C E C I D

Centre for Environmental, Community and Industrial Development

Central University of Technology, Free State

# DELIVERY OF MUNICIPAL HEALTH SERVICES IN DISTRICT MUNICIPALITIES IN SOUTH AFRICA

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# Contents

# Executive summary

**Background**

Local authorities (local municipalities and metros) and provincial health departments provided environmental health services in South Africa, prior to 1994. The new Constitution gave the mandate for provision of environmental health services to district municipalities and metros, and as of 1 June 2004, these authorities were required to provide environmental health services, now termed municipal health services. There are, however, indications that the provision of the service by district municipalities was evolving unevenly, with differences in the provision, capacity to provide and financing of municipal health services.

The aim of this research was to review how municipalities are delivering municipal health services and the constraints that still exist in delivering the service.

The specific objectives were:

(a) To determine if district municipalities are rendering municipal health services or have delegated the service to local municipalities or other entities, and if so, whether service level agreements and section 78 processes have been concluded.

(b) To determine whether district municipalities have accessed funding for municipal health services from the basic services component of the equitable share, and the funding level per household.

(c) To determine the adequacy of existing funding sources and the funding in (b) above in maintaining existing municipal health services and in establishing new services to cover the district population in an equitable manner.

(d) To assess the capacity of the district or local municipality in establishing municipal health services where these are being established.

(e) To assess the capacity needs of district and local municipalities in running existing municipal health services or in the establishment of the service.

**Methodology**

A structured questionnaire completed via telephonic interviews was used to collect the data from district municipalities, and a 100% sample was targeted. Managers responsible for municipal health services and chief financial officers were interviewed.

**Key findings**

An 83% response rate was achieved and the following key findings emanated from the investigation:

a) A third of district municipalities still do not provide municipal health service, two years after they were required to do so. Local municipalities still play a significant role in rendering the service in instances where district municipalities do not render the service.

b) Some district municipalities are not complying with the legislative requirement of undertaking Section 78 investigations before they render municipal health services. Only about 60% of district municipalities had undertaken section 78 investigations.

c) District municipalities are opting to provide municipal health services rather than get other entities to do so, with 76.5% opting to provide the service. This still leaves a significant number preferring not to render the service.

d) Municipal health services are fairly well integrated into municipal planning processes, especially long-term processes, but provision for staffing is lacking. Eighty-two percent of district municipalities had included municipal health services in their Integrated Development Plans (IDPs), a large number had provided for the service in their 2006/07 budgets and the Medium Term Expenditure Framework (MTEF), but only 41% had placed staff on organograms.

e) Processes for devolution/consolidation of municipal health services were not fully developed, with 68% of district municipalities having established devolution forums and a poor rating for the involvement of government and other role players in assisting with the devolution/consolidation process.

f) Progress on devolution is patchy, with some provinces, such as Eastern Cape, Free State, Western Cape and to a lesser extent, KwaZulu-Natal, doing well, while others such as Limpopo, Northern Cape and North West not making good progress.

g) In terms of capacity, most access to services, except staffing, had shown an improvement. Access to transport, technical support and equipment had improved.

h) A high number (70%) of municipalities provided for a separate budget vote for municipal health services but a smaller number (51.5%) budgeted for the service. Only 54.5% had accessed or planned to access the funding for municipal health services provided for in the equitable share. Most (84.8%) chief financial officers deemed the funding for municipal health services to be inadequate.

i) Municipal health services are not evolving in an equitable manner. In almost half the cases, there were no measures to ensure equitable delivery of the service, in almost half the instances service

level agreements did not cover new geographic areas, and less than half the district municipalities had service plans for under-developed areas.

**Recommendations**

Some of the recommendations made are:

- Government and organisations such as the Municipal Demarcation Board need to continue to monitor the devolution/consolidation of municipal health services with the aim of identifying provinces and district municipalities that are struggling to make progress.

- District municipalities should be sensitised and given more information on the importance of Section 78 investigations.

- Minimum requirements and guidelines and a resource pack for district municipalities on how to devolve/consolidate municipal health services should be developed. Case studies and lessons from provinces that are doing well with the process should be shared.

- District municipalities should be assisted to access funding that is available in the equitable share for provision of municipal health services. A full costing study on municipal health services should be undertaken to inform budgeting for municipal health services in South Africa. This should be preceded by the setting of realistic norms and standards for rendering equitable MHS in South Africa.

- The National Department of Health should monitor the development of equitable municipal health services that address the legacies of the past.

# 1. Definitions and relevant legislation relating to municipal health services

***As per the National Health Act, 2003 (Act 61 of 2003)***

**1.1 "Health services" means: -**

(a) Health care services, including reproductive health care and emergency medical treatment, contemplated in section 27 of the Constitution; (b) basic nutrition and basic health care services contemplated in section 28 (1)(c) of the Constitution; (c) medical treatment contemplated in section 35 (2)(e) of the Constitution; and (d) municipal health services.

**1.2 "Municipal health services" (MHS): -**

e) Includes a list of selected environmental health services (EHS) activities and aspects – with the exception of Port Health Services, Control of Hazardous Substances and Malaria Control – namely:

- Water quality monitoring
- Food control
- Waste management
- Health surveillance of premises
- Surveillance and prevention of communicable diseases, excluding immunisations
- Vector control
- Environmental pollution control
- Disposal of the dead
- Chemical safety

**1.3 Relevant legislation**

The legislation governing municipal health services includes, but is not limited to, the following:

| **ACTS** |
|---|
| National Environmental Management: Air Quality Act, 2004 (Act 39 of 2004) |
| Criminal Procedures Act (56 of 1955) |
| Businesses Act (71 of 1991) |
| Environmental Conservation Act (73 of 1989) |
| Foodstuffs, Cosmetics and Disinfectants Act (54 of 1972) |
| Health Act (63 of 1977) |
| National Health Act, 2003 (Act 61 of 2003) |
| Local Government Municipal Structures Act (117 of 2000) |
| Local Government Municipal Systems Act (32 of 2000) |
| National Environmental Management Act (107 of 1998) |
| Constitution of South Africa, 1996 (108 of 1996) |

| |
|---|
| Tobacco Products Control Act (83 of 1993) |
| Tobacco Products Control Amendment Act (12 of 1999) |
| Tobacco Products Control Amendment Act (2003) |
| National Water Act (36 of 1998) |
| Municipal Finance Management Act, 2003 (Act 56 of 2003) |
| 2nd Draft National Environmental Management: Waste Management Bill, November 2006 |
| |
| **REGULATIONS** |
| Smoke Control Regulations. |
| Regulations relating to businesses (PN 786 of 1991). Made in terms of the Businesses Act (71 of 1991). |
| Notice relating to smoking of tobacco products in public places (R 975 of 29 September 2000). Made in terms of the Tobacco Products Control Act, 1993 (83 of 1993). |
| National Building Regulations, 1977 (Act 103 of 1977). |
| Regulations governing general hygiene requirements for food premises and the transport of food (R 918) (also refer to R328 of 20 April 2007 under Section 5 of FCDA1972). |
| Regulations relating to the powers and duties of inspectors and analysts conducting inspections and analyses in food premises, R328 of 20 April 2007 under Section 5 of FCDA1972). |
| Noise Control Regulations (PN 627 of 1998), promulgated under the Environmental Conservation Act (73 of 1989). |
| Regulation R1411 in terms of section 36 of the Health Act, 23 September 1966; Regulations regarding the prevention of rodent infestation and storage of grain, forage, etc. in urban and rural areas of the Republic of South Africa. |
| Regulation 2438 in terms of sections 32, 33 & 34 of the Health Act, 30 October 1987; Regulations relating to communicable diseases and notification of notifiable medical conditions (GN 2438 of 1987). |
| Section 48 of the Health Act, 1963, relating to the removal and burial of a dead body. |
| Regulations relating to milk and dairy products (R 1555 of 1997) (Updated). |
| Regulations relating to funeral undertakers (R 237 of 1985). |
| Irradiation of Foodstuffs (R 2644). |
| Regulations relating to milking sheds and the transportation of milk (R 1256 of 1986) and (R 217). |
| Regulations relating to the transport of meat (GN 180 of 1967). |
| Regulations relating to the labelling of raw boerewors, raw species sausage and raw mixed-species sausage (R 2718 of 1990). |
| Regulations relating to preservatives and antioxidants in foodstuff (R 965 of 1977). |
| Regulations governing emulsifiers, stabilisers and thickeners and the amounts thereof that foodstuff may contain (R 2527 of 1987). |
| Regulations governing microbiological standards for foodstuff and related matters (R 692 of 1997) (Updated). |
| Regulations relating to labelling and advertising of foodstuff (R 1055 of 2002) (Draft). |
| Regulations relating to the prohibition of the sale of comfrey, foodstuff containing comfrey, and jelly confectionery containing cognac (R 1408 of 2003). |
| Regulations governing the maximum limits for veterinary medicine and stock remedy residues that may be present in foodstuff (R 1809 of 1992) (Updated). |
| Regulations relating to the application of the HACCP system (R 908 of 2003). |
| Regulations governing the registration of homes for the aged (R 3759 of 1969). |

# 2. Introduction

The impact of environmental health on the general health and wellbeing of the population is significant. According to the World Bank, environmental health effects account for at least 20% of the burden of disease in the world, and improvements in environmental health can be considerably beneficial to the poor and underprivileged. Adequate environmental health management prevents many diseases that could eventually result in high treatment costs. South Africa still suffers a high burden of preventable diseases that can be mitigated through improvements in environmental health. Local authorities (district municipalities (DMs) and metros) provide the bulk of environmental health services (now termed municipal health services) in South Africa. However, in recent years there have been major changes to the legislative, institutional and financing frameworks for the delivery of municipal health services in South Africa, and these have not yet been implemented fully by municipalities (DMs and metros).

## 2.1 Legislative backdrop to environmental health services

Historically, in South Africa environmental health services were strongest and most developed in urban, white areas where they were provided by local municipalities and in some cases by district municipalities. In peri-urban and rural areas such as certain former Cape Province areas, the district municipalities rendered EHS, whereas the specified services in other provinces and in the former homelands were generally provided by provincial and national health departments and were not as well developed. The scope of practice of environmental health practitioners included environmental (air, water, solid waste) management, food hygiene, licensing and inspection of food establishments, control of communicable diseases, disposal of the dead, vector control, and animal control. Significant changes were brought in by the new government with the objective of providing equitable environmental health services as part of the district health system. To summarise, the order of establishment of environmental health services at municipal level was as follows:

- Section 156 (1) of the Constitution of the Republic of South Africa (Act 108 of 1996) gave municipalities executive authority, and the right to administer services such as municipal health services, that are listed as part of the local government matters in Part B of Schedule 4.
- In 1999, the Municipal Structures Act (Act 117 of 1998) divided the local government functions – provided for in Schedules 4B and 5B of the Constitution – between district and local municipalities. “Municipal health services” were given to district municipalities, but functions related to environmental health – such as air pollution, noise pollution, licensing and control of undertakings selling food to the public, burial of animals, etc. – were given to local municipalities.
- The National Health Act (Act 61 of 2003) defined municipal health services in terms of the field of responsibility (refer to section 1.2 of this report) and, in accordance with section 32(1) of the mentioned Act, the function of rendering MHS is allocated to metros and DMs in SA.

- Dictated by a MINMEC decision (July 2004), a process of devolution/consolidation amongst the various municipalities was put into operation (Department of Health, Implementation of a MINMEC decision regarding Municipal Health Services, Draft, 21 August 2003).
- The National Health Act 2003 (Act 61 of 2003) was promulgated on 2 May 2005.
- In 2006, the National Treasury allocated funding for municipal health services to local authorities as part of the basic services component of the equitable share.

Under the Municipal Systems Act, district municipalities are also required to undergo Section 78 assessments to determine their capability to render this new service, and in some cases extend the service. To fully implement the provisions of legislation, provincial health departments and local municipalities have to transfer these (municipal health) services, which involve the transfer of staff, assets and liabilities from provinces and local municipalities to DMs and Metro's. In summary, the changes mean that some environmental health services – now known as municipal health services – are to be provided by metro and district municipalities, unless a district municipality has requested that a local municipality render the service on its behalf by means of a service level agreement (SLA).

It is important to note that, although one of the major changes brought about by legislation involves the transfer of the MHS responsibility from local to district municipalities (a process popularly labelled "devolution"), whether it involves movement of functions and resources or delegation through a service level agreement, this process should not be referred to only as devolution but also as a rationalisation or consolidation process. Since the adoption of the Constitution in 1996 and the enactment of the powers and functions stipulated in the Municipal Structures Act of 1998, health services have been in a transitional state and provinces have had no legal mandate to provide the recently defined MHS. Implementation of the more recent MHS policy decisions does, however, require the transfer of certain responsibilities and activities between spheres of government, as well as a shift in resources, which could impact on service delivery. The shifts in resources necessary for service delivery at the correct sphere need to be quantified to guide decision makers at national, provincial and local government level in their planning and, secondly, to assist in monitoring whether the necessary shifts in resources do in fact take place along with the shifts in responsibility for the functions. It is also necessary to monitor how these shifts impact on the delivery of services. In 2002 the health minister and members of the Executive Committee for Health decided to strengthen the implementation of primary health care and municipal health services by a) strengthening functional integration of health between provinces and municipalities; b) signing service level agreements (SLAs) between provinces and municipalities; and c) determining the cost of rendering MHS and primary health care (PHC) services in general.

### 2.2 Funding of municipal heath services

Using municipal revenue, with additional funds from provincial health departments, municipalities mainly provided funding for environmental health services. Larger municipalities had the ability to spend more on these services than smaller municipalities that were more dependent on provincial transfers. DMs that used to render EHS/MHS also funded their MHS from their own municipal revenue (levy income and in selected cases also provincial health subsidies). DMs lost levy income and instead received levy replacement grants as part of their equitable share allocations directly from National Treasury. In addition, DMs also lost municipal revenue from local municipalities (LMs) that used to pay for their own EHS prior to transfer. According to the Division of Revenue Act of 2006/7, with effect from 1 April 2006, funding for environmental health care services in metros and district municipalities has been provided for under the basic services component of the local government equitable share. The funding is intended for all citizens in a municipality and is worked out at R12 per household per year. Provinces will continue to use their own budgets to fund other environmental health services (port health, malaria control, and control of hazardous substances) that are their responsibility.

A study by Health Systems Trust in 2003 showed that total expenditure on environmental health services in the whole country amounted to *circa* R8.78 per capita. The study also concluded that an ideal service would require R10.76 per capita. The initial funding request for municipal health services by the National Department of Health (NDoH) to Treasury was set at R13 per capita in 2003. Treasury's allocation to environmental health services, in the equitable share, translates to R3.25 per capita and thus falls far short of the amount requested by the NDoH.

### 2.3 Capacity at municipal level

The Municipal Demarcation Board performs annual capacity assessments regarding the powers and functions of municipalities, and municipal health services is one of the functions assessed. According to the Board, for the year 2005/6, thirty-two district municipalities out of a total of forty-seven (i.e. 68%) indicated their involvement in the rendering of municipal health services. Only 13 percent indicated that service level agreements were in place for this, while the same percentage indicated that Section 78 processes (processes whereby the various municipalities were tasked to implement strategies and means for the devolution and consolidation of activities and responsibilities across the 3 levels of local government) had been conducted. Almost all indicated the need for additional funding to carry out this function.

## 3. Problem statement

Currently, municipalities are facing a multitude of challenges when it comes to providing effective municipal health services. Capacity limitations in terms of human and financial resources are among the main

consequences of this predicament. For example, although some funds are available, these reside with provincial health departments and local municipalities, with little evidence that such funds will be directed towards district municipalities (Haynes, 2004). In terms of human resources, the majority of environmental health practitioners reside at provincial or local municipality level, and provinces and local municipalities are not keen to transfer staff to district municipalities, as there are environmental health services that also have to be rendered at these levels. Transfer of staff also has its inherent problems, as there are issues of pay parity and transfer of pension funds that have not been resolved and have led to delays in the establishment of services. Although Treasury has provided funds for rendering municipal health services, the funds are inadequate, especially for the setting up of new services. Ironically, although funds are available, these reside with provincial health departments and local municipalities. Even if the funding is channelled effectively, district municipalities thus face the predicament that the funding, at R12 per household, will be inadequate for the setting up of new services. Compounding the problem is the Health Department's lack of capacity when it comes to leading the process and assisting municipalities to set up these services.

## 4. Rationale for the study

Limited information is available on the nature of the capacity constraints faced by district municipalities, making it difficult to intervene appropriately in view of assisting them. Moreover, there is limited information on how the delivery of municipal health services is evolving in the country. This study provides detailed information about how some municipalities are establishing and delivering municipal health services. The capacity constraints that municipalities are experiencing are also examined so as to provide insight to other partners in developing programmes that can assist municipalities. Recommendations are suggested on the basis of the findings of this study.

Lessons regarding the establishment of municipal health services will also be learnt and could be utilised by other municipalities in setting up their own services. It is expected that the results from this study would be ultimately utilised in improving capacity for delivery of the service.

## 5. Aims and objectives of the study

The overarching aim of the study was to investigate South African district municipalities' approach to delivering municipal health services, their progress with the implementation of their legislative mandates, the effectiveness of service delivery, and the constraints that exist in delivering the service.

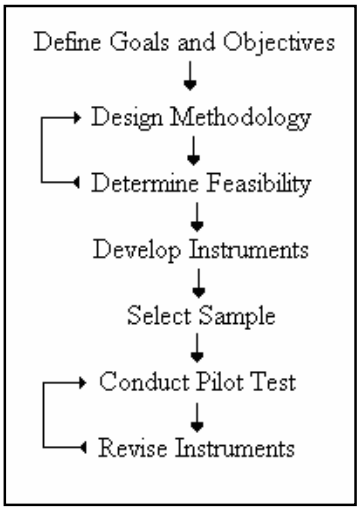
The specific objectives were:

(a) To determine whether district municipalities are rendering municipal health services or whether they have delegated the service to local municipalities or other entities, and if so, whether service level agreements and Section 78 investigations have been concluded;
(b) To determine whether district municipalities have accessed funding for municipal health services from the basic services component of the equitable share, as well as the funding level per household;
(c) To determine the adequacy of existing funding towards maintaining existing municipal health services and in improving establishing new services to cover the district population in an equitable manner;
(d) To assess the capacity of the district or local municipality in introducing municipal health services;
(e) To assess the capacity needs of district and local municipalities in maintaining existing municipal health services;
(f) To determine the overall impact of the devolution/consolidation process on DMs towards providing effective MHS.

# 6. Methodology

## 6.1 Phase 1: Data collection

The project was run on the basis of a survey conducted amongst the managers responsible for municipal health services, as well as the chief financial officer (CFO) for financial issues at each of the ±46 district municipalities in South Africa (giving a total of 92 respondents). The names of these individuals were obtained from, amongst others, the municipal manager. According to a standardised questionnaire, designated data-collection officers conducted telephonic interviews with each respondent, thereby generating a comprehensive set of data. The questionnaire was developed according to the following outline and transferred to an electronic desktop version for direct data capturing:



An appropriate coding scheme was developed together with relevant forms for recording purposes. Raw data was maintained and archived to facilitate an audit trail if required. MS Excel was used for data entry due to its convenience in transferring the data to different statistical packages. After transferring the data into statistical packages, relevant variable names and values were added in order to produce understandable tables and graphs. This was included in the coding scheme.

In order to ensure that all aspects with relevance to the required information were covered, the questionnaire was prepared upon consultation with selected individuals at the Development Bank of South Africa (DBSA) and selected stakeholders within the broader field of environmental health and the Central University of Technology, Free State (CUT). Based on the needs outlined in the DBSA's terms of reference document, the questionnaire required information related to general categories such as the district municipality's contact details, location, demographics and local municipalities, as well as the names of contactable officials and details on organisational arrangements regarding the provision of MHS, strategic and operational considerations with regard to the provision of MHS, and financial arrangements for the provision of integrated MHS (refer to Appendix 1). Meetings with knowledgeable and experienced officials in the field of municipal health services were conducted to ensure that the most relevant, contemporary issues facing MHS delivery in South Africa were adequately covered in the questionnaire. Scrutiny of data collection tools used in similar studies ensured that already-tested and pertinent questions were included in the investigation.

The individuals used for data collection were all in possession of, or busy with, masters' degrees in the field of environmental health or equivalent fields. They were trained in advance on the specific methodology to be used during the telephonic interviews. The training was in the form of a colloquium at the CUT in Bloemfontein that focused on the following:

- Instructions related to the questionnaire, with the emphasis on clear differentiation between questions and responses;
- Outlining the questionnaire check-boxes and other response options;
- Conducting trial runs during which interviewers could provide feedback;
- Coaching interviewers on how to clarify common questions and uncertainties.

The principal developer of the questionnaire undertook the training, and the first five questionnaires were completed in his presence. Moreover, the data capturers were provided with an explanatory guide that detailed the rationale of each question and which served as reference document for the data capturers. It was anticipated that the reference guide would prove useful in facilitating communication between the study team and the statistical services. In addition, one of the data capturers visited the DBSA and completed a number of interviews in the presence of a DBSA representative.

The data capturers were also informed of selected ethical issues surrounding this study. These included:

- The right of any respondent to refuse participation before the start of the questionnaire or during its administration;
- The right of all respondents to refuse to answer any particular questions;
- The need to explain the purpose and potential benefits of the study to the respondents;
- Explaining that all completed questionnaires and responses would be kept confidential and anonymous.

Prior to commencing with the survey, the questionnaire was tested and refined in terms of unambiguousness and relevance by conducting a pilot study amongst at least 2 district municipalities. In order to avoid exclusion from the study, the pilot included officers who were junior to the MHS manager and CFO. These officers were urged to keep the content of the questionnaire confidential and not to discuss it with either the MHS manager or the CFO. Verification (i.e. external consistency) of the responses was carried out either by comparing the data with selected source documents such as financial reports, or by selecting individuals at the various DMs who were not included in the initial survey, to verify some of the responses. Care was also taken to ensure that during compilation of the questionnaire, cross-verification amongst questions was included to ensure a high level of internal consistency.

Upon successful completion of the questionnaire at the two pilot sites, and after affecting all the required modifications, the questionnaire was handed to the statistical services component of the project so that all questions could be coded and all variables named. In this way, the forms necessary for data entry could be developed concomitantly to the physical administration of the questionnaires. In this way, the time required to complete the study was reduced.

### 6.2 Phase 2: Data capturing and processing

The data was captured either directly on computer or on hard copy followed by capturing. Each interview lasted approximately 30 minutes, although numerous follow-ups had to be done in cases where respondents failed to honour appointments. The data was processed into inferential and descriptive statistics outlining the various scenarios in detail. The statistical packages used for this purpose were SAS, SPSS and Statistica. The report also includes a summative section presenting the data unambiguously and highlighting the most prevalent tendencies and shortcomings. Members of the project team gave inputs towards the extent and types of interventions needed to address the shortcomings highlighted in the report.

The study was conducted by way of a survey of all district municipalities in South Africa. Data collection consisted of telephonic interviews with MHS managers and chief financial officers over the period November 2006 to February 2007.

# 7. Results

Data was collected through telephonic interviews with officials responsible for municipal health service and chief financial officers over the period November 2006 to February 2007.

A response rate of 82.6% nationally was achieved with all district municipalities in Eastern Cape, Free State, Gauteng, and Mpumalanga responding (see Table 1). The lowest response rate was in KwaZulu-Natal (60%). In some cases answers were not forthcoming for all the questions, as some respondents felt uneasy in answering questions. This was particularly the case with financial matters.

**Table 1: Response level per province**

| Province | Responses | Number of DMs in the province | Response rate % |
|---|---|---|---|
| Eastern Cape | 6 | 6 | 100 |
| Free State | 5 | 5 | 100 |
| Gauteng | 3 | 3 | 100 |
| KwaZulu-Natal | 6 | 10 | 60 |
| Limpopo | 4 | 5 | 80 |
| Mpumalanga | 3 | 3 | 100 |
| North West | 3 | 4 | 75 |
| Northern Cape | 4 | 5 | 80 |
| Western Cape | 4 | 5 | 80 |
| National | 38 | 46 | 82.6% |

## 7.1 Progress with the devolution/consolidation of municipal health services in South Africa

In assessing progress towards the devolution of municipal health services, the following were reviewed; the entity providing municipal health services, compliance with legislative requirements, the availability of an organisational structure, a budget, placement of staff on the organogram, the inclusion of municipal health services in the planning processes of the district and the establishment of devolution forums.

A significant number (65.8%) of district municipalities provided municipal health services (Table 2). There was great variation between provinces, with all participating district municipalities in the Western Cape providing the service and only 25% of Limpopo district municipalities doing so.

**Table 2: District municipalities providing municipal health services (n= 38)**

| Province | Does the district municipality provide Municipal Health Services? | | | |
|---|---|---|---|---|
| | Yes | | No | |
| | Count | % | Count | % |
| Eastern Cape | 5 | 83.3% | 1 | 16.7% |
| Free State | 2 | 40.0% | 3 | 60.0% |
| Gauteng | 2 | 66.7% | 1 | 33.3% |
| Kwazulu-Natal | 5 | 83.3% | 1 | 16.7% |
| Limpopo | 1 | 25.0% | 3 | 75.0% |
| Mpumalanga | 2 | 66.7% | 1 | 33.3% |
| North West | 1 | 33.3% | 2 | 66.7% |
| Northern Cape | 3 | 75.0% | 1 | 25.0% |
| Western Cape | 4 | 100.0% | 0 | .0% |
| Total | 25 | 65.8% | 13 | 43.2% |

In areas where district municipalities were not providing municipal health services, local municipalities provided the service in 68.8% of cases, as shown in Table 3.The Department of Health provided municipal health services in 5 district municipalities, in Eastern Cape, KwaZulu-Natal, Mpumalanga and Northern Cape. Local municipalities also still provided services in all the provinces except Eastern Cape and Northern Cape.

**Table 3: Providers of MHS other than District Municipalities (n = 13)**

| **Provider of municipal health services in areas where district municipality does not provide the service** | **Number** | **Percent** |
|---|---|---|
| Local Authorities | 11 | 68.8 |
| Department of Health | 5 | 31.3 |
| **Total** | **16** | **100.0** |

Out of a total of thirty-seven (37) district municipalities, 22 (59.5%) had undertaken Section 78 investigations by the time of the survey, while 40.5% had not. All district municipalities in the Eastern and Western Cape had undertaken their Section 78 investigations, and none had been undertaken in North West and Northern Cape, as shown in Table 4.

**Table 4: Number of district municipalities that undertook Section 78 investigations (n =37)**

| Province | Has a section 78 investigation (from the Municipal Systems Act) been undertaken for the district municipality in terms of Municipal Health Services? | | | |
|---|---|---|---|---|
| | Yes | | No | |
| | Count | % | Count | % |
| Eastern Cape | 6 | 100.0% | 0 | .0% |
| Free State | 3 | 60.0% | 2 | 40.0% |
| Gauteng | 2 | 66.7% | 1 | 33.3% |
| Kwazulu-Natal | 2 | 40.0% | 3 | 60.0% |
| Limpopo | 3 | 75.0% | 1 | 25.0% |
| Mpumalanga | 2 | 66.7% | 1 | 33.3% |
| North West | 0 | .0% | 3 | 100.0% |
| Northern Cape | 0 | .0% | 4 | 100.0% |
| Western Cape | 4 | 100.0% | 0 | .0% |
| **Total** | **22** | **59.5%** | **15** | **40.5%** |

As shown in Table 5, the number of district municipalities that had undertaken Section 78 investigations was higher in district municipalities that already provided municipal health services (66.7%), than in district municipalities that did not provide municipal health services (46.2%). In some instances, Section 78 investigations had not been done but the district municipality did provide the service. In three provinces, KwaZulu-Natal, North West and Northern Cape there were more district municipalities providing the service than the number that had undertaken Section 78 investigations.

**Table 5: Status of Section 78 investigations amongst district municipalities**

| **Has a Section 78 investigation (Municipal Systems Act) been undertaken for the district municipality in terms of municipal health services?** | | **Does the district municipality provide municipal health services?** | | | |
|---|---|---|---|---|---|
| | | **Yes** | | **No** | |
| | | Count | Column % | Count | Column % |
| | Yes | 16 | 66.7 | 6 | 46.2 |
| | No | 8 | 33.3 | 7 | 53.8 |

In district municipalities where Section 78 investigations had been undertaken, reports were available in the majority of cases (63.6%), and most (76.5%) were opting for an internal service delivery mechanism/model (either new or expanded), while 23.5% were opting for a model that included local municipalities.

A relatively small number of district municipalities (27%) had signed service level agreements (Table 6).

**Table 6: Number of district municipalities with signed service level agreements for the provision of municipal health services**

| Signed service level agreement? | Number | Percent |
|---|---|---|
| Yes | 10 | 27.0 |
| No | 27 | 73.0 |
| **Total** | **37** | **100.0** |

The Eastern Cape and Free State had the highest number of signed service level agreements, at 66.7% and 60% respectively. Gauteng, North West, Northern Cape and Western Cape had not signed any service level agreements, while Gauteng, Limpopo and North West had district municipalities that provided a service but did not have service level agreements.

Slightly more (55.6%) district municipalities signed service level agreements with local municipalities for the provision of municipal health services, than with other entities. In half the cases the service level agreement covered the same areas as had previously been covered by the entity that had a service level agreement with the district municipality. The rest of the agreements covered new and additional areas. This is significant for extension of services into previously under-served areas.

Over half (52.6%) of the district municipalities had an approved organisational structure for municipal health services, 60.9% had budgeted for their organisational structure in 2006/2007 and 92.4% had provided for the service in their medium term expenditure framework. Less than half (41.2%) had placed their existing staff in the new organogram.

**Table 7: Progress in implementation of organisational structure for municipal health services**

| Province | Approved organogram % | Organogram budgeted for in 2006/07 % | Organogram budgeted for in MTEF % | Placement of existing staff on new organogram |
|---|---|---|---|---|
| Eastern Cape | 66.7% | 40.0% | 66.7% | 33.3% |
| Free State | 80.0% | 75.0% | 75.0% | 50.0% |
| Gauteng | 66.7% | 100.0% | 100.0% | .0% |
| Kwazulu-Natal | 50.0% | 75.0% | 100.0% | 33.3% |
| Limpopo | 50.0% | .0% | .0% | .0% |
| Mpumalanga | 33.3% | 100.0% | 100.0% | .0% |
| North West | .0% | .0% | No response | No response |
| Northern Cape | 25.0% | .0% | No response | No response |
| Western Cape | 75.0% | 100.0% | 100.0% | 100.0% |
| **Total** | **52.6%** | **60.9%** | **92.4%** | **41.2%** |

Only the Western Cape had done well in establishing and budgeting for organograms and placing staff on the new organogram. The performance of other provinces was patchy but placement of staff on new organograms lagged most. Excluding the placement of staff on new organograms, the Eastern Cape, Free State, Gauteng and KwaZulu-Natal were performing well in most areas (scoring more than 50% in most areas), while Limpopo, North West and Northern Cape were not doing well (scoring less than 50% in most areas)

Municipal health services were catered for in the Integrated Development Plans of most (81.6%) district municipalities, and were included as a technical area in 71.1% of cases. Less than half (42.1%) however had service plans for their under-developed areas. Devolution forums had been established in 31.6% of district municipalities, with the most having been established around 2004.

The involvement of key stakeholders such as national and provincial government departments, labour organisations, the South Africa Institute of Environmental Health and South Africa Local Government Association was assessed. Only the Provincial Department of Health and the labour organisations representing affected staff involved in the devolution of MHS solicited a reasonable rating from respondents. (With regard to the Provincial Department of Health, 44.1% selected "Average" and 29.4% selected "Poor" while 23.5% selected "Good" ratings. With regard to labour organisations, 23.5% selected "average" and 32.4% selected "poor", while 23.5% selected "good" ratings.) In the case of the remaining stakeholders, 50% or more selected a "poor" rating (Figure 1).

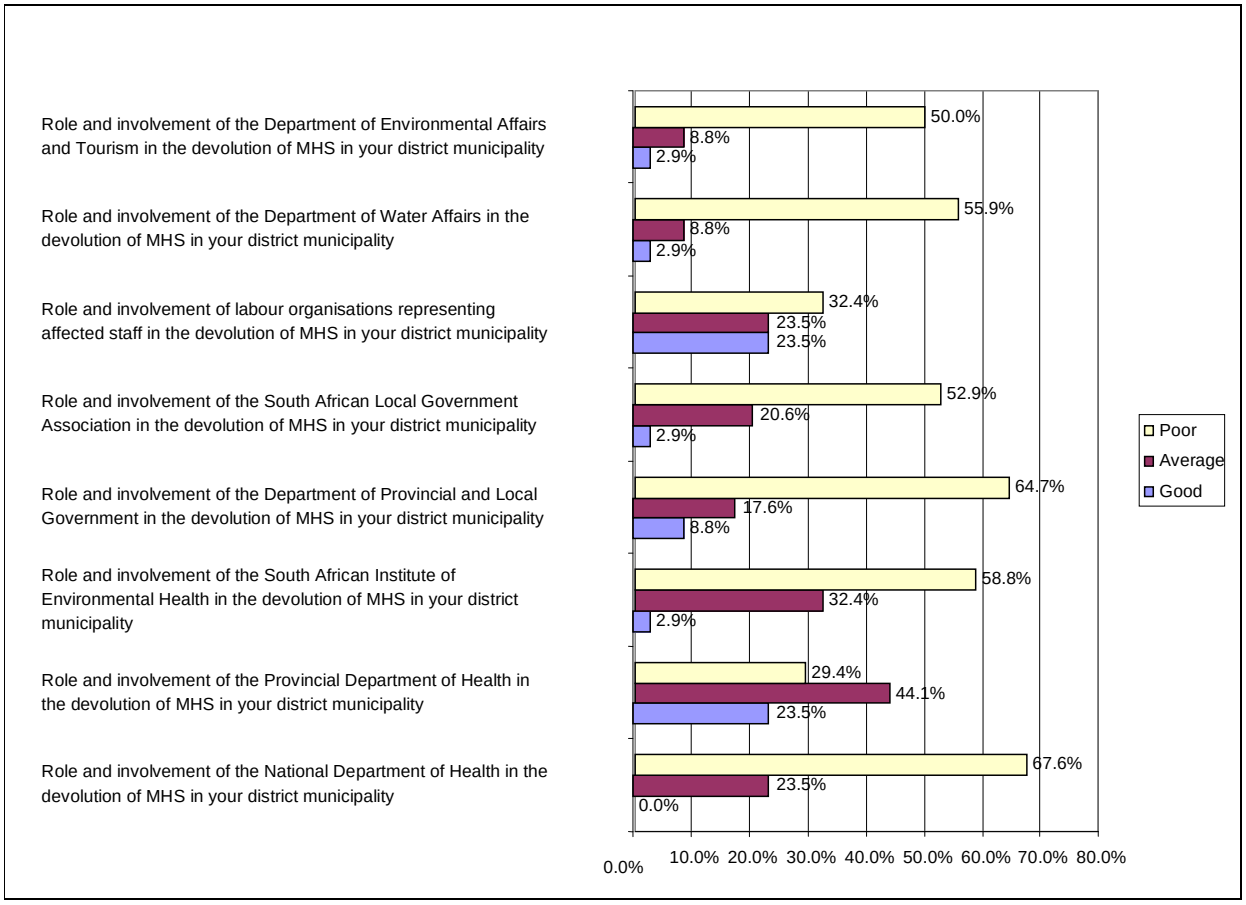



**Figure 1: Percentage distribution of respondents' ratings of the role and involvement of various stakeholders in the devolution of MHS in their district municipality**

### 7.2 Capacity considerations with regard to the rendering of municipal health services in South Africa

The capacity of district municipalities was assessed using comparisons in the availability of resources before and after devolution. Improvements, worsening or no change in rating were noted. In general participants felt that there were improvements in the availability of most services following the devolution.

**Table 7: Rating of access to services, before and after devolution**

| Province | Technical support (training, supervision) | Support services (computers, email) | Equipment for technical operations | Transport | Staff |
|---|---|---|---|---|---|
| Eastern Cape | Improved | Improved | Improved | Improved | Improved |
| Free State | Improved | Improved | No change | Improved | Worsened |
| Gauteng | Improved | Improved | Worsened | Improved | Worsened |
| Kwazulu-Natal | Improved | Worsened | No change | Worsened | Worsened |
| Limpopo | Improved | Improved | No change | Improved | Worsened |
| Mpumalanga | Worsened | Improved | Improved | Improved | Worsened |
| North West | | | | | |
| Northern Cape | Worsened | Improved | No change | Improved | Worsened |
| Western Cape | No change | Improved | Improved | No change | Improved |

A notable difference was in the availability of staff, where most provinces believed that this had worsened after the devolution. The Western Cape showed the least change before and after devolution.

### 7. 3 Funding for municipal health services

Data from chief financial officers in district municipalities was collected to determine funding flows for municipal health services, the level of the funding, and whether it was adequate for existing and future services.

Unfortunately the responses to the second part of the questionnaire developed for the chief financial officers of district municipalities were limited in their usability. Unavailability of respondents, poor honouring of interview appointments, and limited access to organised and accurate information were all issues contributing to this situation. There was reluctance from chief financial officers in providing some of the information as they deemed it sensitive. The level of funding could thus not be determined. The useful information collected, which relates to financial considerations in MHS delivery in South Africa, is reported here.

Almost 70% of all district municipalities had a separate budget vote for municipal health services, but just over half (51.5%) had provided for the service during the 2006/07 financial year (Table 8). More than half (54.5%) had accessed or had plans to access funding from the basic services component of the equitable

share to local government. This left a significant number (42.4%) with no plans to do so. An overwhelming majority (84.8%) expressed the opinion that funding for municipal health services was inadequate.

**Table 8: Funding sources and adequacy for municipal health services**

| | Yes | | No | | Unsure | |
|---|---|---|---|---|---|---|
| | **Count** | **%** | **Count** | **%** | **Count** | **%** |
| Do you have a separate budget vote for municipal health services in the district municipality area? | 23 | 69.7 | 10 | 30.3 | 0 | 0.0 |
| Is provision made in the 2006/2007 budget of the district municipality for the rendering of municipal health services in district municipality? | 17 | 51.5 | 14 | 42.4 | 2 | 6.1 |
| Has funding been accessed, or are there plans to access funding, from the basic services component of the equitable share for MHS provision in the district municipality? | 18 | 54.5 | 12 | 36.4 | 3 | 9.1 |
| Is there adequate funding to maintain existing levels of municipal health service delivery in the district municipality? | 1 | 3.0 | 28 | 84.8 | 4 | 12.1 |

To assessment equitable distribution of resources in the district chief financial officers were asked if there were measures in place to ensure equitable provision of services in the district municipality and in 59.4% of cases measures were in place (Table 9).

**Table 9: Availability of measures to ensure equitably provision of municipal health services in district municipality**

| **Are there measures to ensure equitable provision of MHS?** | | **Number** | **Percent** |
|---|---|---|---|
| | Yes | 19 | 59.4 |
| | No | 13 | 40.6 |
| | **Total** | **32** | **100.0** |

# 8. Discussion

The overall response rate of almost 83% has provided a trustworthy national perspective as far as the aims of this study are concerned. However, the poor response rate obtained in the KwaZulu-Natal Province (60%) is a cause for concern and should serve as caution against extrapolation/generalisation of the national findings to this province.

## 8.1 Progress with the devolution of municipal health services in South Africa

Although devolution is progressing, with 65.8% of district municipalities providing municipal health services, one-third of the district municipalities in South Africa still do not provide the service, two years after they were required to do so. The highest proportion of district municipalities not providing the service is situated in Limpopo and the North West provinces, i.e. 25% and 33.3% respectively. Municipalities that did well in provision of the service are in Eastern Cape, Western Cape, KwaZulu-Natal and Northern Cape.

In instances where district municipalities do not provide the service, the local municipalities provide most of these services. This is to be expected as prior to the new legislation requiring district municipalities to do so, the service was provided by local municipalities, and to a lesser extent provincial health departments.

Despite it being a requirement for district municipalities to conduct a Section 78 investigation before they take over any new service, this requirement is not being adhered to, as only twenty-two (59.5%) district municipalities had done Section 78 investigations. This figure includes district municipalities that had compiled with the requirement but did not provide the service. The North West and Northern Cape provinces had not commenced with a Section 78 investigation in any of their district municipalities at the time of this study.

Section 78 investigations provide an objective method for assessing the capacity of a district municipality in providing any service and are the basis for motivating for the best delivery model and the appropriate level of resources to be allocated for a service. Compliance thus can assist with ensuring that adequate municipal health services are provided for. Considering that less than 60% of the district municipalities had commenced with or had completed a Section 78 investigation, it was evident that the opportunities for improving the quality of municipal health services rendered may not be fully understood and may be missed.

It is clear however that district municipalities are likely to opt for internal mechanisms for the delivery of municipal health services as more than three quarters of the respondents who had commenced with a Section 78 investigation indicated that they had opted for, or were likely to opt for, rendering MHS as a new internal service, or internally as an existing expanded service.

An encouraging finding is that the devolution/consolidation of municipal health services has been catered for in the Integrated Development Plans (IDP) of district municipalities, making the service legal in 82% of district municipalities. However, in contrast, less than three quarters (71%) of the district municipalities have included MHS as a technical service area in their IDP. Bearing in mind that MHS is a basic municipal service forming part of the core business of district municipalities, whether by an internal or external service delivery model, this finding is discouraging. It further raises questions surrounding the awareness and importance assigned to this function by the district municipal councils.

The planning processes for the funding of municipal health services (especially long-term planning), such as provision in the 2006/7 budget and the MTEF were more advanced than planning processes for the staffing of the service. The placing of staff on organograms was particularly low (41%) and signifies the challenges district municipalities are facing in moving staff between local authorities or provincial departments. Transfer of staff involves complex human resource procedures and unions have been opposed to the moving of staff, hence few provinces have managed to overcome these challenges. Again a similar pattern is evident with Western Cape, Eastern Cape, Free State and KwaZulu- Natal seeming to cope best, while Limpopo, North West and Northern Cape are making the least progress.

Less than three quarters of the respondents reported having a representative MHS devolution forum at district municipality level. Sixty-eight percent of the district municipalities that have established a representative forum did so during, or prior to, 2004. It can also be seen that district municipalities rated the involvement of various stakeholders in their devolution/consolidation of the MHS process as *poor*. Of greater concern is that more than three quarters of the district municipalities rated the involvement of their provincial department of health as *average*, *poor* or *unsure*. This is testimony to the lack of guidance received in the management of the devolution/consolidation of the MHS process in South Africa. There appears to have been no guidelines and little support available, even though the statutory deadline for finalising the process has long passed (i.e. 1 July 2004).

In summary, the study has shown that many district municipalities are providing MHS, but their progress in devolution of the service has been patchy, with some provinces, notably Eastern Cape, Free State, Western Cape and to a lesser extent KwaZulu-Natal doing well, while others such as Limpopo, Northern Cape, and North West are struggling.

### 8.2 Capacity considerations with regard to rendering of municipal health services in South Africa

It is common knowledge that resources relating to MHS have historically been distributed in a skewed manner. The devolution/consolidation of MHS is an opportunity to accomplish a more equitable use of available resources within a district municipality area. However, it needs to be kept in mind that the existing

resources at the disposal of authorities are limited, and the resource distribution amongst provinces, and even district municipalities, is highly skewed.

This study has shown a general improvement in access to services such as transport, equipment and support services. This is contrasted with deterioration in the staffing situation, except in the Eastern Cape and Western Cape provinces. The staffing problem is in all probability linked to the inability of district municipalities to fill staff organograms and again underscores the problem with moving staff from other authorities. The general improvement in access to resources signifies that the potential for better resourcing and utilisation of staff exists in the devolution/consolidation process. Given that staffing is limited, the significant improvement in the availability of transport following the devolution/consolidation of MHS implies that the potential effectiveness of the limited staff complement can be improved through the devolution/consolidation process, since staff responsible for the implementation of MHS cannot function effectively without vehicles. Similar improvements in technical and operational equipment and support services have also allowed better utilisation of limited staff complements.

Possibilities for upliftment and maintenance of staff morale and professional development have also been strengthened with the finding that technical support – such as supervision, mentoring and training – improved from "poor" in more than half (i.e. 56%) of cases to one third of the cases upon conclusion of the devolution/consolidation process. The availability of non-financial resources generally improved upon completion of the devolution/consolidation process. It is thus more effective to invest time and resources in skills development for better municipal health services delivery in organisations where the devolution/consolidation process has been completed, since acquired skills are more likely to be implemented in these settings. This does not mean that district municipalities that have not completed the devolution/consolidation process should be excluded from any skills development initiatives; rather, a concerted effort should be made to complete the devolution/consolidation process in all district municipalities of South Africa as a matter of urgency.

### 8.3 Financial considerations for the delivery of municipal health services

Although almost 70% of district municipalities have a separate budget vote for municipal health services, the lower figure showing that 51.5% district municipalities provided for the service in their 2006/07 budget year indicates the reluctance district municipalities had in budgeting for the service from their own resources. This suggests that MHS have to continuously compete with other services for funding. As MHS became a mandate of district municipalities on 1 July 2004, it is crucial that budgetary provision is made for the entire district municipality regardless of the service delivery mechanism. This is the case for only approximately half of the district municipalities. Mpumalanga, North West and Gauteng were particularly poor in this regard. The uncertainty surrounding the so-called *unfunded mandate* of district municipalities, namely municipal health services, is presumably the reason for this finding.

Treasury made additional funding for the service available effective from 1 June 2006, but only 54.5% of municipalities accessed or planned to access this funding. This could indicate a lack of knowledge about the funds or an inability to access the funds for various reasons. The availability of these funds needs to be communicated to all district municipalities.

The study revealed that nearly all (97%) of the financial managers interviewed as part of the second section of the questionnaire reported that in their opinion, insufficient funding is available for MHS to improve, or even maintain, existing levels of service provision.

As resources are known to be very limited for the rendering of public health services it is crucial that these scarce resources are equitably or fairly distributed among the communities served. For this reason, the historic maldistribution of resources should be consciously addressed/rectified by local government. Measures should be put in place to ensure that true equity in allocation of resources is attained. Just more than half of the respondents reported that measures were in place in their district municipality to accomplish equitable municipal health service delivery. It was previously noted that in almost half of the service level agreements signed the areas covered were the same areas that had been previously served. These practices will lead to the entrenchment of previous inequitable service delivery models. Other evidence is that less than half of district municipalities had service plans for their under-developed areas. A dangerous trend is thus appearing where equity is not being considered in the devolution/consolidation of municipal health services.

# 9. Recommendations for the improved delivery of municipal health services in South Africa

It is not the intention of this report to reflect lengthy discussions surrounding the improvement of the current municipal health service situation in South Africa. Rather, this section extracts the most important recommendations, reiterates their importance, and offers some suggestions when it comes to addressing them:

- Government and organisations such as the Municipal Demarcation Board need to continue to monitor the devolution/consolidation of municipal health services with the aim of identifying provinces and district municipalities that are struggling to make progress.

- Decision makers must be sensitised to 1) the legal obligation of district municipalities to undertake a Section 78 investigation into the rendering of MHS; and 2) the potential to improve the quality of MHS provision if a Section 78 investigation is well executed.

- Sensitisation/information sessions surrounding the statutory responsibility of district municipalities to perform Section 78 investigations and assume full responsibility for MHS should be undertaken in all district municipalities where the devolution/consolidation of the MHS process has not yet commenced. In accordance with the findings of this study, it is felt that the North West and Northern Cape provinces should be prioritised. Senior officials in the Departments of Health and Local Government, as well as SALGA, should drive such sensitisation efforts. Where necessary, funding should also be sought for district municipalities to finalise the devolution/consolidation of the MHS process.

- Standardisation in undertaking the devolution/consolidation of MHS can be advanced with the development of minimum requirements and guidelines and a resource pack for district municipalities. Such a management tool could then also be used to gauge the success/quality of devolution/consolidation processes already finalised or well advanced in other district municipalities. In this way, the benefit of such a management tool could also be extended to those municipalities that are advanced in the devolution/consolidation process, but wish to improve general management of their MHS component. Case studies and lessons from provinces that are doing well with the process could be shared.

- District municipalities should be assisted to access funding that is available in the equitable share for municipal health services. A full costing study on municipal health services should be undertaken to inform budgeting for MHS in South Africa. This should be preceded by the setting of realistic norms and standards for rendering equitable MHS in South Africa.

- Short courses aimed at MHS managers should be developed for delivery in an annual summer and/or winter school format. Such courses should be grounded in practice and see stronger relations developing between the academic and operational sectors of MHS. Courses on equitable MHS provision, community development, project management, strategic leadership and decision-making, etc. could all have a significant impact on MHS delivery improvements in the short term.

- The National Department of Health should monitor the development of equitable municipal health services that address the legacies of the past.

- All relevant government departments should support district municipalities in the setting up of municipal health services.

## 10. Conclusion

This study provides useful information that can aid decision makers in guiding the improvement of MHS delivery in South Africa. A number of specific opportunities and constraints have been identified and should be addressed by role players at national level. These role players are the Departments of Health and Local Government, SALGA, the Institute of Environmental Health, and the National Treasury. Clearly, there is also a need for investment by donors and developmental agencies in the field of MHS in South Africa.

This study has also revealed that numerous opportunities exist for the successful improvement of MHS in South Africa. The skills, means and will to accomplish such improvement do exist, but the necessary coordination and support for the process should be forthcoming.

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# Appendix 1

Questionnaire

# QUESTIONNAIRE TO DETERMINE THE PROGRESS WITH THE IMPLEMENTATION OF MUNICIPAL HEALTH SERVICES IN SOUTH AFRICA

***PRE-INTERVIEW DATA***

| | |
|---|---|
| Name of District Municipality | |
| Province | |
| Telephone Number | |
| Name of Interviewer | |
| Date of Interview Scheduled with MHS Manager/Appropriate Person | |
| Name of MHS manager or appropriate person? | |
| Date of Interview scheduled with CFO/Appropriate Person | |
| Name of CFO or appropriate person? | |
| Number of Local Municipalities within District Municipality? | |
| Population covered by District Municipality? | |
| Geographical Area of District Municipality? | |
| Percentage Population without Adequate Sanitation Facilities? | |

| | | | | | |
|---|---|---|---|---|---|
| 1. | Does the district municipality provide Municipal Health Services? | Yes | | No | |
| 1.1. | If yes, since when has the DM been providing the service? | | | | |
| 1.2. | If yes, which authority provided the service prior to the DM doing so? (More than one block may be ticked) | Local Authorities | District Municipality | Dept of Health | No service provided |
| 1.3. | If no, who provides MHS in the area? | Local Authorities | Dept of Health | No service provided | |
| 2. | Has a *Section 78 Investigation* (from the Municipal Systems Act) been undertaken for the district municipality in terms of Municipal Health Services? | Yes | | No | |
| 2.1. | If yes, or in progress, has the report been finalised? | Yes | | No | |
| 2.2. | If yes, or in progress, was the investigation done internally or by appointing an external service provider (i.e. a consultant or consultancy firm)? | Internally | | External service provider | |
| 2.3. | If yes, or in progress (to 2.), were you fully satisfied with the outputs of the Section 78 Investigation? | Yes | No | Unsure | |
| 2.4. | If yes, or in progress, what service delivery model has been, or will likely be, selected? | Internally as a new service | Internally as an existing, expanded service | On an agency basis by contracting local munic's | As a mixed model by partially contracting local munic's |
| 2.4.1. | If on an agency basis, or mixed model, have service delivery agreements for rendering the MHS function on behalf of the district municipality been signed with all authorities? | Yes | | No | |
| 2.4.2. | If on an agency basis, or mixed model, are service delivery agreements operative? | Yes | No | Partially | |
| 2.5. | If yes, or in progress, how many people altogether have been, or would be, transferred to the district municipality from each type of authority? | Amount from local municipalities | | Amount from provincial Dept of Health | |
| 2.6. | If no (to 2.), does your municipality intend to follow a section 78 process in rendering Municipal Health Services? | Yes | No | Unsure | |
| 2.6.1. | If yes, does your municipality intend to initiate the process within the next quarter? | Yes | No | Unsure | |

| | | | | | |
|---|---|---|---|---|---|
| 2.6.2. | If no (to 2.6.), why not? | | | | |
| 3. | Has the DM signed any service level agreements with regard to the provision of MHS? | Yes | | No | |
| 3.1. | If yes; what entity (authority) has it been signed with? | Local authority | | Other entity, specify | |
| 3.2. | If yes, what are the provisions of the agreement with regard to: | | | | |
| i. | Length of the contract | months | | | |
| ii. | Area covered by the authority | Same area previously covered by entity | Same areas covered with additional areas | Less areas previously covered | New areas covered by the entity only |
| iii. | Sources of funding the entity to undertake the MHS function | Please specify all sources | | | |
| iv. | Services provided as part of the service level agreement: (tick next to each service provided) | Water quality monitoring | | | |
| | | Food control | | | |
| | | Waste management | | | |
| | | Health surveillance of premises | | | |
| | | Surveillance of communicable diseases, excluding immunisation | | | |
| | | Vector control | | | |
| | | Environmental pollution control | | | |
| | | Disposal of the dead | | | |
| | | Chemical safety | | | |
| 4. | What is the number of Environmental Health staff, prior to devolution, per authority? | | | | |
| | Provincial Department of Health | Write the number of staff here | Com serv | | |
| | District Municipality | Write the number of staff here | Com serv | | |
| | Local Authorities | Write the number of staff here | Com serv | | |
| | | | | | |
| | | | | | |
| | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 4.1. | How would you rate the availability of the following? | *Prior to Devolution* | | | *After Devolution* | | |
| | Staff | Poor | Adequate | Excellent | Poor | Adequate | Excellent |
| | Transport | Poor | Adequate | Excellent | Poor | Adequate | Excellent |
| | Equipment (technical operational) | Poor | Adequate | Excellent | Poor | Adequate | Excellent |
| | Support services, e.g. computers, e-mail, etc. | Poor | Adequate | Excellent | Poor | Adequate | Excellent |
| | Technical support, e.g. supervision, mentoring, training, etc. | Poor | Adequate | Excellent | Poor | Adequate | Excellent |

| | | | | | |
|---|---|---|---|---|---|
| 4.2. | Where appropriate, please indicate the adequacy of the following elements that were transferred to the district municipality (only for those authorities who have been absorbed into the district municipality): | | | | |
| | Staff | **Local Authorities** | Excellent | Adequate | Inadequate |
| | Transport | | Excellent | Adequate | Inadequate |
| | Equipment | | Excellent | Adequate | Inadequate |
| | Support services, e.g. computers, e-mail, etc. | | Excellent | Adequate | Inadequate |
| | Management information, e.g. workload, inputs, outputs, etc. | | Excellent | Adequate | Inadequate |
| | Staff | **Department of Health** | Excellent | Adequate | Inadequate |
| | Transport | | Excellent | Adequate | Inadequate |
| | Equipment | | Excellent | Adequate | Inadequate |
| | Support services, e.g. computers, e-mail, etc. | | Excellent | Adequate | Inadequate |
| | Management information, e.g. workload, inputs, outputs, etc. | | Excellent | Adequate | Inadequate |

| | | | | |
|---|---|---|---|---|
| 5. | Has a Municipal Health Services organisational structure been determined and approved for the district municipality? | Yes | No | Unsure |
| 5.1. | If yes, has the organisational structure been fully budgeted for in the 2006/2007 financial year? | Yes | No | Unsure |
| 5.2. | If yes, has the organisational structure been provided for in the | Yes | No | Unsure |

| | | | | | |
|---|---|---|---|---|---|
| | Medium Term Expenditure Framework? | | | | |
| 5.3. | If yes, has the placement of existing staff in the new organogram/ organisational framework been finalised? | Yes | No | Unsure | |
| 6. | Is the **devolution of MHS** catered for in the IDP of the district municipality? | Yes | No | Not applicable | |
| 7. | Is Municipal Health Services, **as a technical service area**, provided for in the IDP? | Yes | No | Not applicable | |
| 8. | Do you have a service plan for MHS for the poor, underdeveloped areas in your district municipality? | Yes | No | Not applicable | |
| 8.1. | If yes, what are the main strategies of MHS service delivery in these areas? | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| 9. | In your opinion, do you feel that adequate funding is available to maintain existing levels of environmental/municipal health service delivery? | Yes | No | Unsure | |
| 10. | In your opinion, do you feel that adequate funding is available to improve existing levels of environmental/municipal health service delivery? | Yes | No | Unsure | |
| 11. | How would you rate the roles and involvement of the following parties in the devolution of the MHS in your district municipality? | | | | |
| 11.1. | National Department of Health | Good | Average | Poor | Unsure |
| 11.2. | Provincial Department of Health | Good | Average | Poor | Unsure |
| 11.3. | South African Institute of Environmental Health | Good | Average | Poor | Unsure |
| 11.4. | Department of Provincial and Local Government | Good | Average | Poor | Unsure |
| 11.5. | South African Local Government Association | Good | Average | Poor | Unsure |
| 11.6. | Labour organisations representing affected staff | Good | Average | Poor | Unsure |
| 11.7. | Department of Water Affairs | Good | Average | Poor | Unsure |
| 11.8. | Department of Environmental Affairs and Tourism | Good | Average | Poor | Unsure |
| | | | | | |

| | | | | | | |
|---|---|---|---|---|---|---|
| 12. | Did you, or have you, established a representative Municipal Health Services devolution forum at the district municipality level? | Yes | | No | | n/a |
| 12.1. | If yes, when was it established? | | | | | |
| 13. | What is the estimated furthest distance to a community covered by a MHS rendering authority within the district municipality's area of jurisdiction (from the office as departure point)? | | | | | km |
| 14. | Do any areas exist, within the district municipality's boundaries that only receive municipal/environmental health services when formal complaints are lodged? | Yes | | No | | Unsure |
| 15. | How many Environmental Health Practitioners, per employing authority, have access to transport at any time? | | | | | |
| 15.1. | Local municipalities | Number of staff with constant vehicle access | | | | |
| 15.2. | District municipality | Number of staff with constant vehicle access | | | | |
| 15.3. | Provincial Department of Health | Number of staff with constant vehicle access | | | | |
| 16. | Please illustrate the existing coverage and quality for each of the following Municipal Health Services: | | | | | |
| 16.1. | Water quality monitoring | Coverage | None | Limited | Moderate | Full |
| | | Frequency | None | Only reactive | Occasionally | Regularly |
| 16.2. | Food control | Coverage | None | Limited | Moderate | Full |
| | | Frequency | None | Only reactive | Occasionally | Regularly |
| 16.3. | Waste management | Coverage | None | Limited | Moderate | Full |
| | | Frequency | None | Only reactive | Occasionally | Regularly |
| 16.4. | Health surveillance of premises | Coverage | None | Limited | Moderate | Full |
| | | Frequency | None | Only reactive | Occasionally | Regularly |
| 16.5. | Surveillance of communicable diseases, excluding immunisation | Coverage | None | Limited | Moderate | Full |
| | | Frequency | None | Only reactive | Occasionally | Regularly |
| 16.6. | Vector control | Coverage | None | Limited | Moderate | Full |
| | | Frequency | None | Only reactive | Occasionally | Regularly |
| 16.7. | Environmental pollution control | Coverage | None | Limited | Moderate | Full |
| | | Frequency | None | Only reactive | Occasionally | Regularly |
| 16.8. | Disposal of the dead | Coverage | None | Limited | Moderate | Full |
| | | Frequency | None | Only reactive | Occasionally | Regularly |
| 16.9. | Chemical safety | Coverage | None | Limited | Moderate | Full |
| | | Frequency | None | Only reactive | Occasionally | Regularly |

17. Please indicate the quality and adequacy of each of the following in your district municipality:

| | *Item* | *Quality* | | | *Adequacy of Amount* | | |
|---|---|---|---|---|---|---|---|
| 17.1. | Staffing | Inadequate | Capable | Excellent | Excellent | Acceptable | Too little |
| 17.2. | Funding | [redacted] | | | Excellent | Acceptable | Too little |
| 17.3. | Support Services | Inadequate | Capable | Excellent | Excellent | Acceptable | Too little |
| 17.4. | Transport | Inadequate | Capable | Excellent | Excellent | Acceptable | Too little |
| 17.5. | Specialised equipment | Inadequate | Capable | Excellent | Excellent | Acceptable | Too little |
| 17.6. | Management support | Inadequate | Capable | Excellent | Excellent | Acceptable | Too little |

| | | |
|---|---|---|
| 18. | Please list any additional duties (not mentioned in 16.) that the Provincial Department of Health fulfils as part of its Environmental/Municipal Health section: | |
| 19. | Please list any additional duties (not mentioned in 16.) that the district municipality fulfils as part of its Environmental/Municipal Health section: | |
| 20. | Please list any additional duties (not mentioned in 16.) that the local municipalities fulfil as part of its Environmental/Municipal Health section: | |

| | | | | |
|---|---|---|---|---|
| 21. | Are any measures in place to ensure that Municipal/Environmental Health Services are equitably/fairly provided to all geographical areas occurring in the jurisdiction of the district municipality? | Yes | No | Don't know |
| 21.1. | If yes, what? | | | |

| | | | |
|---|---|---|---|
| 22. | Please estimate the percentage of Environmental Health Practitioners who are appointed, in writing, as health inspectors/officers, under the: | [redacted] | |
| 22.1. | Foodstuffs, Cosmetics and Disinfectants Act, Act 54 of 1972 | | % |
| 22.2. | Health Act, Act 61 of 2003 | | % |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 23. | In your opinion, would structured training courses dedicated to the field of Environmental/Municipal Health Services improve the quality of MHS rendered in the district municipality? | Yes | | No | | Unsure | |
| 23.1. | If yes, please indicate the two most important aspects requiring in-service training programmes: | | | | | | |
| | | | | | | | |
| | | | | | | | |
| 24. | What is your designation/job title? | Designation of the interwee. | | | | | |
| 25. | Under what department and section do you fall in the organogram of the municipality? | Department | | | Section | | |
| 26. | How many people report directly to you? | | | | | | |
| 27. | Who do you report to? (i.e. job designation of superior) | | | | | | |
| 28. | Do you have secretarial support? | Yes | | No | | Yes, shared with other section | |
| 29. | What is your highest academic qualification? | Certif | Dip | B. Deg | Hons | Mast | Doct |
| 30. | What is your gender? | Male | | | Female | | |

TIME TAKEN FOR INTERVIEW: _____ minutes

## INTERVIEW WITH CHIEF FINANCIAL OFFICER OR OTHER APPROPRIATE PERSON

| | | | | |
|---|---|---|---|---|
| 31. | Do you have a separate budget vote for Municipal Health Services in the district municipality area? | Yes | No | Unsure |
| 32. | Who has the responsibility for the management of the budget allocated to MHS? (designation of person, not name) | | | |
| 33. | Is provision made in the 2006/2007 budget of the district municipality for rendering Municipal Health Services in the **entire** district municipality area? | Yes | No | Unsure |
| 34. | Have funding been accessed, or planned to be accessed, from the Basic Services Component of the Equitable Share for MHS provision in the district municipality? | Yes | No | Unsure |
| 35. | In your opinion, do you feel that adequate funding is available **to maintain existing levels** of Municipal Health Service delivery in the district municipality? | Yes | No | Unsure |
| | | | | |

| | | | | |
|---|---|---|---|---|
| 36. | In your opinion, do you feel that adequate funding is available **to improve existing levels** of Municipal Health Service delivery in the district municipality? | Yes | No | Unsure |
| 37. | Please indicate the amount of funding provided for Municipal Health Services in this financial year, in the district municipality, per source: | | | |
| 37.1. | Provincial subsidy allocation from the Department of Health: | R | | Unsure |
| 37.2. | Internal revenue: | R | | Unsure |
| 37.3. | Equitable share: | R | | Unsure |
| 37.4. | Other sources: | R | | Unsure |
| 37.4.1. | Please specify any other sources: | | | |
| | | | | |
| | | | | |

TIME TAKEN FOR INTERVIEW: _____ minutes

# Appendix 2

Sampling and response protocol

# Free State

| | | | |
|---|---|---|---|
| XHARIEP DISTRICT MUNICIPALITY (DC16) | Yes | | |
| MOTHEO DISTRICT MUNICIPALITY (DC17) | Yes | | |
| LEJWELEPUTSWA DISTRICT MUNICIPALITY (DC18) | Yes | | |
| THABO MOFUTSANYANE DISTRICT MUNICIPALITY (DC19) | Yes | | |
| FEZILE DABI DISTRICT MUNICIPALITY (DC20)<br>(Previously known as Northern Free State) | Yes | | |

# North West

| | | | |
|---|---|---|---|
| BOJANALA PLATINUM DISTRICT MUNICIPALITY (DC37) | No | | |
| CENTRAL DISTRICT MUNICIPALITY (DC38) | Yes | | |
| BOPHIRIMA DISTRICT MUNICIPALITY (DC 39) | Yes | | |
| SOUTHERN DISTRICT MUNICIPALITY (DC40) | Yes | | |

# Northern Cape

| | | | |
|---|---|---|---|
| KGALAGADI DISTRICT MUNICIPALITY (DC45) | Yes | | |
| FRANCES BAARD DISTRICT MUNICIPALITY (DC9) | Yes | | |
| NAMAKWA DISTRICT MUNICIPALITY (DC6) | Yes | | |
| PIXLEY KA SEME DISTRICT MUNICIPALITY (DC7)(Formerly Karoo) | Yes | | |
| SIYANDA DISTRICT MUNICIPALITY (DC 8) | No | | |

# Limpopo

| | | | |
|---|---|---|---|
| MOPANI DISTRICT MUNICIPALITY (DC33) | No | | |
| VHEMBE DISTRICT MUNICIPALITY (DC34) | Yes | | |
| CAPRICORN DISTRICT MUNICIPALITY (DC35) | Yes | | |
| WATERBERG DISTRICT MUNICIPALITY (DC36) | Yes | | |
| GREATER SEKHUKHUNE DISTRICT MUNICIPALITY (DC 47) | Yes | | |

# Gauteng

| | | | |
|---|---|---|---|
| SEDIBENG DISTRICT MUNICIPALITY (DC42) | Yes | | |
| METSWEDING DISTRICT MUNICIPALITY (DC46) | Yes | | |
| WEST RAND DISTRICT MUNICIPALITY (DC48) | Yes | | |

# Mpumalanga

| | | | |
|---|---|---|---|
| GERT SIBANDE DISTRICT MUNICIPALITY (DC30) | Yes | | |
| NKANGALA DISTRICT MUNICIPALITY (DC31) | Yes | | |
| EHLANZENI DISTRICT MUNICIPALITY (DC32) | Yes | | |

# KwaZulu-Natal

| | | | |
|---|---|---|---|
| UGU DISTRICT MUNICIPALITY (DC21) | Yes | | |
| UMGUNGUNDLOVU DISTRICT MUNICIPALITY (DC22) | No | | |
| UTHUKELA DISTRICT MUNICIPALITY (DC23) | Yes | | |
| UMZINYATHI DISTRICT MUNICIPALITY (DC24) | Yes | | |
| AMAJUBA DISTRICT MUNICIPALITY (DC25) | Yes | No financial part | |
| ZULULAND DISTRICT MUNICIPALITY (DC26) | No | | |
| UMKHANYAKUDE DISTRICT MUNICIPALITY (DC27) | No | | |
| UTHUNGULU DISTRICT MUNICIPALITY (DC28) | No | | |
| ILEMBE DISTRICT MUNICIPALITY (DC29) | Yes | | |
| SISONKE DISTRICT MUNICIPALITY (DC43) | Yes | | |

# Eastern Cape

| | | | |
|---|---|---|---|
| CACADU DISTRICT MUNICIPALITY (DC10) | Yes | | |
| AMATHOLE DISTRICT MUNICIPALITY (DC12) | Yes | | |
| CHRIS HANI DISTRICT MUNICIPALITY (DC13) | Yes | | |
| UKHAHLAMBA DISTRICT MUNICIPALITY (DC14) | Yes | | |
| O R TAMBO DISTRICT MUNICIPALITY (DC15) | Yes | | |
| ALFRED NZO DISTRICT MUNICIPALITY (DC44) | Yes | | |

# Western Cape

| | | | |
|---|---|---|---|
| WEST COAST DISTRICT MUNICIPALITY (DC1) | Yes | | |
| CAPE WINELANDS DISTRICT MUNICIPALITY (DC2) | Yes | | |
| OVERBERG DISTRICT MUNICIPALITY (DC3) | No | | |
| EDEN DISTRICT MUNICIPALITY (DC4) | Yes | | |
| CENTRAL KAROO DISTRICT MUNICIPALITY (DC5) | Yes | | |