and hospitals have been built and upgraded so that healthcare services can be rendered to patients with ease, following the introduction and implementation of the transformation process. This is just one example of the host of mechanisms that played a role in the improvement and facilitation of service delivery in the whole country without discrimination against or marginalization of certain population groups. 5.7% of the public servants in Makhado subdistrict did not express an opinion in this regard.

**Figure 6.13:** Distribution of responses reflecting that members of the communities are not altogether knowledgeable about the process of transformation and its effects on the quality of service delivery; hence massive service delivery problems

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Agree</th>
<th>Disagree</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>80</td>
<td>13.3</td>
<td>6.7</td>
</tr>
<tr>
<td>Makhado</td>
<td>60</td>
<td>37.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Thulamela</td>
<td>68.3</td>
<td>28.3</td>
<td>3.3</td>
</tr>
</tbody>
</table>

In response to Item 9 in the questionnaire it was indicated in Figure 6.13 that 80.0%, 60.0% and 68.3% of the respondents in Musina, Makhado and Thulamela subdistricts respectively agreed that members of the communities were not altogether knowledgeable about the process
of transformation and its impact on service delivery whereas 13,3%, 37,1% and 28,3% of the respondents from the same respective subdistricts disagreed that the communities were not altogether knowledgeable about the process of transformation and its impact on service delivery, simply indicating that the public servants were quite conversant with the process and were also aware of the impact it had on the quality of service delivery. Only 6,7%, 2,9% and 3,3% of the respondents from the three subdistricts did not respond.

**Figure 6.14:** Distribution of responses reflecting that the current government disregards the implementation of the transformation process as a priority, even the transformation of the public service

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>6.7</td>
<td>93.3</td>
<td>7.1</td>
</tr>
<tr>
<td>Makhado</td>
<td>21.4</td>
<td>71.4</td>
<td>5</td>
</tr>
<tr>
<td>Thulamela</td>
<td>23.3</td>
<td>71.7</td>
<td>5</td>
</tr>
</tbody>
</table>

Item 10 in Figure 6.14 above required the public servants to indicate whether the current government disregarded the implementation of the transformation process as a priority, even the transformation of the public service. In response 6,7%, 21,4% and 23,3% from Musina, Makhado and Thulamela subdistricts respectively responded in the affirmative, emphasizing that the current government disregarded the implementation of the transformation process as a priority, even the transformation of the public service while 93,3%, 71,4% and 71,7% from the same subdistricts respectively mentioned that the current government regarded the
implementation of the transformation process as a priority, even the transformation of the public service. There were significant changes in terms of service delivery, especially in the health-care department where clinics, health centres (CHC) and hospitals have been built since 1994 in order to comply with the set norms that prescribe that clinics must be within the range of 5 kilometres of all members of communities, especially in the remote rural areas in order to address the challenge of transport since the provision of health-care is not the privilege but the right of every South African citizen regardless of colour, religion and creed. Health-care services should be easily accessible to all people of this country. The transformation process has been designed by the government to ensure the accessibility of all health-care facilities to all members of the communities at all times. 7,1% and 5,0% from Makhado and Thulamela subdistricts respectively did not respond to Item 10.

**Figure 6.15:** Distribution of responses reflecting that some public servants lack the necessary skills and knowledge to clearly and perfectly render adequate services

![Bar chart showing distribution of responses](image)

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>40</td>
<td>53.3</td>
<td>6.7</td>
</tr>
<tr>
<td>Makhado</td>
<td>50</td>
<td>44.3</td>
<td>5.7</td>
</tr>
<tr>
<td>Thulamela</td>
<td>56.7</td>
<td>41.7</td>
<td>1.7</td>
</tr>
</tbody>
</table>

It is observed from the above data elicited from Item 11, and indicated in Figure 6.15 above, that 40,0%, 50,0% and 56,7% of the respondents from Musina, Makhado and Thulamela subdistricts respectively indicated in the affirmative that some public servants lacked the
necessary skills and knowledge to render adequate services, whereas 53,3%, 44,3% and 41,7% from the same subdistricts respectively mentioned that some public servants did not lack the necessary skills and knowledge to render adequate services, that means, such public servants had the necessary skills and knowledge to possibly render adequate services to the benefit of the members of the community. Otherwise, there would be a need for development of a relevant development and training programme in order to equip the public servants with the appropriate knowledge and skills, to enable them to implement the process with ease in order to benefit those less privileged citizens who were not active in the implementation of health-care services prior to 1994 due to the deliberate apartheid practices of the former administration in numerous issues, including the health-care of patients.

**Figure 6.16:** Distribution of responses reflecting that all health-related basic needs are easily made available to the very poor people residing in Vhembe Health District

![Graph showing the distribution of responses](image)

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>46.7</td>
<td>53.3</td>
<td>2.9</td>
</tr>
<tr>
<td>Makhado</td>
<td>68.6</td>
<td>28.6</td>
<td>3.3</td>
</tr>
<tr>
<td>Thulamela</td>
<td>63.3</td>
<td>33.3</td>
<td>3.3</td>
</tr>
</tbody>
</table>

According to the responses to Item 12 reflected in Figure 6.16 above, 46,7%, 68,6% and 63,3% of the public servants from Musina, Makhado and Thulamela subdistricts respectively responded in the affirmative, mentioning that all health-related basic needs were easily available to the very poor people residing in Vhembe Health District while 53,3%, 28,6% and
33.3% of the public servants from the same subdistricts respectively disagreed that all health-related basic needs were easily available to the very poor people residing in Vhembe Health District. In order to support the opinions expressed by the first group of respondents, the adoption of the RDP policy of 1994 by the GNU as the national government policy to be observed throughout the country proved that the government was committed to service delivery and that one of the main objectives of the RDP policy is to make provision in terms of service delivery that all citizens of this country regardless of colour, creed or religion have access to appropriate and satisfactory services without discrimination and that they are all entitled to clean water, sanitation, housing, transport services, health-care services, reduction or elimination of unemployment and poverty. These are mentioned as some of the most important basic needs that government must provide, especially to those who live in the most peripheral areas of the country, characterized by hunger, poverty and unemployment.

**Figure 6.17:** Distribution of responses reflecting that public servants render services in a manner that is completely unacceptable to the public

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>6.7</td>
<td>93.3</td>
</tr>
<tr>
<td>Makhado</td>
<td>5.7</td>
<td>94.3</td>
</tr>
<tr>
<td>Thulamela</td>
<td>10</td>
<td>90</td>
</tr>
</tbody>
</table>
The observations resulting from the responses to Item 13 in Figure 6.17 above indicated that 6.7%, 5.7% and 10.0% from the respondents based in Musina, Makhado and Thulamela subdistricts respectively showed that public servants rendered services in a manner that was completely unacceptable to the public while on the other hand, 93.3%, 94.3% and 90.0% argued that public servants rendered services in a manner that was completely acceptable to the public. The Batho-Pele policy sets out a number of principles which all public servants are expected to comply with since members of the community, regardless of race or socio-economic class must be treated with respect and dignity when consulting and furnishing them with the appropriate information they deserve. In terms of the provisions of the Labour Relations Act of 1995 as amended, decisive action might be taken against public servants who render services in a way that members of the communities regard as unsatisfactory since public servants must remain committed to the implementation of the health-related policies which have an impact on service delivery. Public officials or health workers are servants of the public and must, therefore, always carry out their responsibilities in such a way that they are completely transparent and acceptable to members of the public. They have to be accountable for their actions in terms of service delivery.
**Figure 6.18:** Distribution of responses reflecting that the government is keen to ensure that the transformation process takes place in terms of the legislation, but some public servants drag their feet

In the light of Item 14 which elicited data as reflected in Figure 6.18, 33.3%, 18.6% and 28.3% of the public servants from Musina, Makhado and Thulamela subdistricts respectively mentioned that the government was keen to ensure that the transformation process took place in terms of the legislation, but some public servants dragged their feet while 66.7%, 80.0% and 63.3% of the public servants argued that the government was not keen to ensure that the transformation process took place in terms of the legislation and that some public servants did not drag their feet. 1.4% and 8.3% of respondents from Makhado and Thulamela subdistricts respectively did not express their views on this Item. In the situation where some public servants were observed to be dragging their feet, it was that those employed by the structures of the former regime were scared of the emergence of the new democratic government and were afraid of losing their jobs since their outdated skills and knowledge would not entitle them to firmly secure any position as they had to compete with the young ones who were fully academically qualified and conversant with the requirements of the modern technological world. They, therefore, dragged their feet as a way of demonstrating passive resistance during
the first 5 years when the new democratic government was in power. The black employees during that era did not know their work thoroughly because most of their responsibilities and duties were carried out by the white employees seconded to the homelands and territories by the national government.

**Figure 6.19:** Distribution of responses indicating that some public servants display negative attitudes towards the transformation process and service delivery

![Bar Chart]

The responses to Item 15 in Figure 6.19 above showed that 33.3%, 21.4% and 36.7% of the respondents from Musina, Makhado and Thulamela subdistricts respectively argued that some public servants displayed negative attitudes towards the transformation process and service delivery and the service was delivered in a way that was completely unacceptable to the public. On the other hand, 66.7%, 77.1% and 55.0% argued that some public servants did not display negative attitudes towards the transformation process and service delivery services. Only 1.4% and 8.3% of the public servants in Makhado and Thulamela respectively did not express their opinions on this item. The present government has made it clear in its numerous policies, mandates and directives that the implementation of transformation is mandatory and a matter of necessity where the backlogs of service delivery were concerned and it could not compromise as it was a matter of urgency. Many transformation-related pieces of legislation
such as the National Health Act of 2003 (61 of 2003:18), the Labour Relations Act of 1995 as amended, the Public Service Act of 1994, the Public Service Regulations of 2001 and the White Papers such as the White Paper on Transforming the Public Service of 1997 and the RDP policy in 1994 have been promulgated by the government since 1994 in order to address the imbalances of the past.

**Figure 6.20:** Distribution of responses reflecting that the public servants who do not promote and facilitate the transformation process should be disciplined for their unlawful practices

![Bar Chart]

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>33.3</td>
<td>60</td>
<td>6.7</td>
</tr>
<tr>
<td>Makhado</td>
<td>44.3</td>
<td>48.6</td>
<td>7.1</td>
</tr>
<tr>
<td>Thulamela</td>
<td>58.3</td>
<td>40</td>
<td>1.7</td>
</tr>
</tbody>
</table>

The responses provided in accordance with Item 16 in Figure 6.20 above indicated that 33.3%, 44.3% and 58.3% of the respondents from Musina, Makhado and Thulamela subdistricts respectively confirmed that they supported the idea that the public servants who did not promote and facilitate the transformation process should be disciplined for their unlawful practices while 60.0%, 48.6% and 40.0% of the respondents from the same subdistricts respectively argued that the public servants who did not promote and facilitate the transformation process should not be disciplined for their unlawful practices and should be given a fair chance to change their attitude towards the transformation process so that they would also have an opportunity to implement the transformation process to the benefit of all
members of the communities. There were no responses from 6.7%, 7.1% and 1.7% of the respondents from Musina, Makhado and Thulamela subdistricts respectively. In the event of public servants continuing to be non-compliant decisive action may be taken against them so that they should not be a hindrance in the implementation of the legislation and policies put in place by the present government to benefit all South African citizens, especially those populations groups that were discriminated against, marginalized and excluded from participation in the health-care benefits of this country in the past.

**Figure 6.21:** Distribution of responses reflecting that the transformation is a process that needs to be frequently monitored and evaluated by the government

![Bar chart showing distribution of responses](image)

The responses to Item 17 in Figure 6.21 indicated that 13.3% of the respondents from Musina subdistrict, 27.1% of the respondents from Makhado subdistrict and 16.7% of those from Thulamela subdistrict maintained that transformation was a process which needed to be monitored and evaluated by the government on a monthly basis; 53.3%, 52.9% and 55.0% of the respondents from the three subdistricts respectively argued that transformation was a process which needed to be monitored and evaluated quarterly by the government while 26.7%, 14.3% and 28.3% of the respondents from the three subdistricts respectively also...
argued that transformation was a process which needed to be monitored and evaluated yearly by the government. Only 6.7% and 5.7% of the respondents from Musina and Makhado subdistricts respectively did not respond. Although monitoring and evaluation processes are very important, they cannot be done on a monthly basis by the immediate supervisors. It is imperative that a task team comprised of experts in the field of transformation be appointed in order to monitor and evaluate public servants frequently to establish whether they are implementing the transformation process. This process is considered to be one of the mechanisms initiated by the current government to ensure that there is an improvement in the quality of service delivery in this country. Monitoring and evaluation are processes that should be implemented in order to verify whether or not public servants are performing in accordance with the set standards and requirements and also in terms of the provisions of the relevant legislation, policies and mandates of the present government for the eventual benefit of the communities (Limpopo Government PMS, 2004:9).
**Figure 6.22:** Distribution of responses reflecting that the transformation process needs to be regulated within the set timeframes to ensure that targets are met as scheduled

In response to the enquiry in Item 18 reflected in Figure 6.22, 86.7%, 94.3% and 96.7% of the public servants from Musina, Makhado and Thulamela subdistricts respectively argued strongly in favour of the idea that the transformation process needed to be regulated within the set timeframes to ensure that targets were met as scheduled, but 5.7% and 3.3% of the public servants from Makhado and Thulamela subdistricts respectively argued that the transformation process did not need to be regulated within the set timeframes to ensure that targets were met as scheduled, while 13.3% of the respondents from Musina subdistrict did not respond to this Item as reflected in Figure 6.22 above.
Figure 6.23: Distribution of responses reflecting that the attitude of some frontline public servants, especially medical doctors and nursing personnel towards patients is unpleasant

According to Item 19 in Figure 6.23 above, 20.0%, 25.7% and 30.0% of the respondents from Musina, Makhado and Thulamela subdistricts respectively indicated in the affirmative, that the attitudes of some frontline public servants, especially medical doctors and nursing personnel towards patients were unpleasant while 73.3%, 65.7% and 70.0% of the respondents from the same subdistricts respectively argued strongly that the attitudes towards patients of some frontline public servants, especially medical doctors and nursing personnel were pleasant. 6.7% and 8.6% of the respondents from Musina and Makhado respectively did not express their opinions in Item 19.
Figure 6.24: Distribution of responses reflecting that public servants treat patients with courtesy and consideration

In the light of the responses given to Item 21 reflected in Figure 6.24 above, 93.3%, 94.3% and 96.7% of the respondents from Musina, Makhado and Thulamela subdistricts respectively it was revealed that the public servants treated patients with courtesy and consideration while 6.7%, 4.3% and 3.3% of respondents from the same subdistricts respectively mentioned that public servants did not treat patients with courtesy and consideration. In terms of the provisions of the Health Act of 2003 (61 of 2003), the Batho-Pele policy of 1997 and the RDP policy of 1994 respectively, dignity, consideration, politeness, humbleness, respect and fairness are all aspects of a good attitude to be displayed towards patients by all health-care professionals and health-care workers during their interaction with patients. All patients regardless of their race, colour, socio-economic status, creed or religion, deserve to be treated with utmost respect, dignity, courtesy and consideration by all health-care workers in the entire country. 1.4% of the public servants in Makhado subdistrict did not respond to Item 21.
**Figure 6.25:** Distribution of responses reflecting that public servants provide full and better information to the patients about the public service they are entitled to receive

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>93.3</td>
<td>6.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Makhado</td>
<td>88.6</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Thulamela</td>
<td>100</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

In response to the enquiry in Item 22 reflected in Figure 6.25, which dealt with the attitudes of the public servants regarding whether they provided the full and better information to the patients about the public service they were entitled to receive, 93.3%, 88.6% and 100.0% of the respondents from Musina, Makhado and Thulamela subdistricts respectively responded in the affirmative, indicating that public servants provided the full and better information to patients about the public service that they were entitled to receive and 6.7% and 10.0% in Musina and Makhado subdistricts respectively argued that public servants did not provide the full and better information to the patients about the public service that they were entitled to receive. 1.4% of the respondents from Makhado subdistrict did not respond to this Item. In terms of the provisions of the Batho-Pele policy of 1997, it is mandatory upon all health-care professionals and health-care workers to ensure that they provide detailed information to the patients about the public service so that they could assess the standard and quality of services being provided in order to be in a position to determine whether the services were good or poor in terms of the standards set by the government.
Figure 6.26: Distribution of responses reflecting that the public servants offer apologies to the patients, and full, speedy explanations and effective remedies whenever complaints are lodged.

![Bar chart showing distribution of responses among Musina, Makhado, and Thulamela](chart.png)

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>100</td>
<td>4.3</td>
<td>1.4</td>
</tr>
<tr>
<td>Makhado</td>
<td>94.3</td>
<td>1.7</td>
<td>1.4</td>
</tr>
<tr>
<td>Thulamela</td>
<td>98.3</td>
<td>1.7</td>
<td>1.4</td>
</tr>
</tbody>
</table>

It is observed from the above data indicated in Item 23 reflected in Figure 6.26 that 100.0% of the respondents from Musina subdistrict, 94.3% of the respondents from Makhado subdistrict and 98.3% of the respondents from Thulamela subdistrict expressed their opinions based on their experiences that they offered apologies to the patients and full, speedy explanations and effective remedies whenever complaints were lodged with them which were acceptable attitudes for public servants, but 4.3% and 1.7% of the respondents from Makhado and Thulamela subdistricts respectively disagreed that they offered apologies to the patients, and full, speedy explanations and effective remedies whenever complaints were lodged. 1.4% of the respondents from Makhado subdistrict did not respond. In view of the fact that patients are important and of great value, the government has gone to the extent of promulgating pieces of legislation and formulating policies and mandates such as the Health Act of 2003 (61 of 2003), RDP of 1994, the Batho-Pele policy of 1997 and some White Papers which emphasize how the health-care workers must work in order to preserve and sustain the health-care of the patients in the health-care institutions in this country. A huge allocation of the Limpopo provincial
budget annually goes to the Department of Health and Social Development for the purpose of service delivery improvement. This is the second largest allocation in the province in order to cater for the good health-care of the patients.

COMPARATIVE DATA ANALYSIS AND INTERPRETATION OF THE RESULTS OF MEMBERS OF COMMUNITIES IN RESPECT OF THE VHEMBE HEALTH DISTRICT (MC)

**Figure 6.27:** Distribution of responses reflecting the extent within which the government complies with the norm of the range of 5km reach

![Bar chart showing distribution of responses reflecting the extent within which the government complies with the norm of the range of 5km reach.](chart.png)

<table>
<thead>
<tr>
<th>Municipality</th>
<th>&lt; 5 Km</th>
<th>5 Km</th>
<th>&gt; 5 Km</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>80</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Makhado</td>
<td>62.3</td>
<td>14.5</td>
<td>23.2</td>
</tr>
<tr>
<td>Thulamela</td>
<td>73</td>
<td>11.1</td>
<td>15.9</td>
</tr>
</tbody>
</table>

Figure 6.27 above shows that the responses elicited in terms of Item 1 indicated that 80.0%, 62.3% and 73.0% of the respondents in Musina, Makhado and Thulamela subdistricts respectively lived less than 5 kilometres from the nearest clinic whereas 14.5% and 11.1% from Makhado and Thulamela subdistricts respectively mentioned that their nearest clinic was just 5 kilometres from the place where they lived while 20.0%, 23.2% and 15.9% of
the respondents from Musina, Makhado and Thulamela subdistricts respectively stated that their clinics that served them were more than 5 kilometres from their homes. This situation is of great concern to the present government. It warrants additional clinics needing to be provided since the government’s target in terms of the provision of health-care facilities is that clinics must be within the range of 5 kilometres reach of all the patients so that they would not have to walk a distance further than the norm of 5 kilometres. It is, therefore, the responsibility of the current government to ensure that equal and good health-care services are made available to all South African citizens regardless of colour, religion and creed.

**Figure 6.28:** Distribution of responses reflecting the quality of health-care services provided by the health-care personnel

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Good (%)</th>
<th>Poor (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>86.7</td>
<td>13.3</td>
</tr>
<tr>
<td>Makhado</td>
<td>92.9</td>
<td>7.1</td>
</tr>
<tr>
<td>Thulamela</td>
<td>87.3</td>
<td>12.7</td>
</tr>
</tbody>
</table>

It is observed from Figure 6.28 above that the responses pertaining to Item 2 of the questionnaire indicate that 86.7%, 92.9% and 87.3% of the respondents from Musina, Makhado and Thulamela subdistricts respectively mentioned that the quality of services in their respective subdistricts provided by the health-care personnel was good while 13.3%, 7.1% and 12.7% argued that the services rendered by the health-care personnel were poor. Although the latter groups were in the minority, it is vital to note that essential services like
health-care need to be provided to all the people of South Africa residing in the urban and rural areas without discrimination. Some pieces of government legislation and policies such as the White Paper on the Transformation of Public Service and the Batho-Pele policy of 1997, indicate that the public servants should provide services of a high quality and standard to members of the communities and all health-care workers who render services of poor quality have to account for such poor services. After the general elections were conducted on 27\textsuperscript{th} April, 2009 in this country the current government established a new Department of Monitoring and Evaluation in order to check that the pre-set standards and criteria in terms of service delivery were adhered to without any compromise for the benefit of all citizens of this country and especially those categories of the population that were discriminated against during the previous era in terms of the provision of health-care services (Limpopo Government PMS: 2004:9).

**Figure 6.29:** Distribution of responses reflecting that the public servants of Vhembe Health District of Limpopo Province in South Africa lack the capacities and skills to implement the transformation process in order to promote and facilitate the needed health-care services.
The data elicited by the question in Item 3 reflected in Figure 6.29 above show that 53.3%, 44.3% and 39.7% of the respondents in Musina, Makhado and Thulamela subdistricts respectively agreed that public servants lacked the capacities and skills when it came to the implementation of the transformation process in order to promote and facilitate the needed health-care service. On the other hand, 46.7%, 55.7% and 60.3% of the respondents from the respective subdistricts disagreed that public servants lacked the capacities and skills to implement the transformation process in order to promote and facilitate service delivery. The challenge of inequality in terms of the provision of full service delivery has been and is still being addressed since all people are entitled to health-care services in terms of the Health Act of 2003 (61 of 2003) and the RDP policy of 1994 that make provision for equal and better services for all the people in South Africa. Public servants who lack capacities, knowledge and skills with regard to the implementation of the transformation process need to be developed and trained in order to equip them with necessary information pertaining to skills and knowledge.

**Figure 6.30:** Distribution of responses reflecting the attitudes of the health-care personnel towards the patients at their clinics
It is observed from Figure 6.30 above that the responses elicited by the question in Item 4 of the questionnaire indicate that 93.3%, 91.4% and 85.7% of the respondents from Musina, Makhado and Thulamela subdistricts respectively expressed their satisfaction with the attitudes displayed by public servants towards patients in the primary health-care facilities on the one hand, whereas on the other hand 6.7%, 7.1% and 12.7% from the respective subdistricts indicated that they were dissatisfied with the attitudes public servants showed towards patients. The dissatisfaction observed by those patients cannot be denied since some of the public servants have not yet transformed their mind-sets since the changes were introduced when the democratic government came into power in 1994. It is the responsibility of the present government to ensure that such public servants adopt a positive attitude towards the patients who deserve to be treated with courtesy, dignity and respect and have a right to access the best health-care services regardless of their colour, religion or creed. 1.4% and 1.6% of the respondents from Makhado and Thulamela respectively did not respond to this question.

**Figure 6.31:** Distribution of responses reflecting that the transformation process promotes and facilitates the quality of service delivery in the peripheral communities
According to the responses to Item 5 reflected in Figure 6.31 above, it was revealed that two subdistricts of Vhembe Health District, namely, Musina and Thulamela, agreed that transformation process promoted and facilitated the quality of service delivery in the peripheral communities with 93.3% and 87.3% respectively. The exception was Makhado subdistrict, where only 10.0% agreed that the transformation process promoted and facilitated the quality of service delivery in the peripheral disadvantaged communities. 88.6% of the respondents from Makhado subdistrict, 6.7% of the respondents from Musina subdistrict and 12.7% of the respondents from Thulamela subdistrict disagreed that the transformation process promoted and facilitated the quality of service delivery in the peripheral communities. Such an observation might be because the process was not clearly visible since some members of the communities had not yet experienced any socio-economic changes, save political transformation, in their lifestyles since the attainment of democracy in 1994. To them life was still a nightmare since poverty, unemployment and lack of adequate shelter were still the order of the day. 1.4% of the respondents from Makhado subdistrict did not respond.

**Figure 6.32:** Distribution of responses reflecting the respect displayed by health-care personnel towards patients when they seek consultation
100,0%, 95,7% and 95,2% of the respondents from Musina, Makhado and Thulamela subdistricts respectively as reflected in their responses to Item 6 captured in Figure 6.32 above confirmed that public servants displayed respect towards the patients. 4,3% and 4,8% in Makhado and Thulamela subdistricts respectively comment that the public servants in their respective subdistricts did not show respect towards patients. Such attitudes were of great concern since patients, like all other people, have rights in terms of the provisions of the Constitution of 1996 and the Bill of Rights including the RDP policy of 1994. Such public servants need adequate orientation about the provisions of the Batho-Pele policy of 1997 and other transformation-related policies of the present government because no patient should be subjected to any form of ill-treatment by health-care workers.

**Figure 6.33:** Distribution of responses indicating that the primary health-care personnel meet the expectations of the patients whenever they visit their clinics

![Bar chart showing response distribution](chart.png)

The observations in Figure 6.33 above which emanate from the responses to Item 7 of the questionnaire indicated that 100,0% of the respondents from Musina subdistrict, 95,7% from Makhado subdistrict and 92,1% from Thulamela subdistrict confirmed that the health-care personnel of those subdistricts in Vhembe Health District in Limpopo Province met the
expectations of the patients when they visited their respective clinics while 4.3% and 7.9% of the respondents from Makhado and Thulamela subdistricts respectively pointed out that the health-care personnel of those subdistricts in Vhembe Health District in Limpopo Province did not meet the expectations of the patients when they visited their respective clinics.

**Figure 6.34:** Distribution of responses reflecting the possibility of accessibility to the primary health-care facilities by the patients

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>93.3</td>
<td>6.7</td>
<td>0</td>
</tr>
<tr>
<td>Makhado</td>
<td>91.4</td>
<td>7.1</td>
<td>1.5</td>
</tr>
<tr>
<td>Thulamela</td>
<td>88.9</td>
<td>11.1</td>
<td>0</td>
</tr>
</tbody>
</table>

Item 8 reflected in Figure 6.34 above indicated that 93.3%, 91.4% and 88.9% of the respondents or patients from Musina, Makhado and Thulamela subdistricts respectively expressed satisfaction regarding the issue of finding it easy to have access to primary health-care facilities. On the other hand, 6.7% of the respondents from Musina subdistrict, 7.1% from Makhado subdistrict and 11.1% from Thulamela subdistrict argued that it was not possible for patients to have access to those facilities. 1.5% of the respondents from Makhado subdistrict did not respond to Item 8.
Figure 6.35: Distribution of responses reflecting that members of the communities are not altogether knowledgeable about the process of transformation and its effects on the quality of service delivery; hence massive service delivery problems

The responses given to Item 9 as reflected in Figure 6.35 above revealed that 73.3% of the respondents from Musina subdistrict, 44.3% of the respondents from Makhado subdistrict and 34.9% of those from Thulamela subdistrict disagreed that members of the communities were not altogether knowledgeable about the process of transformation and its effect on the quality of service delivery, that is, they maintained that the members of the community were knowledgeable about the transformation process and its effects on the quality of service delivery. 26.7% of the respondents from Musina subdistrict, 50.0% from Makhado subdistrict and 61.9% from Thulamela subdistrict responded in the affirmative, agreeing that members of the communities were not altogether knowledgeable about the transformation process and its effects on the quality of service delivery. If such a situation prevailed, it implied that workshops needed to be held to sensitize them to the importance of the process and the positive impact it had on the quality of service delivery in the rural communities. 5.7% and 3.2% of the
respondents in Makhado and Thulamela subdistricts respectively did not express their views on the matter.

**Figure 6.36:** Distribution of responses reflecting that the health-care personnel respond promptly to the patients’ requests for support during the emergency calls.

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>100</td>
<td>0</td>
<td>1.4</td>
</tr>
<tr>
<td>Makhado</td>
<td>88.6</td>
<td>10</td>
<td>1.4</td>
</tr>
<tr>
<td>Thulamela</td>
<td>93.7</td>
<td>4.8</td>
<td>1.6</td>
</tr>
</tbody>
</table>

Item 10 of the questionnaire as reflected in Figure 6.36 required the respondents to indicate whether the health-care personnel responded promptly to requests by the patients for support during emergency calls. In response, 100.0% of the respondents from Musina subdistrict, 88.6% from Makhado subdistrict and 93.7% from Thulamela subdistrict responded in the affirmative, indicating that the health-care personnel responded promptly to the patients’ requests for support during the emergency calls. 10.0% of the respondents from Makhado subdistrict and 4.8% from Thulamela subdistrict indicated that the health-care personnel did not respond promptly to the patients’ request for support during emergency calls. It is always expected of the health-care workers to give patients the prompt attention and courtesy they deserve especially during emergency calls. 1.4% and 1.6% of the respondents from Makhado and Thulamela subdistricts respectively did not respond to this Item.
In response to Item 11 on the questionnaire in Figure 6.37, 93.3%, 69.6% and 80.3% of the patients at Musina, Makhado and Thulamela subdistricts respectively mentioned according to Figure 6.37 that no health-care personnel shouted at the patients in their respective health-care facilities when they asked for assistance, but 6.7%, 30.4% and 19.7% of the patients from the respective subdistricts answered in the affirmative, indicating that the health-care personnel shouted at the patients when they asked for assistance. Health-care workers are not allowed to display such patterns of behaviour towards the patients since patients are entitled to respect from health-care personnel in their respective health-care facilities. In this instance, all patients needed to be made aware that they could lodge complaints with the health-care authorities at the institutions or clinics so that decisive action could be taken against such public servants as soon as possible, should it be found that they had been guilty of misconduct in the practice of their profession or found to be incorrectly implementing their skills and knowledge. 1.4% of the respondents from Makhado subdistrict did not respond to this item.
**Figure 6.38:** Distribution of responses reflecting that members of the communities are turned away at the primary health-care facilities when they need health-care services

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Respondent (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>Yes: 0, No: 100</td>
</tr>
<tr>
<td>Makhado</td>
<td>Yes: 21.4, No: 78.6</td>
</tr>
<tr>
<td>Thulamela</td>
<td>Yes: 23.8, No: 76.2</td>
</tr>
</tbody>
</table>

Item 12 of the questionnaire reflected in Figure 6.38 reveals that 100,0% of the respondents from Musina subdistrict, 78,6% from Makhado subdistrict and 76,2% from Thulamela subdistrict indicated that they were not turned away at the primary health-care facilities when they needed health-care, but 21,4% and 23,8% of the respondents from Makhado and Thulamela subdistricts respectively confirmed that they were turned away from the primary health-care facilities when they needed health-care. The purpose of all health-care facilities in the entire country is to provide unconditional services to all people and no patient should be refused any services or turned away by any clinic on the basis of any reason whatsoever, including the patient’s inability to pay the health-care levies. It is mandatory upon health-care institutions to provide services regardless of the patient’s socio-economic status. They are prohibited from practising any form of discrimination, the practice of which the present government condemns with all the contempt it deserves. Refusal by any health-care worker to assist a patient who is in dire need of medical help is regarded as a serious misconduct and decisive actions might, whenever necessary, be taken against such health-care professional found practising this type of behaviour.
**Figure 6.39:** Distribution of responses indicating the readily availability of drugs prescribed for the patients’ illnesses after diagnosis are made

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>53.3</td>
<td>46.7</td>
<td>0</td>
</tr>
<tr>
<td>Makhado</td>
<td>60</td>
<td>37.1</td>
<td>2.9</td>
</tr>
<tr>
<td>Thulamela</td>
<td>58.7</td>
<td>39.7</td>
<td>1.6</td>
</tr>
</tbody>
</table>

With regard to the easy availability of the drugs prescribed for the patients’ illnesses after diagnosis as per Item 13 in the questionnaire, the data in Figure 6.39 reflected that 53.3%, 60.0%, and 58.7% of the patients responded in the affirmative, thereby meaning that drugs prescribed for them for their illnesses after diagnosis were readily available, but 46.7%, 37.1%, and 39.7% from Musina, Makhado and Thulamela subdistricts respectively mentioned that drugs prescribed for them for their illnesses after diagnosis were not readily available. The shortage of drugs at the clinics might be attributable to the fact that the pharmaceutical depot, in this instance, referring to the one based at Seshego in Limpopo Province, South Africa, sometimes experienced unexpected challenges with suppliers of drugs who frequently failed to supply drugs to the hospitals and clinics as stipulated in their respective tenders that had been awarded to them. Some of the drugs had to be imported from companies in foreign countries. It is the sole responsibility of the government to ensure that drugs are readily available to the patients whenever they need them as this is an essential service that should be provided to the patients without fail and government has committed itself to providing adequate and satisfactory services in terms of the provisions of the Health Act of 2003 (61 of 2003) and the
RDP policy adopted in 1994. 2.9% and 1.6% of the respondents at Makhado and Thulamela subdistricts respectively did not respond to this Item in the questionnaire for reasons unknown. The question may have been too difficult or beyond their comprehension.

**Figure 6.40:** Distribution of responses reflecting the readily availability of hospital services within the reach of the patients

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes (%)</th>
<th>No (%)</th>
<th>No Response (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>73.3</td>
<td>26.7</td>
<td>0</td>
</tr>
<tr>
<td>Makhado</td>
<td>51.4</td>
<td>47.1</td>
<td>1.5</td>
</tr>
<tr>
<td>Thulamela</td>
<td>51.4</td>
<td>30.2</td>
<td>0</td>
</tr>
</tbody>
</table>

In response to Item 14 on the questionnaire reflected in Figure 6.40 which required the respondents to indicate the availability of hospital services in their respective subdistricts, 73.3% of the respondents from Musina, 51.4% from Makhado and 51.4% from Thulamela pointed out that there were hospital services available within the reach of the patients in those subdistricts and the responses were supported by the fact that there are three hospitals within Makhado subdistrict, namely, Elim hospital, Louis Trichardt Memorial hospital and Siloam hospital. Within the health jurisdiction of Musina subdistrict there is only one hospital, namely, Messina hospital and within Thulamela subdistrict there are four hospitals, namely, Donald Fraser hospital, Hayani Specialized hospital, Malamulela hospital and Tshilidzini Provincial or Regional hospital. The latter hospital also serves as a referral hospital within Vhembe Health
District. 26.7%, 47.1% and 30.2% of the respondents from Musina, Makhado and Thulamela subdistricts respectively indicated that there were no hospital services in their areas within reach of the patients. It would appear that such respondents did not understand the question or were not aware that hospital services were provided in each subdistrict. Despite the fact that it is not part of this study, it is worth mentioning that the only subdistrict without the provision of hospital services is Mutale subdistrict since Vhembe Health District comprises of four subdistricts and Mutale is one of them. 1.5% of the respondents from Makhado subdistrict did not respond.

**Figure 6.41:** Distribution of responses reflecting that female health-care personnel provide better services at the clinics than male health-care personnel

<table>
<thead>
<tr>
<th></th>
<th>Musina</th>
<th>Makhado</th>
<th>Thulamela</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>26.7%</td>
<td>65.7%</td>
<td>68.3%</td>
</tr>
<tr>
<td>No</td>
<td>73.3%</td>
<td>31.4%</td>
<td>28.6%</td>
</tr>
<tr>
<td>No Response</td>
<td>0%</td>
<td>2.9%</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

Item 15 on the questionnaire required the respondents in their respective subdistricts to indicate individually whether the female health-care personnel surpassed the male health-care personnel in the provision of health-care services at their clinics. The responses reflected in Figure 6.41 showed that 26.7%, 65.7% and 68.3% of the respondents from Musina, Makhado and Thulamela subdistricts respectively were of the opinion that female health-care personnel
provided better services at the clinics than male health-care personnel while 73.3%, 31.4% and 28.6% of the respondents from the same subdistricts respectively mentioned that female health-care personnel did not provide better services at their clinics than male health-care personnel. 2.9% and 3.2% of the respondents from Makhado and Thulamela subdistricts respectively did not respond to this question.

**Figure 6.42:** Distribution of responses reflecting that the patients who are pensioners pay health-care levies for services rendered to them by the clinics

![Figure 6.42](image)

The responses advanced to Item 16 reflected in Figure 6.42 above showed that 100.0% of the respondents from Musina, 81.2% from Makhado and 92.1% from Thulamela confirmed in their responses that they did not pay any health-care levies for the services rendered to them by their clinics since they were entitled to free health-care services at all the health-care facilities, including the Community Health-care Centres (CHC) and the hospitals, but perhaps due to lack of knowledge and understanding, 18.8% and 7.9% of the patients from Makhado and Thulamela subdistricts respectively mentioned that they paid health-care levies whenever they consulted at the clinics which is not the practice at all public institutions. Such pensioners have the right to lodge complaints with the clinic authorities or hospital authorities if they are requested by the public servants to pay for such services. Aged people, children under the age...
of 5 years and pregnant mothers are exempted from paying any hospital or clinic levy for the services received since it is contrary to the provisions of the government policies, for instance, the National Health Act of 2003 and the RDP policy of 1994. 1.4% of the respondents from Makhado subdistrict did not respond to this item.

**Figure 6.43:** Distribution of responses reflecting that whenever drugs are out of stock patients are told to come back the following day to collect drugs

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>66.7</td>
<td>33.3</td>
</tr>
<tr>
<td>Makhado</td>
<td>77.1</td>
<td>22.9</td>
</tr>
<tr>
<td>Thulamela</td>
<td>64.5</td>
<td>35.5</td>
</tr>
</tbody>
</table>

The data emanating from Item 17 reflected in Figure 6.43 above, showed that 66.7%, 77.1% and 64.5% of the patients from Musina, Makhado and Thulamela subdistricts respectively confirmed that whenever the prescribed drugs were out of stock, patients were told to come back the following day to collect the drugs, but 33.3%, 22.9% and 35.5% mentioned that whenever the prescribed drugs were out of stock, they were not told to come back the following day to fetch their drugs. Since some of the drugs might get depleted at the clinics due to the fact that even if orders had been placed with the hospital or directly with the pharmaceutical depot at Seshego, it was possible that patients could be advised to come back to fetch them any day if the pharmacist was quite certain that there was going to be a delivery of such drugs within a short space of time.

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**Figure 6.44:** Distribution of responses reflecting that whenever drugs are out of stock at the clinics, patients are advised to buy same from the local private pharmacy or chemist

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes</th>
<th>No</th>
<th>No Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>40</td>
<td>60</td>
<td>0</td>
</tr>
<tr>
<td>Makhado</td>
<td>48.6</td>
<td>50</td>
<td>1.4</td>
</tr>
<tr>
<td>Thulamela</td>
<td>54</td>
<td>42.9</td>
<td>3.2</td>
</tr>
</tbody>
</table>

In response to Item 18 which required the respondents to indicate whether patients were advised to go to the local private pharmacy or chemist whenever drugs were out of stock at the clinics, 40,0% from Musina subdistrict, 48,6% from Makhado subdistrict and 54,0% from Thulamela subdistrict responded in the affirmative, confirming that whenever drugs were out of stock at the clinics, they were advised to buy same from the local private pharmacy or chemist while 60,0%, 50,0% and 42,9% of the respondents from the same subdistricts respectively indicated that they were not advised to go to the local private pharmacy or chemist whenever drugs were out of stock at the clinics. Health-care services provided by government institutions are more often than not financially affordable to patients especially the unemployed compared to those provided by the private sector. The pharmacist should rather advise the patient to come and fetch the drugs within a reasonable space of time if he or she anticipates an immediate delivery or supply of drugs by the hospital or pharmaceutical depot. 1,4% and 3,2%
of the respondents from Makhado and Thulamela subdistricts respectively did not respond to Item 18 of the questionnaire.

**Figure 6.45:** Distribution of responses reflecting that the patients enjoy the full support of the health-care personnel at their clinics

<table>
<thead>
<tr>
<th>Municipality</th>
<th>Yes (%)</th>
<th>No (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Musina</td>
<td>93.3</td>
<td>6.7</td>
</tr>
<tr>
<td>Makhado</td>
<td>90</td>
<td>10</td>
</tr>
<tr>
<td>Thulamela</td>
<td>91.5</td>
<td>8.5</td>
</tr>
</tbody>
</table>

As reflected in Figure 6.45, Item 19 of the questionnaire required the respondents to indicate whether they enjoyed the full support of the health-care personnel at their respective clinics and in response to the question, 93.3%, 90.0% and 91.5% of the respondents from Musina, Makhado and Thulamela subdistricts respectively confirmed that they enjoyed the full support of the health-care personnel at their clinics while 6.7, 10.0% and 8.5% of the respondents from Musina, Makhado and Thulamela subdistricts respectively indicated that they did not enjoy the full support of the health-care personnel at their respective clinics. Despite the fact that the latter group of respondents were in the minority, their expression of dissatisfaction should receive urgent attention of the provincial government, if it is a reflection of precisely what is prevailing in some of the Primary Health-Care (clinics) facilities.
Figure 6.46: Distribution of responses reflecting that the public servants of Vhembe Health District of Limpopo Province in South Africa lack the capacities and skills to implement the transformation process in order to promote and facilitate the needed health-care services.

The responses given to Item 1 of the questionnaire are reflected in the graph labelled Figure 6.46 in which the respondents, the public servants only, were required to indicate whether or not they had the capacities and skills to implement the transformation process with a view to promoting and facilitating the quality of service delivery. 31.1% were of the opinion that they had the capacities and skills to implement the transformation process in order to promote and facilitate the quality of service delivery while 64.1% of the respondents believed that the public servants of Vhembe Health District lacked the capacities and skills to implement the transformation process in order to promote and facilitate the quality of service delivery. The
64.1% who were in the majority argued that there was a dire need for intervention by the government. They believed this intervention was indispensable and that a development and training programme needed to be developed so that the public servants employed by the government would be provided with the relevant assistance in order to equip them with the necessary capacities, skills and knowledge in order to expedite the delivery of services especially in the most-affected rural communities of South Africa. 4.8% of the total respondents in Vhembe Health District did not respond to Item 1 of the questionnaire. The relevant objective and hypothesis for this item are 1.3.2.1 and 1.5.1 respectively.

**TABLE 6.1: DESCRIPTIVE DATA AND TEST STATISTICS**

<table>
<thead>
<tr>
<th>Description</th>
<th>N</th>
<th>(X^2) ((a))</th>
<th>df</th>
<th>Asymp .Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>The public servants of Vhembe Health District of Limpopo Province in South Africa lack the capacities and skills to implement the transformation process in order to promote and facilitate the needed health-care services</td>
<td>145</td>
<td>76.855 ((a))</td>
<td>2</td>
<td>.000</td>
</tr>
</tbody>
</table>

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

Table 6.1 generated from the application of the chi-square test a value of 76.855\((a)\) in which study the sample of 145 respondents participated. It shows the calculated value of 76.855\((a)\) with 2 degree of freedom (df), whereas the level of significance is .000. The calculated value of 76.855\((a)\) shows that it is very significant. The survey finding shows in terms of the statistical analysis that the null hypothesis was rejected in favour of the alternative hypothesis because 76.855\(a\) is greater than the critical value of 5.991. The relevant objective and hypothesis for this item are 1.3.2.1 and 1.5.1 respectively.
Figure 6.47: Distribution of responses reflecting that the transformation process benefits only the public servants

The responses advanced to Item 3 as reflected in the graph recorded as Figure 6.47 above, revealed that 13.1% of the respondents answered in the affirmative, indicating that the public servants benefited from the transformation process. 84.8% believed that the public servants did not benefit from the transformation process. The objective of the transformation process was to address the backlog of service delivery that was the legacy of apartheid. It was considered to be one of the best available mechanisms in 1994; hence the process was implemented to help all the historically disadvantaged members of the different population groups. 2.1% of the respondents in the district did not express their opinion regarding the matter.
Figure 6.48: Distribution of responses reflecting that the places where the public servants work lack relevant resources to enable them to promote and facilitate the transformation process

In the light of the responses elicited by Item 4 on the questionnaire, and reflected on the graph labelled Figure 6.48, which required the respondents to indicate whether the places where they worked lacked the relevant resources to enable them to promote and facilitate the transformation process, 46.2% responded in the affirmative and indicated that the places where they worked indeed lacked the relevant resources to enable them to promote and facilitate the transformation process, but 51.0% mentioned that the places where they worked did not lack the relevant resources to enable them to promote and facilitate the transformation process. In other words, the latter group expressed its opinions by simply mentioning that the resources were available that enabled them to expedite the implementation of the transformation process which had a bearing on their service delivery. 2.8% of the respondents in the district did not respond to Item 4 of the questionnaire.
Figure 6.49: Distribution of responses reflecting that the public servants do not recognize transparency as part of the transformation

According to the response to Item 5 as reflected on the graph reflected Figure 6.49 that required the respondents to indicate whether public servants did not recognize transparency as part of transformation, 31.7% of the respondents answered in the affirmative, indicating that public servants did not recognize transparency as part of transformation, but 65.5% of the same group of respondents mentioned that public servants recognized transparency as part of transformation. 2.8% of the public servants in Vhembe Health District did not express their views on the issue. The majority of the public servants (65.5%) acknowledged that transparency is part of the transformation process.
Figure 6.50: Distribution of responses reflecting that service delivery to the public is the priority of the public servants

The data in the graph above shown in Figure 6.50, elicited by the question in Item 6, indicate that 91.0% of the respondents mentioned that service delivery to the public was a priority to them. 7.6% of the respondents mentioned that service delivery to the public was not a priority to them. 1.4% of the public servants in the district did not express their opinion in this regard.
**Figure 6.51:** Distribution of responses reflecting that there are no pieces of legislation that enforce the implementation of the transformation process in the Republic of South Africa

In response to Item 7 reflected in the graph above as Figure 6.51, 6.2% of the respondents answered in the affirmative, indicating that there were no pieces of legislation that enforced the implementation of transformation, whereas 88.3% of the respondents in the district argued that there were pieces of legislation that enforced the implementation of transformation in this country. Since all the discriminatory laws that prevailed during the apartheid regime were repealed and only those pieces of legislation of which the intentions were to promote, advance and facilitate peace, stability and a high quality of service delivery were promulgated by the present government since democracy was attained, the principles of which were based on democracy, the majority of respondents in Vhembe Health District disagreed with the question which stated that there were no pieces of legislation that enforced the implementation of the transformation process in this country. Some of the transformation-related policies are the Labour Relations Act of 1995 as amended, the RDP of 1994, the Batho-Pele policy of 1997, and the White Paper on Transformation of the Public Service. 5.5% did not respond to this Item.
Figure 6.52: Distribution of responses reflecting that the transformation process promotes and facilitates the high quality of health-care service delivery in the peripheral communities

According to the responses to Item 8 as reflected in the graph above as Figure 6.52, in which it was stated that the transformation process promoted and facilitated the quality of service delivery in the peripheral communities, 89.6% of respondents (public servants) agreed that the transformation process promoted and facilitated the quality of service delivery in the peripheral communities as required in terms of the Health Act of 2003, the Batho-Pele policy of 1997 and the RDP policy of 1994, while 7.6% disagreed that the transformation process promoted and facilitated the quality of service delivery in the peripheral communities. 2.8% of the public servants in the district did not respond to Item 8. The relevant objective and hypothesis for this item are 1.3.2.2 and 1.5.2 respectively.
Table 6.2 reflected above on the basis of scores in Figure 6.52 indicates the test statistics generated as the result of the application of the chi-square test and in which study the sample of 145 respondents participated and it shows the calculated value of $207,490^a$ with 2 degree of freedom (df) which is greater than 5.991 whereas the level of significance is .000. The calculated value of $207,490^a$ shows that it is very significant. The survey finding shows that the null hypothesis was rejected in favour of the alternative hypothesis because $207,490^a$ is greater than the critical value of 5.991. The relevant objective and hypothesis for this item are 1.3.2.2 and 1.5.2 respectively.

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

<table>
<thead>
<tr>
<th>The transformation process promotes and facilitates the high quality of service delivery in the peripheral communities</th>
<th>N</th>
<th>$\chi^2_{(a)}$</th>
<th>df</th>
<th>Asymp.Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>145</td>
<td>207,490$^a$</td>
<td>2</td>
<td>.000</td>
<td></td>
</tr>
</tbody>
</table>
Figure 6.53: Distribution of responses reflecting that members of the public servants are not altogether knowledgeable about the process of transformation and its effects on the quality of health-care service delivery, hence massive service delivery problems

![Graph showing distribution of responses](image)

Item 9 of the questionnaire reflected in the graph above as Figure 6.53 required the respondents to agree or not that the public servants were not altogether knowledgeable about the process of transformation and its impact on service delivery. In response to the Item 9, 65.5% of the total number of respondents (public servants) in the district agreed that the Vhembe Health District public servants were not altogether knowledgeable about the process of transformation and its impact on service delivery whereas 31.0% expressed their disagreement that the public servants were not altogether knowledgeable about the process of transformation and its impact on service delivery, that is, they regarded the public servants as now knowledgeable since 1994 about the process of transformation and its impact on service delivery. 3.5% of the respondents did not express their views on Item 9. The relevant objective and hypothesis for this item are 1.3.2.4 and 1.5.4 respectively.
The public servants are not altogether knowledgeable about the process of transformation and its effect on the high quality of health-care service delivery, hence massive service delivery problems.

Table 6.3 was generated on the basis of scores in Figure 6.53 basically from the application of the chi-square test with the sample of 145 respondents showing the calculated value of 84,138\(^a\) with 2 degrees of freedom (df) whereas the level of significance is .000. The calculated value of 84,138\(^a\) shows that it is very significant. The survey finding shows that the null hypothesis was rejected in favour of the alternative hypothesis because 84,138\(^a\) is greater than the critical value of 5.991. The relevant objective and hypothesis for this item are 1.3.2.4 and 1.5.4 respectively.

(a) 0 cells (.0%) have expected frequencies less than 5.
In response to Item 10 reflected in the graph as Figure 6.54 above, which required the public servants to indicate whether the current government disregarded the implementation of the transformation process and its impact on the quality of service delivery, 20.7% of the respondents responded in the affirmative, meaning that they believed that the current government disregarded the implementation of the transformation process and its impact on the quality of service delivery while on the other hand 73.8% were of the opinion that the current government did not disregard the implementation of the transformation process and its impact on the quality of service delivery. In other words, the current government did not disregard the implementation of the transformation process as a priority, even the transformation of the public service. 5.5% of the respondents did not express their views in respect of Item 10 on the questionnaire.
According to Item 11 reflected in the graph above as Figure 6.55 which required respondents to indicate whether some public servants lacked the necessary skills and knowledge to render adequate services, 51.7% of the respondents replied in the affirmative, indicating that some public servants lacked the necessary skills and knowledge to render adequate services. 44.2% were of the opinion that some public servants did not lack the necessary skills and knowledge to render adequate services. That means that such public servants had the necessary skills and knowledge to provide adequate services to the benefit of members of the communities. 4.1% of the respondents reserved their comments about the situation as it prevailed in Vhembe Health District.
Figure 6.56: Distribution of responses reflecting that all health-related basic needs are easily made available to the very poor people residing in Vhembe Health District

The data elicited as a result of Item 12 reflected in the graph as Figure 6.56 above, in which the respondents were expected to indicate whether they agreed that all health-related basic needs were easily made available to the very poor people residing in Vhembe Health District, 64.1% of the public servants responded in the affirmative, indicating that all health-related basic needs were easily made available to the very poor people residing in Vhembe Health District. 33.1% of the public servants in the district disagreed that health-related basic needs were easily made available to the very poor people residing in the district. 2.8% of the respondents did not express their opinion on this item.
**Figure 6.57:** Distribution of responses reflecting that public servants render services in a manner that is completely unacceptable to the public

It response to Item 13 reflected in the graph above labelled Figure 6.57, which required the respondents to indicate whether they agreed with the statement that public servants rendered services in a manner that was completely unacceptable to the public, 7.6% of the respondents confirmed that public servants rendered services in a manner that was completely unacceptable to the public in Vhembe Health District while 92.4% disagreed that public servants rendered services in a manner that was completely unacceptable to the public in Vhembe Health District. It would always be expected of them to comply with in terms of government legislation such as the Public Service Act of 1994, Public Regulations of 2001, Staff Code and Labour Relations Act of 1995 as amended which regulate their behaviour patterns in the manner that was completely acceptable to the public of this country.
**Figure 6.58:** Distribution of responses reflecting that the government is keen to ensure that the transformation process takes place in terms of the legislation, but some public servants drag their feet

In terms of the data collected in Item 14 reflected in the graph above as Figure 6.58, the respondents were required to indicate whether they agreed that the government was keen to ensure that the transformation process took place in terms of the legislation, but that some public servants dragged their feet. 23.5% of the total respondents in the district agreed that the government was keen to ensure that the transformation process took place in terms of the legislation, but that some public servants dragged their feet, while 72.4% disagreed that the government was keen to ensure that the transformation process took place in terms of the legislation, but that some public servants dragged their feet. 4.1% of the respondents reserved their comments about Item 14.
Figure 6.59: Distribution of responses indicating that some public servants display negative attitudes towards the transformation process and service delivery

In the light of the responses advanced to Item 15 reflected in the graph above as Figure 6.59 in which the respondents were expected to indicate whether they agreed that some public servants displayed negative attitudes towards the transformation process and service delivery, 28.3% of the respondents answered in the affirmative indicating that some public servants displayed negative attitudes towards the transformation process and service delivery. 67.6% answered in the negative, that some public servants did not display negative attitudes towards the transformation process and service delivery, meaning that they displayed positive attitudes towards the transformation process and service delivery. 4.1% of the respondents did not respond to this item.
Figure 6.60: Distribution of responses reflecting that the public servants who do not promote and facilitate the transformation process should be disciplined for their unlawful practices

According to the data elicited in the responses to Item 16 reflected in the graph above as Figure 6.60 which required the respondents to state whether they believed the public servants who did not promote and facilitate the transformation process should be disciplined for their unlawful practices, 48.3% of the respondents answered in the affirmative indicating that public servants who did not promote and facilitate the transformation process should be disciplined for their unlawful practices while 46.9% of the respondents responded in the negative, indicating that public servants who did not promote and facilitate the transformation process should not be disciplined for their unlawful practices. They might not be doing that deliberately and should be given ample time and opportunity to attend workshops and induction courses dealing specifically with the values and importance of the transformation process because some of the public servants were not fully aware of what was expected of them with regard to the implementation of the process and also of how it should be implemented, especially those working in the rural areas where sometimes copies of the legislation and relevant policies were not readily available due to the poor introduction of technological equipment such as
computers following the unavailability of electricity. 4.8% of the respondents did not express their views on the matter.

**Figure 6.61:** Distribution of responses reflecting that the transformation is a process that needs to be frequently monitored and evaluated by the government

![Bar Chart](image)

In the light of the responses to Item 17 reflected in the graph as Figure 6.61 above in response to the question based upon whether the transformation process was a process which needed to be monitored and evaluated frequently by the government, 21.4% confirmed that the transformation process needed to be monitored and evaluated by the government on a monthly basis. 53.8% of the respondents expressed a separate view that the transformation process was a process which needed to be monitored and evaluated by the government on a quarterly basis. Yet another group of 21.4% indicated that the transformation process was a process which needed to be monitored and evaluated by the government on a yearly base. 3.4% did not respond. Although there were different opinions regarding when monitoring and evaluation should be conducted, there was common consensus in respect of the need for the performance of the public servants to be assessed to determine the shortcomings and challenges they might encounter in the execution of their duties from time to time. It is therefore the responsibility of
the Department of Health and Social Development in Limpopo Province to ensure that a schedule is drawn indicating to each public servant when he or she is due for evaluation. Both monitoring and evaluation are important processes to both the supervisor and supervisee because they enable the former to know where the latter is failing to perform in terms of the Performance Instrument (PI) or prescribed duties and they enable the supervisee to request the supervisor to send him/her for further development and training where certain gaps in terms of understanding the process of transformation occur.

**Figure 6.62:** Distribution of responses reflecting that the transformation process needs to be regulated with the set timeframes to ensure that targets are met as scheduled

![Bar chart showing responses](image)

In terms of the data collected in Item 18 and reflected in the graph above as Figure 6.62 which indicated that the transformation process needed to be regulated within the set timeframes to ensure that targets were met as scheduled, 94.5% of the respondents responded in the affirmative indicating that the transformation process needed to be regulated within the set timeframes to ensure that targets were met as scheduled, while 5.5% of the respondents
responded in the negative, indicating that the transformation process did not need to be regulated within the set timeframes to ensure that targets were met as scheduled.

**Figure 6.63:** Distribution of responses reflecting that the attitude of some frontline public servants, especially medical doctors and nursing personnel towards patients is unpleasant

According to Item 19 reflected in the graph above as Figure 6.63, it is required of the respondents to indicate whether the attitudes of some frontline public servants, especially medical doctors and nursing personnel, were unpleasant towards patients; and in response 26.9% of the respondents answered in the affirmative, confirming that the attitudes of some frontline public servants, especially medical doctors and nursing personnel, were unpleasant towards patients, while 68.3% of the respondents indicated that the attitudes of some frontline public servants, especially medical doctors and nursing personnel, were not unpleasant towards patients. 4.8% of the public servants reserved their views on the issue.
Figure 6.64: Distribution of responses reflecting that public servants treat patients with courtesy and consideration

The responses advanced to Item 21 as reflected in the graph above as Figure 6.64 in which the respondents indicated whether the public servants treated patients with courtesy and consideration, 95.2% of the respondents answered in the affirmative, indicating that the public servants treated patients with courtesy and consideration. 4.1% of the respondents indicated that the public servants did not treat patients with courtesy and consideration while 0.7% of the respondents did not respond.
**Figure 6.65:** Distribution of responses reflecting that public servants provide full and better information to the patients about the public service they are entitled to receive

According to Item 22 reflected in the graph above as Figure 6.65 which dealt with whether public servants provided full and better information to the patients about the public service they were entitled to receive, 93.8% of the respondents answered in the affirmative that public servants provided full and better information to the patients about the public service they were entitled to receive and 5.5% indicated that public servants did not provide full and better information to the patients about the public service they were entitled to receive. 0.7% of the respondents did not respond to the question.
Figure 6.66: Distribution of responses reflecting that the public servants offer apologies to the patients, and full, speedy explanations and effective remedies whenever complaints are lodged.

In terms of Item 23 reflected in the graph above as Figure 6.66 in which the respondents were required to indicate whether the public servants offered apologies to the patients, full and speedy explanations and effective remedies whenever complaints were lodged, 96.6% indicated that the public servants offered apologies to the patients, full and speedy explanations and effective remedies whenever complaints were lodged. 2.7% of the respondents responded that the public servants did not offer apologies to the patients, full and speedy explanations and effective remedies whenever complaints were lodged. 0.7% of the respondents did not express their views on the issue.
Figure 6.67: Distribution of responses reflecting the extent within which the government complies with the norm of the range of 5 km reach

In response to the question in Item 1 reflected in the graph above as Figure 6.67, it is revealed that 68.2% of the respondents within the district lived less than the range of 5 kilometres from their clinics whereas 11.5% of the respondents indicated that their nearest clinics were more than 5 kilometres from the places where they lived. This is a clear indication that this is a challenge of great concern to the present government since it warrants that additional clinics need to be provided. The government’s target in terms of the provision of health-care facilities is that clinics had to be within the range of 5 kilometres of all the patients’ dwelling places so that they did not have to walk a distance of further than the norm of 5 kilometres. It is the declared responsibility of the government to ensure that equal and better health-care services are made available to all South African citizens regardless of colour, religion and creed. 19.6% of the respondents indicated that their clinics that served them were 5 kilometres away from their homes while 0.7% of the respondents did not express their personal opinion as far as the
distance between their homes and the nearest clinic was concerned. The relevant objective and hypothesis for this item are 1.3.2.3 and 1.5.3 respectively.

TABLE 6.4 DESCRIPTIVE DATA AND TEST STATISTICS

<table>
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<tr>
<th>Distribution of responses reflecting the extent within which the government complies with the norm of the range of 5 km reach</th>
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<th>df</th>
<th>Asymp.Sig.</th>
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<td>84.245*</td>
<td>2</td>
<td>.000</td>
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</tbody>
</table>

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

Table 6.4 generated from the application of the chi-square test with the sample of 148 respondents, on the basis of scores in Figure 6.67, shows the calculated value of 84,245* with 2 degrees of freedom (df) whereas the level of significance is .000. The calculated value of 84,245* shows that it is very significant. The survey finding shows that the null hypothesis was rejected in favour of the alternative hypothesis because the calculated value 84,245* is greater than the tabled value of 5,991. The relevant objective and hypothesis for this item are 1.3.2.3 and 1.5.3 respectively.
**Figure 6.68:** Distribution of responses reflecting the quality of health-care services provided by the health-care personnel

With regard to the data derived from Item 2 and reflected in the graph above as Figure 6.68, it was revealed that 89,9% of the respondents in the district believed that the quality of services provided by the health-care personnel was good while 10,1% argued that the services rendered by the health-care personnel were poor. Although the latter group was in the minority, it is vital to note that an essential service like health-care needs to be provided to all the people of South Africa residing in the urban and rural areas without discrimination. The present legislation and policies such as the White Paper on Transforming of Public Service of and Batho-Pele policy of 1997, should enable the public servants to provide services of a high quality and standard to members of the communities. All the health-care workers who provide services of poor quality should have to account for such poor services, hence the government has recently, since the general elections conducted in this country in April 2009, established a new Department of Monitoring and Evaluation in order to check that the standards and criteria in terms of service delivery are complied with, without any compromise, for the benefit of all citizens of this country and especially the categories of populations that were discriminated against and
historically disadvantaged during the previous era in terms of, inter alia, the provision of health-care services.

**Figure 6.69:** Distribution of responses reflecting that the members of the community in Vhembe Health District of Limpopo Province in South Africa lack the capacities and skills to implement the transformation process in order to promote and facilitate the needed health-care services

The data from the responses to Item 3 reflected in the graph above as Figure 6.69 showed that 43.2% of the respondents agreed that public servants lacked capacities and skills when it came to the implementation of the transformation process in order to promote and facilitate the quality of service delivery. On the other hand, 56.8% of the respondents disagreed that public servants lacked capacities and skills to implement the transformation process in order to promote and facilitate service delivery. The majority of the respondents indicated that public servants were well equipped with capacities and skills to enable them to implement the process for the benefit of the communities. The challenge of inequality in terms of the provision of service delivery has been and is still being addressed since all the people are entitled to health-care services in terms of the Health Act of 2003 (61 of 2003) that makes provision for equal
and better services for all the people in South Africa. Public servants who lack capacities, knowledge and skills with regard to the implementation of the transformation process need to be developed and trained in order to equip them with the necessary information pertaining to their skills and knowledge. The relevant objective and hypothesis for this item are 1.3.2.1 and 1.5.1 respectively.

**TABLE 6.5: DESCRIPTIVE DATA AND TEST STATISTICS**

<table>
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<tr>
<th>DESCRIPTIVE DATA TEST STATISTICS</th>
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</table>

The members of the community of Vhembe Health District of Limpopo Province in South Africa lack the capacities and skills to implement the transformation process in order to promote and facilitate the needed health-care.

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

Table 6.5 reflected above on the basis of scores in Figure 6.69 indicates the test statistics generated from the application of the chi-square test in which study the sample of 148 respondents participated in the survey study and it shows that the calculated value of $90,919^a$ with 1 degree of freedom (df) was more than the critical value of $3,841^a$, whereas the level of significance is ,000. The calculated value of $90,919^a$ shows that it is very significant. The survey finding shows that the null hypothesis was rejected in favour of the alternative hypothesis because the calculated value was more than the critical value of 3,841. The relevant objective and hypothesis for this item are 1.3.2.1 and 1.5.1 respectively.
Figure 6.70: Distribution of responses reflecting the attitudes of the health-care personnel towards the patients at their clinics

The data observed in Item 4 reflected in the graph above as Figure 6.70 showed that 9.5% of the respondents within the district expressed their dissatisfaction with the attitudes displayed by health-care personnel towards patients in the Primary Health-Care facilities, and 89.1% indicated that they were satisfied with the attitudes of health-care personnel towards the patients. The dissatisfaction observed and experienced by those patients could not be denied since some of the health-care personnel had not yet transformed their mind-sets since the changes were introduced with effect from 1994 and it was still the responsibility of the current democratic government to ensure that such public servants adopted a positive attitude towards the patients who deserved to be treated with courtesy, dignity and respect and had a right to provision of the best health-care services regardless of colour, religion and creed. 1.4% of the respondents in the district did not express their personal views about the personnel’s attitudes towards the patients at their clinics within Vhembe Health District.
In the light of the data elicited by Item 5 reflected in the graph above as Figure 6.71, it was revealed that 89.2% of the respondents (members of the communities) in Vhembe Health District disagreed that the transformation process promoted and facilitated the quality of service delivery in the peripheral community. This observation might be so because the process was not clearly visible since some members of the communities had not yet experienced any socio-economic changes in their lifestyles since the attainment of democracy in 1994. To them life was still a nightmare since poverty, unemployment and lack of adequate shelter were still the order of the day. 10.8% of the respondents agreed that the transformation process promoted and facilitated the quality of service delivery in the peripheral communities as required in terms of the Health Act of 2003 (61 of 2003), the Batho-Pele policy of 1997 and the RDP policy of 1994. The relevant objective and hypothesis for this item are 1.3.2.2 and 1.5.2 respectively.
TABLE 6.6 DESCRIPTIVE DATA AND TEST STATISTICS

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<th>The transformation process promotes and facilitates the quality of service delivery in the peripheral communities</th>
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<th>df</th>
<th>Asymp.Sig.</th>
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<td>2,703a</td>
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<td>.000</td>
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0 cells (.0%) have expected frequencies less than 5.

Table 6.6 generated from the application of the chi-square test with the sample of 148 respondents, on the basis of the scores in Figure 6.71, shows the calculated value of 2,703^a with 1 degree of freedom (df) whereas the level of significance is .000. The calculated value of 2,703^a shows that it is not very significant. The survey finding shows that the null hypothesis was retained in disfavour of the alternative hypothesis because 2,703^a was less than the critical value of 3.841. The relevant objective and hypothesis for this item are 1.3.2.2 and 1.5.2 respectively.
In terms of the responses to Item 6 reflected in the graph as Figure 6.72 above, 95.9% of the respondents confirmed that public servants displayed respect towards the patients while 4.1% of the respondents in the district indicated that the health-care personnel did not show respect towards patients. Such attitudes are of great concern since patients, like all other people, have rights in terms of the provisions of the Constitution of 1996 and the Bill of Rights, including the RDP policy of 1994. Such public servants need adequate orientation about the provisions of the Batho-Pele policy of 1997 and other transformation-related legislation and policies of the present government because no patient should be subjected to any form of ill-treatment by health-care professionals and workers under any circumstances. Their rights need to be honoured and observed in terms of the legal mandates of the present democratic government.
**Figure 6.73:** Distribution of responses indicating that the primary health-care personnel meet the expectations of the patients whenever they visit their clinics

In response to Item 7 reflected in the graph in Figure 6.73 above, it is revealed that 94.6% of the respondents confirmed that the health-care personnel in Vhembe Health District in Limpopo Province met the expectations of the patients when the patients visited their respective clinics. 5.4% of the respondents felt that the health-care personnel in the district did not meet the expectations of the patients when members of the communities visited their respective clinics.
Figure 6.74: Distribution of responses reflecting the possibility of accessibility to the primary health-care facilities by the patients

According to Item 8 reflected in the graph above as Figure 6.74, 90.5% of the respondents in the district expressed satisfaction that they found it possible to have easy access to the primary health-care facilities; whereas 9.5% of the respondents indicated that it was not possible to have easy access to the primary health-care facilities in this district.
**Figure 6.75:** Distribution of responses reflecting that members of the communities are not altogether knowledgeable about the process of transformation and its effects on the quality of health-care service delivery, hence massive service delivery problems.

In terms of the responses to Item 9 reflected in the graph above as Figure 6.75, it is revealed that 52.7% of the respondents (members of the communities) in the district agreed that members of the communities were not altogether knowledgeable about the process of transformation and its effects on the quality of service delivery and if such a situation prevailed, it implied that workshops needed to be held to create awareness among members of the communities about the importance of the process and the positive impact it would have on the quality of service delivery in the rural communities. 43.2% of the respondents disagreed with the statement that members of the communities were not altogether knowledgeable about the process of transformation and its effect on the quality of service delivery, that is, they maintained that the respondents were knowledgeable about the process of transformation and its effects on the quality of service delivery. 4.1% of the respondents in the district did not express their views on the matter. The relevant objective and hypothesis for this item are 1.3.2.4 and 1.5.4 respectively.
TABLE 6.7 DESCRIPTIVE DATA AND TEST STATISTICS

<table>
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<th>N</th>
<th>$X^2_{(a)}$</th>
<th>df</th>
<th>Asymp.Sig.</th>
</tr>
</thead>
<tbody>
<tr>
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<td>59,081$^a$</td>
<td>2</td>
<td>.000</td>
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</table>

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

Table 6.7 generated from the application of the chi-square test with the sample of 148 respondents, on the basis of the scores in Figure 6.75, shows the calculated value of $59,081^a$ with 2 degrees of freedom (df) whereas the level of significance is .000. The calculated value of $59,081^a$ shows that it is very significant. The survey finding shows that the null hypothesis was rejected in favour of the alternative hypothesis because $59,081^a$ is greater than the critical value of 5.991. The relevant objective and hypothesis for this item are 1.3.2.4 and 1.5.4 respectively.
**Figure 6.76:** Distribution of responses reflecting that the health-care personnel respond promptly to the patients’ requests for support during the emergency calls

According to Item 10 of the questionnaire as reflected in the graph above as Figure 6.76, the respondents were required to indicate whether the health-care personnel responded promptly to patients’ requests for support during emergency calls and in response, 91.1% of the respondents responded in the affirmative, indicating that the health-care personnel responded promptly to the patients’ requests for support during emergency calls, but 6.8% of the respondents in the district indicated that the health-care personnel did not respond promptly to the patients’ requests for support during emergency calls. Since nursing and other health-care professionals signify a call and it is, therefore, always expected of the health-care workers to give patients the prompt attention and courtesy they deserve especially during emergency calls. 1.4% of the respondents in Vhembe Health District did not answer Item 10.
**Figure 6.77:** Distribution of responses reflecting that there are some health-care personnel who shout at the patients when they ask for assistance

The responses to Item 11 of the questionnaire reflected in the graph above as Figure 6.77 indicated that according to 75.0% of the respondents in the district, health-care personnel shouted at the patients when they asked for assistance at the health-care facilities, but 23.0% of the patients indicated that the health-care personnel did not shout at them when they asked for assistance. Health-care workers are not allowed to display such negative behaviour patterns towards the patients and it is always expected of the health-care workers to show respect and politeness towards the patients whenever they visit clinics for consultation. Health-care personnel must always exercise patience since patients have their own rights that must be complied with without any violation. In this instance, all patients need to be made aware that they could lodge complaints with the authorities at the institutions or clinics so that decisive action could be taken against such public servants as soon as possible should they be found to have committed a misconduct in the practice of their profession or in implementing their skills and knowledge. 2.0% of the respondents did not express their views in this regard.
Item 12 reflected in the graph above as Figure 6.78 revealed that 18.2% of the respondents in the district indicated that they were turned away from the primary health-care facilities when they needed health-care, but 81.8% of the respondents indicated that they were not turned away from the primary health-care facilities when they needed health-care. The purpose of all health-care facilities in the entire country is to provide unconditional service to all members of the community and provide all with the service they deserved since no patient could be refused any services by any clinic for any reason, including inability to pay the health-care levy. It is mandatory upon health-care institutions to provide services regardless of the patients’ socio-economic background or by simply practising any form of discrimination, the practice of which the present government condemns with all the contempt it deserves. Refusal by any health-care worker to assist a patient who is in dire need of medical help is regarded in a serious light and decisive actions might, whenever necessary, be taken against a health-care professional found practising this type of behaviour.
Figure 6.79: Distribution of responses indicating the availability of drugs prescribed to the Patients for their illnesses after diagnoses are made

The graph as shown Figure 6.79 above reflects the responses elicited by the question in Item 13 in which the respondents were required to indicate whether drugs prescribed for the patients were easily available for the patients after their illnesses had been diagnosed. 58.8% of the patients responded in the affirmative, thereby indicating that drugs prescribed for their illnesses after diagnoses were readily available, but 39.2% of the respondents indicated that drugs prescribed for them for their illnesses after diagnoses were not readily available at the health-care facilities. The shortage of drugs that was noticed at the clinics might have been attributable to the fact that the pharmaceutical depot, in this instance referring to the one located at Seshego in Limpopo Province, South Africa, sometimes experienced unexpected challenges such as that suppliers of drugs frequently failed to supply drugs to the hospitals and clinics as stipulated in the tenders awarded to them since some of the drugs had to be imported from other companies in other countries abroad. It is the sole responsibility of the government to ensure that drugs are available to the patients whenever they need them and is one of the essential services that should be provided to the patients without fail. The present government committed itself to providing adequate and satisfactory services in terms of the provisions of
the Health Act of 2003 (61 of 2003) and the RDP policy adopted in 1994. 2.0% of the respondents in the district did not express their views on Item 13 for reasons unknown.

**Figure 6.80:** Distribution of responses reflecting the availability of hospital services within the reach of the patients

![Distribution of responses reflecting the availability of hospital services within the reach of the patients](image)

In response to Item 14 in the questionnaire reflected in the graph above as Figure 6.80, which required the respondents to indicate the availability of hospital services in their district, 61.5% of the respondents indicated that there were hospital services available within reach of the patients in the district. The responses are supported by the fact that there are three hospitals within Makhado subdistrict, namely, Elim hospital, Louis Trichardt Memorial hospital and Siloam hospital, one hospital, namely, Messina hospital within the health-care jurisdiction of Musina subdistrict, and four hospitals, namely, Donald Fraser hospital, Hayani Specialised hospital, Malamulela hospital and Tshilidzini Provincial or Regional hospital within Thulamela subdistrict. Tshilidzini hospital also serves as a referral hospital within Vhembe Health District. 37.8% of the respondents indicated that there were no hospital services in their areas within reach of the patients. It would appear that such respondents did not understand the question or were not aware that some hospital services are provided in each of the three subdistricts. It is not part of this study, but worth mentioning that the only subdistrict without
hospital services is Mutale subdistrict since Vhembe Health District comprises of four subdistricts and Mutale is one of them. 0.7% of the respondents in the district reserved their views about the matter.

**Figure 6.81:** Distribution of responses reflecting that female health-care personnel provide better services at the clinics than male health-care personnel

According to Item 15 on the questionnaire and reflected in the graph above as Figure 6.81, the respondents in the district were expected to indicate whether female health-care personnel provided better services at the clinics than male health-care personnel. The responses showed that 62.8% of the respondents agreed that female health-care personnel provided better services at the clinics than male health-care personnel while 34.5% of the respondents did not agree with the statement that female health-care personnel provided better services at their clinics than male health-care personnel. 2.7% of the respondents in Vhembe Health District did not respond to this question.
The data reflected in Item 16 in the graph above as Figure 6.82 showed that 25,0% of the respondents in the district confirmed that they paid health-care levies for the services rendered to them at their clinics although aged patients were entitled to receive free health-care services at all the health-care facilities, including the Community Health-care Centres (CHC) and the hospitals. Such patients were not aware of this benefit due to lack of knowledge and understanding that they were not supposed to pay clinic or hospital levies in terms of the provisions of the Health Act of 2003 (61 of 2003). Such pensioners have the right to lodge complaints with the clinic authorities or hospital authorities if they are requested by the frontline public servants to pay for such services. Aged people as well as children under the age of 5 years and pregnant mothers are exempted from paying any hospital or clinic levies for the services received since it is contrary to the provisions of government policies, for instance, the Health Act of 2003 and the RDP policy of 1994. 74,3% of the patients indicated that they did not pay any health-care levies when they consulted at the clinics which is the correct practice at all public institutions. 0,7% of the respondents did not respond to this question.
Figure 6.83: Distribution of responses reflecting that whenever drugs are out of stock patients are told to come back the following day to collect drugs

In response to Item 17 reflected in the graph as Figure 6.83 above, 70.3% of the respondents indicated that whenever the prescribed drugs were out of stock, they were told to come back the following day to collect drugs, but 29.1% denied that whenever the prescribed drugs were out of stock, they were told to come back the following day to fetch drugs. Since some of the drugs might be depleted at the clinics due to the fact that even if orders had been placed with the hospital or pharmaceutical depot at Seshego, it was possible that patients would be advised to come back to the health-care facilities to fetch them any day if the pharmacist was quite certain that there was going to be a delivery or supply of such drugs within a short space of time. 0.7% of the respondents in the district did not express their views with regard to this item on the questionnaire.
Item 18 reflected in the graph above as Figure 6.84 required the respondents to indicate whether patients were advised to go to the local private pharmacy or chemist whenever drugs were out of stock at the clinics. 50.0% of the respondents in the district answered in the affirmative, confirming that whenever drugs were out of stock at the clinics, patients were advised to buy same from the local private pharmacy or chemist. 48.0% of the respondents in the district argued that they were not advised to go to the local private pharmacy or chemist whenever drugs were out of stock at the clinics. Health-care services provided by government institutions are comparatively affordable to most patients, especially the unemployed, compared to those provided by the private sector. Children under the age of 5 years and expectant mothers have been exempted from paying levies for the services rendered to them by the clinics whereas it is not the case when such patients visit the private sector for medical help. The pharmacist should advise the patient to come and fetch the drugs within a reasonable period of time if he or she anticipates an immediate delivery of drugs. 2.0% of the total
respondents in the district did not express their opinions with reference to Item 18 of the questionnaire.

**Figure 6.85:** Distribution of responses reflecting that the patients enjoy the full support of the health-care personnel at their clinics

The data elicited by Item 19 and reflected in the graph above as Figure 6.85, regarding whether patients enjoyed full support provided by the health-care personnel at their respective clinics, 88.5% of the respondents in the district responded in the affirmative, confirming that they enjoyed full support provided by the health-care personnel at their clinics. 8.8% of the respondents disagreed with the statement that they enjoyed full support provided by the health-care personnel at their respective clinics. Such patients were supposed to receive full support from the clinics. Seemingly, some patients were not aware that if they did not receive satisfactory service from any one of the health-care facilities, be it a clinic, the Community Health Centre or the hospital, they had the right to present their grievances to the higher authorities of the institutions who, in turn, would investigate the nature of their grievances, and if the investigations revealed any anomalies being practised in the provision of services by the health-care workers that they were disadvantaging the patients, there was a likelihood that such
health-care personnel could have decisive action taken against them. It was therefore very important that awareness campaigns be conducted either by the CCLO at the clinics or CLO based at the hospitals to make patients aware of their rights and that they must not allow health workers to violate their rights under any circumstances. 2.7% of the respondents did not respond to the question.

6.3 CONCLUSION

Chapter six was basically about the codification, analysis of research data and interpretation of the findings by translating the statistical data into the everyday language that could easily be understood by all non-statistical people and ordinary members of communities. They are all entitled to know and fully comprehend the effects of the transformation process on the quality of service delivery in particular ever since it was introduced and enforced by the present government in terms of the promulgations by Parliament, Provincial Legislatures and Municipality Councils as far as the national pieces of legislation, provincial legislation and bi-laws respectively are concerned.

6.3.1 The interpretations of the research findings

The following statistical analyses of data reflected in Figures 6,1 to 6,85 were now translated into the language that could clearly and commonly be understood by non-statisticians and members of the public such as the public servants, health-care professionals, for example, the doctors, nurses, physiotherapists, psychologists, social workers and ordinary people in the communities to mention just a few.

The data emanating from the application of the chi-square test in Figure 6,46 as reflected in Table 6.1 revealed that the calculated value of 76,855 with 2 degrees of freedom exceeded the book value or critical value of 5,991. The statistical analysis of data in Figure 6,46 as reflected in Table 6.1 above, in terms of the chi-square test, showed that the null hypothesis which stated that capacities and skills of the public servants were unrelated to the implementation of the transformation process in order to promote and facilitate the needed health-care services were rejected in favour of the alternative hypothesis, which stated that the public servants had the capacities and skills to enable them to implement the transformation process in order to
promote and facilitate the needed health-care. In view of the fact that 76,855 was greater than 5,991 the difference was subsequently significant, hence the alternative hypothesis prevailed over the null hypothesis following an @ of 0,05 that was set and the value of which fell at the 95th percentile of the $\Sigma^2$ distribution with 2 degrees of freedom. A one-tailed test was also used in Figure 6.46 because the directional alternative hypothesis formulated in chapter one of the present study indicated the direction from the value proposed in the null hypothesis. A directional alternative hypothesis in this case stated that the population parameter concerned is greater than (>) the particular value proposed in the null hypothesis (Behr, 1983:191 and Huysamen, 1997: 33 and 165).

On the basis of the data analyzed statistically by the chi-square test as reflected in Figure 6.52 as reflected in Table 6.2 in the present study, it was revealed that the calculated value of 207,490 exceeded the book value or critical value of 5,991. The statistical analysis of data in Figure 6.52 as reflected in Table 6.2 above, in terms of the chi-square test, showed that the null hypothesis that stated that the transformation process was unrelated to the promotion and facilitation of the quality service delivery was rejected in favour of the alternative hypothesis, which stated that the transformation process promoted and facilitated the quality of service delivery in the peripheral community for the promotion and facilitation of the quality of service delivery. In view of the fact that 207,490 was greater than 5,991, the difference was subsequently significant, hence the alternative hypothesis prevailed over the null hypothesis following an @ of 0,05 that was set and the value of which fell at the 95th percentile of the $\Sigma^2$ distribution with 2 degrees of freedom. A one-tailed test was also used in Figure 6.52 because the directional hypothesis formulated in chapter one of the present study indicated the direction from the value proposed in the null hypothesis. In this instance, the directional alternative hypothesis thus states that the population parameter concerned is greater than (>) the particular value proposed in the null hypothesis (Behr, 1983:191; Huysamen, 1997: 33 and 165).

The data resulting from the application of the chi-square test in Figure 6.53 as shown in Table 6.3 revealed that the calculated value of 84,138 exceeded the book value or critical value of 5,991. The statistical analysis of data in Figure 6.53 as reflected in Table 6.3 above showed that the null hypothesis which stated that the knowledge of transformation that public servants had was unrelated to the quality of health-care service delivery was rejected in favour of the alternative hypothesis which stated that the knowledge that public servants had about the
transformation process had an effect on the promotion and facilitation of the needed health-care services. In view of the fact that 84,138\(^a\) was greater than 5,991 the difference was subsequently significant, hence the alternative hypothesis prevailed over the null hypothesis following an @ of 0.05 that was set and the value of which fell at the 95\(^{th}\) percentile of the \(\Sigma^2\) distribution with 2 degrees of freedom. A one-tailed test was also used in Figure 6.53 because the directional hypothesis formulated in chapter one of the present study indicated the direction from the value proposed in the null hypothesis. A directional alternative hypothesis was reflected in the specific alternative hypothesis as being concerned is greater than (>\) the particular value proposed in the null hypothesis (Behr, 1983:191; Huysamen, 1997: 33 and 165).

Item 1 in Figure 6.67 as reflected in Table 6.4 required the respondents to indicate whether or not the availability of clinics in Vhembe Health District was in compliance with the norm set by the government since in terms of the government norm, the clinic must be within 5 kilometres reach by the patients. The analysis of the data in terms of the application of the chi-square test in Figure 6.67 as reflected in Table 6.4 eventually yielded the calculated value of 84.245\(^a\) and because 84.245\(^a\) exceeded the table value of 5,991, the null hypothesis that stated that the availability of the clinics is unrelated to the norm of within 5 kilometres reach by patients was rejected in favour of the alternative hypothesis, which stated that the availability of clinics was related to the government norm regulating the distance between the patients’ homes and their respective nearest clinics. In other words, the conclusion was made that clinics in the district were within 5 kilometres reach and were easily accessible by the patients. In view of the fact that 84.245\(^a\) was greater than 5,991 the difference was subsequently significant, hence the alternative hypothesis prevailed over the null hypothesis following an @ of 0.05 that was set and the value of which fell at the 95\(^{th}\) percentile of the \(\Sigma^2\) distribution with 2 degrees of freedom. A one-tailed test was also used in Figure 6.67 because the directional hypothesis formulated in chapter one. A directional alternative hypothesis in this case showed that the population parameter was greater than (>\) the particular value proposed in the null hypothesis (Behr, 1983:191; Huysamen, 1997: 33 and 165).

In terms of the data emanating from the application of the chi-square test, it revealed that the calculated value of 90,919\(^a\) exceeded the book value or critical value of 3,841. The statistical analysis of data in Figure 6.69 as reflected in Table 6.5 above, in terms of the chi-square test,
showed that the null hypothesis that stated that the capacities and skills of the members of the communities were unrelated to the implementation of the transformation process in order to promote and facilitate the needed health-care services were rejected in favour of the alternative hypothesis which stated that the capacities and skills of the members of the communities and the implementation of the transformation process were related in order to promote and facilitate the needed health-care. In view of the fact that the calculated value of 90.919 was greater than 3.841 the difference was subsequently significant, hence the alternative hypothesis prevailed over the null hypothesis following an @ of 0.05 that was set and the value of which fell at the 95th percentile of the Σ² distribution with 1 degree of freedom. A one-tailed test was also used in Figure 6.69 because the directional hypothesis formulated in chapter one of the present study indicated the direction from the value proposed. In this instance, the directional alternative hypothesis thus states that the population parameter concerned is greater than (> ) than the particular value proposed in the null hypothesis (Behr, 1983:191; Huysamen, 1997:33 and 165).

The data emanating from the application of the chi-square test revealed in Table 6.6 that the calculated value of 2.703 was less than the book value or critical value of 3.841. On the basis of the data analyzed statistically by the chi-square test as reflected in Figure 6.71 in the present study, it was revealed that the calculated value of 2.703 was less than the book value or critical value of 3.841. The statistical analysis of data in Figure 6.71 as reflected in Table 6.6 above, in terms of the chi-square test, showed that the null hypothesis that stated that the transformation process was unrelated to the promotion and facilitation of the quality service delivery was rejected in favour of the alternative hypothesis, which stated that the transformation process promoted and facilitated the quality of service delivery in the peripheral community for the promotion and facilitation of the quality of service delivery. In view of the fact that 2.703 was less than 3.841, the difference was subsequently significant, hence the null hypothesis prevailed over the alternative hypothesis following an @ of 0.05 that was set and the value of which fell at the 95th percentile of the Σ² distribution with 2 degrees of freedom. A one-tailed test was also used in Figure 6.71 because the directional hypothesis formulated in chapter one of the present study indicated the direction from the value proposed in the null hypothesis. In this instance, the directional alternative hypothesis thus states that the population parameter concerned is greater than (>) the particular value proposed in the null hypothesis (Behr, 1983:191; Huysamen, 1997:33 and 165).
The data resulting from the application of the chi-square test in Figure 6.75 as shown in Table 6.7 revealed that the calculated value of $59,081^3$ exceeded the book value or critical value of 5,991. The statistical analysis of data in Figure 6.75 as reflected in Table 6.7 above showed that the null hypothesis which stated that the knowledge of transformation that public servants had was unrelated to the quality of health-care service delivery was rejected in favour of the alternative hypothesis which stated that the knowledge that public servants had about the transformation process had an effect on the promotion and facilitation of the needed health-care services. In view of the fact that $59,081^3$ was greater than 5,991 the difference was subsequently significant, hence the alternative hypothesis prevailed over the null hypothesis following an $\alpha$ of 0.05 that was set and the value of which fell at the 95th percentile of the $\Sigma^2$ distribution with 2 degrees of freedom. A one-tailed test was also used in Figure 6.75 because the directional hypothesis formulated in chapter one of the present study indicated the direction from the value proposed in the null hypothesis. A directional alternative hypothesis was reflected in the specific alternative hypothesis as being concerned is greater than ($>$) the particular value proposed in the null hypothesis (Behr, 1983:191; Huysamen, 1997: 33 and 165).

In contrast with the comment made by the former Minister of the Department of Public Administration, Mr Sehkweyiya, at the meeting held in Cape Town in 2008, commenting that ... the survey findings of the present study did not support him. For the past 15 years (1994 – 2009), the country has changed fundamentally in terms of political perspective although socio-economically, nothing significant and tangible has to date been achieved as the majority of the black people who have been disadvantaged for several decades ago are still poor, unemployed and their lifestyles have not been improved significantly since the entire economy is still been controlled by the majority of the white people and a very few black elite black people. It is, however, the responsibility of the government to accelerate the process of socio-economic transformation. It will be to the best advantage and benefit of all the people of this country especially the historically disadvantaged inhabitants if the current government addresses the socio-economic issue as speedily as possible. The Appendix D revealed that in 1994, there were 3 clinics, 42 clinics and 45 clinics at Musina, Makhado and Thulamela subdistricts respectively, giving a total number of 90 clinics built in the entire Vhembe Health District. Although one would have expected to have more clinics built at Musina subdistrict by 2009, none was built, two clinics were erected at Makhado subdistrict by 2009 and only four were
erected in Thulamela subdistrict by 2009. A total of only 6 clinics were provided to the three subdistricts between 1994 and 2009 and looking at the backlogs in terms of health-care service delivery the number of additional clinics is too insignificant and a lot more should have been built within the period of 15 years since 1994 to 2009, also taking into account the huge backlogs in terms of health-care service delivery that have been created during the apartheid regime.
CHAPTER SEVEN

CONCLUSION AND RECOMMENDATIONS

7.1 INTRODUCTION

The present study emanated from the recommendation made by Madzivhandila (2006:135-136). It aimed primarily at extending the study to the remaining three subdistricts of Vhembe Health District. This chapter presents the conclusion and recommendations following the extensive study undertaken to assess the effects of transformation process on the quality of health-care service delivery from 1994 to 2009 in Vhembe Health District of Limpopo Province in South Africa. Different types of data were generated through the application of the questionnaires which yielded both quantitative and qualitative data. The data were analyzed statistically in accordance with the application of the chi-square test. The survey results were also compared between and among the subdistricts within Vhembe Health District.

The purpose of this chapter is, therefore, to publish and release the research findings by presenting some conclusion and recommendations towards possible alternative solutions that the government can take forward in order to improve health-care service delivery in the peripheral communities within Vhembe Health District that were marginalized for several decades prior to the achievement of democracy in 1994. It is the responsibility of the district with the support from the national, provincial and local spheres of government that all imbalances of the past are resolved or addressed as speedily as possible in order to eliminate and eradicate the inequalities and injustices in terms of service delivery, which jeopardized the lifestyles of many black inhabitants of this country for many years.

7.2 CONCLUSIVE CHAPTERS ISSUES

Chapter one was about the introduction and background of the present study, presenting a discussion of the problem statement and justification for the present study, research questions, the objectives of the study, the research hypotheses, significance of the study, the delimitations of the study, ethical considerations and the brief discussion of each of the six chapters of which
the thesis is comprised. Four alternative hypotheses were formulated as shown in chapter one and were scientifically tested in chapter six.

Chapter two of the present study focused mainly upon the historical and political perspectives to highlight how and when the apartheid policy was implemented between 1910 and 1994 and its hideous impact it had on the lives of many black population groups. It illustrated the influences that prompted it to be speeded up by the citizens of this country for 84 years signifying the period during which the apartheid policy was implemented, significantly enforced and intensified. In a nutshell, it is a trajectory and tapestry of the historical past. Whereas this chapter dwelt with the past, apartheid regime has a historical link with the current democratic government, as there are still today, health-care inequalities which make it difficult for the grassroots to live quality life. Chapter three dealt specifically with the establishment of Limpopo Province and Vhembe Health District following the attainment of democracy in 1994 so as to ensure and promote service delivery to all the people of this country.

In chapter four, the study focused mainly on the literature and legislative framework reviews pertaining to the two processes, namely, transformation and service delivery, including the presentation and discussion of the objectives of the reviews, legislation and policies dealing specifically with transformation and service delivery, health-care system in South Africa in particular and the roles of the Department of Health and Social Development of which Vhembe Health District is a part. The chapter reviews of literature and legislative frameworks were taken into consideration in this study in order to bring to the fore precisely what led this country to move basically away from the universal or international democratic principles, for example, the violation of fundamental human rights, to subject all population groups in South Africa to injustices and inequalities and human values to the abominable apartheid system which was characterized by elements of discrimination, exploitation, inequalities, marginalization and violation of respect and human dignity, to mention just a few.

Chapter five paid attention to the research methodology applied during the present study. This chapter focused mainly on the research design, methods of research, the target population, sampling techniques and the sampling procedures. It pointed out that the research methods
used in the collection of data in this study were quantitative and qualitative. Further attention was also paid to data collection methods, data collection techniques and data analysis.

The researcher considered using simple random sampling, stratified random sampling, systematic random sampling and judgmental sampling as the appropriate and relevant procedures of data collection because of the nature of the present study. Stratified sampling was used because there were two subsamples that participated in the study comprised of public servants and members of the communities in the district. The nonparametric statistical test selected and used by the researcher in the present study was the chi-square test (abbreviated Σ² test). The current researcher considered the relevance and appropriateness of the application of the chi-square test in the study because the dependent variables were measured using a nominal scale, subsequently resulting in the obtained data being expressed in terms of the frequencies, percentiles and graphical representations.

To this end, chapter six dealt specifically with the presentation of the analyses and interpretations of the research data in terms of the frequencies, percentiles, figures, tables and graphs for easy analysis and interpretation of the research findings. The four alternative hypotheses formulated in chapter one of the present study were all tested in chapter six and interpreted in this chapter as follows:

- **Hypothesis 1.5.1.1**

  Subsequent to the present hypothesis postulated in chapter one as earlier indicated, the chi-square test yielded the value of 76,855⁴ as reflected in Table 6.1. Since the calculated value of 76,855⁴ was greater than the critical value of the statistic, 5,991 with 2 degrees of freedom (df), the null hypothesis under review that stated that the public servants of Vhembe Health District of Limpopo Province in South Africa lacked the capacities and skills to implement the transformation process in order to promote and facilitate the needed health-care services was unrelated to the achievement of the quality of service delivery was rejected. The alternative hypothesis that the public servants of Vhembe Health District lacked capacities and skills to implement the
transformation process in order to promote and facilitate the quality of health-care service delivery was accepted.

- **Hypothesis 1.5.2.1**

  Since in this hypothesis the calculated value was 207,490\(^a\) and that as a result thereof 207,490\(^a\) exceeded 5,991 with 2 degree of freedom, the null hypothesis was rejected in favour of the alternative hypothesis (Item 8). In a nutshell, the null hypothesis that stated that the transformation process was unrelated to the promotion and facilitation of the high quality of service delivery in the peripheral communities was rejected, and the alternative hypothesis that stated that the transformation process was related to the high quality of health-care service delivery in the peripheral communities was accepted or retained.

- **Hypothesis 1.5.4.1**

  The analysis of the survey data resulted in the value of 84,138\(^a\) as per Item 9 as shown in Table 6.3. Since the calculated value of 84,138\(^a\) was greater than the critical value of the statistic, 5,991 with 2 degrees of freedom, the null hypothesis, which stated that the lack of knowledge by the public servants in South Africa about the transformation process was unrelated to the high quality of health-care service delivery was, therefore, subsequently rejected in favour of the alternative hypothesis that stated that the possession of knowledge about the transformation process by the public servants in the peripheral communities was related to the attainment of the quality of health-care service delivery.

- **Hypothesis 1.5.3**

  The challenges the Department of Health and Social Development in Limpopo Province has faced since the attainment of democracy in 1994 are attested to mainly by the responses from the respondents who indicated that they lived more than five kilometers from the nearest clinic. This is indicative of the challenges that needed to be
addressed and finally resolved as a matter of urgency as the government committed itself 15 years ago to provide decent and affordable services, including health-care, to all the citizens of South Africa, regardless of colour, race, religion and creed. Item 1 required the respondents to indicate the distance between their homes and their nearest primary health-care facilities and Item 8 further sought to establish whether the patients found it possible to access the primary health-care facilities. The analysis of the responses to the enquiry resulted in the calculated value of 84,245 with 2 degrees of freedom while the level of significance is .000 and also as reflected in Table 6.4. On the basis of this hypothesis, it is only safe to conclude that the proximity norm of 5 kilometres has been followed to a certain limited extent, but that there were some areas within the subdistricts where health-care facilities were not in compliance with the set norm and that was considered as the sad deficiency which should be addressed and resolved as speedily as possible by the provincial government.

- **Hypothesis 1.5.1.2**

  Table 6.5 reflected above indicates the test statistics generated from the application of the chi-square test in which study the sample of 148 respondents participated in the survey study. It shows that the calculated value of 90,919 with 1 degree of freedom (df) was more than the critical value of 3,841, while the level of significance is .000. Since the calculated value of 90,919 was greater than the critical value of the statistic, 3,841 with 1 degree of freedom, the null hypothesis under review that stated that the members of the community of Vhembe Health District of Limpopo Province in South Africa lacked the capacities and skills to implement the transformation process in order to promote and facilitate the needed health-care services was unrelated to the achievement of the quality of service delivery was rejected. The calculated value of 90,919 shows that it is very significant. The survey finding shows that the null hypothesis was rejected in favour of the alternative hypothesis because the calculated value was more than the critical value of 3,841.
• Hypothesis 1.5.2.2

Table 6.6 generated from the application of the chi-square test with the sample of 148 respondents, on the basis of the scores in Figure 6.71, shows the calculated value of $2,703^a$ with 1 degree of freedom (df) while the level of significance is .000. 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 retained, and the alternative hypothesis that stated that the transformation process was related to the quality of health-care service delivery in the peripheral communities was not accepted or retained. The calculated value of $2,703^a$ shows that it is not significant. The survey finding shows that the null hypothesis was retained in disfavour of the alternative hypothesis because $2,703^a$ was less than the critical value of 3,841.

• Hypothesis 1.5.4.2

Table 6.7 generated from the application of the chi-square test with the sample of 148 respondents, on the basis of the scores in Figure 6.75, shows that the calculated value of $59,081^a$ with 2 degrees of freedom (df) while the level of significance is .000. The null hypothesis which stated that the lack of knowledge by members of the community in South Africa about the transformation process was unrelated to the quality of health-care service delivery was, therefore, subsequently rejected in favour of the alternative hypothesis that stated that the possession of knowledge about the transformation process by members of the communities in the peripheral communities was related to the attainment of the quality of health-care service delivery. The calculated value of $59,081^a$ shows that it is very significant. The survey finding shows that the null hypothesis was rejected in favour of the alternative hypothesis because $59,081^a$ is greater than the critical value of 5,991.
7.3 RECOMMENDATIONS

The Republic of South Africa, though still a developing country in the world, is commended especially for taking a giant stride of introducing a National Health-Care Insurance (NHI), which will ensure that all South Africans, regardless of their socio-economic status, gender and religious affiliation, have easy access to the health-care services. This noble idea needs to be pursued until the NHI eventually becomes a reality. Based on the critical transformation issues raised in the present study, the following four recommendations were made for the attention and consideration by the government especially the Department of Health and Social Development of Limpopo Province in South Africa since democracy, which is now 15 years old in 2009, is no longer young or new.

- **Recommendation A**

  According to the survey findings it appears that the present transformation process in terms of the availability of additional new clinics was sadly deficient in Vhembe Health district, first, largely due to the revelation in Appendix D that only 6 clinics were built in Vhembe Health District between 1994 and 2009 taking into consideration that Vhembe Heath District is comparatively a vast area in Limpopo Province which is poorly resourced. Some of the patients in the rural communities were still travelling a distance of more than 5 kilometres to the nearest health-care facility as evidenced by the 19.6% of respondents who pointed out that they had clinics situated more than five kilometers away from their homes. The norm of 5 kilometers has not been accomplished in certain villages in some subdistricts since 1994, and this scenario is supported by the observations made by the researcher while visiting villages within all three subdistricts. It was confirmed that certain villages are without clinics within their geographical jurisdiction and the attention of the government is now being drawn to the fact that the objectives of the transformation process have not as yet been fully met or attained possibly due to the prevailing constraints in terms of the limited availability of resources.

  Both the national and the provincial governments are obliged and expected to ensure that health-care facilities are made available, hence it is brought to the attention of the
provincial government in particular to ensure that during the following financial years the outstanding needs in terms of the provision of clinics be addressed as soon as possible in order to reduce the long distances between clinics and also between clinics and the homes of the patients. The most affected areas as revealed by the findings of the present study that were still situated more than five kilometers away from the homes of the patients were in Musina, Makhado and Thulamela subdistricts and these need to be given urgent and unconditional attention by the government to equally benefit all members of the communities in South Africa. It is, therefore, of paramount importance to have additional clinics built to comply with the norm of 5 kilometers within reach of all patients. In order to ensure that transformation process materializes with ease, the Department of Health and Social Development of Limpopo Province in South Africa should be given a reasonable budget allocation during the subsequent financial years to be able to build enough number of health-care facilities since the transformation process could not be possibly implemented without the availability of the necessary and indispensable required resources, especially in the rural communities of Vhembe Health District. It is strongly recommended that despite the appalling inadequate provision of new health-care facilities between 1994 and 2009, a significant number of additional health-care facilities such as the clinics be erected to meet the national target of within 5 kilometers reach, including a hospital in the subdistrict of Mutale in Vhembe Health District be built as a way of promoting and facilitating health-care services as well as addressing the severe imbalances of the past.

- **Recommendation B**

The findings of this study in terms of Item 18 of chapter six revealed that in the event drugs were out of stock at the health-care facilities like clinics and Community Health Centres (CHC’s), patients were advised by health-care providers to buy same from the local private pharmacy or chemist. 47,5% of the respondents answered the question in the affirmative, indicating that if the drugs were out of stock at the health-care facilities, the health-care providers would advise them to obtain them from other service providers such as the local private pharmacy or chemist. 50,9% of the respondents argued that they were not advised to purchase them from other service providers such as the local private pharmacy or chemist. 2,3% of the respondents did not express their
views with regards to the question dealing with whether or not patients were advised to buy drugs from the local private pharmacy or chemist and this group of respondents represented by 50.9% was supported by the responses of a certain category of respondents as per Item 17 in Figure 6.43, and instead the patients were told to come back the following day to collect the same drugs. The present researcher as the Chief Executive Officer (CEO) at Elim hospital cannot dispute that there were no shortages of drugs at the clinics or hospital, but could only attest and confirm that sometimes health-care facilities experienced shortages of certain drugs. It was not always possible to sustain the acceptable stock level due to the fact that such drugs were often not readily available from the local pharmaceutical depot at Seshego due to the management challenges beyond its control.

Some companies to whom tenders were awarded to supply certain drugs were unable to deliver same in time but the local Seshego pharmaceutical depot was frequently reminded to supply such essential drugs as soon as they became available so that the health-care facilities could, in turn, ensure that such drugs were made available to the patients who were desperately in need of them. Due to the inadequate provision of medicine at the clinics it is, therefore, strongly recommended that the stock level of drugs be monitored and regulated at regular intervals, for example, on weekly or monthly basis, to ensure that all different essential drugs are readily available to the patients; and also to introduce and implement management interventions where the expired drugs could be controlled by the ‘First In and First Out’ (FIFO) strategy in dispensing drugs and furthermore not to allow the situation where the stock levels tend to dwindle to an unacceptable level that is contrary to the national norms. Deviation from the national norms is viewed in a serious light by the present government since it has an adverse effect on health-care service delivery and must be avoided at all costs, through monitoring and evaluation instruments in order to minimize or completely avoid any unnecessary financial implications or repercussions.

- **Recommendation C**

  The present study brought to light that the availability of health-care providers well-equipped with relevant and adequate knowledge, capacities and skills that were
indispensable for the implementation of the transformation process to improve service delivery in the deep rural areas were necessary and needed as a matter of urgency. It is, therefore, strongly recommended that long-term accredited training programmes encompassing revitalization of nursing colleges and medical schools, clinical programmes, transformation-related legislation and policies such as the Constitution, 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 1995 as amended; Basic Conditions of Employment Act of 1997; White Paper on Transforming Service Delivery of 1997 (Batho-Pele Principles); Public Service Staff Code, to mention just a few, be initiated by the Department of Health and Social Development. Such programmes should preferably be developed and conducted by the local universities within reach of the district or province as they have the wealth of expertise at their disposal for utilization by all public servants for the benefit of the ‘rainbow nation’ of people who live in this country.

- **Recommendation D**

In spite of the efforts made by the government to ensure that the transformation process is vigorously implemented, the rural areas in this country are still found suffering, staggering and struggling to be on par with urban areas in terms of the delivery of health-care services. Nevertheless, the desired situation of improving service delivery can be reached if the government, the private sector and individuals can join hands to make plans a reality by putting extra effort and dedication into the existing ones. It is, therefore, logical to indicate that the government cannot have an efficient and effective public service without having well and balanced health-care providers who are adequately trained and developed in the process of transformation in order to improve service delivery, especially in the rural areas. It is, therefore, strongly recommended that a team of experts drawn either from the local universities or from the public or private sector or a team comprised of experts from the public and private sectors with versatile expertise in the area of competencies under review, be appointed to develop a programme that encompasses development and training of public servants and members of the community to be comprehensively conversant with the provisions of
the pieces of legislation of the government, especially those that deal specifically with transformation process and its significance and effect on the attainment of the high quality of health-care service delivery to alleviate poverty and hunger, reduce the high rate of unemployment and reverse all types of discrimination, disrespect, injustices and inequalities that were practised among different population groups in the past decades while the abominable and undesirable apartheid system was still in force.
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APPENDIX A

P.O. Box 444
SHAYANDIMA
0945
10th December 2009.

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

Attention: The Research Committee
Directorate: Transformation and Transversal Services

Dear Sir/Madam

REQUEST FOR PERMISSION TO CONDUCT A SURVEY RESEARCH IN VHEMBE HEALTH DISTRICT IN LIMPOPO PROVINCE

The above-mentioned subject has reference.

Kindly be informed that I am a registered student for the PhD research study at the University of Fort Hare. I have now progressed to a stage that I should commence with the empirical research in the health-care facilities within the Vhembe Health District. I am embarking upon the empirical study under the supervision of Prof. MH. Kanyane.

The theme of my thesis is: “THE EFFECT OF THE TRANSFORMATION PROCESS ON THE HEALTH SERVICE-DELIVERY IN LIMPOPO PROVINCIAL GOVERNMENT OF SOUTH AFRICA”, with special reference to Vhembe Health District. The survey research findings will benefit the Vhembe Health District and Limpopo Provincial Government as well as the Republic of South Africa in general.
Once the approval has been obtained, I shall subsequently continue to communicate with the Heads of the randomly selected health-care facilities through the District Executive Manager of the Vhembe Health District.

Attached hereto, kindly receive a copy of my Research Proposal for my doctoral empirical study already approved by the Higher Degree Research Committee of the University of Fort Hare. I hope my request will receive your prompt attention and consideration so as to enable me to commence with the survey research.

Yours faithfully

Dr MW. Madzivhandila.
APPENDIX B

DEPARTMENT OF HEALTH AND SOCIAL DEVELOPMENT

Enquiries: Ramalivhana NJ/Malomane EL
Ref: 42/2

8 December, 2009
Dr Madzivhandila MW
ELIM Hospital
ELIM
South Africa

Dear Dr Madzivhandila MW

“The effect of the transformation process on the health service-delivery of Limpopo Provincial Government of South Africa”

Permission is hereby granted to Dr Madzivhandila MW to conduct a study as mentioned above in Limpopo Province, South Africa

- 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 researcher is expected to avoid disrupting services in the course of his study
- The research results must be used only for the purpose of the study
- The Researcher/s 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

Yours sincerely,

[Signature]

HEAD OF DEPARTMENT
HEALTH AND SOCIAL DEVELOPMENT
LIMPOPO PROVINCE

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The heartland of Southern Africa – development is about people
APPENDIX C

P.O. Box 444
SHAYANDIMA
0945

The District Executive Manager
Vhembe District
Private BagX 5009
THOHOYANDOU
O950.

Attention: Mr FR. Nengudza

REQUEST FOR THE PROVISION OF STATISTICS PERTAINING TO THE HEALTH-CARE FACILITIES IN THE SUBDISTRICTS WITHIN VHEMBE HEALTH DISTRICT.

1. The telephonic discussion with you today, the 25th instant, has reference.

2. I am presently conducting a research study at doctoral level through the University of Fort. My research is basically on the determination of the effects of transformation on health-care service delivery in Vhembe Health District.

3. Subsequently, you are hereby requested to provide me with the number of clinics, Community Health Centres and hospitals per subdistrict within your district. Attached hereto, kindly receive the format of the table you are expected to simply insert or fill in only the data retrieved from your sources for the purpose of this study.

4. I shall highly appreciate it if your responses could be made available to me as soon as possible. Should you need any clarity on the matter, please do not hesitate to contact me on this number: 0836298770. Thanking you in anticipation.

Dr MW. Madzivhandila
APPENDIX D

DEPARTMENT OF HEALTH & SOCIAL DEVELOPMENT
VHEMBE DISTRICT

Private Bag x5009
Thohoyandou
0950
27th May 2010

Dr Madzivhandila M.W
Elim Hospital
Private Bag X312
Elim Hospital
0960

Dear Sir

REQUEST FOR THE PROVISIONING OF STATISTICS PERTAINING TO THE HEALTH-CARE FACILITIES IN THE THREE SUBDISTRICTS WITHIN VHEMBE DISTRICT


2. Subsequent to your request made early this year in which you would like to be furnished with the statistics relevant to your current research envisaged to be conducted in Vhembe District, attached hereto kindly receive a Table reflecting such data as requested and I hope that it will serve the purpose intended to by objective of your research.

<table>
<thead>
<tr>
<th>NAME OF SUB-DISTRICT</th>
<th>CLINICS</th>
<th>COMMUNITY HEALTH CENTRE</th>
<th>HOSPITALS</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>MUSINA</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>MAKHADO</td>
<td>42</td>
<td>44</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>THULAMELA</td>
<td>45</td>
<td>49</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>TOTAL</td>
<td>90</td>
<td>96</td>
<td>6</td>
<td>7</td>
</tr>
</tbody>
</table>

Compiled by Nengudza F.R.

Private Bag X5009 THOHOVANDOU 0950
Old Parliamentary Building Tel: (015) 962 1848, (015) 962 1852, (015) 962 1001/2/3/4/5/6
Fax: (015) 962 2373/ (015) 9622274/ 4623.

The heartland of Southern Africa – development is about people!
3. There are altogether one hundred and twenty (120) Primary Health-care (PHC’s) facilities including the Gateway clinics in Vhembe Health District (Municipality), that is, one hundred and twelve clinics (112) and eight Health-Care Centres (8). Should you feel that you still need the assistance of the district, you are advised not to hesitate to contact the relevant officials so that you could be assisted accordingly and without any delay.

4. The district has interest in the results of your research. Wishing you the best and success with your investigation.

DISTRICT EXECUTIVE MANAGER
VHEMBE DISTRICT

8/10/10
Dear Respondent

THE EFFECT 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 doctoral degree in Public Administration under the auspices of the University of Fort Hare. I am greatly desirous of your assistance for this purpose. Let us assist each other in this endeavour so that both of us can benefit each other and the society at large. I am currently enrolled for the doctoral research at the University of Fort Hare and am conducting this study under the supervision of Prof. MH. Kanyane.

This study is basically aimed at searching for information about the effect of transformation process has on the quality of service delivery especially at Vhembe Health District but within the geographical jurisdictions of three subdistricts, namely, Makhado, Musina and Thulamela. 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 and policies published since 1995 to date would enable me to make informed, suitable and appropriate recommendations to assist the present and the future generations of this country.

You will concur with me that in the study one really needs honest and transparent information for this purpose in particular. Therefore, do not fear to disclose your candid ideas and views asked for in the questionnaire to the best of your abilities and knowledge. The study is undertaken on an anonymous basis, hence you are not required to provide your personal
particulars such as your names and identity number. Furthermore, confidentiality will be upheld in the entire study and you will be the only person as the respondent who will know what your specific responses are.

Please feel absolutely free to actively participate in this study. Hopefully your assistance will furthermore help the communities in this country which have been historically marginalized and disadvantaged for several years ago which are currently in need of scientific information about the role and the effect of the transformation process on the quality of service delivery throughout the Republic 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 latter that 20th November 2009. Thanking you in anticipation.

Yours faithfully

Dr MW. MADZIVHANDILA
SURVEY QUESTIONNAIRE FOR PUBLIC SERVANTS [PS]

YOU ARE HEREBY REQUIRED 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 IS APPLICABLE HEREUNDER:

1. The public servants of Vhembe Health District lack capacities and skills to implement the transformation process in order to promote and facilitate the quality of service delivery
   AGREE □ □ DISAGREE □ □

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

3. The place where I am working lacks relevant resources to enable me to promote and facilitate the transformation process: YES □ □
   If YES, which health-care resources? ………………………………………………………………………………………

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

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

6. There are no pieces of legislation that enforce the implementation of transformation process in the Republic of South Africa: YES □ NO □
   If YES, give three examples: ………………………………………………………………………………………
   ………………………………………………………………………………………
   ………………………………………………………………………………………

7. The transformation process promotes and facilitates the quality of service delivery in the peripheral communities:
   AGREE □ □ DISAGREE □ □
8. Members of the communities are not altogether knowledgeable about the process of transformation and its effect on the quality of service delivery:

AGREE    DISAGREE

9. The current government disregards the implementation of the transformation process as a priority even the transformation of the public service:  YES    NO

10. Some public servants lack the necessary skills and knowledge to clearly and perfectly render adequate services:  YES    NO

If YES, what type of skills:

……………………………………………………………………
……………………………………………………………………
……………………………………………………………………

11. All health-related needs are easily made available to the very poor people residing in Vhembe Health District:  YES    NO

12. Public servants render services in a manner that is completely unacceptable to the public:  YES    NO

If YES, WHY?:  ………………………………………………………………………
……………………………………………………………………
……………………………………………………………………

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

If YES, Why?:  ………………………………………………………………………
……………………………………………………………………
……………………………………………………………………
14. Some public servants display negative attitudes towards the transformation process and service delivery:  YES  NO

If YES, Why?: .................................................................
.................................................................
.................................................................

15. 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?:  .................................................................
.................................................................
.................................................................

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

17. Transformation process needs to be regulated with the set timeframes to ensure that targets are met as scheduled:  YES  NO

18. The attitude of some frontline public servants, especially medical doctors and nursing personnel towards patients is unpleasant:  YES  NO

If YES, Why?: .................................................................
.................................................................
.................................................................

19. Do you treat patients with courtesy and consideration?:  YES  NO

20. Do you provide more, full and better information to the patients about the public service they are entitled to receive?:  YES  NO

21. Do you offer any apology to the patient, and a full, speedy explanation and effective remedy whenever complaints are lodged?:  YES  NO
Dear Respondent

THE EFFECT OF THE TRANSFORMATION PROCESS ON THE QUALITY OF SERVICE DELIVERY [PS]

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particulars such as your names and identity number. Furthermore, confidentiality will be upheld in the entire study and you will be the only person as the respondent who will know what your specific responses are.

Please feel absolutely free to actively participate in this study. Hopefully your assistance will furthermore help the communities in this country which have been historically marginalized and disadvantaged for several years ago which are currently in need of scientific information about the role and the effect of the transformation process on the quality of service delivery throughout the Republic 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 latter that 20\textsuperscript{th} November 2009. Thanking you in anticipation.

Yours faithfully

Dr MW. MADZIVHANDILA
SURVEY QUESTIONNAIRE FOR MEMBERS OF THE COMMUNITY [MC]

YOU ARE HEREBY REQUIRED 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 IS APPLICABLE HEREUNDER:

1. How far are you from your nearest Primary Health-Care facility?:
   LESS THAN 5 KM □   =5 KM □   MORE THAN 5 KM □

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

3. The members of the communities of Vhembe Health 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 clinic?:
   SATISFACTORY □   DISSATISFACTORY □

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 effect on the quality of service delivery:
   AGREE □   DISAGREE □
10. Do the health-care personnel respond promptly to your request for support during emergency calls: 

AGREE [ ] DISAGREE [ ]

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 readily available 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 the collection of drugs?:

YES [ ] NO [ ]

18. Whenever the drugs are out of stock, as a patient, are you advised to buy same from the local pharmacy or chemist?:

YES [ ] NO [ ]

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

YES [ ] NO [ ]
TO WHOM IT MAY CONCERN

I, DR LARAINE 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 thesis:

THE EFFECT OF THE TRANSFORMATION PROCESS ON THE HEALTH SERVICE IN LIMPOPO PROVINCIAL GOVERNMENT OF SOUTH AFRICA

Submitted by

Dr Mushavhani Wilson Madzivhandila

in fulfilment of the requirements for the degree of Doctor of Philosophy of Public Administration, in the Faculty of Management and Commerce, School of Development and Management, at the UNIVERSITY OF FORT HARE

Promoter: Prof. Modimowabarwa Hendrick Kanyane

DR LC O’CONNELL
24 July 2010