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Demonstration social audit in Eastern Cape Province

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First things first: implementing Batho Pele

The Amatole district municipality social audit

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ACKNOWLEDGEMENTS

The most valuable contributors to this consultation are the 2,297 respondents from the Amatole district municipality who took the time to provide information on 11,287 residents of the area. Principals, nurses and social workers who were interviewed at schools, clinics and welfare offices in each community helped to complete the review of service delivery in their region.

Responsibility for the success of the process rests with the field workers who went to each participating community to hear the opinion of the people. Special recognition is owed to Thamie Mokoena, who played a pivotal role in identifying field workers, training, translation, field supervision and data entry. Maps were generated by Steve Mitchell.

The conclusions reflected in this report are not necessarily those of the IPSP, the Government of the Eastern Cape or the Government of the United Kingdom. Once cleared by the provincial government, the results may be quoted and reproduced in any form provided the usual conventions on authorship are respected.

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Bisho
6th July 2001

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Summary

This demonstration social audit shows the combined quantitative and qualitative community base of a social audit and illustrates actionable performance indicators for monitoring progress, using the *Batho Pele* framework. The social audit aimed to identify unifying strategies for the social cluster – education, health, welfare and sport, arts and culture – rather than to meet the specific needs of each sector.

The sample enumeration areas were a stratified last-stage random selection from a listing of 1,933 named localities in the Amatole district municipality in the Province of the Eastern Cape. The final sample of 2,297 households included 11,287 people – roughly one person in every 200 in the district (total 2.6m people).

Consultation: Although nominal mechanisms were in place for all four sectors, only the **education** sector was characterised by systematic consultation, through the school governing boards (SGBs). Some two thirds of households took part in an SGB in the year prior to the consultation, reported participation in rural areas being if anything greater than that in urban areas. In one in three households, someone had met with the teacher. These widely used consultation mechanisms in education could offer a springboard for greater client participation in the social cluster as a whole.

Service standards: An indication of the extent to which client expectations are met (or frustrated) is the level of satisfaction voiced with public services. One in three respondents said she or he was dissatisfied with these public services. In **education,** most respondents who saw the need for change wanted better teachers, while in **health** most asked for more medicine and in the **welfare** department they said better service.

Access: There was good coverage of the basic services reviewed: 89% of youth of school-going age **attended school** on the day of the survey; 92% of children under the age of five years had been **vaccinated** against measles and around 92% of senior citizens **collected their pensions**. There was no detectable difference between urban and rural sites in school attendance or measles immunisation but a senior citizen in an urban area was more likely to receive his/her pension than one in a rural site. Indicating *perceived* access – possibly including cultural, language and financial access – the majority of respondents felt that nurses in the clinics and welfare officers were accessible to them. There was very poor attendance of **Heritage, Freedom and Women's Days** and few could identify the intended message of the celebrations.

Courtesy: The respect people feel they received from the services was estimated from their perception of corruption in public services and, more specifically, what people see as the nature of corruption. Nearly one half of those who volunteered an opinion on the subject viewed **welfare** as the most corrupt government department. Their main reason for this, confirmed in focus groups, was that many who expected a pension cheque did not receive one, and they were not given a reason for this. Since 90% of eligible seniors said they *did* receive their cheques, the perception of corruption appears to be principally one of communication about eligibility. This lends itself to a

quick turnaround improvement with an appropriate communication strategy.

Information: Many social cluster clients simply do not have the information they need. For example, in the **health** sector the audit probed the information available by asking respondents if they knew that children under the age of five years should get free immunisation. One in every four – more in the rural sites – did not know this. This is another potentially quick turnaround for improvement. People also wanted to know why medicines they expected were not available. From the **education** department, people wanted to know more about feeding schemes, free schoolbooks and use of registration fees. In **welfare**, they wanted information on eligibility for pensions and the role of the social worker.

Openness and transparency: One in five could identify the MEC for education and only one in ten knew who was in charge of health, welfare and sports, arts and culture. The "least open" department was welfare, where only 5% knew the name of the MEC.

Redress: Most people did not know *how* to complain: 39% in education and 57%-67% respectively in health and welfare said they did not know how the process of redress worked. Higher levels of complaints and lower proportions who say they do not know how to complain makes **education** the lead sector in the matter of redress.

Value for money: The **health and education** departments were considered the best run and the most valuable public services, followed by **welfare.** Expenditure of public resources was not reviewed in this social audit. However there were also some direct costs to the citizens (official and unofficial user fees) and indirect costs occasioned by not having access to effective services. For example, the average health visit cost to a government facility, for the one third who had to pay, was R2 and transportation cost for a health visit was in the region of R7 for a round trip.

Lessons for improving service delivery in the social cluster

A unifying strategy for improving public services across the social cluster is undoubtedly communication with the shared client base. Key issues include pension eligibility and access to free services like vaccination, schoolbooks and welfare applications. Most focus groups suggested community workshops – headmen or *imbizos* in some rural areas – rather than mass media or use of the service workers themselves to transmit information. These results are only relevant to Amatole district municipality, a province-wide social audit being indispensable for a wider strategy.

A Introduction

The Eastern Cape government embarked on an integrated provincial support programme (IPSP) to improve service delivery in the province. One aim of the IPSP is to establish a service delivery monitoring system based on service delivery standards as set out in the *Batho Pele* (People First) campaign. CIET tendered for and was appointed to demonstrate a social audit of the four departments in the social needs cluster – education, health, welfare and sports, arts and culture.

The objectives of the Amatole district municipality social audit – completed in the first three months of 2001 – were:

1. Demonstrate social audit of the delivery and performance of public services;

2. Document the types and effects of community participation in public services, and track evolving participation mechanisms;

3. Develop communication strategies directed at civil society, service workers and decision makers at district level thus to strengthen informed advocacy of public sector reform; and

4. Build a supportive environment at district level, identifying examples of best practice in institutions and government, preparing these cases for dissemination through mass media.

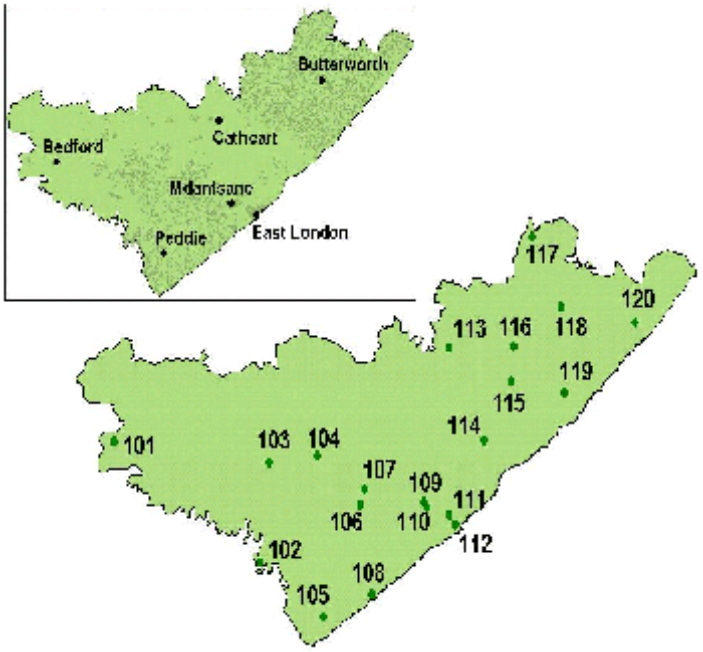
Limits of interpretation

Although representative of the district municipality of Amatole, this social audit cannot be extrapolated to the Province as a whole. Amatole probably has the best access to services and, consequently, the problems and solutions may be quite different from other district municipalities.

Because of the requirement that the whole social cluster be covered, it was not possible to include the full depth that might be required in the social audit of any one sector. The *Batho Pele* principles set the framework for the initial non-financial accounting, the idea being to identify first broad strategies that could improve engagement of stakeholders across the whole social cluster and to get more value from *existing* social sector investment. At a later stage, individual sectors will require in depth social audits to identify sectoral bottlenecks, inefficiencies and system leakage.

B Methods

Figure 1
Participating communities in the Amatole district municipality, Eastern Cape Province (inset map shows main population centres)



To initiate this demonstration cycle in November 2000, CIET conducted a series of interviews with planners and decision makers in each participating sector. These meetings identified the main concerns in each participating sector and the components of their service delivery that they felt would benefit from community-based information. Based on this input, CIET developed the sample, designed, tested, translated and back translated the instruments. The CIET team selected and trained interviewers, piloted and adjusted the instruments to local conditions, supervised the household surveys and double data-entry, analysed the data and produced the report in the first six months of 2001.

The social audit followed an established research methodology. The data collection methods included a household survey to collect information on individual client experiences, key informant interviews to assess community level factors and to obtain the service workers' views, and community focus groups to deepen the understanding of results and to explore corrective strategies.

Sample and sampling

Site selection for the Amatole social audit relied on 1999 data from the Department of Public Works, Eastern Cape Province. The sample frame, made up of updated enumeration areas, was stratified by size of settlement and location. Settlements with 5,000 or fewer than inhabitants (classified as small or "rural") were restratified into those north and south of the N6 highway, which bisects the District Municipality.
Those settlements with 5,001-50,000 inhabitants were classified as medium sized urban and those greater than 50,000 as larger urban. The three population categories (small, medium and large) were subdivided into coastal (on, or within 10km of the coastline) and interior. Within each stratum, proportional to population, a number of sites were picked randomly (Table 1).

Table 1
The sample strata and raising factors

Population category	Location	Population in this stratum	Population fraction in this stratum	Actual sample size	Actual sample fraction	Raising factor applied to each stratum
Larger (>50,000 people)	coastal	229853	0.097	816	0.072	1.35
	interior	350268	0.148	2049	0.182	0.813
Medium (5000-50000)	coastal	74514	0.032	483	0.043	0.744
	interior	166057	0.07	850	0.075	0.933
Small (<5000 people)	North - coastal	117353	0.05	498	0.044	1.136
	South - coastal	65367	0.028	498	0.044	0.636
	North - interior	823886	0.349	4063	0.36	0.969

total of 20 enumeration areas was selected from a total of 1,933 named localities in the district municipality. The final sample was 2,297 households including 11,287 people – approximately one person in every 200 in the district (total 2.6m).

Data collection instruments

Following a standards-based approach, questionnaires used in and outside South Africa were reviewed as a starting point for the household questionnaire. Pre-validated questions were used whenever possible. The design, piloting, translation and back-translation of the questionnaire were completed in early February of 2001.

The household questionnaire was piloted using the standard CIET five-step pilot process. Its 66 questions were divided into five main sections:

- General household questions collected information about the household structure including age, sex, education level, occupation and income. It also documented how the people viewed corruption and the relative importance of government departments in their eyes.

- The second, third and fourth sections dealt with the education, health and welfare departments. Based on the Batho Pele principles, these sections produced performance indicators on application of these principles, covering community consultation, access to information, access to services, courtesy, redress and value for money.

- The fifth section covered the department of sports, arts and culture. The head of this department expressed a special interest to learn how people viewed special day events organised by the department: Heritage Day and Freedom Day. Questions in this section documented public awareness of and attendance at these events.

Key informant interviews collected information about community level factors including staff,

facilities and training needs of primary schools, clinics and welfare offices. The respondents for the three key informant instruments were primary school principals, sisters in charge of clinics and heads of the social welfare offices nearest the sample communities.

Focus group discussion guides were developed, presenting key findings from the household questionnaires and key informant interviews and guiding discussion onto areas useful for programme planning.

Data collection

Household data collection and key informant interviews for this cycle took place during February 2001. Altogether, 2,297 household interviews were conducted. A total of 17 local interviewers and two field supervisors – all with previous experience in at least two CIET field surveys – collected household data, following a one-day training. The training provided an understanding of the project, standardised administration of the interviews and reiterated the issues of confidentiality, quality control and logistics.

Community leaders were notified in advance of the survey and in each site the headman granted permission before the survey began. In the case of urban areas in the sample, the appropriate municipal authorities were informed.

Interviewers were organized into two teams, each with a team supervisor. Teams travelled to a site and interviewed all households in each designated cluster, with no sub-sampling.

After each interview, the interviewer gave the respondent a pamphlet about the social audit, including contact numbers of the MEC of each department. In each site, community profiles were conducted by the data collection team supervisor.
Facilitators and recorders were trained for focus groups. These were set up by field supervisors and interviewers from the household survey, composed of residents from the sites surveyed. Each group included six to nine participants. The focus groups were conducted during March 2001, when the main findings from the household survey and key informant interviews were available.

Confidentiality was a strong focus of the data collection process. No record was made of the name or address of the household informant alongside any information that they provided. Thus, there is no means to trace back to any individual participant. Personal information such as age, sex, education and household income was collected from the respondents but no identifying information was included.

Data entry, validation and analysis

Prior to data entry which took place during March 2001, answers were coded and a series of logical checks conducted. Using public domain software (EpiInfo), data were entered twice.

Discordant data were checked with the source questionnaire, to eliminate all keystroke errors. Further cleaning excluded logical errors.

Analysis also relied on EpiInfo. The vulnerability analysis was enriched by data from key informants and focus groups. Qualitative data were thus "quantified", as characterising the community -- a process known as *meso-analysis* by which data from the individuals can be interpreted in the local context[1]. Meso-analysis essentially deals with factors operating in the community by linking them to the behaviour of the individuals in that community.

Formal epidemiological analysis probed behind the indicators to get a deeper understanding of vulnerability -- who is left out by the services. Promising associations indicating possible vulnerability or social exclusion were analysed using standard epidemiological techniques to identify potentially confounding effects of age, sex of respondent, education, residential area and other factors. Risk analysis used the Mantel-Haenszel procedure[2] [3]. Contrasts are reported as the odds ratio and exact confidence intervals (CI) are those of Cornfield. Heterogeneity between strata was tested using the procedure of Woolf.

Differences between averages (for example, unofficial cost of services and willingness to pay) were tested using standard procedures: where the variances of the two groups were homogeneous (95% confidence), the t-test was used. Where the variances were heterogenous, the Kruskal Wallis test for two samples was used. Only those associations that are significant at the 5% level are reported. Most other associations can be assumed to have been tested and found to be easily explicable by chance alone.

Maps and their interpretation

The raster maps were generated using CIETmap, a public domain mapping software that permits interaction of raster and vector layers. These maps are interpreted rather like modern weather maps, with dark isobars drawing attention to areas of "danger" or where additional resources should be focussed.

When colour is available, two colour schemes are used. Brown reflects outcomes of development or service delivery (for example, income or education status). Green depicts inputs or coverage with public services (vaccination, school attendance or receipt of pensions). In both yellow-brown and yellow-green maps, the lighter or yellow shades are more "desirable" – higher levels of coverage or low levels of undesirable outcomes.

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[1] Andersson N. Meso-analysis: Quantifying Qualitative Data from Communities and Services. In: Evidence-based Planning: the Philosophy and Methods of Sentinel Community Surveillance. EDI/ World Bank 1996.

[2] Mantel N, Haenszel W. Statistical aspects of the analysis of data from retrospective studies of disease. *J Natl Cancer Inst* 1959;22:719-748.

[3] Mantel N. Chi-square tests with one degree of freedom: extensions of the Mantel Haenszel procedure. *J Amer Stat Assoc* 1963;58:690-700.

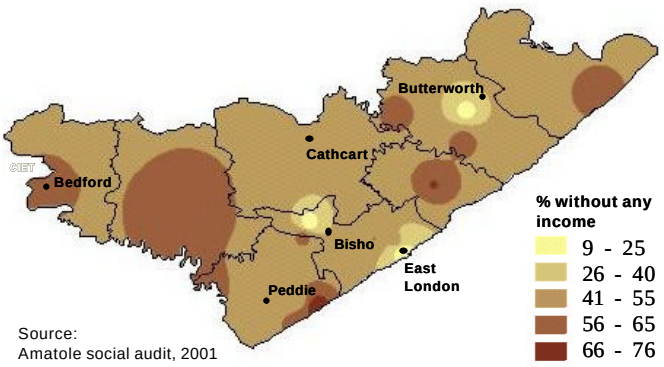
What makes CIETmap special is that the isobars generated by interpolation between sentinel communities are weighted to reflect the population represented by the sample. In this unique and important sense, the maps represent population and not area. Thus, if one third of the surface area is a dark shade, corresponding to those who do not have access to certain services, it means that one third of the population is in this situation (not one third of the land area).

For example, in Figure 2, the areas of highest concentration of households reporting no income in the last month are in the south of the district, although there are scattered areas of higher concentration too. Areas where very few households report no income are in East London, King William's Town and Butterworth.

C Characteristics of the sample population

The population

A total of 2,297 households was included in the social audit, with a population of 11,287 people. The average household size across the whole sample was 4.9 people. There was no significant difference in the average size of the household between urban and rural sites. The proportions of urban and rural households were similar in this sample to the official estimates for the municipality provided by the department of public works of the Province. As is characteristic of the region as a whole, there are significantly more women in the economically active age than men.



Source:
Amatole social audit, 2001

Respondents

Three quarters (75%) of respondents to the household questionnaire were women. In both urban and rural areas, approximately one third of the respondents was under the age of 30 years, one third between 30 and 50 years and one third over the age of 50 years.

Level of education

Roughly one in every ten respondents said they had no education (11%). Only 7% of respondents in urban sites were uneducated, one half the proportion (14%) in rural sites. Another 4% went to school only up to grade 3. One out of every four had an education between grade 4 and grade 7 (24%). Another 30% had achieved between grade 8 and grade 10 education.

In general, respondents had higher levels of education than the head of household. For example,

19% of heads of households did not receive any education, and a further 6% only went to school up to the grade 3 level. Again there was a difference between rural and urban sites. Only 11% of heads of households in urban areas were said to have no education, 24% of heads of households in rural areas were uneducated. Another 28% of heads of households between grade 4 and grade 7, 27% had between grade 7 and grade 10, and 13% achieved a level of education between grade 11 and grade 12.

The proportion of heads of households with tertiary studies was similar to that of respondents (7%).

Education of the respondent and head of household was used in the vulnerability analysis to identify households likely to be more marginalised from the mainstream of service delivery.

Employment of household heads

Over one half of the heads of the households in the Amatole district municipality were unemployed (53%). Another 18% were pensioners. One out of ten of household heads (9%) was a non-specialised worker (domestic, gardener, labourer or part-timer) and another 5% were professionals, clerks or managers. Teaching made up 4% of the occupation of heads of households. Specialised or skilled – workers, electricians, drivers, plumbers or mechanics – made up 4% of the occupations of household heads. Finally, government jobs provided 3% of employment for household heads. Unemployment was used in the vulnerability analysis to identify those households likely to be more marginalised from the mainstream.

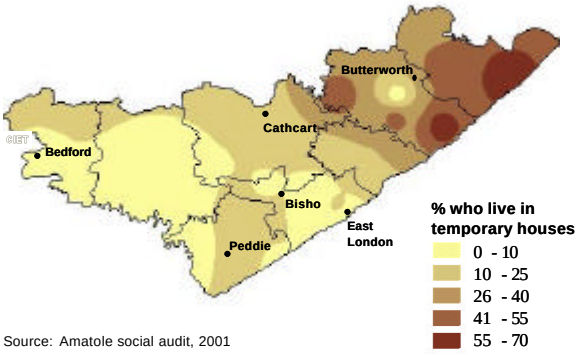
Type of houses

One out of five households surveyed (18%) lived in non permanent structures, namely mud brick houses with a thatch roof, shacks or unfinished houses. Of the remaining households, 23% of those lived in mud brick houses with a corrugated iron roof, 56% lived in cement block houses, and 4% lived in apartment blocks.

Figure 3 shows the uneven distribution of non permanent dwellings in the district municipality, emphasising the concentration in the Wild Coast and former Transkei areas.

The type of dwelling was used in the vulnerability analysis to identify those households likely to be more marginalised from the mainstream of service delivery.

Figure 3
Proportion who lived in non permanent structures or mud houses.



Source: Amatole social audit, 2001

D Service performance

1. Consultation

Citizens should be consulted about the quality of public service they receive and, wherever possible, they should be given a choice about the services offered.

Principals of primary schools in each sentinel site gave their views of service delivery. Asked about the mechanisms available for the community to interact about **education**, most principals referred to the school governing boards (SGB)[4]. Only one principal said consultation should be directly through the principal. In most schools, the SGB meeting was held on a quarterly basis or, in a few cases, monthly.

> Health department officials were here when we selected a committee, but we never heard from them again – Male group, Hamburg

Sisters-in-charge of government health clinics were interviewed to obtain the service view in the **health** sector. The majority thought that the community's health committee[5] was the best mechanism for consultation. In most cases, they said the health committee met monthly. One half of them said service workers provided information to clients routinely in the course of their daily work.

[4] 12/15 principals interviewed mentioned SGBs

[5] 7/12 sisters-in-charge mentioned the health committee

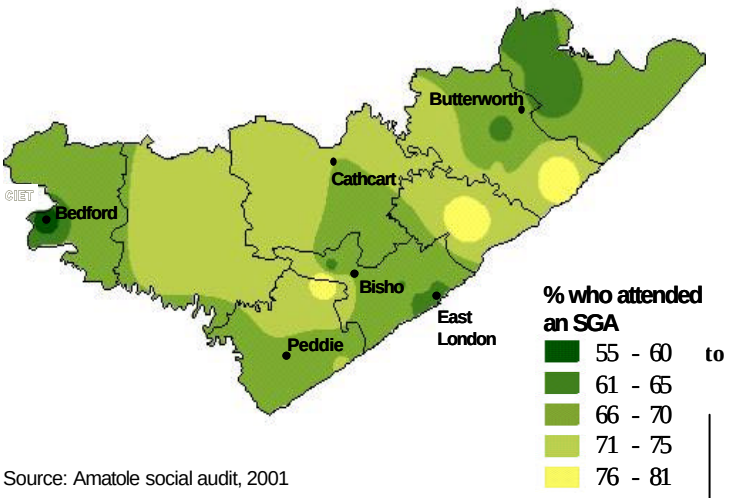
Social workers at the **welfare** offices provided information on community consultation in their sector. One half of the social workers interviewed said that the best way for the community members to consult about the level and quality of services was through the supervisors at the social services offices.

One half of social workers interviewed mentioned community awareness campaigns as the best means to inform people. One third said that no mechanisms were in place, and one mentioned a "**welfare** forum". Social workers said that communities were informed whenever necessary.

In the household survey, one in every three or four household respondents (29%) said that no one from the household ever attended an SGB meeting (Figure 4).

Perhaps demonstrating the unevenness of the consultation process, however, one in five (22%) said that someone from the household attended an SGB meeting five times or more. The spatial variability of SGB attendance is reflected in Figure 5. The sharp contrasts between areas indicate the patchiness of SGBs in different schools.

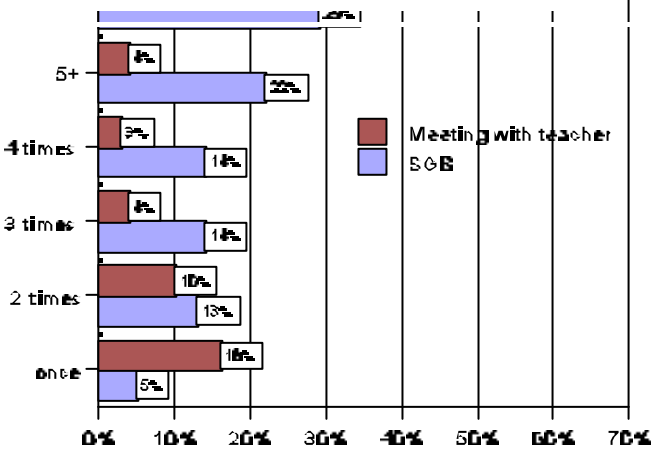
Figure 5
Percent of households that attended a school governing board in the last year (out of all households)



Source: Amatole social audit, 2001

Household respondents were also asked how many times someone from the household met with the teacher to discuss the child's education: only one in three ever met with a teacher in the last year.

More educated respondents were more likely to discuss their child's education with the teacher[6], as were households in



[6]548/1392 respondents with a higher education compared with 292/890 with a lower education level, odds ratio 1.33, 95%CI 1.11-1.60

which the head had more education[7]. People living in permanent houses were also more likely to discuss their child's education with the teacher compared with those living in non permanent houses[8]. The implication is that, if there is an intention to increase consultation through direct contact, these efforts should focus first on those with lower education.

> They do not pay the cheques properly.
> Sometimes they skip a month with no reason
> *Female focus group, Hamburg*

[7]425/1033 households with a head having a higher education level compared with 380/1158, odds ratio 1.43, 95%CI 1.20-1.71

[8]714/1868 living in permanent houses compared with 126/408 living in non permanent houses, odds ratio 1.38, 95%CI 1.09-1.75

2. Service standards

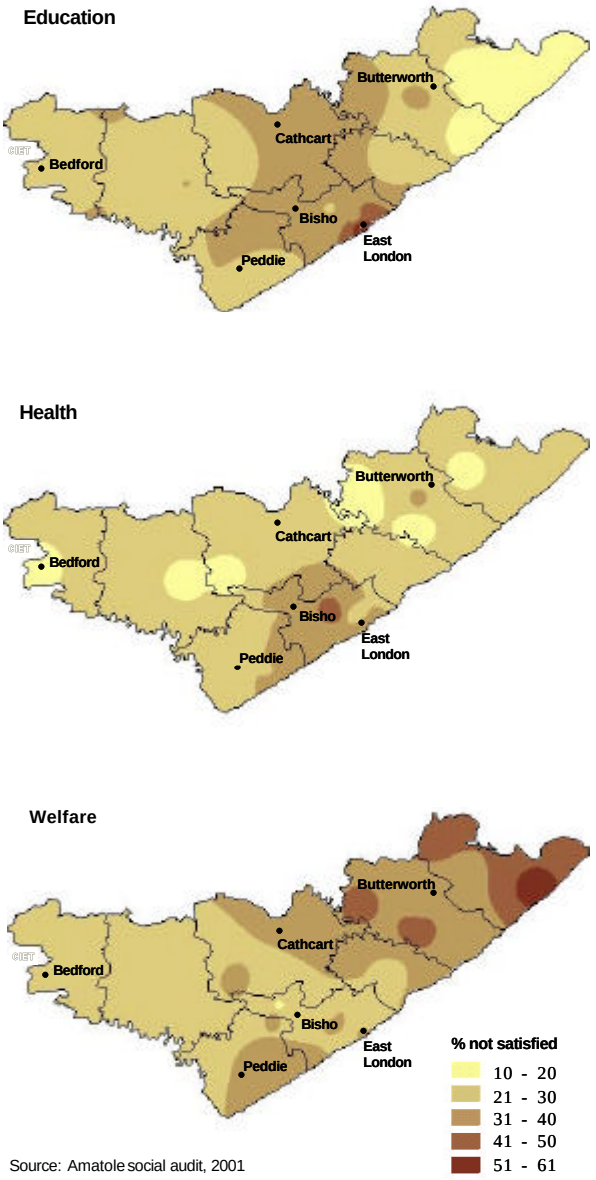
Citizens should be told what level and quality of public service they will receive, so they are aware of what to expect.

An indication of how expectations were met or frustrated is the level of satisfaction voiced with public services. Citizens were asked how satisfied they were with education, health and welfare services.

It is not easy to interpret a response about satisfaction on its own. People who have least understanding of their entitlement are more likely to say they are satisfied. In this context, satisfaction is not just a positive indicator. The expression of satisfaction could coincide with lack of engagement. The negative – active dissatisfaction – is probably more informative, though also not simple. People who are engaged with public services, the better to do or more educated, may be more likely to express dissatisfaction. *Its coincidence with their sense of entitlement does not mean that dissatisfaction is spurious – it is a real perception, and the services should note its causes and act on it.*

The population weighted maps in Figure 6 show the uneven distribution of dissatisfaction with education, health and welfare. Highest levels of dissatisfaction were registered with the **welfare** services in rural areas: one out of three citizens (37%) said they were dissatisfied with those services. People who said they were satisfied with welfare services were more likely to be employed[9].

Figure 6
Levels of dissatisfaction with public services (Percent of households in each site who said they were dissatisfied)



Source: Amatole social audit, 2001

[9]626/871 were employed or received grants, compared with 614/997 who were unemployed, odds ratio 1.59, 95%CI 1.30-1.95

Table 2
Proportion who were dissatisfied or very dissatisfied with public services (education, health, welfare)

	Urban	Rural	Sample
teachers' attendance	19% (155/826)	18% (252/1383)	18% (407/2209)
teachers' behaviour	21% (173/835)	15% (211/1390)	17% (384/2225)
teachers' teaching	15% (126/831)	14% (195/1390)	15% (321/2221)
social welfare services	28% (202/717)	37% (444/1193)	34% (646/1910)
education services	33% (277/847)	26% (360/1383)	29% (637/2230)

Dissatisfaction with **education** and **health** services showed an opposite trend, being more common in urban than rural areas and more common in the central (EL-KWT) area. Respondents who said they were satisfied with education services were less likely to have a higher education[10], less likely to live in a household headed by someone with higher education[11] and less likely to be from a household headed by someone with employment[12]. Male respondents were also more likely to be satisfied with education services, particularly in rural areas[13]. This picture is compatible with an increased sense of entitlement to services leading to voicing dissatisfaction.

In rural clusters, one out of every four respondents (23%) was dissatisfied with health, while one out of three (33%) was dissatisfied in urban sites[14]. Respondents with higher education[15] or living in a household with an educated head[16] were less likely to be satisfied with the health services they received, although they were also more likely actually to have received the services (see below).

Within the **education** services, they were asked about their level of satisfaction with teachers' attendance, behaviour and teaching performance. Table 2 shows those who said they were dissatisfied or very dissatisfied with these public services. With the teachers' attendance and teaching, the levels of dissatisfaction were similar in urban and rural clusters. Male respondents were less likely to be satisfied with the teachers' attendance than were female respondents[17].

[10] 919/1377 have a higher education compared with 670/846 who have a lower education, odds ratio 0.53, 95%CI 0.43-0.65

[11] 678/1023 households with a more educated head compared with 843/1114, odds ratio 0.63, 95%CI 0.52-0.77

[12] 704/1034 households with an employed head compared with 848/1141, odds ratio 0.74, 95%CI 0.61-0.89

[13] 199/448 of females in urban areas compared with 77/186 of males, odds ratio 0.72, 95%CI 0.60-0.87

[14] 599/766 in urban areas compared with 251/443 in rural areas, odds ratio 2.7, 95%CI 2.1-3.58

[15] 951/1378 respondents with a higher education compared with 691/872 respondents with a lower education, odds ratio 0.58, 95%CI, 0.47-0.72

[16] 684/1024 households with a more educated head compared with 892/1138, odds ratio 0.55, 95%CI 0.45-0.68

[17] 405/545 of males compared with 1393/1659 of females, odds ratio 0.55, 95%CI 0.43-0.7

Some 18% of citizens were dissatisfied with the teachers' attendance and 15% with the teaching. One out of every five respondents was dissatisfied with the teachers' behaviour (17%), fewer in rural than urban clusters (15% compared with 21%).

Respondents in households with an employed head were less likely to be satisfied with the teachers' behaviour[18]. Respondents with a higher education were also less likely to be satisfied with the teachers' attendance[19], behaviour[20] or teaching[21]. Households with more educated heads were less likely to be satisfied with the teachers' attendance[22], behaviour[23] or teaching[24].

Table 3
Knowledge of what parents should teach their children before they go to school for the first time

	Urban	Rural
behaviour (discipline, manners)	86% (742)	82% (1166)
skills (read, write, count)	9% (75)	10% (139)
don't know	5% (42)	8% (118)

Parents were asked if they knew what they should teach the child before his/her first attendance at school (for example, to identify colours, to know the days of the week and numbers). The majority (84%) referred to behavioural, particularly discipline, rather than educational aspects (9%) (Table 3).

Perhaps as expected, respondents with higher education[25] or coming from a household with a more educated head[26] were more likely to say they had taught their children skills before they sent them to school for the first time.

Perception of service standards could also be tested in the case of education by asking whether children were assisted when they have difficulties with classes. No less than 76% (1710/2245) of respondents said their children were assisted when they had difficulties with classes. Only 17% (390/2245) thought that their children were not assisted, and 7% (145/2245) did not know.

[18] 813/1020 households with employed head compared with 983/1151, odds ratio 0.67, 95%CI 0.53-0.85

[19] 1071/1353 with higher education compared with 726/849 with lower education, odds ratio 0.64, 95%CI 0.51-0.82

[20] 1076/1366 with higher education compared with 761/852 with lower education, odds ratio 0.44, 95%CI 0.34-0.58

[21] 1132/1357 with higher education compared with 763/857 with lower education, odds ratio 0.62, 95%CI 0.47-0.81

[22] 764/996 households with a more educated head compared with 958/1117, odds ratio 0.55, 95%CI 0.43-0.69

[23] 787/1005 households with a more educated head compared with 977/1123, odds ratio 0.54, 95%CI 0.42-0.68

[24] 823/1003 households with a more educated head compared with 992/1123, odds ratio 0.60, 95%CI 0.47-0.78

[25] 1310/1392 respondents with a higher education level compared with 805/883, odds ratio 1.55, 95%CI 1.10-2.17

[26] 984/1033 households with an employed head compared with 1051/1151, odds ratio 1.91, 95%CI 1.32-2.77

Table 4
The government department people think is the best run. Percent giving response (n=)

	Urban	Rural	Sample
health	24% (179)	24% (265)	24% (444)
education	20% (147)	24% (271)	23% (418)
welfare	11% (83)	12% (137)	12% (220)
water/electricity/public works/ transport	4% (31)	9% (101)	7% (132)
police/security/justice/home affairs	6% (41)	6% (67)	6% (108)
ANC	2% (16)	6% (63)	4% (79)
finance/municipality	7% (50)	2% (19)	4% (69)
labour/housing	3% (25)	1% (10)	2% (35)
agriculture	- (1)	3% (29)	2% (30)
Sports Arts and Culture	2% (14)	1% (8)	1% (22)
other	- (3)	1% (13)	1% (16)
all departments	1% (10)	1% (14)	1% (24)
none	18% (133)	10% (114)	13% (247)

Nurses and social workers as a rule knew whether their clients were not satisfied with the services they were getting – there was a strong convergence between citizens who said they were dissatisfied and **health**[27] or **welfare**[28] workers who said they felt the clients were dissatisfied. This was not the case in **education**, where views of community satisfaction expressed by principals did not resonate with community opinions.

When household respondents were asked **which government department was the best run**, health and education topped the list with 24% and 23% respectively of "votes" (Table 4). In rural sites, health and education were seen as equally important, while in the urban sites the gap was slightly bigger, with 24% choosing health compared with 20% for education. Welfare was the third choice, with 12% of "votes". Respondents with higher education were more likely to view health and education as the best run departments[29]. The same trend could be observed for households with an educated head[30] and people living in permanent houses[31].

[27]172/337 of nurses from sites where respondents are dissatisfied as compared with 294/1060 from sites where respondents are satisfied, odds ratio 2.72, 95%CI 2.09-3.53

[28]165/224 of social workers from sites where respondents are dissatisfied compared to 361/425 from sites where respondents are satisfied, odds ratio 2.02, 95%CI 1.32-3.08

[29]601/1394 for respondents with a higher education compared with 257/887 for respondents with a lower education, odds ratio 1.86, 95%CI 1.54-2.24

[30]434/1035 in households with a more educated head compared with 381/1155 in households with a less educated head odds ratio 1.47, 95%CI 1.23-1.76

[31]739/1866 respondents living in permanent houses compared with 121/408, odds ratio 1.56, 95%CI 0.76-1.5

In focus group discussions, participants said that the main reason the health received the highest rating was because of the service they received at clinics. Some said that, while they were satisfied with health services, they still wanted to know why they did not get sufficient medicine.

Some focus groups also listed grievances with health services in their location. They mentioned bad services, lack of medicine and some complained that the clinic was too far. In those sites where the focus group reported grievances with the health services, the level of satisfaction recorded in the household survey was below average.

3. Access

All citizens should have equal access to the services to which they are entitled

Each of the public services reviewed delivers a complex series of services, and access to these services has several dimensions – geographic, cultural, time and cost. As a first approximation to estimate performance, one major indicator of access was chosen for each sector, with a more detailed illustrative probe in some sub-sectors. In the case of education, the proportion of youth of school-going age (7-18 years) is one such first indication (Table 5).

School attendance was slightly higher in rural clusters (90%) than in urban ones (87%), implying that once they left school they also left home.

Table 5
School attendance among youth of school-going age (7-18)

	Urban	Rural	Sample
youth attending school	87% (977)	90% (2159)	89% (3136)
youth not attending school	13% (142)	10% (247)	11% (389)
TOTAL	100% (1119)	100% (2406)	100% (3525)

Table 6
Number of times the household used health services in the last year

	Urban	Rural	Sample
none	20% (169)	15% (219)	17% (388)
once	11% (91)	9% (134)	10% (225)
2 times	16% (138)	15% (211)	15% (349)
3 times	13% (110)	14% (199)	14% (309)
4 times	9% (75)	11% (152)	10% (227)
5 times	4% (38)	6% (87)	6% (125)
6 times	5% (41)	5% (76)	5% (117)
7 times or more	21% (176)	22% (312)	21% (488)
don't know	2% (17)	2% (34)	2% (51)

This is uneven with pockets of much lower attendance.

Figure 7
School attendance of males and females aged 4-25 years (actual numbers)

An important limitation in interpretation of these data is that they refer to youth attending school *who reside in the household*. It is quite possible that, dropping out of school, a youth would leave the household too. This effect could be examined further by looking at grade and age specific attendance *numbers* (Figure 7). This confirms a fall off only after the age of 16 years for males and 18 for females, suggesting youth might leave home after this age.

If it can be assumed that older children are more likely to leave home than younger ones, this indicates the high measured attendance rates reflect the reality. In the Northern Province, by contrast, the same analysis found a dramatic fall off in numbers attending (and at home) after the age of 13 years.

Table 7
The medical attention that was required in the last visit

	Urban	Rural	Sample
curative	85% (645)	92% (1185)	89% (1830)
prevention and pregnancy	15% (116)	8% (105)	11% (221)
TOTAL	100% (761)	100% (1290)	100% (2051)

Table 8
Coverage with measles immunisation (children under the age of 5 years) based on report of the mother

	Urban	Rural	Sample
child is immunised	93% (286)	91% (538)	92% (824)
not immunised	7% (22)	9% (54)	8% (76)
TOTAL	100% (308)	100% (592)	100% (900)

Table 9
Proportion who felt the nurses at the clinic were accessible

	Urban	Rural	Sample
nurse is accessible	79% (653)	86% (1211)	84% (1864)
not accessible	21% (172)	14% (194)	16% (366)
TOTAL	100% (825)	100% (1504)	100% (2230)

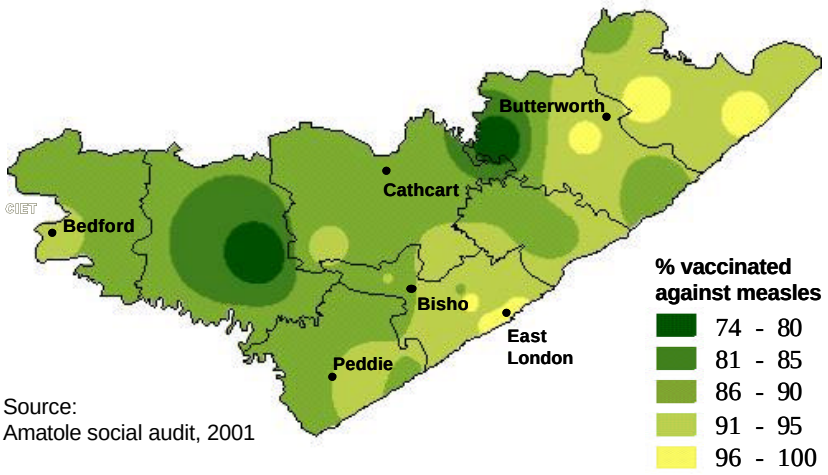
Overall, 17% of respondents said no one had used a health facility in the year preceding the social audit (Table 6). In urban clusters, the proportion of households without a visit to a government-run health facility were slightly higher (20%).

The most common **reason for attending a health facility** was to receive treatment for, in most cases, chronic complaints like asthma or hypertension (89%) (Table 7). While only 8% of respondents in rural clusters used clinics for prevention or pregnancy related services, 15% of respondents visited an urban clinic for the same reason.

A useful indicator of **access to health services** is the coverage with measles immunisation. This is a cornerstone of any primary health care programme, and the ability to achieve and to sustain universal childhood immunisation (UCI) of preschool children is a well-recognised measure of service performance.

Overall (Table 8), coverage was more than 90% – a satisfactory level by international standards. Figure 8 shows that this coverage is very patchy, in some pockets as low as 75%. The service delivery implication of this should be clear, with more resources channelled first to the areas of lowest coverage.

Figure 8
Percent of children vaccinated against measles
(Children under the age of five years, respondents report)



Source:
Amatole social audit, 2001

Citizens were also asked if they felt the **nurses were accessible** to them, implying a combination of time, culture and attitude (Table 9). The majority said yes. In the urban cluster, a slightly higher number of respondents (21%) felt that nurses were not accessible compared with 14% in the rural cluster.

Access to social welfare was measured primarily by the proportion of people over the age of 60 (65 in the case of men) who received their monthly state pension (Table 10). A senior citizen in the rural cluster was less likely to receive a pension than one in the urban cluster.

In the case of health, lowest levels of perceived access were in the East London - KWT central area. This could reflect higher expectations in these areas, or it could reflect higher turnover of staff. In the case of welfare, the perception of no access was highest in the Wild Coast and former Transkei areas.

Tables 10-14 show impressive access to welfare, particularly since so many households have no other source of income.

Table 10
Senior citizens who receive their pension

	Urban	Rural	Sample
received pension	95%(298)	91%(677)	92%(975)
did not receive pension	5%(16)	9%(69)	8%(85)
TOTAL	100%(314)	100%(746)	100%(1060)

Table 11
Access to this service in the last year

	Urban	Rural	Sample
none	81%(686)	83%(1174)	82%(1860)
1 - 4 times	16%(139)	14%(203)	15%(342)
5 - 8 times	2%(20)	1%(20)	2%(40)
9 - 12 times	1%(6)	1%(14)	1%(20)
TOTAL	100%(851)	100%(1411)	100%(2262)

Table 12
The purpose of the most recent visit to the welfare offices

	Urban	Rural	Sample
collect/apply child grant	39%(90)	29%(101)	33%(191)
other	21%(48)	17%(61)	19%(109)
collect/apply OAP	16%(38)	20%(71)	19%(109)
disability/sickness grant	15%(35)	20%(70)	18%(105)
collect/apply welfare	4%(10)	9%(31)	7%(41)
counselling/advice	5%(12)	5%(16)	5%(28)
TOTAL	100% (233)	100% (350)	100% (583)

Table 13
Perception of the most important service provided by the department of welfare (among those who answered the question)

	Urban	Rural	Sample
old age pension	37% (180)	35% (275)	36% (455)
child related services	17% (81)	16% (124)	16% (205)
counselling & advice	13% (65)	9% (72)	11% (137)
disability/sickness grant	9% (44)	10% (78)	10% (122)
welfare	8% (40)	8% (62)	8% (102)
other	16% (75)	22% (170)	19% (245)
TOTAL	100% (485)	100% (781)	100% (1266)

Table 14
Citizens who felt social workers were accessible to them

	Urban	Rural	Sample
yes	56% (484)	50% (718)	53% (1202)
no	29% (248)	34% (484)	32% (732)
don't know	15% (127)	16% (223)	15% (350)
TOTAL	100% (859)	100% (1425)	100% (2284)

People were also asked what service they considered **the most important** and **how many times** they had accessed it in the year prior to the consultation. A summary indicator of perceived access was obtained by asking citizens if they felt the social workers were accessible to them: around one in every two felt they were (Table 14), with significantly more saying this in urban areas.

Almost two-thirds of the primary school principals thought citizens were **satisfied with the education** they received in their schools. Only four of the 15 principals interviewed said people were dissatisfied with the services, and another two thought people were neither satisfied nor dissatisfied with their services. In the health sector, the same trend was apparent: two thirds of nurses interviewed said they thought people were satisfied with the services and one-third thought they were not. One half of social workers interviewed thought people were neither satisfied nor dissatisfied with their services. Only one of the social workers thought that their clients were satisfied with the social welfare services they received.

Service workers from each department were asked about any particular needs to improve access to services. In most cases, principals interviewed mentioned the slow learners. In one third of the cases they mentioned pupils with a certain disability such as blindness or deafness. For nurses, senior citizens were the first group needing access to their services enhanced, followed by the disabled and the mentally disabled. Social workers mentioned widows, single mothers and disabled people.

Access to cultural services – as provided by the department of sports, arts and culture – is not the easiest service performance indicator to measure. For this reason, and at the request of the MEC, specific events were probed. For example, nine out of every ten respondents took no message from Heritage Day and nine out of every ten did not attend any celebration (Table 15 and 16). Similarly with Freedom Day – more than 80% of respondents did not know what it was about. The most successful "special day" from the point of view of attendance was Freedom Day, with the highest levels of participation in events and level of understanding.

This is particularly noteworthy given that Freedom Day had not been celebrated in Amatole in recent years, though it had been in Graaff Reinet and Umtata. Heritage day had been celebrated in East London in 1998, implying very little spillovers from these celebrations.

Respondents were asked **what messages they received** from each day. Related to Heritage Day,

Table 15
Attendance at public celebrations (% of respondents)

	Urban	Rural	Sample
Heritage day	5% (46/862)	5% (68/1429)	5% (114/2291)
Freedom Day	14% (116/862)	11% (163/1426)	12% (279/2288)
Women's day	8% (65/862)	5% (75/1429)	6% (140/2291)

Table 16
No message from public celebrations – % of respondents who said "no message" or "don't know"

	Urban	Rural	Sample
Heritage day	93% (794/855)	94% (1335/1426)	94% (2129/2281)
Freedom Day	77% (661/859)	83% (1179/1424)	81% (1840/2283)
Women's day	73% (620/855)	81% (1157/1428)	80% (1822/2283)

Table 17
Reasons for non attendance at Heritage Day celebrations (among those who did not attend)

	Urban	Rural	Sample
could not attend	44% (360)	30% (410)	35% (770)
no interest	31% (255)	21% (285)	25% (540)
unaware	18% (154)	32% (433)	27% (587)
far/no transport	6% (49)	15% (200)	11% (249)
other	-	3% (36)	2% (36)
TOTAL	100% (818)	100% (1364)	100% (2182)

Table 18
Reasons for non attendance at a Freedom Day celebration (among those who did not attend)

	Urban	Rural	Sample
could not attend	47%(353)	33%(414)	38%(767)
no interest	32%(236)	22%(282)	26%(518)
unaware	14%(105)	23%(302)	20%(407)
far/no transport	7%(53)	19%(237)	14%(290)
other	-	3%(38)	2%(38)
TOTAL	100%(747)	100%(1273)	100%(2020)

Table 19
Reasons for non participation in Women's Day (among those who did not attend)

	Urban	Rural	Sample
could not attend	45% (364)	32% (430)	37%(794)
no interest	36% (291)	24% (327)	29%(618)
unaware	12% (93)	24%(325)	19%(418)
far/no transport	6% (49)	17%(233)	13%(282)
other	-3	3%(45)	2%(48)
TOTAL	100%(800)	100%(1360)	100%(2160)

1% (30/2281) mentioned "ties to the land" and 3% (69/2129) said "unite the nation". There were no significant differences between urban and rural responses. Regarding Freedom Day, 10% of urban and 7% of rural respondents (83/859 and 98/1424 respectively) said "unite the nation"; 5%

of urban and 4% of rural respondents (46/859 and 63/1424 respectively) said "fulfil promises"; and 4% of urban and 1% of rural respondents (30/859 and 9/1424 respectively) said "the vote".

On Women's Day, 9% of urban and 6% of rural respondents (79/855 and 78/1428 respectively) said "fight for women's rights"; 13% of urban and 4% of rural respondents (109/855 and 53/1428 respectively) said "stop abusing women"; and 1% of urban and 2% of rural respondents (10/855 and 23/1428 respectively) said "unite the nation".

Those who did not attend the special day celebrations were asked why this was the case. Something more than 25% in each case said this was because they lacked the interest. A further 30-35% in each case said they had been unavailable or unable to attend for one reason or another. Some 10-15% said they did not have transport and the remaining 20-30% said they were unaware of the celebrations. Needless to say, these were predominantly in rural areas. They should be the first targets of a communication programme to improve attendance and the proportion drawing messages from the special days.

Table 20 shows the proportion of respondents who said they **participated regularly in sport.** Although one might query what people saw as sport and what they considered regular participation, and indeed what sports facilities were available, the question produced the same results in urban and rural areas. The question was also asked exactly the same way for male and female citizens, and females were much less likely to participate. Given the change in the health profile found in this district (most attendances at health centres were now attributed to chronic illnesses like hypertension), the non-participation of women in sport could be an actionable point for public services.

Another issue arising has to do with planning for development of the sector. At present, most government investment in sport in the Province is through half a dozen sport academies, most of them based at tertiary education institutions. Clearly these have little or no relevance for the majority of people. On the positive side, there is a widespread involvement of people – albeit males much more than females – in local community organised sport. Although this social audit cannot offer more evidence on the nature of this involvement, the fact it is so widespread does hint at a positive environment for a strategy that would support village/community sports and culture councils.

Table 20
Household members who play sport regularly

	Urban	Rural	Sample
males doing sport	70% (315)	69% (609)	69% (924)
females doing sport	30% (134)	31% (275)	31% (409)
TOTAL	100% (449)	100% (884)	100% (1343)

Table 21
The government department that people consider the most corrupt

	Urban	Rural	Sample
welfare	24% (206)	17% (240)	20% (446)
education	7% (63)	5% (77)	6% (140)
police/security/justice/home affairs	6% (47)	5% (65)	5% (112)
health	6% (49)	4% (53)	5% (102)
municipality	4% (36)	1% (20)	3% (56)
water/electricity/public works/ transport	2% (21)	3% (35)	3% (56)
housing/labour	2% (15)	2% (27)	2% (42)
ANC	1% (6)	1% (17)	1% (23)
sport arts and culture	1% (4)	-2	-6
other	4% (32)	3% (47)	4% (79)
all departments	2% (18)	2% (24)	2% (42)
none	7% (60)	6% (78)	6% (138)
don't know	35% (301)	52% (738)	46% (1039)
TOTAL	100% (858)	100% (1423)	100% (2281)

Table 22
Reasons for considering this sector the most corrupt

	Urban	Rural	Sample
misused funds	55% (269)	45% (265)	49% (534)
bad service	32% (157)	37% (222)	35% (379)
promises not fulfilled	3% (15)	9% (52)	6% (67)
charge for services	4% (18)	1% (6)	2% (24)
other	3% (13)	3% (16)	3% (29)
don't know	4% (20)	6%934)	5% (54)
TOTAL	100% (492)	100% (595)	100% (1087)

Table 23
Reasons for considering each sector the most corrupt

	Education	Health	Welfare	All departments
misused funds	28%(35)	26%(22)	86%(367)	52%(534)
bad service	54%(68)	55%(47)	11%(49)	37%(379)
promises not fulfilled	2%(3)	2%(2)	2%(9)	7%(67)
charge for services/do not deliver checks	16%(20)	1%(1)	1%(3)	3%(34)
no medicine	-	16%(13)	-	1%(13)
TOTAL	100%(126)	100%(85)	100%(428)	100%(1027)

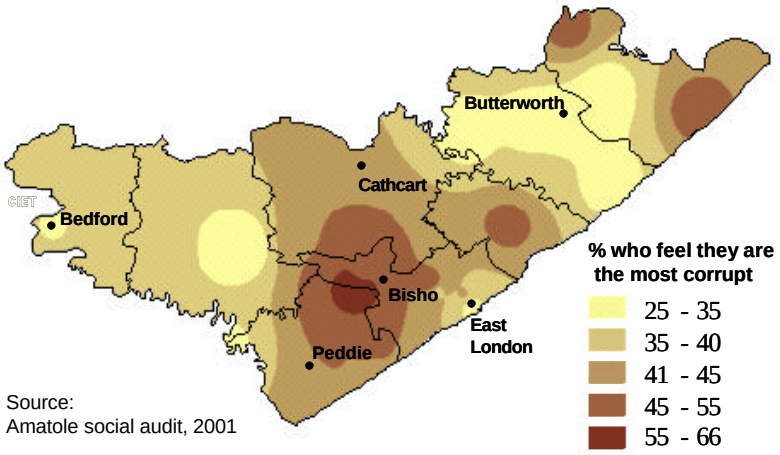
4. Courtesy

Citizens should be treated with courtesy and consideration

The respect people feel they receive from the public services was estimated from their **perception of corruption** and, more specifically, what exactly people saw as corruption.

Not all respondents volunteered an opinion on the most corrupt department. One third of the urban households and one half of the rural households said they did not know which was the most corrupt.

Figure 9
Proportion of respondents who said welfare was the most corrupt department



Source:
Amatole social audit, 2001

The most prominent department in perceived corruption in Amatole district municipality was welfare – 20% of all respondents said they thought it was the most corrupt department, nearly one half of those who ventured an opinion on corruption (Table 21 and Figure 9). Considering only those who named a single department as the most corrupt, 46% (446/1104) of respondents who gave a view mentioned welfare. Out of those who said the welfare department was the most corrupt, 77% said the reason was misuse of funds (Table 22).

Table 23 illustrates how most who thought health and education were the most corrupt attributed this to "bad service".

When the issue was probed in the focus groups, it emerged that the welfare department was considered the most corrupt because of handling of pension cheques. Some participants claimed that their pension claims had been refused without explanation. The main problem, it seems, is a lack of transparency of the criteria for eligibility. When people are refused a pension, most focus groups said, they needed to know why.

> Nurses are talking on their cell phones for hours while we are waiting to be served
> *Female focus group, Msobomvu*

Asked about corruption[32] in the health department, the conclusion of most focus groups about corruption had to do with "lack of medicine". Some groups claimed that medicine destined for their clinics had been rerouted only to be sold to them later. In the education department, while few thought there was corruption, some focus groups drew attention to what they called a "misuse of funds collected as school fees". Others spoke about corruption in the feeding schemes set up in some of the schools. Some groups complained about the lack of books and the need to pay for them while the government led them to believe they were entitled to free books.

In the majority of focus groups, asked how service workers requested illegal payments, people said that they were not asked directly for such payments. In one case, participants said they needed to pay in order to get an old age pension application processed. In another case, they said they had to bribe the officials in order to get the help they needed from the welfare department.

> Nurses are selling medicine in our area
> Male group, Msobomvu
>
> Nurses spend long hours at lunch. Security must check them to see if they take medicines
> Male group, Bolotwa
>
> There should be a tighter security at the clinics so the medicine does not get stolen
> Female group, Ndwayana

In order to stop the corruption in these departments, nearly all groups concluded, a government-appointed person might tour clinics, schools and social welfare offices to identify the persons behind this corruption and get them fired or replaced.

The case of welfare requires prompt action: people *do* seem to be receiving their cheques – even those who are not strictly eligible (men aged 60-64 years) are receiving theirs. Yet they see welfare as corrupt.

The qualitative and quantitative data together raise the possibility that claims of corruption could be, at least in part, a question of communication and thwarted expectations. In the context of reduced confidence in the administration and an evidently limited flow of information, almost any shortfall seems to be called corruption.

While this observation does not exclude true corruption – the use of public resources for personal gain – as a current issue, it implies the *perception* of corruption may be greater than the actual levels of corruption. Any effort to reduce true corruption, in this context, may not even be noticed by the public, until perceptions can be brought in line with actual levels, by providing people the information they need.

[32] Considerable attention was paid to the exact word used to discuss corruption in Xhosa. Across all sites in this sample, "*ubuqhopholo lo*" proved to convey the same sense, and this was used in interviews and focus groups alike.

5. Information

Citizens should be given full information about the public services they are entitled to receive

We live in darkness. These people only show up when they need us to vote for them
Female group, Upper Rabula

In the **health** sector it was possible to probe the level of information clients are given by asking if people knew that children under the age of five years should get free vaccination (Figure 10). A sizeable proportion (24%) – higher in the rural clusters – did not know this. Respondents with a higher education level[33] and those living in a household with a more educated head[34] were more likely to know that vaccination was free for children under the age of five. Also, female respondents were more likely than males to know if their children were vaccinated[35]. People living in non permanent houses were also less likely to know if their children were vaccinated[36].

Figure 10
Percent who said they did not know that vaccinations were free

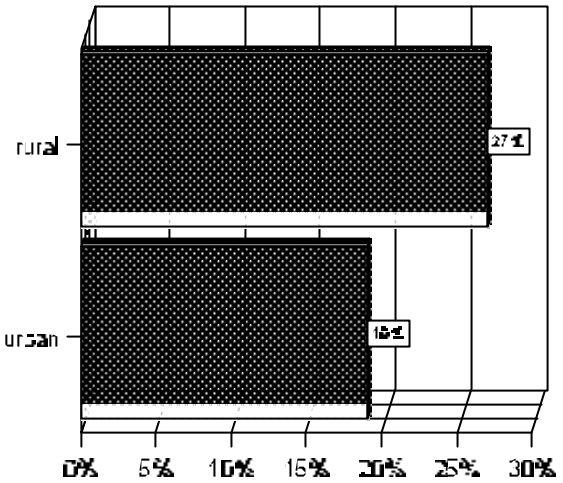


Figure 11 illustrates how information was best in the central EL-KWT area of Amatole. The access to information was further explored in the focus groups. The majority of male and female focus groups concluded that they did not know where to get information about public services. In some cases, people suggested approaching the departments directly.

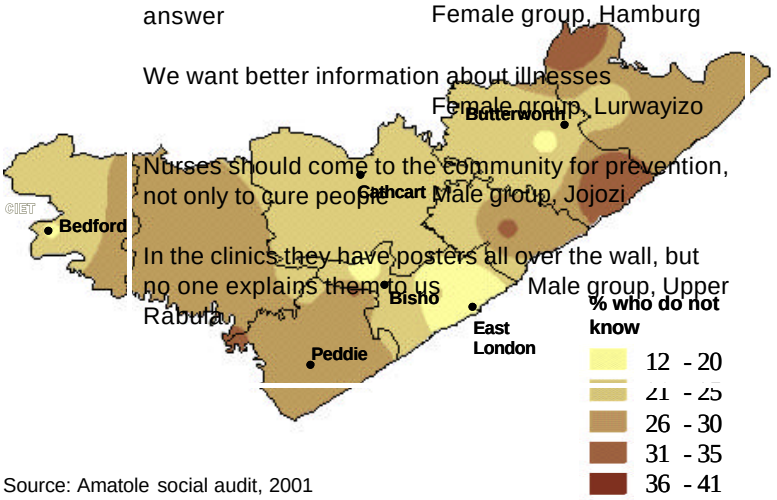
Figure 11
Distribution of knowledge that vaccination should be free

We usually call the hospital, but they never give us an answer
Female group, Hamburg

We want better information about illnesses
Female group, Lurwayizo

Nurses should come to the community for prevention, not only to cure people
Male group, Jojozi

In the clinics they have posters all over the wall, but no one explains them to us
Male group, Upper Rabula



Source: Amatole social audit, 2001

[33] 1107/1394 respondents with a higher education compared with 626/890, odds ratio 1.63, 95%CI 1.33-1.99

[34] 851/1035 households with an employed head compared with 819/1158, odds ratio 1.91, 95%CI 1.55-2.36

[35] 1375/1722 of females compared with 362/565 of males, odds ratio 2.2, 95%CI 1.79-2.75

[36] 287/409 living in non permanent houses compared with 1444/1869, odds ratio 0.69, 95%CI 0.54-0.89

They did not mention the possibility of going to a school, clinic or welfare office in order to get information.

Asked what information they needed from each of the departments, focus groups asked for information about how money was spent and entitlement to free services.

In the **education** sector, people were interested to know more about feeding schemes, free books and stationery; some wanted to know how the money collected through school fees was spent and why it was not used to improve their school buildings. In the **health** sector, people wanted to know more about the availability of medicine and why they did not have free ambulance services. Some wanted to know why clinics were not opened 24 hours when they had no hospitals in their area.

Concerning **welfare,** the main focus was once again the old age pension. People wanted to understand who was entitled to the pension and the reason some get refused occasionally. Some also wanted to know about the exact role of a social worker and what services they could expect. A female focus group summed up their view of information from the welfare department, "No one comes to us and asks us if we have any problems. There's an advice office, but it is dead. There's a social worker there, but she does nothing. We do not even know her face".

Asked about the easiest way to get information about all three sectors, the majority asked for workshops in their communities. While some wanted these workshops organised by the relevant departments, others thought that their own education, health and welfare committees should take care of these workshops. Mainly in the rural sites, participants wanted this role for their chief or headman, so they could get the answers during their *imbizos*. Very few mentioned that they might get information through the service workers or radio, and none by television.

We want government representatives to explain to us why there is no money for us, while other regions have schools, clinics and everything
Male group, Bell

Social workers never visit us to get information
Female group, Hlangana

Social workers are not accessible to the people. We do not know what their job description is
Male group, Bedford

We want to know why social workers know nothing about our complaints and send us to Bisho
Male group, Entombo

We want social workers to come to us and explain about their role
Male group, Ngcweni

6. Openness and transparency

Citizens should be told how national and provincial departments are run, how much they cost, and who is in charge

Asked if they knew who was **in charge of the education** services, 13 of the 15 primary school principals could give the name of the MEC or head of department. Two thirds of nurses interviewed knew who was in charge of health in the province and all social workers knew the name of their MEC.

However, when asked if they thought people knew who was in charge of **education**, most

principals interviewed thought that citizens would not know. Almost all said they did not expect people to know how much it cost the department to run.

In the case of **health**, two thirds of the nurses interviewed said that people would not know how the health department was run, and three quarters thought that people did not know how much it cost to run the health department.

Table 24
Proportion who knew the name of the provincial MEC or departmental head in each sector

	Urban	Rural	Sample
Education	25% (212/863)	14% (196/1420)	18% (408/2283)
Health	12% (103/859)	5% (74/1426)	8% (177/2283)
Welfare	6% (49/862)	4% (58/1423)	5% (107/2285)
Sports Arts & Culture	15% (125/862)	7% (99/1427)	10% (224/2289)

All **social workers** interviewed agreed that citizens would not know how much it cost to run the department of welfare and almost all said that people would not know how the department was run.

From the community perspective, it was an easy matter to ask whether people knew who was in charge of each of the sectors. Table 24 shows the proportion of respondents who correctly identified the MEC or the senior civil servant in each sector. In many cases, there was confusion between the national and the provincial figurehead in each sector.

Knowledge of who was in charge of education, health and sport, arts and culture was better in the central EL-KWT area. Knowledge of who was in charge of welfare was almost uniformly low, with the exception of a few sites on the southern boundary of the district municipality (the home area of the MEC).

In general, respondents with a higher education were significantly more likely to know who was in charge of the education[37], health[38] or welfare[39] departments.
Urban respondents were more likely to know who was in charge of education than their rural counterparts[40]. Male respondents were more likely to know who was in charge of **education**[41]. When the head of the household was more educated[42] or employed[43], respondents were more likely to know who was in charge of education. The same was true of households having some income compared with households without income[44]. Reflecting another dimension perhaps of their marginalisation from the mainstream, respondents living in non permanent houses were less likely to know who was in charge of education[45].

For the **health** department, respondents from households headed by a more educated[46] or employed[47] person were more likely to know who the MEC was. Respondents from households with some income[48] and those living in permanent houses[49] were more likely to know who was in charge of health.

A similar effect was evident in the case of **welfare**, where respondents from households with a more educated[50] or an employed head[51] were more likely to know who was in charge of welfare in the province. Respondents living in non permanent houses[52] were less likely to know who was in charge of welfare in the province.

[37] 357/1391 respondents with a higher education compared with 49/885, odds ratio 5.89, 95%CI 4.25-8.18

[38] 160/1387 respondents with a higher education compared with 15/889, odds ratio 7.60, 95%CI 4.32-13.59

[39] 90/1394 respondents with a higher education compared with 16/884, odds ratio 3.74, 95%CI 2.12-6.71

[40] 212/863 in rural areas compared with 196/1420 in urban areas, odds ratio 2.03, 95%CI 1.63-2.65

[41] 135/564 of males compared with 273/1714 of females, odds ratio 1.66, 95%CI 1.3-2.12

[42] 299/1034 households with a head having a higher education compared with 93/1151, odds ratio 4.63, 95%CI 3.57-6.01

[43] 243/1052 households with employed heads compared with 158/1175, odds ratio 1.93, 95%CI 1.54-2.43

[44] 220/970 households with some income compared with 132/1093 households with no income, odds ratio 2.14, 95%CI 1.67-2.73

[45] 23/407 respondents in non permanent houses compared with 381/1862, odds ratio 0.23, 95%CI 0.15-0.37

[46] 147/1030 households with a more educated head compared with 25/1155, odds ratio 7.52, 95%CI 4.77-11.95

[47] 125/1048 households with an employed head compared with 47/1179, odds ratio 3.26, 95%CI 2.27-4.7

[48] 106/970 households with some income compared with 42/1092. odds ratio 3.07, 95%CI 2.08-4.53

[49] 11/407 living in non permanent houses compared with 165/1862, odds ratio 0.29, 95%CI 0.14-0.55

[50] 75/1036 households with head having a higher education compared with 28/1151, odds ratio 3.13, 95%CI 1.96-5.02

[51] 65/1050 households with an employed head compared with 39/1179, odds ratio 1.93, 95%CI 1.26-2.79

[52] 9/408 living in non permanent houses compared with 213/1871 living in permanent houses, odds ratio 0.18, 95%CI 0.08-0.36

7. Redress

If the promised standard of service is not delivered, citizens should be offered an apology, a full explanation and a speedy and effective remedy; and when complaints are made, citizens should receive a sympathetic positive response

One third of the principals interviewed said there was no mechanism for clients to complain about **education** if they felt the promised standard of service was not delivered. Another third mentioned the SGB as a forum for complaints. Some principals said complaints should go directly to themselves, while some thought that people should use the community meetings to complain about services in education. One third of the principals interviewed heard about people complaining about the services in education.

> We just need to know who to talk to if we have grievances
> *Male focus group, East London*

Nurses interviewed were divided about the mechanisms available for people to complain about the **health** services. One third thought that there were no mechanisms, another third mentioned health committees and the remainder referred to the district office. Most respondents said that they had not ever heard of anyone complaining.

One third of the social workers said that the way for people to complain about services in the **welfare** department was through the welfare forum. Another third said people should complain directly at the welfare office. One social worker mentioned the district office and one said she did not know what mechanisms existed. Two thirds of social workers had heard about people complaining about the welfare services.

Table 25
Citizens who have made a complaint about each of the sectors

	Urban	Rural	Sample
Education	8% (70/865)	9% (127/1428)	9% (197/2293)
Health	5% (43/863)	4% (54/1427)	4% (97/2290)
Welfare	4% (38/861)	4% (62/1428)	4% (100/2289)

Table 25 shows the proportion of household respondents who said they had made a

Focus group views on redress

> We have no idea how and where to complain
> *Male group, Bell*

> If you do not know anybody in the offices, you never get any money for anything
> Female group, Godidi

> There is no help at all in those departments. In the department of Welfare, they give you a number to call and complain, but they never answer to that number
> Female group, Upper Rabula

> Some told us to go to Bisho to complain; we do not have money to go to that Bisho
> Female group, Upper Rabula

> They should send representatives to the community meetings to see if we have complaints

> The complaint office in Bisho is too far, and there are no offices to complain in the area
> Female group, Ngcweni
> Female group, Hlangana

> We need a specified person to give our complaints to

> People do go to Bisho and submit their grievances, but nothing is done about them
> Male group Bedford
> Male group Upper Rabula

> There's no one moving around to take in our complaints

> We raised funds and sent someone to Bisho to complain, but nothing was done about it
> Male group Ndwayana
> Male fg , Entombo

> There should be someone from the government who visits the clinics to register the complaints
> Male group, Upper Rabula

> We do not have the money to go to these offices and complain
> Male group, Taleni

> We are afraid of the social workers in Kentani because they do not respect us, so we cannot go to them
> Male group, Ngcweni

complaint in each of the sectors. Only one in every 10 citizens had made a complaint about **education**, and only half of that proportion number in **health and welfare**. Respondents with higher education were more likely to have complained about the education services[53]. Male respondents were also more likely to complain about education[54], health[55] or welfare[56] services. Respondents coming from a household with some income[57] were less likely to complain about welfare than those coming from a household with no income.

The levels of complaint were fairly low, and much of the reason for this is evident in Tables 26-29 and Figure 12: people do not know ***how* to make a complaint.**

Two out of three people (67%) did not know how to make a complaint in welfare, 57% in health and 39% in education. Again, respondents with a higher education were more likely to complain about education[58] or health[59].

Table 26
Percent who said they did no know how to make a complaint against the social cluster departments

	Urban	Rural	Sample
education	40% (346)	44% (635)	43% (981)
health	63% (542)	64% (907)	64% (1350)
welfare	71% (607)	71% (1019)	71% (1626)

A similar answer came from respondents from a household with a more educated head, where people were more likely to complain about education[60] or health[61]. Male respondents were again more likely to take steps to complain about

[53] 143/1398 respondents with a higher education compared with 54/888, odds ratio 1.76, 95%CI 1.25-2.48

[54] 80/566 of males compared with 117/1722 of females, odds ratio 2.26, 95%CI 1.65-3.1

[55] 41/566 of males compared with 56/1720 of females, odds ratio 2.32, 95%CI 1.5-3.6

[56] 37/567 of males compared with 63/1721 of females, odds ratio 1.84, 95%CI 1.18-2.86

[57] 32/974 respondents coming from households with some income compared with 63/1098, odds ratio 0.56, 95%CI 0.35-0.88

[58] 883/1399 respondents with a higher education compared with 423/891, odds ratio 1.89, 95%CI 1.59-2.26

[59] 568/1378 respondents with a higher education compared with 243/876, odds ratio 1.83, 95%CI 1.51-2.21

[60] 646/1039 respondents coming from a household headed by someone with higher education compared with 615/1159, odds ratio 1.45, 95%CI 1.22-1.73

[61] 426/1029 respondents coming from a household headed by someone with higher education, compared with 360/1135, odds ratio 1.52, 95%CI 1.27-1.82

Table 27
Steps citizens would follow to make a complaint against the education services

	Urban	Rural	Sample
talk to principal or teacher	62% (318)	53% (417)	56% (735)
SGB	17% (90)	24% (190)	22% (280)
district office	16% (83)	15% (119)	15% (202)
other	5% (27)	8% (63)	7% (90)
TOTAL	100% (578)	100% (789)	100% (1307)

Table 28
Steps citizens would follow to make a complaint against the health services

	Urban	Rural	Sample
sister/doctor in charge	40% (127)	35% (173)	37% (300)
hospital warden	23% (75)	16% (77)	19% (152)
district office/MEC	17% (54)	17% (82)	17% (136)
health committee	6% (18)	11% (55)	9% (73)
chief/community leader	3% (9)	8% (39)	6% (48)
other	11% (37)	13% (65)	12% (102)
TOTAL	100% (320)	100% (491)	100% (811)

Table 29
Steps citizens would follow to make a complaint against the welfare services

	Urban	Rural	Sample
district office/MEC	30% (75)	29% (120)	29% (195)
social workers	19% (47)	25% (101)	23% (148)
social office head	26% (67)	17% (68)	20% (135)
community committee	6% (16)	10% (40)	8% (56)
other	19% (49)	19% (81)	20% (130)
TOTAL	100% (254)	100% (410)	100% (664)

education[62] or health[63]. Respondents living in non permanent houses were less likely to take steps to complain about education[64] or health[65].

[62] 372/568 of males compared with 933/1723 of females, odds ratio 1.61, 95%CI 1.31-1.97

[63] 239/556 of males compared with 571/1702 of females, odds ratio 1.49, 95%CI 1.22-1.83

[64] 203/410 respondents living in non permanent houses compared with 1098/1872, odds ratio 0.69, 95%CI 0.55-0.86

[65] 123/402 respondents living in non permanent houses compared with 685/1847, odds ratio 0.75, 95%CI 0.59-0.95

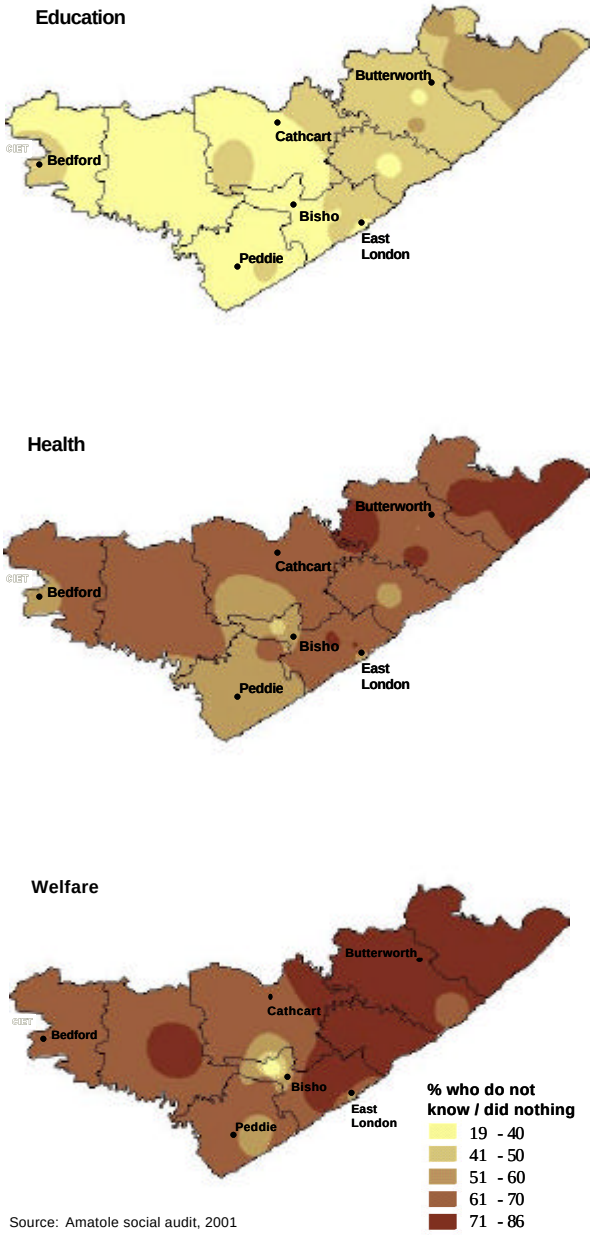
Respondents coming from a household with some income[66] were more likely to complain about education. areas[67], respondents were found to be more likely to take steps to complain about health than those living in rural areas.

Focus groups confirmed that the main reason people did not complain was that they did not know where to go.

Even when they complained, they said, no follow up was made. Asked about what the provincial government could do to make it easier to complain, all participants in both male and female focus groups agreed on the need to have a local complaint facility. All groups said that a complaint office in the main towns created a barrier for redress, particularly with the cost of transport.

Most focus groups concluded that a person nominated by the government to receive the complaints should tour the towns and villages in order to check on service delivery and collect potential complaints from users. While focus group participants said they could do little themselves to improve services, in most they agreed they should have some role in solving their own problems. Many groups suggested the creation of committees or the nomination of one person to follow up their demands.

Figure 12
Distribution of knowledge of how to complain (education, health and welfare)



Source: Amatole social audit, 2001

8. Value for money

Public services should be provided economically and efficiently, in order

[66] 601/975 respondents from households with some income compared with 592/1100 no income, o/r 1.38, 95%CI 1.15-1.65

[67] 331/777 respondents in urban areas compared with 145/449 in rural areas, odds ratio 1.56, 95%CI 1.21-2.01

to give citizens the best possible value for money

People were asked **which government service they see as the most valuable**. On the top of the list came the department of **health** with 24% of respondents giving it their "vote" (Table 30). Health was closely followed by the department of **education** with 23% . In the rural areas, more

Table 30
The government department people consider most valuable
Percent giving response (n=)

	Urban	Rural	Sample
health	28% (240)	21% (299)	24% (539)
education	21% (181)	24% (335)	23% (516)
welfare	11% (91)	9% (134)	10% (225)
water/electricity/public works/ transport	3% (27)	6% (84)	5% (111)
police/security/justice/home affairs	5% (39)	4% (56)	4% (95)
ANC	1% (12)	5% (76)	4% (88)
finance/municipality	5% (44)	2% (26)	3% (70)
agriculture	- (4)	3% (42)	2% (46)
housing/labour	3% (22)	1% (19)	2% (41)
sports arts and culture	1% (8)	- (6)	1% (14)
other	1% (4)	1% (9)	1% (13)
all departments	2% (18)	1% (9)	1% (27)
none	8% (70)	4% (59)	6% (129)
don't know	12% (101)	19% (271)	16% (372)
TOTAL	100% (861)	100% (1425)	100% (2286)

considered education as the most valuable department (24%), while health followed with 21%. The urban gap was bigger between the two departments (28% for health, compared with 21% for education). Respondents saying that health and education were the most valuable had higher education[68], they came from households headed by a more educated person[69] and permanent houses[70].

The department of **welfare** was considered the most valuable by 12% of the respondents, while 6% said that none of the departments were important to them and 16% did not know.

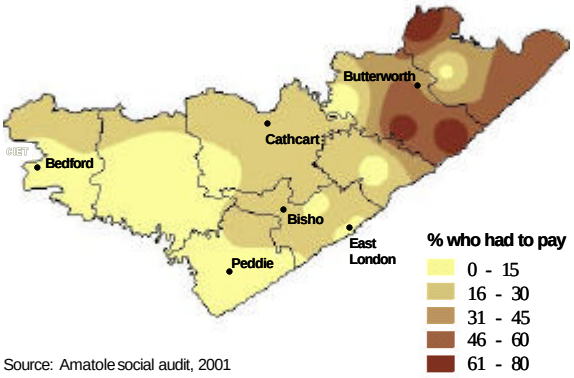
[68]740/1393 for respondent with an education of grade 6 and above compared with 310/886 for respondents with an education lower than grade 6, odds ratio 2.11, 95% CL 1.76-2.52

[69]531/1034 in households with a head having a higher education compared with 463/1154 with a lower education, odds ratio 1.58, 95%CI 1.32-1.88

[70]911/1866 in permanent houses compared with 139/407 in other structures, odds ratio 0.54, 95%CI 0.43-0.59

There are several types of cost of public services, including public resources (taxes and national revenues), direct costs to the citizens (official and unofficial user fees) and indirect costs occasioned by *not* having access to effective services. An example of cost to citizens that is *not* usually taken into account by the public service planners is that of transportation to access the services. In the case of health (Table 31), average transportation costs were in the region of R7 per visit, being significantly more in the rural clusters and, as is often the case, for poorer households in more remote communities. In addition to this transport cost, one in every three users said they paid an average of R2 for the health visit, the costs also being slightly higher in the rural clusters (Table 32).

Figure 13
Distribution of those who had to pay for health services



Source: Amatole social audit, 2001

Table 31
Cost of transport (return trip) to the nearest government clinic/hospital

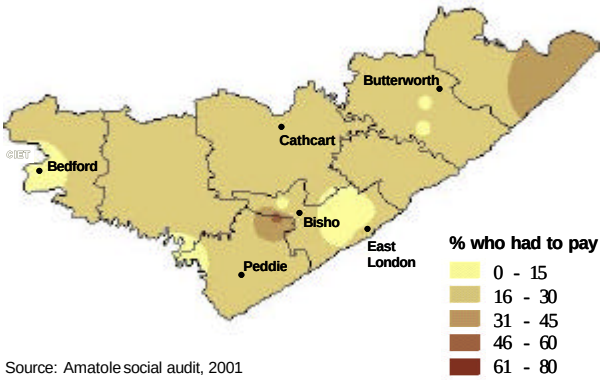
	Urban	Rural	Sample
Proportion paying	59% (503/857)	65% (929/1424)	63% (1432/2281)
Average amount paid	R 5.43	R 7.68	R 6.84
standard error of mean	R 0.265	R 0.269	R 0.197
t-statistic		34.777 (df=2280, p=0.00000)	

Table 32
How much did you have to pay for the health service?

	Urban	Rural	Sample
Proportion paying	23% (194/854)	38% (539/1413)	32% (733/2267)
Average amount paid	R 1.50	R 2.21	R 1.95
t-statistic		12.843 (df=2065, p=0.00000)	

According to the nurses, ten of the twelve clinics said they did not charge for any of the services they provided. One clinic charged a R1.00 fee for minor ailments. In two cases, nurses said that services should not be free, in order to relieve the pressure and let only patients who really needed the service to come to the clinic.

Figure 14
Distribution of those who had to pay for welfare



Source: Amatole social audit, 2001

Table 33
How much did you have to pay for the welfare service?

	Urban	Rural	Sample
Proportion paying	23% (194/854)	38% (539/1413)	32% (733/2267)
Average amount paid	R 1.50	R 2.21	R 1.95
t-statistic		12.843 (df=2065, p=0.00000)	

These unofficial charges, levied unevenly on rural residents and those least able to complain, probably represent an added barrier for access. It evidently increases the transaction costs, passing a greater part of the cost to clients and, quite possibly, affects the public view of service workers. The population weighted distribution of payments are reflected in Figures 13 and 14.

Willingness to pay

One measure of perceived value for money is the willingness of clients to pay for the services they receive. This is also an indicator of seriousness of expressed need for the services to improve: the logic is that if complaints about the services are motivated merely by an exaggerated sense of entitlement, people would not be prepared to pay for the changes they request.

Education: Overall, 35% of respondents said they were willing to pay for the changes they would like to see in the education system. More educated respondents were more likely to say this[71] as were those who considered education the most valuable[72] and best run[73] government department. Those who knew how to complain about education services[74], and those who had complained about education[75] were also more likely to be willing to pay to see changes in the education services.

Health: Nearly one third of the respondents (31%) were willing to pay for changes in the health services. Those who considered the health department to be the most valuable department[76] were

[71] 473/1246 respondents with higher education level compared with 234/791 of respondents with a lower education level, odds ratio 1.46, 95%CI 1.20-1.77

[72] 181/463 respondents who said education was the most valuable department compared with 524/1569 of those who mentioned another department, odds ratio 1.28, 95%CI 1.03-1.60

[73] 148/373 of respondents who said education was the best run department compared with 560/1661 of those who mentioned another department, odds ratio 1.29, 95%CI 1.02-1.64

[74] 471/1167 of those who know how to complain compared with 237/875 of those who don't know how to complain, odds ratio 1.82, 95%CI 1.50-2.22

[75] 83/185 of those who have complained compared with 625/1855 of those who have never complained, odds ratio 1.60, 95%CI 1.16-2.20

[76] 174/501 of those who thought that the health department was the most valuable compared with 464/1574 of those who mentioned another department, odds ratio 1.27, 95%CI 1.02-1.59

more likely to say this as were those with higher education[77] and those from a household where the head was more educated[78] or employed[79]. Respondents who were satisfied with health services[80] were less likely to express willingness to pay to see changes while those who had complained about health services[81] were more likely to be willing to pay in order to see improvements.

Welfare: Only one out of ten (11%) of respondents was ready to pay in order to see changes in social welfare services. Respondents with higher education[82] or from a household headed by someone with higher education[83] were more likely to be ready to pay in order to see changes in the welfare services.

[77] 439/1284 of respondents with a higher education level compared with 201/793 of respondents with a lower education level, odds ratio 1.53, 95%CI 1.25-1.88

[78] 335/953 of respondents from a household with a more educated head compared with 277/1039 of respondents with a less educated head, odds ratio 1.49, 95%CI 1.22-1.82

[79] 343/966 of respondents coming from a household with an employed/pensioner head compared with 286/1067 coming from a household with an unemployed head, odds ratio 1.50, 95%CI 1.24-1.83

[80] 413/1489 of respondents who were satisfied with the health services compared with 221/562 who were dissatisfied with the health services, odds ratio 0.59, 95%CI 0.48-0.73

[81] 44/89 of respondents who complained about health services compared with 596/1991 of those who have never complained, odds ratio 2.29, 95%CI 1.46-3.60

[82] 159/1221 of respondents with a higher education compared with 56/755 with a lower education, odds ratio 1.87, 95%CI 1.34-2.61

[83] 117/927 of respondents coming from a household with a more educated head compared with 90/978 with a less educated head, odds ratio 1.43, 95%CI 1.05-1.93

E Steps for action

Education

Asked about any particular groups that need better access to educational services, most primary school principals mentioned slow learners. In one third of the cases they mentioned pupils with a physical disability such as blindness or deafness.

All except one principal said they did not have enough books to meet the needs of their pupils. More than half of them said that this had been the case since 1994. Slightly more than one third said that not enough books were supplied between 1995 and 1999. Only one said that his school never had enough books. The material that the schools lacked most, according to the principals, were textbooks, stationery and Outcome-based Education (OBE) manuals for teachers. Around a third mentioned computers and machinery, such as photocopy or fax machines.

Head teachers in each of the schools were asked where they thought the bottleneck was that stopped books and supplies reaching them in sufficient quantities. Twelve of the 15 school principals blamed the department of education for lack of communication, and for not having a good system of supplying. They were asked if each one could recommend one change or improvement in the education services, what would that be. Eight of the 15 principals said that schools should deal directly with the suppliers to allow goods to be delivered on time.

Most head teachers (13/15) when asked directly, said they had never heard of Batho Pele.

In the household survey, people were asked what single thing they would most like to see changed in the education, health and welfare departments.

In the case of education, one out of every three (35%) said they would not want to change anything. Some 15% said they would like to have better or more teachers in the schools and 11% wanted more schools. One out of ten did not know what they would like to see changed in education. Respondents who did want to see changes in education typically had higher education[84], came from households with a more educated head[85], from households with an income[86], and lived in permanent dwellings[87].

Health

Nurses said that old people were most in need of increased access to health services, followed by

[84]838/1394 respondents with higher education level as compared with 374/889, odds ratio 2.08, 95%CI 1.74-2.48

[85]628/1036 households with a higher educated head compared with 540/1156, odds ratio 1.76, 95%CI 1.47-2.09

[86]529/1098 of respondents in households with no income compared with 569/971 in households with an income, odds ratio 0.66, 95%CI 0.55-0.79

[87]192/408 living in non permanent houses as compared with 1016/1868 living in other structures, odds ratio 0.75, 95%CI 0.60-0.93

the physically and mentally disabled. Social workers mentioned widows, single mothers and disabled people.

To improve service standards in the clinics, most nurses suggested more space, better buildings and infrastructure. Some mentioned the need to hire more staff. One third said educational posters or pamphlets would improve service delivery. Another suggestion was to train village health workers.

Nurses at most clinics thought they did not have enough medicine. However, one clinic said it had enough medicine to cover the needs of the patients. More than two thirds said the lack of medicine started in the last two years. One third said that medicine was what they lacked most, followed by blood pressure machines. In two clinics, nurses said they lacked space to receive and to treat their patients, and another two said they needed vehicles to visit patients at home. One half of the nurses thought that the main problem that prevented medicine supplies reaching them was a financial one and one third identified it as a transport problem.

In the health system, the main thing respondents wanted to see changed (22%) was availability of medicine. Some 26% of urban respondents asked for more medicine compared with 21% of rural respondents. A similar trend appeared in the proportions who asked for better services (14%): 20% of urban respondents wanted better services, only 10% of rural respondents said this. This urban bias in expectations is common in service delivery surveys.

Reflecting much the same "expectation bias," respondents with a higher education level[88] and households with a more educated head[89] were more likely to ask for changes in the health system. Male respondents[90] were more likely to ask for changes in the health system than were their female counterparts.

Table 34
The single thing people would most like to see changed with the social welfare services?

	Urban	Rural
nothing	46% (394)	42% (604)
better service	14% (122)	10% (149)
home visits	8% (72)	10% (136)
higher grants	3% (25)	3% (35)
other	8% (64)	9% (121)
don't know	21% (181)	27% (381)
TOTAL	100% (858)	100% (1426)

Welfare

In the welfare offices, most of the social workers interviewed said they lacked vehicles to visit clients and office equipment such as photocopy machines. One third of them blamed the lack of supplies in their offices to the non existence of an organigram defining roles and responsibilities of each employee in the department. Other reasons mentioned was the lack of funds, the lack of transport, weak communication between staff and poor services.

[88] 852/1255 respondents with higher education level as compared with 436/761, odds ratio 1.58, 95%CI 1.30-1.91

[89] 658/945 households with a more educated head compared with 592/995, odds ratio 1.56, 95%CI 1.29-1.90

[90] 369/513 of males compared with 919/1508 of females, odds ratio 1.64, 95%CI 1.31-2.06

Asked what single thing they wanted to see changed in welfare, better services featured again (Table 34): 10% in rural areas and 14% in urban sites. Home visits were also a concern: 9% of respondents wanted more home visits. No less than 44% of respondents said they did not want to see anything changed in the welfare department, and one in four did not know what they would want to see changed in the welfare services provided to them. This could reflect the reality that welfare services were not required or used by everyone.

Conclusions

Amatole is not a typical district municipality in the Province of the Eastern Cape. Service delivery is likely to be much better here than anywhere else. The high levels of coverage with basic services in the social cluster and the low levels of communication between the services and citizens (with the exception of education), cannot be extrapolated to the rest of the province.

By the same token, the conclusion that communication rather than service delivery was the first issue to be tackled may not be relevant to the rest of the province.

The case of Amatole demonstrates how a systematic social audit can reveal the starting point of a cluster strategy to improve service delivery. In Amatole, until the communication gap has been breached, investment in improved service will not be the best use of resources.

The next step is to extend the social audit to the rest of the province. If the Amatole result is reiterated in the remaining five district municipalities, it would be appropriate to develop and implement a cluster-wide strategy of communication.

Once the communication issue has been solved, it will then be appropriate to focus – service by service – on the performance of each department to obtain more in depth evidence of performance and mechanisms for improvement. The finding of unofficial payments for health and welfare could provide a starting point in these departments.