DISCLAIMER

Responsibility

This report was financed by the Embassy of Ireland as part of their aid programme to the Government of South Africa. However, the views and recommendations contained in this report are those of the consultants, and the Embassy of Ireland is not responsible for or bound to the recommendations made.

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CHAPTER 1 BACKGROUND AND METHODOLOGY

1.1 INTRODUCTION

This study focuses on **Official Development Assistance** (ODA) in the South African health sector. First and foremost, it aims at analysing the nature, flow, allocation and distribution of ODA in the South African health sector for the period 1994 to 1999. Secondly, it also aims at analysing the institutional arrangements pertaining to ODA in the SA health sector, and how these arrangements enhance and/or impede the ODA process. The study is not primarily intended, and should thus not be seen, as a critique of current policies and arrangements on ODA. However, due to realities encountered, a critical discourse of issues could not be and was not avoided. In places, the analyses therefore tend towards the critical, while criticism was not avoided where due. Even so, these critical observations and conclusions are constructively intended, i.e. to serve the broader interest of ODA, and to benefit the many partners, beneficiaries and potential beneficiaries of ODA in the SA health sector.

The *terms of reference* for this study identify primary health care, clinic building and HIV/AIDS awareness as focus areas for the targeting of ODA in the SA public health sector. However, in view of policy directions, strategic priorities and known problems in the SA health sector, other issues that are indeed crucial and therefore deserving of attention in a study of this nature are:

- permanent infrastructure development / Capital Investment Projects (including clinic building)
- transformation, reconstruction & development (including organisational development and human resource development)
- equity and equality
- district development

Although attempts were made to reconstruct and analyse the degree and extent to which the cross-cutting issues/themes of gender, water & sanitation, environment, capacity development, democracy & governance and poverty relief benefit from ODA in the SA health sector, this proved difficult, even impossible. Available data renders it difficult, if not impossible, to clearly and meaningfully distinguish which component/s of ODA is targeted at any specific cross-cutting issue. Often, cross-cutting issues are merely implied or vaguely referred to in a programme or project that receives ODA. It would be invalid to assume that any particular cross-cutting issue benefits from ODA unless it is explicitly stated in the goals of the project/programme at stake. Given the timeframe and manifest purpose of the study, time and attention could not be devoted to disentangling and analysing these issues at the expense of the overriding health-specific theme and focus of the study.

The approach towards the study is characterised by an outright focus on

a. a reconstruction and critical analysis of the current situation regarding ODA in the SA health sector;
b. formulation of strategic, yet practicable and acceptable solutions for overcoming problems, constraints and impediments as far as ODA in the SA health sector is concerned; and
c. putting forward strategic, yet practicable and acceptable suggestions for enhancing SA ownership and optimising the impact of ODA in the SA health sector.

Methodologically speaking, the focus is on the collection of relevant ODA information and, based on a critical analysis of this information, the formulation of strategic, yet

practical recommendations and proposals that are aimed at optimising the impact of ODA on the SA health sector. This would include the establishment of systems, structures and processes for efficiently managing all aspects of ODA in a comprehensive, inclusive manner.

1.2 STRUCTURE OF THE REPORT

After dealing with general and methodological issues pertaining to the study, the following aspects of ODA in the SA health sector will be dealt with systematically in this report:

- *Firstly*, the allocation and distribution of ODA in the South African public health sector during the period 1994 to1999 will be reconstructed according to primary recipients, as well as health- and geographical target areas.
- *Secondly*, the alignment between ODA on the one hand and health care needs and priorities on the other hand, will be critically assessed.
- *Thirdly*, institutional arrangements relating to ODA will be examined with a view to enhancing such arrangements for effective management and co-ordination of ODA in the SA health sector. The analysis of institutional arrangements will also look at co-ordination and complementarity among donors, between donors and recipients/beneficiaries, and among recipients/beneficiaries.
- *Fourthly*, and against the background of current problems and mismatches between ODA and critical objectives and priorities in the SA public health sector, the way towards optimal synergy between ODA and official initiatives and policies in pursuit of strategic health priorities in SA over the medium and longer terms will be outlined. This will include recommendations and suggestions regarding systems, mechanisms, processes and tools for managing and co-ordinating ODA, as well as for conducting impact assessments and evaluations of ODA in the SA health sector. An attempt at putting forward a generic monitoring framework for evaluating the impact of ODA in the South African health sector, as well as a framework for tracking ODA and ensuring its dynamic alignment with the MTEF and relevant health-specific policies, will be made in the process.

1.3 CONCEPTUALISATION

Certain concepts take on a specific meaning within the context of this study. It is therefore deemed necessary to present the working definitions of the following such concepts:

- **Official Development Assistance**

In accordance with the *Assistance Guidelines of the Department of Finance*, the working definition of **ODA** that initially applied to this study was as follows:

> *Official Development Assistance (ODA) is regarded as assistance provided by international donors to the South African Government in the form of grants, technical assistance (eg consultants) and concessionary finance (loans).*

This implied that:

(a) donor **countries** and **multi-lateral agencies** were to be included in the review;
(b) the study was to be limited to the South African **public** health sector;
(c) only national and provincial Departments of Health were to be considered **direct** recipients of ODA;
(d) local NGOs as direct recipients or beneficiaries of ODA were **not** to be included in the review;
(e) ODA that is disbursed to NGOs *via* official channels (Departments of Health) for purposes of complementing and supplementing official functions was to be **included** in the review.

However, shortly after the study commenced it was realised that a reconstruction of ODA in the SA health sector would be incomplete if NGOs that are funded directly by donors were excluded from the analysis. For this purpose, the definition put forward in the *Assistance Guidelines of the Department of Finance* was adapted as follows for purposes of this study:

> *Official Development Assistance (ODA)[1] is regarded as assistance provided by international donors to the South African Government* ***and NGOs operating in the health sector*** *in the form of grants, technical assistance (eg. consultants) and concessionary finance (loans).*

This implies that:

(f) donor **countries** in their official capacity, as well as **multi-lateral donor agencies** were included in the review[2];

(g) although the concept of the SA health sector that applies to the study is comprehensive (see below), the focus of the study is on the SA **public** health sector;

(h) national and provincial Departments of Health were considered as **direct** recipients of ODA;

(i) local NGOs that are direct (from donors) and indirect (*via* government channels) recipients or beneficiaries of ODA in the health sector were **included** in the review.

▪ ODA Process

The **ODA process** includes the following steps/phases:

- Solicitation of ODA
- Structuring and signing of bilateral/multilateral agreements
- Planning and prioritisation of ODA
- Management and co-ordination of ODA
- Implementation of ODA initiatives (programmes, projects, etc.)
- Monitoring and Evaluation of ODA initiatives (including impact assessment)

▪ Institutional Arrangements

Institutional arrangements refer to the mechanisms, processes, systems, structures, policies and procedures that are created by the various stakeholders to deal with the ODA process.

▪ SA health sector

For purposes of the DCR health sector study, the **SA health sector** is defined broadly to encompass, in addition to the national and provincial Departments of

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[1] ODA includes:

- **Grants**, i.e. financial transfers under agreed terms to achieve specific project goals
- **Technical co-operation**, i.e. skills transfer, secondments and similar expert assistance for specific projects/purposes
- **Concessional loans**, i.e. loans on terms more favourable than those available commercially
- **Official assistance to the private sector**, i.e. credit and similar guarantees that are mainly organised through the Department of Trade & Industry.

However, this study excludes official assistance to the private sector.

[2] It is acknowledged that the exclusion of donor NGOs in a study of this nature is a major disadvantage. However, no readily available and accessible database for ODA from NGOs exist and it was not possible to create such a database within the scope and timeframe of this study.

Health, also NGOs that are active in the health field, relevant parastatals, as well as the interface between the public and private health sectors.

- **Sector-Wide Approach to ODA**

A **Sector-Wide Approach** towards ODA is described by Cassels (1997:ix) as " … a medium-term collaborative programme of work [between donors and recipients] concerned with the development of sectoral policies and strategies; projections of resource availability and expenditure plans; the establishment of management systems by government *and* donors, to facilitate the phased introduction of common management arrangements; and institutional reform and capacity building, in line with agreed policies. In addition, structures and processes need to be established for negotiating strategic and management issues, and reviewing sectoral performance against jointly agreed milestones and targets". ODA is provided in the form of budget support, and the donor cedes attribution in favour of influence in the processes of policy development and performance evaluation.

- **Project-Based Approach to ODA**

A Sector-Wide Approach is contrasted to a **Project-Based Approach towards ODA.** This (a project-based approach) can be defined as the targeting of ODA towards planned initiatives designed to achieve specific objectives within a given period of time. ODA is linked to a specific project, which gives the donor a clear sense of attribution, while retaining control over the processes of project monitoring and evaluation.

1.4 METHODOLOGY

The strategy that was followed for purposes of the DCR health sector study comprised of a number of well-considered, methodologically justifiable operational choices and their subsequent implementation.

Firstly, the study entailed the collection and analysis of information on the nature and flow of ODA according to, *inter alia* country of origin, donor organisation, type, value, target areas, etc. This part of the study also entailed an overview and attempted reconstruction of extant policy and institutional arrangements pertaining to ODA in the SA health sector. Generally, the quality of data and information available on these aspects of ODA in the SA health sector leaves much to be desired in terms of completeness, consistency and realibility.

Secondly, and with a view to obtaining in-depth, field-related and first-hand insight into ODA, a large number of stakeholders in government (national and provincial), donor organisations and NGOs in the health field were interviewed. As to government, interviews were conducted with relevant stakeholders/respondents in the National Departments of Health and Finance, as well as in the Departments of Health and Finance of five selected provinces. In the selection of provinces, the following criteria applied:

- Level and extent of donor activity (flow of ODA)
- Profiles of need and priority, including needs and priorities deriving form burdens of disease, risk, inequity and poverty, as well as geographical, socio-economic and political conditions
- Status of health services (provision, organisation, management)
- Sufficiency of provincial MTEF in meeting strategic health priorities

Based on these criteria, a selection of "favourable case scenarios" and "less favourable case scenarios" was made. It was reasoned that the differences between

provinces that are major recipients/beneficiaries of ODA and those that receive/benefit comparatively less from ODA are significant in itself within the context of this study, and may have important implications for ODA in the future. The provinces that were eventually selected are the following:

- Free State (that was included in compliance with the requirements of the funder of the DCR health sector study)
- Gauteng
- Kwa Zulu-Natal
- Northern Province
- Eastern Cape

Interviews with respondents covered a variety of ODA-related topics, including existing policy and institutional arrangements (or the lack thereof); past experiences of ODA; the co-ordination of ODA and suggestions to optimise such co-ordination; prevailing needs and priorities in the health sector; appropriate targets for ODA in the health sector, with specific reference to a particular province/programme/experience; current mechanisms for prioritising needs and areas for ODA; perspectives and preferences on the use and impact of ODA; trends and directions in the flow of ODA; ideas about the redirection of ODA and enhancing its impact; success and failure in ODA initiatives; problems, deficiencies, constraints and frustrations relating to ODA, etc. In many respects, this process of first-hand data collection also served to clarify and validate observations and conclusions based on broader *a priori* analyses of data obtained from secondary sources.

The data collection process involving stakeholders eventually materialised as follows:

RESPONDENT	DATE (2000)	RESPONDENTS INTERVIEWED
National Dept of Health	27 - 30 March 27 March	Dr Gopolang Sekobe (Chief Director: Environmental and Occupational Health) Ms Gail Andrews (Director: Women's Health & Human Genetics) Mr Gerrit Muller (Director: Finances)and mr Andre Venter Mss Cynthia Mgijima (Acting Director: Nutrition) and Dianne Kloka, Bennie Sekakane, Anne Bear & Maudie de Hoop (Assistant directors: Nutrition) Dr Ray Mabope (Chief Director: Special Projects) Ms Tsakani Mnisi, ms Winnie Moleko and mr Kgomotso Mogale (Deputy Directors: Policy & Donor Coordination)
Gauteng Dept of Health	30 – 31 March	Dr Rafik Bismilla (Chief Director: DHS) Ms Dawn Joseph (Chief Director: Human Resources) Mr Gert Cromhout (Acting Director: Finance) Ms Mary-Grace Msimango (Director: Professional Services) Dr Caroll Marshall (Chief Director: Strategic Development) Dr Ahmed Valli (Director: Hospital services)
Northern Province Dept of Health	31 March	Mr Sam Mathikhi (Human Resource Development) Dr John McCutcheon (Health Care Support Services) Dr Mathumi Masipa (Primary Health Care) Ms Elizabeth Malumani (Information Management) Ms Rose Mazibuko (District & Primary Health Care) Mr Professor Moshanu (Finances)
KwaZulu-Natal Dept of Health	6 - 7 April	Dr Olaf Baloyi (Deputy Director-General) Ms Ruth Kitching (Finances)
Eastern Cape Dept of Health	13 April	Ms Vidah Mayana (HIV/Aids Unit) Ms Marlene Poolman (Communicable Diseases) Ms Joyce Matebese (Acting Chief Director: District Health Services) Mr Danie Voster (Acting Director: Finances) Ms Maudline Tembani (Planning & Information)
Free State Dept of Health	20 April	Mss Elize Malan (Director: Finances) Andrea Crouse (Programme Manager, Irish Aid Clinic Building Programme) Priscilla Moshebi (Human Resources)

		mr Leon Joubert (Budget Office)
IDC	14 April	Alex Saeleart
JICA	28 March	Group interview with: Mr Toshiyuki Nakamura (Deputy Resident Representative) and Ms Kazumi Larhed (Project Formulation Advisor)
USAID	29 March	Ms Anita Sampson (Project Specialise: Equity Project)
DfID	30 March	Anna DeCleene
European Union	6 April	Roberto Rensi
Health Systems Trust	6 April	David Mametja
Equity Project (Management Sciences for Health)	12 April 13 April	Dr Thobile Mbengashe (Director: Equity Project) and Ms Ileana Fajaro (Deputy Director: Equity Project) Individual interviews with Dr Yogan Pillay Mr Alan Vos / Foss
MRC (Durban)	5 April	Prof SS Karim

The results of these analyses and investigations were presented as the preliminary findings and recommendations for the strategic management of ODA in the SA public health sector at a stakeholder workshop that was held in Pretoria on 5 May 2000[3]. The workshop, facilitated by ms Annalize Fourie, prof Dingie van Rensburg and mr Christo Heunis (all from the Centre for Health Systems Research & Development and DCR Health Sector Team) and arranged with support from CWCI, was attended by:

NAME	POSITION	ORGANISATION REPRESENTED
Mr Rajan Soni	MD: IOD-SA	DCR Project Team
Ms Winnie Moleko	Deputy Director: Policy & Donor Co-ordination	National DoH
Mr Kgomotso Mogale	Deputy Director: Policy & Donor Co-ordination	National DoH
Ms Rhea Schoeman	Representative	Mpumalanga DoH
Mr G Sithole	State Accountant	Mpumalanga DoH
Dr Watson Shilomane	Representative	Northern Province DoH
Dr Ronald Chapman	Director: Primary Health Care	Free State DoH
Dr Ahmed Valli	Director: Hospital Services	Gauteng DoH
Dr Olaf Baloyi	Deputy Director-General	Kwa-Zulu DoH
Ms Nosicelo Mbele	Directorate: Health Information, Evaluation & Research	Northern Province DoH
Ms Tina Martins	Deputy Director: Quality Assurance	Mpumalanga DoH
Mr Dean Mhlongo	Deputy Director: Administration	Mpumalanga DoH
Dr S Stamper	Permanent Secretary	Eastern Cape DoH
Mr Sydney Mafu	Assistant Director: Policy Planning	Eastern Cape DoH
Mr Roberto Rensi	Head of Health	European Union
Ms Anita Sampson	Project Specialist: Equity Project	USAID
Dr Thobile Mbengashe	Director	EQUITY Project, Eastern Cape
Mr David Mametja	Director	Health Systems Trust

Invitations to the workshop were originally extended to the following people, who either apologised or were represented: Dr R Mgijima (Gauteng DoH), Prof C Household (Free State DoH), Mr LDF Thobejane (Northern Province DoH), Dr MB Kistnasamy (Northern Cape DoH), Dr Hugh Gosnell (North

[3] The programme of the workshop is attached as appendix 1.

West DoH), Dr G Karim (Mpumalanga DoH), Dr T Sucliffe (Western Cape DoH), Mr F Booysen (Dept of Economics, UFS), Mr Ray Mabope (Special Projects, National DoH), Mr Pat Masobe (Health Financing and Economics, National DoH), Ms Catherine Makwakwa (International Health Liaison, National DoH), Ms Tsakanai Mnisi (Policy & Donor Co-ordination, National DoH), Dr Tim Wilson (Hospital Services and Management, National DoH), Ms Mmathari Matsau (Health Information, Evaluation and Research, National DoH), Dr Nono Semelela (HIV/AIDS/STDs, National DoH), Mr Gerrit Muller (Financial Management, National DoH), Dr Ayanda Ntsaluba (Director-General, National DoH), Dr Tony Mbewu (Medical Research Council), Mr Toshiyuki Nakamura (JICA), Julian Lambert (DfID), ms Theresa McDonell (Embassy of Ireland), Steve Topham (IOD-SA) and Gary Moonsamy (IOD-SA).

It was expected that ODA and the ODA process in the SA health sector could benefit from open deliberations and mutual sharing of experiences and ideas among a variety of stakeholders at a workshop of this nature. The workshop, which constituted an integrating component of the methodology, was therefore held with a view to:

- presenting and sharing the preliminary findings of the study to a representative group of stakeholders in ODA in the SA health sector
- verifying and validating the preliminary findings
- obtaining collective inputs and comments on the preliminary findings from stakeholders
- reviewing the findings of the study in the light of the inputs obtained during the workshop.

The workshop indeed contributed towards an enhanced understanding and appreciation of the problems of and impediments to ODA in the SA health sector. Also, common understanding was established among stakeholders regarding possible interventions towards solving problems and overcoming obstacles that impact negatively on ODA in the SA health sector. Generally speaking, the workshop inputs proved invaluable for purposes of reviewing and "maturing" the preliminary findings of the study. Throughout, proceedings were characterised by a high level of discussion that can be ascribed to an apparent commitment to the purpose and objectives of the workshop on the part of participants and a sincere desire among stakeholders to enhance the ODA process in the SA health sector.

In an area as politically sensitive as ODA in the SA health sector, it was important to consult widely and verify information often and continuously. It is the opinion of the consultants that the methodology made sufficient provision for this. The comprehensive scope of the study also required wide consultation with a view to covering as inclusive and representative a variety of stakeholders as possible. Also in this regard the methodology proved adequate.

CHAPTER 2 ODA IN THE SA HEALTH SECTOR

This section entails an attempt at reconstructing and analysing the flow of ODA in the SA health sector. It is based on information obtained from the following sources:

- a survey conducted mainly among donors by the DCR II study data collection team
- records kept by the Directorate: International Health Liaison in the National Department of Health
- records kept by donors

Reconstructing the flow of ODA in the SA health sector proved to be a major challenge. In addition to difficulties experienced in accessing available information, the following factors complicated the effort of systematising and analysing it:

- **Inadequate record-keeping and information**

Information obtained from all three the above-mentioned sources was in many respects incomplete and inaccurate. In addition, information is recorded and kept in non-standardised formats, rendering a conclusive reconstruction of the allocation and distribution of ODA in the SA health sector impossible.

The following appear to be the main deficiencies of existing databases and record-keeping practices on ODA in the SA health sector which significantly complicated the reconstruction of its allocation and distribution:

- Data is incomplete
- Data is captured in non-standardised format
- Programme/project descriptions are either absent or too scanty to enable conclusive categorisation of ODA according to target areas
- Non-standardised and inconsistent currency conversion rates are used
- Information on the further devolution of funds (from national to provincial levels and NGOs) is insufficient
- The status of programmes/projects is unknown
- Periods over which actual disbursements take place are not specified
- Efforts aimed at verifying data and obtaining further information were complicated because implementing agencies and beneficiaries are not identified, and particulars of contact persons for various projects/programmes/initiatives are not recorded
- The type of ODA is not specified
- Official names of programmes/projects are not indicated
- Differences in the understanding and application of concepts such as *sector-wide approach* and *project-based approach* complicates the categorisation of ODA
- Discrepancies between funds committed, funds disbursed and actual expenditure to date are inexplicable
- Records are not updated frequently enough

These deficiencies have multiple causes. Essentially, they appear to emanate from lack of effective co-ordination and standardisation of record-keeping as part of the ODA process. Donors, government departments, parastatals and NGOs all require different information pertaining to ODA and apply different record-keeping and reporting mechanisms, procedures and formats. It is believed that greater co-ordination and standardisation would allow all stakeholders to engage more meaningfully with the ODA process in the SA health sector. This should result in more effective targeting and efficient application of ODA in the SA health sector, and place them in a better position to monitor and evaluate its impact. This is but one

dimension of the ODA process in the SA health sector that national health authorities have to assume greater responsibility and leadership for.

- **Currency conversion rates**

In reconstructing the flow of ODA to the SA health sector, currency conversions contribute to major confusion. For example, amounts forthcoming from the DCR II master set had already been converted to SA Rand, while those obtained from the Directorate: International Health Liaison and directly from donors had to be converted from foreign currencies to SA Rand. For these conversions, average exchange rates as contained in the SARB of March 2000 were used. These rated fluctuated significantly during the period 1994-99 as a result of the opening up of the SA economy and other reasons such as the Asiatic crisis. It would have been misleading to have simply based conversions on an average exchange rate for the entire period since the standard deviations would have been too large. The rates eventually used for conversions, indicated as SA cent per British Pound and SA cent per US Dollar respectively, are as follows:

Year	SA cent : 1 British Pound	SA cent : 1 US Dollar
1994	543.74	354.97
1995	572.43	362.70
1996	671.96	429.64
1997	754.84	460.73
1998	916.33	553.16
1999	989.21	611.31

2.1 ALLOCATION AND DISTRIBUTION OF ODA IN THE SA HEALTH SECTOR

With these difficulties and limitations in mind, an attempt at reconstructing the allocation and distribution of ODA according to donor (origin), primary recipient and purpose (target area) in the SA health sector was made. The result is not as illustrative of the situation it is supposed to portray as it is of the severe shortcomings and deficiencies of information on ODA in the SA health sector – a problem to which inadequate systems and practices on the part of both donors and recipients contribute. Caution has therefore to be taken when inferences and conclusions are made from such incomplete and generally inadequate data records, and mainly for the following reasons:

- Available data do not in all instances clearly indicate the further distribution and allocation of ODA from a national level downwards. Provinces undoubtedly benefit selectively from ODA that filters down from the national level, but available data do not allow the tracking or estimation of the value of such support.
- The themes, programmes and projects that ultimately receive ODA are generally very vaguely described. This hardly warrants conclusions on the thematic targeting and allocation of ODA, which is very unsatisfactory.
- While NGOs and CBOs are required to "declare" ODA received to the national Department of Health for record-keeping purposes, there is no system in place to formalise and give effect to this requirement. Therefore, available data do not allow the reconstruction of the flow of ODA to provinces through NGOs and CBOs.
- Due to poor record-keeping systems and practices, it is possible that major ODA-supported initiatives are not reflected in available data at all.
- The study did not allow for the reconstruction of ODA channelled to the SA health sector *via* private foundations and trusts.

Where available, project names, aims and descriptions were used to classify ODA in the following table. The different categories represent the main focus area of a project/programme/initiative that could be distinguished. Note that the categorisation is based on information emanating from available records. It was not a matter of slotting/forcing projects/programmes/initiatives into pre-determined categories. It was evident that several of these projects/programmes/initiatives involve a number of cross-cutting issues. However, project names, aims and descriptions in available records are generally too vague and inadequate to justify an attempt at disentangling these cross-cutting themes. The result would have been highly misleading. Based on available information[4], the following picture of the allocation and distribution of ODA in the SA health sector according to health target areas emerged:

[4] The original, consolidated records from which these tables were compiled are contained in Appendix 3

TABLE 1: ALLOCATION AND DISTRIBUTION OF ODA IN THE SA HEALTH SECTOR ACCORDING TO HEALTH TARGET AREA[5] (R million[6])

TARGET AREA ▶ / DONOR ▼	PHC & District Develop-ment	Human resource & management capacity development	HIV/AIDS & STDs	Capital investment: Equipment	Community-based care	Reproductive health & Family planning	Women & Children's health	National health sector reconstruction & reform	Provision of doctors	Organisational & Systems development	TB
1. EU	32.9	142.2[7]	43.9		60.7			2.5	4.7		
2. USAID	196.1										
3. DfID	30.6	25.8	37.0			47.9		10.9			5.5
4. Japan				66.1							
5. Italy	13.6						5.36			9.5	
6. Belgium		2.7	3.9					16.0			3.5
7. UNICEF							24.6				
8. Finland											
9. UNDP			1.2						7.2		
10. Sweden			5.7								
11. The Netherlands											
12. Norway			2.35							2.02	
13. Flanders	0.01	0.13				0.18					
14. Ireland		0.15	0.17	0.01	1.5						
15. Australia		1.5				0.76					
16. UNFPA						1.46					
17. Canada		0.06	0.1								
18. Austria		0.01									
TOTAL	**273.2**	**172.6**	**94.4**	**66.1**	**62.2**	**50.4**	**30.0**	**29.4**	**11.9**	**11.5**	**9.0**

[5] Amounts refer to the **total** committed by a funder for various projects/programmes/initiatives related to a particular target area.
[6] All amounts are those **committed** by donors for specific projects/programmes/initiatives, and **not** amounts that have actually been disbursed to date. Conversions are based on rates specified on p. 11 of this report.
[7] An unspecified part of this amount was earmarked for facility rehabilitation and construction.

TABLE 1 (continued) : ALLOCATION AND DISTRIBUTION OF ODA IN THE SA HEALTH SECTOR ACCORDING TO HEALTH TARGET AREA

TARGET AREA ▶ / DONOR ▼	Parasite control	Infrastructure development (mainly transport)	TOP	Care & support of the handi-capped	Construction and rehabilitation of facilities	Care of terminally ill	Health education	Pharm. research	Target area not distinguish-able	**TOTAL**
1. EU										**286.9**
2. USAID										**196.1**
3. DfID		6.8	7.8	4.0						**176.3**
4. Japan										**66.1**
5. Italy										**28.7**
6. Belgium		1.5		0.12						**27.7**
7. UNICEF										**24.6**
8. Finland	8.8									**8.8**
9. UNDP										**8.4**
10. Sweden										**5.7**
11. The Netherlands					1.2				3.4	**4.6**
12. Norway										**4.4**
13. Flanders				0.34					2. 62	**3.3**
14. Ireland				0.27	0.9	0.29				**3.3**
15. Australia							0.28			**2.5**
16. UNFPA										**1.5**
17. Canada								0.11		**0.27**
18. Austria										**0.01**
TOTAL	**8.8**	**8.3**	**7.8**	**4.7**	**2.1**	**0.29**	**0.28**	**0.1**	**6.02**	**848.65**

Conclusions: Table 1

It has to be reiterated that the categorisation of ODA according to health target areas as presented in Table 1 is based on project descriptions that are not always very comprehensive and clear. Also, in many instances ODA is targeted at a variety of areas that are not always distinguishable. The data in Table 1 is therefore not claimed to be fully accurate, mainly because the final categorisation of ODA presented here is the result of the interpretation or of a deduction from very sketchy data. However, it is the conviction that the breakdown of ODA data in this manner is fundamental to a study of this nature, while it would also prove invaluable for various stakeholders when it comes to planning and co-ordinating ODA. Even if the analysis presented here is not very accurate, it will have served an important purpose if stakeholders realise what they stand to benefit form keeping records that will allow more accurate analyses of this nature.

On this cautionary note, the data in Table 1 points to the following:

- An aggregation of all the ODA from various donors suggest that the total value of ODA to the SA health sector for the period 1994 to 1999 amounts approximately R850 million. This excludes ODA received from various private trusts and foundations which, by all indications, contribute substantially towards the health and medical sectors in South Africa.
- It appears that Primary Health Care and the concomitant establishment of the District Health System, as well as human resource and management capacity development, HIV/AIDS and capital investment in health care equipment particularly, are the target areas benefiting most from ODA. This is largely attributable to the concentration of larger donors (EU, DfID and USAID) on these areas. For example, all ODA from USAID can be categorised under Primary Heath Care and District Development.
- If ODA allocated to the care and support of the handicapped and terminally ill is added to ODA allocated for Community-Based Care, the latter also constitutes a major target area for ODA.
- Note that ODA for capital investment in equipment ranks among the top target areas because of a single large investment of R66.1 million from a single donor (Japan).
- Of the larger donors, the EU apparently prefers to allocate relatively substantial proportions of ODA to a few selected target areas. On the other hand, DfID allocates relatively smaller proportions of ODA to a wider selection of target areas.
- Apparently the smaller donors typically focus on one or two target areas only. The exception is Ireland, which targets seven areas for smaller allocations.

TABLE 2: ALLOCATION AND DISTRIBUTION OF ODA IN THE SA HEALTH SECTOR ACCORDING TO PRINCIPAL RECIPIENT[8] (R million)

RECIPIENT ▶ / DONOR ▼	National DoH	Provincial Departments of Health									NGOs, Parastatals & Civil Society	Principal recipient not identifiable
		Western Cape	Gauteng	Eastern Cape	Northern Cape	Northern Province	North West	Mpuma-langa	Free State	KwaZulu-Natal		
1. EU	166.3										120.7[9]	
2. USAID											196.1[10]	
3. DfID[11]	101.7		4.8		12.9[12,13]	12.4	12.9			1.6	30.4[14]	
4. Japan	66.1											
5. Italy	19		9.5									4.36
6. Belgium	27.7										0.12	
7. UNICEF											12.6	7.32
8. Finland								5.3		3.5		
9. UNDP	1.2					7.2						
10. Sweden											5.7	
11. The Netherlands			1.2									3.4
12. Norway	4.35											

[8] Available information enables the identification of principal recipients. This refers to the recipient to whom the donor allocates ODA directly and with whom it enters into agreement with. In many instances, the principal recipient serves as an administrator of ODA only and in that capacity distributes it to secondary recipients which then utilises it for a particular purpose. In most cases, available records do not allow the identification of these secondary recipients. In the above table, principal recipients are in many instances also the principal beneficiaries of ODA, i.e. the ODA it receives is used mainly for the benefit of the recipient. Those cases in which the principal recipient devolves ODA to secondary recipients and beneficiaries are mostly not distinguishable.

[9] North West was one province that could be distinguished as a beneficiary of this ODA

[10] Eastern Cape is the principal beneficiary of this ODA. Through the so-called Equity-project that is being implemented in the Eastern Cape with ODA from USAID, a very close relationship has been established between the donor, the implementing agent of the Equity Project (Management Sciences for Health) and the Eastern Cape Department of Health.

[11] Many initiatives that DfID is currently supporting through NGOs are to be transferred to official programmes in the Department of Health in due course. The management of the associated resources will therefore become the responsibility of the Department of Health. One project was taken from the National Department of Health to the CSIR because the National Department of Health could not guarantee payment of the running costs associated with the project.

[12] DfID committed a total of R21 762 620 for provincial reproductive health in three provinces, i.e. Northern Cape, North West and Northern Province. The records do not indicate how the amount was divided among the three provinces. For purposes of this analysis, the amount was divided equally and resulted in an amount of R7.3 million being added to each of these provinces' ODA from DfID.

[13] DfID committed a total of R6 414 310 for PHC services in targeted communities in four provinces, i.e. Northern Cape, North West, Northern Province and KwaZulu-Natal. The records do not indicate how the amount was divided among the four provinces. For purposes of this analysis, the amount was divided equally and resulted in an amount of R1.6 million being added to each of these provinces' ODA from DfID.

[14] Free State was one province that could be distinguished as a beneficiary of this ODA

TABLE 2 (continued): ALLOCATION AND DISTRIBUTION OF ODA IN THE SA HEALTH SECTOR ACCORDING TO PRINCIPAL RECIPIENT (R million)

RECIPIENT ▶ / DONOR ▼	National DoH	Provincial Departments of Health									NGOs, Parastatals & Civil Society	Principal recipient not identifiable
		Western Cape	Gauteng	Eastern Cape	Northern Cape	Northern Province	North West	Mpuma-langa	Free State	KwaZulu-Natal		
13. Flanders	0.35										10.9[15]	
14. Ireland									0.53		2.8	
15. Australia	2.5											
16. UNFPA											1.5 [16]	
17. Canada											0.27	
18. Austria											0.01	
TOTAL	**389.2**	**-**	**15.5**	**-**	**12.9**	**19.6**	**12.9**	**5.3**	**0.53**	**5.1**	**381.1**	**15.08**

[15] Free State, Gauteng and Western Cape were among the provinces that could be distinguished as beneficiaries of this ODA
[16] Northern Province, Northern Cape, North West, Gauteng and Mpumalanga were among the provinces that could be identified as beneficiaries of this ODA.

Conclusions: Table 2

- According to the data presented in Table 2, it appears as though the National Department of Health is the principal recipient of the largest proportion of ODA in the SA health sector. However, this does not imply that the National Department of Health is the main beneficiary of ODA. It has to be emphasised that a large proportion of this ODA is eventually devolved to provincial departments of health and to NGOs, as will become apparent in Table 3.
- It is meaningful to notice that the National Department of Health is followed closely by NGOs as principal recipients of ODA. Prior to 1994, ODA for the SA health sector was allocated almost exclusively to NGOs. There could be various explanations for the apparent continuation of this trend, one of which could be donors' perceptions of unsatisfactory management and ownership of ODA on the part of SA public health authorities.
- Different donors apparently follow distinct approaches in the allocation of ODA to the SA health sector. Based on which recipient and for which purpose ODA is targeted at, four approaches can be distinguished, namely a national-sectoral approach, a provincial-sectoral approach, a programme approach and an "NGO-approach". In broad terms, the differences between these approaches are as follows:
  - The approach adopted by the EU can be referred to as a **national-sectoral** approach. Here, the emphasis is on supporting macro-processes and the transformation of the health sector at large. Support is directed towards processes and structures at a national level rather than at a provincial level. (Although ODA from the EU is allocated principally along these lines, it has also supported programmes at a provincial level in the Western Cape, North West, KwaZulu-Natal, Mpumalanga and Northern Province.)
  - The second approach, which can be termed **provincial-sectoral**, typifies the approach adopted by USAID. This donor provides wide-ranged support to health-related processes and structures in a particular province. The so-called Equity Project in the Eastern Cape is an example of this approach.
  - The third approach, which is notably adopted by DfID, is the programme approach. Here, a range of projects related to a particular field/theme in health care are supported. Examples of such fields/themes include reproductive health, HIV/AIDS, policy development and capacity development.
  - The fourth approach entails the targeting of ODA to **NGOs** rather than to government health services. UNFPA is an example of a donor that supports a larger NGO (PPASA), while Ireland supports smaller and more localised NGOs and CBOs. Of course, these approaches are not mutually exclusive, with different donors often adopting a variety or combination of approaches. Smaller donors appear to prefer entering into ODA agreements with NGOs. However, some also have agreements with the National Department of Health and with individual provinces.
- According to available information, the only two provinces that do not have direct ODA agreements with donors are the Western Cape and Eastern Cape. However, the Eastern Cape is known to be a major recipient of ODA from USAID channelled to this province via an NGO. Poor record-keeping and the fact that the Western Cape was not samples for first-hand data collection in this study could explain why this province is apparently not a primary recipient of any ODA. It is highly unlikely that this is in fact the case.
- The province apparently benefiting most from direct ODA agreements with donors is Northern Province, followed by Gauteng. The Free State apparently has only one direct ODA agreement (with Ireland) to the value of R0.53 million.

TABLE 3: GEOGRAPHICAL DISTRIBUTION OF ODA IN THE SA HEALTH SECTOR (R million)

AREA ▶ / DONOR ▼	National DoH[17]	Province[18]									Health services nationally through NGOs and parastatals[19]	Secondary recipient not identifiable
		Western Cape	Gauteng	Eastern Cape	Northern Cape	Northern Province	North West	Mpuma-langa	Free State	KwaZulu-Natal		
1. EU	194.4	60.7				1.6[20]	26.4	1.6		1.6		
2. USAID				196.3								
3. DfID	17.7	4	4.8		12.9[21]	12.4	12.9		4.8	1.6	99.7	
4. Japan		6.5[22]	6.5	6.5	6.5	6.5	6.5	6.5	6.5	6.5		7.7
5. Italy			9.5							13.6	5.4	4.4
6. Belgium	16										11.7	
7. UNICEF											11.3	7.3
8. Finland								3.5		5.3		
9. UNDP						7.2					1.2	
10. Sweden											5.7	
11. The Netherlands			1.2									3.4
12. Norway	2										2.4	
13. Flanders	0.35	0.01	0.19			0.17					1.36	

[17] In this analysis, the National Department of Health does not represent a geographical area. According to available information, the ODA listed here was not devolved further, but was used mainly for projects and programmes within the Department itself and for its benefit. However, a real appreciation and realistic conception of the geographical distribution of ODA in the SA health sector would not have been possible had this been omitted.

[18] In this analysis, the provinces represent specific geographical areas. The ODA listed under a specific province include ODA that the province receives directly form donors, as well as ODA allocated to it *via* the National Department of Health and/or *via* NGOs.

[19] These refer to cases where NGOs are the primary recipients of ODA and the programme/project for which the ODA is/was allocated is identified. However, available information does not allow the identification of a particular geographical area to which it was allocated. In most instances, ODA in this category was allocated for NGOs that run national programmes/projects. These vary from *i.a.* rehabilitation and construction of health care facilities, human resource and management capacity development, policy development and implementation, health care programmes and initiatives aimed at specific groups such as mothers and their children, the youth, the handicapped, etc., and national health care programmes such as reproductive health, PHC, HIV/AIDS and district development.

[20] An amount of R4.7 million was made available to improve health care in rural areas by placing European medical doctors in hospitals in underserved areas of three provinces, i.e. Northern Province, Mpumalanga and KwaZulu-Natal. No indication of the division of the total amount between the provinces is given. For purposes of this analysis, the total was divided equally between the provinces.

[21] An amount of R 21.8 million was made available to improve reproductive health services for adolescents and the youth in the poorest communities in three provinces, i.e. Northern Province, Northern Cape and North West. No indication of the division of the total amount between the provinces is given. For purposes of this analysis, the total was divided equally between the provinces. It came to R7.3 million per province.

[22] Although the exact division of a total grant of R58.4 million among the nine provinces is not known, it was divided equally for purposes of this analysis. Note that the total amount was received by the National Department of Health, from where it is known to have been divided among all nine provinces for purchasing medical equipment for hospitals.

TABLE 3 (continued): GEOGRAPHICAL DISTRIBUTION OF ODA IN THE SA HEALTH SECTOR (R million)

AREA ▶ / DONOR ▼	National DoH	Province									Health services nationally through NGOs and parastatals	Secondary recipient not identifiable
		Western Cape	Gauteng	Eastern Cape	Northern Cape	Northern Province	North West	Mpuma-langa	Free State	KwaZulu-Natal		
14. Ireland		0.4	0.3		0.08	0.09	0.4	0.14	1.3	0.13		0.4
15. Australia	1.5										1.1	
16. UNFPA			0.02		0.2	0.042	0.2	0.02			1.05	
17. Canada											0.1	
18. Austria											0.01	
TOTAL	**232**	**71.6**	**22.5**	**202.8**	**19.7**	**28.0**	**46.4**	**11.8**	**12.6**	**28.7**	**141.02**	**23.2**

Conclusions: Table 3

- As far as the geographical distribution of ODA in the SA public health sector is concerned – and this provides perhaps the most meaningful indication of who the eventual beneficiaries of ODA are – the following can be observed:
- Of the R398.2 million allocated directly to the National Department of Health, the largest proportion appears to be used for project at a national level and thus for the benefit of the National Department of Health. Apparently R157.2 million of this ODA eventually flow to provinces and NGOs.
- Of the provinces, the Eastern Cape is the recipient of the most substantial ODA. This can be attributed to an agreement to the value of R196.3 million involving this province, an Eastern Cape-based American NGO and USAID.
- NGOs and parastatals providing services that have a national focus or that do not have a specific geographical focus receive ODA to the value of R141.02 million. It is not clear what impact such a relatively small proportion of ODA could have on projects/programmes/initiatives with a large – even national – geographical focus.
- Although the Western Cape does apparently not benefit from direct ODA agreements with donors (cf. Table 2), many NGOS that receive ODA are active in this province. This changes the position of the Western Cape compared to other provinces dramatically as far as ODA is concerned. After the Eastern Cape, the Western Cape then becomes the second largest provincial beneficiary of ODA.
- Of all the provinces, the Free State and Mpumalanga are apparently the smallest beneficiaries of ODA.

CHAPTER 3 ALIGNMENT BETWEEN ODA AND SA HEALTH AND HEALTH CARE NEEDS/PRIORITIES, 1994 – 1999

During the past decade, ODA in the SA health sector witnessed commendable achievements and successes. However, it also has to be recognised that much of the initial preparation and thrust for transformation in the health system prior to 1994, as well as the development of subsequent blueprints for reform, were supported and facilitated substantially by generous ODA channelled mainly to the then banned ANC and NGOs sympathetic to its cause (cf. Deloitte & Touche, 1994:14). Since 1994, a significant proportion of ODA continued to be allocated to NGOs. This raises questions about the perceived effectiveness and efficiency of the Department of Health's management and co-ordination of ODA. Furthermore, while some donors have engaged in longer-term commitments and agreements with the Department of Health and are supporting larger programmes in one or more identified priority aspects and areas of need, other donors are largely project-based in their approach towards ODA in the health sector. This complicates the co-ordination and alignment, as well as attempts at assessing the impact of ODA on the performance of the health sector at large.

3.1 Needs and priorities: Transformation of health services

In order to assess the alignment between ODA and South African health needs and priorities for the period 1994 to 1999, a clear understanding of those needs and priorities is required. These needs and priorities are mainly articulated in health policies and legislation, as well as in policies and legislation that have an impact on the health sector. The health care needs and priorities of the population are reflected in demographic and epidemiological profiles, as well as in the status of health services available to the population. The following summary admittedly represents a largely over-simplified view of South Africa's health and health care needs and priorities for the period 1994 to 1999. However, the purpose of this summary is not to provide a comprehensive overview of these needs and priorities, but to identify indicators of the most critical needs and priorities from available documents and records with a view to comparing these with the areas and themes ODA was targeted at during this period.

National health priorities are articulated mainly in constitutional and legal reforms which have provided the framework for the transformation of the South African health care system since 1994. In fact, the transformation of the SA health care system as such constituted perhaps the main priority during the period concerned. The main themes around which the transformation of the SA health care system revolved are the following:

Unifying fragmented health structures

In the previous dispensation health care was fragmented to the extreme along geographical, structural, racial, as well as authority lines. The public health sector consisted of 14 health authority structures - 1 national ("white" South Africa), 10 homeland (per ethnic group) and 3 own affairs (based on race) ministries. A major priority of the new government is the dismantling of this fragmentation by unifying the segregated and divided structures. Health had to be consolidated under a single national ministry supposed to oversee, support and co-ordinate the entire health system of the country. The nine newly established provincial governments (PHAs) embody a "federal-like" decentralised system, with more powers entrusted unto the

provinces than before. In turn, these PHAs had now to develop, co-ordinate and support the emerging district health authorities (DHAs). The implementation of the District Health System as vehicle for the shift in emphasis towards PHC and for bringing about equity in the provision and accessibility of health services, represented a major challenge for health authorities during the period 1994 –1999. The *White Paper on Local Government* (1998) introduced an entirely new phase in the restructuring of health, intending to shift the responsibility for PHC increasingly onto local authorities and communities. In turn, this implies that the current still fragmented provincial and municipal authority and service structures are to be integrated into consolidated district structures underscored by co-operative government structures.

Dismantling apartheid in health

The implementation of laws and measures aimed at dismantling apartheid structures and practices and revoking racially discriminatory laws and regulations in the public health sector constituted and still constitute major priorities. As part of such a de-racialising process, stern employment equity measures which pertinently encompass a striking Africanisation of the public health system and a pronounced sensitivity for gender to ensure equity in representation, were introduced. The almost "all-white" and "all-male" top management structures (prior to 1994, whites accounted for 90,2% of management staff at national head office, while 87,8% of all managers were male) had to be systematically revised to reflect the race and gender composition of the population more accurately (Mametja & Reid 1996).

Rectifying distributive disparities in health provision

One of the main priorities in the public health sector during 1994 to 1999 was the redressing of pronounced discrepancies and inequalities in the apportionment and distribution of health resources that have been entrenched over centuries. These inequities and inequalities manifested notably in the favouring of white, urban populations as far as the distribution and allocation of health care resources were concerned. Reforms aimed at redressing these inequities include, i.a. large-scale resource reallocations and the redeployment of available resources to smooth out gross geographical and racial disparities, as well as the implementation of a health care referral system aimed at equalising and regulating access to and utilisation of health services. The implementation of a referral system in the public health sector was also aimed at effectuating the ***shift in emphasis towards Primary Health Care.***

Developing human resources to accommodate new priorities and needs

The post-1994 era was a period of unprecedented training and development of HR in the public health sector, especially the preparation of new cadres of managers (many inexperienced or with limited exposure in state bureaucracies), mainly necessitated by the transformation of the public sector at large, The shift towards PHC and DHS confronted health managers and heath providers with entirely novel demands for which they had to be prepared and trained. Therefore, human resource and management capacity development and training constituted a main priority for health authorities during the period 1994 – 1999.

Democratising labour relations

The Labour Relations Act of 1995 introduced an era of major achievements in the health sphere. Implementing and facilitating the changes that this implied for the management of labour relations in the workplace constituted a major challenge for health authorities.

Expanding free health services to deprived and vulnerable groups

A major step towards equity and accessibility in health care, and particularly to remove barriers to access for vulnerable groups, was the introduction and expansion of free health services. Such socialisation of health care stands in sharp contrast to policy under the previous government where the deliberate strengthening and expansion of the private sector in health care was one of the mainstays in health policy.

Involving communities in governance of health

After a protracted history of undemocratic, authoritarian and top-down government - excluding in particular the "non-white" population from decision-making processes - it became one of the prime dictates of the new government to create a people-driven culture and restore democratic involvement. In public health, the focus on participatory health care, i.e. empowering communities to participate actively in planning, prioritising and monitoring health care in their specific areas and to take greater responsibility for their own health, became a main priority (Department of Health, 1996b; 1997a; 1997c; Ministry of Provincial Affairs and Constitutional Development 1998).

In summary, then, as far as the transformation of SA health system is concerned, the main health and health care priorities during the period 1994 to 1999 appear to have been the following:

- The establishment of a comprehensive, integrated national Health System based on health districts.
- The integration of 14 health authority structures into nine new provincial governments, each with its own integrated provincial Department of Health, under central governance of the National Department of Health.
- Effectuating the shift in emphasis towards PHC
- Implementation of employment equity
- Promotion of equity, accessibility and utilisation, especially for the previously disadvantaged and disenfranchised, and specifically for the poor, aged, vulnerable and youth.
- Democratisation of the health services, with a focus on new styles of management and for community involvement in matters pertaining to health and health care.
- Improvement of all aspects of planning and management of health services through astute information management. This implied the need for the development of systems, tools and indicators, as well as the need for training and capacity development in information management.

The need for these changes and initiatives to be effectuated in practice placed a prominent emphasis on institutional and organisational development in the public health sector, as well as on legislative reform and policy formulation at national and provincial levels of government.

3.2 Needs and priorities: Profiles and burdens of disease

The aim of this section is to provide an overview of the challenges facing the South African health sector as seen from demographic, socio-economic and epidemiological perspectives. These issues are fundamentally inter-related. However, in South Africa, peculiar political-historical developments underpin demographic, socio-economic and epidemiological patterns and profiles which find manifestation in major discrepancies and inequities in health and health care among

the different geographical areas and population groups that comprise the South African population. The targeting of priority needs and issues in the provision of health services to the South African population at large was a major challenge for health authorities during the period 1994 to 1999.

In identifying core needs in health and health care it has to be recognised that the health status of the South Africa population is not a function of health care only. The broader natural and man-made environments are the main determinants of the health and health status of the population. Especially the general socio-economic circumstances, as well as living and working conditions of people are as crucial to their health as is the health care they have access to. More particularly, poverty, unemployment, low household income, low levels of literacy, poor housing and sanitation and lack of proper infrastructure leave large proportions of the South African population severely vulnerable to the risk of disease, ill health, injury and disability. At the same time, these conditions also deprive large sections of the population of health care for reasons of inaccessibility and unaffordability. In addition to the mere manifestation of disease, these conditions also have to be taken into account when identifying priority needs in health and health care.

3.3 Needs and priorities relating to the health status of the population

At the onset, it has to be emphasised that the health and health care needs and priorities of different groups and in different areas of South Africa vary considerably. During 1994 to 1999, based on the realisation that varying degrees of urbanisation, varying levels of literacy and varying standards of living find reflection in varying profiles of morbidity and mortality among different geographical areas and population groups in South African, the focus was on redressing inequities that existed in this regard. Demographically speaking, the focus of ODA should therefore have been on the health needs and priorities of the relatively youthful black and coloured populations, large proportions of whom live in rural and deep rural areas of South Africa, since they were most adversely affected by disparities in development and health care provision that arose during the apartheid era. The health and health care needs of these populations revolve mainly around diseases associated with poverty (so-called "social disease profiles"), while accessibility of services in terms of financial cost and distance is a major concern. Therefore, a good indicator of the alignment between ODA and the health and health care needs and priorities of the South African population during the period 1994 to 1999, would be the proportion of ODA allocated to the needs and priorities of these disenfranchised populations during this period[23]. Appropriate alignment would be indicated by a targeting of ODA towards:

- Northern Province and Eastern Cape, since available socio-economic, morbidity and mortality data indicate towards the poor health status of the populations of these provinces compared to other provinces;
- Initiatives and interventions aimed at curbing high child mortality among blacks and coloured people;

[23] The needs and priorities identified here are derived from a comprehensive analysis of relevant data from the following sources:
Health Systems Trust (1998 & 1999); Central Statistical Services (1997 & 1999); Bradshaw (1996, 1997 & 1998); South African Institute of Race Relations (1997 and 1997/98); Department of Health (1998); Budlender (1998); Mokaba & Bambo (1996); Statistics South Africa (1997); Möller (1998); CASE (1995); Marais (1999); Epidemiological Comments (1996/97); Floyd (1997); South African Demographic and Health Survey (1998); Fourie & Steyn (1995); Health Professionals Council for South Africa (1998); South African Nursing Council (1998); PERSAL Establishment Administration (1999); October Household Survey 1995)

- Initiatives and interventions aimed at curbing the high incidence and prevalence of communicable diseases – especially TB - among blacks and, to a lesser extent among coloured people;
- Initiatives and interventions aimed at curbing the increasing incidence and prevalence of Hypertension and Ischaemic Heart Diseases among black women;
- Initiatives and interventions aimed at improving the nutritional status of Black and coloured children;
- Initiatives and interventions aimed at promoting a healthier lifestyle among all South Africans;
- Initiatives and interventions aimed at curbing the HIV/AIDS epidemic in the entire South African population.

3.4 Needs and priorities relating to the distribution and provision of health services

As far as needs and priorities related to the unequal distribution of health resources and services are concerned, appropriate allocation of ODA during the period 1994 to 1999 would be indicated by a targeting of ODA towards:

- Initiatives aimed at alleviating shortages of health care resources among populations living in rural and deep rural areas of South Africa;
- Initiatives aimed at bridging the divide between the public and private health sectors as far as the availability and utilisation of resources and quality of services are concerned;
- Initiatives aimed at alleviating shortages of health care professionals in Northern Province, Eastern Cape and North West;
- Initiatives aimed at alleviating shortages of public hospital beds in Mpumalanga, North West, KwaZulu-Natal and Eastern Cape;
- Initiatives aimed at improving that ratio of population:clinics in KwaZulu-Natal, Northern Cape, Gauteng and Mpumalanga;
- Initiatives aimed at improving access to PHC services in Northern Province and Kwa-Zulu-Natal, Eastern Cape, Mpumalanga and Northern Province.

3.5 Mixed profiles: the implications for health care

The highly mixed demographic, socio-economic and epidemiological profiles of the South African population indicate towards a need for care and services to address acute, infective social diseases/diseases of poverty on the one hand, and care and services to address chronic, degenerative lifestyle diseases/diseases of civilisation on the other hand. The South African health care system has to cater for a broad and complex spectrum of needs and requirements through a diffuse and extensive spectrum of services and facilities. Limited available resources have to be divided among different levels of care and governance covering a large geographical area, and among highly variable needs, requirements and demands. This predictably provides scope for various kinds of shortages, discrepancies and inequalities to arise. The need to prioritise, to incur savings, to remain focused on real needs and the need to integrate and co-ordinate as far as the allocation and utilisation of resources and the provision of services are concerned, are of critical importance in such a scenario – also as far as the allocation and distribution of ODA is concerned. However, to render the provision of health care more responsive to real needs and priorities is a daunting challenge. This reiterates the importance of a system and mechanisms that will ensure the equal and equitable allocation and distribution of health care resources according to need. In turn, this emphasises the need for more sophisticated and refined health information systems that will capture and reflect the real health status and burden of disease in the population, more information

management capacity and better skills to plan provision in accordance with real need.

The relationship between health needs and priorities on the one hand, and factors outside the health sector and beyond the scope of health services deserves special attention when it comes to allocation of resources and planning of interventions. It points clearly to the fact that an **intersectoral** approach to health should be pursued. The eventual benefit that ODA and other resources that are allocated to areas such as water and sanitation, poverty relief, welfare services, education, agriculture could have for health should not be underestimated, especially in a society where socio-economic, living and working conditions have such a fundamentally negative impact on the health status of large sectors of the population.

3.6 Alignment between ODA and needs/priorities: critical analysis

In broad terms, the targeting of ODA towards areas and themes illustrated in Tables 1 to 3 are in accordance with the main priorities and challenges on the health sector development agenda in South Africa. During interviewing of provincial stakeholders in the SA public health sector, the need for assistance to carry the transformation process forward was pertinently emphasised, since provincial health budgets often do not allow much scope for initiatives beyond the provision of services. The targeting of areas such as Primary Health Care and District Development, as well as human resource and management capacity development therefore seems appropriate.

The same applies to the targeting of HIV/AIDS and STDs. However, especially in an area such as HIV/AIDS and STDs, care has to be taken that absorption capacity correlates with the amount of resources allocated to the area. Most ODA targeted at HIV/AIDS is used for education and information campaigns. However, increased knowledge has so far made little impact on the HIV/AIDS epidemic. This indicates that alternative interventions where better absorption capacity would result in more impact should be explored and that the ODA to projects and programmes aimed at education and interventions should be linked to clear performance, impact and outcome indicators. In an area such as HIV/AIDS where impact is a complex and contentious issue, any form of ODA and ODA initiatives should in any case be linked to clear performance, impact and outcome indicators.

The close relationship between HIV/AIDS and TB is well known. Again, available data often did not indicate whether ODA allocated to HIV/AIDS and STDs in fact also incorporates TB. Only DfID and Belgium apparently provide ODA for TB-related projects and initiatives. If this is the case, it would appear as though TB is a highly neglected target area for ODA.

As far as the flow of ODA to provinces is concerned, the targeting of Eastern Cape appears to be justified. However, based on available data, provinces such as KwaZulu-Natal, Northern Cape and Mpumalanga could benefit more from ODA – both as recipients and beneficiaries of ODA.

From a technical point of view, it is not evident that ODA is targeted towards the filling in of crucial gaps that exist or are emerging in national and provincial health budgets. No evidence was found of any process or system in the SA health sector according to which target areas for ODA are aligned with existing or emerging gaps where national and provincial health budgets fall short, or where shortages are likely to emerge in future. Therefore, available data on the allocation and distribution of

ODA in the SA health sector would not summarily support the conclusion that it has been effectively allocated and distributed.

In order to re-iterate that fact that the above analyses are based on the best available, yet highly inadequate data; and to repeat the acknowledgement that conclusions are therefore exposed to contention, the last word in this section would again have to address the issue of record-keeping. It appears that both donors and recipients of ODA underestimate the importance of record-keeping about the "basics", i.e. the amount/value, type, purpose and allocation of ODA in the health sector. In the absence of accurate, complete and standardised information, donors and recipients are at risk of planning, implementing and evaluating ODA-supported initiatives in an *ad hoc* manner. Certainly, the selection of target areas in line with broadly agreed upon priorities in the health sector is impeded by insufficient information on the past and current flow of ODA and, importantly, the impact it has, has had, and could have had on priorities relating to the health of the nation and the transformation of the still distorted South African health care system.

However, the same argument applies to the planning and management of South African health services in general. In the absence of good quality information about the health status and health care needs of the population at large, alignment between the allocation of health care resources (including ODA) and the real needs and priorities of the population would hardly be possible. All aspects of information management in the health sector, i.e. systems development, development of criteria and indicators, infrastructure and training could therefore benefit substantially form ODA.

CHAPTER 4 ANALYSIS OF INSTITUTIONAL ARRANGEMENTS PERTAINING TO ODA IN THE SA HEALTH SECTOR

Relative to the total annual public health budget of South Africa and those of the respective provinces, ODA remains but a small resource. Nevertheless, the health system stands to benefit significantly from ODA that is well co-ordinated, specifically targeted and well managed so as to ensure optimal and sustainable impact. At present, however, the ODA process is constrained by a variety of problems related to inadequate institutional arrangements.

At the onset of an analysis and discussion of institutional arrangements pertaining to ODA in the SA health sector it is imperative that the roleplayers in the ODA process, as well as existing laws and policies on ODA in the SA health sector, are identified. In the SA health sector, the roleplayers in ODA would include:

- the Office of the President
- Selected other government departments, e.g. the Departments of Foreign Affairs, Arts, Culture Science & Technology and Trade &Industry.
- IDC
- National Dept of Health, and the Directorate: International Health Liaison, Sub-Directorate: Policy & Donor-co-ordination in particular
- MINMEC (Monthly meeting between the Minister of Health and Provincial MECs for Health)
- PHRC (The Provincial Health Restructuring Committee, which acts as a technical advisory body for MINMEC)
- Offices of provincial premiers
- Provincial health departments (which are, of course, not one-dimensional stakeholders, but have the concerns of labour unions, as well as inter-departmental dependencies and decentralised levels of management and governance to take into consideration)
- SALGA (South African Local Government Association)
- LGTP
- Various donors who have a particular interest or established relations with the SA health sector
- NGOs and CSOs operating in the health sector that benefit directly or indirectly from ODA
- NDA (National Development Agency)
- PMS (Programme Management Services, based in the Department of Finance)
- In view of the increasing prominence of the Southern African Development Community in matters pertaining to development in the sub-continent, those SADEC-bodies with an interest in health would also feature on this list.

The legal requirements pertaining to ODA in the SA health sector are complex and complicated. In addition to financial laws and regulations, the Public Finance Management Act (Act 1 of 1999) – and specifically Chapter 2, Part 2 (13) and Chapter3, Part 2 (22), the Public Finance Management Amendment Act (Act 29 of 1999), and the RDP Fund Amendment Act of 1998 apply. The RDP Fund Amendment Act of 1998 provides the legal framework within which bi- and multi-lateral relations with the SA health sector are conducted. The amendment of the original RDP Act was aimed at streamlining the process of development co-operation in SA by allowing agreements to be signed without Presidential approval.

With the closure of RDP office, ODA management and coordination was transferred to the Chief Directorate International Development Cooperation (IDC) in the Department of Finance and a centralised management system (through IDC) was established. Another "residue" of the former RDP office is Programme Management Services. This is a directorate in the Department of State Expenditure that is aimed at contributing to the development of SA by promoting Project Management as the cornerstone of effective development and implementation of Government policies. However, at the same time "the affairs of government" (including RDP interventions) were becoming increasingly decentralised, with financial and policy accountability vested in heads of departments and provinces. The centralisation of essential elements of the ODA process within IDC appears to be contradictory to the movement towards decentralisation of management in the health sector. It could be reasoned that the relatively firm hold that IDC has maintained on the ODA process, whether intentionally or not, prevented other roleplayers from coming to a clearer conception of their respective roles and responsibilities in the ODA process and from establishing the necessary structures and processes to deal with it.

While the technicalities of the RDP Amendment Act will not be elaborated on in this report, it is of crucial importance that all stakeholders in the ODA process are thoroughly informed about and aware of its conditions. Of particular importance for purposes of this study is the conditions and arrangements for ODA stipulated in the *White Paper for the Transformation of the Health System in South Africa* (Department of Health, 1997: 184 - 202). Although the roles and responsibilities of all stakeholders are not circumscribed in this policy document, its relevant content does provide constructive guidelines in this regard. However, what became clear during the study is the fact that all roleplayers in the ODA process lack clarity about their roles and responsibilities in this regard. This is evident from differences and discrepancies between their interpretation and resulting self-circumscribed roles and responsibilities on the one hand, and their legal and political obligations pertaining to the ODA process on the other hand. This will subsequently be discussed.

The Office for International Development Co-ordination and Programme Management Services

The office for International Development Co-ordination (IDC) is a Chief Directorate in the Department of Finance. The mission of the IDC is to ensure the effective and efficient mobilisation of all available ODA resources towards the achievement of the reconstruction and development objectives of the SA government and the effective management of ODA in SA. Together with Programme Management Services (PMS) in the Department of State Expenditure, it strives to:

- efficiently mobilise all ODA available to SA
- ensure that ODA is managed and co-ordinated effectively
- prevent duplication of effort and funding
- channel ODA towards the development priorities of the Government
- optimise the use of ODA by learning and benefiting from comparative international experience and expertise
- ensure that the necessary legal, policy, strategy and procedural framework is established to facilitate the effective and efficient mobilisation and management of ODA
- offer management and technical assistance and support to national and provincial departments
- promote crosscutting on initiatives from different departments and to encourage co-operation among departments
- ensure implementation of ODA initiatives

- ensure that the skills vested in Programme Management Services are transferred to relevant stakeholders.

Towards these ends, IDC:

- informs potential donors of SAs development priorities
- facilitates the negotiation and signing of international assistance agreements
- negotiates framework agreements within which assistance is given to various government Departments, Provinces and local governments
- provides information on existing programmes, policies, procedures, etc. to Parliament, the President's Office, government departments, donors, implementing agencies and the public in general
- assures regular negotiations/consultations between the International Development Assistance Community (IDAC), government departments and implementing agencies
- monitors project activities and progress
- publishes Development Co-operation Reports for SA
- monitors the flow of donor funding

In addition, PMS:

- assists with the development of project/programme management capacity and the creation of project management units in government departments
- offers management assistance and support (also technical support) to national and provincial departments

The National Development Agency

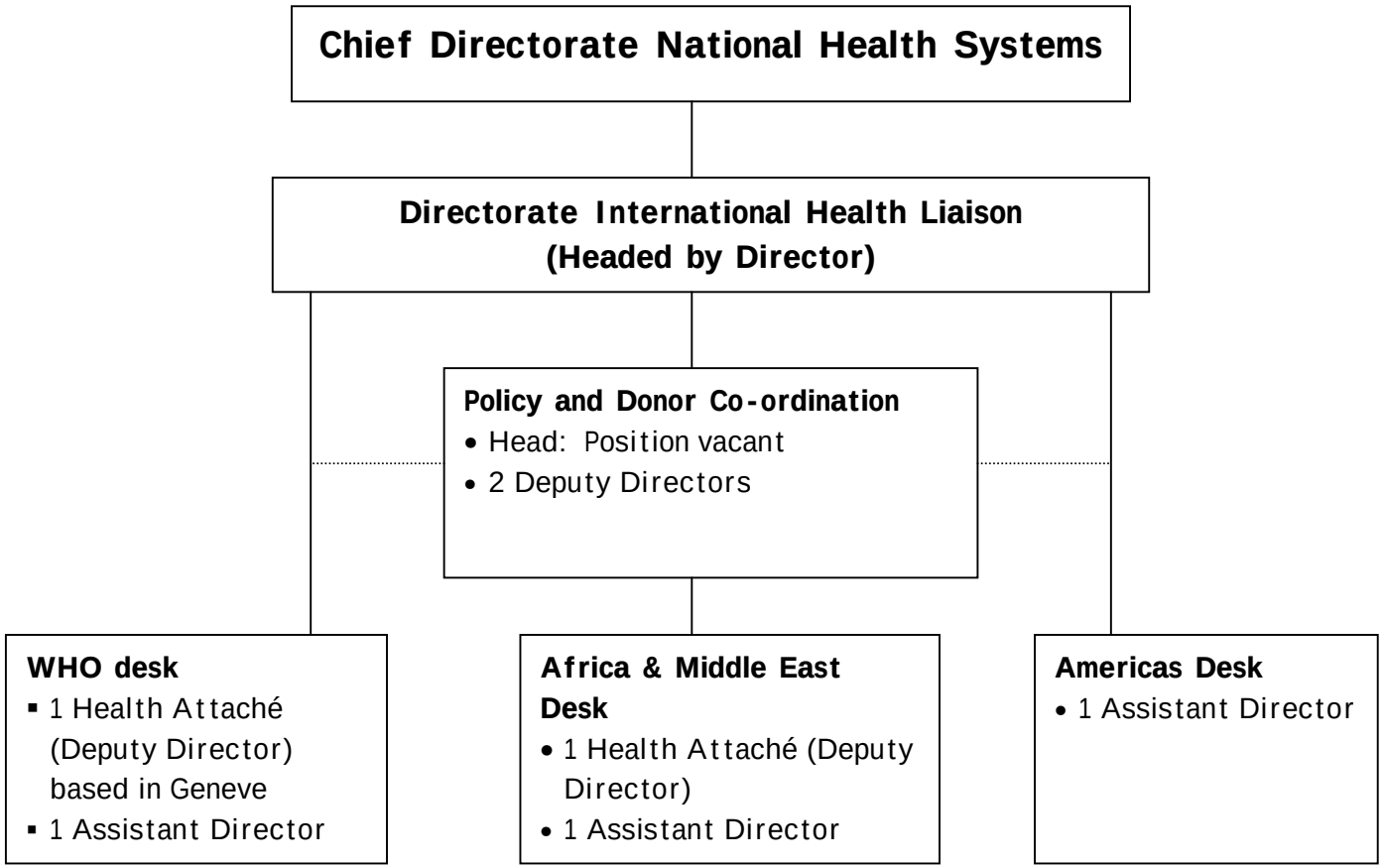
The National Development Agency (NDA) is a statutory body that was established by the IDC to promote an appropriate and sustainable partnership between Government and Civil Society Organisations (CSOs) in the implementation of programmes to address reconstruction and development. The primary function of the NDA will be to act as a conduit for funding of development work to be carried out by CSOs and to create a platform for interaction between Government and CSOs in matters relating to development policy and practice.

National Department of Health: Chief Directorate National Health Systems, Directorate International Health Liaison and Sub-Directorate Policy & Donor Co-ordination

In the Department of Health, the Directorate International Health Liaison and Sub-Directorate Policy & Donor Co-ordination were established in 1994 to deal with ODA in the SA public health sector. It is anticipated that the responsibilities of these structures and their ability to perform them will in the immediate future increasingly become the focus of attention, since one of the ten points in the Department of Health's Strategic Framework for 1999 – 2004 is the "strengthening [of] co-operation with our partners internationally", and specifically the consolidation and revisiting of "the wide range of bilateral and multi-lateral agreements entered into over that last five years …" (Department of Health, 2000:4 and 18). This emphasises the importance and urgency of the need for these structures to engage purposefully and strategically in developing policies, guidelines and mechanisms that will facilitate all phases and aspects of the ODA process in the SA health sector.

The current composition of the Directorate International Health Liaison is as follows (note that the positioning of components in the diagram is **not** indicative of their organisational relationships or relative status):

FIGURE 1: COMPOSITION[24] OF DIRECTORATE INTERNATIONAL HEALTH LIAISON, NATIONAL DEPARTMENT OF HEALTH



[24] Role-playing positions only – administrative and support staff excluded

The *White Paper* (1997:191) describes the role and responsibility of the structure(s) concerned with the ODA process in the Department of Health, *i.e.* Directorate International Health Liaison, as follows:

- leadership in the development of international health relations;
- guidance in setting priorities for development assistance utilisation;
- management to ensure the effective utilisation of these resources; and
- acting as an effective link between the South African health sector and the international community.
- It also has a role in advocating for health improvements to be recognised as a developmental priority within South Africa and the international community.

At present, the Directorate International Health Liaison defines its role and responsibilities[25] (broad objectives) with regard to ODA as follows:

- facilitating and co-ordinating the SA health sector's participation in the SADC (Southern African Development Community);
- expanding Bilateral and Multilateral relations between the SA health sector and Southern Africa, Africa and the rest of the world
- soliciting funding, i.a. by identifying donors and potential donors through the IDC;
- liaising with donors through annual bilateral meetings;
- monitoring and co-ordinating all donor assistance to the health sector (ODA channeled to NGOs in the health sector also has to be "declared" to the Dept of Health in order " … to avoid duplication, misplacement of funds and "embarrassment");
- facilitating and co-ordinating donor activities within the health sector;
- facilitating the implementation of ODA-initiatives/programmes/projects by
  - liaising with donors in the drafting and signing of agreements and Memoranda of Understanding;
  - monitoring implementation;
  - reviewing and evaluating progress;
  - facilitating site visits for donors;
- maximising the capacity of the Directorate by improving skills of core staff and creation of new posts;
- facilitating and co-ordinating the SA health sector's participation in all international organisations by
  - ensuring SA participation in the promotion of public health;
  - maintaining a database on international visitors, visits and conferences and;
  - facilitating SAs scientific and technical co-operation in health-related fields.

However, these self-circumscribed roles and responsibilities reflect only a fraction of the Department of Health's roles and responsibilities in relation to ODA as circumscribed and implied in the *White Paper*. Looking at the principles and implementation strategies supposed to be guiding the Department of Health's international relations as spelled out in the *White Paper*, it is noticeable that these principles are "loaded" and the implementation strategies complicated in the sense that roles and responsibilities associated with their implementation are often implied and not explicitly clear. While some of these roles and responsibilities are spelled out explicitly in *the White Paper*, others are implicit and require deeper analysis and "unpacking" to uncover and concretise. The fact that crucial conditions for the implementation of these strategies have apparently not been met and strategies have

[25] This information was obtained during interviews with Deputy-directors in the Sub-directorate Donor Co-ordination in the Dept of Health. At the time, the information was not available to the consultants in print, although a summary of the broad objectives of the Directorate International Health Liaison was later made available.

not been sufficiently "unpacked" into objectives and activities have serious consequences for the ODA process. It would appear as though the functions spelled out and implied in the *White Paper* for structures dealing with ODA have not been sufficiently conceptualised, operationalised and institutionalised. This is a key observation that will be elaborated on in a subsequent section of the report.

While there appears to be signs of emerging clarity about the role and responsibilities of the Directorate International Health Liaison in relation to ODA in the SA health sector, as well as a clear intention and commitment on the part of officials within this Directorate to fulfill these roles and responsibilities, self-acknowledged uncertainty and even confusion still prevail. This became evident in comments such as "[W]e don't know what we have to be monitoring and evaluating, so we don't know what [lessons / best practices] to identify and share" from officials in the Directorate.

Some stakeholders reported reservations about the political/bureaucratic status of the Sub-directorate Donor Co-ordination & Policy in view of its role and function in the ODA process. This complicates its relationship with provincial recipients and implementing agencies of ODA, especially when it comes to the monitoring and evaluation of ODA-initiatives in provinces. For example, oral progress reporting on highly complicated and often technically specialised projects are sometimes required. Implementing agencies, accountable officers and technical experts go to great lengths and incur considerable expenses for purposes of such progress reporting, " … only to be heard in Pretoria by two or three deputy-directors".

Line Departments at national level

Line departments in the National Department of Health are involved in the ODA process in as far as the development of Terms of Reference, guidelines and frameworks for ODA initiatives are concerned. For example, where an ODA initiative pertains to the decentralisation of hospital management, the appropriate Directorate at national level will be involved in the planning and management, including the monitoring, of the initiative. There are no clear indications or evidence that line departments at national level are involved, as a matter of process, in the planning and co-ordination of ODA in the SA health sector at that level.

The ODA Process at Provincial level

The White Paper (1997:188) describes the role of provinces with regard to the co-ordination of ODA as follows: "The provinces will be responsible for the co-ordination of offers of aid made to them, or to specific local communities. The national Department should be informed of all offers accepted."

At the moment, provincial health departments are found to be poorly geared and prepared for their role in the ODA process within a quasi-federal context. This would include the following:

- Provincial coordination of ODA
- Development and communication of provincial policies and procedures relating to ODA (in line with IDC policy and procedures)
- Facilitation of provincial planning and prioritisation per sector
- Consolidating and presenting provincial inputs to overall sector planning and prioritisation processes
- Facilitating capacity building of provincial departments and local government in terms of ODA management and coordination.

- Identification of weaknesses regarding ODA programme implementation and recommendation of measures for improvement
- Monitoring ODA at provincial level (progress, equitability)
- Overall evaluation and impact assessment of provincial ODA programme

Formally, co-ordination of ODA at provincial level resides in Premier's office. Some provincial health departments have an assigned function/responsibility for co-ordination of ODA, albeit to a single person. The function is also based on a limited concept of ODA co-ordination in that it focuses on the co-ordination of administrative issues pertaining to ODA initiatives in the provincial health department, e.g. the submission of progress reports. It does not include co-ordination in the sense of aligning ODA with provincial needs and priorities, or the targeting and allocation of ODA among districts, groups, issues and communities according to decentralised needs and priorities.

The ODA Process at the level of Local Government

The process of District Health System development and the integration of local government within the health system at the district level are still in progress. However, the increasingly important role of the health district and, within that context, of local government in the SA health system is clearly articulated in policy and enshrined in legislation. In this view, the development of mechanisms and processes to allow for local government's engagement in the ODA process is of critical importance. At this stage, LGTP has been identified as the co-ordinating mechanism for local government's engagement in the ODA process. However, this role is not well circumscribed and established. Provision has to be made for the development and implementation of institutional arrangements within LGTP to ensure its visible and meaningful participation in the ODA process.

The key issue to be addressed is the establishment of structures and mechanisms at local government level that will ensure that local government needs and priorities feature appropriately on the ODA agenda for provinces. To this effect, the LGTP should:

- appoint local government ODA coordinators for the province;
- develop systems, processes and mechanisms to enable local governments to consolidate their health and health care needs and priorities with those at provincial level;
- develop policies, processes and procedures for dealing with ODA and for interfacing and integrating with provincial and national ODA processes without losing their identity to those of higher levels of government.

"Clusters" and the ODA process in the SA health sector

The Office of the President proposed that a sector approach be followed towards reconstruction and development in SA. This lead to the formation of "clusters" (sectors) dealing with cross-cutting issues involving relevant departments and stakeholders in reconstruction and development processes in an integrated, co-ordinated manner.

The process of establishing clusters in the SA health sector is currently still in an early stage and its is not clear which government departments and stakeholders will eventually belong to which clusters. It is also possible that the constitution of clusters may vary according to different reconstruction and development issues that need to be addressed. However, once clarity about the constitution and functions of clusters is obtained, the idea would be for these clusters to be mirrored at the following levels:

- National government
- Provincial Government
- Local Government
- IDC
- Donors

It is anticipated that the ODA process could benefit substantially from the creation of these clusters, provided that their role and responsibilities regarding the various phases of the ODA process are clearly conceptualised and integrated into their roles and agendas at an early stage. The potential of these clusters in mainstreaming cross-cutting issues in an appropriate and co-ordinated way within the health sector is also obvious. Some provinces have made progress with the establishment of clusters. However, these are still early days and an assessment of their contribution to the ODA process is at this stage not feasible.

ODA and NGOs

Prior to 1994, the bulk of ODA to the SA health sector flowed directly to NGOs, particularly those NGOs that were sympathetic to and pursued the goals of the then banned ANC. In this way, ODA contributed substantially to the preparation of SA's reigning health policies, as well as to preparing the ground for and facilitating the transformation of the SA public health sector.

Although a significant proportion of ODA in the SA health sector is still channeled to and *via* NGOs, bi- and multi-lateral agreements with the democratic SA government have since 1994 resulted in an increase in the flow of ODA through official government channels. NGOs that previously played a major role in pursuing democratic ideals and in serving the needs of those disadvantaged by the apartheid regime found themselves in dire straits. Both financially and politically speaking, a considerable number of NGOs could not survive the transition of government. However, the transition of government also brought new opportunities and avenues for growth to NGOs. Some NGOs established sound working relations with provincial health departments. For donors, these NGOs offer an avenue around the bureaucratic red-tape that would otherwise have characterised the relationship had the provincial health department been the principal recipient of ODA. Such NGOs also allow health departments more flexibility and better responsiveness in the use ODA. NGOs therefore continue to play an important role in the SA health sector and the period 1994 to 1999 saw the establishment and rise of a number of formidable NGOs in this sector. Substantial amounts of ODA have in fact been targeted directly at NGOs involved in the health sector during this period. Such is the volume of this flow of ODA that the DCR II Health Sector Study team adapted the working definition of ODA in the SA health sector according to the conviction that the reconstruction of a comprehensive picture of ODA in the SA health sector would not be possible with the exclusion of NGOs as direct recipients of ODA.

The White Paper (1997:189) is clear about the role of NGOs in the reconstruction and development process. In this context, NGOs are viewed " … as part of civil society [and] are, therefore, expected to contribute to the attainment of national priorities and programmes". Although the funding of donors are according to the White Paper (1997:189) clearly stated to be " … a matter between donors and the NGOs concerned", a symbiotic relationship between NGOs and the Department of Health as far as the achievement of national objectives is concerned, is certainly not ruled out: "Where the Department of Health commissions an NGO(s) to execute some of its programmes, the Department will be responsible for mobilising the financial resources for such a programme. It will sign a contract with the donor(s)

concerned, and will be responsible for expenditure accounting" (White Paper, 1997:189). However, clear guidelines are provided in the White Paper as far as the funding of NGOs by the Department of Health is concerned and the conditions that NGOs have to meet in order to qualify for such funding are clearly spelled out.

CHAPTER 5 ODA IN THE SA HEALTH SECTOR : CRITICAL ANALYSIS

Based on the strategy/methodology that was followed in the study, the observations that was made about the ODA process in the SA health sector will subsequently be dealt with. The observations are substantiated by the "gap" between what is generally put forward as the "ideal" with regard to ODA in the SA health sector (contained mostly in relevant policy documents and models/proposals that have been developed previously) on the one hand, and what was found actually to be in place and practically happening with ODA in the SA health sector. Firstly, some general observations will be discussed, followed by observations that apply particularly to the phases of the ODA process, *i.e.* the planning of ODA, its management and co-ordination, the implementation of ODA initiatives, the monitoring and evaluation of ODA and the assessment of its impact on the SA health sector.

5.1 General observations

Although ODA for health constitutes but a fraction of health spending in SA compared to the health budget, it nevertheless contributed substantially to the preparation for and support of (health) transformation in SA, both prior to and after 1994. The main value of ODA is perceived to be its responsiveness to new and emerging needs/priorities and the fact that it can be directed towards areas of need/priority that are not directly concerned with practical service delivery, but which are nevertheless crucial determinants of the quality of service delivery (most notably items on the "transformation agenda" that would otherwise have been stalled due to budget constraints).

During 1994 to 1999, ODA in the SA health sector appeared be targeted at the following:

- ***the shift in emphasis to PHC and the establishment of the District Health System as vehicle for the effectuation of this shift***
- ***human resource development;***
- ***improved planning and management of health services and increased democratisation of health care management;***
- ***capital investment in equipment and;***
- ***a specific focus on HIV/Aids.***

Unfortunately, it would be misleading to assume that ODA served the real priorities on the SA health agenda, mainly because analyses are based on records, data and information that leaves much to be desired as far as quality (comprehensiveness, accuracy, availability, accessibility and user-friendliness) and standardisation are concerned. This renders even the most rudimentary analyses of ODA in the SA health sector speculative. Importantly, assessments of the allocation and distribution of ODA in terms of health target areas, national and provincial priorities and policy directives would be neither reliable nor meaningful given the lack of and poor quality of available information. Therefore, the first and most fundamental observation that implies all stakeholders in ODA in the SA health sector, and one which equally jeopardises all phases of the ODA process, is that record-keeping and information management are not conducive to the effective planning, management, co-ordination, monitoring and evaluation of ODA in the SA health sector.

Even if ODA is targeted at relevant priorities on the SA health agenda, the foundation upon which and process according to which decisions in this regard are made, are

questionable. Due to the lack and poor quality of data and record-keeping, decisions about the distribution and allocation of ODA in the SA health sector are perceived as subjective and strongly politicised. Concerns were expressed and questions were raised about decision-making by decision-makers who do not have complete, reliable or accurate information on at least the following:

- where ODA in the health sector is and has been going;
- what ODA is being and has bee used for;
- what impact ODA has, and has had, on areas targeted in the past;
- whether duplication or overlapping of allocations is taking place or has occurred;
- what the real and crucial needs and priorities of eventual recipients and beneficiaries of ODA are.

The decision-making process is therefore perceived to be highly politicised and, in addition, appears to be influenced by dominant personalities and interest groups. This is perceived as contradictory to democracy and obscures transparency. Terms that stakeholders used to describe the process include the following: "too much power play"; "too much behind-the-scenes discussions"; "too many opportunities for wheeling-and-dealing" and "too little transparency". It is not implied that better information will necessarily lead to better planning, management, co-ordination and evaluation of ODA. However, it would lay the foundation for perceivably less idiosyncratic and more objective, technical, transparent and accountable decision-making.

Continuing on a critical note, stakeholders on all sides reported difficulties in engaging meaningfully in the ODA process, mainly because of problematic, unclear and/or confusing institutional arrangements, as well as ignorance about institutional arrangements pertaining to ODA in the SA health sector. Donors and NGOs generally held the opinion that the initiative and leadership for clarifying, institutionalising and popularising such arrangements should come from relevant SA stakeholders, notably from the structures that were created within the National Department of Health to deal with ODA.

The apparent lack of ownership of ODA and the ODA process on the part of SA stakeholders in the health sector was a continuous theme throughout the investigation. Not only does this find manifestation in difficulties and problems that are encountered as a result of problematic institutional arrangements; it also impels donors to some extent to set and follow their own agendas as far as ODA in the SA health sector is concerned. The accompanying preconditions, specifications and requirements stipulated by donors are not always clear to SA stakeholders and give rise to mutual confusion and mistrust. This appears to indicate that Memoranda of Understanding between donors and SA stakeholders are not clear, or are not sufficiently incorporating of ODA policies, conditions and requirements on the part of both donor agencies and the SA health sector. It could even be an indication that such policies, conditions and requirements are not (yet / formally) in place in all instances.

A final general observation which have fundamental implications for ODA and the ODA process is the fact that the approach to ODA in the SA health sector is still largely project-based as opposed to sector-wide. With the exception of the European Union and USAID, whose approaches to ODA in the SA health sector can broadly be described as programmatic, most donors identify distinct projects that are supported as part of larger ODA packages. This implies that ODA is mostly targeted at short-term initiatives that have their own aims, budgets, as well as their own frameworks and timeframes for implementation, monitoring and evaluation. Although the intention and understanding are that

such initiatives should be integrated with normal duties and functions in the public health service, they are not implemented, managed, evaluated or funded as such. The decision of whether a sector-wide or a project-based approach towards ODA in the SA health sector should be pursued is critical, since this will affect all further decisions regarding all other aspects of ODA and the ODA process in the SA health sector. In this rubric, the following emerged during discussions with stakeholders:

- Some stakeholders are in favour of a sector-wide approach towards ODA in the SA health sector, while others are opposed to it. On the one hand, those in favour argue that ODA should support the broad development agenda in health and should therefore not be "tied" to specific projects, programmes, budgets, frameworks and timeframes. Because development is a dynamic and multi-faceted process, ODA should support and not restrain the dynamics of this process. ODA should therefore take the form of budget support to be aligned, along with the actual budget, to broad development priorities in the health sector. As such, it would not be possible to monitor and evaluate the progress, outputs, outcome and impact of specific ODA initiatives. Instead, the evaluation of ODA within a sector-wide approach would focus on the alignment of donor agendas with development priorities in the health sector, and the degree of flexibility on the part of donors to respond to the dynamics of the development process within the health sector. Should these priorities be pursued and achieved as objectives within the sector concerned, the aim of ODA would have been achieved. Along these lines, it is argued that a sector-wide approach is more suited to the dynamics of the SA health sector than is a project-approach.
- On the other hand, the proponents of a project-based approach argue that ODA should be kept out of the health budget until the capacity to align resources with real needs and priorities in the health sector, as well as the capacity for planning and management of public health services in general have become more established. They also argue that, in view of the federal country context, a nationally-focused Sector-Wide approach to ODA in the SA health sector would no be advisable. A more appropriate focus for the establishment of a Sector-Wide approach to ODA in the SA health sector would be the provincial level. Towards this end, the planning and management of ODA in the SA health sector could serve as a practical case study in aligning resources with real needs and at the same time provide an opportunity for capacity building in project management among SA stakeholders. Therefore, this standpoint does not rule out a sector-wide approach to ODA in the SA health sector, but proposes that the principles of a Sector-Wide Approach should be applied at a provincial level and not a national level, as well as a steady progression towards such an approach and the consistent monitoring and evaluation of this process. However, since a conclusion has not been reached, it is proposed that the debate on a sector-wide approach *versus* a project-based approach towards ODA in the SA health sector be continued as part of ongoing discussions among all stakeholders concerned, and that the outcomes of this debate should be incorporated in the review and amendment of institutional arrangements, and/or the establishment of new arrangements pertaining to ODA in the SA health sector.

The continuation of such discussions is strongly advised since it became apparent during the study that SA stakeholders are highly appreciative of the role the ODA has played, is playing and will expectedly continue to play in the SA health sector, while donors appreciate and understand the many and varied challenges confronting the SA health sector and at the same time demonstrate a commitment to help develop, expedite and support firm and strategic responses to these challenges.

Problems encountered with institutional arrangements in the ODA process in the SA health sector has serious implications, since donors indicated that it could lead to a direction of ODA away from the SA health sector to other state departments where institutional arrangements are in place, or to non-governmental agents operating in the health sector where such problems are not encountered or not experienced as debilitating as in government. This will have serious implications for the structures that have been created within the health sector to deal with ODA, and will complicate the meaningful co-ordination, management and monitoring of ODA in the SA health sector considerably.

5.2 Observations: Planning of ODA in the SA health sector

First of all, observations pertaining to the planning of ODA nationally will be discussed, followed by a discussion of observations pertaining to the planning of specific ODA initiatives. The first level of planning of ODA takes place at national level. This planning concerns the alignment of ODA with priorities and guidelines as articulated in national policies and strategic plans. The notion is that this level of planning should provide a broad framework and guidelines for multi- or bilateral agreements regarding ODA in the health sector and would ensure that these agreements are formulated and ODA packages are structured in accordance with these frameworks and guidelines. The study indicated that much of the prevailing uncertainty and confusion regarding the planning of ODA in the SA health sector can be ascribed partly to insufficient communication, co-ordination and co-operation among national structures involved with planning of ODA in the SA health sector (i.e. Sub-Directorate Donor Co-ordination, Directorate International Health Liaison, the Office of the Director-General of Health, other national health directorates and the IDC), which is complicated by the strong influence of the Directorate Special Projects, MINMEC and the PHRC. Poor communication between SA stakeholders (national, provincial, local, NGOs) and between SA national structures on the one hand and the donor community on the other hand also contribute to this uncertainty and confusion.

During the period 1994 to 1999, it was possible and appropriate for ODA to be targeted and allocated according to such national priorities. The issues and priorities at stake were indeed national, as all provinces were affected and confronted more or less equally with the challenges posed by reconstruction and transformation. However, during this period, distinct trajectories of progress and development became evident among the different provinces and it became apparent that the provinces, in their new-found independence, were dealing diversely with the challenges of reconstruction and transformation amidst real decreases in their health budgets. A divergence of provincial needs and priorities ensued, but the planning of ODA at national level didn't adequately keep track of the maturation of provinces in the new federal context, nor of the emerging and increasingly prominent role of local government in the health sector. Concerns were expressed that current arrangements do not make sufficient provision for the needs and priorities associated with DHS development at that level (district; local) to be "heard" and addressed when it comes to planning of ODA.

The interpretation and implementation of a Sector-Wide Approach to ODA in the health sector remained centralist, while provincial health sector needs and priorities were no longer articulated specifically enough in national Reconstruction and Development priorities and national policies to validly serve as a comprehensive

framework for ODA in the SA health sector. The result is that the planning of ODA in the SA health sector is perceived as unfair by some SA stakeholders, notably those on provincial level who are not familiar with or aware of the planning process at the level of MINMEC, as advised by the PHRC. Also, some donors find this process confusing and rather unilateral. Some donors have resorted to contracting the services of independent consultants to advise them on the structuring of their ODA in the SA health sector because the purposes for and directions in which ODA was being channeled contradicted with the findings of sustainability studies and their previous experiences with ODA in the SA health sector. The main observation is that progression to a Sector-Wide Approach to ODA in the SA health sector will be enhanced if provincial and local stakeholders become involved in the planning of ODA.

However, this rests on the assumption that the concept of planning and an understanding of what the planning of ODA entails are clear among all stakeholders. Currently, there appears to be insufficient understanding among stakeholders of what the planning of ODA entails. In the absence of a comprehensive concept and clear understanding of what the planning of ODA entails, stakeholders have not identified and communicated their mutual expectations of each other in the process, nor have accompanying roles and responsibilities been identified and assigned to different stakeholders. On the part of SA stakeholders, the planning of ODA will entail, amongst others, the systematic identification and prioritisation of needs/areas where ODA could make a meaningful contribution/difference in the health sector. At present, no evidence of attempts at systematically conducting such "gap analyses" and the subsequent compilation of coherent ODA "agendas" were observed. As a result, the planning of ODA in the health sector was found to be not sufficiently strategic. Also, the concept of sectoral planning has not been clarified and concretised. Inter-departmental planning appears to be confused with sectoral planning. As far as ODA is concerned, no attempts have so far been made to systematically identify roleplayers in the SA health sector and to involve them in sectoral planning of ODA. Specifically the role and position of the private health sector in relation to the planning of ODA have apparently not been contemplated.

Not all provinces find that the specific and varying, yet real needs and priorities of all provinces are "gauged" equally when first-level decisions about the targeting and allocation of ODA are made. This is mainly the result of all needs and priorities being "weighed" against, and decisions about the targeting and allocation of ODA being subjected to national Reconstruction and Development priorities. As a result of these strong national influences in the planning of ODA in the SA health sector, as well as the apparent absence of a system and/or mechanisms according to which needs and priorities for ODA can be identified in a transparent, decentralised and participatory manner, i.e. in a manner that could be described as technical/objective, and with a focus on decentralised levels of government and ownership; and on sustainability of ODA initiatives at the level of implementation, is often lacking.

Many stakeholders were of the opinion that the absorption capacity of recipients of ODA is not sufficiently accounted for in the planning of ODA. Absorption capacity refers to the capacity of the recipient of ODA to utilise ODA optimally for intended purposes. What is referred to as "the myth of unlimited absorption capacity in the face of infinite need" appears to prevail. This means that, where needs are vast and seemingly infinite, there is the temptation to think that ODA - any ODA - will necessarily be meaningfully absorbed by the recipient and used to the advantage of beneficiaries. Several examples exist where ODA-initiatives failed as a result of

inadequate evaluation and account of the recipient's absorption capacity in the planning of ODA. Absorption capacity is influenced by, i.a., the alignment of ODA with real needs and priorities as experienced by the recipient, the extent to which institutional arrangements for the management of ODA are established and the degree of synchronisation between the release of ODA and the recipient's readiness to utilise it for intended/planned purposes that form part of dynamic and volatile processes.

The second level of ODA planning takes place when a specific ODA initiative is planned. Typically, such initiatives involve direct stakeholders such as the donor, the recipient, the implementing agent and the beneficiary. In most initiatives, these stakeholders are situated in different departments, sectors, disciplines, etc. Also included are direct and indirect stakeholders that could be either supportive of or opposed to the initiative. It is imperative that all stakeholders be involved in the planning of ODA initiatives. On the one hand, it appears as though difficulties experienced with some ODA initiatives can be attributed to the fact that the mutual expectations and responsibilities of all stakeholders, as well as a clarification of and agreement on the outputs, outcomes, monitoring and evaluation of ODA initiatives were not sufficiently incorporated into the original planning of such initiatives. On the other hand, the identification and involvement of all stakeholders in an ODA initiative in the planning of the initiative has been identified as a critical success factor in some initiatives, notably in the case of the EQUITY project in the Eastern Cape. However, all new ODA initiatives apparently don't benefit from these lessons and valuable past experiences.

The same applies to the planning of new ODA initiatives in general. The planning of these initiatives appears to be benefiting far too little from lessons learnt from past experiences and the reasons for failure and critical success factors identified for a variety of ODA initiatives. The planning of ODA for capital investment initiatives, as well as that of ODA for "soft investments" such as capacity development and training and ODA in the form of Technical Assistance can benefit meaningfully from evaluations conducted on and lessons learnt from previous initiatives and past experiences. However, a process aimed at the systematic identification and sharing of critical success factors and reasons for failure with a view to their incorporation into the planning of new initiatives, is not in place, partly because the responsibility for this has not been identified and assigned.

The following case study is illustrative of the problems and frustrations associated with the planning of ODA in the SA health sector:

CASE STUDY

This case study concerns a donor country that has recently established an office of its international co-operation agency in South Africa. There is as yet no clearly established relationship between this office and the national Department of Health, specifically with those structures tasked with ODA in the latter Department. At this stage, the local office of the donor country's international co-operation agency is in the process of structuring and negotiating its country's recently announced ODA package to the SA health sector with the Department of Health. The difficulties it is encountering are illustrative of the problems plaguing the ODA process in the SA health sector. Prior to the establishment of the office of the donor country's international co-operation agency in South Africa, in 1994, this particular country

made grant aid available to the SA health sector. This was subsequently directed through the national Department of Health for investment in hospital equipment in all nine provinces. Upon the establishment of the office of the country's international co-operation agency in South Africa, and with a view to informing the structuring of its newly announced ODA package in the health sector, an assessment of the previous grant was conducted. Based on this assessment, future investment of grant aid in capital equipment in hospitals was found to be inadvisable.

The donor has found it excessively difficult to negotiate a new investment agreement with the Department of Health. This can be ascribed mainly to the fact that the Department has, rather prematurely, on its own initiative and upon advice of MINMEC, started a process according to which the ODA package was to be allocated and divided among three selected provinces. These decisions were not discussed with or communicated to the donor. The manner in which the allocation and release of the package was structured did not meet the conditions that apply to ODA from this particular donor. However, these conditions were not communicated to the relevant stakeholders in the Department of Health; mainly because, until that stage, the negotiations between the embassy of the particular country and the SA government excluded the country's local office of its international co-operation agency. By the time the National Department of Health made the decisions about the allocation and release of the ODA package, the conditions that apply to ODA from the donor country were not known to the Department of Health.

A subsequent fact-finding mission initiated by the donor with a view to informing the structuring of its ODA package in the SA health sector encountered major problems. The donor consulted directly with four provinces in an attempt to prioritise real needs where ODA could benefit health care in a sustainable manner. However, in view of the prominent position that representatives of Policy and Donor Co-ordination at National Level awarded themselves in this consultation process, it is doubtful whether the real needs and priorities of the provinces concerned were eventually identified. Communication problems (language-related) between the Department of Health and the donor also resulted in the latter's domination of a debriefing meeting in which decisions were made of which the implications were not fully understood by the donor's representatives at the meeting. In the light thereof, the possibility exists that the donor would be hesitant to go along with these decisions. This will further retard the release of this ODA package and will certainly reflect negatively on the ODA process in the SA health sector. In the process, faith in the ODA process is inevitably being lost on all sides.

5.2 Observations: management and co-ordination of ODA in the SA health sector

Key processes in managing and co-ordinating ODA in the SA health sector are not taking place because of insufficient clarification and an inadequate understanding among stakeholders of what the management and co-ordination of ODA entails. These concepts, as components of the ODA process, have not been sufficiently "unpacked" into a series of co-ordinated actions and associated responsibilities. The result is that activities/responsibilities aimed at the management and co-ordination of ODA in the SA health sector are carried out selectively and in an unco-ordinated fashion – if at all. However, the definition and operationalisation of management and co-ordination of ODA are directly dependent on the approach towards ODA in a particular sector. In the SA health sector, no single approach can be distinguished, with various combinations of Sector-Wide and Project-Based approaches evident in the relationship between donors and SA, and in the different initiatives supported by

different donors. This does not mean that co-ordination and management are not possible or necessary, but implies that the co-ordination and management of ODA have to be adapted according to the approach that underlies a specific agreement or initiative. The ideal would be to have one system for managing and co-ordination ODA in accordance with a prevailing approach.

Processes, mechanisms and systems for the management and co-ordination of all aspects and dimensions of ODA are not in place, and associated responsibilities have not been clearly identified and assigned to specific stakeholders. Present processes aimed at co-ordination of some aspects of ODA, e.g. donor co-ordination and co-ordination of the flow of ODA among provinces, are perceived by the majority of stakeholders as ineffective, inefficient, unfair and untransparent. It is not clear whether specific criteria, except for broad national Reconstruction and Development priorities, are applied in the co-ordination of the flow of ODA among provinces. Provincial stakeholders, donors and NGOs apparently do not experience this process as being transparent. Despite efforts to access ODA through the national Department of Health, some provinces repeatedly fail to receive any benefit in return. Some provinces have "given up hope" to ever be considered for ODA and are of the opinion that "… if national has taken a decision in principle that we will not get ODA then they should tell us so. They musn't bother to invite proposals form us and create expectations that something might come our way if they have decided in advance that it will not". The opinion prevails that these provinces do not receive ODA *via* National mechanisms because their needs and priorities are not in accordance with those on the "political agenda".

Such provinces nevertheless succeed in soliciting ODA by directly approaching and then establishing firm relations with "their" donors. Strictly speaking, the National Department of Health is then able to co-ordinate ODA only to the extent that donors structure and formulate their Memoranda of Agreement with stakeholders at national level (bi-laterally or multi-laterally). Where provinces solicit ODA directly, or donors pledge ODA directly to provinces, the structuring and negotiation of such ODA-agreements cannot be co-ordinated at national level. However, the National Department of Health still has to "sign off" the agreement and ensure that it is recorded in an ODA database for purposes of future planning and co-ordination. It is not clear to what extent existing arrangements aimed at co-ordination of ODA between the National Department of Health on the one hand, and Provincial Departments of Health and donors on the other hand, make provision for this.

Donors experience current arrangements aimed at the co-ordination of donor activities at national level as unsatisfactory. These arrangements take the form of annual one-to-one consultations between a donor, the IDC and the Directorate: International Health Liaison. Annual consultations with individual donors by the IDC and Directorate International Health Liaison (Dept of Health) are experienced as informative and useful for purposes of information sharing. However, donors are generally of the opinion that these consultations could be dealt with more strategically, and that a change in their format could also serve purposes of coordination, evaluation and mutual learning. For donors to define their position within the wider ODA playing field such multi-lateral interaction and co-ordination could prove valuable. The present arrangement is not conducive to donor co-ordination, and donors engage in "non-official" co-ordination amongst themselves while awaiting leadership (a mandate; facilitation of a process) from the National Department of Health in this regard. At the same time, there is concern among donors that national co-ordination of ODA appear to be on the level of a Sub-Directorate. While it as agreed that the

process of donor co-ordination could be facilitated by the sub-directorate concerned, decision-making should reside with the Director-General.

The co-ordination between all dimensions and of aspects of ODA in the health sector is also hampered by an apparent breakdown of communication among stakeholders. Crucial information is not made available to or shared and communicated among stakeholders. Many donors and recipients are totally in the dark as far as financial legislation and regulations pertaining to ODA in the SA health sector are concerned. For example, confusion about VAT-regulations has caused many consuming and extremely disrupting delays in the finalisation of agreements and implementation of ODA initiatives. Also, many recipients of ODA in the form of equipment are not aware of the fact that the recipient has to make provision for, i.a. inland transport costs (in the case of imported equipment), VAT, as well as costs associated with the installation, operation and maintenance of such equipment.

5.3 Observations: Implementation of ODA initiatives in the SA health sector

Lack of clarity, confusion and ignorance about legal and technical requirements pertaining to ODA in the SA health sector, as well as lack of capacity to manage and implement ODA projects/programmes were among the main reasons blamed for delays in the implementation of ODA initiatives. As with other problems in the ODA process, confusion and ignorance about legal and technical requirements pertaining to ODA can also largely be ascribed to either the fact that roles and responsibilities of different stakeholders in the ODA process have not been identified, concretised and/or operationlised, or that breakdowns in communication are preventing information from reaching the stakeholders. The result is the delays occurring at various stages of the ODA process results in the delayed release of ODA, which forces recipients to implement projects/programmes within unrealistic timeframes. Confusion about VAT-regulations is once again an example in point.

Another impediment to the implementation of ODA initiatives is insufficient planning. Often, the implementation of an ODA-initiative is an inter-departmental affair that requires the co-operation and collaboration of various government departments, and sometimes that of stakeholders outside the government sector. All these stakeholders are not always included or sufficiently consulted during the planning of the initiative, with negative results when it comes to their participation in the implementation thereof. Sometimes, the capacity on the part of stakeholders to deliver is misjudged, or not determined or ascertained by the implementing agent in advance. This has jeopardised and impeded the implementation of various ODA-initiatives. For example, a clinic building initiative in one of the provinces was significantly delayed because of the Department of Works' lack of capacity to deliver according to an agreement with the Department of Health in that province. The work subsequently had to be contracted out, with further delays caused by the lengthy tendering process.

Finally, the absorption capacity of the recipient/beneficiary could also impede the implementation of ODA initiatives. Where needs are vast and desperate, impact of ODA on these needs is often assumed by the stakeholders involved. Sight is lost of the fact that, in order for ODA to achieve its objectives, the recipient must have the capacity to implement, manage and sustain ODA initiatives, and must have the necessary structures and arrangements in place to ensure that ODA impacts

optimally on the intended purposes. The opinion of some stakeholders is that absorption capacity of recipients/beneficiaries is not sufficiently considered in the allocation of ODA.

5.4 Observations: Monitoring and Evaluation of ODA in the SA health sector

Generally speaking, the monitoring and evaluation of ODA refer to the monitoring of the progress of ODA initiatives and the administration of such initiatives, as well as an evaluation of their outcome. The underlying assumptions are that the development of indicators, criteria, processes and systems according to which an initiative is to be monitored and evaluated should form part of the planning and implementation cycle of that initiative, and that the findings of such monitoring and evaluation processes should inform and enhance the conceptualisation, planning, management, implementation and evaluation of the particular initiative as well as subsequent initiatives. However, indications are that for many ODA initiatives this is not the case.

As with other phases of the ODA process in the SA health sector, the concept "monitoring and evaluation of ODA" has not been sufficiently clarified, concretised and operationalised in its full extent and meaning. Roles and responsibilities pertaining to different aspects of monitoring and evaluation of ODA have not been identified and divided among/assigned to different stakeholders. The result is that critical aspects of monitoring and evaluation of ODA initiatives are not materialising or are unsatisfactory. For example, the opinion among recipients is that monitoring and evaluation of ODA initiatives focus too strongly on reporting about administration and inputs, while outputs and outcomes, as well as the identification of "best practices" and "reasons for failure" are neglected.

Attempts at more comprehensive monitoring and evaluation of ODA initiatives in the SA health sector are largely donor-driven, e.g. where donors include requirements, objectives and indicators pertaining to the monitoring and evaluation of processes, outputs and outcomes in the planning and negotiation of initiatives with recipients. However, there is little evidence of the findings of such monitoring and evaluation processes being consolidated and shared among stakeholders in an organised, systematic manner. Lessons form past experience and previous ODA initiatives are therefore not sufficiently incorporated into the planning, implementation and management of new initiatives. Several stakeholders (donors, provincial health departments and donors) have conducted comprehensive evaluations of ODA initiatives, with little benefit to other initiatives. For example, during 1999 the European Union conducted a comprehensive investigation of its involvement and investment in the SA health sector. Valuable lessons pertaining to initiatives involving capacity and systems development, as well as Technical Assistance, are contained in this report. However, little evidence exist that these findings and lessons have been shared with the larger donor community in SA, or with SA stakeholders.

It was found that reporting systems aimed at monitoring and evaluation of ODA initiatives are not standardised, which complicates the ODA process. In most instances, the format and frequency, as well as the level of detail required in progress reports are determined by project managers for individual ODA

initiatives. The complexity and confusion surrounding monitoring and evaluation of ODA initiatives are exacerbated by the fact that donor reporting cycles are not co-ordinated. At present, financial monitoring of and reporting on ODA initiatives are in most instances based on the Government Financial Management (FMS) which, if not interfaced with electronic programmes enabling the manipulation of data by end users, is unsuitable for tracking, monitoring and reporting on expenditure related to the implementation of ODA initiatives. In Gauteng and some other provinces, this type of interfacing between programmes is used with good result for, amongst others, the monitoring of and reporting on expenditure related to the implementation of ODA initiatives. In Gauteng, an FMS interface with Excel-based worksheets is used for this purpose. In other provinces, an ORACLE-based interface with the FMS holds real potential for financial management of ODA resources.

Finally, donors, recipients and implementing agents indicated that, as far as progress reporting is concerned, care must be taken that evaluators have the necessary skills, knowledge and technical capacity to optimise and add value to the monitoring and evaluation process.

5.5 Observations: Impact assessment of ODA in the SA health sector

Impact assessment of ODA is closely related to the prevailing approach to ODA in a particular sector. On the one hand, the impact of individual projects or programmes can be assessed when comparing inputs to outcomes achieved for a particular programme or project. This rests on the assumption that the desired/anticipated outcome of a programme/project has to be clearly identified, contextualised and conceptualised, while the assessment process should take place according to objectives, indicators and methods that should be identified and developed during the planning of the programme/project.

On the other hand, impact assessment in the case of a Sector-Wide Approach to ODA would focus on the alignment between ODA initiatives and government initiatives aimed at the achievement of strategic goals and objectives of a particular sector. The more linear this alignment, the stronger the motivation that ODA is in fact impacting on the achievement of strategic goals and objectives in this sector. In terms of a Sector-Wide Approach, the idea would be not to differentiate between ODA and government resources when impact is assessed.

Another perspective on impact assessment of ODA that emerged during the investigation can be classified as a quasi-sectoral perspective. According to this perspective, gaps between available government resources and priority needs in the SA health sector have to be identified. Those gaps that could meaningfully be filled in by ODA should be identified. That would constitute the “ODA agenda” of the SA health sector at which ODA would be directed. Impact assessment would then focus on the extent to which originally identified gaps are in fact filled. A critical question remains, however, and that is at which level of government, *i.e.* national or provincial, ODA agendas should be compiled and such impact assessments should be focused.

During the investigation, very little evidence was found of impact assessment of ODA in the SA health sector being conducted. Impact assessment of ODA in the SA health sector is at least not an established process that is carried out regularly and systematically. Concerns that were expressed about the assessment of impact of ODA in the SA health sector are the following:

- ***ODA constitutes a too small proportion of health spending in SA to meaningfully assess its impact on the SA health sector;***
- ***It would be difficult to "disentangle" the impact of ODA on the performance of the health sector from that of other contributing factors;***
- ***Donors would be hesitant to compromise their association with specific ODA-packages and initiatives with a view to sector-wide impact assessment;***
- ***Limited capacity for impact assessment in accordance with a Sector-Wide Approach to ODA.***
- ***Since impact assessment necessarily has a long-term focus, any attempts at assessing the impact of ODA on the South African health sector for the period 1994 to 1999 at this stage would be premature.***

5.6 SUMMARY OF OBSERVATIONS: INSTITUTIONAL ARRANGEMENTS FOR ODA IN THE SA HEALTH SECTOR

Broadly speaking, observations regarding ODA in the SA health sector can be relayed to the following causes:

- The absence of a clear policy framework, guidelines and institutional arrangements for dealing with ODA result in confusion and dubious decision-making which impact negatively on the entire ODA process in the SA health sector.
- The status, roles and responsibilities of various structures and stakeholders in the ODA process in the SA health sector have not been sufficiently clarified and institutionalised.
- The ODA process in the SA health sector is not friendly towards donors, a situation that is sometimes compounded by language-related communication problems.
- There is lack of decisive leadership on the part of SA stakeholders when it comes to seeking solutions for the problems confronting ODA and the ODA process in the health sector.

More specifically, the main observations about institutional arrangements pertaining to ODA in the SA health sector can be summarised as follows:

1. Stakeholders on all sides and levels find it difficult to engage meaningfully in ODA processes in the SA health sector, mainly because of the absence of clear policy frameworks, as well as guidelines, structures and processes for dealing with the different phases and aspects of the ODA process. Where such policies, guidelines, mechanisms and processes are in place, they are not always co-ordinated with those of other structures involved in the ODA process, nor communicated to all stakeholders.
2. Unclear and incoherent institutional arrangements of various kinds and from different origins render the ODA process highly bureaucratic and "unmanageable", resulting in the dampening of enthusiasm about ODA and the perception that the effort in accessing ODA is not worth the result. Institutional arrangements of both government and donors are implied.

3. It is difficult to create a coherent and comprehensive reconstruction of the target and flow of ODA in the SA health sector because of insufficient and unstandardised record-keeping and poor/unsatisfactory information management on the part of both SA stakeholders and donors. Information to determine and understand exactly where, how and in what form of ODA could have the most and most meaningful benefit for/impact on the SA health sector is generally lacking, both in quantity and in quality. The issue of record-keeping of ODA in the SA health sector raises a key problem, namely whose responsibility it should be to keep comprehensive records. This would require the collation of several data sets that are currently kept by different stakeholders. In finding a solution to the problem, it must also be kept in mind that not all ODA in the SA health sector flows through the National Departments of Finance or Health.
4. The processes according to which ODA is channeled to provinces, and the grounds for decision-making in this regard are not clear and transparent.
5. The confusion and lack of clarity on critical issues pertaining to the management and coordination of ODA in the SA health sector may lead to a channeling of ODA away from the health sector to other sectors where these issues have been resolved.
6. The need for appropriate targeting and efficient coordination of ODA should be formally institutionalised responsibilities and a technical process for which the initiative and leadership must come from relevant SA roleplayers.
7. At the moment, coordination among donors remains informal because donors would consider it presumptuous to formalise donor coordination without the mandate and without facilitation by the relevant SA stakeholders. The need for formal donor coordination under the auspices of SA stakeholders was clearly expressed.
8. While it is understandable why donors sometimes prefer to fund NGOs directly (and why some provinces contract NGOs for the implementation and/or management of ODA projects and programmes) the coordination of NGO activities and involvement in the health sector proves to be problematic.
9. Mechanisms and processes according to which needs and priorities for ODA in the SA health sector are identified, are not transparent. The motivation for and justification of (political) decisions about the channeling of ODA are not always clear and/or clearly communicated to all stakeholders. This is not to say that the matching of ODA in the health sector with national priorities and objectives has so far been poor, but simply that the processes according to which "alignment" is decided are not always clear to all stakeholders.
10. National Reconstruction and Development priorities, while being extremely relevant and critically important in a broad sense, are not specific enough, and sometimes even not appropriate, to guide the channeling of ODA in a specific sector such as health, especially when considering in addition that various provinces and local communities are affected disparately by burdens of disease, risk, poverty and inequity. It could be inappropriate and unfair to subject provincially and locally-identified, real health-sector related needs and priorities to a broad, national and politically-dominated agenda when decisions about the channeling of ODA have to be made.
11. With the establishment of the District Health System and the concomitant increasing emphasis on the role and responsibilities of local government and district governance structures concern arises about the alignment of ODA with the real needs and priorities that are emerging from these developments. It is uncertain/unclear whether, or to what extent, mechanisms and processes for

identifying and prioritising needs for ODA in the health sector are sufficiently accommodating of these levels and structures.

12. In the absence of mechanisms/processes for provincial and local stakeholders to participate in the development of a coherent ODA agenda for the health sector, the risk of an experience of lack of ownership of ODA initiatives on the part of recipients beneficiaries is increased – with negative consequences for the sustainability of such initiatives.
13. In the absence of a coherent ODA agenda for the health sector, care must be taken that some stakeholders do not come to perceive ODA as perpetuating or creating inequity in the SA health sector.
14. While most donors, recipients and/or implementing agencies engage in some form of progress evaluation and outcome assessment of ODA initiatives/programmes/projects, little evidence was found of impact assessments being conducted on a regular basis. The lack of quality data and information on ODA in the SA health sector would render any attempt at impact assessment speculative, at best.
15. Some ODA-initiatives/projects/programmes in the health sector require inter-departmental, and sometimes inter-sectoral co-ordination and co-operation. In some instances, stakeholders from other departments and/or sectors are not involved in the planning of such initiatives, thus jeopardising the implementation of the entire initiative. Sometimes, the capacity of other departments to deliver on critical aspects and/or phases of implementation puts the entire initiative in jeopardy and could even lead to project failure.
16. Structures and processes for mainlining cross-cutting issues in the health sector generally, and potentially also in the ODA agenda for the health sector in particular, are in the process of being established. "Sectors" or "clusters" hold tremendous opportunity for cross-cutting issues to be integrated meaningfully into the health agenda.
17. Critical success factors and reasons for failure of ODA initiatives/programmes are not systematically identified and shared with other stakeholders that could benefit considerably from the lessons being learnt along the way.
18. There is little evidence of attempts by the Directorate International Health Liaison and Sub-directorate Donor-Co-ordination to critically question the appropriateness, practicability and efficiency of existing institutional arrangements pertaining to ODA in the health sector with a view to enhancing the ODA process in the health sector. This applies specifically to institutional arrangements regulating the relationship between the National Dept of Health on the one hand and the IDC, Provincial Depts of Health, donors and NGOs on the other hand as far as the planning, management and co-ordination of ODA is concerned.
19. While the policy direction in the public health sector has clearly been towards decentralisation, a concomitant (paradigm) shift has not taken place as far as the ODA process is concerned. It is observed that the IDC, notably, is overloaded with functions and responsibilities that should have been decentralised to structures and mechanisms that have been created in the National Department of Health (Directorate IHL and the Sub-Directorate Policy and Donor Co-ordination). Similarly, the National structure should have devolved specific aspects of the ODA process to provinces, which should have created structures and mechanisms that mirrored those at national level for dealing with the ODA process. On the one hand, centralised structures (IDC and IHL) have been slow and reluctant to cede, while decentralised levels have been slow to establish

structures and mechanisms that would justify the further devolution of roles and responsibilities without significant risk.

It is important to note that most of the negative findings/observations raised above are manifestations of problems that different stakeholders experience with ODA in the SA health sector. These multiple manifestations often have their origin in a few common causes. In seeking solutions to these problems, it is important not to become fixated on manifestations, but to identify and address the main causes of problems. It is also of critical importance to build on, learn from, strengthen and/or expedite initiatives (of which clear and commendable evidence was found) that have already been taken to address/solve many of the problems that are raised here. These are not limited to the health sector, of course, but would include other sectors and government departments where considerable progress towards effective management and coordination of ODA have been made and whose institutional arrangements in this regard are widely acknowledged as “best practices”.

CHAPTER 6 RECOMMENDATIONS

Shcneider and Gilson (1999:266) rightfully identify the following conditions to the potentially meaningful role that ODA can play: "These conditions include not only appropriate mechanisms to manage aid, but also a degree of trust and dialogue between donors and recipients. As an 'encounter between individuals with different interests, resources and power', the aid relationship is prone to conflict. The ability to manage conflict in a productive way is of key importance".
The recommendations that follow are proposed with a view to:

- enhancing SA ownership of the ODA process;
- enhancing coordination and management of ODA in the SA health sector;
- optimising the impact of ODA on the SA health sector

and are, as such, based on the assumption that the key to SA ownership of the ODA process lies in the following:

- Leading the ODA agenda
- Ensuring alignment to national development priorities
- Driving effective management and coordination
- Developing appropriate capacity (at national, provincial and local government level) to deal effectively with the ODA process
- Ensuring cohesion and integration for maximum results/impact
- Monitoring and evaluation of impact.

Available data indicate that ODA in the health sector appears to be levelling off. Many ODA-supported initiatives have been completed, while many will be drawing to a close during 2000. The larger donors such as EU, USAID, DfID and Japan will be continuing their support to the SA health sector beyond 2000. It is especially the smaller donors that end their ODA to the health sector as the initiatives they are supporting are completed. This emphasises the necessity of managing remaining ODA with a view to optimal impact.

Recommendations are directly associated with the observations that were made during the course of the investigation and in many instances represent and reflect the opinions of stakeholders who were consulted in the process. The presentation and discussion of recommendations in the subsequent section will correspond to the deployment of the arguments pertaining to the critical analysis of institutional arrangements in the SA health sector in the previous section of the report. First of all, general recommendations reflecting on general observations will be discussed, followed by recommendations that pertain to specific phases of the ODA process.

6.1 General recommendations: ODA in the SA health sector

It is generally recommended that inclusive deliberations on ODA in the SA health sector be continued under the leadership of the Directorate: International Health Liaison. At the onset of such deliberations, critical matters for discussion - including the discussion of all applicable principles, requirements and implications - would include:

- Identification and involvement of stakeholders in the transformation of the ODA process in the SA health sector;

- The approach to ODA in the SA health sector and its implications for institutional arrangements;
- Decentralisation of functions, roles and responsibilities pertaining to the ODA process in the SA health sector;
- Models and systems for the management of ODA in the SA health sector (including record-keeping and information management on ODA).

It is proposed that the deliberation of these issues be continued as part of ongoing discussions among all stakeholders concerned, and that the outcomes of this debate be incorporated in the review and amendment of institutional arrangements, and/or the establishment of new arrangements pertaining to ODA in the SA health sector.

As far as the decentralisation of functions, roles and responsibilities pertaining to the ODA process in the SA health sector is concerned, the following general recommendations would apply:
In view of the increased independence and maturation of provinces and the increasingly important role that local government is bound to play in the new health dispensation, it would be advisable for the planning of ODA to be decentralised accordingly. The focal point for a Sector-Wide approach to ODA in the SA health sector should therefore be the provincial level rather than the national level. This implies that needs and priorities for ODA in the various provinces should enjoy equal consideration when national frameworks and guidelines are applied to decide on the targeting and allocation of ODA in the SA health.

For purposes of the ODA process, the SA government should not be seen as a monolithic entity, but as comprising of three spheres. The roles and responsibilities of these three spheres in relation to the ODA process should be clear. For example, broad inter-country liaison and negotiation, general approval of ODA pledges and initiatives, support, advice and guidance to donors, fund-seekers and initiators of projects, as well as the development of frameworks and guidelines for co-ordination and monitoring of ODA in accordance with national policy, naturally the national sphere of government has to be the principal role-player. However, when it comes to actual priority setting for ODA, as well as targeting, prioritisation and implementation of ODA in a specific sector, programme or project, and in specific provinces, districts/sub-districts and communities, the provincial and district/local spheres of government should clearly become more, and also more directly involved in decisions about ODA. Such middle and lower levels of government should then also take the responsibility and the concomitant accountability for ODA.

A fundamental issue that has to be resolved is the conceptualisation of the "SA health sector" with specific application/reference to ODA. The concept that eventually applies will affect all subsequent discussion and decisions in this regard. Concepts that were encountered during the study are the following:

- The SA health sector as constituting of public health services managed and provided by national, provincial and local levels of government, *i.e.* the SA health sector as the sum total of governmental health structures and services.
- The SA health sector as consisting of both public and private health services, *i.e.* the SA health sector as the sum total of the public/governmental **and** private (for-profit and non-profit) structures and services.

Arriving at a working definition of the SA health sector is of critical importance for the identification of stakeholders in ODA in the SA health sector whose main immediate responsibility will be to take the transformation of the ODA process forward in a participatory and transparent way, have to. It is also fundamental to the concepts

that will eventually be adopted for "sectoral planning of ODA" and a "Sector-Wide Approach to ODA" in the SA health sector. Other key components/phases in the ODA process should also be conceptualised and operationalised/"unpacked" into responsibilities and activities that can be assigned to relevant stakeholders. However, this must be done with due account of the approach to ODA that will apply in the health sector. If a Sector-Wide Approach is to be pursued, then the components/phases of the ODA process have to be conceptualised and "unpacked" accordingly, and roles and responsibilities have to be assigned to different stakeholders in accordance with their position in the national context. For example, if a Sector-Wide Approach is to be pursued, it must be decided which level of government will be regarded as the focal point for such an approach. Depending on this decision, national government, provincial government, local government, as well as donors would all have distinct roles and responsibilities regarding the planning, co-ordination, implementation, management and evaluation of ODA. These roles and responsibilities will be different depending on whether the focal point for a Sector-Wide approach is the national or provincial level of government. Note that not all responsibilities and activities are always manifest in a particular concept. A concept often contains several latent/hidden/implied responsibilities and functions. Those sections of the *White Paper for the Transformation of the Health System in South Africa* that deal specifically with ODA could be used as a starting point and guideline in the process of analysing and "unpacking" concepts into responsibilities and activities. An example of how this could be gone about is contained in Appendix 4.

These recommendations have direct implications for different stakeholders in ODA in the SA health sector at national, provincial and local level, as well as for donors and NGOs. As such, they could/should constitute the common ground on which different stakeholders could further negotiate the issues involved. It could also serve as basis and framework for SA stakeholders to develop appropriate and process-friendly institutional arrangements for managing and coordinating ODA by assigning the responsibility to implement these recommendations to the various existing structures and bodies that have been created to manage the ODA process, or by establishing such necessary structures and bodies, as well as the interfaces among them. Structures and bodies dealing with, or which will be established to deal with the ODA process must have the necessary political status and mandate to fulfill this role without additional levels of bureaucracy being created in the process.

In this rubric several dimensions pertaining to ODA are at stake, *viz.* solicitation, information systems and management, communication and co-ordination, need identification, prioritisation and target setting, distribution and allocation, monitoring and evaluation. The mechanisms to be considered to enhance intergovernmental co-operation could comprise a process that will accommodate the following:

Firstly, the **needs, wishes and priorities of various tiers of government** (national, provincial and district/local) **and interest holding beneficiaries** (including NGOs and CBOs) should be accommodated in a representative and transparent way. In this context, the following procedures or mechanisms could be explored, as these emerged from discussions with various stakeholders in the ODA field:

The **establishment of a national representative mechanism for the management and coordination of ODA in the health sector** of which the IDC and IHL should merely be administrative extensions. Three models present in the thinking of respondents who were consulted/interviewed:

The **first model** represents current though within the National Department of Health, namely to establish a representative but essentially **governmental mechanism** consisting of government and governance representatives and with the proviso that such a mechanism also pertinently encapsulates and represents those decentralised structures at regional and district level that have thus far been excluded. Note, however, that strong feelings were raised that if such a mechanism is to be merely an added layer of government bureaucracy without allowing for flexibility and innovation, it is destined to fail.

The **second model** argues firstly for more thorough deliberation on institutional mechanisms for dealing with ODA. The point of departure is that co-ordination and arrangements pertaining to ODA need to be taken out and kept out of the impairing bureaucratic mechanisms of government, and to make these the responsibility of a joint body representative of government and NGOs with a view to explore best possible practices. The plea is thus for an **extra-governmental mechanism** to deal with ODA. In this regard, a health-sector-specific agency of the kind of the emerging National Development Agency (NDA), the National Development Trust (a re-engineered IDT) or the HST were put forward as a possible options or model bodies to co-ordinate, dispense, monitor and evaluate ODA. (In similar vein, provincial representative mechanisms or processes could be established to fulfil essential functions for decision-making on ODA flowing to the provinces, while keeping in mind that the magnitude of provincial ODA does not justify the establishment of major structures and processes.)

A **third model** that has to be added with a view to comprehensiveness is the **status quo model**, that would mean that the structures and mechanisms that are currently involved in and responsible for various aspects related to the ODA process in the SA health sector should be maintained in their present forms and functions.

These issues can only be resolved with the participation and commitment of all stakeholders in ODA in the SA health sector. It is proposed that the initiative and leadership for a participatory process aimed at transforming the ODA process in the SA health sector should come from the Directorate: International Health Liaison in the Department of Health.

Other aspects of ODA in the SA health sector that affect the entire ODA process and should receive urgent attention as part of the transformation of this process are the following:
Systems, mechanisms and processes for record-keeping and management of information on ODA in the SA health sector should be developed and implemented as part of the transformation of the ODA process. All due requirements for quality record-keeping and principles of sound information management should be observed in the process. Systems and mechanisms must be developed and implemented to ensure that standardised, relevant information on **all** ODA flowing to the SA health sector is captured in a central databank for purposes of planning, co-ordination and management.

Effective channels and mechanisms of communication between the various stakeholders in ODA in the SA health sector must be developed. There must be continued dialogue and flow of information between donors and relevant SA stakeholders on the mutual conditions, specifications and requirements that apply to ODA in the SA health sector, as well as on all other administrative and operational issues pertaining to ODA in the SA health sector. Memoranda of Understanding between donors and the relevant SA stakeholders must be based on a clear, mutual

understanding of all policies, conditions, specification, requirements and other issues involved.

Against this background, the following recommendations regarding specific phases of the ODA process are put forward:

6.2 Recommendations: Record-keeping on ODA in the SA health sector

What became evident during this study, is that record-keeping on ODA in the SA health sector is grossly inadequate. The lack of comprehensive and reliable information affects the planning, management, co-ordination and evaluation of ODA. It is therefore strongly recommended that the National Department of Health, as well as provincial health departments, donors and NGOs/CBOs implement record-keeping systems and processes that will enhance the ODA process as a whole. Ideally speaking, such a record-keeping system would capture information that will enable an accurate reconstruction of the origin, allocation and distribution of ODA in the SA health sector. It would therefore capture the following minimum data on the origin, type, value, purpose and recipients of ODA:

- **Origin of ODA and name of donor:**
  - Name of bilateral government/ embassy/official agency
  - Name of multilateral organisation/agency
  - Name of private trust, foundation, NGO or organizations

- **Type of ODA,** e.g.**:**
  - Grant Aid
  - Technical co-operation
  - International Emergency Assistance
  - Loan
  - Contributions to multilateral institutions, formally classified as capital subscriptions and contributions to international organisations. The advantages of this type of ODA are described as follows: "Unlike bilateral loans, which are direct diplomatic initiatives extended by donor countries to recipients, aid provided through multilateral organizations has the advantage in that political neutrality is guaranteed. It also allows advanced specialist knowledge and experience in each multilateral organization to be harnessed and the resources of the global aid network to be put to greater use" (Association for the Promotion of International Cooperation (APIC), 1999;5).

- **Monetary value of ODA** (in currency of donor **and** converted to SAR – with indication of exchange rate during time of conversion)

- **Date on which ODA was committed**

- **Dates on which payments were received**

- **Disbursements to date**

- Information on any **adaptations, amendments or extensions** of ODA that imply a deviation from the original agreement

- **Recipient**
  - Name and level of government department that received ODA (National or which specific province/s)
  - Name of NGO / CBO

- **Further allocation/devolution**
  - Where an original recipient allocates the ODA it received or part thereof to another recipient, the name of this recipient, the type and value of the ODA allocated to it, as well as the purpose of the allocation have to be recorded. (For example, where the national Department of Health receives ODA and further allocates it to selected provinces for specific purposes, it has to be recorded.)
  - Dates on which payments/transfers were made

- **Administrator of ODA**

- **Project/programme information**, including
  - official name of project/programme receiving the ODA, as well as the names of sub-projects/-programmes if applicable;
  - nature of the project/programme, with specific reference to its goals and objectives;
  - specification of which theme/field/area of health the programme/project relates to;
  - date of commencement;
  - anticipated date of completion;
  - status of project (ongoing, completed or suspended);
  - dates of receipt and value of ODA received;
  - expenditure to date.

- **Implementing agency**, i.e.
  - the name and level of the government department, or the name of the NGO, parastatal, institution or individual responsible for the implementation of the project/programme.

- **Contact person/s,** i.e
  - particulars of person/s who can be contacted in connection with projects/programmes, including names, mailing addresses, physical addresses, telephone and fax numbers, and e-mail addresses.

In addition, the information system should allow for manipulation of data to allow reconstruction of the allocation and distribution of ODA according to

- Sector (public, private, parastatal)
- Level (National, provincial, local)
- Geographical area targeted (whether ODA is for the benefit of SA as a whole, or for a particular province, region, district or community – in which case it has to be named)
- Theme/area of health targeted (e.g. technology development, human resource development, specific diseases, policy development, etc.)

It is essential that such a record-keeping system constitutes an integrating part of planning, management and decision-making processes pertaining to ODA. For this reason, it is imperative that the National Department of Health, in close collaboration with the Department of Finance, takes the lead in developing this record-keeping system so that a comprehensive database on ODA can be established. At the same time, the connection of the database with planning, management and decision-

making processes pertaining to ODA has to be effectuated. This does not imply that donors are exempt from record-keeping responsibilities. In addition to their accountability towards their own governments or governing bodies, they should be sensitised towards the information needs for purposes of planning, management and co-ordination of ODA on the part of SA authorities. However, this could hardly be expected of donors if a concerted effort aimed at putting the planning, management and co-ordination of ODA on a sound, information-based footing on the part of SA health authorities is not evident. In other words, it would not make sense to invest resources of any kind in the development of an ODA information system for the SA health sector if the process of decision-making on, and planning, management and co-ordination of ODA in this sector will not benefit from it.

Should the managerial need and political will for the implementation of a comprehensive, standardised database on ODA in the SA health sector exist, it is proposed that it takes on an interactive electronic format. Donors, recipients and administrators of ODA in the health sector should be able to contribute to this database in a regulated and standardised manner and to make use of it according to their own needs. The development and implementation of such an information system for ODA in the SA health sector is a real need that could benefit considerably from official grant aid and technical assistance. Donors could thereby demonstrate their commitment to accountability and transparency of decision-making in the ODA process.

6.3 Recommendations: Planning of ODA in the SA health sector

Planning of ODA at a national level

First of all, recommendations pertaining to the planning of ODA at a national level will be dealt with. Since the main value of ODA is perceived to be its responsiveness to new and emerging needs/priorities in the health sector and the fact that it can be directed towards areas of need/priority that are not directly concerned with practical service delivery, but which are nevertheless crucial determinants of the quality of service delivery (most notably items on the "transformation agenda" that would otherwise have been stalled due to budget constraints), it is important that the planning of ODA in the health sector should make provision for the retention of this flexibility and responsiveness.

The objectives and flow of ODA should, within a larger synergetic policy framework, broadly harmonise with strategic objectives in the SA health sector. (Note that, once again, the importance of arriving at a working definition for the "SA health sector" within the context of ODA is hereby reiterated). However, the broad political objectives of government should not necessarily and in all respects coincide with or dominate the objectives and flow of ODA (*i.e.* the ODA agenda). In many cases, it is imperative that these priorities are different to ensure that the real needs and priorities of various stakeholders are dealt with and considered equally in the planning of ODA. In this view, ODA should be targeted at those areas in the health sector where

- critical[26] shortfalls, backlogs and neglect are evident or imminent, but

[26] In this context, the concept "critical" refers to the magnitude of real and potential **consequences/impact** of shortfalls, backlogs and neglect that are evident or developing in the health sector. These consequences/impacts can manifest in social, political and epidemiological spheres of society at large, or specifically within the health sector.

- absorption capacity on the part of recipients could maximise the benefit and impact derived from ODA and
- ODA initiatives can be sustained (i.e. where recurrent costs ensuing from the initiatives can be provided for in the longer term, and where dependencies and long-term reliance on ODA are not likely to develop).

In addition, where ODA takes the form of
- loan financing, it must be integrated into (and not additional to) the budget, and must fit the country's overall loan repayment profile
- technology investment, the technology invested in must be appropriate, sustainable and affordable for the beneficiary
- technical assistance, sufficient provision for transfer of skills/expertise must be made in the terms of reference, placement and contracts of TAs.

(cf. Department of Finance, 1998:45 – 46).

Therefore, the main considerations in the allocation of ODA should be to ensure that it is targeted at:
- real and practical needs and priorities (versus perceived and untenable needs and priorities)
- areas where real impact can be achieved or where a real difference can be made
- areas and recipients where optimal absorption capacity is evident
- areas and recipients where responsible utilisation, stewardship and ownership can be ensured
- areas and recipients where the benefits of ODA-initiatives can be sustained
- areas and recipients who, or who are prepared to, subject ODA-initiatives to rigorous monitoring and austere evaluation

It would be one of the responsibilities of the principal national SA roleplayer in the ODA process to ensure that these conditions are met. In this instance, it would be the Directorate: International Health Liaison. This Directorate must ensure that the formulation of bi- and multi-lateral agreements and the structuring of ODA packages at national level are guided by these criteria. However, other stakeholders must be sufficiently consulted and afforded an equal opportunity to contribute to the development and implementation of such guidelines and frameworks. Specific attention must be devoted to the varying needs and priorities of different provinces, as well as the emerging and increasingly prominent role of local government within the context of the District Health System.

The planning of ODA in the SA health sector must further be experienced by al stakeholders as inclusive and transparent. Processes, mechanisms and systems aimed at aligning ODA with real needs and priorities in the SA health sector, as well as the criteria according to which this alignment is effected, must be clear, understandable and acceptable to all stakeholders. It is the responsibility of the Directorate: International Health Liaison to ensure that such processes, mechanisms, systems and criteria are developed in a participatory manner, and that they operate and are applied in a fair and transparent manner. One of the criteria that should apply in decisions about the targeting and allocation of ODA in the SA health sector is the absorption capacity of the recipient.

The national agency/mechanism (and where necessary also provincial ones) should essentially comprise a technical process when it comes to need identification, priority setting, monitoring and evaluation of ODA in the particular sphere of jurisdiction. Such mechanisms should meet regularly, and especially when ODA is to flow into the country (or into a particular province). The structuring of these ODA agencies or mechanisms should honour the principles of decentralised planning and "bottoms-up"

decision-making, i.e. provincial and local authority representation at national level, and provincial and district representation at provincial level, and in both cases providing for management and governance interests to participate.

The agendas for both the national (and provincial) agency/mechanism should pertinently focus on the following tasks: soliciting of ODA, communication and flow of information, co-ordination of ODA and networking with stakeholders, needs identification and priority setting for ODA, allocation and disbursement of ODA, monitoring, control and evaluation of ODA investments, as well as record-keeping for purposes of information management. As far as record-keeping is concerned, examples of best practices and proposed best practices that could inform the development of mechanisms and structures for the SA health sector exist and should be explored.

It is anticipated that the establishment of "clusters" holds potential for both improved inter-departmental, inter-sectoral and inter-disciplinary co-ordination and collaboration as far as the planning of ODA in the SA health sector is concerned, as well as for "cross-cutting" issues to be mainlined in the ODA agenda for this sector. However, the planning of ODA should then be pertinently placed on the agenda and be made part of the role and responsibilities of such "cluster committees". The recommendation is that the establishment of clusters should be supported and facilitated, if necessary, while their role in the inter-departmental, inter-sectoral and inter-disciplinary planning of ODA in the SA health sector should feature on their agendas from the beginning.

The following case study is illustrative of an attempt by a donor to establish a foundation for the planning of its sector-wide support to the SA health sector:

CASE STUDY

In an attempt to improve the planning of its ODA in the SA health sector, this donor is structuring is co-operation with the SA government according to a medium-term framework based on a regular collaborative review of priorities. ODA to the health sector is planned according to a sector support programme aimed at funding priority elements of the new health policy that would otherwise have been stalled due to budgetary constraints. Under this umbrella programme, ODA is provided for purposes of capacity development, systems development, rehabilitation of health facilities and control of the HIV/AIDS epidemic. The assistance itself is linked to specific projects within these areas.

In the absence of a clear, transparent and long-term strategy for co-operation between the SA Government and the donor, support has been based on individual requests for project support from the Department of Health and NGOs. The donor and the national Department of Health have since agreed to establish a coherent, transparent and comprehensive strategic framework to facilitate longer-term planning of and provide clearer direction for support. The purpose of such a framework would be to:

- provide a comprehensive description of public health sector priorities and challenges to guide co-operation between the donor and SA public health sector for at least the next three years;
- assist internal co-ordination, as well as co-ordination between this donor and other donors in the SA health sector;
- enable the donor and the Department of Health to draw up and evaluate specific proposals/requests for support for the period 1999 to 2002;

- provide a platform for a movement away from fragmented and *ad-hoc* project-based interventions to a more focused, impact-orientated and sector-wide approach.

Planning of specific ODA initiatives

Recommendations pertaining to the planning of **specific ODA initiatives** are the following:

It is the responsibility of the donor, recipient and implementing agent of an ODA initiative to ensure that all stakeholders are identified and engaged in the planning and subsequent implementation of the initiative to minimise the risk of the initiative being disrupted or derailed by stakeholders who are either not supporting of the initiative or who are not supportive of the initiative because they haven't been involved in the planning and implementation thereof. Mutual expectation and responsibilities of all stakeholders, as well as agreements on the outputs, outcomes, monitoring and evaluation of ODA initiatives have to be negotiated and clarified as part of planning.

Planning of new ODA initiatives should benefit optimally from the lessons learnt and experience gained during previous processes. One of the key responsibilities in the ODA process should be the systematic identification and sharing among stakeholders of "best practices" and reasons for failure in ODA initiatives. This should include international experiences and should not be limited to SA initiatives only. However, to incorporate this into the ODA process implies that the responsibility has to be identified and assigned to a specific stakeholder, while the necessary processes, mechanisms and systems to support this function should be developed and implemented.

6.4 Recommendations: Management and Co-ordination of ODA in the SA health sector

The concept "management and co-ordination" has to be clarified, "unpacked" and operationalised within the context of ODA in the SA health sector. Key questions that have to be answered are, *i.a*.:

- What does the management and co-ordination of ODA in the SA health sector entail?
- What aspects and areas of ODA in the SA health sector have to be managed and co-ordinated?
- How, and by whom?

Dimensions, elements, aspects and areas of ODA that have to be managed and co-ordinated and the level at which management and co-ordination of different aspects of ODA have to take place need to be identified. Specific responsibilities associated with the management and co-ordination of different aspects of ODA have to be assigned to appropriate stakeholders, who must have the necessary skills and capacity to fulfil these responsibilities. The clarification of roles and assignment of responsibilities associated with the co-ordination of ODA should not be done in isolation by different stakeholders. Co-ordination is by nature a complex process reliant on a clear understanding among different stakeholders of their mutual expectations and respective roles and responsibilities. The development and implementation of systems, processes and mechanisms aimed at the co-ordination of ODA should therefore be inclusive of all stakeholders. However, as with other phases of the ODA process, the management and co-ordination of ODA are associated directly with the approach towards ODA in a particular sector. This reiterates the need for clarity to be obtained and a negotiated agreement to be

reached among stakeholders about the approach towards ODA that should be pursued in the SA health sector.

The co-ordination of ODA in the SA health sector encompasses several dimensions, *i.a.* the co-ordination of stakeholders, the co-ordination of the flow of ODA, and the co-ordination of the different phases of the ODA process at large. As for the co-ordination of stakeholders, it is important that the activities of donors and recipients (governmental and NGOs) in the health sector are co-ordinated as far as the soliciting, commitment, release and receipt of ODA are concerned. The co-ordination of stakeholders should inform the process of co-ordinating the flow of ODA among areas, recipients and issues with a view to equity. This dimension of co-ordination rests on the assumption that guidelines, terms and conditions regarding the soliciting, commitment, release and receipt of ODA are in place and enforced. Finally, the different phases of the ODA process should be co-ordinated to ensure that the planning, management, implementation, monitoring and evaluation of ODA initiatives run smoothly, effectively and efficiently. For all these aspects and dimensions, responsibilities have to be assigned and processes and mechanisms have to be established to ensure that co-ordination takes place in an effective, efficient and transparent manner.

A satisfactory arrangements aimed at the co-ordination of donor activity in the SA health sector should be developed. Regular, inclusive, participatory discussions involving donors and relevant SA stakeholders appear to be preferred above the annual one-to-one discussions that are taking place at present. Some stakeholders referred to past arrangements facilitated by the former IDCC and IDT that worked well, and are of the opinion that the implementation of systems, mechanisms and processes aimed at donor co-ordination in the SA health sector could benefit from the lessons ensuing from these past experiences.

Government departments (national and provincial), as well as donors and NGOs must be the targets of intensive information and training campaigns regarding the role of IDC in the ODA process and their respective roles and responsibilities in relation to this. It is the responsibility of national and provincial government departments, as well as donors and NGOs, to ensure that the systems, mechanisms and processes they develop and implement for purposes of managing and co-ordinating ODA are compatible with those of IDC and are standardised along the same lines.

A decision has to be taken whether the process of identifying needs and priorities for ODA must be an internal affair, or whether it should be a technical affair facilitated by outside agents. An agent of this nature could develop and facilitate processes according to which needs and priorities for ODA are identified in a comprehensive, technical and impartial manner. The assumption and accompanying recommendation are that the agent must, in close collaboration with all other stakeholders in the ODA process, formulate criteria for identifying and prioritising needs for ODA, as well as the process according to which such needs are identified and prioritised,

6.5 Recommendations: Implementation of ODA initiatives in the SA health sector

The identification and clarification of all legal and technical requirements pertaining to ODA in the SA health sector is an important function of the IDC and Directorate:

International Health Liaison, as is the explanation and communication of these requirements to all other stakeholders in the ODA process.

The successful implementation of ODA initiatives could benefit from capacity development in project management among implementing agents. It is anticipated that Programme Management Services (PMS) in the Department of Finance could be instrumental in such a process and that the envisaged role of this expert service in relation to project management capacity development should be facilitated and supported.

The general opinion among the majority of stakeholders is that the implementation of ODA initiatives will benefit if prior bureaucratic processes could be completed in time for committed ODA to be "released" in the form of budget support at the beginning of the particular financial planning cycle/period for which it formed part of the recipient's strategic planning.

In as far as the implementation of ODA initiatives are impeded by inadequate planning and limited absorption capacity on the part of recipients, the same recommendations that were proposed for addressing these impediments in relation to the planning of ODA initiatives would also apply to the implementation of ODA initiatives.

6.5 Recommendations: Monitoring and Evaluation of ODA in the SA health sector

As with other phases of the ODA process in the SA health sector, the concept "monitoring and evaluation of ODA" has to be clarified, concretised and operationalised in its full extent and meaning. Roles and responsibilities pertaining to different aspects of monitoring and evaluation of ODA have to be identified and divided among/assigned to different stakeholders. Care should be taken that monitoring and evaluation do not focus on administration and inputs, but make provision for outputs and outcomes as well.

In this regard, a recommendation that was originally made by Petersen, *et al*. (2000:47) with specific reference to the monitoring and evaluation of EU-supported initiatives in the SA health sector, is as appropriate for purposes of this study. It is proposed that: "A standardised reporting system should be introduced immediately, employing uniform formats and levels of detail to allow for effective monitoring of the progress made with the implementation of ODA initiatives in the SA health sector.
The reports should include verifiable information on:
Implementation

- Results to be achieved within the reporting period
- Level of achievement using specified indicators
- Activities planned for the initiative
- Activities implemented to date of reporting
- Realisation of assumptions
- Deviations from the planned schedule
- Corrective actions taken or proposed

Financial reporting

- Expenditure budgeted for the period per planned activity
- Actual expenditure per planned activity
- Accumulated budget
- Accumulated expenditure
- Deviations from the budget

- Motivation/explanation for deviations
- Corrective measures taken or proposed
- Cash flows
- Notes to budget"

(Petersen, *et al*. 2000:47)

The development of indicators, criteria, processes and systems according to which a specific initiative is to be monitored and evaluated should form part of the planning and implementation cycle of that initiative, and the findings of such monitoring and evaluation processes should inform and enhance the conceptualisation, planning, management, implementation and evaluation of the particular initiative as well as that of subsequent initiatives.

The monitoring and evaluation process should make provision for the identification of best practices, critical success factors and reasons for failure in ODA initiatives and the sharing of this information with other stakeholders to the benefit of the planning and implementation of future ODA initiatives.

As far as the monitoring and evaluation of financial aspects of ODA initiatives are concerned, Gauteng and the Free State among the provinces that that have developed effective interfaces with the FMS to enable the manipulation of data for purposes of tracking, monitoring and reporting on expenditure related to the implementation of ODA initiatives. It is recommended that best practices should be identified form these two models, and that these should be rolled out to other provinces and stakeholders.

The skills and capacity of those responsible for monitoring and evaluating ODA initiatives have to be developed so as to optimise the value of this crucial phase in the ODA process.

6.6 Recommendations: Impact assessment of ODA in the SA health sector

This is another phase of the ODA process that is intrinsically linked to the prevailing approach towards ODA in a particular sector. It is therefore recommended that the issue of impact assessment be included pertinently on the agenda for continued deliberation among all stakeholders in the ODA process. Until the issue of which approach to ODA would apply in the SA health sector is resolved, impact assessment could take various forms. For example, the impact of individual projects or programmes can be assessed by comparing inputs to outcomes achieved, provided that the desired/anticipated outcome of a programme/project has been clearly identified, contextualised and conceptualised, and the assessment process takes place according to objectives, indicators and methods that were be identified and developed during the planning of the programme/project.

Should a Sector-Wide Approach to ODA in the SA health sector be pursued, it is recommended that objectives and indicators enabling the long-term monitoring and assessment of the alignment between the targeting and allocation of ODA on the one hand, and government initiatives aimed at the achievement of strategic goals and objectives in the SA health sector on the other hand, be developed. Should a quasi-sectoral approach to ODA be found to be appropriate, it is proposed that objectives and indicators enabling the long-term monitoring and assessment of the degree to which ODA fills in

critical gaps in the SA health sector where local resources cannot reach is developed.

Systems, processes, instruments and mechanisms developed with a view to assessing the impact of ODA in the SA health sector must enable the disentanglement of the impact of ODA on the health sector (which constitutes a very small proportion of health spending in SA) from that of other contributing factors. It must also make provision for the fact that impact assessment is by nature a long-term process.

A cross-cutting recommendation pertains to information management and record-keeping on ODA in the SA health sector. Better co-ordination and a more standardised format of record-keeping would allow donors, recipients and implementing agencies to plan, manage and evaluate ODA-initiatives in a more rational manner, thereby enhancing the impact of ODA.

6.8 Recommendations: A summary

1. Both SA stakeholders and donors must guard against the myth of "infinite need and absorption capacity" as far as ODA in the SA health sector is concerned. It is often assumed that, in an area where needs are many, varied and fundamental, any kind of support pledged and utilised for any purpose will inevitably hold benefit. In the process, sight is sometimes lost of the capacity of the recipient/beneficiary to meaningfully absorb the support – i.e. to turn it into tangible and sustainable benefit in areas where it is most needed.
2. Common ground and a clear framework for collaboration in and coordination of ODA in the SA health sector must be established. This must culminate in a shared notion and agreement among all stakeholders (and among SA stakeholders, those at all levels of authority and care) on what the impact of ODA on the SA health sector must be. It must be based on the understanding and agreement that ODA can contribute significantly to filling in critical gaps where SA health care resources fall short.
3. It is not possible to conceptualise the ODA process and the key components that comprise this process in a generic fashion. Broadly speaking, the ODA process consists of the planning, management, co-ordination, monitoring, evaluation and assessment of impact of ODA. Different stakeholders have different, yet crucial roles and responsibilities with regard to each of these components. However, there has to be sufficient clarity among all stakeholders about the nature and scope of these components in order for them to meaningfully perform/fulfill their roles and responsibilities in relation to each component. However, before this can be done, the approach towards ODA in the sector concerned has to be clarified, since this will determine the nature and scope of the components of the ODA process, as well as the roles and responsibilities of different stakeholders in relation to the ODA process.
4. In developing institutional arrangements for dealing with the ODA process in the SA health sector, examples of best practices in other SA government departments, as well as appropriate best international practices, should be explored with a view to their implementation in the SA health sector.
5. The framework for collaboration in ODA in the SA health sector must make provision for participatory, objective (technical) processes of strategic needs identification and prioritisation involving all SA stakeholders (national, provincial, local and NGO). These stakeholders must identify needs and priorities according

to standardised guidelines and criteria that will allow for fair comparisons between needs and priorities identified by different stakeholders and potential beneficiaries of ODA. The process of needs identification and prioritisation must remain focused on the objective/technical identification of critical gaps where SA health care resources (national, provincial, local and NGO) fall short and which can be meaningfully and sustainably "filled" by appropriate types of ODA. The absorption capacity of the recipient/beneficiary must also be taken into account. Tendencies towards centralising arrangements and decision-making on ODA should be seriously reconsidered and preferably avoided. The ideal should rather be to free up and facilitate the flow and utilisation of ODA.

6. The ODA agenda for the SA health sector should be based on a ranking of stakeholders' needs and priorities according to a "gauge" of need providing for current and projected burdens of disease, poverty, risk and inequity, as well as status and performance of health services, absorption capacity for ODA, sustainability of ODA-supported initiatives and political and diplomatic priorities on the one hand, and available capacity and resources on the other hand. ODA should be targeted at areas of most critical need where capacity and resources are clearly lacking, where ODA can be maximally and most sustainably absorbed, and which carry the highest political and diplomatic priority. Although donors' preferences should be accommodated as far as possible, the allocation and utilisation of their ODA should be negotiated and guided on the basis of such an ODA agenda.
7. Policies, priorities and institutional arrangements pertaining to ODA in the SA health sector must be formalised and communicated directly to all stakeholders. Communication of this nature must take place at a frequency and in an inclusive, participatory manner that will facilitate coordination and the maintenance of mutual cooperative relationships.
8. With the mandate from and facilitation by SA, donors should attempt to optimally structure and coordinate their support in the SA health sector according to the SA health sector ODA agenda.
9. The utilisation and impact of ODA on the SA health sector can be greatly enhanced if the institutional arrangements and processes aimed at managing and coordinating ODA can be completed in such time that the "release" of ODA to the relevant recipients can coincide with the beginning of the financial year.
10. Clear guidelines, mechanisms, processes and indicators for the regular assessment of ODA programme/project outcomes must be developed in a participatory manner and adhered to by all stakeholders.
11. Based on the anticipated aims, outputs and outcomes of the ODA agenda, guidelines, mechanisms, processes and indicators for the assessment of the impact of ODA on the SA health sector should be developed.
12. Monitoring and assessment of ODA programmes/projects and the impact of ODA on the SA health sector should be participatory, transparent processes of which the results should be presented to and discussed by all stakeholders at an appropriate place and time so as to enhance ownership, accountability and coordination.
13. NGOs with impeccable records for spending ODA effectively and optimising the impact of ODA should be strengthened and entrusted. In addition, NGOs on the periphery should be supported and empowered to facilitate the decentralised spread and utilisation and ODA. However, structures and mechanisms must be (put) in place to optimise coordination between NGOs and official health services as far as provision of services and receiving of ODA are concerned.

14. The establishment of “clusters” / “sectors” to deal strategically with cross-cutting issues in the health sector should be fast-tracked and supported. The structuring and composition of “clusters”/”sectors” must ensure that justice is done to cross-cutting issues such as gender, water & sanitation and environment in the health sector – also as far as ODA initiatives are concerned. The identification and prioritisation of ODA needs in these collective fields of interest should be a fixed item on the agendas of the co-ordinating/managing bodies of such “clusters”/”sectors”. Their role/functions should also include the co-ordination of ODA in a particular “cluster”/”sector”, as well as the development of frameworks, guidelines an criteria according to which these issues are to be incorporated/addressed in ODA initiatives in the health sector.
15. Since a conclusion has not been reached in the debate on a sector-wide *versus* a project-based approach towards ODA in the SA health sector, it is proposed that this debate be pursued as part of ongoing discussions among all stakeholders concerned.
16. Record-keeping and information management on ODA in the SA health sector are in need of drastic improvement. Co-ordination and standardisation of these aspects of the ODA process should be among the priority issues to be clarified among the various stakeholders.

It should be clear that many of these recommendations imply a change in, or different, responsibilities and functions for various existing stakeholders in the ODA process in the SA health sector. Perhaps the most significant implications are for the IDC and Directorate: International Health Liaison. In accordance with the observation that the IDC has retained too many responsibilities and functions relating to ODA in various sectors instead of devolving those responsibilities and functions to structures that have been established to deal with ODA and the ODA process in various line departments, it is anticipated that continued negotiation between the various stakeholders involved in ODA in the SA health sector should lead to a transfer of responsibilities and functions from the IDC to the Directorate: International Health Liaison, and from the Directorate: International Health Liaison to appropriate structures at decentralised levels of government. In the process, there should be a clear identification and demarcation of the roles and responsibilities of the various stakeholders to ensure that critical functions are performed, but that those functions are performed by the most appropriate stakeholder at the most appropriate level of government.

6.9 Optimising impact of ODA in the SA health sector

Sight may never be lost – also in deliberating the possible direction and redirection of ODA – of the need to harness and secure the momentum of reconstruction and transformation. The implementation of existing policies and plans has in many respects reached a critical stage, particularly as far as the development and reinforcement of districts and local government, and thus the further devolution of authority and decision-making in the health sector, are concerned. Just as ODA has supported the process of policy development at a central, national level until now, new decentralised management and governance structures have to be supported to implement those policies in order to soothe the inequities, obliterate the fragmentation and soften the sharper edges of injustice, discrimination and inequity in the health sector.

CHAPTER 7 TOWARDS AN ODA AGENDA FOR THE SA HEALTH SECTOR

Since the briefing of the DCR health sector study included the development of guidelines according to which ODA in the SA health sector could be strategically directed over the medium term, the following is an attempt at proposing such guidelines, with due recognition of the fact that any attempt of this nature is at this stage premature, and could rightfully be regarded as presumptuous. Therefore, what is presented here are not clear indications of areas where ODA can have maximum impact, but simply the identification of broad areas where, based on the findings of the DCR health sector study, donor support would be regarded as well-directed:

- In tracing the origin of all the tragic distortions in the SA health sector, particularly those arising from persistent fragmentation, inequality and inequity, the private-public divide appears to emerge as major contributing factor. It would appear as though the forging of public-private sector interfaces and the bridging of profound gaps and divides between these two distinct sectors in the SA health system emerge increasingly as the main challenges for ongoing transformation and democratisation.
- Generally, the quality of data and information available on the flow of ODA in the SA health sector leaves much to be desired. Also, in conducting analyses in an attempt to reconstruct burdens of disease, risk, poverty and inequity in SA, the poor quality of data available cannot be ignored. This renders attempts at monitoring and evaluation of ODA, as well as identification and prioritisation of needs for ODA, ambiguous and rather precarious. Donor support for developing, reinforcing and broadening health information systems in SA in general, and management information systems for ODA in the SA health sector in particular, would be regarded as well-targeted.
- The continued restructuring of the public health sector, as well as the accompanying devolution of power to district health authorities and the important role that local government is intended/expected to assume in the health sector, constitute significant challenges in the SA health sector. There is a real need for supporting the process of continued restructuring in the SA health sector, for consolidating the gains that have so far been made, and for assisting and capacitating district health authorities and local government structures in meeting the expectations and challenges that confront them in the new health dispensation.

  In this regard, the reasoning and intention of the National Department of Health to work systematically towards more decentralised arrangements for need identification, priority setting and targeting of ODA should be welcomed as moves in the right direction. Within this mould the future role of provincial governments in ODA will be mainly to provide guidelines, co-ordinate and monitor ODA flowing to health regions and districts. Similarly, strides by the National Department of Health towards forging stronger involvement of governance structures (*vis-à-vis* management structures) at provincial and district levels clearly fall within the broader policy parameters and will certainly lend embodiment to rather neglected representation of these lower echelons in planning and decision-making. Also for health, for ODA in the health sector, and for priority setting for ODA, moves closer to the local governance sphere appear to be in the appropriate direction, the support and facilitation of which would be regarded as appropriate.
- The process of transformation affects all social institutions in SA and public health services are no exception. This means that public health authorities at all levels (national, provincial and local) have a "transformation agenda" in addition to a "continued service delivery agenda" to maintain with ever decreasing budgets and means. Most provincial and local health authorities reported that it is the

"transformation agenda" that is affected first and most fundamentally by limited resources. There is lack of capacity at provincial and local levels to "translate" policy into action – a situation which is aggravated by primary resource shortages. The building of capacity at provincial and local levels of government to carry the transformation agenda forward through the effective implementation of policies will expedite the transformation process so that a situation where resources will be directed from transformation to the provision of core services can be achieved sooner.

- Support for and facilitation of smoothing out problems and the clarification of roles and responsibilities of different stakeholders in the ODA process would be regarded as appropriate and meaningful. This includes the clarification of options and the facilitation of choices to be made between a Sector-Wide and a Project-Based Approach towards ODA in the SA health sector and the processes flowing from that.

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APPENDIX 1: ITINERARIES OF CONSULTANTS

RESPONDENT	DATE (2000)	RESPONDENT REPRESENTED BY	FACILITATED BY
National Dept of Health		Individual interviews with:	
	27 March	Dr Gopolang Sekobe (Chief Director: Environmental and Occupational Health)	Annalize
	28 March	Ms Gail Andrews (Director: Women's Health & Human Genetics)	Annalize, Dingie & Christo
	28 March	Mr Gerrit Muller (Director: Finances)and mr Andre Venter	Annalize, Dingie & Christo
	28 March	Mss Cynthia Mgijima (Acting Director: Nutrition) and Dianne Kloka, Bennie Sekakane, Anne Bear & Maudie de Hoop (Assistant directors: Nutrition)	Annalize
	30 March	Dr Ray Mabope (Chief Director: Special Proejcts)	Annalize, Dingie & Christo
	27 March	Ms Tsakani Mnisi, ms Winnie Moleko and mr Kgomotso Mogale (Deputy Directors: Policy & Donor Coordination)	Annalize
Gauteng Dept of Health	30 – 31 March	Individual interviews with: Dr Rafik Bismilla (Chief Director: DHS) Ms Dawn Joseph (Chief Director: Human Resources) Mr Gert Cromhout (Acting Director: Finance) Ms Mary-Grace Msimango (Director: Professional Services) Dr Caroll Marshall (Chief Director: Strategic Development) Dr Ahmed Valli (Director: Hospital services)	Christo, Dingie & Annalize Christo, Dingie & Annalize Annalize Annalize Annalize Annalize
Northern Province Dept of Health	31 March	Group interview with: Mr Sam Mathikhi (Human Resource Development) Dr John McCutcheon (Health Care Support Services) Dr Mathumi Masipa (Primary Health Care) Ms Elizabeth Malumani (Information Management) Ms Rose Mazibuko (District & Primary Health Care) Mr Professor Moshanu (Finances)	Dingie & Christo
KwaZulu-Natal Dept of Health	6 - 7 April	Group interview with: Dr Olaf Baloyi (Deputy Director-General) Ms Ruth Kitching (Finances)	Dingie & Christo
Eastern Cape Dept of Health	13 April	Individual Interviews with: Ms Vidah Mayana (HIV/Aids Unit) Ms Marlene Poolman (Communicable Diseases) Ms Joyce Matebese (Acting Chief Director: District Health Services) Mr Danie Voster (Acting Director: Finances) Ms Maudline Tembani (Planning & Information)	Dingie & Christo
Free State Dept of Health	20 April	Group interview with: Mss Elize Malan (Director: Finances) Andrea Crouse (Programme Manager, Irish Aid Clinic Building Programme) Priscilla Moshebi (Human Resources)	Dingie & Annalize

RESPONDENT	DATE (2000)	RESPONDENT REPRESENTED BY	FACILITATED BY
		mr Leon Joubert (Budget Office)	
IDC	14 April	Alex Saeleart (IDC)	Annalize
JICA	28 March	Group interview with: Mr Toshiyuki Nakamura (Deputy Resident Representative) and Ms Kazumi Larhed (Project Formulation Advisor)	Annalize
USAID	29 March	Ms Anita Sampson (Project Specialise: Equity Project)	Annalize, Dingie & Christo
DfID	30 March	Anna DeCleene	Annalize
European Union	6 April	Roberto Rensi	Annalize
Health Systems Trust	6 April	David Mametja	Dingie, Christo
Equity Project (Management Sciences for Health)	12 April 13 April	Group interview with: Dr Thobile Mbengashe (Director: Equity Project) and Ms Ileana Fajaro (Deputy Director: Equity Project) Individual interviews with Dr Yogan Pillay Mr Alan Vos / Foss	Dingie & Annalize Dingie & Christo
MRC (Durban)	5 April	Prof SS Karim	Dingie & Christo

APPENDIX 2 : PROGRAMME OF THE DCR II HEALTH SECTOR STAKEHOLDER WORKSHOP

AGENDA

09:30 Opening & Welcome

09:40 ODA: Orientation and Conceptualisation

09:50 Purpose, expectations and outcomes of the workshop

10:05 Finalisation of the programme/agenda

10:15 Strategy, findings and recommendations of an investigation into the impact of ODA in the South African public health sector.

11:30 Optimising the impact of ODA on the SA health sector: Expectations, requirements, assumptions, roles, responsibilities, structures, processes, mechanisms and institutional arrangements (including management, coordination, reporting and record-keeping) (to be continued after lunch)

12:45 – 13:30 LUNCH

13:30 Optimising the impact of ODA on the SA health sector: Expectations, requirements, assumptions, roles, responsibilities, structures, processes, mechanisms and institutional arrangements (including management, coordination, reporting and record-keeping) (continuation of pre-lunch discussion).

14:45 Wrap-up

APPENDIX 3: CONSOLIDATED TABLES BASED ON AVAILABLE INFORMAITON ON ODA IN THE SA HEALTH SECTOR

European Union (EU)

The EU consists of 15 member countries, namely Austria, Belgium, Denmark, Finland, France, Greece, Germany, Ireland, Italy, Luxembourg, the Netherlands, Portugal, Spain, Sweden and the United Kingdom. Many of these countries also provide ODA to the SA health sector on a bilateral basis. Apart from being South Africa's biggest trading and investment partner, the EU is also the largest foreign donor to South Africa, contributing approximately R900 million (Euro 127.5 million) each year to South Africa through the European Programme for Reconstruction and Development (EPDR). Likewise, the EU is the largest contributor of ODA to the SA health sector. For the period 1994-99, the total value of EU funding to this sector amounts to approximately R286.6 million, with a further R240.2 million pledged for the 2000-02 Public Health Sectoral Programme.

The EU usually channels its ODA to the National Department of Health and it may thus be termed **broad** or **national-sectoral support**. The major thrust in EU ODA is towards broad health sector support and transformation through **PHC provision**, **health policy development** and the establishment of an effective **health care financing system**. Since 1994, ODA from the EU for what may be termed broad sectoral support has amounted to ± R150.4 million. This includes technical assistance to **national health restructuring** (1995-96), the **District Health Support Programme** (1995-96) and the **Public Health Sector Support Programme** (1997-99).

The EU has also supported PHC at a provincial level. Provinces that have benefited include North West (± R26.4 million for 1998 - 2001); Western Cape (R60.7 million); the **HIV/AIDS Programme** at national level (± R11.2 million for 1994 –97); **HIV/AIDS awareness** – the Soul City Series (± R29.2 million for 1996 – 2001); and the **foreign doctors programme** (R2.6 million for 1996 – 99).

More specifically, the EU provided the following ODA to the SA health sector:

European Union

	Source: DCR-data collection master set				**Source: International Health Liaison Directorate (Department of Health) / EU records**					
Master data set no.	396	400	407	414	-----	-----	-----	-----	Project not mentioned in HLD data	Project not mentioned in HLD data
Currency used	Euro	Euro	Euro	Euro	-----	-----	-----	-----	-----	-----
Status	Ongoing	Ongoing	Ongoing	Completed	Completed	Completed	Completed	Recruit-ment of doctors has been suspen-ded	-----	-----
Project name	Winter-veldt Umbrella PHC Programme	Soul City Series IV and V	Public Health Sectoral Support Programme	Soul City III	National HIV/AIDS Program-me	Technical Support to National Health Sector restructuring	District Health System Support Programme	Young European Doctors Programme	Public Health Sector Support Programme	2000 Sector Support Health
Sector descrip-tion (DAC sector code)	Health (120)	Health (120)	Health (120)	Health (120)	Health	Health	Health	Health	Health	Health
National total	R26 396 562.31	R16 649 323.62	R117 065 556.71	R12 560 128.27	R11 216 081	R2 545 000	R5 699 269	R2 633 544 (R750 000 according to EU records)	R22 500 000	R38 000 000
North-West	**26396562.31**	**-----**	-----	-----	-----	-----	-----	-----	-----	-----
Year	**1998-2001**	**1998-2001**	1998-9	1996-2000	1994-7	1995-6	1994-6	1996-9	1997-8	1999-?
Imple-mentor	**Cathca**	**Institute of Urban Primary Health Care**	Department of Finances	Institute of Urban Primary Health Care	Depart-ment of Health	Depart-ment of Health	Depart-ment of Health	Depart-ment of Health	Depart-ment of Health	Depart-ment of Health
Benefi-ciaries	Seven clinics	Low income house-holds	Health sector managers	Low income house-holds	-----	-----	-----	-----	-----	-----
Grant Technical	-----	-----	R14 568 158.17	-----	-----	-----	-----	-----	-----	-----
Grant **Other funds**	-----	-----	R102 497 398.54	R12 560 128.27	-----	-----	-----	-----	-----	-----
Total Grants	R26 396 562.31	R16 649 323.62	R117 065 556.71	R12 560 128.27	R11 216 081	R2 545 000	R 5 699 269	R2 633 544	R22 500 000	R38 000 000
Total Disbur-sed	**R649 989.50**	**R6 243 496.36**	**R106 456 633.71**	**R12560128.27**	**R11 216 081 (R10 008 067 according to EU records)**	**R2 545 000 (R2 155 500 according to EU records)**	**R5 699 269** **(R5 063 020 according to EU records)**	**R2 633 544 (R186 250 according to EU records)**	**R20 460 966**	**-----**

United States of America

Among the individual countries that provide ODA to the SA health sector, the USA is the largest single provider. A bilateral agreement between the USA government (acting through USAID) and the SA government was signed in 1995. In terms of this agreement, US $50 million (R196.3 million) was committed to the SA health sector for the period to March 2004. In 1999, in response to the HIV/AIDS epidemic, a further US $R10 million was committed.

USAID has adopted a unique approach to ODA in the SA health sector in that it is focusing its support on one province, the Eastern Cape. This may be termed a **provincial-sectoral approach** since the support programme entails a comprehensive and flexible response to needs and priorities identified by the Eastern Cape Department of Health. The support programme, generally referred to as the ***Equity Project***, and the relationship between the donor and province are managed and facilitated by a US agent, Management Sciences for Health. Plans are in progress to expand the Equity Project to Mpumalanga in the near future.

Based on available information, ODA from the USA was allocated and distributed as follows:

UNITED STATES OF AMERICA

	Source: USAID				
Master data set no.	1503	1511	1512	1513	
Donor	USAID	USAID	USAID	USAID	USAID
Currency used	USD	USD	USD	USD	USD
Status	Ongoing	Ongoing	Ongoing	Ongoing	Ongoing
Project name	Equity in Integrated Primary Health Care Project	Equity in Integrated Primary Health Care Project	Equity in Integrated Primary Health Care Project	Equity in Integrated Primary Health Care Project	Equity in Integrated Primary Health Care Project
Sector description (DAC sector code)	Health (120)	120 (Health)	120 (Health)	120 (Health)	
Data type	Project level	Project level	Project level	Project level	Project level
Year	1995	1996	1997	1998	1999
Implementor	Management Sciences for Health	Management Sciences for Health	Management Sciences for Health	Management Sciences for Health	Management Sciences for Health
Beneficiaries	Historically disadvantaged South Africans, especially women	Historically disadvantaged South Africans, especially women	Historically disadvantaged South Africans, especially women	Historically disadvantaged South Africans, especially women	Historically disadvantaged South Africans, especially women
Total **Committed according to USAID calculation of exchange rate**	R9 432 000 ($8 000 000; exchange rate of 3,6)	R15 436 000 ($10 907 000; exchange rate of 4,25)	R22 555 755 ($8 403 000; exchange rate of 4,6)	R14 848 470 ($9 100 000; exchange rate of 4.9)	R9 909 880 ($5 125 800; exchange rate of 5.8)
Total **Committed according to researchers' own calculation of exchange rate**	R29 016 000 "C" ($8 000 000; exchange rate of 3,6270)	R46 860 834 "C" ($10 907 000; exchange rate of 4,2964)	R38 715 141 "C" ($8 403 000; exchange rate of 4,6073)	R50 337 560 "C" ($9 100 000; exchange rate of 5.5316)	R31 334 527.98 "C" ($5 125 800; exchange rate of 6.1131)
Expenditure	None	$20 108	$1 034 509	$4 171 069	$12 300 141

United Kingdom

The UK approach to ODA in the SA health sector displays elements of both the national and provincial sectoral approaches, but could perhaps most appropriately be termed a **programme approach**. The UK, working through its Department for International Development (DfID), is the second largest provider of ODA to the SA health sector among the bilateral donors. Its total commitment since 1994 amounts to ± R176.5 million.

A major focus of DfID has been on **reproductive health**, and **HIV/AIDS/STDs** in particular. In this cause, ODA has been availed to **PPASA** (± R18 million for 1997 – 2000); the reproductive health programmes in the Northern Cape, North West and Northern Province (± R21.8 million for 1999 - 2001), reproductive health services in Greater Johannesburg (± R4.7 million for 1995 – 2000), **condom social marketing** for HIV/AIDS prevention (± R26.2 million), the **National AIDS Control Programme** (± R6.2 million for 1997 - 2000), STD/HIV prevention in the mining industry at Carletonville and Welkom (± R4.8 million for 1997 – 2000), the **Reproductive Health Research Fund** (± R3.3 million for 1997 – 1998), and **youth reproductive health services** in Northern Cape, North West, and Northern Province (± R21.8 million for 1999 – 2000).

Another focal area has been **human resource development** and **policy and organisational development**. ODA has been allocated for, amongst others, management and organisational development in the National Department of Health (Chief Directorate: Health Resources Planning), and the provincial health departments of North West, Northern Cape and Northern Province (in total ± R21.8 million during 1995 – 2000), the ISDS programme aimed at developing viable health policy options at district level (± R3.6 million from 1995 – 1998), and the National Department of Health's Know-How Fund (± R7.3 million for 1998 – 2000).

Many of the UK-supported programmes/projects are coming to an end in 2000. Projects that will continue beyond 2000 are the Khayelitsha project to develop the capacity of key community members to deal with psycho-social problems (± R4 million for 1995 – 2002), projects for youth reproductive health services in Northern Cape, North-West and Northern Province (± R21.8 million for 1999 – 2001), and the Reproductive Health Projects in Northern Cape, North-West and Northern Province (± R21.8 million for 1999 – 2001).

It has to be noted that the records kept by DfID on the UKs ODA to the SA health sector were among the most complete, accurate and useful of all donors. According to these records, ODA from the UK found its way to the following destinations in the SA health sector:

United Kingdom

	Source: International Health Liaison Directorate (Department of Health) / DfID Health and Population Projects records – March 2000				
MIS Code.	059-555-004	059-555-010	059-555-012	059-555-013	059-555-014
Donor	DfID	DfID	DfID	DfID	DfID
Implementing agency	PPASA		UCT Department of Psychiatry, Cape Town	RHRU Johannesburg	
Currency used	British pound	British pound	British pound	British pound	British pound
Status	Extended to April 2000 – support will continue as part of the National Reproductive Health Programme	Completed – further assistance to be provided for strengthening District Management Teams as part of new National Management Support Programme	Ongoing	Extended to April 2000 – support will continue as part of the National Reproductive Health Programme	Due to be completed in mid 2000 – to be succeeded by the National Health Management Programme
Project name	PPASA	(HST) ISDS	Empelweni Project	Strengthening Reproductive Health Services in Greater Johannesburg	Health Service Management
Project description	To support work of PPASA to extend coverage of planned parenthood, reproductive health services and responsible sexuality to the youth of SA	To develop viable health policy options to provide a quality, effective, efficient, equitable and affordable health service to all South Africans, especially previously disadvantaged groups	To make cost effective primary mental care available to children and adolescents in Khayelitsha by developing capacity of key community members to deal with psycho-social problems	To strengthen reproductive health services delivery in the Greater Johannesburg area as a model for other services	Pilot course in PHC management
Sector description (DAC sector code)	Health	Health	Health	Health	Health
Actual start date	Feb 1997	Feb 1995	March 1995	August 1995	August 1994
Planned end date	March 2000	December 1998	October 2002	March 2000	July 2000
Total commitment	R18 040 915 “C”	R3 630 923.40 “C”	506 000 pound (DfID records state 700 000 pounds – R4 007 010 “C”)	R4 751 169 “C”	R3 887 741 “C”
Expenditure to date	**R15 051 709 “C”**	**R3 152 160.20 “C”**	**R1 167 757.20 “C”**	**R3 327 444 “C”**	**R2 392 456 “C”**

United Kingdom (continue)

	Source: International Health Liaison Directorate (Department of Health) / DfID Health and Population Projects records – March 2000				
MIS Code.	059-555-020	059-555-029	059-555-024	059-555-026	059-555-027
Donor	DfID	DfID	DfID	DfID	DfID
Implementing agency	IHSD London	International Family Health – London	CSIR Johannesburg	WHO Drug Action Programme	SCF UK
Currency used	British pound	British pound	British pound	British pound	British pound
Status	Project reviewed in October 1999 – further support to be discussed in context of support to the National HIV/AIDS Control Programme and Regional AIDS Initiatives	SA National AIDS Control Programme has played an important role in developing a regional proposal	Project management unit transferred to CSIR following failure of National Health Department to guarantee running costs	The restructuring of the Medicines Control Council, with assistance from DfID will standadise treatment of common health problems	Request for support for a motorcycle opertaion programme for increasing access to PHC received.
Project name	Condom Social Marketing for HIV/AIDS Prevention	Technical Assistance to the National AIDS Programme	STD/HIV Prevention in the Mining Industry	SA Drug Action Programme	Health Service Transport
Project description	To increase condom use among sexually active urban youth in South Africa	National AIDS Control Programme strengthening – To provide external and local technical expertise in support of the National AIDS Control Programme	To reduce the transmission of sexually transmitted infections, including HIV among miners, sex workers and their partners in Carltonville and Welkom	To improve the effectiveness and efficiency of health care in South Africa by providing support for the implementation of an essential drug programme	To develop and implement an effective health transport system which supports the delivery of primary and secondary health services
Sector description (DAC sector code)	Health	Health	Health	Health	Health
Actual start date	Jun 1995	July 1997	May 1997	September 1996	Jan 1996
Planned end date	September 1999	September 2000	August 2000	August 2000	March 2001
Total commitment	3 700 000 pound (DfID records state 4 570 938 pounds – R26 165 420)	R6 219 964 “C”	R4 839 479.22 “C”	R24 190 560 “C”	R6 820 394 “C”
Expenditure to date	**R18 396 720 “C”**	**R2 403 080 “C”**	**R1 630 906.20 “C”**	**R13 117 290 “C”**	**R3 400 117.60 “C”**

United Kingdom (continue)

	Source: International Health Liaison Directorate (Department of Health) / DfID Health and Population Projects records – March 2000					
MIS Code.	059-555-028	059-555-030	059-555-021	This project not listed in the International Health Directorate records – information from DfID records	059-555-034	059-555-036
Donor	DfID	DfID	DfID	DfID	DfID	DfID
Implementing agency		IHSD London	Provincial Department of Health – Kimberly	Provincial Department of Health – Pietersburg		
Currency used	British pound	British pound	British pound	British pound	British pound	British pound
Status	Project due to be completed in mid 2000, to be succeeded by National Health Management Programme	Project due to be completed in mid 2000, to be succeeded by National Health Management Programme	Project due to be completed in mid 2000 – to be succeeded by the National Health Management Programme	Project due to be completed in mid 2000 – to be succeeded by the National Health Management Programme	Project completed – research capacity mainstreamed within HST and support for reproductive health services included in basic package of district health services	Mid-term OPR scheduled for Nov/Dec 1999
Project name	M & OD National	M & OD North West	M&OD Northern Cape	M&OD Northern Province	Reproductive Health Research Fund	Department of Health Know How Fund
Project description	To develop human resource systems and skills capacity within the Chief Directorate of Health Resources Planning and formulate and implement HR policies which will lead to the development of equitable, efficient and effective integrated tertiary, secondary and primary care	To develop systems and skills capacity eithin the provincial health service of North West to develop equitable, efficient and effective integrated tertiary, secondary and primary care	To develop management and organisational capacity of the Provincial Health Service in the Northern Cape to enable the PHD to develop an efficient, integrated primary and secondary health care system within a district framework	To develop the capacity of the Provincial Department of Health and Welfare to provide primary and secondary health care services within a district health service throughout the Northern Province	To improve the quality, efficiency and effectiveness of reproductive health services by funding high quality operations research and implementing selected findings	To make available to the National Department of Health technical assistance to assist in policy formulation and facilitate the process of health sector reform in South Africa
Sector description (DAC sector code)	Health	Health	Health	Health	Health	Health
Actual start date	December 1995	April 1996	May 1996	June 1996	Jan 1997	March 1998
Planned end date	May 1999	April 2000	June 1998	July 2000	Dec 1998	August 2000
Total commitment	R10 355 075 “C”	R3 993 713 “C”	R3 991 442 “C”	R3 460 594 “C”	R3 283 597.50 “C”	R7 330 640 “C”
Expenditure to date	**R487 796.22 “C”**	**R2 767 326.10 “C”**	**R3 038 892 “C”**	**-----**	**RR2 148 416.30 “C”**	**R923 028.37 “C”**

United Kingdom (continue)

	Source: International Health Liaison Directorate (Department of Health) / DfID Health and Population Projects records – March 2000			
MIS Code.	059-555-038	059-555-039	059-555-040	059-555-042
Donor	DFID	DFID	DFID	DFID
Implementing agency	UNFPA	RHRU Johannesburg	WHO GTB	Centre for Integrated Rural Development, Stellenbosch
Currency used	British pound	British pound	British pound	British pound
Status	New project, has made good progress in identifying service providers for community based adolescent RH services	Mid-term OPR rated project highly successful, all targets met	Project extended, 15 operational research projects funded and demonstration districts strengthened	Annual review scheduled for November 1999 to discuss how to mainstream project into district health systems
Project name	Provincial Reproductive Health	Abortion Care Project	National TB Control Programme	Community-based PHC Programme
Project description	Effective reproductive health services for adolescents and youth in the poorest communities in the Northern Cape, North West and Northern Province	To develop the capacity of provincial health departments to provide more effective, efficient and accessible abortion services	To support the strengthening of South Africa's National Tuberculosis Control Programme	To improve access to and utilisation of cost effective PHC services in targeted communities in four provinces: Northern Province, North West, KwaZulu-Natal and Northern Cape
Sector description (DAC sector code)	Health	Health	Health	Health
Actual start date	Jan 1999	April 1998	October 1998	October 1998
Planned end date	July 2001	March 200?	March 1999	July 2000
Total commitment	R21 762 620 "C"	R7 880 438 "C"	R5 497 980 "C"	R6 414 310 "C"
Expenditure to date	**R5 648 389 "C"**	**R2 040 859 "C"**	**R3 078 319 "C"**	**R1 519 229 "C"**

Japan

Japan manages its ODA in South Africa through the local office of the Japan International Co-operation Agency (JICA). Available information indicates that Japanese ODA to the SA health sector has totalled approximately R66 million between 1994 and 1997. A large proportion of this is constituted by a single grant amounting to approximately R58.3 million that was committed in 1997 for the procurement of hospital equipment in all nine provinces. In 1998, Japan announced a new ODA package amounting to US $100 million for the health, education and water sectors in South Africa. The health sector is to receive 30% of this grant.

The structuring of this package in the health sector is currently being negotiated between JICA and the National Department of Health. JICA agrees with the Department of Health in as far as the targeting of selected provinces, i.e. **KwaZulu-Natal, Eastern Cape** and **Northern Province,** is concerned. However, JICA also wishes to extent its support to **Mpumalanga**. The issue has not been resolved as yet. Also, in the light of an independent assessment by JICA of the previous Japanese-supported initiative (procurement of hospital equipment in all nine provinces), it has indicated that it would be hesitant to embark on a similar venture. The National Department of Health has in the mean time initiated a process whereby three provinces were invited to submit applications to access Japanese grant aid for purposes of procuring equipment for health facilities. At the time of writing, this remained a matter of contention between JICA and the National Department of Health.

Japan

	Source: DCR-data collection master set						
Master data set no.	895	908	911	918	919	920	921
Donor	-----	-----	-----	-----	-----	-----	-----
Currency used	Yen	Yen	Yen	Yen	Yen	Yen	Yen
Status	Ongoing	Ongoing	Ongoing	**-----**	**-----**	**-----**	Project for Medical Equipment for hospitals in the RSA
Project name	-----	-----	-----	**-----**	**-----**	**-----**	**-----**
Sector description (DAC sector code)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)
Data type	Project level	Project level	Project level	Sector level	Sector level	Sector level	Sector level
National total	R755 635.78	R271 352.42	R1 089 871.40	**-----**	**-----**	-----	R58 361 720 "C"
Gauteng	-----	R122 108.59	R871 897.12	**-----**	**-----**	**-----**	**-----**
Northern Province	-----	R149243.83	**-----**	**-----**	**-----**	**-----**	**-----**
Northern Cape	-----	**-----**	R217 974.28	**-----**	**-----**	**-----**	**-----**
Start date	1 Apr 1998	1 Apr 1998	1 Apr 1999	**-----**	**-----**	**-----**	**-----**
Year of commitment	1998	1994	1999	1994	1995	1996	1997
Agreed end date	31 Mar 1999	31 Mar 1999	31 Mar 2000	**-----**	**-----**	**-----**	**-----**
Actual end date	31 Mar 1999	31 Mar 1999	31 Mar 2000	**-----**	**-----**	**-----**	**-----**
Agreement with	-----	NGO/Civil society	NGO/Civil society	**-----**	**-----**	**-----**	**-----**
Government type	-----	**-----**	**-----**	**-----**	**-----**	**-----**	**-----**
Implementor	JICA	Embassy of Japan	Embassy of Japan	**-----**	**-----**	**-----**	**-----**
Beneficiaries	SA	NGO/Civil Society	NGO/Civil Society	**-----**	**-----**	**-----**	**-----**
Grant Technical	R755 635.78	**-----**	**-----**	**-----**	**-----**	**-----**	**-----**
Grant **Other funds**	-----	**-----**	**-----**	**-----**	**-----**	**-----**	**-----**
Total Grants	R755 635.78	R271 352.42	R1 089 871.40	**-----**	**-----**	**-----**	**-----**
Total **Committed**	R755 635.78	R271 352.42	R1 089 871.40	R1 258 886.93	R906 235.06	R3 426 092.53	R58 361 720
Total Disbursed	**-----**	**-----**	**-----**	**R1 258 886.93**	**R906 235.06**	**R3 426 092.53**	R58 361 720

Italy

Although Italy's ODA to the SA health sector has been substantial, *i.e.* some R33 million, information about its exact allocation and distribution is sketchy. Amongst the broad areas to which ODA was targeted are **PHC support** (1999 – 2002), support of the **network data system** and health management in **Gauteng** (2000 – 2003), and **child health** (1998).

Italy

	Source: DCR-data collection master set						
Master data set no.	882	883	884	888	889	890	891
Donor	Italy-South Africa Development Aid	Italy-South Africa Development Aid	Italy-South Africa Development Aid	Italy-South Africa Development Aid	Italy-South Africa Development Aid	Italy-South Africa Development Aid	Italy-South Africa Development Aid
Currency used	USD	USD	USD	USD	USD	USD	USD
Status	Ongoing	Ongoing	Ongoing	-----	-----	-----	-----
Project name	Primary Health Care Support Programme	Support to the network data system and the health management in Gauteng	Child Health Support	-----	-----	-----	-----
Sector description (DAC sector code)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)
Data type	Project level	Project level	Project level	Sector level	Sector level	Sector level	Sector level
National total	R13 616 304.65	R9 474 565.12	R5 359 894.16	-----	-----	-----	-----
Gauteng		R9 474 565.12	-----	-----	-----	-----	-----
KZN	R13 616 304.65	-----	-----	-----	-----	-----	-----
Year	1999-2002	2000-2003	1998	1994	1995	1996	1997
Government type	Provincial	Provincial	-----	-----	-----	-----	-----
Implementor	Italian Cooperation	Italian Cooperation	Unicef	-----	-----	-----	-----
Beneficiaries	Local people and DoH	Local people and DoH	Children and DoH	-----	-----	-----	-----
Total Grants	R13 616 304.65	R9 474 565.12	R5 359 894.16	-----	-----	-----	-----
Total Disbursed	**R4 479 479.98**	**-----**	**R3 781 164.29**	**R851 667.85**	**R881 392.82**	**R1 936 453.27**	**R725 913.48**

Belgium and Flanders

Belgium has supported the **National Department of Health** (195-98), control of **STDs** (1995 – 98), improving the **cold chain** (1995 – 98), health **management development** (1995 – 98), and the national **TB** control programme (1995 – 98) with a total amount of approximately R26.2 million.

Flanders has supported **research** through its "universitaire samenwerken" programme, as well as selected programmes and projects related to **reproductive health**, **neural networks**, the **revalidation strategy**, **assistive devices**, training of the **mentally handicapped**. The *Re Amogetswa* and Khayelitsha Cervical **screening projects** were also supported by Flanders. Total support to these projects amount to approximately R900 000. Five other unspecified projects received support of a further R900 000.

Belgium

	Source: DCR-data collection master set		**Source: International Health Liaison Directorate (Department of Health)**			
Master data set no.	159	179	N/A	N/A	N/A	N/A
Donor	Belgium Embassy	Belgium Embassy	Belgium	Belgium	Belgium	Belgium
Currency used	Belgian Franc	Belgian Franc	-----	-----	-----	-----
Status	Completed	Ongoing	Completed	Completed	-----	-----
Project name	Grant for the National Department of Health	Program support / Caraes	Control of STDs	Improving of the cold chain	Health Management Training Project	National TB Project
Sector description (DAC sector code)	Health (120)	Health (120)	Health	Health	Health	Health
Year	1995-8	1998-2002	1995-8	1995-8	1995-8	1995-9
Agreement with	-----	NGO/Civil society	-----	-----	-----	-----
Implementor	BADC	Caraes	-----	-----	-----	-----
Beneficiaries	Departmental services	Physically challenged poor	-----	-----	-----	-----
Total budget	-----	-----	R3 885 542	R1500 000	R2 700 000	R3 453 947
Disbursed via RDP	R16 016 164.01					
Disbursed Direct		R120 681.85				
Total Disbursed	R16 016 164.01	R120 681.85	R3 276 391	R1 500 000	R1 231 228.94	R3 453 947

Flanders

	Source: DCR-data collection master set							
Master data set nr.	**446**	**447**	**452**	**464**	**465**	**467**	**468**	**470**
Donor	**Flemish Embassy**	**Flemish Embassy**	**Flemish Embassy**	**Flemish Embassy**	**Flemish Embassy**	**Flemish Embassy**	**Flemish Embassy**	**Flemish Embassy**
Currency used	**Belgian Franc**	**Belgian Franc**	**Belgian Franc**	**Belgian Franc**	**Belgian Franc**	**Belgian Franc**	**Belgian Franc**	**Belgian Franc**
Status	**Completed**	**Completed**	**Completed**	**Completed**	**Completed**	**Completed**	**Completed**	**Completed**
Project name	**Universitaire Samenwerken**	**VDAB/VIZO**	**Neural Networks**	**Revalidation Strategy**	**Assistive Devices**	**In service Training of the mentally handicapped**	**Social director Re Amogetswe**	**Khayelitsha Cervical Screening Project**
Sector description (DAC sector code)	**Health (120)**	**Population Policies, Programmes and Reproductive Health (130)**	**Health (120)**	**Health (120)**	**Health (120)**	**Health (120)**	**Health (120)**	**Health (120)**
Data type	**Project level**	**Project level**	**Project level**	**Project level**	**Project level**	**Project level**	**Project level**	**Project level**
National total	**R130 244.08**	**R182 608.54**	**R59 912.66**	**R242 846.73**	**R113 076.18**	**R115 861.97**	**R46 344.85**	**R14 137.87**
Western Cape								**R14 137.87**
Northern Province						**R115 861.97**	**R46 344.85**	
Year	**1998-9**	**1998-9**	**1998-9**	**1998-9**	**1998-9**	**1998-9**	**1998-9**	**1999-2000**
Agreement with	**-----**	**Parastatal**	**-----**	**-----**	**-----**	**NGO/Civil society**	**NGO/Civil society**	**NGO/Civil society**
Implementor	**KUL/RUG**	**VDAB**	**KUL/VUB**	**Department of Health**	**Department of Health**	**FENIKS VZW**	**FENIKS VZW**	**Khayelitsha Cervical Screening**
Beneficiaries	**UOFS/UP**	**Province of Gauteng**	**Universities**	**Department of Health**	**Department of Health**	**Day care centres**	**Re Amogetswa**	**Khayelitsha Cervical Screening**
Grant Technical	**R130 244.08**	**R182 608.54**	**R59 912.66**	**R242 846.73**	**R113 076.18**	**R115 861.97**	**R46 344.85**	**R14 137.87**
Grant Other funds	**-----**	**-----**	**-----**	**-----**	**-----**	**-----**	**-----**	**-----**
Total Grants	**R130 244.08**	**R182 608.54**	**R59 912.66**	**R242 846.73**	**R113 076.18**	**R115 861.97**	**R463 44.85**	**R14 137.87**
Total Committed	**R130 244.08**	**R182 608.54**	**R59 912.66**	**R242 846.73**	**R113 076.18**	**R11 5861.97**	**R46 344.85**	**R14 137.87**
Disbursed via RDP				**R226 278.47**	**R113 076.18**			
Disbursed Direct	**R130 244.08**	**R182 608.54**	**R59 912.66**			**R115 861.97**	**R46 344.85**	**R7 675.73**
Total Disbursed	**R130 244.08**	**R182 608.54**	**R59 912.66**	**R226 278.47**	**R113 076.18**	**R115 861.97**	**R46 344.85**	**R7 675.73**

Five other Flemish health sector projects are included in the DCR main data set. However, very little information is provided on these projects other than that they totaled R908 017.94 (1995), R538 572.21 (1996), R340 841.03 (1997), R40 388.88 (1994)and R51 3128.30 (1996) respectively and that they were “sector level” projects. Two other projects funded by the Flemish included as “health sector” projects in the main data set are respectively the Albrow Gardens Project (1999-2000) and the Bright Lights Shelter Project (1999-2000), both in the Western Cape and administered by the *Afrikaans Christelik Vroue Vereniging* (translated as Afrikaans Christian Women Society), and totaling R22 759.66 and R12 116.51 respectively.

United Nations Children's Fund (UNICEF)

From the unsubstantial data available can be inferred that R13.9 million has been channelled from UNICEF to the SA health sector since 1994. It has apparently been allocated to NGOs for initiatives related to **women and children's health**.

United Nations Children Fund

	Source: DCR-data collection master set			
Master data set no.	**1418**	**1427**	**1431**	**1432**
Donor	**UNICEF**	**UNICEF**	**UNICEF**	**UNICEF**
Currency used	**USD**	**USD**	**USD**	**USD**
Status	**Completed**	**Completed**	**-----**	**-----**
Project name	**Health [YH103]**	**Health 1999 [YH103]**	**-----**	**-----**
Sector description (DAC sector code)	**Health (120)**	**Health (120)**	**Health (120)**	**Health (120)**
Data type	**Project level**	**Project level**	**Sector level**	**Sector level**
National total	**8228195.28**	**9168704.16**	**-----**	**-----**
Year	**1998**	**1999**	**1994-7**	**-----**
Agreement with	**NGO/Civil society**	**NGO/Civil society**	**-----**	**-----**
Implementor	**Various**	**Various**	**-----**	**-----**
Beneficiaries	**Women and children**	**Women and children**	**-----**	**-----**
Total Grants	**R8 228 195.28**	**R9 168 704.16**	**-----**	**-----**
Total Committed	**8228195.28**	**R9 168 704.16**	**-----**	**R7 179 015.19**
Total Disbursed	**R3 391 113.55**	**R7 891 198.04**	**R138 041.16**	**R2 431 661.30**

United Nations Development Programme (UNDP)

Data on ODA provided by the UNDP seemingly relate to two projects only. The first entails support for the **provision of doctors in rural areas** (± R7.2 million for 1997 – 2001), while the second comprises support for greater involvement of people living with **HIV/AIDS** in prevention programmes (± R1.2 million for 1997 – 2001).

United Nations Development Programme

	Source: DCR-data collection master set	
Master data set no.	1444	1455
Donor	UNDP	UNDP
Currency used	USD	USD
Status	Ongoing	Ongoing
Project name	UNV Support to the Health Sector in Rural Areas (Doctors)	UN Support for the Greater Involvement of People Living with HIV/AIDS – SAF/96/016
Sector description (DAC sector code)	Health (120)	Health (120)
Data type	Project level	Project level
National total	R7 151 403.59	R1 189 608.84
Northern Province	R7 151 403.59	
Year	1997-2001	1997-2000
Implementor	United Nations Volunteers	United Nations Office for Project Services
Beneficiaries	Northern Province	People with HIV/AIDS
Total Grants	R7 151 403.59	R1 189 608.84
Total Committed	R7 151 403.59	R1 189 608.84
Total Disbursed	-----	-----

Finland

The **parasite control programmes** in **KwaZulu-Natal** and **Mpumalanga** received approximately R8.8 million from Finland during 1998 – 1999.

Finland

	Source: DCR-data collection master set*
Master data set nr.	436
Donor	Finnish Bilateral Assistance Programme in South Africa
Currency used	Finnish Mark
Status	Completed
Project name	Parasite Control Programme (KwaZulu-Natal and Mpumalanga)
Sector description (DAC sector code)	120 (Health)
Data type	Project level
National total	R8 831 458.59
KwaZulu-Natal**	R5 298 875.15
Mpumalanga**	R3 532 583.43
Start date	01 Jan 1998
Year	1998-9
Implementor	Department of Health
Beneficiaries	Pupils in selected schools as well as their families and communities
Disbursed via RDP	R8 831 458.59
Total Disbursed	**R8 831 458.59**

* Correctness of data confirmed with Marko Laine, Embassy of Finland.

** According to International Health Liaison Directorate (Department of Health) the amount is to be split evenly between the two provinces.

Sweden

Sweden pledged ODA amounting to R5.7 million to **NGOs** in the field of **HIV/AIDS and human rights** for the period 1999 – 2001. It appears as though some R3.5 million has been disbursed to date.

Sweden

	Source: DCR-data collection master set
Master data set no.	1270
Donor	SIDA
Currency used	Swedish Kroner
Status	Ongoing
Project name	HIV/AIDS/Human Rights
Sector description (DAC sector code)	Population Policies, Programmes and Reproductive Health (130)
Data type	Project level
National total	R5 697 794.88
Year of commitment	1999-2001
Agreement with	NGO/Civil society
Implementor	NGOs
Beneficiaries	HIV/AIDS infected people
Total Grants	R5 697 794.88
Total Committed	R5 697 794.88
Disbursed Direct	R3 514 433.18
Total Disbursed	**R3 514 433.18**

The Netherlands

Information on the allocation of Dutch ODA in the SA health sector is incomplete. Grants received to date appear to amount to a total of R4.6 million.

Netherlands

	Source: DCR-data collection master set	**Source: International Health Liaison Directorate (Department of Health)**
Master data set no.	1171	N/A
Donor	Royal Netherlands Embassy	Netherlands
Currency used	Guilder	-----
Status	Completed	----- (According to the IHL records of 17 April 2000 the contract still has to be signed
Project name	???	Building of a clinic in Mamelodi, Pretoria
Sector description (DAC sector code)	Health (120)	Health
Data type	Sector level	Project level
National total	R3 397 690.16	R1 200 000
Gauteng	-----	???
Year	1996	1997-2000
Total Grants	-----	R1 200 000
Total Committed	R3 397 690.16	R1 200 000
Total Disbursed	**R1 415 043.10**	**-----**

Norway

Norwegian ODA to the value of approximately R4.3 million was targeted at the development of the **health information system** (1995 – 1998) and **AIDS prevention** (1995 – 1997).

Norway

	Source: DCR-data collection master set	
Master data set no.	969	1009
Donor	NORAD	NORAD
Currency used	Norwegian Kroner	Norwegian Kronerorea
Status	Completed	Completed
Project name	RSA 0018: Health Information System	GLO-021: AIDS prevention
Sector description (DAC sector code)	Health (120)	Population Policies, Programmes and Reproductive Health (130)
Data type	Project level	Project level
Year	1995-8	1995-7
Total Grants	R2 020 022.88	R2 350 114.42
Total Disbursed	**R2 020 022.88**	**R2 350 114.42**

Ireland

Ireland appears not to provide ODA to the national or provincial health departments, with the exception of a **clinic building programme in the Free State**. Rather, it actively supports smaller health NGOs. Since 1994 Ireland has supported more than 20 **NGOs operating in the fields of health, welfare in development**, and particularly those NGOs with Catholic associations. Total ODA amounts to approximately R3.3 million.

Ireland

	Source: DCR-data collection master set								
Master data set #.	611	614	629	637	648	671	686	690	698
Donor	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid
Currency used	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound
Status	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed
Project name	Refugee Health Camp	A E Haviland Memorial Clinic	New Castle Hospice	The Caring Network project	Clinic Garage	St John the Baptist Church	Blaauwbosch Rosary Clinic	St John Ambulance Foundation	Kalafong Hospital
Sector descrip-tion (DAC sector code)	120 (Health)	120 (Health)	120 (Health)	120 (Health)	120 (Health)	120 (Health)	120 (Health)	120 (Health)	120 (Health)
Data type	Project level	Project level	Project level	Project level	Project level	Project level	Project level	Project level	Project level
National total	R4 570.52	R40 678.69	R9 802.33	R45 415.53	R3 405.99	R52 458.10	R32 240.39	R41 075.42	R59 853.35
KZN		R40 678.69	R9 802.33				R32 240.39		
Northern Province	R4 570.52								
Western Cape				R45 415.53		R52 458.10		R41 075.42	R59 853.35
North West					3405.99				
Year	1994-5	1994-5	1995-6	1996-7	1996-7	1997-8	1997-8	1997-8	1997-8
Agreement with	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society
Implemen-tor	Missionary Sisters of Assumption	AE Haviland Clinic	Dominican Sisters	Catholic Welfare and development	Marist Brothers	Stigmatine Welfare Association	Rosary Clinic	St John Ambulance Foundation	Motivational education Trust
Benefi-ciaries	Mozambican refugees	Welfare Clinic in Weenen	St Mary Community	Community in Cape Town	Community in Padstow	Community in Winterveldt	Blaauwbosch Community	Cape Town	Cancer sufferers
Total Grants	R4 570.52	R40 678.69	R9 802.33	R45 415.53	R3 405.99	R52 458.10	R32 240.39	R41 075.42	R59 853.35
Total Committed	R4 570.52	R40 678.69	R9 802.33	R45 415.53	R3 405.99	R52 458.10	R32 240.39	R41 075.42	R59 853.35
Total Disbursed	**R4 570.52**	**R40 678.69**	**R9 802.33**	**R45 415.53**	**R3 405.99**	**R52 458.10**	**R32 240.39**	**R41 075.42**	**R59 853.35**

Ireland (continue) **Source: DCR-data collection master set**

Master data set #	709	728	733	734	751	755	761	762	781	782
Donor	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid
Currency used	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound
Status	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Ongoing	Completed	Completed
Project name	Johannes House Primary Health Care Centre	The Right to Live Campaign	Day Care Centre for the Handicapped	Advanced Centre at the School for the Deaf	Hantam Community Education Trust Health Care Centre Construction	Bertoni Mobile Clinic	Eukhanyeni Clinic Equipment	Nazareth Hse Children's Home Construction	AIDS Sufferers Programme	MUCPP Clinic
Sector description (DAC sector code)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)
Data type	Project level	Project level	Project level	Project level	Project level	Project level	Project level	Project level	Project level	Project level
National total	R34 388.15	R39 353.08	R42 915.04	R9 594.70	R80 450.52	R80 450.52	R12 292.84	R203 942.08	R170 299.73	R423 603.54
Northern Cape					R80 450.52					
Gauteng	R34 388.15									
KZN		R39 353.08					R12 292.84			
Mpumalanga			R42 915.04							
What province?									R170 299.73	
Western Cape								R203 942.08		
Free State										R423 603.54
North West				R9 594.70		R80 450.52				
Year	1998-9	1998-9	1998-9	1998-9	1999-2000	1999-2000	1999-2000	1999-2001	1996-7	1996-7
Agreement with	NGO/Civil Society	NGO/Civil Society	NGO/Civil Society	NGO/Civil Society	NGO/Civil Society	NGO/Civil society	Parastatal	NGO/Civil society	NGO/Civil society	Parastatal
Implementor	The Johannes House Committee	Catholic Archdiocese of Durban	Ukhutula Advice Office	Dominican School for the Deaf	Hantam Community Trust	Bertoni Mercy Sisters	Convent of St Rose	Nazareth House Children's Home	St Francis House	MUCPP
Beneficiaries	Unemployed Local Community Patients	Community in Pinetown	Community in Kwa Mhlanga	Deaf children	Community in Colesberg	Community in Rosslyn	Community in Verulam	Orphans and abandoned children	AIDS patients	Community
Total Grants	R34 388.15	R39 353.08	R42 915.04	R9 594.70	R80 450.52	R80 450.52	R12 292.84	R203 942.08	R170 299.73	R423 603.54
Total Committed	R34 388.15	R39 353.08	R42 915.04	R9 594.70	R80 450.52	R80 450.52	R12 292.84	R203 942.08	R170 299.73	R423 603.54
Total Disbursed	**R34 388.15**	**R39 353.08**	**R42 915.04**	**R9 594.70**	**R80 450.52**	**R80 450.52**	**R12 292.84**	**R203 942.08**	**R170 299.73**	**R423 603.54**

Ireland (continue)

	Source: DCR-data collection master set									
Master data set no.	783	784	792	809	812	827	836	843	854	855
Donor	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid	Irish Aid
Currency used	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound	Irish pound
Status	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed	Completed
Project name	Extension of Health Facilities	Training at MUCPP Health Clinic	Mercy Centre	Morokweng Community Centre	Sacred Heart House	Bertoni Mercy Clinic	People Against Human Abuse	The Valley Trust	Rivoni Society for the Blind	Society for African Missions
Sector descrip-tion (DAC sector code)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)	Health (120)
Data type	Project level	Project level	Project level	Project level	Project level	Project level	Project level	Project level	Project level	Project level
National total	R197 696.25	R155 884.65	R53 022.27	R116 883.72	R17 209.30	R112 370.57	R81 743.87	R116 382.68	R83 798.88	R99 162.01
What province?	R197 696.25	R155 884.65					R81 743.87			
North West			R53 022.27	R116 883.72		R112 370.57		R116 382.68		
KZN										
Mpumalanga										R99 162.01
Northern Province									R83 798.88	
Gauteng					R17 209.30					
Year	1998	1998-9	1994-5	1995-6	1995-6	1996-7	1996-8	1997-8	1997-8	1997-8
Agreement with	Parastatal	Parastatal	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society	NGO/Civil society
Imple-mentor	MUCPP	MUCPP	Mercy Sisters	Catholic Church Morokweng	Sacred Heart House	Mercy Sisters	People Against Human Abuse	The Valley Trust	Rivoni Society for the Blind	St Martin de Porres Clinic
Benefi-ciaries	Community	Patients	Community of Winterveldt	Morokweng Community	People who suffer from AIDS	Mmakau community	Mamelodi Township	Bothashill community	Patients at Elim Hospital	Marapyane community
Total Grants	R197 696.25	R155 884.65	R53 022.27	R116 883.72	R17 209.30	R112 370.57	R81 743.87	R116 382.68	R83 798.88	R99 162.01
Tot.Committed	R197 696.25	R155 884.65	R53 022.27	R116 883.72	R17 209.30	R112 370.57	R81 743.87	R116 382.68	R83 798.88	R99 162.01
Total Disbursed	**R197 696.25**	**R155 884.65**	**R53 022.27**	**R116 883.72**	**R17 209.30**	**R112 370.57**	**R81 743.87**	**R116 382.68**	**R83 798.88**	**R99 162.01**

Ireland (continue)

	Source: DCR-data collection master set			**Source: International Health Liaison Directorate (Department of Health)**
Master data set no.	857	867	870	N/A
Donor	Irish Aid	Irish Aid	Irish Aid	Irish Aid
Currency used	Irish pound	Irish pound	Irish pound	Irish pound
Status	Completed	Completed	Completed	Ongoing
Project name	St Francis Care Centre	Unica School	Mercy Clinic	Building of new clinics and upgrading existing clinics in Botshabelo, Bloemfontein
Sector description (DAC sector code)	Health (120)	Health (120)	Health (120)	Health
Data type	Project level	Project level	Project level	Project level
National total	R73 324.02	R129 898.67	R155 884.65	Irish pound 257 677
Gauteng	R73 324.02	R129 898.67	-----	-----
Free State	-----	-----	-----	According to ILH records (17 April 2000) only R36 995.73 had been spent although R531 252.56 had been deposited in an interest-bearing account at a local bank
Year	1997-8	1998-9	1998-9	1998-2000
Agreement with	NGO/Civil Society	NGO/Civil Society	NGO/Civil Society	-----
Implementor	St Francis Care Centre	Autism South Africa	Sisters of Mercy	-----
Beneficiaries	Community at Reiger Park	School children	Winterveldt community	-----
Total Grants	R73 324.02	R129 898.67	R155 884.65	-----
Total Committed	R73 324.02	R129 898.67	R155 884.65	-----
Total Disbursed	**R73 324.02**	**R129 898.67**	**R155 884.65**	R531 252.56

Australia

Australia has so far been conservative in its support of the SA health sector. Three projects received ODA from Australia, i.e. two, respectively on **health education** and **STD control** in 1995, and one allowing senior officials from the Department of Health to undertake **study tours** to Australia in 1997. In total, this ODA amounted to approximately R2.5 million.

Australia

	Source: DCR-data collection master set		Source: International Health Liaison Directorate (Department of Health)
Master data set no.	10	12	N/A
Donor	Ausaid	Ausaid	Australia
Currency used	USD	USD	USD
Status	Completed	Completed	Completed
Project name/description	Health education	STD control including HIV/AIDS	Study tours undertaken by senior officials from the Department of Health
Sector description (DAC sector code)	Health (120)	Population Policies, Programmes and Reproductive Health (130)	Health
Year	1995	1995	1997
Total Committed	R282 916.21	R758 070.37	**R1 497 737.25**
Total Disbursed	**R282 916.21**	**R758 070.37**	**R1 497 737.25 C**

United Nations Family Planning Association (UNFPA)

UNFPA disbursed ODA to a total value of some R1.3 million. However, it is not clear whether only PPASA has received support from UNFPA (throughout referred to as "implementor" in information that was made available), or whether other organisations received support as well. What is clear, is that the **Women's Health** project received support to the value of about R900 000 during 1995 – 1998.

United Nations Family Planning Association

	Source: DCR-data collection master set						
Master data set no.	1486	1487	1488	1489	1490	1491	1494
Donor	UNFPA	UNFPA	UNFPA	UNFPA	UNFPA	UNFPA	UNFPA
Currency used	USD	USD	USD	USD	USD	USD	USD
Status	Completed	Completed	Completed	Completed	Completed	Completed	Completed
Project name	Strengthening the Reproductive Health and Family Planning Programme	Strengthening the Reproductive Health and Family Planning Programme	Sexuality Education Programme	Community based Distribution of Contraception	Adolescent Reproductive Health Services Programme	Reproductive Health Education Programme	Strengthening Reproductive Health Services Programme
Sector description (DAC sector code)	Population Policies, Programmes and Reproductive Health (130)	Population Policies, Programmes and Reproductive Health (130)	Population Policies, Programmes and Reproductive Health (130)	Population Policies, Programmes and Reproductive Health (130)	Population Policies, Programmes and Reproductive Health (130)	Population Policies, Programmes and Reproductive Health (130)	Population Policies, Programmes and Reproductive Health (130)
Data type	Sector level	Sector level	Sector level	Sector level	Sector level	Sector level	Sector level
National total	R89 307.22	R57 939.79	R18 228.77	R882 338.88	R200 230.47	R76 547.16	R135 384.26
Northern Province			R18 228.77			R19 136.79	
Northern Cape					R100 115.24		R67 692.13
North West					R100 115.24	R19 136.79	R67 692.13
Gauteng						R19 136.79	
Mpumalanga						R19 136.79	
Year of commitment	1995-8	1995-8	1996-8	1996-7	1996-7	1996-8	1997-8
Implementor	Women's Health Project	UNFPA	UNFPA	PPASA	PPASA	UNFPA	UNFPA
Beneficiaries	Women	Women	Population	Population in rural areas	Young people	Health care practitioners	Women
Total Grants	R89 307.22	R57 939.79	R18 228.77	R882 338.88	R200 230.47	R76 547.16	R135 384.26
Total Committed	R89 307.22	R57 939.79	R18 228.77	R882 338.88	R200 230.47	R76 547.16	R135 384.26
Total Disbursed	**R252 045.70***	**R131 142.55***	**R30 179.26***	**R470 426.80**	**386402.05**	**R12 846.78**	**R12 846.78**

* It is difficult to explain that these totals as reported in the main data set are actually are higher than the amounts of money committed by the donor.

Canada

Canada's ODA to the SA health sector has been small compared to other countries. It has apparently concentrated mostly on the activities of the **International Development Research Centre** in South Africa. These focused largely on **research** relating to health care evaluation, a survey on the **medicinal value of plants**, **research capacity development** and the **AIDS Review 2000**. In total, some R270 000 was committed to these activities.

Canada

Master data set no.	257	285	307	341
Donor	IDRC (International Development Research Centre)	IDRC	IDRC	IDRC
Currency used	Canadian Dollar	Canadian Dollar	Canadian Dollar	Canadian Dollar
Status	Completed	Ongoing	Completed	Ongoing
Project name	Health Care Evaluation and Management Skills Programme	Medicinal Plant Survey	Research Capacity Development Initiative	AIDS Review 2000
Sector description (DAC sector code)	Health (120)	Health (120)	Health (120)	Health (120)
Data type	Project level	Project level	Project level	Project level
Year of commitment	1996-8	1998	1994-6	1999-2000
Agreement with	NGO/Civil society	NGO/Civil society	Private sector consultants	NGO/Civil society
Implementor	University of Toronto	IDRC	Consultant	University of Pretoria
Beneficiaries	Various	Various including the Institute of Natural Resources in South Africa	Consultant	University of Pretoria
Total Committed	R46 933.67	R111 234.71	R9 085.00	R98 765.43
Total Disbursed	R46 933.67	R42 639.97	R9 085.00	R83 950.62

Austria

Only one project associated with health apparently received ODA from Austria during 1994 to 1999, i.e. the support of **living costs of nurses during their training** (± R11 000 in 1998).

Austria

	Source: DCR-data collection master set
Master data set nr.	137
Donor	Austrian Embassy
Currency used	Austrian Schilling
Status	Completed
Project name	Supporting living costs of nurses undergoing training
Sector description (DAC sector code)	Health 120
Year	1998
Implementor	Private
Total Committed	R10 615.24
Total Disbursed	**R10 615.24**

DENMARK

According to the DCR master data set, Denmark (the Danish Embassy) had committed R1 062 625.54 to the Democratic Nursing Organisation of South Africa (Denosa) in 1998. However, upon confirmation with Knud Verner Johansen of the Danish Embassy, it was suggested that this might be a misunderstanding since Denmark has never allocated ODA to the health sector in South Africa.

APPENDIX 4

White Paper for the transformation of the health system in South Africa

Chapter 19: The role of donor agencies and Non-Governmental Organisations

POLICY GUIDELINE	EXPLICIT AND IMPLICIT RESPONSIBILITIES AND ACTIVITIES
International assistance should be used to support the process of transforming society, and to meet the health priorities of the country	ODA to be aligned with transformation and reconstruction priorities in the health sector, which implies that these priorities must be identified and conceptualised in a way that makes sense to donors and recipients
The areas of support to which donor assistance will be channelled will be by agreement between the Government of SA and the donor(s) concerned	Clear guidelines and priorities for the channelling of ODA to be developed by SA Government and communicated to donors Mechanisms, structures and processes for agreements between the SA Government and donors on the channelling of ODA must be developed and implemented
In the evaluation, acceptance and agreement of donor assistance, the following problems must be guarded against: ▪ Fragmented and unco-ordinated external financing of health services, leading to the implementation of conflicting health policies; ▪ Donations not necessarily addressing priority issues in the recipient country, thus diverting emphasis from real health needs; ▪ Conditions attached to donations having a negative impact on the economy and health services of the recipient country; ▪ Capital projects being undertaken without ensuring that Government has the necessary resources to fund the recurrent costs; ▪ Donor programmes which fail to appreciate the importance of the multisectoral dimensions of health; ▪ Donations of equipment creating problems with appropriate utilisation and maintenance as a result of lack of skills, expertise and/or parts; and ▪ Donor assistance failing to strengthen the recipient nation's capacity to manage public policy and administration. (Assistance has, in some instances, undermined the recipient government's policies to such an extent that these nations are wholly dependent on foreign assistance for service delivery.)	Criteria, instruments, processes and mechanisms for the evaluation of ODA "offers" must be developed. The admonitions listed on the left should be incorporated into the criteria for evaluation of ODA "offers" and structuring of subsequent agreements with donors.

POLICY GUIDELINE	EXPLICIT AND IMPLICIT RESPONSIBILITIES AND ACTIVITIES
Policy guidelines for donors must ensure that donations dedicated to health in SA are managed in such a way that they optimise the benefits to local health services	Concepts such as "benefits" and "local health services" must be concretised and clarified. If ODA is to benefit local health services, it must be aligned with the needs and priorities of local health services. These needs and priorities must be established at a local level in collaboration with providers and managers of local health services. Policy guidelines must be continuously evaluated on the basis of benefits ensuing from ODA in "local" health services, which implies that criteria, instruments, mechanisms and processes for such evaluation and feedback must be developed and implemented
All donations should be supportive of the RDP health priorities and those of the Department of Health	The Department of Health should develop a strategy for identifying the needs and priorities of public health services in South Africa, and not those of the Department.
Donor contributions should be used to support integrated programmes that meet the people's needs in a coherent manner, as opposed to the unco-ordinated vertical projects of the past. These contributions should help to develop sound health policies and create an enabling environment in which they will be realised, as well as giving rise to health systems reform.	"People's needs" should be conceptualised and concretised. There must be an identification and indication of which "integrated programmes" are considered to be in line with "people's needs" Provision must be made (mechanisms, processes must be created) for health policy development to benefit from donor contributions and experiences
Conditions attached to donations should ▪ Be acceptable to both the donor agency and Government ▪ Be in accordance with broad Government policies ▪ Assist and support the sound planning and management of health services ▪ Be aimed at making an impact on the health services ▪ Promote intersectoral collaboration and co-ordination ▪ Develop South Africa's capacity (at the national, provincial and/or local levels).	Areas where planning and management of health services can be assisted must be identified Areas of impact, as well as areas where capacity development is required, must be identified "Intersectoral collaboration and co-ordination" must be conceptualised and concretised. The above must be made available to donors in the form of general guidelines for the structuring of agreements.
As far as sustainability is concerned, donations which have recurrent cost implications for Government must be evaluated to ensure that the required financial resources are available to sustain such programmes or projects. The sustainability of ODA initiatives must be ensured in the short, medium and long term.	Criteria, instruments, processes and mechanisms for the evaluation of ODA "offers" in terms of sustainability and subsequent structuring of agreements with donors must be developed.
As far as accessibility is concerned, donations should be directed at making health services accessible to all South Africans, irrespective of race, gender, income status or geographic location.	Criteria, instruments, processes and mechanisms for the evaluation of ODA "offers" in terms of its contribution towards accessibility and subsequent structuring of agreements with donors must be developed.
As far as efficiency is concerned, donations should promote the efficiency of the health services through different mechanisms, e.g. training programmes for health workers, establishment of sound information systems, technical support initiatives and strengthening community involvement and participation in health service delivery.	Criteria, instruments, processes and mechanisms for the evaluation of ODA "offers" in terms of its contribution towards efficiency and subsequent structuring of agreements with donors must be developed.

POLICY GUIDELINE	EXPLICIT AND IMPLICIT RESPONSIBILITIES AND ACTIVITIES
As far as acceptability is concerned, donations should not only be acceptable to Government structures, but also to the communities for whom such donations are intended.	Criteria, instruments, processes and mechanisms for the evaluation of ODA "offers" in terms of its acceptability to Government and beneficiaries and subsequent structuring of agreements with donors must be developed.
In view of the multidimensional nature of health, intersectoral collaboration among health, education, agriculture, housing, water provision and sanitation and other relevant Government departments must be fostered by donations. Donations should be flexible enough to allow for the inclusion of those sectors which are major contributors to health.	The concept "intersectoral collaboration" must be clarified. Structures, mechanisms and processes for intersectoral planning must be established. The identification and prioritisation of needs and areas for ODA must be an intersectoral process.
Donations should be in accordance with South Africa's priority health needs. Prospective donors and the SA Government must agree on the areas to which donations will be directed.	SA's priority health needs must be identified in a comprehensive, objective, technical, participatory, decentralised and transparent way. Decisions about the direction of ODA must be negotiated between government and donors. Clarity must be obtained about the level of government where agreement must be reached with donors in this regard
Donations should promote and encourage self-reliance and the development of communities, and not foster dependency	This admonition should be incorporated into the criteria for the evaluation of ODA "offers" and structuring of subsequent agreements with donors.
The acceptance of funds donated by external agencies must be in keeping with SAs fiscal policy and financial legislation.	Relevant aspects of fiscal policy and legal requirements pertaining to ODA in SA must be identified and communicated to all stakeholders in a user-friendly format. The implications of these policy and legal requirements for the acceptance, administration, management and utilisation of ODA must be spelled out clearly. Their implications for the costing of specific programmes/initiatives must also be clarified, e.g. whether provision must be made for VAT.
Subject to the general guidelines, the donation of funds should be focused initially on bridging finance for the reconstruction and rationalisation of the health services.	"Gaps" where such funds are most needed and where they could be targeted with maximum impact must be identified in a comprehensive, transparent, objective and technical way.
Funding of recurrent expenditure for predetermined periods should focus initially on priority areas, as identified in the Government document titled "The Health Priorities of the Reconstruction and Development Programme" and other government policies.	These priority areas should be identified, conceptualised and contretised in a manner that would be acceptable to and understandable/useful for all stakeholders.

POLICY GUIDELINE	EXPLICIT AND IMPLICIT RESPONSIBILITIES AND ACTIVITIES
The Department will solicit and accept contributions of a technical nature from the donor community. This will only occur if there is a local shortage of such skills, or if such contributions are geared to enhancing local skills. Costs related to the provision of international expertise will be supported by the donor agency(ies), upon review and agreement with the Department.	Local "skills gaps" in the health sector should be identified by means of a skills audit. A databank on local technical skills should be established. The role descriptions, terms of reference and criteria for evaluation of technical experts working in the health sector must be clear, agreed on and make pertinent provision for the transfer of skills. There must be appropriate and sufficient capacity in the relevant structures within the Department of Health to effectively manage all aspects of technical assistance programmes. Responsibilities of different stakeholders, as well as requirements and conditions pertaining to the payment of technical experts must be clarified and performed accordingly.