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Description of terms

Aid

A source of finance in the form of soft loans or outright grants to developing countries, either given to the government or through nongovernmental organisations (NGOs).

Tied Aid

A USA started phenomenon in which aid is tied to the purchase of goods and/ or services in the providing country. This phenomenon has since been adopted by other donors.

Conditionality

A term used in development cooperation to describe some constraints on broader policy imposed by donors to recipients as conditions for receiving the aid. These constraints mainly revolve around the requirement to instigate policy reforms.

Overseas Development Assistance (ODA)

Overseas Development Assistance (ODA)¹ includes grants and loans from developed countries (undertaken by the official sector) to developing countries and territories with the promotion of economic development and welfare as the main objective. To qualify as ODA, a loan should have a grant element of at least 25%.

Technical Cooperation

Technical cooperation is the provision of advice and/or skills in the form of specialist personnel, training, scholarships and grants for research and associated costs.

¹ Aid and ODA are used interchangeably in this study

CHAPTER 1

Introduction

The concept of aid effectiveness is currently one of the topical issues in the international development discourse. Aid effectiveness can be defined as the extent to which development aid is disbursed and employed in order to meet the development needs in a specific area or country that it is assigned.² The idea of aid effectiveness emerged in the 1990s when industrialised countries began to realise that the aid that they were providing to developing countries was not leading to intended development results. The momentum behind the Millennium Development Goals (MDGs), adopted in 2000, was also reinforced by the realisation that even as both the volume and sources of development finance increased substantially around the 1990s, indications were that many countries in the world, particularly in Africa, were falling behind. Questions started to be asked on what can be done to ensure that aid is disbursed and employed in a manner that ensures that it leads to intended development results.

Developed countries, mainly through the Organisation for Economic Cooperation and Development (OECD), are the main sources of aid and have been the main proponents of “aid effectiveness”, arguing that the principles espoused by the Paris Declaration should be adhered to by all recipient countries in order to ensure that the aid disbursed to them is put to optimum use and is not deviated to fund other activities. In this way, they believe aid effectiveness will be ensured.

The signatories to the Paris Declaration of 2005 regard it as an important tool for improving aid effectiveness. The Declaration reaffirms a broad international consensus developed in the 15

² Joint Progress Toward Enhanced Aid Effectiveness : Paris Declaration on Aid Effectiveness : High Level Forum, Paris February 28 - March 2, 2005

years up to 2005 that new relationships between developed countries and partner countries are essential if development results are to be assured, aid well spent and aid volumes maintained. The aid architecture preceding this had been criticised for being donor driven and it was recognised that if aid was to be effective, a new international aid architecture had to be introduced. See for example, Callaghy (1988). The five Paris Declaration principles on aid effectiveness, outlining obligations for both donor and recipient countries as a basis for aid effectiveness are as follows:

- Ownership - Developing countries set their own strategies for poverty reduction, improve their institutions and tackle corruption.
- Alignment - Donor countries align behind these objectives and use local systems.
- Harmonisation - Donor countries coordinate, simplify procedures and share information to avoid duplication.
- Results - Developing countries and donors shift focus to development results and results get measured.
- Mutual Accountability - Donors and partners are accountable for development results.³

The aid effectiveness agenda and the Paris Declaration are however embroiled in some degree of controversy. Developing countries, still view the process as a rich country driven and evaluated, which is in fact a contradiction in the very terms of the Paris Declaration.

South Africa is one of the aid recipient countries that acceded to the Paris Declaration. Even though South Africa is regarded as a relatively self sufficient country, it remains a significant aid

³ Joint Progress Toward Enhanced Aid Effectiveness : Paris Declaration on Aid Effectiveness : High Level Forum, Paris February 28 - March 2, 2005

recipient in terms of volumes. The Organisation for Economic Co-operation and Development (OECD) reports that the country received about US\$ 715 million in 2006, US\$ 800 million in 2007 and US\$ 1,125 in 2008.⁴ Nonetheless, this is an insignificant proportion of the country's GDP, about 1% of the country's GDP. More than 50% of the aid flows to the health infrastructure and services sectors. According to OECD statistics, most of the aid into the health sector goes to Sexually Transmitted Diseases (STD) control initiatives, including HIV, health policy and administrative management, infectious disease control and basic health care. According to the 2007/8 OECD statistics, most of the aid comes from the United States, the European Union (EU), the United Kingdom, Germany and France. The OECD further reports that much of the aid flows is in the form of technical assistance and in kind.

For its part, the OECD DAC report⁵ on a visit to South Africa indicated that South Africa seems to illustrate strong ownership in its management of development aid and that donors appear to be aligning well with government priorities and country systems. Moreover, the report indicates that there is little donor harmonisation in South Africa but that the country is capable and content on engaging bilaterally with donors. This is interesting given that literature indicates that donor assistance to developing countries has been associated among others with disruption of the organisational capacity of the recipient countries as well as lack of ownership. (See for example, Mkandawire and Soludo (1999). Utilising the case of the health sector, the purpose of this study is to determine the accurateness of this assertion which may shed light on the relevance of the Paris Declaration as a guiding framework for aid management in South Africa and more importantly, on the relevance of aid to addressing health challenges in South Africa.

⁴ Information available at stats.oecd.org/Index.aspx?DataSetCode=ODA_DONOR

⁵ OECD DAC report on a visit to South Africa in July 2009.

Research Questions

The Research question guiding the study was as follows.

- To what extent are the principles of the Paris Declaration being applied in the South African public health care context?
- To what extent is the Paris Declaration relevant as a guiding framework for aid management in South Africa?

Rationale for the Study

There has been controversy surrounding the Paris Declaration as a relevant aid management guiding principle for relations between donors and recipients. International aid relations have always been characterised by conditionalities (with some constraints on broader policy imposed by donors to recipients as conditions for receiving the aid) and geopolitical considerations, which play a major role in the allocation of aid. In general, the aid architecture has been criticised for being donor driven and it has been recognised that if aid was to be effective, a new international aid architecture needed to arise. Tarp (2006) indicates, that there is an overall recognition that aid works in promoting growth and development, although there are still disagreements on the necessary and sufficient conditions for aid to have a positive contribution on the development process. If aid is important for development, it is therefore vital that we strive to find out whether the circumstances under which aid is being disbursed are relevant and render aid useful for development results. Moreover, the literature discussed in this section points out that donor aid to developing countries tends to be donor driven as well as misaligned from government priorities, making aid to have less positive impact on development. It is therefore interesting to find out what the situation is in South Africa, a country in which donors generally perceive to be “progressive and easy to work” in and in which the Paris Declaration is therefore expected to be easily implemented by the donors

Findings of the research will be made available to the Department of Health to assist them reflect on their aid management strategies and aid them identify areas of improvement where necessary. The research report will also be made available to the National Treasury International Development Cooperation (IDC) unit as the unit responsible for overall overseas donor assistance management in South Africa, also for reflection.

The Scope of the Study

The scope of my study will be from 1994 to 2009. This is because its aim is to concentrate on the post-apartheid regime, which has been understood to be very sceptical of aid. While the apartheid regime took a number of loans from the World Bank for example, the post-apartheid regime decided to keep an arms-length relationship with the Bank and had by 2005 taken only one loan with the Bank. I chose the health sector because it is one of the sectors that receives more aid than others and health delivery ranks high amongst the priorities of government. In order to narrow the focus of the study, GIZ was chosen as a case study because it is one of the donors that have put more funding into the South African health sector. Since the GIZ is also a bilateral donor with independence on the decisions it takes, it is possible to attribute the decisions it takes with regard to ODA management to itself alone.

According to initial findings, the health sector receives donor funding mainly in the areas of HIV/AIDS prevention, child and maternal health and combating Tuberculosis (TB).

Conceptual Framework

This study utilises the concept of Aid effectiveness as employed by the OECD Development Assistance Committee (DAC). Aid effectiveness is defined as the extent to which development aid is disbursed and employed to meet the development needs in a specific area or country that it is assigned.

Developed countries, through the OECD, have been the main proponents of aid effectiveness, arguing that the principles espoused by the Paris Declaration will, if adhered to by all recipient countries, lead to aid effectiveness by ensuring that the aid disbursed to them is put to optimum use and is not deviated to fund other activities.

Developing countries have generally viewed the OECD driven aid effectiveness process as a developed country initiative that is being imposed on developing countries as a new form of conditionality for aid. This study made the hypothesis that the Paris Declaration is another form of the good governance regime that has been advocated by donors.

Methodology

In order to undertake the study, I focus on two levels of interaction with the National Department of Health, the Treasury and International Aid Organisations (based in South Africa) to answer the research questions.

The study focuses firstly on policies and guidelines that direct the management of donor funding to ascertain whether these call for a results based, accountable and alignment to government priorities approach as envisaged in the Paris Declaration. Secondly, the study also draws from examples of donor funded projects and practices to ascertain whether actual management and disbursement of donor funded projects is in line with the Paris Declaration. The data collection method that employed to answer the research questions was document analysis and qualitative interviewing of the GIZ and identified government ODA managers. Document analysis was used as an entry strategy to indentifying areas that would require a more detailed enquiry and further guide interactions with the most relevant role-players for the qualitative interviewing. Policy documents and reports from the National Department of Health, the Treasury, Aid organisations and Non Governmental Organisations were solicited to answer the research questions.

Taking this approach has made it possible to collect credible evidence and present what I believe are important insights into ODA management and practices in South Africa and how these affect the relevance of aid as a tool for improving health standards in South Africa.

CHAPTER 2

Literature Review

Introduction

Overseas Development Assistance (ODA)⁶ includes grants and loans from developed countries (undertaken by the official sector) to developing countries and territories with the promotion of economic development and welfare as the main objective. To qualify as ODA, a loan should have a grant element of at least 25%. In addition to financial flows, technical co-operation is included in aid. Grants, loans and credits for military purposes are excluded.⁷ According to this definition ODA must be untied, that is, the aid should not be tied to the purchase of goods and/or services in the providing country. This can be seen as a response to developing countries' grievances over the years, that donor countries are always inclined to tie the aid to the purchase of capital equipment from the country providing the loan while also imposing a series of constraints on broader policy governing the release of the aid. The experience of most developing countries with aid, and particularly as was administered during the Structural Adjustment Programmes (SAPs)⁸ of the 1980s and 1990s, have left them to view aid as creating dependency.

There have been many studies on aid, and these have concentrated mostly on its developmental impact – some finding that it is negative, others that it is positive. An influential view is that aid works in “well-governed” countries but not in “poorly governed” countries. (See for example, Easterly (2001) and Lancaster (1999). The principles of aid effectiveness

⁶ Aid and ODA are used interchangeably in this study. Aid is however broader than ODA in that it is not limited to the government. It is funding either given to the government or through nongovernmental organisations (NGOs).

⁷ This is an OECD Development Assistance Committee definition, which is widely used in the international donor community. It is available at www.oecd.org

⁸ During the Structural Adjustment Programmes of the 1980s, aid was given to developing countries on condition that they introduce political and economic reforms.

espoused by the Paris Declaration seek to induce “good governance” in the management of aid and place specific obligations on both donors and aid recipient countries. The “good governance” literature simply tends to blame recipient countries for their poor capacity and proposes a number of policy options that they should adopt to ensure development results. Some of this literature shows that many of the reasons why aid has not been working have to do with improper conduct on the part of the donor community, particularly the manner in which they have interfered with State capacity.

Various case studies and analysis of aid are provided by observers from contrary perspectives. (See for example, Callaghy (1988), Easterly (2001) and Lancaster (1999).

This section reviews this literature while analysing its implications for this study. Because the case study is on the health sector, a portion of the literature review will be specific to this sector.

Aid and Good Governance

Lancaster (1999) indicates that while aid flows to Africa have increased substantially over the years, this has not translated into meaningful economic development. Her study finds that part of the reason for this lies in the unhelpful policies of African countries, connected with the patron-client political systems of African countries, where aid has been used to enrich the elites who hold or are connected to those in power. Similarly, Easterly, (2001) points out that aid to Africa has been used for military spending, and that in some instances recipient governments have had no capacity to plan properly the utilisation of aid. He indicates that partly because of this, the adjustment loans that were afforded to African governments to undertake reform, which would lead to economic growth, did not bear fruits as developing countries were not sincere about what they wished to do, and did little to change economic policies fundamentally. The implication of Easterly’s assertion is that some policies are good for development and others are

not. He however proposes that rather than imposing economic policies on recipient countries, donor institutions should only offer advice.

Van der Wall (2001) asks why Africa remains underdeveloped, despite huge inflows of aid into the continent. He uses quantitative data to show that a lot of the countries that received aid in Africa did not show improvements in economic growth and illustrates that those that performed worse than others are those whose political and economic governance was also bad.

Even as it there seems to be evidence that good governance is important for development, some have questioned the international institutions' tendency to prescribe similar "good governance" policies and institutions to all aid recipient countries, irrespective of the level of development and unique local conditions. Khan (2007) indicates that evidence suggests that there is no common set of institutions that all successful developing countries have shared. He further points out that failure to tailor reform strategies to the particular circumstances of countries can have a damaging effect by setting developing countries unattainable targets and creating demoralisation and reform fatigue. Birdsall (2007) also indicates that although institutional reform is important for aid effectiveness, experience suggests that the institution building process is a local task and is not amenable to outside help. She argues that prescribing institutions or governance reforms for aid recipient countries might undermine existing and incipient institutions. She suggests that broad reforms of aid practice, including harmonisation and aid predictability could greatly assist to bring about aid effectiveness in developing countries. Similarly, McGillivray et al (2006) argue that the implication of the "good governance" agenda is that countries with "bad policies" would receive less aid than would be the case, despite there still being controversy over where and how development aid works. They further indicate that there seems to be evidence that aid works in some instances at the micro level and little evidence for the macro level. This perhaps indicates that there may be some particular variables at play in different localities which renders aid effective or less effective. This view is

supported by Tarp (2006) who argues that aid has worked in the past and criticises the macro criterion of evaluating aid. He argues that we need to find out how best aid can be channeled to the poor when the State is not capable. Similarly, Oya and Pons-Vignon (2009) are critical of the good governance agenda for eroding the policy space of recipient countries. Thus, the good governance agenda denies recipient countries the space to maneuver and design and implement an appropriate set of policies tailored to the specific characteristics of their countries. Moreover, the good governance is criticised for not being tolerant of a culture of learning lessons from successful episodes of economic development elsewhere, but instead prefers implementation of one size fits all prescriptions of economic development approach.

The implication of the good governance literature for my study is that i would find that the donors do not do much to implement their obligations as per the Paris Declaration but instead insist on South Africa to implement the declaration. This is because the good governance literature posits that donors impose set of policies on recipient countries as conditionalities for funding. In this instance, the good governance agenda would be another form of conditionalities imposed on developing countries by the donor community while they are not prepared to abide by its obligations.

Aid and loss of State capacity

Mkandawire and Soludo (1999) analyse the reasons for the failure of the World Bank and International Monetary Fund (IMF) Structural Adjustment Programmes (SAPs) of the 1970s and 1980s. Countries undertaking SAPs were normally given aid as an incentive to implement them. The authors indicate that in their desire to get government out of the economic development sphere, these institutions neglected the essential government functions of development and instead utilised foreign experts to work on projects or programmes that they financially supported in the recipient countries. This resulted in a collapse or decline of institutional

capacity and civil services, which also rendered aid ineffective, since there was no capacity and ownership at the local level. The authors call upon Africa to reclaim leadership over its own development process. Similarly, Callaghy (1988) blames the failure of aid in Africa, and the consequent poverty and underdevelopment, on the nature of relations between the developed and the developing countries. He indicates that these relations are highly foreign policy oriented, with donor countries offering aid mostly to pursue their interests, and not for developmental purposes. In this instance, most of the aid provided to developing countries is accompanied by some levels of conditionality, with a series of constraints on broader policy.

Moreover, donor projects seem not to be tightly managed for results and the donors are not concerned at timely responding to grave situations. He indicates that this situation deepened Africa's dependency on the donor community, a situation that affected Africa's development negatively as could be seen in countries such as Zambia in the 1990s. He points out that the situation in Africa deteriorated sharply under SAPs. For example, between 1980 and 1984, the GNP of African countries declined by an average of 4.4%. However, ownership of the development process is the cornerstone of any development programme.

By not sticking to their promises of allowing recipients to take ownership, donors might be hindering aid effectiveness. Riddle (2007) analyses the impact of donor conditions for aid, such as insisting on utilising foreign experts and procuring abroad, and argues that this will have a negative impact on aid effectiveness. He indicates that 'the greater the degree and intensity of conditionality applied by the donors, the more recipients are likely to feel they are not in control, so they will be less committed to ensuring the funds are used as effectively as possible'. Easterly (2001) rejects claims by Jubilee 2000, (an international aid lobby group) that more aid and debt relief will empower countries to make their own choices. He indicates that the World Bank and the IMF require countries to prepare Poverty Reduction Strategy Papers (PRSPs), and that the World Bank handbook advising countries on how to prepare such documents runs

to well over 1000 pages, prescribing the paths to take to realise developmental objectives, which clearly erodes the ownership that the Paris Declaration advocates. Similarly, Browne (2007) alludes to the fact that the present international aid architecture is such that the content and terms of aid are strongly influenced by the needs and interests of the suppliers, rather than the recipients, which render the solutions ineffective and inadequate. He proposes that donors should be more concerned about country wide development goals and the Millennium Development Goals (MDGs). This literature is important as it reveals the nature of relations between donors and recipient countries. It rightly points out that these relations are political and embedded with national interests. However, it assumes that recipient countries were passive actors in this relationship. As we will see in the paragraphs to follow, this might not have necessarily been the case. The implication of this literature is that management of donor funds in South Africa might be characterised by donors placing conditions on the aid they provide. As the literature suggests, this has the effect of alienating the recipient countries from the process of aid management and eroding State capacity thereby hindering aid effectiveness.

Aid and Health sector: A literature review

Literature on aid in the Health sector mainly covers three areas; the loss of State capacity, limited aid into the sector and the impact of aid in the sector.

Aid and Coordination in the health sector

Leise and Schubert (2009) indicate that aid into the health sector of African countries is uncoordinated, with various donors coming up with an array of similar projects, leading to duplication. A related problem is that donors impose unrealistic demands on what processes the recipient countries should undertake as a condition to receiving the funds. The authors argue that this leads in practice to the recipient countries losing control of the health development processes. Moreover, high levels of dependency on donors undermine planning capacities

while uncoordinated external resources weaken health systems through promotion of different administrative systems and disparate therapeutic regimes. The authors argue that current donor driven attempts to coordinate aid will not be helpful and insist that initiatives like this should be driven by the recipient countries themselves. Levine et al. (2005) indicate that in spite of the donor countries' initiatives to impose governance practices on the recipient countries, there is also little evidence that health aid is more effective in countries conforming to the good governance agenda. This literature highlights important issues of coordination, which has been identified by the donor community, through the OECD - DAC, as one of the major problems facing the international aid regime. Its weakness is to assume that recipient countries are passive actors and have little to do with the management or mismanagement of aid. In fact, as has been indicated earlier, donor and recipient countries are equally to blame for mismanagement of donor funds. This literature also assumes that there is an abundance of donor funds flowing to the developing countries. As will be seen from the following literature, this has not always been the case. The implication of this literature for my study is that donors in the South African health sector are not coordinated, weakening health systems through promotion of different administrative systems and disparate therapeutic regimes. Is this the case in a middle income country like South Africa that is considered capable of creating and managing its own policies?

Tied health aid

It is also recognised that the scope of health problems is very big and the burden this places on the resources of developing countries make it impossible for some of them to deal with these problems alone, without the assistance of international donors. Look for example at Levine et al. (2005). As can be seen from the introductory part of this report, in terms of the MDGs, the health sector covers three of the eight priority goals, which is more than any other sector. These

are: goal four: reduce child mortality, goal five: improve maternal health and goal six: combat HIV/AIDS, malaria and other diseases.

In this instance, Levine et al. (2005) lament that health aid to Africa constitutes only 6% of overall aid into the continent even though the continent faces serious challenges in the area of health and is likely not to achieve Health MDGs. Sachs and Attaran (2001) note that although Sub – Saharan Africa is wrecked by a number of pandemics including Tuberculosis and malaria, the continent has not received enough health aid to deal with these pandemics. They also indicate that if loans are excluded to leave just grants, the assistance given to Sub-Saharan Africa is disappointing. They illustrate that programmes designated by donors as AIDS control programmes to the region during 1996-98 amounted to only about US\$77 million annually on average, which amounts to about \$3 per HIV infected person. Reports however indicate that total funding for AIDS nearly tripled between 1998 and 2007, while funding for other health related problems did not receive that much boost.⁹

It is clear though that although it started very slow, health aid has been increasing. The question is whether the conditions under which it is channelled are relevant. The effectiveness of aid is hampered again, they lament, by the fact that most of the health aid given is “tied aid”, which refers to a peculiar form of loan tying to the purchase of capital equipment produced by the country giving the loan¹⁰. In this way this is aid where the content and terms of aid is influenced by the needs and interests of donors, which limits its benefits to the local economy. This is aid tied to the purchase of imported goods such as pharmaceuticals. This particular literature is important as it highlights the important issue of scarcity of health aid and its impact on Health outcomes. Although the literature highlights the issue of “tied aid”, it fails to appreciate that this

⁹ Global AIDS funding debate heats up. Article available at <http://www.plusnews.org/report.aspx?ReportId=86754>

¹⁰ For a more detailed discussion on tied aid, see Alice Amsden, (2007) *Escape from Empire: The Developing World's Journey Through Heaven and Hell*. The MIT Press, New York.

basically renders health aid a foreign policy tool being utilised by donor countries to pursue their national interests. The other weakness of this literature is that it assumes that more aid automatically translates to improved health outcomes, without acknowledging the specific health policy areas that should be addressed by the health aid to ensure positive outcomes.

The impact of aid in the sector

Mishra and Newhouse (2009) look at the impact of aid on infant mortality, using data from 118 countries from 1973 to 2004. Their study finds out that health aid has a significant effect on infant mortality, with a doubling per capita health aid associated with a 2% reduction in the infant mortality rate. Consistent with the literature reviewed above, they indicate that this is small relative to the 2015 target envisaged by the MDGs. Levine et al. (2004) find out that health aid has a positive impact on health outcomes regardless of the governance quality or institutions. They argue that this is because health aid is not fungible, that is it cannot be diverted to something else; much of it is directed towards specific projects in particular regions. They argue therefore that increased allocation of aid towards health purposes in the future could improve recipients' health outcomes. I have a problem with this study in that it focuses on health outcomes and not systems. If aid money gives some sort of health insurance for individuals, what would happen to them if aid is no longer there if the systems are not in place because of bad management? If, as indicated earlier, uncoordinated flows of aid negatively affect policy making, what would happen to health systems and outcomes, especially in the long run? This literature fails to answer these pertinent questions.

The South African Health Sector: Some Issues

With an estimated Gross National Income (GNI) of \$113.5 billion, South Africa is regarded as a middle income country and considered not dependent on foreign aid flows for its development. However, the country has at the same time serious challenges of poverty and inequality, which necessitate and attract the presence of donors. Gelb (2009) indicates that both poverty and inequality are intractable and deeply rooted issues in South Africa. He indicates that for example, in 2005, 47% of the population was in poverty, using the R322 per capita per month poverty line in 2000 prices. At the same time, he indicates that in 2006, the GINI Coefficient was officially calculated at 0.73, amongst the highest in the world.

South Africa has one of the highest prevalence of HIV and AIDS as well as TB. According to the 2010 UNAIDS report around 5.6 million (around 11% of the population) South Africans were living with HIV at the end of 2009, which is more than any other country, including 300,000 children under 15 years old.¹¹ This is despite the report indicating a meager decline in new infection rates. There is correlation between high HIV/AIDS rate in South Africa and the high poverty levels in country. Marais (2008) quotes studies that indicate that the burden of HIV Aids weighs disproportionately towards urban informal settlements, the vast majority of who are poor black Africans. He however indicates that even as many of the AIDS infected are the poor, they are not the poorest. Evidence also suggests that women are also the most infected. It is indicated that although just 9% of the population lives in informal settlements, about 29% of new HIV infections in 2005 occurred there.

It follows from the above indication that there is little linkage between poverty and AIDS prevalence, that although most of the health resources should be channeled to the poorest people, who are mostly in the rural areas, this will require a more cautious formulation. If

¹¹ UNAIDS (2010) '[UNAIDS report on the global AIDS epidemic](#)'

poverty is not the major cause of HIV/AIDS in South Africa, it might be for example that lifestyle and behavior are, and as such prevention messages should be targeted as such.

The South African two –tier health system has not offered much in terms of assisting to tackle the situation. In this system, only about 7,5 million South Africans have medical insurance and access to a large and expensive private health care sector, catering a small minority , while the majority has to rely on poor and overloaded State facilities. The South African government is of the view that this dispensation is not sustainable and that the sector is in urgent need of revision to make it more accessible and affordable. The public sector is said to be unable to adequately meet the needs of the population as it suffers from capacity challenges, both human and technical. South Africa's health system also offers little preventive and promotive care compared to curative care, which is said to be expensive, ineffective and unsustainable among other things.¹² Tackling these problems would therefore require more than financial resources but also innovative interventions that require collaboration with other international partners to harness knowledge and best practices. The system managing this financial transfer and knowledge sharing will also have to be relevant and appropriate if it is to produce desirable results.

The implications of this literature for my study are many and vary. Firstly, the literature suggests that there might be aid effectiveness (aid well spent and delivering intended results) in the health sector if good governance, as prescribed by the Paris Declaration is practised. The literature indicates that aid, and health aid in particular, is characterised by lack of good governance, epitomised by constant problems of coordination, harmonisation, conditionalities and misalignment to national priorities. Generally, although aid into the health sector is not enough compared to the huge problems in this sector, literature suggests that it has the potential to improve health outcomes if applied well. The literature argues that lack of good governance has contributed to the lack of aid effectiveness in the sector. The concept of good

¹² Minister of Health 2010 Budget Vote Speech available at www.doh.gov.za

governance, especially as it is applied in the aid effectiveness agenda is however being criticised for assuming that there can be a similar set of good governance policies that can be applied in any country irrespective of the local circumstances. This practice, it has been observed, mostly results in the erosion of policy spaces and capabilities of the recipient countries and consequent discontent on the part of recipient countries, resulting in lack of determination to manage aid.

It is interesting that although the literature points out that health aid is generally associated with problems of misalignment, ownership and harmonisation, the OECD DAC indicates that South Africa does not seem to have problems associated with these. It is imperative therefore to find out the circumstances within which this disjuncture occurs which might assist in the current debates on aid effectiveness.

CHAPTER 3

The implementation of the Paris Declaration in South Africa: Some evidence

Consistent with the aims of this study, this chapter presents evidence pertaining to the management of aid in the South African health sector. Specifically the section presents evidence on how the Principles of the Paris Declaration are implemented in the sector, findings of which are used to analyse the relevance of the Paris Declaration as a guiding framework for aid management in South Africa particularly its impact on the relevance of aid as a tool for addressing health challenges in South Africa

An analysis of relevant available data, including statistics and documents as well as interviews suggests the following:

- That donor funding is not adequately aligned to the priorities of the health sector;¹³
- That, in terms of the Paris Declaration principles, the South African health sector takes ownership of donor funding, but a close examination of the process reveals some gaps, with donors able to take control of the design and implementation of these projects; The fact that evidence portrays ownership without alignment suggests that the Paris Declaration principle does not cover all the important aspects of ownership that would otherwise translate ownership into alignment in the South African health sector;
- That there is no harmonisation of donor funding in the health sector;

¹³ I refer to not adequately for a number of reasons. Firstly, the study reveals that aid in the health sector is skewed towards HIV/AIDS and less towards other areas. Secondly, in the HIV/AIDS sector itself, it is skewed more towards treatment, even when the Minister of Health has repeatedly indicated that preventative measures would be more effective and less expensive. Check for example The Aid Effectiveness Framework for Health in South Africa, Department of Health, December 2010 (p3). Further, the study also finds that the donor focus on HIV is both not entirely appropriate and not very efficient.

- That there is no results based management and accountability for results of donor funded projects in the health sector;
- Lack of alignment, harmonisation, and results based management and accountability as well as the nature of ownership in the management of ODA in the South African health sector minimises the relevance of aid as a tool for addressing health challenges in South Africa.
- That there is no proper prioritisation of donor funding in the health sector and,
- There is more donor focus on AIDS in South Africa, which is both not entirely prioritised and not very efficient.

Alignment of donor funding in the South African Health Sector

The Paris Declaration urges donor countries to align their development assistance behind developing countries' own strategies for poverty reduction objectives and use local systems. This is important as it portrays the donors' commitment to assist developing countries implement their own strategies which might ensure harnessing of resources to areas where it is most needed. To determine whether this is the case in the South African health Sector, the study looks at the donor assistance given to the sector and analyses whether this is in alignment and relevant to the development needs of the sector. Moreover, the use of South African systems in the sector by donors is evaluated.

The National Department of Health outlines priority areas of focus for the sector for a specific year, which forms the background for the development of the annual performance plans. According to the department of health 2010/2012 strategic plan¹⁴, the general focus of the sector is on the following areas.

- Implementation of the updated National HIV and AIDS strategy;

¹⁴Available at <http://www.doh.gov.za/docs/policy-f.html>

- Intensified campaign against various TB strains and other communicable diseases;
- Campaign against non - communicable diseases -including accelerated campaign for Health Lifestyle programmes in South Africa;
- Strengthening malaria control;
- Improving maternal; child; women health and nutrition;
- Implementation of health facilities improvement plan;
- Health financing especially design of a national health insurance system;
- Reduction in prices of pharmaceuticals;
- Strengthening human resources for health;
- International relations; and
- Management and communication systems

In addition to the above, in 2009, the government introduced the 10 point plan of the health sector (2009 to 2014) which is aimed at transforming the health sector into a well functioning health system capable of producing improved health outcomes.

The 10 point programme consists of the following priorities:

- Provision of Strategic leadership and creation of a social compact for better health outcome;
- Implementation of National Health Insurance (NHI);
- Improving quality of health services;
- Overhauling the health care system and improving its management;
- Improved human resources planning, development and management;
- Revitalisation of infrastructure;
- Accelerated implementation of the HIV and AIDS and Sexually Transmitted Infections (STI) national strategic plan 2007 to 2011 and increased focus on TB and other communicable diseases;
- Mass mobilisation for better health for the population

- Review of the drug policy;
- Strengthen research and development;

The National Government Programme of Action (POA) which required National and Provincial Departments of Health to adopt and accelerate the implementation of the updated strategy on HIV and AIDS and to intensify efforts to eradicate all strains of TB in the country led to the special attention given to these two programmes in the 2008/9 planning period.

Moreover, in a meeting between the National Department of Health and Development Partners, the department identified a number of health priorities that donors were neglecting and requiring donor assistance. These were:

- Health Systems Development
- Referral Systems
- IT systems
- Programme development
- Primary Health Centre (PHC) Survey
- PHC cost designation study
- TB survey
- eHealth Survey
- Hospital Improvement plan
- Maternal , Women and Child Survey¹⁵

¹⁵ 2008 Annul Donor Consultation meeting between the South African Department of Health and Development Partners, Boksburg, South Africa. 30 June 2008. Presentation by FG Muller.

No details of the extent of support needed under each of the areas highlighted above are given. An analysis of statistics however shows that support by donors is consistent with the requirements of the sector; the concern is that there is over concentration of donor activities and support on strategic health programmes, especially on HIV and AIDS and little support towards other areas. Table 1 presents data on aid to South Africa's health sector during the year 2006 -2008. It provides an overview of donors' cumulative total commitments over three years (2006-2008) on aid to the health sector in South Africa. The data is broken down by donor and includes ODA from bilateral donors as well as the concessional outflows from multilateral organisations. The data shows that more than 50% of donor funding into the health sector is geared towards HIV/AIDS, and less focus to other areas. The data shows that the US is the biggest ODA provider in the sector, with specific emphasis to HIV/AIDS and TB prevention.

Although acceleration of HIV/AIDS prevention and treatment is part of the POA and thus required special attention, this does not necessarily imply that other areas should be neglected. Evidence to be provided in this chapter indicates that the donor focus on AIDS in South Africa is both not entirely prioritised and not very efficient. Firstly, the evidence to be provided points to the fact that the attainment of the objective on prevention and treatment of HIV/AIDS relies on the realisation of other priorities such as an efficient primary health care system, health systems development, hospital improvement plan and improved referral systems. Evidence to be provided suggests that lack of improvement in these and other areas has hampered progress in the fight against HIV/AIDS and the general struggle to improve health standards in the country. Table 1 below depicts an overview of donors cumulative three year ODA commitments to the South African health sector between 2006 - 2008. Table 1 shows that HIV/AIDS received the most funding in the period indicated.

Given the above statistics and what I have just alluded to, an area where aid could be increased and concentrated is improving the South African primary health care system, especially its capacity to

deal with the HIV/AIDs pandemic. A phenomenon that has always been alluded to with regard to this issue is that in rural areas and primary health facilities is that there is not enough capacity to handle the burden of disease in South Africa, especially the HIV/ AIDS pandemic. Writing about the problems relating to capacity constraints in the health sector post apartheid, Khutzky and Tollman (2008) indicate that the privatisation of health care which was introduced during the apartheid era led to the rapid expansion of hospital-based curative services and facilities, thereby exacerbating already severe rural / urban disparities in resource and personnel distribution, and increasing financial barriers to service access, further disadvantaging low-income groups. They further indicate that, the quality and nature of health care available to South Africans throughout the apartheid era was largely determined by three factors; race, income and location and this legacy has persisted to disadvantage the poor black areas, which although attempts being made by the new government to improve them, continue to be characterised by poor quality of health services.

Although the South African government has acknowledged the need and value of caring for people living with HIV and AIDS in their homes, and in 2001 called for the establishment of 600 home based care programmes by 2005, many carers and home based care organisations are not sufficiently supported and lack the necessary links with formal health facilities which therefore inevitably, lead people living with HIV to suffer due to this inadequate care. It is also argued that discharging an HIV/ AIDS patient to receive home based care is tantamount to discharging a patient to face his or her death at home. Moreover, AIDS patients have to travel long distances to take their medication.¹⁶

In a nutshell, the system faces capacity challenges at the coalface - where the patient meets the health care system. It therefore follows that successful treatment of HIV/AIDS patients need capacitated rural health systems and improved primary health care in general and thus this is the area where more donor funds could be channelled. To improve efficiency and to expand access more

¹⁶ Jack, E et al (2010) "Home based care: Caring for people in the Community – challenges and opportunities" in South African Family Practice Vol 52, No 6.

funding should be allocated to decentralising access to treatment through a process of training and capacitating rural and or local facilities to take on the role of initiating HIV treatment. The HIV and AIDS and STI Strategic Plan for South Africa: 2007-2011 which was launched with the key objectives of providing antiretroviral drugs to 80% of people who need them and cutting new infections by 50% by 2011¹⁷ is a noble cause but will have to be accompanied by a concerted effort to build a functioning primary health care for it to be cost effective and sustainable. Atruin (2004) indicates that there are some advantages for health systems that rely relatively more on primary health care and general practice in comparison with systems more based on specialist care in terms of better population health outcomes, improved equity, access and continuity and lower cost. In the same vein, the World Health Organisation (WHO) indicates that the reason gaps in health outcomes continue to widen, although the world poses a sophisticated arsenal of interventions and technologies is because the power of existing interventions is not matched by the power of health systems to deliver them to those in greatest need, in a comprehensive way and on an adequate scale.¹⁸ This underscores the importance of channeling resources to improving systems that best delivers interventions to the population, rather than concentrating on the interventions themselves. The data also shows that although TB treatment is also part of the POA and thus required special attention, it did not receive close the ODA received by HIV/AIDS. The National Treasury indicates that excessive concentration of ODA to HIV/AIDS is in part a result of donor inflexibility, wherein donors focus on specific programme areas that they regard as more “visible” and sometimes on preferred regions.¹⁹ The case study used in this research suggests that these projects are identified largely by the funding agencies

¹⁷ Department of Health(2007)HIV/AIDS & and STI Strategic Plan for South Africa, available www.doh.gov.za/docs/misc/stratplan/2007-2011/part1.pdf

¹⁸ World Health Organisation (2007) Strengthening Health Systems To Improve Health Outcomes: WHO’s Framework For Action, www.who.int/healthsystems/strategy/en/

¹⁹ National Treasury (2010) Phase Two Evaluation of the Implementation of the Paris Declaration and Accra Agenda for Action in South Africa, Pretoria

with minimal input by government, which in turn denies the government an opportunity or flexibility to influence the use of the resources to bridge funding gaps in areas of real need. Indeed, there is potential and opportunity to use donor resources to bridge funding gaps in the sector, especially in light of the huge challenges facing the sector.

The Minister of Health hinted at the need to take a holistic approach to health management when he indicated that, “It is important to remember that apart from the challenges of HIV and AIDS, the government has the challenge to transform our health system from one that, under the apartheid system, denied millions of people basic health care services because of their race”.²⁰ Donor funding in the health sector must, in light of these challenges, really be aligned towards addressing issues around the improvement of the entire health system and primary health care in particular. It has already been indicated earlier in the literature review about the importance of improving health systems for improved health outcomes in the long run. In this regard, as earlier argued, I believe that the starting point for a health strengthening system in South Africa should be at the primary health care level, encompassing community health work, clinics and community health centres.

The fact that HIV/AIDS is where proportionally the donor contribution is most significant, means that this 'sub sector' offers the most possibilities and incentive on both sides to pursue the aid effectiveness agenda and to get the most benefits from coordination and alignment. This is even more important when one considers that South Africa has one of the highest prevalence of HIV/AIDS. For example, in 1990 the HIV/AIDS prevalence amongst pregnant women who attended public sector antenatal clinics was a mere 0.9%. However in 15 years (2005) it had reached 30%. Over the past three years it seems to have stabilised around 29% - but is still extraordinarily high.²¹

²⁰ Speech by the Minister of Health in South Africa, Dr Aaron Motsoaledi at the XVIII International AIDS Conference. 20 July 2010, Vienna

²¹ Ibid

The South African Minister of Health, Dr Aaron Motsoaledi, has expressed concern over the cost of coping with HIV /AIDS in South Africa given the high prevalence rate and the fact that health performance in South Africa is hampered by among others, financial problems. As it has been hinted before in this paper, other related problems are that South Africa's health care system has a large and expensive private health care sector, catering a small minority; and a small public health sector, catering a huge majority of the population. The public sector is said to be unable to adequately meet the needs of the population as it suffers from capacity challenges, both human and technical.

South Africa's health system also offers little preventive and promotive care compared to curative care, which is said to be expensive and unsustainable among other things. In this regard, Harrison (2009) raises concerns around South Africa's future costs for antiretroviral treatment programmes which it is forecast will cause significant strain on the health system by 2020, unless South Africa experiences economic growth. He refers to a report which indicates that based on current spending levels; projected costs suggest 40% of the health budget will be absorbed by ARV programmes. Although literature has pointed out that prevention could be beneficial to the fight against HIV/AIDS in South Africa, and is one of the major objectives of the National Strategic Plan for HIV/AIDS and STI management, 2007 to 2011, the data shows that the greatest aid input is to treatment, with the United States Agency for International Development (USAID) being the biggest contributor mainly through its Presidential Emergency Plan Fund Aids Relief (PEPFAR) programmes. An interview with USAID indicated that the US spends about US\$ 550 million a year in health funding to South Africa, with about 93% of the of the funding going to NGOs and only 7% going to government institutions, including the department of health. During the years 2010-2011, the US government is funding the department of health to the tune of US\$120 million for the purchase of Antiretroviral (ARVS). A new funding agreement for the health sector is currently being negotiated between USAID and the department of health.

The huge strain on the health resources of the country is experienced as the country still faces other challenges including amongst others high maternal mortality and child mortality rates and declining life

expectancy. This backs the point that the country needs to resort to a preventative health care, and this paper has argued that a well functioning primary health care is the first step towards that. The paper has also argued that ODA funding should be channeled towards this course.

Dr Motsoaledi has acknowledged these challenges and indicated that with so many problems in health care, the proposed National Health Insurance (NHI) is the main solution to the country's health care system.²² The NHI has precipitated much debate in the country with some arguing that the country should instead concentrate on improving management and accountability in the public health sector and monitoring of the quality of care and cost in the private sector, before moving to introduce the NHI. A Centre for Development and Enterprise (CDE) report posits that “the reason why the public sector does not consistently provide satisfactory services, despite the sometimes heroic efforts of its clinical staff, are not related to funding but to inconsistent management and weak accountability. Market mechanisms in the health sector have many advantages but also some areas of weakness peculiar to health issues. Who monitors the quality of care and its cost, for example?”²³ The report further states NHI may be good way of funding health services in the longer term, but presently, the country's high levels of unemployment present a major challenge to the affordability of an NHI, and therefore the country should concentrate on improving its economic growth.

From the above, i would reiterate that South Africa should utilise the extra resources from ODA to enhancing the effectiveness of its primary health care system, which, as discussed earlier, would form the basis of an efficient and affordable preventative health care system in South Africa, which could be a good launching pad for a sustainable NHI. My criticism of the argument that South Africa should concentrate on improving its economic growth is that, what would happen to the affordability of the NHI when the country experiences a longer period of economic recession? If an NHI is tied to a well functioning primary health system, then it can be sustainable, given the advantages of the system

²² Minister decries expensive health care (www.sabcnews.co.za 20110203)

²³ A Nation's Health in Crisis: International experience and public-private collaboration, CDE Round Table Number 16 • November 2010

discussed earlier. The country's total HIV expenditure from government and development partners in 2009 alone was a combined R17.6billion (\$2.33billion) - 83% of this provided by government. This is up from just under R14billion (\$1.84billion) in 2008.²⁴ The 2010 UNAIDS reports indicates that South Africa ranks first in terms of dedicating resources to the fight against HIV/AIDS.

A phenomenon that has always surprised many observers is the relative slow decline of the HIV/AIDS pandemic in South Africa even in the face of more resources directed into this area and can be linked to the point earlier made about the inefficiency and lack of salience of the donor focus on AIDS in South Africa. The lack of salience of the donor focus in this area can also have to do with the project approach to funding. The DoH indicated that projects remain the main modality for delivering donor assistance to the health sector. According to a study by Cordella and Dell'Ariccia (2003), using projects as the modality for aid delivery gives responsibility for the management of the resources to the development partner – with little provision for accounting of expenditures to the government.

The study further reveals that budget support is preferable to project aid when total aid is small relative to the resources of the recipient while project aid is superior for relatively large programs. In addition, it is indicated that the project approach is preferable when the preferences of the donor and those of the recipient are relatively apart. Taking into account this assertion, it is clear that budget support would be preferable in South Africa given that ODA forms a small portion of the country's GDP. The department of health has, through its new framework for aid effectiveness, indicated that it is to resort to budget support as a preferred means of receiving funding from donors. This is as they have realised that project funding allows for isolated funding that is in most cases not in consonance with the sector's needs.²⁵ Examples of projects of this nature are however not given.

²⁴Speech by the Minister of Health in South Africa, Dr Aaron Motsoaledi at the XVIII International AIDS Conference. 20 July 2010, Vienna

²⁵ The Aid Effectiveness Framework for Health in South Africa, Department of Health, December 2010.

This study has however found that most of the big donors such as USAID, EU, GIZ and DFID are increasingly organising their aid in terms of programmes that normally supports the country's health priorities, as opposed to small projects. This, however does not relate to the department of health taking ownership of the programmes since most of this aid goes directly to NGOs, where the department of health currently does not control the details of implementation of donor funded programmes. As indicated earlier, about 93% USAID funding goes to NGOs. If most of this aid went directly to the department of health, it would be possible for the department to share it equitably, depending on its own hierarchy of priorities. The exception seems to be the European Union, whose funding in the main goes directly to the department of health and fund the priorities of the department.

This is compounded by the provincial and local spheres of governments, who the National Treasury indicated that although mostly lacking the necessary capacity to negotiate with donors, sometimes single handedly enter into agreements with donors which are in some instances not of strategic importance in the quest towards the attainment of health priorities in the country. The Treasury could not however provide an example of a project where this happened. National Treasury further indicated that some development partners work with people in departments, provinces, municipalities who do not know the process and then they agree to a project that the ODA coordinators would not have agreed to. The health sector therefore requires a more coordinated approach, as well as capacity building to ensure that the other spheres of government do not undermine the fight against HIV and AIDS and health standard improvement in general.

There is also a potential and opportunity to use donor resources to bridge funding gaps in the sector, if, coupled with an adoption of a coordinated approach, the sector itself adopts a systematic process to identify and communicate in concrete terms resource needs and gaps. For example, at the 2008 Annual Donor Consultations organised by the department, donors requested a matrix showing available funding and funding gaps as well as details of who is doing what and future commitments.

²⁶The European Union (E) seems to be doing well in terms of aligning its funding to sector priorities. The EC has a specific focus on primary health care and health service delivery programmes that address the DoH priorities while as indicated earlier , donors such as the US seems to have a specific focus on HIV/AIDS treatment.

Donors seem not to be aligning well with South Africa's systems. It was indicated that they are reluctant to use South Africa's robust Public Finance Management Act (PFMA) systems. However, few (typically those Development Partners who provide relatively small amounts of ODA to South Africa, such as the Nordic countries and multilateral organisations such as the European Union (EU) make use of South Africa's country systems. Reasons given by Development Partners for not using South Africa's systems include concern that use of country systems delay speedy implementation of projects and Head Quarter directive to field staff not to use systems as in most cases their domestic regulations prohibits them from the use of country systems. The prohibition exists because in most cases the donor countries regulations indicates that with regard to outgoing aid management, their laws, with regard to example, procurement and financial management has to be used. I was told by Treasury officials that although donors indicate the reasons for not using locals systems in other countries to be "bad systems", i.e. bad financial management and procurement systems according to donor standards, the first round of monitoring of the Paris Declaration and the first phase evaluation clearly stated that the use of systems and quality of systems had nothing to do with each other because even countries with good systems like South Africa struggle to get donors to use its systems. This supports the point made in the underscored by literature that the Paris Declaration is a good governance agenda that the donors are just imposing on recipient countries, without themselves willing to implement it.

²⁶ 2008 Annul Donor Consultation meeting between the South African Department of Health and Development Partners, Boksburg, South Africa. 30 June 2008. Meeting Report - pp 18.

The conclusion that donor funding is not adequately aligned, as indicated earlier is borne by the fact that as evidence presented in this section shows, although the donor funding support the health sector priorities, it is skewed heavily towards HIV/AIDS and less on other important aspects of the health sector deliverables. Even with HIV/AIDS funding, this study has found that the funding is more towards treatment, even when, as indicated earlier, the minister of health has indicated that prevention would better serve the fight against the HIV pandemic. This implies, once again, that donors fund areas which they believe are more visible or where they believe they can gain some leverage, whether political or economic or sometimes where they think the need is, as the case in the next chapter will show. The excessive donor focus on HIV/AIDS therefore appears to be inappropriate and ineffective.

ODA ownership in the South African Health Sector

The problems indicated with regard to alignment in the South African health sector leads us to consider another related principle of the Paris Declaration; that of Ownership. The Paris Declaration urges developing countries to set their own strategies for poverty reduction, improve their institutions and tackle corruption. It could be asked whether the fact that there is no adequate alignment has to do with lack of institutions and strategies for development, as advised by the Paris Declaration. In South Africa, the International Development Cooperation (IDC) unit at the National Treasury is charged with the mandate of overall coordination and management of aid flows into the country. Simultaneously, donor coordination units within each National Department have been created to complement the work of IDC in ensuring proper coordination of ODA. Within the Department of Health, the Development Cooperation directorate with the International Health Liaison branch is mandated with the coordination and management of Overseas Development Assistance (ODA). To ensure efficient use of ODA, a management structure linking the national level down to the district levels has been set up, with ODA coordinator officers, operating at each of the nine provinces and some of the municipalities.

Despite the existence of the different layers of engagement, the government's policy regarding official overseas assistance requires that the relevant sphere of government notifies the national level about the agreement with a prospective donor so that documentation is "processed" at the National Level. Within the department of health, it is expected that while the provinces are free to enter into funding negotiations with a prospective donor, full information of the scope of support i.e. project and level of funding must be provided to the national department, specifically the ODA coordination management office and in turn, the IDC for formalisation of the funding agreement.²⁷ I have indicated earlier in this paper that an issue pertaining to the provincial and local spheres of governments, who although mostly lacking the necessary capacity to negotiate with donors, single handedly enter into agreements with donors which are in some instances not of strategic importance in the quest towards the attainment of health priorities in the country. This has the potential to undermine the achievement of health targets, as exemplified by the HIV/AIDS issue. It is also recommended that no funding arrangements, outside the funding gaps identified by the sector must be allowed to be entered into by any sphere of government. In this regard, it is proposed that the national government should not approve any proposal that does not conform to the above requirements.

There should be centralisation of the ODA management as far as possible as it is clear that provinces and municipalities do not necessarily conform, or perhaps that the national department of health does not offer enough leadership and direction to the lower levels in terms of which areas aid should be channelled most, and simply rubber stamp the process. Centralisation is possible in terms of chapter 6, section 146 of the constitution, which allows national government to establish policies to deal with a matter that, to be dealt with effectively, requires uniformity across the nation. Centralisation would provide that uniformity and allow the government to deal with aid management effectively, considering the loopholes that this study has exposed. Moreover, one of the comments from the donors on the draft ODA policy of the health department is that there is no coordination between the spheres of

²⁷ National Treasury (2007) ODA Policy Framework and Guidelines, Pretoria, available at www.dcis.gov.za/Documents/Guidelines_final_dr.doc

government, and that roles delineation between different players are not clear enough.²⁸ The Department of health ODA coordination policy prescribes some procedures for solicitation of ODA. Firstly, a strategy document forms the basis on which any identified donor support should start. Any identified projects for possible donor support must derive from the strategy. Once a project has been conceptualised, a relevant donor is approached followed by the formulation and presentation of a proposal. A departmental steering committee, consisting amongst others, the Director-General (DG) and the Branch Manager must approve the project before it is handed over to the donors.²⁹

From the above, it is clear that despite the problems of alignment identified earlier, South Africa and the health sector in particular, has taken strides to improve its institutions and emphasises on strategy documents as the basis on which any identified donor support should start. This should, as the evidence here has shown, be improved to avoid a situation in which donors take charge of the processes. Moreover, the case study in the following chapter indicates that donors can have more influence in the design of projects than the department of health, which also enables them to take ownership of the projects. Perhaps the fact that evidence portrays a level of ownership, as per the Paris Declaration definition, which does not translate into alignment, indicates a need to broaden the definition of Ownership. The present definition, which only assesses the existence of a national development strategy, is simply an inadequate measure of ownership. There is a need to adopt a broader definition that takes greater cognisance of civil society and grassroots communities' involvement in the process as well as the ability and capacity of the State to coordinate aid across the different spheres of government and the broader civil society. Ownership should also take into account who designs the projects or programmes. The case study in the next chapter will illustrate this point clearly.

²⁸ Department of Health (2010) Comments by the Donors on the Draft Department of Health ODA Policy. Unpublished Paper

²⁹ Department of Health (2010) The Aid Effectiveness Framework for Health in South Africa, Department of Health, Pretoria.

Donor harmonisation in the South African health sector

The Paris Declaration call upon Donor countries to coordinate, simplify procedures and share information to avoid duplication. This also reduces costs and allows for a greater harnessing of resources across a sphere of sectors. In the South African health sector, the increase in the number of donors, cumulative growth in the number of projects as well as the mix in the value of contribution by the various donors necessitate better coordination, with government leadership, to encourage sharing of efforts among the donors represented in the health sector on the basis of their comparative advantages.

Evidence however suggests that donors in the health sector are still unorganised. The lack of harmonisation of donor practices such as in areas such as monitoring and evaluation of programmes means that discussions with the donors active in the sector takes an individual approach, thus imposing high transaction costs, but also makes it difficult to facilitate collaboration for organised and optimal use of the available donor resources. The joint consultative meeting between donors and the DoH referenced earlier is important but cannot be equated to proper harmonisation in the sense provided by the Paris Declaration, which requires that donors themselves coordinate their activities without the intervention of the recipient country. Harmonisation in the health sector is only made possible and visible in the EC + Working Group on health, which is a working group trying to ensure that aid into the South African health sector is effective and aligns to the needs of the government.

The Treasury indicates that part of the reason donors do not harmonise their funding may be caused by competition for their specific niche areas.³⁰ This again, underscores the argument that the Paris Declaration is another form of the good governance agenda that is imposed on recipient countries, whereas donors are not willing to implement obligations imposed on them by the declaration. One can ask the question, if donors are not willing to implement the Paris Declaration in a country like South

³⁰ National Treasury (2010) Phase Two Evaluation of the Implementation of the Paris Declaration and Accra Agenda for Action in South Africa

Africa that they perceive to be progressive and easy to work in, how they will be able to implement it in other countries. There is a need therefore for the government to adopt a strategy of deliberate discrimination on the basis of relative contribution in dealing with the donors, including negotiations for the adoption of budget support especially with those partners with relative ideological flexibility. It may also require the government to provide incentives for delegated cooperation among the donors. This could also minimise costs and time wasting, as well as limit over concentration of donor funding in certain programmes. The lack of harmonisation can also be ascribed to the fact that the practice of providing ODA has a lot of foreign policy elements, and so countries prefer a unilateral approach so as to push their agendas unabated.³¹

Results based management and donor funding

Another important requirement of the Paris Declaration is that a results oriented approach be adopted. This implies that donor funding should be managed and utilised in such a manner in which it addresses priorities of the government and subsequently the performance indicators of the sector. Does this happen in the South African health sector? As indicated earlier in this report, in terms of the planning process in the sector, the National Department of Health outlines priority areas of focus for the sector for a specific year, which forms the background for the development of the annual performance plans.

Reports on performance on the said plans are provided for in the departmental annual reports and performance reports at the end of each financial year. In terms of the reporting process, although donor funding does not have to be appropriated or allocated into the vote of the department, it has to be reflected in the annual report of the department, indicating also which programme the funded project falls under. The fact that donor funding does not have to be appropriated means that it is treated as an additional to the budget, which in essence means that donor funding does not form part of the national planning process.

³¹ Ibid

The fact that donor funding does not form part of planning processes poses a risk of allowing for funding to be allocated to projects that are not necessarily priorities or duplication of already funded projects, which can also hinder a result based management approach. This also erodes accountability as it is difficult to report on projects that were not in the plan. This is also aggravated by the fact that, as has been indicated here before, project funding remains the major mode of ODA financing, as has also been pointed out, this approach gives responsibility for the management of the resources to the development partner – with little provision for accounting of expenditures to the government. In essence, this also hinders accountability of donor funding. The major hindrance with regard to results management of donor funding in the South African context is that the funding seems to be skewed in favour of other areas such as HIV/AIDS, to the disadvantage of other sectors.

The recommendation for an effective results based management of donor funding in the health sector is, as with the recommendation for improved alignment, that centralisation of the process, together with a systematic arrangement, whereby a matrix showing available funding and funding gaps as well as details of the funders at different sectors should be made available to the donors. It is once again recommended that no funding arrangements, outside the funding gaps identified in the matrix must be allowed to be entered into by any sphere of government. In this regard, the national government must not approve any proposal that does not conform to the above requirements. The centralisation of the process and the use of a matrix might decrease the opportunities for donors to take advantage of coordination weakness or lack of capacity in some levels of government in the sector whereby they fund projects that are not in consonance with the priorities of the sector. Harmonisation of donor activities, whereby donors cluster according to areas of funding and comparative advantage could also assist.

Mutual Accountability and donor funding

The Paris Declaration indicates that donors and partners are accountable for development results. This implies that donors and partners have to be held responsible for the success or failure of donor funded development programmes or projects. Does the donor funding process in the health sector allow for that? For donors and partners to take responsibility for results, these should firstly be measured. I have already indicated the problems that hinder the adoption of a result based donor management approach in the health sector. These problems also make it difficult for donors and the government to be accountable on results. I have also indicated that the fact that donor funding does not form part of planning processes poses a risk of allowing for funding to be allocated to projects that are not necessarily priorities or duplication of already funded projects. This can also poses problems of accountability, where donors just fund projects that are of national interest to them and not necessarily concerned about the results thereof. Donor forums should also be a platform where donors and the sector discuss not only plans, but also evaluate results for each donor and programme funded through donor funding.

The relevance of the Paris Declaration as a guiding framework for aid management in South Africa

Another important question that should be asked, considering the above findings, which indicates that the Implementation of the Paris Declaration in the South African health sector is not adequately implemented and that South Africa, is whether the Paris Declaration is relevant to the South African situation, especially since the country is a middle income country, unlike other recipients, who are mainly less developed.

It should be indicated that the Paris Declaration needs to be improved to ensure it is relevant as a guiding framework for aid management in South Africa. For aid to be meaningful to the development of

the South African population, it should be aligned to the priorities of the government, so that it really addresses the socio - economic developmental challenges of the South African population, especially the poor. Although aid in the health sector is aligned to various priorities of government, it is skewed more towards HIV/AIDS, with less emphasis on other priorities such system development and hospital management. Huge problems of management and technical capacity have been identified and this, as has been suggested before, indicate that donors fund areas in which they anticipate the greatest advantages, whether politically or economically.

The fact that evidence suggests that ownership of aid management exists in the South African health sector, although there is lack of alignment, indicates that the concept of ownership as prescribed by the Paris Declaration is not comprehensive enough in terms of its requirements. The definition of ownership in the Paris Declaration is essentially flawed because it is too limited and overlooks the issue of articulation of projects across different levels of government. It would seem that the Paris Declaration is an adapted tool for improving aid efficiency in the context of a middle income country such as South Africa which has enough capacity to develop its own (owned) health policy, but is too shallow and does not take into account other intricacies related to development planning in a middle income country like South Africa. For example, the requirement for countries to develop development plans, from which donors should align their funding, does not necessarily means that there is always a coordination mechanism which ensures that there is no duplication of efforts or that indeed the donors funds the priorities as set out, even if these are clearly stipulated in the development plans.

The Paris Declaration requirements need to be expanded to include issues around coordination, spelling clearly the obligations for both donors and recipients. If these are clearly stipulated, it will be easy for aid to make a visibly positive contribution in the South African health sector, especially if one takes into account the health challenges facing the country and the fact that as has been suggested in this paper, funding of the fight against HIV/AIDs is not sustainable in the long run, given the relatively high rate of new infections.

Even in the area of HIV/AIDS for example, where as the data portrays, most of the aid is going, it does not seem that the health sector is benefiting from the generous funding offered by donors, given that, compared to other countries, the fight against HIV/AIDS has not been as successful as in other countries, such as Uganda and Kenya which were facing the same problems. This indicates that prioritisation of efforts in ODA disbursements may not have been correct. In Uganda for example, it is documented that HIV/AIDS was reduced through concerted efforts towards social mobilisation than medical relief alone. In this case, the government initiated dialogue with communities on HIV/AIDS which culminated in communities debating and understanding the behavioral causes of HIV transmission, leading to society advocating and mobilizing for behavioral change, which caused a steep decline in HIV transmission.³² It can be argued that in this instance, a community led approach was the one that assisted the fight against HIV/AIDS in Uganda. The implication of the preceding study for ODA involvement in South Africa is that donors must actively hold in high regard those campaigns which originate from the local community and stem from local practices if HIV transmission and AIDS related mortality is to be effectively addressed. Unfortunately, evidence provided in this report suggests that more attention seems to be put on imported curative measures than on social mobilisation. The Paris Declaration concept of ownership” should also insist on “community based approaches” as the basis for ownership in ODA management.

The lack of salience of the Paris Declaration can also be seen with regard to harmonisation, where donors remarked that they do not see the relevance of harmonisation in a country like South Africa that is able to deal with donors individually. The lack of salience of the Paris Declaration is in conformity with the literature criticising the good governance agenda, especially as it is applied in the aid effectiveness agenda for assuming that there can be a similar set of good governance policies that can be applied in any country irrespective of the local circumstances.

³² Epstein H (2007) *The Invisible Cure – Why we are losing the Fight against AIDS in Africa*. Picador, New York.

CHAPTER 4

The German Development Cooperation (GIZ) and the application of the Paris Declaration in the South African health sector: A case study

This chapter presents a case study of the German Development Cooperation (GIZ)³³ health funding in South Africa.

The GIZ is an implementing agent of the German government for programmes that have been agreed between the two countries at a bilateral level, usually through a forum called a bi-national commission, (BNC) chaired by the heads of State of the two countries. Programmes agreed upon by the two countries are supposed to be to the mutual benefit of the two countries and adhere to the prescripts of the Paris Declaration.

GIZ funding into the South African health Sector

Evidence to be presented in this chapter indicates that when it comes to the operationalisation of the programmes agreed upon by the two countries, GIZ has a lot of influence in the design and implementation thereof. Evidence suggests that it has the latitude to diagnose for the department of health the nature of the problems that are leading to non performance of departmental plans and come up with solutions. This means that GIZ is the one which comes up with proposals, although these are discussed with the department of health. They also have the influence to choose their partners, who they will implement the programme with, since most of their funding is in the form of technical cooperation and is not given to the department of health but rather to Non Governmental Organisations (NGOs) and consulting firms.

³³ GIZ stands for “Deutsche Gesellschaft für Internationale Zusammenarbeit” it can be translated in English as follows. German International Cooperation. It changed from GTZ (German Technical Cooperation) to GIZ since 2011.

The following analysis, derived out of an interview with the GIZ office on 25 March 2011 at the GIZ Pretoria office, as well as an analysis of GIZ and government reports reveals how SA health authorities contribute to the formulation of policy/understanding of the problems relative to the donors in the health sector. .

The GIZ is of the view that one of the reasons for the continuously high rate of new HIV infections in South Africa is that the multi-sector measures of HIV prevention contained in the HIV/AIDS National Strategic Plan (NSP) 2007-2011 are not effectively implemented and the therefore the objectives set cannot be reached. This suggests that GIZ is of the view that the DoH initiatives to implement the NSP with regard to HIV prevention are not enough and should be improved. They have thus come up with a number of initiatives that seek to address this problem, including the GIZ's HIV's Prevention Programme, support to the Nelson Mandela Foundation, "love life" programmes and the Aids Workplace Programmes in Southern Africa.

Ownership and alignment

An examination of the GIZ's HIV's Prevention Programme, which started in the year 2011 and whose overall term is anticipated to take to 15 years (01/2011 to 12/2025) shows that there is some ownership of the management of aid by the national department of health, but the GIZ has even much more ownership of the process, particularly with regard to the formulation of policy and understanding of the problems relating to the donor funded programmes in the health sector. When one takes into account the level of control that GIZ has in the process, one can conclude that the ownership that the department of health has in the process is "imposed ownership". This is different from the "donor-driven ownership" articulated by some scholars when explaining some of the donor – recipient relations.³⁴ While donor-driven ownership describes a situation in which the recipient country shows few signs of genuine policy ownership

³⁴ Look for example at Bergamasch I (2008) Mali: Patterns and Limits of donor driven ownership. GEG Working Paper 2008/41

and lacks both the 'capacity' and 'political will' to pursue development goals and take the lead in the aid relationship, by imposed ownership I describe a situation in which although the government has some policy ownership and 'political will' to pursue development goals, it lacks the capacity to implement those policies and as a result does not have much influence on how the programmes are implemented.

Even though the GIZ's HIV Prevention Programme is a response to a specific department of health plan, (the HIV/AIDS National Strategic Plan (NSP) 2007-2011), and therefore this arrangement should be enough enough to qualify as "ownership" in terms of the Paris Declaration, a closer examination of the process of operationalisation of the programmes illustrates a different picture.

The objective of the GIZ's HIV Prevention Programme is "to ensure that the multi-sector HIV/AIDS prevention strategy of South Africa is successfully implemented at all levels of interventions". For the first three-year phase from 01/2011 to 12/2013 a German contribution of 3 million EUR is planned.

According to GIZ, document detailing the implementation of the programme, to effectively and successfully implement the multi-sector measures of the NSP and win the fight against the scourge of HIV/AIDS in South Africa requires giving particular attention to the decentralised steering bodies for the implementation of the NSP - the Provincial, District and Local Government Aids Councils as well as supporting local churches and NGOs.³⁵ This is because they are the ones who are better placed, it is argued, to mobilise people for social change, through various means, such as discouraging alcohol abuse and encouraging teenage abstinence and condom use, which are some of the best HIV/AIDS prevention methods. Furthermore, according to GIZ, neither the Aids Councils nor the DoH is currently meeting the requirements of coordination of sector strategies, knowledge management, Monitoring and

³⁵ GIZ (2010) Multisector HIV Campaigns in South Africa: Presentation of an offer for the first implementation phase, GIZ unpublished document, Pretoria

Evaluation and optimisation of the utilisation of personnel and financial resources that are imperative in the fight against HIV/AIDS in South Africa. Moreover, GIZ believes these institutions are lacking the capacity for planning and implementation of innovative, evidence based, target group-specific HIV measures. If we consider how that Uganda used local originated approaches of social mobilization against HIV/AIDS defeat the AIDS scourge, then it is easy to conclude that even GIZ's strategy has limitations in that it seems to be heavily top down in its approach. This also highlights the fact that imposing Eurocentric strategies on African conditions might not necessarily be the best way to go about solving African problems.

Through its HIV Prevention programme, GIZ believes it can make a difference by adopting a strategy of building the capacity of these organisations in the identified provinces and to show them that its proposed strategy can work. The plan is to help them understand and design "appropriate" prevention measures. Since the attitude is already that GIZ should illustrate to these organisations that their strategies work, it is difficult for the identified organisations to convince GIZ to adopt strategies that are way outside of the presented plans especially when they are looking for funding and when the department of health is not taking the lead in the design of the programme and allocation of funds. The fact of the matter however, is that the design of this programme has been the responsibility of GIZ, with little input from the department of health. This means that ownership of the programme rests with GIZ. The fact that the funding does not go through the department of health also means that the department is denied the freedom to control how it should be used.

Another point that can be drawn out GIZ's programme is that there is huge risk of erosion of the capacity of the department of health in the planning and implementation of health outcomes, as a result of GIZ's interventions. It could be argued that by taking on the role of capacity building of local AIDS councils' in the planning and implementation of knowledge management of

innovative, target group specific HIV measures, GIZ is taking some of the department of health's responsibilities of knowledge management and coordination which could deny the department the experience of policy design and implementation that they could otherwise get by closely getting involved in the overall project management of the programmes.. Through this programme and other GIZ funded Aids prevention programmes such as support to the Nelson Mandela Foundation (NMF), Love Life), GIZ utilises its "experts" to build various capacities, including planning and best HIV/AIDS prevention methods with little collaboration with the department of health.

The problem therefore is twofold, firstly that the GIZ utilises its own experts to do some work that should normally be done by the department without also imparting its expertise to the department and secondly, that GIZ supports mainly NGOs and the department does not have influence on which programmes they implement with donor funding. What this tells us therefore is that the threat to policy making and implementation capacity to recipient countries does not only come with donors using their own experts and not imparting their expertise to the policy making institutions, in their technical cooperation programmes such as the ones undertaken by GIZ, It also shows that the direct support to NGOs, wherein the government does not have control over the use of the resources can also undermine capacity building as it denies the government the experience of being intimately involved in programmes. This can also have the effect of increasing dependency on the donors in the execution of health functions. The practice of direct support seems to be the norm among many donors in the sector, especially the bilateral donors, while the multilateral donors such as the EU and UNAIDS mostly support the department directly. Where the funding goes to the department of health, such as in the EC's support, the department of health seems to demonstrate better ownership of the projects, through involvement in the design and implementation of the programmes. Since 1994, the EU has made financial commitments of some €300m to the health sector in South Africa, mainly to

Primary Health Care and HIV/AIDS. According to the EU, they are supporting the Department of health in the contracting of over 1000 NGOs, through the Expanded Partnerships Programme for the Delivery of Primary Health Care, providing home- based care services to close on 1 million people.³⁶ The EU is thus only playing a supporting role. The EU has also recently approved €126m for the DoH Primary Health Care Sector Policy Support Programme, which will be the largest health programme of the European Commission in the world. The programme will support the Department of Health in the revitalisation of Primary Health Care throughout the country. The EU is here supporting a specific DoH programme and not coming up with a new programme as the GIZ seems to be doing.

In terms of alignment to government plans, these programmes are aligned to the priorities of the department of health, as they attempt to implement the multi-sector measures of the NSP and win the fight against the scourge of HIV/AIDS in South Africa. The problem is however that GIZ deals directly with some NGOs and uses its own experts, which allows it to utilise its own methods of implementation.

In terms of results, GIZ indicates that one of the major achievements of their programmes is that, through the efforts of “love-live”, the taboo subject of HIV/AIDS is increasingly being discussed openly and it encourages elders to start talking about the epidemic. Overall some 60 facilitators have been trained with four community dialogue projects initiated. Another four projects are presently being prepared. This has also maintained public interest in HIV and AIDS which has proven to be key to challenging individuals and organisations on an increasing and significant scale to help those who are affected and infected ³⁷

³⁶ Remarks by Mr Nils Jansons, Acting Head of the EU Delegation to South Africa, at the Official Launch of the Partnership Framework for Health Service Delivery, Pretoria, 21 January, 2011.

³⁷ GIZ (2010) Institutionalising Demand-led Approaches to Service Delivery in South Africa: Summary of a successful GTZ intervention & its underlying principles. A presentation by By Pier Paolo Ficarelli, project mgr. GIZ consultancy team

Furthermore, the Nelson Mandela Foundation (NMF), which GIZ has financially supported to the tune of 5.5 million Euros to strengthen its “community dialogues” project and increase its awareness and prevention campaign, has been assisted to transform into a well structured and adequately funded NGO employing 38 staff. The NMF has also, through the assistance of GIZ, established itself as a unique catalytic think tank in the field of HIV-AIDS in South Africa.³⁸ This also shows that GIZ manages its programmes for results and can account to what they have set themselves to achieve, which shows accountability. This accountability however, will remain accountability to themselves only, as long as ownership of the programmes is skewed in their favour.

Literature reviewed earlier in this report points to the problem of tied aid in the disbursement of aid to developing countries, with regard to GIZ’s involvement in the South African health sector, considering that GIZ interventions are attached to the use of German expertise, as illustrated above, it is not unfair to classify their technical assistance as “tied aid” considering the description of tied aid given earlier. This also shows that it is easy to tie the aid if the form of assistance is technical cooperation and support is directly to NGOs, where the government does not have control over the content of the funding.

Harmonisation

The GIZ coordinates its programmes with other development partners such as the European Union, (EU), Britain, Sweden and America. All donors meet regularly for an exchange of experiences, whereby the EU holds the coordinating role. The coordinating role of the EU tells us that it is easier for multilateral organisations to be at the forefront of harmonisation efforts than bilateral donors who can have varying and sometimes conflicting interests, making it

³⁸ ibid

difficult to harmonise efforts. According to a Treasury study³⁹, some donors were quite candid and indicated that their bilateral interests are more important.

Conclusion

Evidence presented here indicates that GIZ is contributing significantly to health initiatives in South Africa. The problem, though, it seems that GIZ has more ownership and control of the programmes than the department of health which has the potential to pose problems in terms of the sustainability and effectiveness of the programmes. Ownership is lost when GIZ has much more control on the design and implementation of the programmes, which also has the potential to undermine planning capacity in department of health. Lack of adequate ownership by the department of health means although there seems to be accountability on the part of GIZ, it is accountability to itself and not the department of health. Evidence of the use of a country strategy as a planning reference was evident in the case of HIV and AIDS, whereby 2007 -2011 HIV and AIDS and STI National Strategic Plan (NSP) serves as the basic reference point for the programming of donor support on HIV and AIDS., although this is not adequate, given the influence that GIZ has in operationalising its programmes and the fact that most of the aid is given to NGOs, where the department of health does not have control on the nature of the programmes to be implemented.

³⁹National Treasury (2010) Phase Two Evaluation of the Implementation of the Paris Declaration and Accra Agenda for Action in South Africa. Draft Country Evaluation Report, Pretoria

CHAPTER 5

Conclusion and Recommendations

This study sought to analyse the implementation of the Paris Declaration in South Africa, utilising the health sector as a case study. The health sector was chosen because most of the ODA funding to South Africa is channeled there,

The rationale for the study was that the declaration, which reaffirms a broad international consensus developed in the 15 years up to 2005 that new relationships between developed countries and partner countries are essential if development results are to be assured, aid well spent and aid volumes maintained, is regarded as a novel and important tool for improving aid effectiveness. This is despite some literature pointing out that donor aid to developing countries tends to be donor driven as well as misaligned from government priorities, making aid to have less positive impact on development. It was therefore interesting to find out what the situation is in South Africa, a country in which donors generally perceive to be “progressive and easy to work” in and in which the Paris Declaration is therefore expected to be easily implemented by the donors

Evidence presented in this paper points to a number of important revelations, mostly in consonance with the literature.

Firstly, evidence conforms to the point suggested by the literature that the Paris Declaration is another form of the good governance agenda that is imposed on recipient countries, whereas donors are not willing to implement obligations imposed on them by the declaration. While it would have been expected that in a middle income country such as South Africa which has enough capacity to develop its own health policy and considered by the donors to be easy to

work in, the Paris Declaration would easily be implemented, some donor practises directs one to a different conclusion.

This study has found that although there is some level of alignment between the funding provided and the priorities of the sector, there is a huge donor focus on AIDS in South Africa, which is both not entirely prioritised and not very efficient given that it focuses more treatment than on prevention and also the sector faces many other serious problems such as human resource constraints and a dysfunctional primary health care, that should be dealt with if donor funding on AIDS is to be really useful. Most of the funding in the HIV/AIDS is to treatment, whereas it is prevention initiatives that would bear better fruits, a point that is suggested by literature and recognised by the government through its HIV/AIDS strategic plan. The study also found that the fact most of the funding is not budget support contributes to the non alignment of funding while also allowing for donors to take ownership of projects. Where budget support is the mode of funding, the study found better alignment and ownership of programmes by the government. The planning capacity of the State can also be undermined by donors taking some of the duties that are supposed to be undertaken by government, especially where technical cooperation is the mode of funding. Furthermore, the study found that it is possible to tie aid, even in a middle income country like South Africa, where one would expect that most of the goods and services would easily be secured locally. I have suggested that this is caused by the fact that aid is a foreign policy tool where countries pursue their interests. Recipient countries, even middle income countries should therefore be stringent in the approach as they deal with donors.

The study also found a lack of results based approach and accountability in the management of ODA funding in the sector. This is also a result of the project approach that is used to deliver ODA funding in the sector. It was found that using projects as the modality for aid delivery gives

responsibility for the management of the resources to the development partner – with little provision for accounting of activities and expenditures to the government. .

This study refuted the literature which advocated for an increased allocation of aid towards health purposes in the future, on the basis that pumping financial resources into health sectors improves recipients' health outcomes. The study found instead that a more cautious approach should be employed, wherein more funding should rather be channeled to improving health systems as they are the foundation for improved health outcomes, without which the latter cannot be sustainable.

This is can be seen in the manner in which aid funding has not succeeded in substantially reducing HIV/AIDS cases in South Africa.

The study found that there is no harmonisation of donor activities in the health sector, although there was no evidence, as suggested by the reviewed literature, of the uncoordinated external resources weakening health systems through promotion of different administrative systems and disparate therapeutic regimes. This might be an indication that in middle income country such as South Africa, this is usually not the case, although evidence suggests that individual discussions with the donors active in the sector imposes high transaction costs and also makes it difficult to facilitate collaboration for organised and optimal use of the available donor resources. The lack of harmonisation has also been ascribed to the foreign policy nature of the practice of providing ODA.

The study has also found that the lack of salience of the Paris Declaration is inconformity with the literature criticising the good governance agenda, especially as it is applied in the aid effectiveness agenda for assuming that there can be a similar set of good governance policies that can be applied in any country irrespective of the local circumstances. The example of how

Uganda has been able to use local originated initiatives to thwart the HIV/AIDS scourge has also underpinned this point.

Recommendations

Given the evidence presented in this paper, this study recommends that there should be centralisation of the ODA management as far as possible in South Africa. It is also clear that there is no proper coordination between the spheres of government, while the roles delineation between different players are also not clear enough. If this is not done, it is evident, as the failure to reach better health outcomes despite huge flows has shown; the country will not cope with the increase in the number of donors and the cumulative growth in the number of projects. This should be accompanied by capacity building initiatives that are geared towards ensuring that every sphere of government is capacitated to deal with ODA management, particularly in ensuring that the government officials are well vested with the government's ODA policy and guidelines as well as government priorities. This should lessen the effect of donors trying to push their own foreign policy agendas to the detriment of the sector. It has also been recommended that efforts should be made to encourage coordination among donors while also providing a clear set of priorities and financial gaps that donors should fill. In this regard, a strategy of a pro - poor ODA funding, that addresses the needs of the vulnerable should be adopted. In the South African context, a case has been made that this should be the development of a well functioning primary health system, which the department of health is prioritising through its various plans. The pertinent issue of accountability should also be taken into account in crafting a new aid effectiveness architecture for South Africa. In this regard, it might be useful to consider allocating donor funding into the vote of the department, so as to ease the process of reporting the use of these donor funds and increasing accountability in the process.

This study has shown that application of the Paris Declaration might not be as relevant as in other developing countries. For it to be relevant, the principles of ownership and alignment should be expanded to take into account the issue of articulation of projects across different levels and spheres of government., who designs and implements the projects and what kind of accountability is there in place? In essence, OECD may offer general guidelines; the nature and content of each and every donor-recipient country should be negotiated by the relevant countries. It has also been recommended that the Paris Declaration concept of ownership” should also insist on “community based approaches” as the basis for ownership in ODA management in view of the weakness of the Paris Declaration “ownership” concept explained earlier.

