Challenges in the integration of Municipal Health Services in the uMgungundlovu District municipality, KwaZulu-Natal

BY

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Supervisor: Mr Andy Gray
Co-supervisor: Dr Catherine Blanchard

DECLARATION

I, Nompumelelo Chapi declare that:

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LIST OF ACRONYMS

ANC   African National Congress

CoGTA   Department of Co-operative Governance and Traditional Affairs

DHS   District Health System

EHP   Environmental Health Practitioner

HPCSA   Health Professions Council of South Africa

EHS   Environmental Health Services

MHS   Municipal Health Services

NDoH   National Department of Health

NHS   National Health System

PDoH   Provincial Department of Health

PHC   Primary Health Care

PPHC   Personal Primary Health Care

SALGA   South African Local Government Association

UMDM   UMgungundlovu District Municipality

ABSTRACT

The National Health Act (Act 61 of 2003) defined Municipal Health Services and gave full responsibility for this function to district municipalities and metropolitan municipalities. District municipalities were required, by law, to provide municipal health services which were previously rendered by local municipalities and the Provincial Department of Health. This, therefore, required the transfer of staff, assets and liabilities from local municipalities and the Provincial Department of Health to district municipalities. The purpose of the study was to identify barriers to and facilitating factors for the transfer of municipal health services from the seven local municipalities and the Provincial Department of Health to the uMgungundlovu district municipality.

A cross-sectional, descriptive study design was employed. A structured questionnaire was used to collect quantitative data from local municipalities and the Provincial Department of Health on the package of environmental health services offered and the available human resources. Qualitative data was collected through in-depth interviews and focus group discussions with key role players in the provision of environmental health within the district.

The key findings of the study were:
- o There were no changes to the package of environmental health services offered by local municipalities and the Provincial Health following the definition of Municipal Health Services.
- o The Provincial Department of Health continues to play an important role in the provision of Municipal Health Services in the district
- o There was a lot of awareness-raising on the integration process; however planning for the integration was very poor.
- o The lack of progress in integration has had a negative impact on service delivery and on the environmental health personnel involved.
- o The relationship between district and local municipalities, a lack of understanding of environmental health, budget allocation, communication,

lack of commitment, capacity, and lack of a champion were seen as the main barriers to the integration process.

The study was able to identify possible gaps in the planning process that, if revisited, could assist the district municipality in better handling the process.

CHAPTER 1: INTRODUCTION

1.1 Introduction

This chapter will explore briefly the decentralisation of municipal health services. In this chapter, the background to the research, purpose of the research, the research objectives, and the structure of the dissertation will also be presented.

1.2 Background to the research

Environmental health, as defined by the World Health Organization, is broadly aimed at addressing all the "physical, chemical and biological factors external to a person and related factors impacting behaviour" (World Health Organization, 2012). Environmental health is targeted at addressing environmental health priorities as defined by the United Nations Conference on the Human Environment held in 1972 in Stockholm (United Nations Environment Programme, 1972). These priorities have been supplemented by the United Nations Conference on Environment and Development (UNCED) Agenda 21 strategy, agreed to at the Rio de Janeiro Earth Summit in 1992 (United Nations Department of Economic and Social Affairs, 1992). Locally, environmental health has been informed by the White Paper on Reconstruction and Development (President of the Republic of South Africa, 1994), and the corresponding Year 2000 Health Goals and Objectives as laid down in Chapter 21 of the White Paper for the Transformation of the Health System in South Africa (Minister of Health, 1997).

After the democratic transition in 1994, the Department of Health (DoH) was entrusted with the improvement of South Africa's health system, including environmental health services. Starting with the White Paper for the Transformation of the Health Services in 1997 (Minister of Health, 1997), the DoH endeavoured to limit health risks arising from the physical and social environment. In order to be in

line with the Republic's constitutional principle of providing everyone with the right to a living and working environment which is not detrimental to his/her health and wellbeing (Republic of South Africa, 1996), the health sector set about implementing developmental environmental health legislation as opposed to the law enforcement approach that have used in the past. In addition, the Constitution (Republic of South Africa, 1996) brought other changes, including the devolution of certain responsibilities for health services to the provincial and municipal levels.

A range of legislative changes after 1994 have also had a bearing on the provision of environmental health services. The Municipal Structures Act (Act 117 of 1998) (Republic of South Africa, 1998a), stated that Municipal Health Services (MHS) were to be the responsibility of the district municipalities (Category C) and not local municipalities (Category B). This was further confirmed by the National Health Act, (Act 61 of 2003) (Republic of South Africa, 2003), where MHS were formally defined for the first time, and metropolitan (Category A) and district (Category C) municipalities were given exclusive competency to provide municipal health services.

1.3   What is known so far?

District municipalities are required, by law, to take responsibility for municipal health services. This has required the transfer of staff, assets and liabilities from local municipalities to district municipalities, and from provinces to districts. The transfer of MHS to uMgungundlovu district municipality (UMDM) has been discussed over many years. However, implementing the transfer has been a challenge. Meetings between the affected local municipalities and the district have been held since 2005, with the prospect of a transfer at the beginning of each financial year (July of every year), but this has never materialised. This uncertainty has had a negative impact on the staff responsible for this function, and has to some extent affected budgeting within the current local municipalities. Some municipalities have frozen the posts of Environmental Health Practitioners (EHPs), and have been reluctant to provide resources for municipal health services. To date, the integration of municipal health services into the uMgungundlovu district has not been completed.

1.4 What needs to be known?

The study will attempt to establish why the integration of municipal health services in the uMgungundlovu district has not happened. It will seek to identify the barriers to the transfer of municipal health services from the seven local municipalities and Provincial Department of Health to the UMDM.

1.5 Why is this important?

Identifying barriers to the integration of municipal health services will assist in developing appropriate solutions to the problems in the UMDM and other districts, and will, hopefully, facilitate the implementation of the legislation and the improvement of service rendered to the inhabitants of the country.

1.6 Statement of the problem

UMgungundlovu district municipality (UMDM), like most municipalities in the country, has not consolidated municipal health services from the seven surrounding local municipalities, nor delegated the function to them, as required by law.

1.7 Purpose of the study

The purpose of the study was to investigate obstacles to and facilitating factors for the integration of municipal health services in UMDM.

1.8 Objectives

The following objectives were set for the study:

1. To document, through a literature review, existing evidence of how the District Health Systems (DHS) policy has been implemented in South African districts, specifically in relation to Environmental Health Services.

2. To describe the changes that are taking place towards achieving the goal of integrated (and decentralised) Environmental Health Services in UMDM.

3. To identify and describe the key factors enabling the integration of municipal health services in district municipalities, using UMDM as an example.

4. To identify and describe the key factors preventing the integration of municipal health services in district municipalities, using UMDM as an example.

5. To make recommendations, based on the study findings, to guide implementation of the integration of municipal health services in district municipalities.

1.9   Definitions of terms

Decentralisation: The transfer of various functions of government, management or administration from the national (central) level to "sub-national levels". These functions include power, authority, resources and responsibilities. The "sub-national level" usually refers to lower levels of government, but can include entities such as parastatals, administrative field offices, non-governmental organisations (NGOs) and structures representing the community or public (Hall, Haynes & McCoy, 2002).

Deconcentration: The transfer of resources, responsibilities and authority internal to an organisation or administration. Deconcentration shifts power from central offices to

peripheral offices of the same administrative structure. (Hall *et al.*, 2002).

Devolution: The shifting of power and responsibility to separate administrative structures but that are still within the public sector (Pillay, McCoy & Asia*,* 2001)

Environmental health: The World Health Organisation defines environmental health as those aspects of human health including quality of life that are determined by physical, chemical, biological, social and psychosocial factors in the environment. Environmental health also refers to "the theory or practice of assessing, correcting, controlling and preventing those factors in the environment that can potentially adversely affect the health of present and future generations (World Health Organization, 1993).

Health System: A system that "consists of all organizations, people and actions whose *primary intent* is to promote, restore or maintain health and is inclusive of efforts to influence determinants of health as well as more direct health-improving activities e.g. a mother caring for a sick child at home; private providers; behaviour change programmes; vector-control campaigns etc." (World Health Organization, 2007)

Integration: The act of combining or adding parts to make a unified whole (Collins English Dictionary, 2003).

Municipal Health Services: The sub-set of the bigger basket of environmental health services (EHS), excluding malaria, port health and control of hazardous substances, as defined in the National

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Health Act (Act 61 of 2003) (Republic of South Africa, 2003).

Municipal Manager: A person appointed in terms of section 82 of the Municipal Structures Act (Act 117 of 1998) (Republic of South Africa, 1998).

Personal Primary Health Care: These are services directed at individual patients, as opposed to the environmental-focused services that are encompassed in the definition of municipal health services.

Primary Health Care: A strategy to achieve health for all by the year 2000, as adopted by the World Health Assembly in 1977 and further enunciated by the Declaration of Alma-Ata in 1978 (World Health Organization, 1978).

Social Compact: An agreement, entered into by individuals, that results in the formation of the state or of organized society, the prime motive being the desire for protection, which entails the surrender of some or all personal liberties (Collins English Dictionary, 2003).

1.10 Scope of the study

The study entailed conducting in-depth interviews and focus group discussions with four Municipal Managers, five managers responsible for environmental health, union representatives and 23 Environmental Health Practitioners in the uMgungundlovu district municipal area. Quantitative data on the human resources and environmental health package delivered by environmental health practitioners in each local municipality was also collected from environmental health managers in the district. Furthermore, the study involved documenting existing evidence on the

implementation of district health system in South Africa by reviewing available documents.

1.11 Structure of the dissertation

This report is divided into five chapters. Chapter 1 provides the introduction to the study and its objectives. Chapter 2 provides an overview of the rationale and principles for integration of municipal health services, and reviews the available literature on the District Health System, including the decentralisation process, both locally and internationally. This chapter also includes the theoretical framework for the analysis. Chapter 3 provides the methodology employed in conducting this study. Chapter 4 contains the results of the study. Chapter 5 discusses the main findings of the study and makes recommendations.

1.12 Summary

Municipal Health Services, which is a term that evolved in South Africa to define the package of health services to be rendered by local government, are clearly defined in the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003), as being environmental health services, excluding those functions that are to be provided by Provincial Health. A decade into the new dispensation, Cullinan (2004) wrote that "Government has also committed itself in the 2003 Health Act to the gradual devolution of more health responsibilities to local government, starting with environmental health services in July 2004. However, this policy direction needs careful consideration given the many weaknesses at local level".

Some district municipalities have been able to consolidate MHS within their districts. However, this has not been the case in the UMDM. This study, therefore, attempted to identify facilitating factors for and existing barriers to this process of integration. This study will hopefully make a contribution towards addressing these challenges.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

This chapter presents a review of the relevant literature, in order to establish the context for the integration of municipal health services in the uMgungundlovu district municipality (UMDM).

There is very little documented information available on the status of municipal health services in South Africa, especially after the enactment of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003).In particular, documentation of the process of integration of municipal health services, and the devolution of the function in those districts that have managed this, is required. It is, however, evident that a lot has been done to develop policy documents regarding the decentralisation of the municipal health function. However, not much is available on the actual processes and procedures to be followed in order to achieve decentralisation. There are, nonetheless, some lessons that could be learned from other countries on the matter of decentralisation of health services in general.

This chapter first examines the legislative framework for the provision of municipal health services, and then describes the district health system and how the approach to the decentralisation of municipal health services has evolved over the years.

This chapter also focuses on the theoretical framework that will be used to evaluate the decentralisation process in the UMDM.

2.2 Purpose of the literature review

The role of the literature review, according to Joubert and Katzenellenbogen (1997), is to:
- Find out all work that has been done on the research subject

- Critically review methods used in previous studies and how these can be adapted to suit the research at hand
- Reveal how the current study differs from what has already been done and what contributions the current study can make.

2.3   Scope of the literature review

2.3.1   Defining Environmental Health Services

This study is guided by the understanding that environmental health services, which is concerned amongst other things with the investigation of outbreaks of diseases and the monitoring of factors in the environment affecting health and health promotion, has an important role to play in mitigating preventable diseases through improvements in the environment. A number of communicable diseases emanate from the environment. These include diseases such as diarrhoeal diseases resulting from contaminated food and water, and respiratory conditions associated with poor air quality. The World Health Organization (World Health Organization, 2007), in a report entitled "Everybody business: strengthening health systems to improve health outcomes: WHO's framework for action", pointed to the failure of the health system as being central to the poor health outcomes in all developing countries. WHO believe that much of the burden of disease can be prevented or cured with known and affordable technologies.

In an report posted on the Development Bank of Southern Africa's web site, Balfour (n.d) pointed out that four of the eight elements of Primary Health Care (PHC) outlined at Alma-Ata (namely education on health problems, promotion of food supply and nutrition, safe water and basic sanitation, and prevention of locally endemic diseases) can be considered part of the promotive and preventive health activities that fall within the scope of practice of Environmental Health Practitioners (EHP). The role of environmental health in the health system is important and, therefore, environmental health services in the country should be strengthened to help in improving public health. It is possible to reduce the burden of diseases by ensuring that hazardous environmental health issues are controlled through

investments in environmental health services (Agenbag & Balfour-Kaipa, 2008). This investment should not be solely associated with monetary investment, but should also focus on the human resources responsible for rendering the service.

2.4 Literature reviewed

2.4.1 Context for the transformation of the health system

Healthcare provision under the apartheid era government was characterised by being highly fragmented and officious. Health care services were provided in a discriminatory manner. When the government of national unity came into power in 1994, it was faced with the challenge of developing a programme that would redress social and economic injustices, eradicate poverty, reduce waste, increase efficiency and promote greater control by communities and individuals over all aspects of their lives. For the health sector this meant complete transformation of the national health care delivery system and all relevant institutions. All legislation, organisations and establishments dealing with health had to be re-examined, as discussed in the African National Congress National Health Plan (African National Congress, 1994:1), so as to:

- "Ensure that health is considered holistically and that focus is shifted from one aspect of health which is medical care."
- "Underscore the important role that is played by all health care workers in the health system and ensuring that team work plays an important role in the system."
- "Acknowledge that communities are key aspects of the health system and therefore ensuring that systems which will allow for effective community participation, involvement and control were created."

Recognising the pressing need for total transformation of the health sector in South Africa, the African National Congress (ANC) started a process of developing an overall National Health Plan even before assuming the role of government in 1994. In the ANC National Health Plan (African National Congress, 1994), the Primary Health Care (PHC) approach was identified as the guiding principle for the

restructuring of the health system. The plan embraced the concept of community development, and committed to full community participation in the planning, provision, control and monitoring of health services. The overall objective was to reduce inequalities in access to health services, especially in the rural areas and deprived communities.

The ANC National Health Plan (African National Congress, 1994) also called for the establishment of a National Health System (NHS). In the NHS, the provision of health care is to be co-ordinated among local, district, provincial and national authorities. These were, as far as possible, to concur with provincial and local government boundaries. The plan also emphasises the creation of Community Health Centres (CHCs) to provide comprehensive services, including promotive, preventive, rehabilitative and curative care. In accordance with the ANC National Health Plan (African National Congress, 1994), it was necessary to decentralise the powers, including accountability and management of financial resources for the provision of health care services to the "lowest possible level of governance".

The ANC National Health Plan also gave much needed attention to health education on issues relating to sexuality, child spacing, oral health, substance abuse, and environmental and occupational health. The role of environmental health services within the system was included in the plan and a plan of action for translating the associated environmental health policy principles was highlighted. This included giving responsibility for services such as public utilities (water, sanitation, roads, food-handling premises, and recreational facilities) to local authorities with whom the NHS was to interact for technical advice, surveillance, inspection and enforcement purposes.

The ANC National Health Plan, therefore, laid the foundation for a number of legislative changes that were to follow. While an over-arching new National Health Act was not enacted until 2003 (Republic of South Africa, 2003), a number of important policy documents and other legislative instruments were developed in the immediate post-1994 period. The first of these was the White Paper for the Transformation of the Health System in South Africa (Minister of Health, 1997),

which was informed by the requirements of the new Constitution (Republic of South Africa, 1996).

2.4.2 Legislative framework

Since the initial publication of the ANC National Health Plan in 1994 and the White Paper for the Transformation of the Health System in South Africa in 197, the provision of environmental health services has been informed by the following pieces of legislation (listed in chronological order of enactment):

- The Health Act (Act 63 of 1977) (Republic of South Africa, 1977)
- The Constitution of the Republic of South Africa (Act 108 of 1996) (Republic of South Africa, 1996)
- The Local Government: Demarcation Act (Act 27 of 1998) (Republic of South Africa, 1998b)
- The Local Government: Municipal Structures Act (Act 117 of 1998) (Republic of South Africa, 1998a)
- The National Health Act (Act 61 of 2003) (Republic of South Africa, 2003)

The Constitutional demands on health are described below, followed by the major elements of the 1997 White Paper and subsequent legislation.

2.4.2.1 The Constitution of the Republic of South Africa (Act 108 of 1996)

Section 27 of the Constitution of the Republic of South Africa (Act 108 of 1996) (Republic of South Africa, 1996) gave all South African citizens the right to health care services, inclusive of reproductive health care, and adequate food and water.

Section 27 reads as follows:

"27. Health care, food, water and social security

1. Everyone has the right to have access to:
   a. health care services, including reproductive health care;

    b. sufficient food and water; and

    c. social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.

2. The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.

3. No one may be refused emergency medical treatment."

It is important to note the requirement in sub-section 27(2) that the State take active steps to ensure the "progressive realisation of each of these rights".

In addition, Section 24 of the Constitution gave every citizen a right to a protected environment, stated as follows:

"24. Environment

Everyone has the right

    a. to an environment that is not harmful to their health or well-being; and

    b. to have the environment protected, for the benefit of present and future generations, through reasonable legislative and other measures that

        i. prevent pollution and ecological degradation;

        ii. promote conservation; and

        iii. secure ecologically sustainable development and use of natural resources while promoting justifiable economic and social development".

In light of the above, legislation for re-organising the health system in relation to public health, including the living environment, had to be developed. This supreme law of South Africa dictated an array of changes, including the devolution of certain responsibilities for health services to the provincial and municipal levels. The Constitution first mentioned MHS as part of the powers and functions of municipalities in Section 156 (1). In this section, municipalities were given executive authority in respect of and the right to administer the local government matters listed

in Part B of Schedules 4 and 5. Part B of Schedule 4 listed the following as "local government matters to the extent set out in section 155(6)(a) and (7)":

- Air pollution
- Building regulations
- Child care facilities
- Electricity and gas reticulation
- Fire fighting services
- Local tourism
- Municipal airports
- Municipal planning
- **Municipal health services** (emphasis added)
- Municipal public transport
- Municipal public works only in respect of the needs of municipalities in the discharge of their responsibilities to administer functions specifically assigned to them under this Constitution or any other law
- Pontoons, ferries, jetties, piers and harbours, excluding the regulation of international and national shipping and matters related thereto
- Stormwater management systems in built-up areas
- Trading regulations
- Water and sanitation services limited to potable water supply systems and domestic waste-water and sewage disposal systems.

The matters listed in Part B of Schedule 5 also included some of relevance to environmental health services, such as:
- Cleansing
- Control of public nuisances
- Licensing and control of undertakings that sell food to the public
- Markets
- Municipal abattoirs
- Noise pollution
- Refuse removal, refuse dumps and solid waste disposal.

However, the Constitution did not specify the type of municipality responsible for "municipal health services", nor did it define the term.

2.4.2.2 The White Paper for the Transformation of the Health System

In order to give effect to the Constitutional mandate established in 1996, and to address issues of equity, fragmentation, efficiency, access to services and accountability, the White Paper for the Transformation of the Health System in South Africa was issued in 1997 (Minister of Health, 1997). The White Paper called for the establishment of a District Health System (DHS). The restructuring of the health services as outlined in the White Paper, required the assignment of different functions to the national department, provinces and districts.

The National Health Department

The National Health Department was to undertake a leadership role for health policy and legislation formulation. Issues of capacity building, equal provision of the required resources, and ensuring that these were appropriately used by both the provinces and municipalities, were entrusted to the National Health Department. This was to be an important role for national health during the decentralisation process, especially in the devolution of municipal health services to district municipalities who had no previous involvement in the provision of this service.

The Provincial Health Department

In the White Paper, the Provincial Health Departments were entrusted with the promotive and monitoring role of public health within the province. They were also entrusted with developing and supporting a caring and effective provincial health system through the establishment of a province wide district health system, based on the primary health care principles. Their function also included provision of regional and specialised hospital services, as well as academic health services where

appropriate. Technical and logistical support needed by health districts for provision of non-personal health services was to be rendered at the provincial level.

The Districts

According to the White Paper the District Health System (DHS) was to be housed in the districts. It was necessary for the DHS to make health promotion possible, ensure that essential health care was universally available, and also to allow for proper planning and use of resources both from public and private health sectors. For better management it was important that the country be divided into geographically sound, practical health districts which would be locally situated at a level closest to the people. Each district was to create a team that was to take responsibility for planning and management of all local health services for a defined population, including arranging for the delivery of a comprehensive package of PHC and district hospital services (level 1). The districts had to do this within national and provincial policy guidelines.

The White Paper for the Transformation of the Health System in South Africa (Minister of Health, 1997) first proposed a single countrywide salary grade and similar conditions of employment for district level staff. However, as a variety of conditions existed between and within provinces, three governance options were proposed. These were:

- A provincial option – where provinces, through a district health manager, were to assume responsibility for all health districts at a local level in areas lacking adequate capacity.
- The statutory district health authority – where legislation could be made to create a district health authority for each health district. This was to apply in cases where all local authorities in a health district had no capacity to provide a comprehensive service.
- The local government option – where a local authority with boundaries coterminous with those of a health district and with capacity to render a comprehensive service, was to be given full responsibility for the district health service.

In the White Paper (Minister of Health, 1997), functions of a health district as they relate to health care were listed as follows:

"(a) Health Care

  i.   Ensuring health promotion services;

  ii. providing for collaboration with other sectors of Government and NGOs in promoting health and ensuring the rendering of health services in the health district;

  iii. providing for community participation in health promotion and health service provision;

  iv. **ensuring the availability of a full range of PHC and other relevant health services in communities, clinics, community health centres, district hospitals and other facilities;**

  v.   **ensuring primary environmental health services, the promotion and maintenance of environmental hygiene; the prevention of water pollution; enforcement of environmental health legislation, i.e. regarding sanitation, housing, smoke, noise, fitter, food hygiene and occupational hygiene, and the identification and control of local health hazards** (emphasis added);

  vi. rendering essential medico-legal services; and

  vii. ensuring services to those arrested and charged, in collaboration with the relevant authorities."

According to this list, it was expected that personal health services be made available through districts. Furthermore, all environmental health services (through the identification, preventive, promotive and enforcement role) were to be delivered at a district municipal level. District municipalities were more likely to be coterminous in terms of boundaries with the health district after the demarcation of municipal boundaries as compared to local municipalities, which are geographically smaller.

What was also important about the DHS was the fact that the communities being served were to have a say over their own health, which was a step forward when compared to the past.

2.4.2.3   The Local Government: Demarcation Act (Act 27 of 1998) and the Municipal Structures Act (Act 117 of 1998)

In 1998, while the National Health Bill was still being developed, legislative developments in other sectors, including local government, were significantly shaping the future health system. The boundaries, types, categories, powers and functions of municipalities, as determined by these two laws, was in large measure to form the basis for the establishment of a District Health System and the delivery of primary health care services in South Africa.

The Local Government: Demarcation Act (Act 27 of 1998)

The Local Government: Demarcation Act (Act 27 of 1998) (Republic of South Africa, 1998b) made provision for a Demarcation Board, which was to be responsible for the determination of municipal boundaries for the whole of South Africa. The Act listed various factors to be considered when determining municipal boundaries. These included ensuring a co-ordination of municipal, provincial and national programmes and services. The Demarcation Board then went on to divide the entire country into 285 municipalities, all falling into the different categories as per the Constitution. The existence of these municipalities was cemented by the local government elections which took place in December 2000. This, therefore, gave shape to the health districts which were to have the same boundaries as the district municipal boundaries (i.e. to be coterminous).

The Local Government: Municipal Structures Act (Act 117 of 1998)

Closely following the Demarcation Act was the passing of the Local Government: Municipal Structures Act (Act 117 of 1998) (Republic of South Africa, 1998a), which provided for the establishment of various categories and types of municipalities, as well as their functions and powers. When this Act was amended in 2000 as the Local Government: Municipal Systems Act (Act 32 of 2000) (Republic of South Africa, 2000), powers and functions relating to municipal health services were given to

district municipalities; thereby clarifying this matter first mentioned in the Constitution. This was a noticeable departure from the past, as this function had historically been performed by local municipalities and provinces. This was to be a new responsibility for the district municipalities.

2.4.2.4   The National Health Act (Act 61 of 2003)

After a number of drafts, a National Health Bill was finally published for public comment in 2001 (Minister of Health, 2001). The National Health Bill set out the framework for setting up a District Health System as the foundation for a national health system. Although this Bill generally advanced progress towards a DHS, there were still areas of confusion that needed clarification. One of those areas was the inability of the Bill to clarify the roles of the provincial and district level when defining MHS and setting out functions and responsibilities. The draft Bill gave a broader definition of MHS, including "environmental health services, promotive and preventative health services as well as other health services that were rendered by other municipalities at time of coming into operation of the Act".

Barron and Asia (2001) have pointed out that MHS were purposely defined as such so as to safeguard for the health sector that portion of municipal rates revenue being spent on PHC. However, in July 2002, the forerunner of the National Health Council, then known as 'MinMec', took a decision to narrowly define MHS as "environmental health services" only, in contrast to the earlier, broader definition of MHS (Haynes & Hall, 2002). This narrow definition of MHS meant that mobile clinics, clinics and district (level 1) hospitals were to remain the legal responsibilities of provincial government. The 'MinMec's definition of MHS was now in conflict with the national policy's long-term vision, as discussed in The White Paper (Minister of Health, 1997), of local government being responsible for the full package of district health services (up to and including district hospitals) (Hall *et al.*, 2002). In order to accommodate this deviation from the White Paper, 'Minmec' expected provincial government to delegate other primary health care services to a district or metropolitan municipality

where the capacity to render such services existed, by arrangement and with the necessary resources.

Also, in the absence of a clear definition of MHS, and to prevent disruption of service delivery, the Minister of Provincial and Local Government made legal provision in terms of Government Notice No. 1280 of 28 November 2000, for local authorities to continue with the provision of those health services which they had provided prior to the enactment of the Municipal Structures Act (Haynes, 2005). These provisions were later revoked after the definition of MHS was legalised.

The National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) was enacted in 2003, and assented to by the President in 2004. In the National Health Act, important elements of the District Health System (DHS) were finally established. The DHS consisted firstly of health districts, which had the same boundaries as district and metropolitan municipalities. MHS were clearly defined in the Act as including nine components of Environmental Health Services (EHS), namely:

- Monitoring water quality and availability;
- Food control;
- Waste management;
- Health surveillance of premises;
- Surveillance and prevention of communicable diseases, excluding immunizations;
- Vector control;
- Environmental pollution control;
- Disposal of the dead; and
- Chemical safety.

The traditional activities comprising EHS were split into Municipal Health Services (to be provided by the metropolitan and district municipalities), and the remaining activities – port health, malaria control and control of hazardous substances – to be provided by the Provincial Departments of Health. The Provincial Departments of Health were given the function of monitoring and supporting municipalities in their execution of the municipal functions as envisaged in the White Paper.

Therefore, the implementation of the Act required the devolution of environmental health functions rendered at that time by Provincial Health Department to districts and metropolitan municipalities (Hall *et al.*, 2005). Furthermore, section 32(1) of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) stated that it was the exclusive competency of every metropolitan (Category A) and district (Category C) municipality to ensure the provision of municipal health services. This legislation, in the interests of health service delivery, also allowed for district municipalities to enter into a service level agreement with local (Category B) municipalities if they were not in a position to deliver MHS (i.e. if the necessary capacity did not exist). This meant that, as from July 2004, MHS were to be taken over by district or metropolitan municipalities, or else the function had to be delegated to local municipalities, through a service level agreement. Taking over this function was not going to be easy for district municipalities, as most of them were newly formed with little revenue generating power. Proper planning, as well as the right personnel to oversee the integration, was going to be very important.

In the National Health Act, responsibility for Personal Primary Health Care (PPHC) services was given to the Provincial Departments of Health (PDoH).

Although the Health Act of 1977 (Act 63 of 1977) (Republic of South Africa, 1977) was replaced by the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003), some sections of this Act have remained in force, in order to enable Environmental Health Practitioners (EHP) to execute their duties. This has been necessary, as some of the provisions of the National Health Act of 2003 have not yet been promulgated, in particular those dealing with environmental health investigations.

2.5 Other developments towards decentralisation and progress made

2.5.1 The District Health System explained

The District Health System (DHS) was adopted as a tool for achieving equity, improving access to services, and providing appropriate and responsive services for uplifting the health status of formerly disadvantaged South African communities. The DHS has been globally accepted as a medium for the delivery of the Primary Health Care approach (Hall *et al.*, 2002). Improving the health of all citizens requires a well-coordinated health system and good administration of health services, which are essential in the provision of a full range of promotive, preventative, curative, and rehabilitative health care and this translates into a comprehensive package of PHC. As previously indicated; environmental health, which is the subject of the current study, forms an important part of promotive and preventative health care.

The DHS is part of the National Health System (NHS). For all health systems to achieve their goals, they have to carry out some basic functions, regardless of how they are organised. As part of these functions, they have to provide services; develop health workers and important resources for delivering this service; mobilize and allocate finances; and ensure health system leadership and governance or stewardship (World Health Organization, 2007). All the above were key aspects that needed to be carefully considered and planned for before and during the decentralisation process

The DHS was to be an administrative home to between 200 000 and 500 000 people (Harrison, 1997).

Central to the DHS concept is a decentralisation process of moving health care management from the central to the peripheral levels of government. The government of national unity, therefore, settled on decentralisation as a model for governing and managing the DHS (Pillay *et al.*, 2001). Decentralisation is said to take different forms, which include deconcentration, devolution and delegation; and

in South Africa it takes the form of a mixture of all three. For decentralisation to be realised, the promulgation of enabling legislation was necessary.

The District Health System is about moving health services closer to the communities being served. Although district municipalities and local municipalities are both part of local government, local municipalities seem to be the closest to the communities. When looking at the current local government political system, as set out in the Local Government: Municipal Structures Act (Act 117 of 1998) (Republic of South Africa, 1998a), district councillors are elected by a system of proportional representation, with 60 percent of district councillors elected indirectly. By contrast, local councillors are directly elected by communities and 50 percent of local councillors are ward councillors and are true representatives of the communities they live in. One might say that residents, therefore, have no direct access to district councillors through their ward political representatives, and also have limited contact with district municipalities. For some, it would seem that moving MHS away from local municipalities would mean moving this service one step further from the communities who access it. Local municipalities would seem to have more direct accountability to their communities.

2.5.2   District Health System developments and progress made

Whilst the Demarcation Board was still working on municipal boundaries, work on implementing the DHS was in progress. As a way of taking the policy forward, 'MinMec' took the following key decisions: local government was to take responsibility for the health districts, and these health districts were to be aligned with district and metropolitan municipal boundaries.

At the beginning of 1999, there were 39 health regions, 174 health districts and 843 municipalities nationally (Pillay *et al.,* 2001). All health regions were provided with a management team and staff to sustain district development. In the majority of health districts, management staff was appointed. Great efforts were made by staff at district level to implement this concept. However, progress in amalgamating health systems at district level was slow (Pillay *et.al*, 2001).

Following the demarcation of municipal boundaries, however, all this had to change. Health district boundaries drawn before demarcation of boundaries in terms of the Local Government: Demarcation Act (Act 27 of 1998) (Republic of South Africa, 1998b) had to be aligned with metropolitan and district municipal boundaries. This meant that health district boundaries had to be redrawn in many provinces to align the 174 health district with the new municipal boundaries. This had a negative impact on health personnel who had worked very hard on the DHS concept and they became demoralised (Cullinan, 2006). In some instances, the new health districts had very large catchment populations which created a huge challenge in their management in terms of the PHC approach (Barron & Sankar, 2000). Overall, there was not much progress made towards establishing the DHS in the provinces because of the uncertainty that followed the local government transformation.

It was during 2001 that the District Health System (DHS) model was more firmly established and some important goals were achieved. These, as discussed by Barron and Asia (2002: 17), included:

- "Putting in place a formal finalised version of the third sphere of government. This meant that South Africa was to be covered by wall to wall metropolitan (Type A) municipalities and district (Type C) municipalities. Each of the district municipalities was sub-divided into two or more local (Type B) municipalities.
- A health Ministerial Forum (MinMec) decision endorsed the vision of a municipality-based DHS in South Africa, where comprehensive Primary Health Care (PHC) services were to be delivered."

The decision to deliver a comprehensive PHC service by municipalities meant that Personal Primary Health Care (PPHC) was also to become a district municipal function. This would further add to the challenge facing district municipalities in terms of available resources, organisation and administration. However, this decision was later reversed when the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) assigned responsibility for PPHC, including its financing, to Provincial Departments of Health (Hall, Ford-Ngomane & Barron, 2005).

By 2005, provinces were adopting different approaches and plans for the provision of PPHC, with some provinces opting for the Provincial Department of Health to transfer all PPHC staff from municipalities, while others opted for local government PPHC staff to remain with the existing municipalities (Hall *et.al*, 2005). The KwaZulu-Natal province decided to maintain the status quo until further arrangements were made between provincial and local government. The plan included placing a moratorium on staff movement, pending creation of a single public service (Hall, *et.al*, 2005).

Since then, there has been some progress in transferring of PPHC to provincial level. In 2011, two KwaZulu-Natal municipalities (Emnambithi and Endumeni) completed transfer of their PPHC staff to the Provincial Department of Health. These transfers happened as these local municipalities felt that the subsidy they were receiving from the Department of Health to render PPHC as part of their standing Service Level Agreement (SLA) was not enough to permit for service expansion or salary improvement for staff employed in these clinics (Greveling, 2011). More local municipalities are set to follow suit and transfer their PPHC services to the province.

The definition of MHS as defined in the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) did not enjoy full approval from everyone. In 2008, the Independent Municipal and Allied Trade Union (IMATU) made a court application whereby they challenged various provisions of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) on the grounds that they were inconsistent with various provisions of the Constitution of the Republic of South Africa (Act 108 of 1996) (Republic of South Africa, 1996) relating to the status and powers of local government. IMATU viewed the definition of MHS as inconsistence with the constitutional provision in that the definition excluded "primary health care services" as part of "health care service" The constitutional challenge was premised on the contention that the National Health Act created a single exhaustive national health system in which local government was obliged to participate, and which left no other space for municipalities to perform their functions as public providers of health services. IMATU argued that the definition of MHS was restricted to "environmental health services" and, therefore, disempowered municipalities from rendering

services, including PPHC, which normally rested within their powers. In his ruling on this matter, Judge Makgoba stated: "It is declared that Municipal Health Services within the meaning of Section 1 of the National Health Act (Act 61 of 2003) includes health services ordinarily provided by municipalities at the time the Act came into operation" (Independent Municipal and Allied Trade Unions & Others v The President of the Republic of South Africa, 2008). Section 34 of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) states that "until a service level agreement contemplated in section 32(3) is concluded, municipalities must continue to provide, within the resources available to them, the health services that they were providing in the year before this Act took effect".

Though slow, there has been some progress in terms of developments in environmental health. Agenbag and Balfour-Kaipa (2008) stated that, by February 2007, some district municipalities were providing MHS. There were signs of progress in that MHS were receiving attention by being included in municipal planning processes. However, the authors mentioned that the key role players, namely the South African Local Government Association (SALGA), the National Department of Health (NDoH) and the Department of Provincial and Local Government (now the Department of Co-operative Governance and Traditional Affairs (CoGTA)), which were designated to drive the transfer and devolution process had, up to that point, played an insignificant role in the process (Agenbag & Balfour-Kaipa, 2008).

In an attempt to decentralise and build a district-based PHC, too much emphasis had been placed on the structure and organisation of local services, thus leading to loss of impetus in systems development and service delivery. This further resulted in under-performance of PHC services in large parts of the country (Schaay & Sanders, 2008). According to Schaay and Sanders (2008), a combination of different factors, namely high rates of medical migration and severe health worker shortages; deep-seated imbalance of resources and inequities in the distribution of personnel; a complex and evolving burden of disease with emerging infectious and non-communicable epidemics; a curative-oriented health service; and deficiencies in managerial capacity and health system leadership at all levels; have continued to be an obstacle in the attainment of PHC in South Africa.

Some of these issues have been taken into account in national planning. The 10 Point Plan of the Health Sector for the 2009-2014 period (Department of Health, 2010) is aimed at crafting an operational health system that is enabled to produce improved health outcomes. The 10 Point Plan (Department of Health, 2010) has identified the following priority areas:

i. Provision of Strategic leadership and creation of a social compact for better health outcomes;

ii. Implementation of National Health Insurance (NHI);

iii. Improving the Quality of Health Services;

iv. Overhauling the health care system and improve its management;

v. Improving Human Resources Management, Planning and Development;

vi. Revitalization of infrastructure;

vii. Accelerated implementation of HIV & AIDS and Sexually Transmitted Infections National Strategic Plan 2007-11 and increase focus on TB and other communicable diseases;

viii. Mass mobilisation for better health for the population;

ix. Review of the Drug Policy; and

x. Strengthening Research and Development.

The Minister of Health, Dr Motsoaledi, felt it was important to renew the health system using the PHC approach in order to implement the above priorities successfully (Department of Health, 2010). This involves a "re-engineered PHC" approach, which requires the strengthening of the DHS, improved implementation of the basic system, and the assignment of responsibility and accountability to district management teams (DMT) for improved health of the population and the management of the district.

A task team, led by Dr Yogan Pillay, was tasked with producing a strategy for "re-engineering PHC in South Africa". A discussion document by the team notes that a great deal of work has been done in gearing up the health system for effective implementation of PHC (Barron, Shasha, Schneider, Naledi, Subedar, 2010). The authors, however, point out that little has been done to ensure that the PHC

approach being implemented includes taking comprehensive services to communities that have an emphasis on disease prevention, health promotion and community participation.

For the successful execution of PHC, a well-functioning DHS is necessary. The discussion document made the following recommendations relating to the DHS:

- Full implementation of Chapter 5 of the National Health Act (Act 61 of 2003) pertaining to DHS;
- A need for provincial legislation enabling formal creation of district councils which are to play an oversight role over district management teams (DMT);
- Devolution of remaining personal health services from local municipalities and Metros to Provinces.

As shown in the diagram below, the task team envisions environmental health services as part of the specialist support teams, which are to render support to facilities.
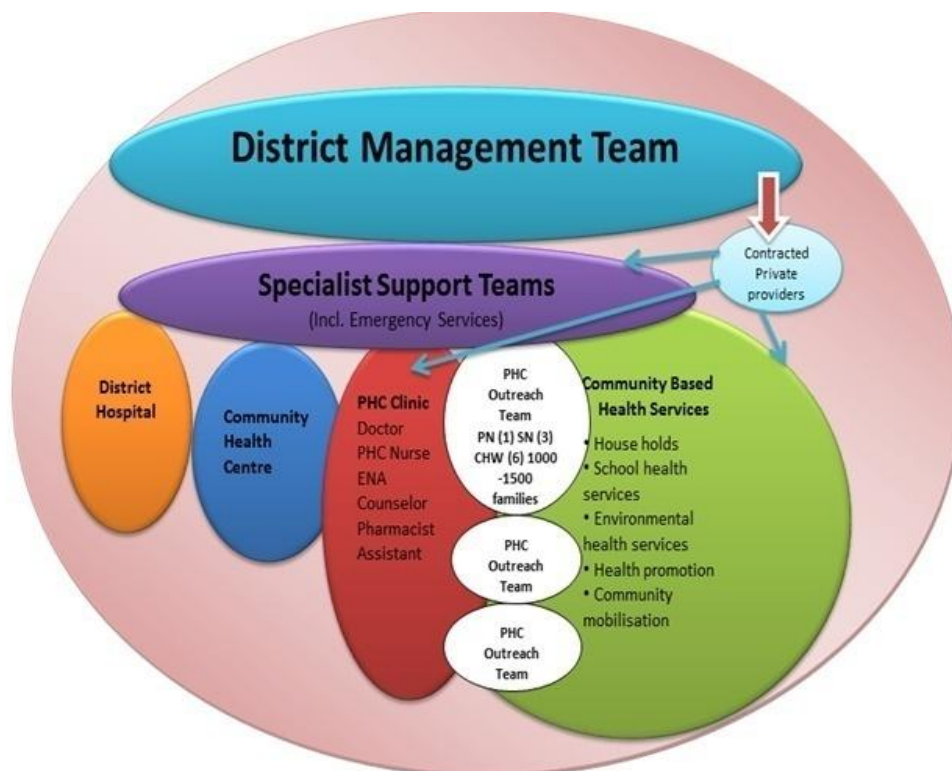
**Figure 1: PHC model within the District Health System (*adapted from discussion document on Re-engineering Primary Health Care in South Africa)*

2.6   Funding Arrangements for Municipal Health Services

For proper establishment of the DHS, it was necessary to put forth sufficient and guaranteed financial arrangements. These funds were mainly needed to set up a district health authority, the district management team and its support structures. This was also necessary as there were already concerns in the local government sphere of having to take over unfunded mandates (Barron & Sankar, 2000).

When the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) was passed and gave a broad definition of MHS, as discussed above, there were concerns expressed about the possible confusion of roles, duplication and fragmentation between the provinces and the local authorities. As Hall *et al.* (2002) point out; the decision to exclude PPHC from MHS was to have financial implications, as metropolitan municipalities spent about 80% of their municipal revenue-funded health expenditure on PHC services that excluded environmental health. If local government was to withdraw funding for non-environmental health services, it would mean that these services were then to be funded by the Provincial Health Department. There were reports of municipalities threatening to withdraw funding of PHC services (Andrews & Pillay, 2005).

PPHC have always been provided and financed by different stakeholders (i.e. Provincial Departments of Health, metropolitan municipalities, district municipalities and local municipalities) (Hall *et al.*, 2005). Although the bulk of the funding for the function was provided by Provincial Departments of Health, metropolitan municipalities were also funding PPHC with larger amounts from their own income. It was for that reason that Barron and Asia (2001) pointed out that the indistinct definition given to MHS in the National Health Bill of 'other municipal health services that are rendered by municipalities at the time of coming into operation of this Act' was strategically provided to protect that part of municipal income spent on MHS for the health sector.

In 2005, implementation of functional integration between provincial and municipal health services had commenced. However, there were still challenges relating to the

funding of MHS and full PHC funding that was based on the cost of provision of a package of PHC services.

The available literature indicates that provisions for funding the function from the budget of district municipalities were indeed made. According to the Division of Revenue Bill for 2006/7 (Minister of Finance, 2006), with effect from 1 April 2006, funding for MHS in metropolitan and district municipalities was provided for under the basic services component of the local government equitable share. This component was to be for all citizens in a municipality and it included a provision of R12 a year per household (Balfour, n.d). Provisions for funding MHS, even though viewed as inadequate, were made. However, there was no progress towards integrating MHS. The lack of progress towards integration points to other additional challenges in local government, besides finance, that hinder the transfer of this function to district municipalities.

Andrews and Pillay (2005) called for urgent ring-fencing of PHC funding in each province, so as to ensure that these funds were better utilised for their intended purpose. Balfour (n.d.) also raised concerns around funding for MHS being included in the equitable share, as opposed to a conditional grant. She argued that, as a conditional grant, the funding would have been ring-fenced for MHS, but as part of the equitable share allocation it was not protected from use for other purposes at a municipal level. This was more likely to be a problem in district municipalities with no health staff, and thus limited awareness of the issues of health.

2.7   Decentralisation in other countries

Uganda has done well in decentralising extensive administrative functions to local government, but has been found to be lacking in terms of financial decentralisation (Khanya-aicdd, May 2006). In their process of decentralisation, some practical advances were introduced, which other countries could learn from. For example, a "carrot and stick" approach was used to encourage local governments to improve their performance: if performance measured is greater than expected, local

government will receive higher financial support. Nonetheless, Uganda has not done well in promoting active community involvement in creating a community-driven decentralisation process, as opposed to their top down approach to decentralisation (Khanya-aicdd, May 2006). In contrast to Uganda, Mali, has effectively implemented a community-driven decentralisation process, but has failed to transfer functions and necessary resources to lower levels. A close look at Uganda shows that Uganda shares a technocratic approach with South Africa, with more work done on systems, and less on mobilization at local level to sustain decentralization (Khanya-aicdd, May 2006).

Khanya-aicdd was part of a study for the Belgian Government, which reviewed experiences in a number of countries, with case studies in Uganda, Burundi, Mali and Benin (Khanya-aicdd, May 2006). From the review, three elements emerged as critical for decentralisation to realise its benefits. These elements were:

- "Active involvement of citizens in the process, so that decentralization is embedded in a drive by citizens to take responsibility for their own development, and to hold the state accountable;
- The will and the capacity of local governments to practice the principles of good governance and to offer adequate services to residents; and
- The capacity and will of central government to provide a suitable enabling environment which provides adequate authority, decision-making powers and resources to local levels, as well as suitable oversight mechanisms, and the will to deal with emerging problems as they inevitably arise" (Khanya-aicdd, May 2006: 8).

In the case of South Africa, community involvement in the decentralisation processes has been minimal and communities have not been empowered to take responsibility for their own development. Much of the South African legislation encourages public participation and involvement. However, when it comes to its actual implementation, community participation and involvement is often limited. It is mainly advantaged communities that seem to take an interest in the developmental issues affecting them. There is no doubt that the will and capacity for practising principles of good

governance and offering adequate services to communities does exist, but what could be lacking is the monitoring mechanism.

2.8 Theoretical framework

Experience has shown that, for successful programme implementation, it is important first to understand the factors linked to a health problem or issue, paying attention to the needs and motivations of the target population, and taking into consideration the framework for programme implementation. The use of theory can help us to better comprehend the nature of the problem being addressed, the needs and motivations of the target population, and the context for intervention, thus helping us to achieve a better fit between problem and programme (Nutbeam & Harris, 1999). The theory of organisational change was chosen for application in the current study.

2.8.1 Theory of organisational change

Theory is commonly defined as "systematically organised knowledge applicable in a relatively wide variety of circumstances devised to analyse, predict or otherwise explain the nature or behaviour of a specified set of phenomena that could be used as the basis for action" (Nutbeam and Harris, 1999: 10).

Basically, change theory gives one a picture of where one may want to go, what to look for in one's journey, and helps one make sure that one is on the right track to reach one's intended destination. Connell and Kubisch (1998) say that, if change theory is used during the design phase, it increases the probability of role-players' clarifying the end goal of their initiative, all that is necessary for them to attain their goal, and the associated dynamics that are likely to influence these outcomes. Linking theory to programme planning models can be useful in developing interventions, predicting issues that may be important and helping to explain difficulties. The theory of change is a sensible and important part of a successful transformation (Organizational Research Services, 2004). Theory provides an

important planning, implementation and evaluation tool to individuals, communities and organisations.

Goodman, Steckler and Kegler's theory (1997) as cited in Nutbeam and Harris (1999) proposed a four-stage model for organisational change. They highlighted the importance of recognising the different stages of change and putting in place matching strategies that will enable change in each stage. As described in Nutbeam and Harris (1999), the four stages are as follows:

Stage 1: Awareness-raising - This stage is about getting buy-in from the senior level of the organisation for organisational change through clarifying problems in the organisational environment and identifying possible solutions.

Stage 2: Adoption - This stage involves planning for and adoption of a policy, program or other innovation, which addresses the problem identified in stage 1. All resources necessary for change implementation will be identified in this stage. Adoption usually involves a different level of management from stage 1, usually people involved in the day to day running of the organisational function. Nutbeam and Harris (1999) point out that this important stage of change in organisations is often missed.

Stage 3: Implementation. This stage is concerned with ensuring that provision for training and material support is made available for successful implementation of change. It is said that most failures in policy initiatives occurs at this point, due to giving insufficient details of the implementation process.

Stage4: Institutionalisation. This involves planning for the long-term maintenance of an innovation, following its successful implementation. Monitoring and quality control systems get established by senior administrators, including continuous investment in resources and training,

In the current study, the Goodman, Steckler and Kegler's theory of organizational change will be used to help understand how change has been managed in the

organisation (district municipality). This theory emphasises the importance of recognizing the different stages of change and matching strategies to promote change. The theory will be used to evaluate the integration process in the district municipality, by looking at the following stages of organizational change:

- *Awareness-raising*: How much awareness-raising was done in terms of stimulating interest and support for the integration by clarifying possible problems and potential solutions to the integration?
- *Adoption:* Was there planning for and adoption of a policy and/or programme to address the integration?
- *Implementation*: What capacity building and material support needed was provided for the integration?
- *Institutionalisation:* What plans have been put in place for long-term maintenance of the MHS once fully integrated?

Managing change entails thoughtful planning and sensitive implementation and, above all, consultation with and involvement of the people affected by the changes (Chapman, 2005). The same process would have been expected to be followed for the successful implementation of the integration at UMDM.

Research has typically neglected investigating the execution of change from the employee's viewpoint (Nelson, 2005). Employees that are to be affected by change are generally expected to deal with change as it occurs, without much thought being given to the effect of the planned change on them as individuals. Since change can be unsettling, it is important that the champion driving the process be fully understanding of their role in the process and be willing to push for change, whilst engaging with all role players, in order for them to be a settling influence on all concerned.

2.9   Research findings already in use

Recent research highlights several challenges to the delivery of municipal health services by district municipalities. In a study conducted between November 2006

and February 2007, a lack of section 78 investigations by district municipalities was mentioned as one of the challenges to delivery (Development Bank of Southern Africa, 2007).

Section 77 of the Local Government: Municipal Systems Act (Act 32 of 2000) (Republic of South Africa, 2000) requires a municipality to review and decide on the appropriate mechanism to provide a municipal service in the municipality when they have to provide a service that is new to the municipality. This, therefore, requires that the municipality undertake a full assessment as per section 78 of this Act. This section 78 investigation is aimed at assisting municipalities in making informed decisions relating to *inter alia* the direct and indirect costs and benefits associated with the project, and the municipality's capacity and future capacity to furnish the skills, expertise and resources necessary for the provision of the service. Studies have highlighted the need to conduct the section 78 assessments prior to district municipalities' transferring of MHS.

The other issue highlighted in the Development Bank of Southern Africa study (Development Bank of Southern Africa, 2007) was budget. When it came to financing, almost 70% of district municipalities had a separate budget vote for municipal health services, with about 51.5% providing for the service in their 2006/7 budget year. This highlighted the need for district municipalities to have a separate budget for MHS.

The National Department of Health has developed a document on devolution of MHS, arising from existing studies' call for strong leadership and direction to assist district municipalities in implementing the transfer and devolution process (Department of Health, 2011).

2.10 Strengths and weaknesses of other studies

Madikiza (2008), in an article entitled "Municipal Health Services in the spotlight", discussed a study conducted by the Centre for Environment, Community and

Industrial Development (CECID), on the delivery of municipal health services by district municipalities in South Africa. The CECID study managed to quantify and map progress made in terms of district municipalities that are rendering MHS. They found that 65% of districts were providing the function, 59.5% of district municipalities had done their section 78 assessment, and 51.5% had a separate MHS budget provision. This gives a national picture of MHS provision. However; the fact that data for the CECID study was all collected telephonically, with no follow-ups or verification of the information collected, weakened the findings of the study.

2.11 Summary

In this chapter, the policy and legislative changes accompanying the transformation of the health system, particularly as related to the rendering of environmental health services, were reviewed as per the Constitution of the Republic of South Africa (Act 108 of 1996), the Local Government: Demarcation Act (Act 27 of 1998), the Local Government: Municipal Structures Act (Act 117 of 1998), the National Health Act (Act 61 of 2003), the ANC National Health Plan (African National Congress, 1994) and The White Paper for the Transformation of the Health System in South Africa.

The District Health System as a vehicle for health care delivery, developments, progress made and implementation challenges were reviewed. Decentralisation experiences of other countries were presented.

The chapter also discussed the use of theory in change management, with specific reference to Goodman, Steckler and Kegler's four-stage model for organisational change, which was used for understanding the change process in the uMgungundlovu district.

The following chapter discusses the methodology applied in investigating the challenges to the integration of MHS in the uMDM area.

CHAPTER 3: METHODS

3.1   Introduction

This chapter discusses the research design, study population, sample, measurement instruments, and data collection procedures. A mixed methods approach was employed. First, a structured questionnaire was used to collect quantitative data from three local municipalities and the Provincial Department of Health. Qualitative data was collected using in-depth interviews and focus group discussions with key role players in the provision of environmental health within the UMDM district.

Data collected included the profile of human resources available for MHS (number of EHPs in each local municipality), the package of environmental health services being provided in relation to the newly defined municipal health services in each local municipality, planning for the integration process, and the barriers and enabling factors affecting the integration process.

3.2   Type of research

The current study involved Health Systems Research. The information obtained will be used for developing appropriate solutions to the problems in this district; with the aim of improving the functioning of the health system and, ultimately, leading to improved health status.

3.3   Study setting

The study was conducted in the uMgungundlovu district municipality (UMDM), which is made up of seven local municipalities.

3.4   Study design

A cross-sectional descriptive study design was employed.

3.5   Target population

The reference population was all district and local municipalities in KwaZulu–Natal, with the target population located in the uMgungundlovu district.

3.6   Study population

The study population was Municipal Managers, managers responsible for environmental health, union representatives and Environmental Health Practitioners (EHPs) in the UMDM area. This district was selected because it was easily accessible to the researcher.

The UMDM (DC22) is located in the centre of KwaZulu-Natal. It contains the following local municipalities within its area of jurisdiction:

- uMshwathi local municipality (KZN221)
- uMngeni local municipality (KZN222)
- MooiMpofana local municipality (KZN223)
- Impendle local municipality (KZN224)
- The Msunduzi local municipality (KZN225)
- Mkhambathini local municipality (KZN226)
- Richmond local municipality (KZN227).

Of the seven local municipalities within the district, only three have EHPs in their employ.

3.7   Inclusion and exclusion criteria

All seven local municipalities within the district were included in the study, as they are all affected by the integration of Municipal Health Services (MHS). In addition, the Provincial Department of Health was included as the legislation required devolvement of environmental health service from province to district.

When it came to conducting the interviews, local municipalities that had no EHPs in their employ were excluded from the interview process.

3.8   Sampling and sample size

3.8.1   Sampling methodology

The seven municipalities within uMgungundlovu have a combined total of 4 319 employees (Municipal Demarcation Board 2007/2008). For the purposes of the current study, the following people were purposively selected from the combined district total as study participants, because of their involvement in environmental health services within the district:

- Municipal Managers of the three local municipalities that have EHPs in their employ (n=3)
- The Municipal Manager from the district municipality (n=1)
- The General Manager: Public Health Services Cluster (Provincial Health) (n=1)
- Managers responsible for environmental health from each of the three local municipalities (n=3)
- Environmental Health Manager :Provincial Department of Health (n=1)
- A union representative from each union (i.e. SAMWU, IMATU, Hospersa, and PSA) (n=4)
- Financial Manager and Human Resources Manager from the district
- All 23 EHPs in the district.

3.8.2 Sample Size

As detailed above, a maximum sample of 38 was available to be used in the study. In qualitative research an appropriate sample size is the one that adequately answers the research question (Marshall, 1996). Therefore, in practice, the sample size could be small or large. The number of required subjects usually becomes obvious as the study progresses, because new themes or categories stop emerging from the data. This is referred to as the point of data saturation. As Siegle (n.d) explains, data saturation occurs when the researcher is no longer hearing or seeing new information.

In-depth interviews and focus group discussions were conducted with the following people:

- Municipal managers: an in-depth interview was conducted with one municipal manager
- Managers responsible for Environmental Health Services: in-depth interviews were conducted with two managers
- Environmental Health Practitioners: focus group discussions were conducted with two groups of Environmental Health Practitioners (Group 1 consisting of five EHPs and Group 2 made up of four EHPs).

3.9 Data Sources

3.9.1 Measuring Instruments

Questionnaires were used to collect quantitative data (Phase 1). A semi-structured interview guide was used to conduct the in-depth interviews (Phase 2) with key role players. Using themes that emerged from the in-depth interviews, a focus group discussion guide was developed and used for facilitating the focus group discussions (Phase 3).

3.9.2 Data Collection

Data for the study was collected in three phases.

3.9.2.1 *Phase 1*

Quantitative data on the profile of human resources (number of EHPs in each local municipality), the package of environmental health services being provided in relation to the newly defined municipal health services in each local municipality, and workload were collected using structured self-administered questionnaires (Annexure A). This phase involved collecting data from managers responsible for environmental health services from the three municipalities that have Environmental Health Practitioners in their employ, as well as from the Environmental Health Manager from the Provincial Department of Health (n = 4).

Information letters on the study and informed consent forms were faxed to the study participants. Questionnaires were electronically distributed via e-mail, with telephonic follow-up. Responses were returned via e-mail to the researcher. The researcher checked questionnaires for any discrepancies or missing data, printed them and locked them away until analysis.

3.9.2.2 *Phase 2*

Qualitative data for the study was collected through conducting face-to-face, semi-structured in-depth interviews with municipal managers, and managers responsible for EH Services – a possible sample size of 13 (Annexure B). A total of three people were interviewed and a point of data saturation was reached. The researcher scheduled appointments with the study participants.

Data was collected in the interviews under the following headings:

1. Knowledge of the integration process

2. History of and preparation for the integration process

3. Perceptions of benefits of the proposed integration

4. Perceived challenges to the integration process

5. How these challenges to the process have impacted on environmental health service delivery in the district

6. Suggestions for change in the manner in which the integration was planned (What could have been done differently?).

During Phase 2, documents on planning and policy, legislation, and minutes of meetings held were also reviewed to establish the policy framework and guidelines for the process of integration.

3.9.2.3   Phase 3

Themes or issues identified during the semi-structured interviews (Phase 2) were explored further in two focus group discussions (Annexure C). The groups consisted of EHPs and each group lasted approximately two hours. Focus group discussions were audio-recorded with the permission of the participants. It was emphasised that the identity of participants would remain anonymous, and that participants could withdraw from the study at any time.

3.9.3   Data Handling

3.9.3.1   Quantitative Data

Once received, data was checked for any discrepancies or missing data. Data from the self-administered questionnaires was locked in an office, accessible only to the researcher, for safekeeping. This data was analysed descriptively using frequency tables and graphs.

3.9.3.2   Qualitative Data

The sound files from the digital recording device were copied onto a password-protected computer. The audio-taped in-depth interviews and focus group discussions were transcribed verbatim. Thematic analysis was used as the primary analytic strategy. Thematic analysis is a search for themes that emerge as being important to the description of the phenomenon (Daly, Kellehear & Glicksman, 1997). This process involves the identification of themes through "careful reading and re-reading of the data" (Rice & Ezzy, 1999, p. 258).

In seeking to analyse data, thematic analysis can either identify the themes pertaining to a particular research question (deductive analysis) or it can identify themes that are observed across the entire data range (inductive analysis) (Braun & Clark, 2006). Inductive thematic analysis occurs when the researcher observes themes from the data without having had a particular preconception of the various themes that would emerge. Deductive thematic analysis on the other hand, is guided by the researcher's particular thematic interest and seeks to analyse a specific area of the data.

The present study followed an inductive thematic analysis approach. Transcripts were coded by the principal investigator and a fellow researcher. After reading a transcript, the analysis team collaboratively developed a codebook of themes around the main topics. The second transcript was then reviewed to add additional topic areas and themes that emerged. This process was then repeated with the final transcript to arrive at a final coding scheme. Data were entered into QSR International's NVivo 8 qualitative data analysis software (QSR International, 2008) and coded per the resulting coding scheme. NVivo is a useful organizational tool which allows the researcher to index segments of the text to particular themes, carry out complex search and retrieval operations quickly, and link research notes to coding. However, software remains an aid to the organization of the material and is not in itself an interpretive device (King, 2004). The coding team met regularly throughout the process to discuss coding, modifying the coding scheme and maintaining fidelity to the coding scheme, until consensus was reached. Weber (1990, p.12) notes: "To make valid inferences from the text, it is important that the

classification procedure be reliable in the sense of being consistent. Different people should code the same text in the same way".

3.9.4 Validity and Reliability

The researcher employed certain strategies to ensure trustworthiness of the data. The basic question addressed by the notion of trustworthiness, according to Lincoln and Guba (1985, p. 290), is simple: "How can an inquirer persuade his or her audiences that the research findings of an inquiry are worth paying attention to?" Lincoln and Guba specify four criteria for ensuring trustworthiness, namely: credibility, transferability, dependability and confirmability.

Attention was given to credibility (checking the true value of findings) by means of independent coding. Transferability was established by thoroughly describing the research context and the assumptions that were central to the research. The person who wishes to "transfer" the results to a different context is then responsible for making the judgment of how sensible the transfer is. The researcher also needs to provide sufficient information that can then be used by the reader to determine whether the findings are applicable to the new situation (Lincoln and Guba, 1985). To this end the researcher has included a number of quotes from the verbatim transcriptions.

Dependability was maintained through keeping of the raw material, giving a full description of the research method, and applying the same procedure throughout. Conformability was established through analyst triangulation - two analysts reviewed and analysed data independently and then compared their findings.

3.10 Ethics

3.10.1 Institutional Ethical Review

Ethical approval was granted by the University of KwaZulu Natal Biomedical Research Ethics Committee (Annexure D).

3.10.2 Permission from Institution and Participants

Following the Ethics Committee's approval, permission to undertake the study in the uMgungundlovu district was requested from the district municipality under which all the local municipalities in the study fell. This permission was granted (Annexure E).

A letter communicating the essential information pertaining to the evaluation was given to each of the participants in the data collection, and written informed consent was obtained from all participants (Annexure F). The participants were assured of anonymity. Furthermore, participants were assured that participation in the study would not have any negative outcome on their work.

3.11 Summary

Sampling decisions were made with the rationale of obtaining the richest possible source of information to answer the research question. The decisions were appropriate as the researcher managed to gather the necessary information to answer the research question. The data collection instruments and method used were able to gather the necessary information for answering the research question.

The subsequent chapter will describe the results of the study obtained through the use of this methodology.

CHAPTER 4: RESULTS

4.1 Introduction

This chapter presents the results of the study and consists of three sections. The first section presents a description of the policy and legislative documents reviewed, so as to establish the policy framework and guidelines for the analysis and the process of integration.

The second section deals presents the quantitative data obtained on the profile of human resources and the package of environmental health services being provided in the district. These data were collected using structured self-administered questionnaires. The questionnaires were sent to three local municipalities which are the only municipalities within the district that have environmental health practitioners, and to the Provincial Department of Health. The questionnaires were completed by managers directly responsible for environmental health services.

The third section of this chapter presents the results of the qualitative analysis of the in-depth interviews and focus group discussions. For collection of the qualitative data, the researcher planned to conduct in-depth interviews with municipal managers, environmental health managers, and environmental health practitioners. Three in-depth interviews were conducted. The participants were a Municipal Manager, a General Manager: Community Services, and a Manager of Environmental Health.

For the focus group discussions, the plan was to have one group of municipal managers and one group of environmental health practitioners. However, there were management challenges throughout the district at the time of the study, with resultant changes in municipal management. As a result, a focus group was not conducted with municipal managers as the newly appointed managers felt that they could not contribute to the discussion, due to their lack of involvement in the process.

Two focus group discussions were, therefore, conducted with Environmental Health Practitioners. The first group consisted of five participants (two females and three males), whose number of years of experiences as an EHP ranged from 15 to 40 years. The second focus group had four participants (two females and two males), with between five and 30 years of experience.

4.2 Review of documents relating to the integration process

Initially, the researcher planned to review the following documents in order to establish the policy framework and guidelines for the process of integration:

- Policy on the integration process
- Reports on general progress toward integrations, including challenges and proposed solutions
- Minutes of meetings held (on MHS integration), so as to examine resolutions taken on the integration of MHS
- Guidelines developed to guide and assist managers in implementation of the integration process
- Plans or draft plans for integration and restructuring of MHS (including time frames)
- Agreements concluded, such as service level agreements (SLAs), memoranda of agreement, secondment agreements, and status quo agreements.

The current study reviewed policy, reports, and minutes of meetings held, as these were the only documents found to be available.

4.2.1 Policy

No policy has been developed or adopted by the district municipality to guide the integration process. However, there was a document made available by the National Department of Health entitled "Framework for the devolution of Environmental Health

Services in South Africa – Implementation Strategy" to assist municipalities in undertaking this process (Department of Health, n.d.).

The above-mentioned framework set the timeframe for the transfer to take place as 1 July 2004. The document proposed transfer and secondment processes to be followed for the devolvement of Environmental Health Services from province to district and from local municipalities to the district. The documents makes note of the prescripts and legislation impacting on the transfer process of Municipal Health Services to districts. The document called for ring-fencing of MHS funding from National Treasury, and for provinces to continue funding the function until National Treasury makes provision for funding, in order to avoid service disruptions

The framework also mentions different tools to be used for communication. With regard to monitoring and evaluation, the document mentioned a need for:

- Setting time frames for the implementation of the plans
- Quarterly reports from district to the National Environmental Health directorate as a tool for monitoring and
- Setting up an evaluation Committee.

A district municipality report (dated 6 July 2005)[1] mentions that this framework was discussed at length at a Summit on Environmental Health which was attended by a district representative.

4.2.2 Reports

District Municipality

Report of the Strategic Executive Manager: Community Services to the Management Committee dated 16 July 2005[2]

In this report, the following were noted:

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[1] Consolidated report on environmental health services in uMgungundlovu district municipality. Report of the Strategic Executive Manager: Community Services to the uMgungundlovu district's Management Committee dated 6 July 2005

[2] Report of the Strategic Executive Manager: Community Services to the uMgungundlovu district municipality's Management Committee dated 16 July 2005

- The first meeting regarding the devolution that was organised by the Provincial Department of Health was held in September 2003.
- A further eight meetings were held between October 2003 and October 2004 with a number a stakeholders involved in the integration. The district was aware of their legal mandate to take over the function, including having to make plans for the transfer of the function by July 2004.
- Discussions were held at the Summit on Environmental Health Services where participants learned of the need to negotiate with provincial government and local municipalities on taking over the function, including budgeting for it.

Report of the Strategic Executive Manager: Community Services to all Environmental Health Practitioners (undated)[3]

The aim of this report was to provide an update to EHPs on the progress made, the meetings that had been held, and the main issues/challenges to the process that has been raised in these meetings. These included:
- The provincial department's failure to make budgetary provisions for the transfer of their staff
- The Provincial Department of Health's concern of having insufficient environmental health staff. As a result, they were reluctant to transfer an "incomplete resource to the district municipality.

The report mentioned that, because of the above-mentioned challenges, the transfer process was to be put on hold pending provision of funding for the function. The provincial EHPs were, therefore, requested to provide the environmental health service "wherever necessary".

In the report, the district municipality also re-affirmed its intention to complete the transfer process by January 2006 and, therefore, felt that there was an urgent need

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[3] Report detailing the processes that have taken place to date regarding the transfer of the environmental health unit from the District Health Department to the district municipality. Report of the Strategic Executive Manager: Community Services to the Environmental Health Practitioners located in the seven local municipalities within uMgungundlovu area of jurisdiction (undated)

for municipal managers (Administrative Technical Committee) to meet for the formulation of recommendations to the Change Management Committee for the transfer.

It was reported that the local municipal managers' response to an invitation to comment on the draft Service Level Agreement was poor.

Provincial Department of Health

The Provincial Department of Health started preparation for the transfer in June 2003 by consulting with the district municipalities, organised labour and affected staff on the impending transfer of 1 July 2004 (Report dated 20 May 2010)[4]. There were consultation campaigns held by the Provincial Department of Health which were aimed at informing staff on the function to be transferred, staff to be transferred, provisional dates for transfer and matters relating to conditions of service. The consultation process was strengthened by the establishment of the Provincial Coordinating Structure on Environmental Health on 28 July 2004. This structure was established to coordinate and facilitate the transfer of Municipal Health Services. The Provincial Coordinating Structure was made up of representatives from provincial and national health departments, organised labour for public service and local government, the Department of Provincial and Local Government, KWANALOGA and district and metropolitan municipalities.

In a report dated 19 February 2009[5], it is mentioned that district municipalities and metropolitans resolved not to take over responsibility for municipal health services on 26 October 2006, because of the inadequate funding that was allocated by National Treasury - R12 per capita per annum.

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[4] Service Level Agreement with district and metropolitan municipalities for the provision of Municipal Health Services. Report of the Provincial Manager: Environmental Health dated 20 May 2010
[5] Transfer of environmental health services. Report of Provincial Manager: Environmental Health dated 19 February 2009

The Provincial Co-ordinating Structure met on 28 October 2004, 14 March 2005 and 13 April 2005. However, it failed to make any considerable progress on resolving transfer problems pertaining to the financial implications associated with the transfer process. This, therefore, led to their resolution of suspending further meetings until the funding issues were resolved by the main stakeholders i.e. the National Department of Health, Department of Local Government, SALGA and National Treasury.

The report (dated 19 February 2009)[5] further mentioned that, on 1 April 2006, Municipal Health Services were included in the package of basic services funded through the equitable share. This funding was to allow for the phasing in of Municipal Health Services until the estimated costs of providing the function were matched.

Following the inclusion of Municipal Health Services in the package of services funded through the equitable share, the Provincial Co-ordinating Structure resumed their meetings and information required for the bilateral meeting between the Provincial Department of Health, organised labour and the district municipality was gathered. However, when the bilateral meeting was held on 26 October 2006, they still could not resolve the funding issues, and discussions on the matter were further suspended (report dated 17 August 2009)[6].

A report dated 15 July 2010[7] mentioned that, at the time of the report, the funding problems had still not been resolved. Concerns were raised with regard to the provincial health department continuing with the provision of municipal health services when there was no formal agreement in place between the department and the district municipalities and metropolitans

The report also mentioned that the delay of transfer because of funding problems had led to further challenges. These challenges were:

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[6] Signing of Service Level Agreement with municipalities in respect of Environmental Health. Report of the Provincial Manager: Environmental Health dated 17 August 2009
[7] Implementation of Chapter 5 of the National Health Act (Act 61 of 2003): Transfer of Environmental Health Services. Report of the Provincial Manager: Environmental Health dated 15 July 2010

- The placement of environmental health staff on the interim structure, which consequently deprived them of career advancement opportunities.

- Large scale staff turnover, which negatively impacted on service delivery.

- Grievances lodged by affected staff regarding issues such as payment of the Occupational Specific Dispensation (OSD) and the implementation of a new organisational structure before implementing the transfer of staff. A transfer before payment of the OSD would be detrimental to staff concerned. On the other hand, payment of the OSD would have a large financial implication for the department.

In this report the provincial health department also acknowledged its role of providing monitoring, providing support, and promoting development of local government capacity in order to enable municipalities to perform their functions, including MHS. The province felt that there was an urgent need for building institutional capacity in their department in order to fulfil this obligation, whilst also delivering on the three provincial components of EHS (malaria control, control of hazardous substances and port health). The province, therefore, requested urgent approval of a service level agreement which was to provide mechanisms for the necessary financial resources to be made available to them.

4.2.3 Minutes of meetings

Budget issues

In a meeting held on 6 July 2004[8] a concern was raised that the district municipality had been given an environmental health function without funding to support the function. It was mentioned that, in July 2004, all but one local municipality had budgeted for environmental health services in the 2004/2005 financial year.

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[8] Minutes of the district municipality environmental health technical team meeting held on 6 July 2004 at the uMgungundlovu district municipality's council chamber

On 25 April 2006[9], it was reported that the provincial health department had no budget in that financial year to allow for the transfer of services. It was, therefore, agreed that the transfer would be put on hold until the provincial health department made funding available for the transfer of its staff.

On 23 May 2006, a resolution was taken that the district municipality should budget and provide adequate funds to supplement the funding allocation made for municipal health services as part of the local government equitable share. Furthermore, the district municipality was to review its mid-year (October-December 2006) budget and allocate funding to Community Services for the full transfer and takeover of the function from province and local municipalities.

Communication issues

Communication problems between local municipalities and the district municipality were raised at a meeting held on 6 June 2006[10]: The municipal manager of one of the local municipalities stated that there was a communication breakdown between district municipality and local municipalities. The chair responded by saying that, since 2003, the district municipality endeavoured to link with local municipalities through reports, notices, etc. but had not received any reports from them.

Service Delivery

On 06 June 2006[10], it was agreed that the status quo would be maintained until 31 December 2006 and that the district municipality would assume full responsibility for the function on 1 January 2007.

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[9] Minutes of Environmental Health Services Forum held on 25 April 2006 at the uMgungundlovu district municipality's council chamber
[10] Minutes of Inaugural meeting of the Municipal Health Services Forum meeting held on 6 June 2006 at the uMgungundlovu district municipality's council chamber

On 14 July 2006[11], it was resolved that, while transfer of the function remained a challenge, the available environmental health practitioners needed to "be of service where a need arises within uMgungundlovu district".

4.2.4 Agreements

There are draft service level agreements available, and a transfer agreement; however, none of these agreements were finalised and signed off.

Generally, the documents reviewed indicated that engagements between the different stakeholders on the integration started as early as 2003. A lack of policy guidelines for the process, lack of funding for the function, and poor communication between stakeholders were noted in these documents as the main challenges to the integration process.

4.3   Quantitative data results

Quantitative data were collected by means of structured self-administered questionnaires (Annexure A) from managers responsible for environmental health services in the uMsunduzi municipality, uMngeni municipality, Richmond municipality and the Provincial Department of Health. Specifically, details were sought on the package of environmental health services being provided in relation to the newly defined municipal health services in each local municipality, the environmental health human resources in the district (number of EHPs in each local municipality), and the workload of each EHP. Each of the managers completed the questionnaire, providing a 100% response rate.

The populations served by the different local government structures and the Provincial Department of Health vary widely, as shown in Figure 2 and 3.

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[11] Minutes of Municipal Health Services Forum meeting held on 14 July 2006 at the uMgungundlovu district municipality's council chamber
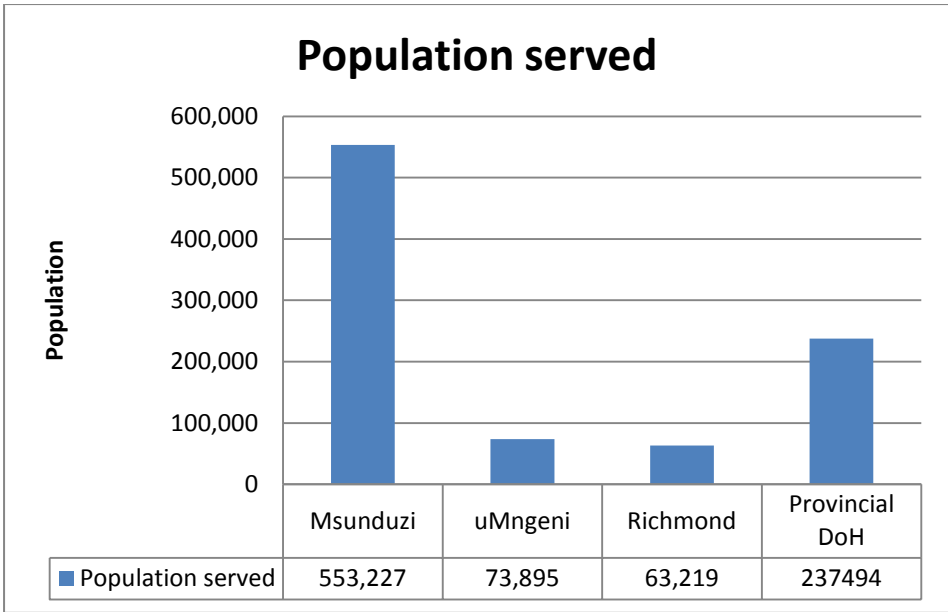
Figure 2: Population served by each local municipality and the Provincial Department of Health

In percentage terms, the largest proportion of the population is served by the Msunduzi municipality, as depicted in Figure 2. However, the Provincial Department of Health still delivers municipal health services to a quarter of the population of the uMgungundlovu district.
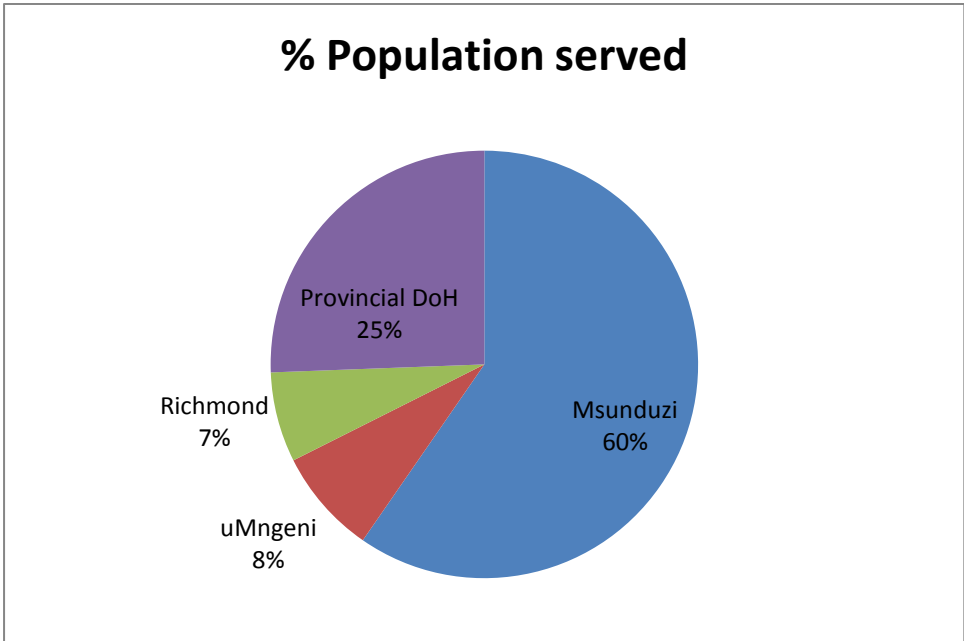
Figure 3: Percentage of the district population served by each local municipality and the Provincial Department of Health

As Table 1 below shows, the range of Environmental Health Services delivered by each local municipality and the Provincial Department of Health within the district varied. Local municipalities were still rendering services defined in the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) as the responsibility of the provincial department, whereas the province was still rendering services in the basket of environmental health service defined as Municipal Health Services. Environmental management services are, however, generic to both the Provincial Department of Health and local municipalities.

Table 1: Package of environmental health services provided by local municipalities and the Provincial Department of Health EHPs in the district in 2010

A. Provincial EH Services	Services Rendered (Yes / No)			
	Msunduzi	**uMngeni**	**Richmond**	**Provincial DoH**
Port health services	No	No	No	No
Control of hazardous substances	Yes	Yes	No	Yes
Malaria control	No	No	No	No
B. Municipal Health Services	Services Rendered (Yes / No)			
Water quality monitoring	Yes	Yes	Yes	Yes
Food control	Yes	Yes	Yes	Yes
Waste management	Yes	Yes	Yes	Yes
Health surveillance of premises	Yes	Yes	Yes	Yes
Communicable diseases	Yes	Yes	Yes	Yes
Vector control	Yes	Yes	Yes	Yes
Environmental pollution control	Yes	Yes	Yes	Yes
Disposal of the dead	Yes	Yes	Yes	Yes
Chemical safety	Yes	Yes	Yes	Yes
C. Management Activities	Services Rendered (Yes / No)			
EH Management functions	Yes	Yes	Yes	Yes
Other work beyond the EHPs scope of practise	No	No	No	No

As shown in Table 2, the proportion of filled environmental health posts in the three local municipalities and the Provincial Department of Health services located within the district varied considerably. In Richmond and Msunduzi municipality, the majority

of EHP posts were vacant (67% and 56%, respectively). Overall, while almost half of EHP posts in the district were vacant (48%), most other EH posts were not (7%).

Table 2: Environmental health personnel in the uMgungundlovu district in 2010

	Number of Posts					
	EH Practitioners			Other EH Staff		
	Filled	Vacant	% Vacant	Filled	Vacant	% Vacant
Msunduzi Municipality	11	14	56	10	0	0
uMngeni Municipality	3	1	25	1	1	50
Richmond Municipality	1	2	67	2	0	0
Provincial Department of Health	6	2	25	1	0	0
Total	**21**	**19**	**47.5**	**14**	**1**	**7**

Figure 4 below shows the workload for each Environmental Health Practitioner in all the study sites, relative to the population they each serve. The national norm with regard to workload is 1 EHP per 15 000 people. Richmond EHPs each serve 63 219 people, followed by uMsunduzi with just over 50 000 people per EHP. UMngeni is closest to the norm, at just over 20 000 people served per EHP.

Chart title: Workload per EHP

	Msunduzi	uMngeni	Richmnond	Provincial DoH
Population served	553,227	73,895	63,219	237494
Workload per EHP	50293	24631	63219	39582
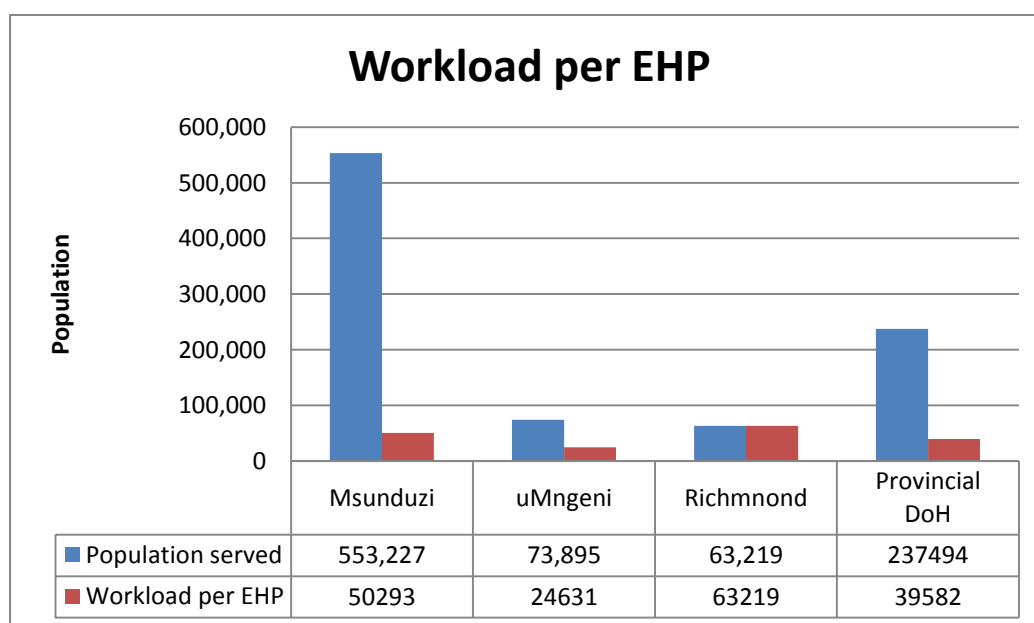
Figure 4: Workload for each Environmental Health Practitioner in the district

4.4 Qualitative results

The following major themes emerged from the qualitative data:

- Implications of the National Health Act (Act 61 of 2003)
- Awareness-raising
- Adoption
- Progress with integration
- Service level agreements
- Barriers to the integration
- Impact on service delivery
- Staff issues
- Change needed for the integration to succeed.

The major themes are discussed below and enforced with quotations from the participants. Where necessary, quotations were adapted to read without effort and to make more sense.

4.4.1 Implications of the National Health Act (Act 61 of 2003)

All respondents described various implications of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) on the environmental health function. These implications were: the clarification of functions, change in day-to-day functioning, and resource implications.

4.4.1.1 Clarification of the function

Respondents in the in-depth interviews felt that the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) was positive in so far as it set out and clarified the nine functional areas of environmental health when it defined Municipal Health Services

"Ok, I feel initially that it is a good thing, because it sets out the nine core

functions. It's good to know what your core functions are; you know we have such a rounded out job we do - from crowing cockerels to important matters - so it is good that we have an idea of our core functions just to get the main points right." (In-depth 1)

"So it was that broad understanding, and as of now we've got in our possession a document that lists nine specific functions. I may not know all of them off hand, but I know that there are nine specific functions that are associated with environmental health." (In-depth 3)

4.4.1.2 Change in day-to-day functioning

One of the in-depth respondents felt that the passing of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) and definition of Municipal Health Services had no effect on the day-to-day functioning of Environmental Health Practitioners*: "I can say for sure no, because we never did it* (the three functional areas that had been excluded from the basket of municipal health services i.e. port health, malaria control and control of hazardous substances) *in the past, so us not going to be doing it is no change"* (In-depth 1). Another respondent felt that there have been some changes relating to the powers to perform their functions: *"Powers of entry have now been withdrawn with the new health act; it's now changed"* (Focus group 2).

4.4.1.3 Resources

Most respondents' understanding of the implications of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) on resources was that environmental health personnel and the resources attached to the function were to be transferred to the district municipality.

"Our understanding was that the function will come with requisite resources in so far as the staff is concerned, and in so far as the financial implication is concerned." (In-depth 3)

*"The way I understood it, the staff were going to be taken over as a whole by the district municipality." (*In-depth 1)

One respondent felt that it was not clear what resources would be transferred, and whether local municipalities were going to be compensated for these assets, as he felt that these were local municipal property.

"The other thing was going to be on the asset side. All assets belong to the local municipality and, therefore, we couldn't see how they (district) *were going to compensate for that or pay or rent/lease those; more especially the offices and everything in it. That's the asset part of it."* (In-depth 2)

4.4.2 Awareness-raising

All of the respondents mentioned that there had been various attempts to raise awareness about the integration process, at all levels. Some respondents heard about a possible devolution as early as 2003. All respondents seem to have been informed, at some point, of the integration and devolution. Some of them were called to a meeting for all provincial environmental health staff; others attended a meeting which resulted in the establishment of a provincial co-ordinating committee.

"We got correspondence from our Director that we had to attend a meeting where we were told about the changes. I think it was only provincial staff that was told about this; then the other local municipalities were informed later." (Focus group 1)

"When I came back from maternity leave there was a meeting where all the EHPs from KZN were called into that meeting. It was in Port Shepstone where our directorate came to address us on devolution." (Focus group 2)

"Soon after the provincial meeting of EHPs we were invited to a meeting, at which the provincial co-ordinating committee was set up, that is where we had

representatives from all districts and local municipalities, and they spoke about devolving service to the district municipality." (Focus Group 1)

"I have been in management for over 15 years now, so when it was gazetted I was dealing with the admin and legal sections from the municipality, so I knew about it. We were aware of it; we went for provincial meetings and devolution meetings." (Focus group 2)

Some respondents mentioned that regular meetings were held to make sure that all staff were well informed.

"Yes we had meetings regularly." (In-depth 1)

"It was also not a once off meeting; it was a road show, so they called us on a regular basis for these meetings. To give us feedback on meetings that he used to attend at the national level." (Focus group 1)

Even participants who were not part of the environmental health staff at the time had heard about the process.

"I heard through hearsay while I was still at school; I thought, wow, we will get good jobs." (Focus group 2)

One respondent felt that, although they held a number of meetings, these meetings were not well-planned or informative.

"It has been there in a very much unplanned fashion because there were meetings and then it will take another 6 months without any follow-up, and then they will keep on repeating on what they were meeting for." (In-depth 2)

Some respondents commented that, after attending a number of meetings, the process just stopped.

"It started well because we had regular meetings and we attended the meetings and we were kept informed. It looked like things were on track, but it's just died a death." (In-depth 1)

4.4.3 Adoption

The majority of respondents felt that preparation and planning for the integration was poor and that there was no plan in place to guide the process.

"When this legislation was drafted in 2003, there was no planning, there was no preparation. There was just an idea - that was it. That is partially the reason why we are sitting here today." (Focus group 1)

"It was not planned. It was just gazetted, but there was no plan behind what was to happen after it was gazetted. The municipalities were not ready either, they were just told that this was supposed to happen, but there was no plan. I don't even think they knew what was expected, or what they were supposed to do." (Focus group 2)

In addition , respondents mentioned that, thought they had been made aware of the integration, there was not enough consultation on issues concerning them as staff, nor were they given a proper platform to raise their concerns and have their issues addressed.

"I wouldn't like to lie to you, there has not been that much consultation with regard to this devolution. I will not lie. Ever since I came here, maybe I have attended one meeting which was in the district office; they have not been in consultation with us." (Focus group 2)

"There were a few meetings with practitioners, just general meetings, but there were a lot of meetings where there was not enough consultation." (Focus group 2)

In terms of planning of resource provision to ensure that integration takes place, respondents mentioned that initially no resources were made available. Later on, funding was made available, but even then there was no clear directive on the funding.

> *"The concern of district municipalities at the time was that they were expected to provide a service without funding coming from national government. That was their concern throughout the negotiations. They said: 'You don't expect us to take over the service without the funding coming with it'. That carried on until 2008 when national government was funding the service and they gave all district municipalities money to provide the service in their districts. What has happened now is that we have gone two years down the line - the monies that were given to them were not used for the service."* (Focus group 1)

4.3.4 Progress with integration

Most respondents felt that there has been no progress with the integration; instead the process has just "died".

> *"It started well because we had regular meetings and we attended the meetings and we were kept informed. It looked like things were on track, but it just died a death. I think it is dead so far."* (In-depth 1)

> *"We had a meeting with the district to try and facilitate this devolution, but at that time we thought we would be transferred as soon as possible, but due to some financial constraints we were told that this would be on hold for some time. Up to now we don't know when we are going to be transferred."* (Focus group 1)

Other respondents mentioned that some people have lost interest in the integration process and don't think it will succeed.

"Nothing has happened; the staff has lost interest. Devolution: it's a joke; it will never happen." (Focus group 2)

"It's like when my niece borrows money; I will believe it when I see it when she says she will give it back." (In-depth 1)

One respondent felt there has been some progress, as they have seen funding for the function being provided.

"Government acknowledges that the function goes to the district and the funding did happen. Funding has been moving to district and metros in terms of equitable shares, we know that." (Focus group 2)

In addition to the provision of funding, the respondent mentioned there is also a document available that details the reporting lines from district municipality to district health, and then to the Provincial Department of Health.

"There was a document about the reporting procedure after devolution that said district municipalities are supposed to report to district health office, so they can report to province, and province can report to national. So there is a document in place; so they thought about reporting lines." (Focus group 2)

One respondent mentioned that there has been some progress in that there is an "environmental health resource" that has been provided by national to assist the district in moving the process forward. Moreover, the district has recently taken over environmental health staff from one local municipality.

"It is now that we are putting in place plans for the full takeover of environmental health. In fact we even have a dedicated resource from environmental health nationally. A resource that is going to assist us in terms of putting in place a particular plan to respond to what needs to be done by a certain time. I think there is a backlog; we are lagging behind and quite

seriously in so far as the takeover of the function, as well as the full implementation of the plan." (In-depth 3)

"With Richmond I think we are just finalizing one or two issues, but we've taken over their staff. They are now on the payroll and we are just finalizing one or two elements of the transfer; then we will only be ready to run with them. There are still challenges, but at least we now talking. There are plans on the table, and we are moving in that particular direction; although the pace is frustratingly slow." (In-depth 3)

4.4.5 Service level agreements

The National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) allowed for district municipalities to enter into a service level agreement with local municipalities if the district was not in a position to deliver municipal health services.

Most respondents mentioned that they have at least seen or commented on a draft service level agreement, but none of these agreements have been signed.

*"I know there has not (*been any SLA signed between the local municipality and the district municipality*). And I know I was given the other day a draft SLA between local municipality and the district and I made some comments on it, discussed it with the staff, and I've just handed it back."* (In-depth 1)

*"We were even in the process of signing service level agreements, but then there were obstacles." (*Focus group 2)

One respondent mentioned that the lack of an agreement between the local and the district municipality created problems when they needed to be reimbursed by the district for providing the service.

"They (district municipality) *never had any agreement. We had problems when we had to send memoranda of agreement so that we can be able to claim our money from them* (the district) *for paying for the staff."* (In-depth 2)

4.4.6 Barriers to the integration

All respondents described aspects that they saw as barriers to the integration process. Barriers that were mentioned included: the poor relationship between the district and local municipalities, a lack of understanding of environmental health, a lack of budget allocation, poor communication, lack of capacity, lack of commitment, lack of a champion, and misunderstanding of the implications of the transfer.

4.4.6.1 The relationship between district and local municipalities

The relationship between district and the local municipalities was mentioned as a barrier by participants in the in-depth interviews and the focus groups. Some of the respondents felt there was no relationship between the district and the local municipalities: "*We do not have a relationship*" (In-depth 1) and "*There was such a huge divide*" (In-depth 1). Respondents felt this lack of a relationship means that they have no connection with the people at the district office whom they are supposed to report to, and that they lack clarity as to what the district office staff actually do: "*We don't know what these people are doing in these positions….We don't even know the people in these positions*" (Focus group 1). This lack of a relationship has caused a breakdown in communication.

> *"They don't even reply to us, but we are expected to deliver even with our limited resources."* (Focus Group 1)

> *"I have been communicating with that office* (their supply chain management) *and they don't even reply to my emails."* (Focus Group 1)

One of the respondents described the relationship between district and local as a bad one, fraught with contestation around powers and functions. He felt that the "bad

blood" between them resulted in the breakdown in communication.

> *"Communication is bad, if I could use that word, because communication takes place within a context, and you must understand the context within which local municipalities and district municipalities function. It's a very contested area; contested in so far as clarity on roles, responsibilities, powers and functions. So there is a lot of contestation around powers and functions. So that's the kind of climate within which the takeover is taking place and certainly the climate, the context, will impact on the communication. If there is bad blood between you and I because of certain issues that are hanging, it will impact. Because of the climate and the contestation between the local municipalities and the district municipality, communication was equally affected by this. There is just a breakdown in communication."* (In-depth 3)

4.4.6.2   Lack of understanding of environmental health

Most respondents identified lack of understanding of the environmental health function as one of the barriers to the integration. This lack of understanding by the district municipality resulted in them taking too lightly the responsibilities that were to come with taking over the function. Respondents felt this, in turn, negatively affected the integration process.

> *"I think the district did not fully appreciate the function and, as a result, it did not apply its mind in terms of what needs to be done. I keep on saying people are undermining the value of environmental health. They don't have a sense of appreciation of the magnitude of the responsibilities. They take it very lightly that any comrade could do that." (*In-depth 3)

The lack of understanding was evident when transfer matters were being discussed. One respondent voiced his concerns over the exclusion of support staff when they talked about staff to be transferred.

"I am worried, because when they were talking about this devolution they were talking about the EHPs only. They were not talking about the support staff, like the admin staff, and the health assistant, the sanitation team, health education unit. They are all interested in the EHPs only. That will delay this process as far as I am concerned; these people are people who we cannot work without." (Focus group 1)

One respondent felt that the district and local municipalities, because of their lack of understanding of the environmental health function, are not aware that the current situation means that environmental health staff are acting outside of their mandate when performing their day to day duties.

"This is an illegal function at the moment; we are way out of our mandate and we are enforcing." (In depth 2)

4.4.6.3   Budget allocation

Respondents mentioned that, although initially there was no budget allocated for the transfer, funding was made available at a later stage. When this funding was made available, it was not 'ring-fenced' and this became a barrier to the integration. This funding ended up being used, and continues to be used, in other areas not related to environmental health. Even when the environmental health staff from local municipalities approaches the district municipalities with environmental health programmes requiring funding, they are unable to access this funding.

"It's two financial years (that funding has been made available)*. You see when National treasury gave them this money, it wasn't ring-fenced. I've got correspondence well into that effect, that we are challenging this, that you've got the money why don't you assist to fund some of our services. Right now we've got a cholera outbreak preparedness plan. We have a brilliant plan in place, but there is no funding. So that is the frustration that we have, that they've 18 million rand, but they* (district municipality) *are not prepared to share it with us."* (Focus group 1)

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Budget allocation was not only a challenge for the district municipality. One respondent mentioned that the Provincial Department of Health also failed to budget for the provision of staff packages when staff moves over to the district

> *"The Department of Health was supposed to have their own funding, especially for our pension and things like leave. They were supposed to transfer a package to us. We were meant to have funding, especially the department of health, they did not have that amount of money to transfer with us. When it comes to Province I don't think the Department of Health was ready."* (Focus group 2)

4.4.6.4 Communication

For effective implementation of the integration process, communication between all role-players was important.

Respondents felt that communication at all levels (i.e. between national role players and the district municipality, as well as between district and local municipalities) was poor: "*Communication is bad*" (In-depth 3) and, therefore, a challenge to the integration.

> *"My sense is that there was a serious gap in communication between the two* (national role-players and the district municipality)*. There was just no effective communication on the matter."* (In-depth 3)

> *"Yes, without a doubt* (there has been a breakdown in communication between the high level structures of local municipalities and district municipality)*. I'm sure you will get a unanimous yes from everyone who is involved on that."* (In-depth 1)

One respondent felt that the contestation between district and local municipalities over powers and functions led to the "breakdown in communication"

"You must understand the context within which local municipalities and district municipalities function. It's a very contested area, contested in so far as clarity on roles, responsibilities, powers and functions. So there is a lot of contestation around powers and functions. So that's the kind of climate within which the takeover is taking place and certainly the climate, the context, will impact on the communication. There is just a breakdown in communication." (In-depth 3)

4.4.6.5 Capacity

One respondent felt that insufficient capacity is a barrier to the process

"Capacity! I mean if you begin to look at what needs to be done and you compare it with what has been done, it seems we have not done anything." (In-depth 3)

4.4.6.6 Commitment

One respondent felt that the district municipality is not totally committed to the integration process and to the provision of the service to the communities as required.

"I think the main challenge from my side is the willingness from the district to take over the service, because we (local municipality) *are prepared. We will assist them to inform our community that the service has been taken over by the district."* (In-depth 2)

4.4.6.7 Lack of a champion/leadership

Some respondents cited as a barrier the lack of a champion who will assume leadership and commit to seeing the process through.

"The biggest challenge that we facing is that no one wants to champion this from government. You find that we have the National Department of Health and we've got COGTA, then you have your Provincial Department of Health and the provincial COGTA, no one now wants to say: 'Let us drive this process'." (Focus group 1)

"He summed it up, no one was driving it; and that is why nothing is happening." (Focus group 1)

"If this piece of legislation was drafted by the department of health, surely that department should be driving the process, because that understanding about the district system is their understanding." (Focus group 1)

4.4.6.8 Misunderstanding the implications of the transfer

One respondent felt that the key people in the integration did not fully understand what the transfer would entail. This misunderstanding is a barrier to the integration

"There was a serious misunderstanding in terms of the full implications of the transfer. There could have been different interpretations of the same legislation." (In-depth 3)

4.4.7 Impact on service delivery

When change occurs, it is likely that service delivery could be affected, either positively or negatively. Respondents described how they thought the integration would impact on service delivery.

4.4.7.1 No impact

One respondent felt that service delivery has not been affected, as the local municipality has continued to render a full environmental health service: "*No, service*

(delivery) *has never been affected, because we've been having full control of the service as the municipality*" (In-depth 2).

4.4.7.2   Positive impact

One respondent felt that the integration was going to be positive, as it will mean that environmental health will be part of a District Health System, which looks at health holistically: "*I was excited that we were going to move into a district health system because the district health system is holistic system of providing health care, your preventative and curative medicine*" (Focus group 1).

Some respondents mentioned that being part of the district will mean delivering an environmental health service of the same quality in all areas of the district.

> *"Well, the possible benefits will be what we call economies of scale, in the sense that you are able to respond to the needs of the environmental health on a more consistent and standardised kind of basis. You don't want to have a situation where, in one area, the standards are low. You want to show some kind of harmony district-wise."* (In-depth 3)

> *"By us creating wall-to-wall municipalities you find that the health act talks about an effective and equitable service, and that is the only way you can do that: by making sure that people have the access to basic services."* (Focus group 1)

In addition, respondents felt they are likely to get a picture of the status of the district population through Environmental Management Plans when they become part of the district

> *"The Health Act talks about the districts doing an Environment Health Plan; an Environmental Health Plan will give you an idea of the status of your communities; but at this stage we don't know what the status is."* (Focus group 1)

One respondent's expectation was that communities lacking basic services, such as water and sanitation, will benefit from the integration, as the district municipality is also a water services authority.

> *"When it came to community benefits, we as DoH deal with a lot of rural communities where people do not have water. So it was going to benefit the community as well. The district provides water and sanitation, so it was going to be easy for us to be working with them, and the communities would benefit."* (Focus group 2)

One respondent felt, that with the funding that is expected to follow the function, it might make it easy for all environmental health practitioners to deliver on their expected functions in all areas.

> *"In terms of the funding for the function, yes perhaps better, because there will be more emphasis now with the funding following function that you will be able to do your work. My work is more scientific and technical, and I need money to do that; and if I don't have money to do that function I have a problem. If funding came with it, I was always excited about that. I thought I could now establish more stations and expand my network and get it across to the rural areas as well."* (Focus group 2)

Respondents also had an expectation of increased environmental health staff, which would mean more areas gaining coverage

> *"It does affect service delivery. If you were to look at the ratio of the EHPs, we might have more EHP's in our area. We cover a very big area; it will be easier if there were more people to cover the areas. Community could benefit from that."* (Focus group 2)

4.4.7.3 Negative impact

Some respondents mentioned that moving environmental health services from local municipalities to the district could mean that this service becomes further removed from the communities being served, and this could possibly have a negative effect on service delivery

"It could be that we're just that bit further away, and there is just another bridge to cross before people can contact us. It may affect it (service delivery) *in that way, and they may be a bit confused as well; initially maybe, not forever."* (In-depth 1)

"For our local municipal customers, I thought it was going to be difficult to contact the district or to send the complaint to the district." (In-depth 2)

Most respondents felt that service delivery has been compromised as a result of the delay in the integration process. Some areas within the district are not being serviced currently.

"There are non-existent services in some areas. Province, with their limited resources, needs to provide a service in those areas where there is no service; that is a major challenge for them." (Focus group 1)

"What is sad about this whole process is the poorest of the poor are suffering: the people who should be getting clean water, the people who should be getting sanitation, refuse removal. People who should be getting housing are not getting it, because there is not anyone driving those processes." (Focus group 1)

"Serious negative effect (on service delivery)*. There is no service delivery in the real sense that is taking place. Maybe in built-up areas there could be an element of service delivery, because the community there is conscientious*

about the environment… but in the townships people are less demanding, and because they are less demanding we take them for granted." (In-depth 3)

Some respondents felt that the high staff turnover, which is a result of the uncertainty and lack of progress, impacts negatively on service delivery, because local municipalities are failing to retain skilled and experienced professionals, or at the very least to transfer these skills.

"Staff are leaving the profession and going to other fields….In the years to come I am not sure what is going to happen; the basic services are going to be compromised. It's because they are not retaining their skills or transferring skills." (Focus group 1)

Some respondents mentioned that carrying on a function without a mandate is also impacting on service delivery, as they are unable to enforce some parts of the legislation.

"As I sit here I cannot do certain functions….It has affected our service delivery. If the legislation is saying environmental health is a district function, you then cannot enforce some of the legislation, because you are not employed by the district municipality. So now we are not enforcing anything; we are like advisors." (Focus Group 2)

"You cannot really do your job properly, because you do not have the power to do that. We can only advise people; you can't do anything." (Focus group 2)

4.4.8 Staff Issues

In both the in-depths and focus group discussions respondents described various issues that impact on them as environmental health staff. These issues were the general lack of understanding of environmental health, the lack of support of the Health Professions Council of South Africa (HPCSA), the positive and negative

impacts of the integration on environmental health staff, and the coping strategies employed by environmental health staff.

4.4.8.1 General lack of understanding of Environmental Health

Most respondents felt that there is a general lack of understanding by the public of the work that Environmental Health Practitioners do. They attributed this misunderstanding to various factors, including: the scope of practice that is very broad: "*We are like a jack of all trades*" (Focus group 1); the number of name changes that the profession has undergone over the years: "*Going back to what was said earlier on, people do not know us; in the old days we were called sanitary inspectors, then we became health inspectors, then health officers, and now we are Environmental Health Practitioners*" (Focus group 1); as well as the HPCSA failing to "market" the environmental health profession: "*I blame all this on HPCSA; we pay heavy fees every year and they do absolutely nothing for us; you get other professions; they market the professions, but EHPs nothing happens*" (Focus group 1).

4.4.8.2 Lack of support by the Health Professions Council of South Africa

Most respondents felt that the Health Professions Council of South Africa (HPCSA) is not playing an active enough role. Respondents felt the HPCSA should be looking after their interests as professionals, as well as looking after their interests in the integration process.

> "*HPCSA should have been heading this whole process of devolution, so that as EHP we would know where we are going; we should have been supported through this.*" (Focus group 1)

> "*The Health Professions Council is not doing their job.*" (Focus group 2)

4.4.8.3   *Positive impact of the integration on environmental health staff*

Most respondents mentioned that when they first heard of the integration, they thought there could be possible personal benefits, such as getting better salary packages and other fringe benefits.

> *"When we heard about it initially it was quite exciting, because we were told that we were going to be better off in terms of salaries and benefits."* (Focus group 1)

> *"You used to hear that people who worked for the district got a lot of money and there were a lot of benefits that comes with it. We were hoping that, if we went there, we would have a good life and get a lot of things, a lot of money."* (Focus group 2)

One respondent felt that being part of a bigger entity than the local municipalities could possibly give EHPs an opportunity to enhance their skills: "*We would get more skills if you were employed by the district rather than a small municipality*" (Focus group 2)

4.4.8.4   *Negative implications of the integration on environmental health staff*

Most respondents felt that the lack of progress with the integration has had a lot negative implications on them as staff. This was related not only to the respondents' personal concerns about their employment status in the DHS, but mainly to their concerns about how failure of the integration effort would affect their ability to perform.

When the integration process started, respondents had many concerns about possible negative impacts on them. These initial concerns ranged from "*competition for positions*" (Focus group 2), to anxiety over where staff are going to be based (Focus group 2), to concerns about the organisational structure: "*with regard to the*

organogram, who is on top, who is the new boss; where will I be" (In depth 1). Staff generally felt threatened: "*Everyone will feel threatened*" (In-depth 1).

Some respondents mentioned that they are constantly worried and uncertain about the future. Staff were uncertain about the progress made and the next steps. They described the situation as very "unsettling".

> "*Up to now, we don't know when we are going to be transferred.*
> *I think it worries a lot of staff, because they don't know where they stand.*"
> (Focus group 1)

> "*It is unsettling, not so much for me and* (name) *as we have 2 more years of work, but for young people who have their careers ahead of them it must be very unsettling.*" (Focus group 1)

Some respondents mentioned that the lack of progress in the integration process has resulted in them losing interest in the integration and even their jobs.

> "*I, for one, have lost interest…. I no longer have the will to be in this, should I say department. Hence I'm looking for a job.*" (Focus group 1)

> "*I was so excited in the beginning, but now I am not so excited. I am happy where I am. If they said the devolution was tomorrow and they needed people to volunteer I would not volunteer to move; I would rather stay behind.*" (Focus group 2)

Some respondents felt that staff turnover, mostly due to the uncertainty, has not only affected service delivery, but also has increased their workload

> "*We are also short staffed; we can't even employ new staff. People just go and we can't fill in the posts. This thing has really affected us.*" (Focus group 1)

Respondents mentioned that the expectation of service delivery when the available resources are limited is putting strain on staff, as they are still expected to do more with the little that they have.

> *"The province and national government expect us to be very productive with limited resources. It has affected me as well personally, because I do EHP work, I do admin, and I'm also expected to attend meetings - provincial, local municipalities, and at district offices."* (Focus group 1)

> *"It is one of the issues that affect us a lot. We are expected to do all this, yet we have nothing: no support, nothing."* (Focus group 1)

Respondents described the various benefits they have lost as a result of the changes. Amongst these were accrued leave benefits. When discussions around the integration were in progress, some staff were required to take leave, so as to reduce accumulated leave before being taken over.

> *"Leave was one of the sore thumbs, because I had accrued 250 days leave .It was like a year's annual leave, and that was a concern from both parties - as a year's leave, that is a lot of money. It was, in fact, more than a year's salary. We were allowed to accrue that amount of days, and district was saying – we will only take you with so many days, and the municipality was saying you must take your leave because we are not prepared to pay you all. That left us having to take huge amounts of leave, I was taking up to a week of leave a month, whereas if we had been paid for the leave we would have benefited quite nicely. So I think a lot of staff lost out on those kinds of things, especially staff who had been around for a while."* (Focus group 2)

Another aspect staff felt they lost out on was being put on the "interim structure", which put them in a disadvantaged position: "*we have been put on the interim structure by the department and therefore cannot apply for posts and other things*" (Focus group 2). Staff felt that the hold on the process has even deprived them of personal growth as they cannot progress.

"I would say it has de-motivated us, for me very much so. I have a degree, yet I am still working as a general inspector. I was hoping that if I went over to the district I would become an EHP, but that has not happened." (Focus group 2)

4.4.8.5 Coping strategies

Despite the many challenges they face in their day-to-day functioning, and for the sake of ensuring that a service is delivered to communities, respondents mentioned that they have learnt to be innovative, and have learnt to make do with what they have.

"My staff always says to me that I am not showing that we cannot cope: 'You are always making a plan'. I say, well as long as I'm here I will make it work. I was in court yesterday, we are the only ones who are prosecuting, and the other municipal departments are not. Despite all the short-comings we are still committed to providing the service." (Focus group 1)

"I say to my staff let's do what we can with the resources we have got; we need to have pride in what we do. I know that staff are demoralised, but we still squeeze them. There have been a lot of problems." (Focus group 2)

4.4.9 Change needed

Respondents in the in-depth interviews and the focus group expressed what they felt could assist the integration process, if it was to be handled differently or changed. These changes included: having a champion for the process, building better relationships and better communication, more education, having detailed plans, following a staged process, learning from others who have succeeded with integration, and monitoring and evaluation of the process.

4.4.9.1 A champion for the process

Some respondents felt that for successful integration it is important to have a strong committed leader, at a national level, who will commit to the integration

> *"Another thing would be to get someone who would just champion the whole process; someone who will put their foot down and say: 'This thing must be implemented'. At national level."* (Focus Group 1)

Respondents felt that it is important that this leader ensures that the timing of the integration is correct as leadership, especially political leadership, can also change, which could cripple the process.

> *"It has got to be done at the right time, there has been so many right times and so many wrong times…. The person who is driving this now has to be strong to ensure that it is done at the right time. Things change; the leaders change, then you have a different political leader."* (Focus group 2)

4.4.9.2 Better relationships and better communication

Some respondent mentioned that all parties need to invest in building relationships for better and effective communication.

> *"I think over time it* (communication) *will improve. There will be an improvement, but I think there will need to be investment in terms of improving those relationships."* (In-depth 3)

Respondents felt that communication should be improved, so that they all can be better informed of the progress made and of future plans

> *"They should make sure that every single person is informed."* (Focus group 2)

"We want to know what the status is, where we are going. We want to know what is going to happen and we want someone to give us feedback about what is going on. We need some follow-up sessions to find out what is going on; we need to move forward." (Focus group 1)

4.4.9.3   More education

One respondent felt that there is a need to sensitise all top-level role players about the integration.

"Some education at the top, politically and the CoGTA (Co-operative Governance and Traditional Affairs), treasury, health." (Focus group 2)

4.4.9.4   More detailed plans

Most respondents felt that the district municipality should have been better prepared for the integration. Respondents would like to see them review their current plans, ensure that these plans are well communicated to all stakeholders, and ensure that their concerns as staff are addressed.

"They should have planned it better." (Focus group 2)

"There must be a review of the plans, and stumbling blocks must be identified." (Focus group 1)

"Communications with the timeframe and a date of when it will take place, so that we could all be involved and move forward; and also all be informed." (In-depth 1)

Respondents felt that communication should also filter down to communities who will be affected by the integration

"I think the district, together with the local municipality, should sit down and plan a way or prepare a plan to inform the communities about this change." (In-depth 2)

One respondent felt that it was premature for the district municipality to inform EHPs of the integration and to raise their expectations before proper plans were in place.

"They should not have communicated this with us until they made sure that everything was ready, and they know what is going to happen and when; then they should involve us." (Focus group 2)

4.4.9.5 A staged process

Respondents felt that planning for the integration should involve a staged process. They mentioned that it is important to first get buy-in and commitment from political leadership.

"First of all, the administration head of the district should brief and request the will from the political head of the district and they should have a clear presentation to the politicians, and then agreement that the service should be taken over." (In-depth 2)

Respondents felt that there is a need for a detailed plan that would be negotiated with and agreed upon by all parties.

"The district administration head (the Municipal Manager) *should have a clear draft program that can be debated with all local Municipal managers and accepted. The plan should have clear timelines that should be agreed to by all stakeholders."* (In-depth 2)

"What plans do they have and time frames do they have in place to ensure that service is being devolved to all district municipalities? What funding arrangements are in place?" (Focus group 1)

4.4.9.6   Monitoring and evaluation

Respondents felt that there should be a way to monitor and evaluate the process. This should include monitoring of financial resources provided for the function

> *"There should be a monitoring and evaluation program in place."* (Focus group 1)

> *"When money is given, who is monitoring and evaluating how that money is being spent. If funding has been provided, what funding has been going to the district municipality, and what monitoring and evaluation do they have in place to ensure that service is being delivered."* (Focus group 1)

> *"The implementation of the said plan should be closely monitored by all municipal managers."* (In-depth 2)

4.4.9.7   Learning lessons from others

Some respondents felt that the district municipality should learn from best practices of others who have successfully dealt with the integration.

> *"Municipalities need to learn and consult with other district municipalities as well. At some municipalities devolution has already happened; they need to consult with other municipalities and learn from them."* (Focus group 2)

4.5 Summary

The results of the current study show that not much has changed in the provision of environmental health services within the district since the promulgation of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) and the definition of MHS.

It is apparent from the study results that planning for the integration was poor. The following were viewed by participants as the main barriers to the integration process: the poor relationship between district and local municipalities, limited understanding of environmental health, inadequate budget allocation, poor communication, lack of commitment, insufficient capacity, and the lack of a champion for the process.

These results are discussed in detail in the following chapter.

CHAPTER 5: DISCUSSION

5.1 Introduction

The previous chapters provided insight into the currently available literature on the transfer and devolution of environmental health services into district municipalities, as well as findings of previous studies conducted on related topics. The research methodology adopted for this study was also explained, followed by presentation of the results of the study. This chapter will endeavour to highlight any relationships between the literature reviewed and the findings presented in the previous chapter.

The discussion will focus on the available human resources for the environmental health function within the district, the package of environmental health services rendered, implications of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) on the provision of the environmental health function, service level agreements between the district and local municipalities or Provincial Department of Health, barriers to the integration, and the impact of the delay in the integration on service delivery as well as environmental health staff.

Furthermore, the discussion will attempt to link the theory of change to UMDM's change process, discuss the changes required for better management of the process as suggested by the study participants, and describe the limitations of the study.

5.2 Human resources for environmental health function in the district

The staff audit exercise was aimed at ascertaining the number of environmental health personnel in the district, and their workload in relation to the district population.

According to the data, the district has a combined environmental health vacancy rate of 47%, which means that environmental health services in the district are rendered

by almost half of the personnel that are on the local municipalities' original staffing plans. In some cases, the numbers of vacant positions exceeds those that are filled e.g. Msunduzi and Richmond. This translates into an increased workload for the practising EHPs.

This increased workload is further evident when comparing the number of EHPs to the population being served. In Richmond municipality, delivering EHP services to the entire population of 63 219 people, rests with one EHP. Considering that the WHO's norm for EHP staffing is 1EHP per 10 000 of the population, and South Africa's adopted national ratio is 1EHP per 15 000 of the population (Agenbag and Gouws, 2004), it is clear that there is still a lot that needs to be done in order to improve staffing levels. MHS are service delivery oriented; as a result they are reliant on adequate human resources for efficient and equitable delivery. The lack of adequate personnel to render the service raises concerns as to the quality of environmental health service being delivered to communities. In addition, it raises the question of the impact of the increased workload on the staff concerned. Addressing these issues without full integration and the take-over of municipal health services by the district municipality will be challenging, as local municipalities are reluctant to provide staffing for a function that should be rendered by the district authorities. The length of time it takes for the integration to materialise will further widen the staffing gap, as there will be natural attrition of staff.

5.3   Package of environmental health services provided

The National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) split environmental health services into MHS, which were to be provided by district municipalities and metropolitan municipalities, and provincial environmental health services, which were to remain the responsibility of the Provincial Department of Health (PDoH). In the current study it was found that all local municipalities continued to render the same services that they rendered prior to the enactment of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003), including the control of hazardous substances, which now falls within the Provincial Department of Health's scope of practice.

The provincial EHP's functioning has also not changed, as they have continued to render the same services that are inclusive of MHS. Not only has there been no change in the provincial environmental health functioning, but the province continues to play a major role in the provision of MHS within the district. A quarter of the district population, which covers four of the seven local municipalities that make up the district, is serviced by the provincial EHPs. Instead of the PDoH focusing its resources on the newly defined core functional areas and assuming responsibility for monitoring and supporting municipalities as defined in the Act, it is currently utilising its resources for the provision of MHS. Section 32(1) of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) requires metropolitan municipalities and district municipalities to ensure provision of an effective and equitable MHS in their areas. The district municipality has done little to fulfil this legal requirement.

5.4 Implications of the National Health Act (Act 61 of 2003)

After a period of a lack of a clear definition of MHS to accompany the transformation process, the definition of MHS in the National Health Act (Act 61 of 2003) was a step forward as it clearly defined the core functional areas for EHPs in municipal and provincial employ.

The Act gave responsibility of MHS to district municipalities; however, it seems that not enough was done to assist district municipalities in fulfilling this mandate. The passing of the Act was a step forward in the District Health System development; however, provisions for its proper implementation and the fulfilment of its requirements as they relate to MHS should have been given proper attention.

When the Act came into being, most district municipalities were fairly new and had a number of other equally important functions that they had to take responsibility for (e.g. water and sanitation). The Department of Health, as the custodians of the Act, could have played a decisive role in assisting district municipalities by ensuring that they fully understood the implications of the Act, as well as by offering more guidance to district municipalities about the process of integration, including

developing relevant policies and making available knowledgeable human resources to champion the process.

5.5   Service level agreements

District municipalities have an option of delegating the provision of MHS to local municipalities through a service level agreement. Such agreements would give local municipalities the legal authority to carry out the function, as well as put in place clear service delivery arrangements for the function with that particular authority. Furthermore, a service agreement would give both the local municipality and province a platform for obtaining necessary funding, or claiming from the district for delivery of this function.

Currently there are no service level agreements in place. A disjuncture exists where local municipalities and province are still responsible for rendering the service, but have no financial resources to do so, and district municipality receive the necessary funding for the function, but have not yet taken responsibility for the function.

5.6   Barriers to the integration process

The delay in the integration process can be attributed to a combination of factors. The barriers observed in the study are discussed below. Most of the problems impacting on the integration are those that have been general concerns and challenges to the DHS implementation as a whole in the country. As these barriers are discussed below, parallels with the DHS implementation challenges will be drawn

5.6.1   Budget allocation

Existing literature has made reference to lack of adequate funding - one of the main challenges to the integration and devolution process. Balfour (n.d) pointed out that

prior to the 2006 inclusion of MHS in the equitable share allocation it was unclear how MHS, as part of the district function, were to be funded. A situation existed where legislation was enacted for implementation without making available the necessary financial resources for its proper implementation.

The current study provides evidence that consultation and discussions between the districts, local municipalities and province commenced as early as 2003, in anticipation of the impending legislative changes. However, these consultations were later halted due to lack of the necessary budget to effect the changes required. The current study revealed that discussions around the integration were suspended as the role-players saw no way of moving forward with the process whilst lacking the financial muscle to do so.

Lack of finance for change implementation was also observed with the DHS implementation as a whole. Barron and Asia (2001) noted that while 'MinMec' gave strategic direction on what was necessary for establishing a well-functioning DHS, the necessary financial and other resources that were to allow for its establishment were limited. Funding for DHS was also not clarified early. Details on funding for the municipal-based DHS implementation were unclear as to how the DHS was to be funded, by whom, with what amount and the route for channelling the funding (Barron & Sankar, 2000).

Even after the R12 per household equitable share allocation for MHS in 2006, district municipalities felt that this funding was grossly inadequate (Agenbag & Balfour-Kaipa, 2008). The funding allocation has noticeably increased since 2006, with a 2010 allocation of R18 per household, but district municipalities still feel that this allocation is inadequate. The Sedibeng district municipality 2011/2012 Integrated Development Plan (IDP) turnaround strategy points out that the equitable share allocation they are receiving is not enough to fully fund MHS (Sedibeng district municipality, 2011/2012 IDP).

It is possible that some district municipalities' view of the available funding as inadequate for MHS results in the channelling of this allocation to aid them in other

service delivery needs, instead of taking over MHS. Although the available funding might be inadequate to fully fund the provision of environmental health services, it surely does provide district municipalities with a base to start the implementation of decentralisation of the MHS function. This could be done in stages, through a gradual takeover from one local municipality at a time, whilst setting realistic goals for the full takeover.

Andrews and Pillay (2005) called for ring-fencing of MHS funding, in order to ensure that these funds are utilised for their intended use. Balfour (n.d) also suggested that the funding for the function be allocated as a conditional grant, in order to safeguard its use. Arguably, that would ensure that the allocated funding would indeed serve the provision of MHS, as conditional grants specify both the content and outcomes of the project implementation. However, decentralization is about shifting powers to the lowest level of governance possible, including fiscal powers. This will be in accordance with the vision of the ANC National Health Plan (African National Congress, 1994) of decentralising powers inclusive of accountability and management of resources to the lowest possible level of governance" that is in line with sound planning and maintenance of high quality care. It could, therefore, be argued that by ring–fencing funding for MHS, full decentralization will not be realised, as the responsibility for the function will be decentralised to district whilst withholding autonomy over its finances. According to Stanton (2009: 178) "the Constitution instructs national government to support the devolution of political and administrative powers and functions to local government by means of transferring adequate fiscal resources in order for local government to independently meet their Constitutional mandate". Therefore, when national government provide funding for the function, district municipalities need to fully understand the importance of MHS as a basic service and the role it plays in safeguarding public health, and must commit to 'independently' fulfil their constitutional mandate.

The current study revealed all-round poor budgetary planning. The Provincial Department of Health were also unable to make the necessary funding allocation for payment of staff benefits, such as leave, due to them prior to their transfer, and this further delayed the transfer process. In the 2004/2005 financial year, all but one local

municipality (i.e. Msunduzi) made no budget allocation for MHS, as they expected the district municipality to fund the function when implementing the requirements of the National Health Act. This had a serious impact on the delivery of MHS.

5.6.2 The relationship between district and local municipalities

For a successful transformation and transition of service delivery, an enabling environment for discussion around changes is vital. Unfortunately, in most cases, and in the case of uMgungundlovu, transfer of MHS from local to district municipalities took place in an environment characterised by contestation around powers and functions.

If we look at the context under which the transfer of MHS from local to district was to take place, it is clear that it was not a good one. Prior to the enactment of legislation, which gave powers over delivery of basic services to district municipalities, local municipalities were the ones playing a service provision role. According to the Municipal Structures Act (Act 117 of 1998) (Republic of South Africa, 1998a), district municipalities were to be responsible for co-ordinating, supervising and playing a supporting role to local municipalities in the delivery of basic services. District municipalities were mainly responsible for the bulk supply of services for the district as a whole, for the achievement of economies of scale. However, this changed when the Municipal Structures Amendment Act (Act 33 of 2000) (Republic of South Africa, 2000) was passed. There was a shift in the allocation of powers and functions over services that had previously been rendered by local municipalities, with power being given to district municipalities. In the Amendment of the Act, the actual provision and distribution of basic services (i.e. water, electricity, sanitation, waste and municipal health services) rested with district municipalities. This, in a way, created a "two-tiered" system of local government that placed local municipalities at a secondary level, simply as a delivery arm of the district municipality, forcing them to part with some of their income-generating services and stripping them of powers and functions that had previously been assigned to them (Stanton, 2009).

Another aspect of the relationship between district and local municipalities is the fact that district municipalities are regarded as sites of fierce political contestation (Community Law Centre, 2008). Political parties tend to "deploy" more experienced and senior councillors to district municipalities, rather than to a local level. This has, therefore, created a situation where the "highly placed councillors assume that their party superiority carries over into their elected role and that they are the bosses of their local counterparts" (Community Law Centre, 2008:.8). This notion gives rise to discord, and local municipalities tend to distance themselves from the district. This discord colours the relationship between local and district municipalities, and is the context within which changes to MHS had to take place. UMgungundlovu was not immune to this discord, and the current study shows that the "relationship" between the "two tiers" was at best non-existent. However, the relationship between uMgungundlovu district and local municipalities seems to be improving slowly, as they learn to complement and assist each other rather than compete for powers and superiority. This is evident in regular interactions between these municipalities through the various district forums

These intricate relationship issues were not only confined to MHS implementation as they were also observed in the entire DHS policy implementation. McCoy and Engelbrecht (1999) point out the difficulties that surrounded DHS implementation, among these the different interpretation and understanding of the roles and relationship between health district and local government, the relationship between local government and the PDoH and that of the three spheres of government (national, provincial and district).

5.6.3 Communication

With the strained relationships between local municipalities and district municipalities, lack of co-operation and poor communication was inevitable. As local and districts municipalities competed for the same resources and opportunities, communication was affected. The current study pointed strongly to poor communication between local and district municipalities as a major factor in the failure of the integration process. Even when the district approached local

municipalities for comments on and discussion of service level agreements, there was no response from local municipalities. There was generally a divide between the two, and communication was seen as very "bad" by study participants. Without a good foundation for communicating the legislative requirements of integrating MHS into the district municipality, and a good base for addressing issues, problems and concerns relating to the integration by all concerned, transfer of the function was always going to be a challenge. Barron and Sankar (2000) pointed out the need for all role-players who will be necessary in the DHS implementation to be sufficiently informed of the new structure and the possible changes.

5.6.4 Lack of a champion/leadership

Whose responsibility was it to ensure successful integration and devolution of MHS into district municipalities? It seems that, initially, there was no clarity as to who should lead or drive this process. The roles of the important stakeholders (i.e. National and Provincial Department of Health, CoGTA, SALGA, local and district municipalities) should have been clarified earlier, by means of a policy to guide the process.

According to the final draft of the Guideline Document for the Devolution of Municipal Health Services (Department of Health, 2011), the National Department of Health is the main driver of the process, and is responsible for successful finalisation and ensuring that service delivery is not compromised. Therefore, the NDoH had a duty, in consultation with CoGTA, to ensure that district municipalities commit to the process and are held liable for the promotion of public health. The National DoH has, thus far, done little to ensure integration. It is only in the present year (2011) that they have produced the policy document that is set to guide the devolution and transfer process and assist district municipalities in fulfilling this role. In this document the role of every stakeholder is clarified. When roles are clear, it becomes easy for everyone to take responsibility for what need to be done.

Available literature reveals that there have been concerns around poor leadership in the decentralisation as part of DHS implementation. Strong leadership is key to the

DHS process. Schaay and Sanders (2008) mentioned the shortage of managerial capacity and health system leadership at all levels as one of the current hindrances in achieving PHC in South Africa. Without capacitated leadership, implementation of policies will be a challenge. Barron and Asia (2001) stressed that government's commitment alone to DHS is not enough, but should be accompanied by clear leadership and vision.

5.6.5 Capacity

According to Balfour (n.d) some district municipalities have faced difficulties in performing the functions allocated to them, due to insufficient institutional capacity, financial and human resources. In the current study, capacity was mentioned as one of the key challenges to the integration process, as the district municipality lacked the necessary capacity to plan and follow through with the transfer process.

According to the White Paper for the transformation of the Healthcare System in South Africa (Republic of South Africa, 1997), issues of capacity building, equal provision of the required resources and their appropriate use were entrusted to the NDoH. Therefore, the NDoH, in consultation with CoGTA, had a critical role to play in ensuring that the required capacity for the process was developed.

In the earlier literature, Barron and Sankar (2000) had expected capacity for newly formed municipalities to be inadequate to cope with DHS demands and challenges. They called for the drawing up of plans to obtain necessary and well-trained staff that would allow for orderly decentralisation ensuring that service delivery was not negatively affected.

5.6.6 Misunderstanding of the implications of the transfer

In the current study it was also evident that the implications of the transfer were not fully understood by key people involved in the implementation of the transfer process within the district. The district municipality needed to conduct a Section 78 investigation in terms of the Local Government: Municipal Systems Act (Act 32 of

2000) (Republic of South Africa, 2000) in order for them to make informed decisions on the direct and indirect costs and benefits associated with rendering MHS, and the municipality's current and future capacity to provide the skills, expertise and resources necessary for the provision of the service. This was necessary to inform the district municipality as to the full implications of the transfer and to enable them to decisively move forward with the process. The district municipality had no basis for moving forward with the transfer, as they had not done the necessary self-assessment of their own capacity to take over and render the function.

5.6.7 Lack of understanding of environmental health

Environmental health is often a misunderstood area because of its broad scope of operation. In most instances, there are other departments or organisations rendering similar functions to those performed by EHPs, which may create confusion about the role of an EHP. According to Agenbag and Balfour-Kaipa (2008: 152), "the overlap and conflict of powers and functions" is posing a challenge for district municipalities in the implementation of MHS. Some of the areas that are a source of confusion are air pollution control (which is mainly controlled by the Department of Environmental Affairs and Tourism), water and waste management.

5.7   Impact on service delivery

Everyone involved in the current study had their own expectations of the integration process. There were positive and negative expectations of changes. Overall, as part of the integration process, people expected improved service delivery as resources would tend to be distributed more evenly throughout the district. This would hopefully balance the scales in terms of service provision and prevent situations where areas with a profound rate base receive better services than rural areas with little or no revenue and limited services. Development of district wide plans would mean standardisation of service delivery, and this would, in turn, improve the overall health status of communities in the district.

On the flipside, there were concerns about possible negative impacts on service delivery resulting from the integration. Amongst these was the concern that environmental health services were moving a step further away from the communities being served, which contradicts what the DHS is all about, namely moving service "closer to the people". It means 'another bridge to cross' for communities to make contact with environmental health services, whereas local municipalities are much closer to the people, with ward committees and councillors amongst them to raise and follow up on their environmental health concerns.

According to the Financial and Fiscal Commission (2001), the prevailing political system supports the policy of placing municipal services as close as possible to the communities served by that service, as 60 percent of district councillors are indirectly elected through a system of proportional representation. By contrast, local councillors are all directly elected by communities. Half of local councillors are ward councillors, which is an advantage as they are in direct contact with and are much more accountable to their communities. With movement of the function from local to district municipality, it can be argued that direct contact is slightly removed.

For the sake of service delivery, the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) called for municipalities to continue rendering the function "within the resources available to them" until a service level agreement was put in place. This has been the case in the uMgungundlovu area, where local municipalities have continued rendering the function. However, there have been some challenges to maintaining the *status quo.* Local municipalities in the district (except for uMsunduzi) have not been budgeting for MHS, except for the payment of salaries for environmental health staff. This has meant poor performance in the provision of MHS as per the nine core functional areas defined in the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003). Only functionalities that require no funding, such as conducting routine inspection of premises are rendered, with those that require budgeting (such as sampling of water, food and milk) being compromised.

The level of staff attrition as a result of job insecurity, and the fact that staff who leave are not replaced also impacts negatively on service delivery, as well as on the remaining staff. Environmental health services are dependent on human resources to be delivered effectively, and without human resources the service is compromised. Communities in townships and rural areas are not getting the same service as the urban areas because they are less vocal than the urban communities and, therefore, the minimum resources available tend to be spent in urban communities

5.8   Linking theory to the change process

The use of theory in programme planning is often neglected. Connell and Kubisch (1998) mentioned that the use of change theory in the design phase of a programme could assist role-players in a programme to set clear goals for the programme, clarify what needs to be done to reach the desired goals, and identify the contextual factors that are likely to influence change. Linking theory to programme planning lays a good foundation for change implementation, as issues that are likely to impact on change are predicted early on, and proper interventions are then developed before embarking on the change process. The use of theory is not only important in the planning phase, but also serves as an important implementation and evaluation tool.

The current study used Goodman, Steckler and Kegler's model for organisational change (cited in Nutbeam and Harris, 1999) to evaluate the different stages in the integration process in the uMgungundlovu district, to identify what could have been done differently in each of the stages.

Awareness-raising
There was a lot of awareness-raising done regarding the integration process. Consultations and discussions around the transfer and devolution process began as early as 2003, before the passing of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003). However, the downside to the awareness-raising process was that it was a blanket approach that involved all levels simultaneously.

Goodman, Steckler and Kegler's model suggests that awareness-raising be limited to the senior level of the organisation at first, to generate interest and to garner support for the programme from all those who will be key to its successful implementation. Second, limiting awareness-raising to a senior level initially will allow for early identification of possible problems that might be encountered in the process, and the subsequent development of solutions to these problems. Challenges to the process, such as funding, could possibly have been identified at this stage and plans could have been made to resolve the problem before the consultations went any further. What is very important in this stage is ensuring the engagement of the correct level of stakeholders, namely people who are likely to be involved in the decision making process.

In the current study, consultation with affected staff started before a plan for the transfer process was made. When the first hurdle of lack of a budget was encountered, discussions with environmental health staff were already underway. By then, expectations of change had been created among environmental health staff and local municipalities had prematurely withdrawn funding for the function for the 2004/2005 financial year. Had awareness-raising been done properly and at the correct level, many of the challenges encountered later on could have been predicted and appropriate solutions could have been devised.

Adoption

As a follow up to the awareness-raising stage, Goodman, Steckler and Kegler's model proposes development of a plan and adoption of a policy for the programme to address the issue of interest. The same should have happened before any attempts at implementing the integration were made. A detailed plan, supported by policy to guide the process, needed to be in place. Unfortunately, this was not in place to guide the integration process, and the district, together with the rest of the stakeholders, resorted to planning as they go. It also appears that attempts at all processes were running concurrently. Whilst they were busy raising awareness, they were also attempting to plan and implement the integration. This seemed to confuse the process and demoralise the people who were trying to implement the transfer.

Implementation

This stage is concerned with making available the necessary resources, support materials and capacity to ensure that the change process is implemented successfully. By failing to identify problems relating to resources early on (possibly in stage 1), failing to carefully consider the capacity necessary to implement change, and failing to develop and adopt a plan to guide the process, the transfer process failed to reach the implementation stage.

Institutionalisation

Goodman, Steckler and Kegler's model proposes that this last stage is necessary for the long-term maintenance of the change process, and it includes the development of monitoring and quality control tools. However, in the current study, because there was no plan for the actual implementation of the change process, no thought was given to the long-term maintenance of the change process.

5.9   Staffing issues

The stalling of the integration process has had a very negative impact on environmental health personnel. A number of issues affecting environmental health staff emerged during interviews. Human resources are an important resource in the provision of an effective service and, therefore, issues affecting them cannot be ignored.

There is a general feeling amongst EHPs in the district that environmental health as a profession is often misunderstood and its importance underestimated. The EHPs felt strongly that the Health Professions Council of South Africa (HPCSA) needs to be looking after the profession, and should have played an active role in the integration process in terms of protecting the interests of EHPs.

Since the enactment of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003), the anticipated changes have caused great anxiety amongst environmental health personnel. Change is usually accompanied by apprehension,

as the people to be affected by change have concerns and questions related to their future. The importance of proper communication and creating a forum where all parties can discuss their concerns cannot be stressed enough. The study revealed that environmental health staff were, and still are, concerned about job security and where they will be placed geographically. Lack of progress in the integration process makes them feel insecure, and their morale is generally low. The increased workload resulting from staff attrition and their current employer's reluctance to employ more staff for an unfunded mandate has resulted in burnout. Lack of the necessary resources to perform effectively is also putting a lot of strain on them, as communities still expect them to deliver the service effectively.

The lack of integration has robbed many EHPs of personal growth opportunities, as provincial staff were put on the interim structure and, therefore, could not apply for posts. Accumulated leave is an investment for staff, especially for the long-serving members, and the integration process meant having to take or forfeit that leave.

Despite the many negative impacts the integration has had on staff, there is still strong commitment from environmental health staff in the district to safeguard public health. They have learnt to cope with the many challenges by devising innovative ways of delivering the same quality service. These include the development of pro-forma compliance notices, that they issue on the spot during inspections, and task shifting.

5.10 Change needed

When respondents were asked what they wanted to see being done differently in order to ensure the integration moves forward, the following suggestions for change were made:

5.10.1 A champion for the process

According to Agenbag and Balfour-Kaipa (2008) the existing problems in the devolution process are as a result of lack of strong leadership, support and guidance for district municipalities. There is a need for strong national leadership to direct the process and work with district champions to implement change. As respondents mentioned, it is important for this champion to ensure that the implementation of change is correctly timed as the political environment and leadership, which influences change in an organisation, can also undergo a change.

5.10.2 Better relationships and better communication

It is necessary to improve relations between the "two tiers" of local government in order to facilitate discussions around the integration. We are starting to see progress towards realisation of this in the UMDM as there are forums (i.e. the Municipal Managers' Forum and the Mayors' Forum) where municipal managers and mayors for all local municipalities meet and engage on service delivery issues in the district. This will hopefully improve communications and relations between the two tiers.

5.10.3 More education

For better implementation of change, it is vital that people who will be key to its implementation are well-informed, understand the process, and are in agreement about the changes required.

5.10.4 A staged process

Following a staged process that will involve garnering support and commitment from stakeholders, especially political heads in the district, and the development of detailed plans is important for change implementation. A staged process would involve use of change theory (theory of organisational change) in planning for and implementation of change.

5.10.5 Monitoring and evaluation

It is necessary to monitor financial resources received by district municipalities for funding the function, so as to ensure that they are used for their intended purpose. Respondents felt that UMDM have been receiving funding for the function since 2006, and yet are not providing the function. Is there a way they are accounting for the use of the funding?

5.10 Limitations of the study

Although the current study shows promising results, it is important to note the limitations of the study. Firstly, it focused on only one district municipality with a resulting small number of participants, thus raising questions around transferability. Like most qualitative research, however, this study does not make an attempt at generalisability. While descriptive studies like the current study may not offer the highest level of evidence, they remain important in areas where there is little other research. Green and Thorogood (2004) point out that in researching relatively under-researched topics, the issue of sensitizing readers to new ways of thinking or participant experience is more salient than the issue of generalisability. The transferability of the findings from this study will be enhanced when further comparative qualitative studies in other districts are conducted.

A further limitation of the study is that the researcher was not able to access all the participants who were initially to be included in the sample. The researcher intended to conduct a focus group discussion with municipal managers who had been involved in the integration process when it was started; however, they were no longer in service during the data collection process and, therefore, both focus group discussions consisted of Environmental Health Practitioners.

It might be seen as a limitation of the study that the researcher herself is an Environmental Health Practitioner. The researcher, therefore, already had knowledge and perceptions of the integration process, which might be viewed as bias. This existing understanding can, however, also enhance the depth of the

qualitative data collection and analysis. As Stiles (1993: 614) states: "deep personal involvement and passionate commitment to a topic can bring enmeshment, with its associated risks of distortion, but they can also motivate more thorough investigation and a deeper understanding".

5.12 Summary

The lack of progress in the integration process is a cause for concern as its negative implications are not only limited to service delivery, but extend further to the staff who provide the function.

Challenges to the integration which are inclusive of poor planning, inadequate budget allocation and poor communication need to be addressed. The importance of linking the theory of change to programme planning cannot be overlooked. Gaps in the planning for and the implementation of the integration were identified through use of the theory of organisational change using Goodman, Steckler and Kegler's four stage model.

CHAPTER 6:   CONCLUSION AND RECOMMENDATIONS

6.1   Introduction

Chapter 5 discussed the status of MHS provision in the UMDM area, the various challenges to the integration, and their impact on service delivery and environmental health personnel. The next section will draw conclusions regarding the current study and make recommendations

6.2   Conclusions

A number of important legislative changes took place with regard to DHS implementation in relation to environmental health services. Progress toward full implementation and realisation of decentralisation has been very slow. Transfer and devolution of MHS to district municipalities is in progress, though at a slow pace, which negatively impacts on the delivery of this function. Some district municipalities have successfully decentralised the function, and in these districts the function is gaining prominence and is being included in municipal planning processes (Agenbag & Balfour-Kaipa, 2008). This is important for effective and equitable delivery of the function.

Attempts are being made to fast track the decentralisation process. The NDoH has taken up its responsibility of policy development by developing the Guideline Document for the Devolution of Municipal Health Services (Department of Health, 2011), which district municipalities can use as a baseline for development of district specific plans for the transfer and devolution process. The availability of funding for the function through the equitable share, though arguably small, does enable district municipalities to make a start in the fulfilment of their legislative mandate and they can build on it over years.

The challenges to the integration process as discussed in the previous chapter need to be addressed in order to ensure that the focus is shifted towards service delivery and upliftment of the health of the public. The following recommendations are made.

6.3   Recommendations for improvements

The following are recommendations for better implementation of the change process and improvement of environmental health service delivery. An action plan for integration for UMDM has been included.

6.3.1   Legislation and resource provision

Legislation alone is not enough to ensure decentralisation. Legislative developments should be accompanied by considerations for resource provision to ensure effective implementation of the said legislation. These resources include financial and human resources. The lack of financial resources and necessary human resource capacity to implement the requirements of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) in relation to decentralisation of municipal health services was a major stumbling block in the integration process.

6.3.2   Integration of MHS needs to be fast-tracked

It is evident that MHS delivery in the UMDM area was compromised. For proper service delivery planning, inclusive of human resources provision, integration of MHS into UMDM should be completed as a matter of urgency. In the current situation, up-scaling of MHS provision is impossible as no one at either local municipality or district municipality level is taking full responsibility for the function. The failure of the district municipality to transfer and consolidate MHS has had a ripple effect, as it affects resource provision to render the function, which in turn affects service delivery, leading to poor health outcomes.

The prevailing situation of provision of fragmented MHS, with some areas receiving minimum MHS cannot be allowed to continue. The National Department of Health (NDoH) must assume its leadership responsibility in health provision and assist district municipalities in planning for, provision of capacity where necessary, and implementation of the integration process. District municipalities have a responsibility in terms of Section 32(1) of the National Health Act (Act 61 of 2003) (Republic of South Africa, 2003) to ensure equal provision of an effective MHS in their areas and it is, therefore, necessary for the NDoH to assist district municipalities to fulfil this requirement. The National Department of Health (2011) emphasised the need to understand that MHS forms part of health services (as referred to in the National Health Act of 2003) and, therefore, MHS remain the responsibility of the NDoH, including ensuring their implementation, making available guidelines and policy relating to the function, and monitoring the service.

6.3.3 Service level agreements

Whilst the district municipality is busy with plans to transfer the function from local municipalities and PDoH, service level agreements need to be signed. Having service level agreement in place will assist in formalising the temporary service delivery relationship between the parties, ensure that all parties have a common understanding as to the expected outcomes of the services delivery, and set delivery priorities, responsibilities and operational arrangements.

6.3.4 Budgeting

Through the equitable share provision, the district municipality needs to plan and make the necessary provisions for a phased transfer. This will entail gradual transfer of possibly one local municipality at a time, until full transfer from all municipalities and province is completed. This will allow the district to start assuming responsibility for the function, get the feel and understanding of MHS operations, and measure the MHS needs of the district.

6.3.4 Development of plans

A district municipal champion needs to develop plans in consultation with relevant stakeholders, and the NDoH champion to guide the process. The NDoH has developed a guideline document for the devolution of MHS, and this guideline forms a good basis for the development of district specific plans to guide the integration process. The champion needs to be guided by theory, such as the theory of organisational change, when planning and implementing the change.

Plans made for the integration need to be specific as to the stakeholders to be consulted and must have a timeframe for implementation. A communication plan should form part of the main plan so as to allow for discussion of issues and concerns with all stakeholders. Communication of changes with affected communities is also necessary to prepare them for integration, address their concerns, and attempt to bridge the gap between local communities and district

6.3.5 Section 78 assessment

District Municipalities have to fulfil requirements of Section 77 of the Municipal Systems Act (Act 32 of 2000) (Republic of South Africa, 2000) when assuming a new function, by deciding on the appropriate mechanism for providing that function. This is done by conducting a section 78 assessment, which assists them in making this decision. According to Agenbag and Balfour-Kaipa (2008), in a Development Bank study, it was revealed that 40% of district municipalities failed to conduct the section 78 assessment. According to the Department of Health (2011), who outlined the roles and responsibilities of stakeholders in the Guideline Document for the Devolution of MHS (final draft), it is expected of CoGTA to facilitate funding for district municipalities to conduct their Section 78 assessment.

Associating conducting this assessment with funding could arguably be seen as unnecessary and could prevent district municipalities from conducting the assessment. It is argued that this assessment could possibly be done by developing

a comprehensive business plan, which can be done internally. The plan should include:

- Details of the functions to be assumed by the district municipality
- An audit of the staff to be transferred, their capacity in relation to the function, and the benefits and allowances they currently receive
- Operational arrangements (including looking at the current operational expenditure and capital expenditure patterns), a proposed organogram for incorporating new staff within the organisation, and the implementation proposition of the said plan.

This plan is something that a designated champion could produce in consultation with relevant stakeholders.

A comprehensive business plan will allow the district municipality to assess the direct and indirect costs of rendering the function internally, and its impact on the organisation. It will also allow the district to gauge current capacity, and the capacity needs for the future in order to furnish the skills, and the resources necessary to provide the function. This business plan can be discussed and debated at the various levels within the district municipality before a decision is taken on the best way to render the function.

6.3.6 Suggested action plan for the transfer of MHS in the uMDM

Step 1
The district municipality would need to identify a district champion with an understanding of MHS functioning who will work with the NDoH in driving the process.

Step 2
The champion would prepare a business plan through consultation with relevant role-players in order to establish the best mechanisms for service provision.

Step 3

The business plan would be discussed at the following levels of the district municipality, seeking agreement and decision making on the appropriate service provision mechanism. All possible barriers to the transfer and rendering of function should be addressed during these consultations:

- Management Committee (MANCO)
- Local labour forum
- Relevant portfolio committee
- Council.

Step 4

Once the above internal structures have agreed and decided on the rendering of the function, discussions regarding transfer of MHS to district can then be cascaded to external stakeholders, with the aim of facilitating the transfer. Discussions should be held with the following stakeholders to garner support for the process and to address the issues and concerns of stakeholders:

- Municipal Managers' Forum
- Mayors' Forum
- Relevant provincial stakeholders
- Affected communities.

The district municipality needs to request a valuation of accrued staff benefits s of all affected staff members as of the date of transfer i.e. accrued leave, service bonuses, long service awards, pension benefits, etc.

Step 5

Affected staff members would need to be consulted regarding the transfer and their concerns around the transfer would be addressed. Trade unions need to be part of this consultation.

Step 6

The district municipality needs to make the necessary resources available for taking over and rendering of the function. The district will also need to apply for the

necessary statutory authorisation for rendering some of the environmental health functional area e.g. foodstuffs. A written employment contract will need to be offered to each transferring employee.

Step 7

Transfer of function to be effected in line with the requirements of Section 197 of the Labour Relations Act (Act 66 of 1995) (Republic of South Africa, 1995).

STEP 1
Identification of a district champion with an understanding of MHS functioning to work with NDoH in driving the process.

⬇

STEP 2
Preparation of business plan in consultation with role-players to decide on service delivery mechanism.

⬇

STEP 3
Discussion of business plan with internal structure seeking agreement on service delivery mechanism.

⬇

STEP 4
Disussion of tansfer of MHS with external roleplayers. District municipality to request acrued benefits from transferring employers.

⬇

STEP 5
Consultation with affected staff regarding the transfer. To involve trade unions.

⬇

STEP 6
Make available resources for the function. Apply for the necessary statutory authorisation for rendering some of MHS function. Offer employment to staff.

⬇

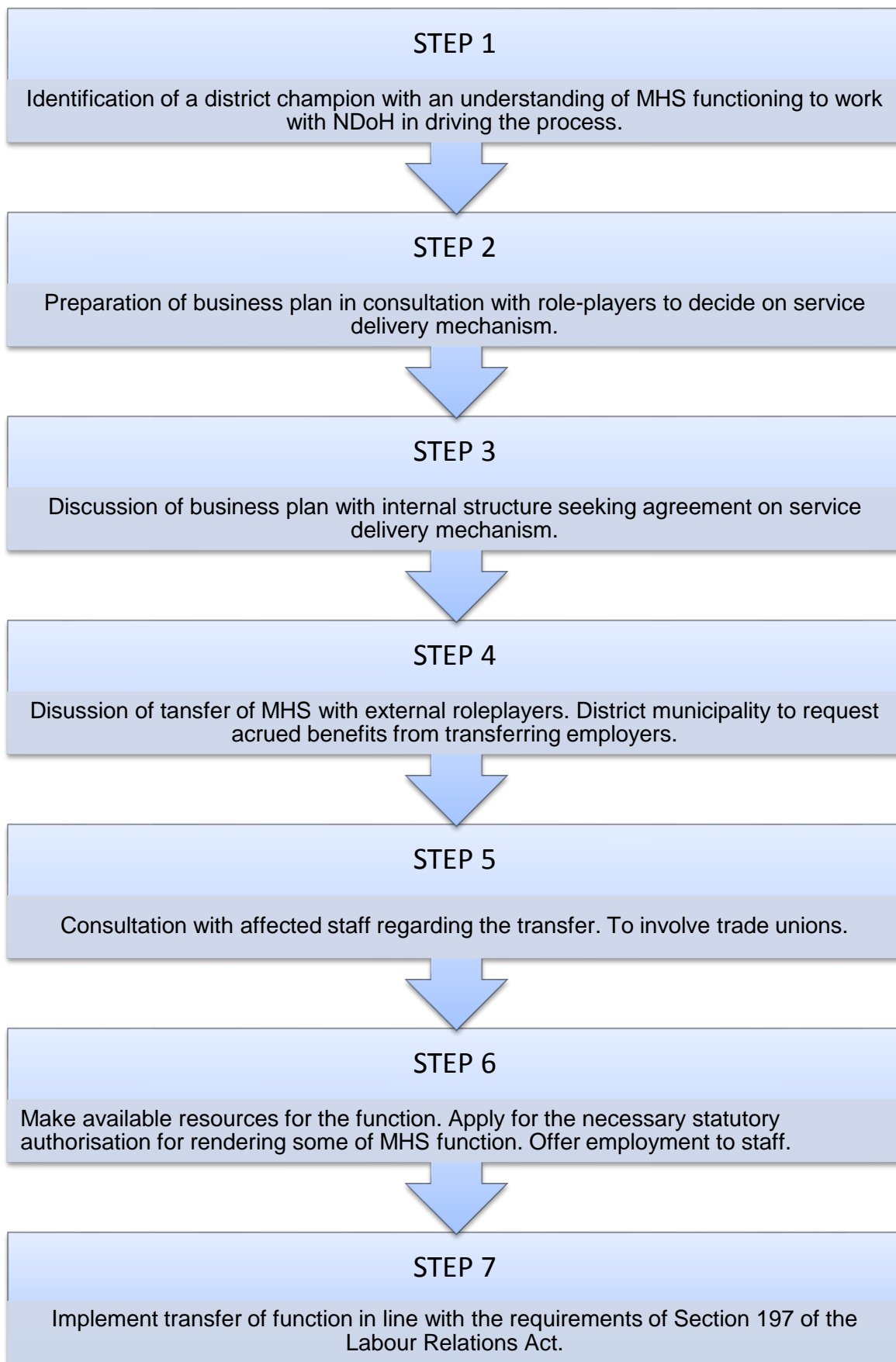| STEP 7 |
| :---: |
| Implement transfer of function in line with the requirements of Section 197 of the Labour Relations Act. |

Figure 5: Action plan for transfer of MHS to uMgungundlovu district municipality

6.4   Recommendations for further studies

There is a need to explore the experience of district municipalities that have successfully integrated their MHS. How did they overcome the barriers to integration, and are there possible "best practice" for integration that can be disseminated?

The impact of decentralisation of MHS on service delivery needs to be explored further, particularly from the viewpoint of the people to whom the services are rendered.

The impact of the integration on environmental health staff needs to be explored further due to the high levels of demotivation noted among staff, and a number of them expressing a desire to leave the service.

6.5   Summary

Problems encountered in the delivery of municipal health services in the UMDM area as a result of failure to integrate MHS into the district municipality have necessitated an investigation into the challenges to the integration process.

The DHS is based on the principle of provision of an accessible, good quality service that is delivered effectively and efficiently in an equitable manner. MHS are currently fragmented, unequal, and of poor quality, with some areas receiving the minimum service. This calls for an urgent need for the transfer and devolution of the function in order to allow for co-ordinated planning and provision of the necessary resources.

The study identified a combination of factors that hindered the integration. Whilst existing literature has shown most of these challenges to have been general challenges for the transfer and devolution of the integration process (i.e. lack capacity, lack of leadership, inadequate budgeting and lack of section 78 assessment), the current study has gone on to propose measures to address these challenges, as well as providing an action plan for the process.

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ANNEXURES

Phase 1: Quantitative data collection

Local Municipality/Provincial DoH: _____

A. Audit of Services

PACKAGE OF EH SERVICES

	ALLOCATION OF WORK TIME (IN GENERAL		
Services rendered (Yes/No)	EHP	OTHER EH STAFF	TOTAL

A Provincial EH services

1 Port health services

2 Control of hazardous substances

3 Malaria control

B Municipal Health Services

4 Water quality monitoring

5 Food control

6 Waste management

7 Health surveillance of premises

8 Communicable diseases

9 Vector control

10 Environmental pollution control

11 Disposal of the dead

12 Chemical safety

C Other Municipal EH services

13 ....

14 ....

15 ....

16 ....

17 ....

D Management Activities

18 EH management functions

19 Other work beyond the EHPs

Scope of Practice

B. STAFF AUDIT

NUMBER OF STAFF / POSTS			
STAFF CATEGORY	FILLED	VACANT	TOTAL
EH Practitioners			
Other EH Staff			
EH Staff Total			

Population of Geographic Area served

Questionnaire Completed by: _____**Tel. No.** _____**Date**_____*

(* **Note**: In accordance with the requirement for maintaining anonymity, this portion was not completed)

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Phase 2: Semi-structured interview guide

BACKGROUND

The current project aims to investigate and describe obstacles to and facilitating factors for the integration of municipal health services into district municipalities, using uMgungundlovu district municipality as an example. The study is being conducted in uMgungundlovu municipal area (local municipalities and Provincial DoH within this district)

Quantitative data is being collected from the sites. Some qualitative data is required to augment the quantitative data. A number of EHS/MHS role-players from different positions are being interviewed to gather this data.

INTERVIEWER'S NOTES

Name of study site   _____

Date of interview   _____

Position held by interviewee   _____

Interview may be recorded: Yes / No

1.   History and preparation for the integration process

a) Following the definition of Municipal Health Services (MHS) in the National Health Act of 2003 as nine core functional areas, which excluded malaria control, port health and control of hazardous substances, and it being confirmed as a district or metropolitan function, what was your understanding of the implication of this Act on

- Provision of the environmental health function?
- EH staff and assets?

b) How has your municipality prepared for implementing the requirements of the Act, as it relates to MHS, in terms of:

- Planning for the changes;
- Staffing; and
- Budgeting for and financing of the service?

c) What support mechanisms have been put in place for this process at national/provincial (DoH) to districts? (before or during the integration process)

- Financial Resources
- Human Resources
- Policy guidelines

d) Have these support mechanisms been helpful?

e) What monitoring and evaluation mechanisms have been put in place for this process to measure progress?
(Who, how, when, where?)

f) How has communication been between local/district/province regarding the developments in environmental health? How often has there been communication?

g) Has your municipality concluded any agreements in connection with the transfer of MHS? If yes, can you supply details/copies? For example:

- Service Level Agreements   No/Yes
- Memoranda of Agreement   No/Yes
- Secondment Agreements   No/Yes
- Status Quo Agreements   No/Yes

h) Has your organisation prepared an organogram for EHS/MHS for the post-integration process? If so, please provide details.

2.   Perception of benefits of the integration process

a) In your opinion, how will the integration of local municipalities into the district be of benefit to: (a) municipalities (b) EH employees (c) the community?

b) Following the definition of MHS in the National Health Act of 2003 what, in your opinion, are the implications of the MHS definition for:

i) The delivery of environmental health services in your area;

ii) Relations between provincial and local government health-related structures; and

iii) Relations between district and local municipalities?

3.   Perceived challenges in the integration process

a) What do you see as the main challenges to the integration process in relation to moving staff from:

- Local municipality to district municipality?
- Provincial health to district municipality?

4.   Impact of these challenges on service delivery

a) Have these challenges caused any delay to the integration process? If yes, do you think the delay in the integration process has any implications for EH service delivery? Please explain.

5.   Knowledge of the integration process

a) Have you been involved in any planning for the integration process? What was your role?

b) To you knowledge, where is your district in terms of the integration process?

c) How has the DHS in relation to environmental health been implemented in your district?

d) What is your opinion on how DHS implementation is happening in different provinces?

6. **Suggestions for change in the manner in which integration was planned**

a) In your opinion, do you feel that planning for implementation of the requirements of the Act could have been done differently? Please explain.

b) If the process was to be started all over again, what in your opinion would you like to see done differently?

7.   Do you have any other comments which you feel would contribute to helping address the challenges to integration?

8.   Are there other people in your organisation who you feel could contribute further insights in describing the different challenges to the integration (i.e. the subject of this project)?

Ask for copies of policies, report, guidelines that have been developed in preparation for integration or drafts of plans for restructuring environmental health services.

CHECKLIST FOR DOCUMENT REVIEW

DOCUMENTS	INFORMATION
1. Policy	Guidance for the integration
2. Reports	General progress on the process including challenges and solutions
3. Minutes of meetings held (on MHS integration)	Resolutions taken on integration of MHS
4. Guidelines developed	To guide and assist managers in implementation of the integration process
5. Plan or draft plans	Integration and restructuring MHS (time frames included)
6. Agreements concluded	e.g. service level agreement, memoranda of agreement, secondment agreement, status quo agreement

Phase 3: Focus group discussion guide

CHALLENGES TO THE INTEGRATION OF MUNICIPAL HEALTH SERVICES IN THE UMGUNGUNDLOVU DISTRICT MUNICIPALITY

Ground rules of the group

- Your name will not be attached to anything you say, so please be as honest as possible in your responses
- There are no right or wrong answers. We all have different opinions and everyone's opinion is valid.
- The group is being audio-recorded, so please speak loudly and remember only one person to speak at a time.

Introduction

We all know that, in terms of the National Health Act 2003, section 32(1), it is the exclusive competency of every metropolitan (Category A) and district Municipality to ensure provision of municipal health services. This meant that, as from July 2004, the municipal health function was supposed to be taken over by district municipalities or metros, or else the function had to be delegated to local municipalities through a service level agreement.

The purpose of today's discussion is to get information from you about the different challenges and facilitating factors in the integration of municipal health services into uMgungundlovu district municipality (what we normally refer to as the devolution process). You were invited here today because, as EH personnel, you are an important stakeholder in the process. Your views could provide valuable information about the barriers to the integration, as well as information that could be useful in moving the process forward.

Ask respondents to introduce themselves:

- Who they are
- Where they work

- How long they have been involved in EH

Do you feel that, in general, people understand how complex EH work is? If no, why do you say that?

<u>Questions</u>

- When did you first hear about the devolution of Environmental Health?

- How did you get to hear about it?

- Was there enough awareness-raising about the devolution process?

- Think back to when you first heard about this process, what were your impressions in terms of the possible benefit to all concerned (community, EH staff)?

- What were your impressions about potential barriers or challenges for all concerned?

- What are your thoughts on the preparations and the planning for the integration; do you feel this was done adequately? Why do you say that?

- What capacity building and material support or resources was provided for the integration? Was it adequate? What other resources or support could have been provided to assist the District?

- Generally, there has been a delay in the process of integration.
    - Has this been your experience?
    - If so, what has the effect of the delay been?

- Has service delivery of EH changed since the process was started? Explain?

- What would you have like to see being done differently in this process?

- What is the way forward with this process? Have systems been put in place at District level to make sure the integration is successful? How will the quality of the service be monitored at District level?

- Are there any other comments you would like to make?

UNIVERSITY OF
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14 August 2009

Mrs N Chapi
Family & Public Health medicine
Nelson R Mandela School of Medicine
University of KwaZulu Natal

Dear Mrs Chapi

PROTOCOL: Challenges to the integration of municipal health services in the uMgungundlovu District Municipality, KwaZulu Natal Dept. of Family and Public Health medicine. Mrs N Chapi. Ref: BE117/08

EXPEDITED APPLICATION - RATIFICATION

This letter serves to notify you that at a full sitting of the Biomedical Research Ethics Committee meeting held on **11 August 2009**, the Committee **RATIFIED** the sub-committee's decision to approve the above study.

Yours sincerely

Ms D Ramnarain
Senior Administrator: Biomedical Research Ethics

Enquiries: TLS Khuzwayo
Our Ref: 16/8/2/R

08 July 2009

The University of KwaZulu-Natal, Westville Campus
Biomedical Research Ethics Administration
Research Office, Govan Mbeki Building
Private Bag X54001
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To Whom It May Concern

PERMISSION TO CONDUCT RESEARCH PROJECT : CHALLENGES TO THE INTEGRATION OF MUNICIPAL HEALTH SERVICES IN THE uMGUNGUNDLOVU DISTRICT MUNICIPALITY

Permission is hereby given to <u>Nompumelelo Chapi</u> to undertake her research project in the municipal area of uMgungundlovu District Municipality, to interview relevant role-players in the provision of environmental health services and to use the information so collected for the purpose of her study.

Yours in development

TLS KHUZWAYO
MUNICIPAL MANAGER
hp

Office of the Municipal Manager
PO Box 3235, Pietermaritzburg, 3200
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Information document

Challenges in the integration of municipal health services in the uMgungundlovu District Municipality, KwaZulu Natal

I, Nompumelelo Chapi, a Masters of Public Health student at the University of KwaZulu-Natal, am doing research on challenges to the integration of municipal health services into the uMgungundlovu district municipality. Research is the process to learn the answer to a question. In this study we want to explore and describe the different obstacles and facilitating factors in the process of integrating municipal health services into the uMgungundlovu district municipality

We are inviting you to participate in the research study. The study will involve interviewing role players in environmental health service delivery in the uMgungundlovu district municipal area. The aim of the study is to gain an in-depth understanding of the different challenges faced by district municipalities regarding the integration of municipal health services into district municipalities, using UMDM as an example.

A total of 38 role players from municipalities within the district and Provincial Department of Health are expected to take part in the study.

Participation in the study is voluntary, and refusal to participate will involve no penalty, nor will it affect your job in any way.

No personal information will be collected to ensure total anonymity of study participants and to guarantee you will not be victimised in any way. Organizations that may inspect and/or copy these research records for quality assurance and data analysis include groups such as the Research Ethics Committee, which are bound by confidentiality

For further information or the reporting of study related adverse events you can contact Nompumelelo Chapi on 084 208-1660.

Should you wish to report any complaints or problems relating to the study, please contact the Biomedical Research Ethics Committee Administrator or Chair:-
Biomedical Research Ethics, Research Office, UKZN, Private Bag X54001, Durban 4000.
Telephone: +27(0) 31 260-4769/260-1074
Fax: +27 (0) 31 260-4609
Senior Administrator: Ms D Ramnarain, email: ramnaraind@ukzn.ac.za
Chair: Prof D R Wassenaar, email c/o   BREC@ukzn.ac.za

Consent document

Consent to participate in the research

You have been asked to participate in a research study of which you have been informed by……………………………….

You may contact Nompumelelo Chapi at 084 208-1660 at any time if you have questions about the research, or if you experience any problems as a result of the research.

You may contact the Medical Research Office at the Nelson Mandela School of Medicine on (031) 260-4604 if you have questions about your rights as a research participant.

This research is for a Masters in Public Health; therefore, all information collected will be used solely for degree purposes.

The interview will be recorded, with your permission, for quality purposes. The information will be transcribed verbatim. This information is confidential and will be used by the researcher. A report will be written about the outcomes of the discussions. This report will cover all the discussions on the topic, and will not identify which individual made any particular statement. No names of any participants will appear on the report. At the conclusion of the study, all notes and tapes will be filed away for any future reference relating only to this study.

Your participation in this research is voluntary, and you may not be penalised or have your job affected in any way if you refuse to participate or decide to withdraw at any point.

If you agree to participate, you will be given a signed copy of this document and the participant information sheet, which is a written summary of the research.

The research study, including the above information, has been described to me orally. I understand what my involvement in the study means and I voluntarily agree to participate

_____   _____

Signature of Participant   Date

_____   _____

Signature of Witness   Date
(Where Applicable)