

# Financial Resource Flows for Population Activities

Report of a case study in South Africa

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The views expressed in this report are those of the mission and not necessarily those of the United Nations Population Fund.



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# Preface

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In the Programme of Action, adopted at the International Conference on Population and Development (ICPD) in Cairo on 5-13 September 1994, countries have committed themselves to attain specific goals in the field of population and sustainable development. Measuring financial resources, which countries commit to population activities is an important way to monitor the progress of the implementation of the Programme of Action of the ICPD.

UNFPA is collaborating with the Netherlands Interdisciplinary Demographic Institute (NIDI) to develop and maintain an updated system for the collection, analysis and dissemination of information on both international and domestic financial resource flows for population activities.

The classification of population activities in this study closely reflects the principles of the ICPD. For operational reasons, it was decided to restrict data collection to the 'ICPD costed package' mentioned in paragraph 13.14 of the Programme of Action. This means four categories of population activities:

- family planning services;
- reproductive health services;
- STD and HIV/AIDS programmes;
- basic research, data and population and development policy analysis.

In paragraph 13.15 of the same document, it is estimated that, in developing countries and countries with economies in transition, the implementation of programmes in the area of reproductive health, including those related to family planning, maternal health and the prevention of sexually transmitted diseases, as well as other basic actions for collecting and analyzing population data will cost \$ 17.0 billion in 2000, and increase to \$ 21.7 billion in 2015. Two-third should be paid by the recipient countries, one-third will be paid by the international donor community.

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In order to measure global financial resource flows for population activities, the UNFPA/NIDI Resource Flows project has mailed questionnaires in 1998 to public and private donor organizations in developed countries, and to government departments and national in developing countries. Collecting all this information from a broad range of respondents requires in-depth attention to issues of definitions, classifications, response rates and time lines. To better understand and resolve these problems, country case studies are conducted. These case studies will complement our knowledge about financial flows for population activities which were obtained through the mail enquiry.

The case study in South Africa was conducted from 16/11/1998 to 1/12/1998, and forms part of the UNFPA-NIDI project which measures global financial resource flows for population activities. Data for this report were gathered by Mr. Ernst Spaan, staff member of the UNFPA/NIDI Resource Flows Team, together with Mr. Steve McGarry, an international health consultant based in Pretoria. Valuable help and advice was provided by Mr. Jay Parsons, the UNFPA Representative, and his staff.

We would like to extend our sincere gratitude to Jay Parsons, the UNFPA representative, and his staff, for the warm welcome and providing the necessary logistic support for this case study. Many thanks are due to the respondents, who kindly shared their time and information with us at a busy period. A special word of thanks is due to Professor Di McIntyre, Bupendra Makan and Nicole Valentine, of the Health Economics Unit, UCT Medical School, University of Cape Town, for preparing insightful presentations of the budgeting and financial structure of the health sector in South Africa.

Considering the complexity of resource flows in South Africa, exacerbated by the current processes of decentralization, administrative reform and transition, together with the short duration of this study, it may be that this report contains serious omissions and errors. Therefore, the presented data should be looked at with appropriate caution. However, the authors take full responsibility for any errors and welcome any comments and suggestions for the improvement of this report.

Ernst Spaan and Steve McGarry

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# 1. Demography of South Africa

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Despite the fact that South Africa is ranked as an upper middle income country, there are sharp contrasts in income, wealth and health indicators between men and women, the different ethnic groups and between regions within the country. About two thirds of South Africans are affected by low incomes and poor living conditions, such as overcrowding, lack of clean running water and sanitation, which seriously affects their health condition (KFF, 1995). Moreover, access to health services varies greatly by ethnic and income groups. The majority African population is the most deprived group in this regard.

South Africa's population was estimated at 40.6 million inhabitants in 1996 (Population Census 1996), representing a doubling of the population since 1970 (Health Systems Trust 1997, p. 1). The average population growth rate during 1991-95 was 2.06 percent per annum, down from 2.47 in the 1980-91 period and 2.52 in the 1970-80 period. The population is projected to grow to 46.2 million in 2000 and 56.4 million in 2010 and will double in the next 32 years (UNFPA, PRSD, 1998, p. 17). The South African population is characterized by its relative youthfulness, with 45 per cent younger than 20 years and 60 per cent aged between 15-64.

*Table 1. Basic demographic indicators South Africa*

		Year	Source
Population (million)	40.6	1996	Pop. Census
Annual growth rate 1980-1995	2.3	1996	UN Pop. Division
Per cent urban	51	1996	UN Pop. Division
Crude birth rate (birth / 1000 pop.)	30	1996	UN Pop. Division
Crude death rate (deaths / 1000 pop.)	8	1996	UN Pop. Division
Total Fertility Rate	4.0	1995	UN Pop. Division
IMR (per 1000 live births)	50	1996	UNICEF / WHO
MMR (per 100.000 live births)	230	1990	UNICEF / WHO
Life expectancy at birth	65	1996	UN Pop. Division

Source: UNAIDS / WHO Epidemiological Fact Sheet, South Africa.

Table 1 provides some recent demographic indicators for the whole of South Africa. The TFR was 4.0 in 1995, relatively low in comparison with many other African countries. It has decreased from 4.6 during the 1985-1990 period, mainly due to an increase in contraceptive use and urbanization (PRSD, p. 18). As is clear from figure 1 contraceptive use is quite common

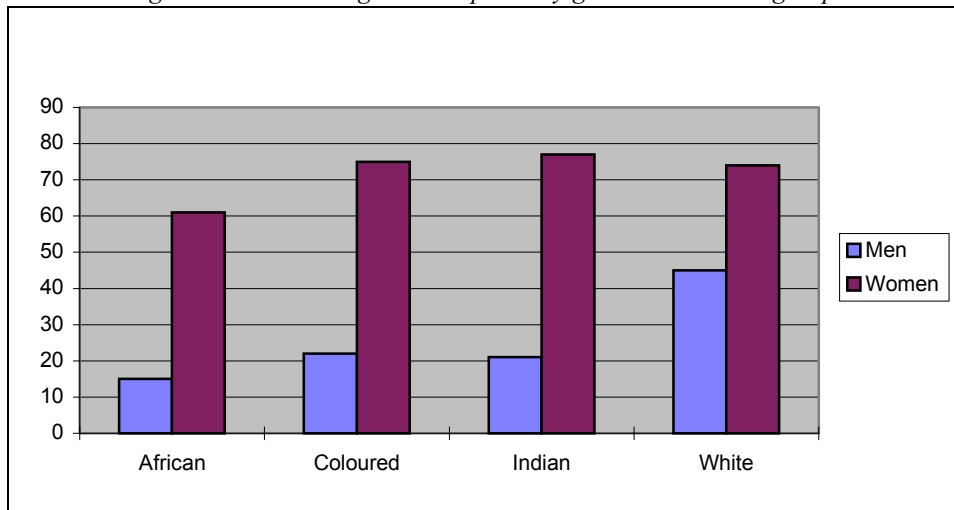
in South Africa, but in particular in the case of women with men lagging behind.

As to family planning, a survey conducted in 1995 found that only 20 per cent of men use contraceptive methods, but the majority of women (63 per cent) did. It should be noted that this pertains to respondents stating they had a sexual partner (Hirschowitz *et al.*, 1995, p.107).

The latest available mortality data indicate that mortality rates have been declining over time. In 1970 the crude death rate (CDR) was 14 per 1000 persons and this declined to 9.4 in 1994. The infant mortality rate (IMR) of 50 per 1000 live births in 1996 has declined from a high 89 deaths per 1000 live births in 1960.<sup>1</sup>

The maternal mortality rate (MMR) of 230 per 100,000 live births in 1996 is low in comparison with much poorer countries in Southern Africa, such as Angola (1,500) and Mozambique (1,500) but is still high in comparison with other middle income countries. Life expectancy at birth was 65 years in 1996.

Figure 1. Adults using contraceptives by gender and ethnic groups



Source: CASE survey, 1995

1 The data presented here are subject to error however, as a large proportion of births (82 per cent) and deaths (44 per cent) are not registered according to a survey in 1994. The registration system is under reform by the Department of Health and the Central Statistical Service. The data of the DHS of 1997 are not yet available (Health Systems Trust 1997, p. 6).

South Africa has a number of characteristic features in this context. While peri-natal conditions, gastro-enteritis and respiratory infections are some of the main causes of infant deaths, among adults causes associated with lifestyle, violence, road accidents and AIDS (and in combination with TB) are conspicuous. Maternal mortality is mainly due to hypertension, sepsis and unsafe abortions.

Given that South Africa is a multi-ethnic country with large disparities over geographic regions and population groups, the above aggregate figures hide considerable differentials in demographic indicators. The population is distributed very unevenly over the country, with the three provinces Gauteng (with large urban centers as Johannesburg and Pretoria), KwaZulu-Natal and Eastern Cape accounting for about 55 per cent of the total population.

*Table 2. Life expectancy at birth (years)*

	South Africa	Africans	Coloureds	Indians	Whites
1980	58,8	56,2	58,5	65,4	70,4
1991	62,8	60,3	66,5	68,9	73,1

Source: Central Statistical Authority, Republic of South Africa

The life expectancy at birth provides a good indicator of the quality of life of the different ethnic groups. Although the life expectancy increased for all groups between 1980 and 1991, there are considerable differences as is indicated by table 2.

As is clear from table 3, demographic indicators vary by ethnic group. The data show the favourable situation of the white population *vis á vis* the other groups, but particularly in comparison with the African population, the latter which have the most unfavourable scores on all indicators. For example, the infant and maternal mortality rates for the African population are eight times higher than that for whites, reflecting the large differentials in living conditions and reproductive health services among the white and African populations. In addition, the African population has the highest growth, fertility, birth and death rates, but the lowest contraceptive prevalence.

Table 3. Demographic indicators by ethnic group, South Africa

		White	Coloured	Indian	African	RSA average
Average annual population growth rate (%)						
1995	1995	0.7	1.5	1.5	2.4	2.1
TFR	1994	1.6	2.3	2.2	3.7-4.3	2.9
% teenage pregnancy	1990	6.3	14.8	6.1	10.7	-
CPR	1994	80.0	74.0	77.0	66.0	-
Crude birth rate	1994	13.7	21.7	18.1	25.3	23.4
Crude death rate	1994	6.7	7.2	7.3	10.2	9.4
IMR	1994	7.3	36.3	9.9	54.3	48.9
MMR	1994	8	22	5	58	-
Male Life expectancy at birth	1990	69	59	64	60	62
Female Life expectancy at birth	1990	76	65	70	67	68

Source: South African Health Review, 1997.

Because the ethnic groups<sup>2</sup> are unevenly distributed over the different regions and provinces of South Africa, the quality of life indicators also vary across the country. If we take the Human Development Index (HDI) as indicator, it appears that there is some correspondence between the quality of life and the ethnic composition of the respective provinces. The highest scores are found in the provinces with the largest concentrations of whites, i.e. Western Cape (0.826) and Gauteng (0.818). The provinces with lowest scores, such as Northern Province (0.470) and North West Province (0.543) have majority African populations (CSS, 1998).<sup>3</sup> This corresponds with the total public health care expenditure per capita in the different provinces: in 1992/3 these were highest in the Western Cape (491 Rand per capita) and Gauteng (381 Rand per capita) and lowest in the Northern (R164/capita) and North-West (R179/capita) provinces (McIntyre *et al.*, 1995, p. 40).<sup>4</sup>

Administratively, South Africa has recently undergone a structural transformation, replacing government structures based on race into unified governmental bodies. Before 1994, the country was divided along racial lines into four 'white' provinces (Cape, Natal, Orange Free State, Transvaal), six Self-Governing Territories (KwaZulu, KaNgwane, Lebowa, QwaQwa, Gazankulu and KwaNdebele) and four 'Independent' States (Transkei, Bophuthatswana, Ciskei and Venda). These administrative

<sup>2</sup> The term "ethnic groups" refers here to broad population categories based on racial features and not to the various tribal groups within the African population, such as Xhosa, Zulu, Tswana, *et cetera*.

<sup>3</sup> For comparison, the mean HDI score for high, medium and low human development are 0.886, 0.649 and 0.355 respectively.

<sup>4</sup> Exchange rate SA Rand for the US dollar: 0.2977 (Dec. 1993), 0.1805 (Dec. 1998).

divisions have now been restructured into nine provinces with an elected legislature and an executive body headed by a Premier. In addition, the 800 local level authorities of the pre-1994 period, divided into “White” and “African”, are now being replaced by about 300 unified local governments.

This restructuring process has serious implications for the health sector too. Formerly, the urban authorities were responsible for the provision of preventive and promotive health care services, financed out of national government grants and locally generated revenue through taxation, levies and fees. In the rural areas, services were organized at the provincial level out of necessity, due to the weak administrative and political structures at lower levels.

In the first years of its implementation, the system will vary across the different areas of the country. In some areas, municipal governments are formed which will have the capacity to finance their own basic services, while in others, local government structures will depend more on fiscal transfers from national and provincial governments (McIntyre *et al.*, 1995). In paragraph 3.2, the changes in the institutional framework of the health sector is discussed more extensively, as it has implications for the tracking of resource flows for population activities.



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## 2. Methodological issues

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The specific objectives of the case study in South Africa are:

- to fine-tune and refine data collection procedures for estimating financial resource flows for population activities. These procedures can be used at a later stage in the global mail enquiry;
- to provide more information on how resource flows are directed towards population activities within the country and, to some extent, how the ICPD Programme of Action is implemented;
- as benchmarks for studying the quality of data gathered through the mail enquiry in other countries;
- to investigate the roles of NGOs in the field of population activities;
- to study possible methods for sustainability used within the country: e.g. cost recovery in public programmes;
- to gather more information on financial sources in relation to the implementation of the Programme of Action of the ICPD: are there any changes in priority at the government or at the donors' level; has the ICPD Plan of Action influenced the population policy and programmes within the country? And how?
- to study co-ordination between and among government departments, NGOs and donors.

Next to geographical considerations, South Africa was chosen as a case study for the following reasons: the country is currently undergoing rapid political and socioeconomic change, it is a relatively rich country (HDI index level of 0.716 in 1994) and it is an example of a country with a decentralized, federal system of government, with important implications for the devising and implementing of population policy.

From 16/11/98 to 2/12/98 interviews were held with representatives from Ministries, provincial and metropolitan governments, international donors (bilateral, multilateral, private), national and international NGOs and academics in Pretoria, Johannesburg, Cape Town and Pietersburg. Annex 1 provides a list of all persons and organizations contacted during the case study. All respondents were very cooperative and shared their information without any reluctance. All government departments which received a questionnaire provided information and all NGOs filled in the questionnaires.

As South Africa represents a country with a federalized system of government, just as for example India, and is in the process of putting a

decentralized and integrated health system in place, it was considered opportune to look specifically into the idiosyncrasies of the federalized system and its implications for tracking resource flows.

To optimize the quality of the information, the team followed as much as possible a standard strategy:

- data were collected through the questionnaires;
- questionnaires were controlled and internal and external quality checks were done;
- during the interview with representatives from the organization, inconsistencies and uncertainties in the data were clarified;
- if necessary information was corrected or adapted, in some cases a second visit was made to the organization;
- written documentation or information on the web about activities and the financial situation of the organization were collected as much as possible;
- in-depth oral information was gathered about various activities of the organization such as: historical overview of funding, implementation of the ICPD Programme of Action, future plans and activities, future financial outlook, *et cetera*.

The team is confident that the information obtained in the case study is of good quality. The fact that many of the organizations provided official financial overviews for 1997 or audited accounts has certainly improved the quality of the data. In many cases respondents had to invest considerable amounts of time and effort to come up with exact figures on financial aspects of their operation.

#### *Shortcomings of the case study*

During the case studies it became clear that some aspects of the data collection pose some problems and that there is still further room for improvement in the coming years: within the Resource Flows-project the population categories as defined in paragraph 13.14 of the ICPD 'Programme of Action' (United Nations, ICPD94, vol. 1, p. 70) are used. An important problem is formed by the fact that the four population activity groups which are used to categorize financial flows are not completely mutually exclusive. Especially the lines between reproductive health, family planning and sometimes HIV/AIDS prevention activities are not always obvious. For instance, a condom distribution programme could easily be seen as a family planning or HIV/AIDS prevention programme. Equally, a project to promote longer periods of breast-feeding can be seen as a reproductive health activity, but equally has a natural family planning dimension.

Other complications are:

- indirect national expenditures on staff, housing, utilities and so forth are sometimes ignored, as well as other indirect financial mechanisms like e.g. television and radio broadcasting time for messages on population and family planning;
- the complexity of the funding of government health and family planning services, make it difficult to estimate exact expenditure figures;
- Given the fact that past policies under *apartheid* in the field of family planning are currently seen in a negative light, usage of the term “Family Planning” is usually avoided. Furthermore, the term does not match the reality of life in South African. There are many single parent households (the result of apartheid policies such as the migrant labour system), escalating teenage pregnancy rates, gay and lesbian emancipation, etc., so the more holistic term "reproductive health" is used instead, with a well-developed contraceptive framework and guidelines sub-component. This is in keeping with ICPD.
- Because the government health system is under reform, and its information systems are under revision or inadequate for the tracking of resource flows for population activities, the requested information was difficult to obtain. The information in this report therefore cannot claim to be exhaustive and could suffer from errors. Despite these limitations, the authors have striven to be as accurate as possible.
- Given the time of the year (end of year holidays; World AIDS Day) and length of notice, some intended visits of organizations failed to take place as respondents lacked the time. In these cases, we tried to elicit information by other means (e.g. telephone, e-mail, the internet).



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## 3. Official Population Policy and Programmes

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### 3.1 | Government Population Policy

Population policies in South Africa have always been politically sensitive due to their genesis under successive repressive apartheid governments. It is only since the country's first democratic elections in 1994, the end of its international isolation, and the commitment of the new government to an integrated and holistic approach to development for all its citizens, that a sound and equitable approach to population development has begun.

South Africa has had a strong vertical family planning programme which began with the establishment of a separate directorate for Family Planning in the national Department of Health in 1974. The political rationale for the programme was to attempt to reduce the population growth rate, particularly that of the black population, by promotion of fertility reduction. It originated from an increasing fear within the white community of being 'swamped' by large numbers of black people, as reflected in 1972 by the Government of the day (Minister Vorster), " We would like to reduce them [blacks], and we are doing our best to do so....".

There was a huge number of family planning service delivery points, and by the end of 1992 there were more than 65,000 family planning service points. Free family planning services were made available to all racial groups on a segregated basis. As a result, modern contraceptive prevalence amongst women in South Africa is relatively high - 66% for black women, and 80% for white women.

However, whilst there was a wide method mix available for white women, injectibles were frequently the only method promoted for black women. This was largely due to political pressure to limit black fertility, poor counseling, and bad service provider attitudes.

Since 1991, with the subsequent integration of family planning services into primary health care services, contraceptive methods are normally available in all clinics. Nevertheless, there are inequalities between well-serviced urban areas and under-serviced rural areas, and not all methods are available (or promoted) in all health facilities.

In the early 1980s the South African Government decided to implement a policy aimed explicitly at lowering the national population growth rate in line with resource availability (especially water). This approach to population growth was based on the recommendations of a government commission report which argued that South Africa did not have the water resources to maintain a population larger than 80 million people. Ironically at the time, the black population was either denied access to very well water resourced arable land or was being removed and relocated to poor water resourced areas. The Population Development Programme (PDP) was established in 1984 to implement this policy.

The PDP set a demographic target of achieving a total fertility rate of 2.1 by the year 2010 to stabilise the population. The major thrust of the PDP was fertility reduction through family planning. At the same time, as programmes were being expanded to try to reduce the number of black South Africans, positive incentives were offered to whites to increase the number of children per family (e.g. child benefit payments). The family planning program led to an increase in contraceptive prevalence and a decline in fertility. In 1990, 44 per cent of black women were using contraceptive methods and the TFR had decreased from 6.0 to 4.4, a low figure for African nations at the time (Kaufman 1998).

A new population development policy was finalised in 1996/97 after extensive consultations throughout South Africa, and at all levels of society. This policy exposed the inadequacies of the previous PDP and based itself on the new paradigm and principles of the Cairo Conference. The Policy now shifts primary attention away from fertility control and looks at sexuality and reproductive health within the context of the development of basic social services, gender equity, economic upliftment, directly addressing the inequalities created by apartheid.

The year 1994 forms a watershed in South Africa's political history and in the history of its population policy: the change from the *apartheid* government under President F.W. de Klerk to the Government of National Unity (GNU) under president Nelson Mandela coincided with the Cairo ICPD in September of that year. The South African government fully endorses the ICPD PoA and after the conference teams were established within the Chief Directorate of Population Development (CDPD) to undertake follow-up and formulate a new population policy. Population issues are perceived by the GNU as central to the countries development, in particular sustainable human-centered development and in relation to the eradication of inequities between men and women and the different ethnic groups in the country. The new government has made the improvement of

the health and health services of the under served black communities a national priority. The government now aims at a 'community-driven' development policy, so that the outcomes of development are organized and distributed in a equitable, accessible and acceptable manner (Health Systems Trust 1997, p. 23).

#### *The RDP and GEAR programmes*

Under the former governments, an overall socio-economic development framework for the whole South African population was lacking, but this situation has been remedied by the adoption of the Reconstruction and Development Programme (RDP) after 1994. The RDP aims at the improvement of basic needs of the whole population, upgrading of human resources, democratization of society and the strengthening of the economy, taking into consideration population dynamics, the environment, gender, inequality and poverty. Under the RDP, so-called Presidential Lead Projects were initiated, including the building of clinics and free health care services.

In 1996, the government introduced a new programme, complementary to RDP, called GEAR (Growth, Employment and Redistribution Programme). Although the principles of RDP are acknowledged, the main emphasis of GEAR is on economic growth and employment creation, while social development holds second position. The GEAR has received some criticism as being a return to top-down policy and for prioritizing economic growth, while relying on trickle-down effects for social development, including health. However, its impact is not clear as of yet.

At present, the RDP and GEAR form the overall framework within which South Africa's population policy is to be integrated.

#### *Population policy*

In June 1994, the Government of National Unity initiated a review of the national population policy adopted during the *apartheid* era, including the functions of the existing population units at national and provincial levels. A public discussion document was published in April 1995 on the basis of this review and was widely advertised. Subsequently, almost 750 written submissions, with comments and criticisms, by academics, government departments, NGOs, the private sector and community groups were received and analyzed. The major elements of the submissions were that the new population policy should be an integrated part of the national development strategy; provide for a broad range of social services centering on the improvement of the quality of life of South Africans, instead of achieving demographic objectives; establish effective mechanisms for the collection, analysis and interpretation of demographic and socioeconomic data, so as to improve policy formulation, and the processes of planning, programming,

monitoring and evaluation in population related sectors; and finally, lay the groundwork for interventions related to population as part of the implementation of specific programmes in sector departments.

On the basis of this public debate, a Draft White Paper on the population policy was presented to the Minister for Welfare and Population Development in September 1996, and subsequently made public. On the basis of a new round of submissions and analysis, a revised White Paper draft was approved by the Cabinet in August 1997. This document has been discussed in parliament and was published in March 1998 (Department of Welfare 1998). It outlines the new population policy of South Africa, which was promulgated in April 1998.

The goal of the new population policy is stated as “to bring about changes in the determinants of the country’s population trends, so that these trends are consistent with the achievement of sustainable human development” (Dept. of Welfare, 1998, p. 35). The main objectives of the policy are to enhance the quality of life of South Africans through systematically integrating population factors into government policies, programmes and strategies within all levels, sectors and institutions of government. The government aims to use a multi-sectoral, interdisciplinary and integrated approach in designing and implementing their programmes, informed by reliable and up-to-date population and human development data. Population and gender issues are being integrated into the government’s sectoral and inter-sectoral development policies (UNFPA, 1997, p. 2).

Among other things, the strategies of the policy are designed to improve the accessibility, quality and affordability of primary health care, including those in reproductive health and family planning, with an aim to reduce mortality, unwanted pregnancies and eliminating disparities in health services. Special attention will be given to disadvantaged groups such as women and adolescents. In particular, gender and domestic violence will be addressed, and responsible and healthy reproductive and sexual behavior among adolescents and youth will be promoted, in order to reduce teenage pregnancies, abortion and STD’s, including HIV/AIDS.

From 1996, all primary health care services (excluding hospital outpatient services) are free for all South African citizens (Klugman *et al.*, 1998). The South African Department of Health has set a number of goals and objectives for the year 2000 (White Paper, Department of Health 1998), which in the field of reproductive health are the following:

- development of a comprehensive and integrated health system
- reduction of MMR by 50 per cent

- increase the proportion of pregnant women receiving ante-natal care to at least 90 per cent
- reduction of IMR by 30 per cent
- reduction of the proportion of births among teenage girls to 5-10 per cent
- reduction of transmission of STDs and HIV
- increase accessibility to male and female condoms
- increase clinic attendance for contraceptive and FP services

In November 1998, the National Population Unit drafted a mid-term review of the implementation of the ICPD PoA (Department of Welfare 1998b). Although the document reports limited progress in integrating population concerns into aspects of development planning, decision-making and resource allocation, some new legislation has been passed, new departments set up and a number of successful programmes have been initiated. For instance, the Transformation of the Health System Act 1997, lays down the objectives and guidelines for the restructuring of the health sector, with emphasis on integrated health services, the provision of IEC on life skills, sexuality, reproductive health and STD/HIV/AIDS, and improved delivery systems at the PHC level. Moreover, the government has put free health services for pregnant women and under five year children into place. An example of a successful programme is the nationwide Working for Water Programme, which uses an integrated and multisectoral approach and addresses ICPD related issues such as HIV/AIDS education (see section 4.2).

Some more specific strategies and initiatives that are currently implemented are:

- introduction of a system for the identification of causes of maternal deaths;
- expansion of reproductive health services, including family planning counseling, infertility treatment and free access to contraceptives;
- development of a life skills programme for adolescents, in cooperation with the Planned Parenthood Association of South Africa (PPASA);
- the establishment of National and Provincial Population Units, which should facilitate and promote population and development issues in policies, plans and legislation at all administrative levels of government;
- in the field of HIV/AIDS, mass IEC campaigns, improved counseling and care for affected persons and the establishment of an Inter-Ministerial and Inter-departmental Committee to promote political, technical and financial support for HIV/AIDS related activities.

In addition to the above, population and health matters are being addressed with more or less success in other South African policies in the field of social welfare, poverty eradication, employment creation and international migration.

Considering the few years that have passed since the ICPD of 1994, and the major sociopolitical changes that are taking place, the implementation of the new population programme, encompassing twenty-three strategies is a daunting task, which will take many more years of reorientation and restructuring of policies and administrative structures.

### **3.2 | Institutional framework and current restructuring of the health sector**

Under the old apartheid regime public services in South Africa were racially segregated and administered in a highly fragmented and compartmentalised fashion. The country was divided into a myriad of administrative areas, national, provincial, municipal, homelands and self-governing states. The public health system was characterised by a fragmentation into 18 departments of health and about 800 local authorities, defined according to race, all responsible in some measure for the planning and implementation of health services.

The Directorate of Family Planning was established with the Department of Health in 1974. The family planning services were structured along racial lines and were vertically organized. The programme was based on targets and the reduction of fertility through the introduction of contraception. In 1988, the Directorate of Primary Health Care incorporated the family planning programme, which became the Sub-directorate of Family Planning. Provincial and local authorities now provide family planning services with the sub-directorate of Maternal, Child and Women's Health responsible for overall policy and financing, for research, training and education.

Since 1994, in line with the complete review and reorientation of government since South Africa's first democratic elections, the National Department of Health and the new nine provincial Departments of Health have embarked upon a process of integration, restructuring, policy development, and the reorientation of services. Former homelands and self-governing states are now incorporated into a national and provincial system

of administration. Emphasis is placed on the district health system.<sup>5</sup> At present, because the district health system is not fully in place, during a transitory period the provincial departments of health will perform functions which will be devolved to the districts at a later stage. Health regions are established as sub-provincial structures in order to assist in these tasks (Dept. of Health 1998). For instance the northern province now has six regions and 25 (health) districts. The districts are demarcated according to indicators such as population (density), available health infrastructure and common service boundaries. Each district has between 50,000 to 200,000 population. Planning takes place along these boundaries. The district health system is still being implemented and under debate. The exact relationship between the different tiers in the administration are still to be determined, next to the form of representation of communities. The UNFPA predicted in 1994 that the first fully functional health districts could be expected to be operational between 1998-2000 (UNFPA, 1997, p. 46).

### **Fund flow and budgeting system**

The last few years major changes have been put into place in the budgeting system: before the new 1994 Constitution, the health system was centrally managed with vertical programmes. Data at that time were hard to get as the management information systems in the homelands and four provinces were poor.

In health, major shifts have been made toward a decentralized system focusing on the provinces. At central level, shifts have been made in the government bodies drawing up and evaluating the budget, with the major changes an increasing role of the Department of Finance, at the expense of the Department of State Expenditure, and a change from budget allocation based on historical budgeting to one based on 'needs' (McIntyre, 1998). Inter-ministerial committees have also been established to coordinate the budgeting process.

The national health budget includes conditional grants to the provinces, for among others, central hospitals grant, health training and research grants, redistribution of specialized health services and health infrastructure development (Dept. of Finance 1998, p. 6.28). Next to this there are national programmes (functions), such as the National AIDS programme, and special presidential programmes, e.g. the rapid expansion of health infrastructure.

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5 The guiding principles, goals and objectives have been laid down in the White Paper for the Transformation of the Health System in South Africa, published by the Department of Health in 1998.

The national budget is divided into a budget for national and provincial functions, intended for debt servicing and the RDP programme; a budget for health training programmes and health services at tertiary level and a budget for global provincial allocations. The latter allocations are distributed by the provinces over the different sectors (health, education etc) and departments, on the basis of the recently introduced Medium Term Expenditure Framework (MTEF). The provinces now get a 'global budget', which is then divided among sectors. From fiscal year 1997/8 on, the Medium Term Expenditure Framework (MTEF) is used by the provincial treasuries and national spending agencies as a basis for proposals for state central funding. The MTEF is drawn up taking into consideration the recommendations of various stakeholders e.g. sectoral provincial MTEF teams for health, education *et cetera*, the Executive Councils of the provincial cabinets and the Budget Council. Under the MTEF, spending agencies should draw up a three year budget under two scenario's: 1) 'no-growth' scenario, i.e. review of how one could stay within the former budget, by rationalizing and down-scaling existing programmes and 2) a 'needs-based' or 'zero-based' budget, which costs current (expanding) activities and new programmes.

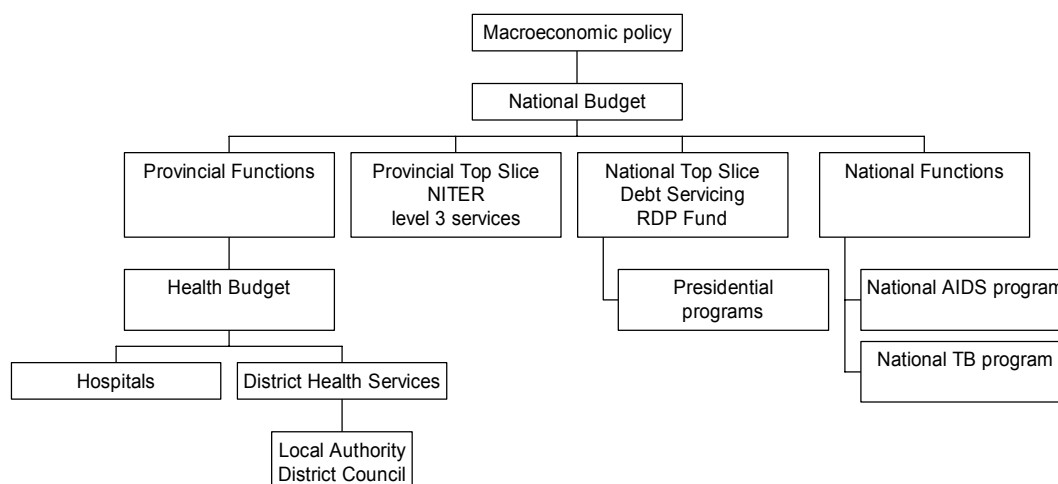
At the local level, the budgeting process is still in flux as the system of funding mechanisms from province to local level are still under review. Figure 1 shows the basic elements in the current fund flow mechanism.

The total future national allocations for the health sector are projected to increase from US\$ 948 million (Rand 5,251.6 million) in 1998/99 to US\$ 1,100 million (Rand 6,072.2 million) in 2000/01. This includes transfers to provinces of US\$ 859 million (R 4,759.8) in 1998/99 and US\$ 910 million (Rand 5,044.4 million) in 2000/01<sup>6</sup>

*Figure 1. Fund flow mechanism for health in South Africa*

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<sup>6</sup> Exchange rate used in this report 1 Rand = US\$ 0.1805. 1 US\$ = 5.54 Rand (1998)



Note: NITER is the 'National increase for teaching, education and research'

Source: Makan *et al.* (1997)

Table 3 shows the Financial and Fiscal Commission projection of allocations to the district health system by province (1996 Rand - millions)

Table 3. Allocations to the district health system (million Rands), South Africa, 1997-2003

Provinces	1997/98	1998/99	1999/2000	2000/01	2001/02	2002/03
W. Cape	713	764	791	820	850	882
E. Cape	1,690	1,826	1,900	1,977	2,058	2,143
N. Cape	167	177	182	188	194	200
KwaZulu-Natal	2,018	2,172	2,255	2,341	2,433	2,528
Free State	663	720	751	783	817	853
North West	846	919	958	1,000	1,043	1,089
Gauteng	1,462	1,602	1,679	1,760	1,846	1,937
Mpumalanga	644	694	721	749	779	810
Northern	1,252	1,342	1,390	1,440	1,493	1,548
South Africa	9,454	10,216	10,626	11,058	11,511	11,989

Source: Financial and Fiscal Commission's Recommendations for the Allocation of Financial Resources to the National and Provincial Governments for the 1997/98 Financial Year, May 1996, table 6.

The national government also transfers funds to local governments for agency functions<sup>7</sup> performed on behalf of provincial administrations. For fiscal years 1995/6 to 1997/8 the total transfers for health were US\$ 138 million (Rand 762,848,000) in 1995/6, US\$ 152 million (Rand 844,906,000) in 1996/7 and US\$ 157 million (Rand 871,809,000) in 1997/8.

### **3.3 | Reproductive health and family planning**

Reproductive health is still a relatively new concept in South Africa and is placed in the context of mother, child and women's health (MCWH). The current restructuring of the health sector from a curative based fragmented system to a community oriented one, emphasizes the improvement of preventive, promotive and curative services for children and women (Department of Health 1998a: chapter 8). In particular, the rural and urban poor are targeted. The aim is to establish community health centers and clinics providing integrated services in rural, peri-urban and urban areas with a coverage rate of 1:20,000 population by the year 2000. The services should be provided on a one-stop "supermarket" basis (truly integrated), should be efficient, cost-effective and of high quality.

At all levels of administration the MCWH services are reorganized. At the national level a MCWH Directorate has been established, responsible for the coordination of the reorganization process, policy formulation, planning and support for provincial activities. Similarly, at the provincial level MCWH units are established. At the district level, trained district health teams are responsible for the implementation, monitoring and evaluation of MCWH programmes, in coordination with the local governmental structures. In addition, the government specifically recognizes the role NGOs and grassroot organizations play in furthering MCWH services. At the provincial and district levels, annual health plans are to be drawn up stating the targets to be achieved. Protocols and training programmes concerning priority health problems are devised including those for child health problems (diarrhoea, measles, respiratory infections); ante-, peri- and neo-natal care (Perinatal Education programme); adolescent health; reproductive health (midwife training).

### **3.4 | Gender, women, youth and children**

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<sup>7</sup> Agency functions are functions rendered by municipalities on behalf of provincial governments. The municipalities provide the services (e.g. health, social) and receive funding from the provinces for these (Department of Finance, 1998).

A national Gender Commission has been established in the Office of the Deputy President, complemented by the Office on the Status of Women. These government bodies have as their main task facilitating the improvement of the position of women, the drawing up of a gender policy and the promoting of gender issues in all departments. Gender desks have been established in all government departments for this purpose. In particular, these bodies promote, advocate and facilitate measures in order to:

- promote equal participation of men and women in household responsibilities, especially responsible parenthood, reproductive health, child rearing and household work.
- eliminate forms of gender based discrimination and disparities, including those encoded in state laws
- reduce gender based domestic violence
- increase the participation of women in decision-making bodies through affirmative action
- promote gender-sensitive education

The government, together with the NGO sector, has introduced life skills programmes for youth and adolescents, focusing on sexuality, teenage pregnancies, general health promotion and HIV/AIDS prevention.

### **3.5 | HIV / AIDS and other STD activities**

The HIV/AIDS epidemic has hit South Africa hard. The Government of South Africa estimates that about 3,2 million people have been infected and each day an estimated 1,500 new infections occur (Dept. of Health 1998). A national survey conducted at the end of 1995 showed that 10 per cent of women attending public antenatal clinics were HIV infected. In 1997 the HIV prevalence among this group was risen to 16 per cent (Dept. of Welfare 1999, p. 12). It is recognized that the youth, women and migrants are particularly at risk of contracting HIV/AIDS.

The government of national unity especially targets youth and adolescents and promotes responsible, healthy reproductive and sexual behavior, with the aim to reduce the prevalence of STD's (including HIV/AIDS), high-risk teenage pregnancies and abortion. These aims are to be met through the provision of more user-friendly health services, life-skills and sexuality education and IEC on reproductive health and STD's/HIV/AIDS.

The government has set up a National AIDS Control programme based on the National AIDS Plan, developed by the National AIDS Convention of

South Africa. The plan aimed at greater control of HIV/AIDS through behavioral change, early detection, greater distribution of barrier methods and improved blood screening. New thrusts in the combat of AIDS is the establishment of AIDS Training and Information centres with lay counselors responsible for HIV test counseling, community outreach and HIV/AIDS education. In 1996/7 Rands 18 million was made available from the RDP funds for the training and employment of 270 lay counselors, i.e. 30 per province.

The government recognizes that, in order to combat the epidemic effectively, underlying socio-economic factors should be addressed and the involvement of NGOs, private sector and community based organizations (CBO's) is needed. The government aims at working together with NGOs, such as the Planned Parenthood Association of South Africa, in providing these services including life-skills and sexuality education.

### **3.6 | Co-operation with NGOs**

Although the South African government wishes to continue to monitor the NGO sector in the future, it aims at giving NGOs far greater autonomy. Therefore, it has reviewed and revised the legislation pertaining to NGOs, i.e. the Fund-raising Act which regulates NGO activities. It is possible for NGOs to receive foreign assistance and implement its programmes without government intervention.

Recently, the Government of South Africa has established a National Development Agency (NDA), a statutory body which represents the primary link between government and the NGO sector. On the board of the NDA are nine representatives from government and six from the NGO sector. Funding for the NDA has come from the Government of South Africa (US\$ 9.02 million; R 50 million) and the EU (50 million ECU; US\$ 57 million).<sup>8</sup> In addition, the Government of South Africa funds NGOs on a contracting out basis and is now experimenting with private/public partnerships.

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<sup>8</sup> Personal communication, Central Government Donor Coordination Unit.

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## 4. Financial Flows

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The foregoing sections have shown that the funding situation for health sectors interventions and programmes is quite intricate and under major transformation. In the following sections, the focus will be on the financial aspects of interventions and programmes in the South African population and health sector. Paragraph 4.1. deals with the role the international donor community has played in past and present health sector and population programmes, followed by an overview of the major bilateral, multilateral donors and NGOs in this field. Next, the role of the South African government and South African NGOs is discussed, with an overview of the major projects and programmes. The final section focuses on the private sector.

### **4.1 | The Role of the International Donor Community**

#### *4.1.1. Historical development of foreign donor funding*

Due to the apartheid system, South Africa has been isolated politically and was sanctioned by the international community. Most donor funds went to the NGO sector, particularly the anti-apartheid movement within and without the country, for work on human rights, development and political action (Klugman *et al.*, 1998, p. 35).

The Government of South Africa organized the first donor conference for South Africa in Pretoria in April 1996. After the transition to the democratically elected government in 1994, most donor governments increased their support significantly and shifted from NGO support to the bilateral channel. New donor support in the health sector is mainly geared toward infrastructure development, strengthening of basic PHC through capacity building and training, technical assistance and support for specific national programmes, i.e. HIV/AIDS.

Because of the sanctions and isolation of South Africa prior to 1994, the government lacks experience in the management of donor funding. Moreover, the South African government avoids dependence on donors, and donor funding is but a fraction of the total budget (in health a mere one per cent!). Moreover, due to the current transferring of staff, changes in policy

and unfamiliarity with (tender) procedures the disbursement of funds is sometimes delayed.<sup>9</sup>

However, one source has estimated the total grant aid for the health sector for the transitional period (1994-1999) at between US\$ 230-250 million (Schneider, quoted in Klugman *et al.*, 1998, p. 36). Within the health sector, most donor funds go to capacity building, health system development, technical support and management. In reproductive health, support is geared toward the public sector capacity building and infrastructure development, and the HIV/AIDS programme. Additional support is for CBD programmes, adolescents, education and social marketing, which is often done through the NGO sector.

*Table 4. Donor funding for population activities, by channel, 1992-1997*

South Africa	1992	1993	1994	1995	1996	1997
Total US \$ 000	211	169	872	9.693	15.588	20.654
By channel						
Bilateral	148	17	183	8.336	9.224	12.428
Multilateral	0	0	26	679	897	1.239
NGOs	63	152	663	679	5.467	7.037

Source: RF database 1997

These developments are reflected in the development of foreign donor funding for population activities in the country. Before the transition of government in 1994, total foreign funding was relatively small, but increased from US\$ 211,000 in 1992, to US\$ 169,000 in 1993, up to 872,000 in 1994. After 1994, donor funding increased very rapidly, from US\$ 9,693,000 in 1995, US\$ 15,588,000 in 1996 to US\$ 20,654,000 in 1997.

Although the amount of funds channeled through the bilateral, multilateral and NGO channel increased the proportion of bilateral funding is largest. This is in contrast to the situation before 1994, when most funding for population was channeled through NGOs.

#### *4.1.2 Main International Donors in the Field of Population and Development*

After the change of government in 1994, all major donor countries, increased their activities in South Africa, in order to provide support to the transition and restructuring process. The major donor countries in the field

<sup>9</sup> Klugman *et al.* (1998, p. 37) point out that the EU, for instance, had allocated Rand 53 million for 1995/6, of which only Rand 7 million was disbursed by May 1997.

of population are currently USAID, DFID (formerly ODA) and the EU. Multilateral organizations active in the field of population and reproductive health are the UNFPA, UNDP, WHO and UNICEF. In addition, there are international NGOs, some of which implement programmes funded by primary donors, e.g. MSH and the Rockefeller Foundation (for USAID).

## **A. Donor countries**

### **The European Union**

Under the bilateral agreement between the EU and South Africa, EU funds for South Africa's development are channeled through the European Programme for Reconstruction and Development (EPRD), which is managed by the European Investment Bank. With an annual budget of 125 million ECU, the EU development co-operation with South Africa is aimed at supporting, furthering and consolidating policy reforms of the South African Government of National Unity.

The EPRD grants focus on six different sectors:

- education and training;
- health ;
- rural development;
- urban development;
- good governance;
- private sector development.

In the health and population field, the European Union has supported South African programmes and projects in PHC, health infrastructure development, HIV/AIDS education and NGOs co-operation and strengthening. In 1997, a new EU programme for South Africa was formulated. The funding in the health and population field has increased significantly: the commitments rose from 174 million Ecu for the 1986-90 period to 867 million Ecu for 1991-5. The share of the health and population sector in terms of total aid has risen from one per cent to nearly 3 per cent. The EU has made health policy reform and the development of strategies for tackling HIV/AIDS a priority.

Between 1991-96, the EU supported 37 projects in primary health care and health research and coordination, with a total expenditure of US\$ 23 million. In the field of HIV/AIDS, 5 projects (capacity building, prevention, research) were funded with total expenditure of US\$ 11.5 million (table 5)

*Table 5. European Union Funding in health sector, 1991-1996*

Sector	Projects	Rands ('000)	US\$ ('000)
Primary health care	24	72.022	16.005
Health research and coordination	13	31.307	6,957
HIV / AIDS	5	51.887	11.530
<b>Total</b>		<b>155.216</b>	<b>34.492</b>

### **DFID (formerly the Overseas Development Administration-ODA)**

DFID's population assistance in South Africa is aimed at health sector reform, women's reproductive health and support to the Department of Health for the promotion of STD/HIV/AIDS awareness campaigns. In these projects DFID support goes directly or indirectly to the Department of Health, the University of Witwatersrand (Women's Health project) and NGOs (social marketing of condoms through the Society for Family Health). The total approved budget for assistance to population projects is currently US\$ 30 million.

The number of DFID health projects in South Africa has increased sharply: from only one in 1991 with a budget of US\$ 543,150 (about £ 300,000 in 1991) to 24 projects in 1998 with a budget of about US\$ 42 million (£ 25 million). Since 1994, the percentage of DFID funds spent on health fluctuated between 18-20 per cent. At present there is a trend from small projects towards larger projects and a sectoral approach.

DFID also channels funds to South African NGOs. For instance, a new DFID project on reproductive health, officially under the Department of Health, is financed from DFID through UNFPA to the Planned Parenthood Association of South Africa and the Reproductive Health Research Unit in Johannesburg. The NGOs are contracted to implement projects. Most projects have a three-year life cycle. The total annual budget is £ 30 million at a maximum.

DFID has 22 active projects since 1995, with total funding of about £ 23 million pounds sterling (US\$ 37.7 million). This includes one TB project of US\$ 961,000. In 1997, DFID disbursed a total of US\$ 3,440,965 for seven RH projects and five HIV/AIDS related activities, including support to the National HIV/AIDS programme, the Women's Health project, the Reproductive Health Research Unit and the PPASA.

Next to the above approved programs DFID is currently preparing four projects for 1998/99 and support a projects on reproductive health in the

Eastern Cape and Kwa Zulu Natal, with a budget of £ 279,440 (about US\$ 458,000).

## USAID

In the health sector, USAID's main aim is to help establish a uniform, equitable and integrated system of delivering PHC services. USAID has five priority areas in health:

- increased access to an integrated package of PHC services;
- effective health care referral system in operation;
- improved provincial level integrated PHC delivery systems;
- PHC training programs strengthened at provincial level;
- increased capacity for PHC system to provide appropriate HIV/AIDS prevention and treatment services.

USAID has been active in South Africa since 1985, when its country office was opened. Since then, over US\$ 1 billion has been allocated, mainly to the NGO sector. However, after 1994, USAID channeled funds bilaterally (quite unlike DFID for instance) and funded projects aimed at institutional development and capacity building of government ministries, and for establishing mechanisms for development activities including the NGO and private sector. At present, USAID is contemplating more co-operation through national NGOs. USAID works through contractors which channel funds through the provincial level.

*Table 6: Bilateral funds USAID- South Africa, health sector (US\$ millions)*

	Total planned	FY94	FY95	FY96	FY97	FY98 (plan)
Equity project	49.7	na	8.0	10.9	14.7	9.6
HIV / AIDS capacity building	10.0					2.0

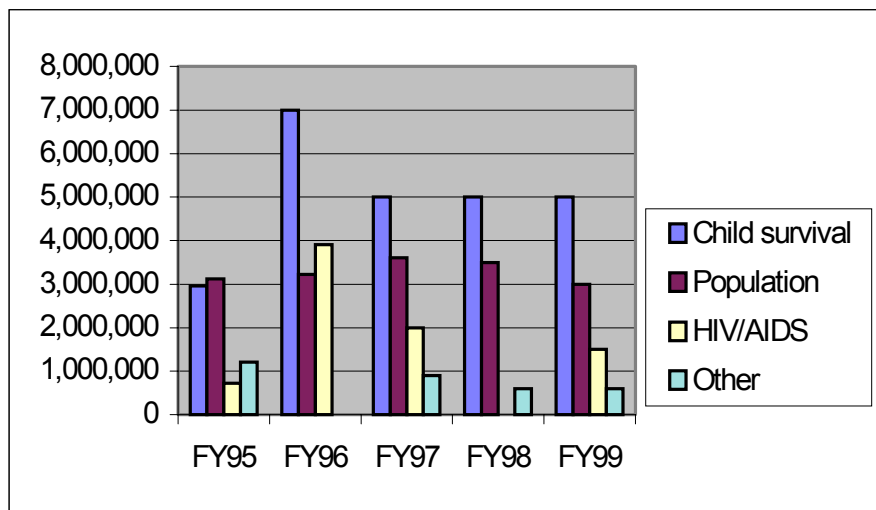
As shown in table 6, USAID's funding has increased between 1995 and 1998. As South Africa is a middle income country, USAID's activities will be scaled down and eventually cease (in about five years time). Total health support for the period 1996-2000 will show a decreasing trend (table 7): from US\$ 14.1 million in 1996, US\$11,5 million (FY1997), US\$12,0 million (FY1998), US\$10,0 million (FY 1999) to US\$ 4,4 million in FY2000 (USAID July 1997). In population, USAID's main activities are the EQUITY project and HIV/AIDS activities.

### *EQUITY project*

The implementation of the EQUITY project was started in February 1997. It aims at capacity building and assistance to South Africa in changing and strengthening its national health system, so that essential services of high quality will become accessible to all South Africans, with an emphasis on reproductive health. Under the Equity project the health structure of the Eastern Cape is being restructured. In addition, the DHS survey, implemented in 1997, was also supported by USAID.

The HIV/AIDS funding is earmarked from congress. Initially USAID provided no health support; rather good governance and democratization received much support. Currently, line items in population are child survival, population, HIV/AIDS, infectious diseases and other activities. As figure 2 shows child survival and population receive much funding followed by HIV/AIDS activities.

Figure 2. Cumulative earmarks FY 1995-2000 of the USAID/EQUITY project (\$US)



Note: US\$ 2 million for HIV/AIDS in FY98 not obligated, but figures as additional HIV/AIDS funding in FY99.

USAID supports South Africa's national HIV/AIDS/STD programme. Three interrelated activities within the HIV/AIDS filed are envisaged, namely: 1) capacity building, on the national but especially on the provincial level; 2) advocacy and political leadership and 3) targeted intervention-linked research activities.

## **B. International NGOs and Foundations**

### **Rockefeller Foundation**

For the implementation phase of its African Gender Institute, the University of Cape Town (Rondebosch) received a grant of \$450,000 in 1997. In 1997, the Rockefeller Foundation provided support (US\$ 100,000) for the Health Systems research and Planning Skills Development programme, which is implemented through the South African Health Systems Trust.

### **Henry J. Kaiser Family Foundation**

The Henry J. Kaiser Foundation is a private philanthropic trust with the aim of improving the life chances and health of disadvantaged people. It is currently one of the largest private foundations dedicated to health in the United States with an endowment of US\$ 450 million and annual grants of US\$ 30 million. South Africa is the only country outside the USA where the foundation is active. Its grantmaking program in South Africa, started in 1988, is aimed at supporting the country to establish a more equitable national health system. In particular it has given support to the ANC government in formulating policies pertaining to reproductive health, women, adolescents and termination of pregnancy. To establish a baseline from which to measure impacts of policy interventions, the foundation commissioned a national household health survey in 1994.<sup>10</sup> The survey was coordinated and the report prepared by the Community Agency for Social Enquiry (CASE) and published in October 1995 under the title *National Household Survey of Health Inequalities in South Africa*.

In addition, the foundation funded a number of projects in the field of health. In reproductive health, the foundation provided support for maternal mortality research and activities in adolescent reproductive health (table 7).

### **Other NGOs**

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<sup>10</sup> The survey covered a representative sample of 4,000 households, which was weighted to the universe of 7,594,000 households in South Africa.

Other NGOs working in the field of population and reproductive health in South Africa are Marie Stopes of the UK, IPAS, Margaret Sanger Center International and AVSC. They have small but growing programmes.

*Table 7. Expenditure Henry J. Kaiser Foundation, 1995*

	Rands	US\$	Years
<b>Reproductive health</b>			
Maternal mortality research	562.500	125.000	
Establishment of RH fund	2.475.000	550.000	2,0
Pilot adolescent RH services	3.082.500	685.000	3,0
Sub-total	6.120.000	1.360.000	
<b>Health</b>			
Media training for health leaders	1.620.000	360.000	
Household survey and publication	382.500	85.000	
Capacity building research	832.500	185.000	
Health and human rights award	900.000	200.000	
Advocacy	900.000	200.000	
Community services and nutrition	1.215.000	270.000	3,0
NGO research and policy analysis	5.287.500	1.175.000	2,0
Child health	450.000	100.000	1,5
Sub-total	11.587.500	2.575.000	
<b>Total</b>	<b>17.707.500</b>	<b>3.935.000</b>	

Source: Henry J. Kaiser Family Foundation, 1996.

- IPAS is mainly involved in improvement of abortion services (US\$ 60,000 in 1997).
- Marie Stopes South Africa (MSSA) started activities in 1994. To cater to the reproductive health needs of women, nine clinics around Durban, Johannesburg and Cape Town have been established. Clinics in low income communities in Soweto and Pretoria are also supported. In 1996, they spent US\$ 82, 000 (1996) on its clinics in South Africa. MSSA is also involved in advocacy and plays a role in the reproductive rights campaign in South Africa.
- Margaret Sanger Center has initiated a South Africa programme for 1994-1997 with a total budget of US\$ 450,000 (expenditures in 1996 were US\$ 102,353). This programme is partly funded by the Hewlett Foundation.

### **C. UN Organizations**

#### **UNFPA**

The UNFPA has played an important role in aiding South Africa implement the goals of the ICPD PoA. Before 1996, the UNFPA programme provided support to the South African government for the population census in 1996,

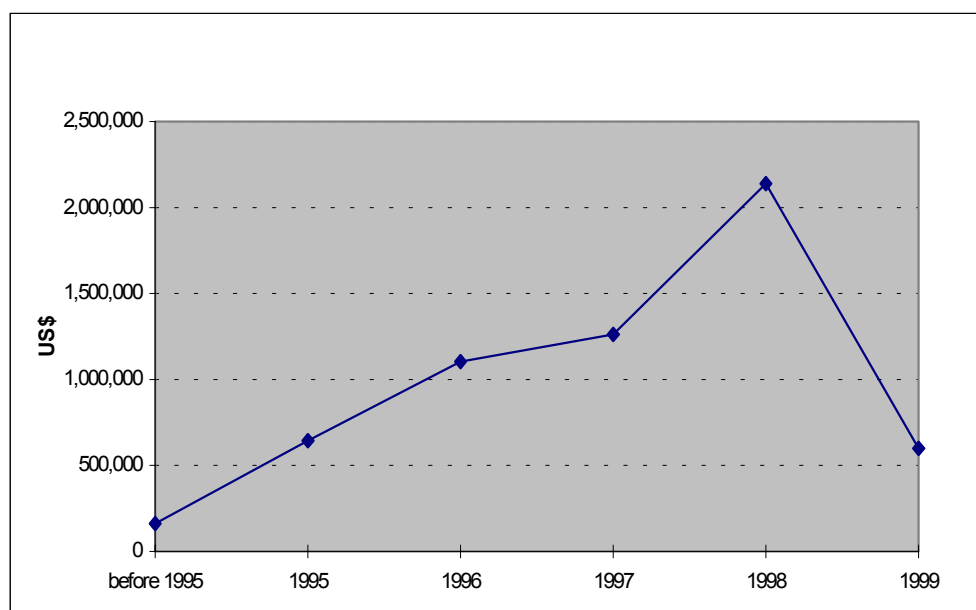
post ICPD activities, a women's conference and funding for the Women's Health project (see section 4.3). From 1996 on the programme expanded in terms of funds and activities. The UNFPA provided technical assistance to the Department of Health, has given capacity training for staff of the National Population Unit and in 1998, UNFPA will provide funds for the South African multi-sectoral Working for Water project.

In 1997, UNFPA funded training activities for NGO researchers. In the field of reproductive health, UNFPA has provided support for projects in adolescent reproductive health and sex education since 1996. Support for family planning activities include two ongoing projects, started in 1996, aimed at the expansion of contraceptive choice and CBD.

The UNFPA year to year expenditures have shown a steady increase, as can be inferred from figure 3. Between 1994 and 1998, UNFPA expended a total of US\$ 5.3 million, including support to post ICPD activities, the population census, capacity building, adolescent reproductive health and sex education.

In addition, support has been given to NGOs (Women's Health project), the National Population Unit of the South African government and the Working for Water programme. However, due to budget cuts, it is expected that UNFPA's expenditures in South Africa will decline considerably.

Figure 3. UNFPA expenditures South Africa, 1994-1999



## **UNAIDS**

UNAIDS started activities in South Africa in early 1996 as part of the activities of the Intercountry Technical Team responsible for backstopping East and Southern Africa.

During 1996/97, the programme allocations of UNAIDS in South Africa were US\$ 1,679,917. This includes funding for the organization of conferences on HIV/AIDS, a multi-media campaign for the promotion of safe sex and condoms (US\$ 27,000) and support for research on HIV and STD prevention, including the development of drugs (UNAIDS, Geneva).

In addition, UNAIDS allocated US\$ 7,302 for technical support for South Africa and US\$ 100,000 on programmes such as HIV in the workplace, gender, HIV/AIDS and the constitution and the National Programme on AIDS.

Under the Strategy Planning Development Fund, UNAIDS spent US\$ 140,000 on small initiatives during fiscal year 1998/99. US\$ 50,000 has been spent on the programme 'HIV in the workplace'. The same amount was spent for a locally recruited national programme officer for HIV/AIDS and for the support of an interagency gender advisor.<sup>11</sup>

## **United Nations Children's Fund (UNICEF)**

UNICEF has been active in South Africa since 1990. Following on its bridging programme of 1994-1996, the first Country Programme was launched in mid-1996. The programme covers the period 1997-2001, with a total allocation of \$US 25 million. The major areas of support are Social Policy and Programme Development, Advocacy, Social Mobility and Programme Communication, Health and Nutrition, and Education.

## **World Health Organization (WHO)**

WHO has mainly supported the health systems reform in South Africa since 1994 through technical support to the Ministry of Health. Special studies on emerging reproductive health issues in South Africa and on emergency contraception have been supported (the latter in collaboration with the UNFPA). There has also been some support to HIV/AIDS programmes.

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<sup>11</sup>Personal communication.

In its program in South Africa, the WHO recognizes the links between development and health. Therefore, in its advocacy activities the WHO stresses the need for political commitment to health sector reform, adequate financial resources, an integrated approach and giving priority to vulnerable groups such as women, children and poor communities.

The WHO pursues five priority areas in its technical co-operation program with South Africa namely:

- The establishment of a district health system, offering a basic health package for each community covered by a basic Health Unit;
- Health promotion activities;
- Increasing the access to health care services, particularly women and children;
- Improvement of health planning and monitoring;
- Human resource development for the health sector.

Some specific activities supported by WHO are the establishment of PHCs at district level; support for legal reform needed to back-up health sector reform and the development of norms/standards for care for pregnant women and gynaecological emergencies.

### **United Nations Development Programme (UNDP)**

In the field of population, the UNDP in South Africa has concentrated on support for HIV/AIDS related activities. It has aimed at the expansion of and greater integration of the involvement of the MOH and the planning ministries of government, in addressing the socio-economic impacts of the HIV/AIDS epidemic.

### **World Bank**

The World Bank has supported South Africa since the 1950's, but the focus has not been on population. Loans provided in the early years were for infrastructural development. Current funding is aimed at economic development and poverty reduction. The Bank's support is mainly in the form of technical assistance in these areas, mainly in the field of conducting surveys on poverty and policy analysis. The Bank has cooperated with the UNDP, DFID and local NGOs within its South Africa programme.

## 4.2 | Role of the Government of South Africa

About 8,5 per cent of South Africa's GDP is spent on the health sector, which is quite high in comparison to other countries. The total allocation for health in 1995/6 was R 16.8 billion or R 400 (about US\$ 22) per capita (PRSD 1998, p. 43).

There are currently three main central departments dealing with reproductive health issues. These are the Directorate of HIV/AIDS/STD's, the Directorate of Maternal, Child and Women's Health, both within the Department of Health and the National Population Unit of the Department of Welfare and Population Development.

Table 8 provides basic expenditure data for these three departments.

*Table 8. Government of South Africa*

Reproductive health expenditures (US\$)		
	Expenditure 1996	Expenditure 1997
Department of health, directorate HIV/AIDS	15.635.970	14.028.715
Department of Health, directorate of MCH	na	1.352.290
Department of Welfare and Population Development	1.333.350	1.829.044

Source: RF databases 1996 and 1997.

The government departments address different population issues and programmes. While the Department of Health spends on RH, the Department of Welfare & Population Development spends mainly on research activities.

Next, the mandates, programmes and financial aspects of the different government departments are discussed.

### **Department of Health- Directorate of HIV/AIDS/STD's**

HIV/AIDS has become a serious problem in South Africa. UNAIDS/WHO have estimated that, at the end of 1997, 2.8 million adults and 80,000 children were HIV positive. For adults this represents a prevalence of 13 per cent (UNAIDS/WHO, 1998). The national ante-natal clinic survey of HIV status showed that HIV/AIDS is spreading very fast; HIV prevalence among ante-natal clinic attendees increased from one per cent in 1990 to a high 20 per cent in 1997. It is estimated that some 1500 people a day are infected in

South Africa and there are already 200,000 orphans due to the epidemic (Dept. of Welfare 1998, p.30).

The directorate of HIV/AIDS/STD's within the Department of Health undertakes and co-ordinates activities within the framework of the national HIV/AIDS programme. In addition, inter-ministerial and inter-departmental committees have been set up to strengthen the government in tackling the epidemic and generating sufficient funding and technical support.

A large portion of the expenditures of the National HIV/AIDS prevention programme is channeled through national NGOs, Departments of Education, Department of Correctional Services and national research institutes. In 1996, 27 per cent of the total expenditures were spent via 119 national NGOs and research institutes contracted to undertake HIV/AIDS activities and research for the department (RF96 database).

The Department of Health, Directorate of STD/HIV/AIDS received US\$ 77,764,560 from the central government budget in FY1997. It has expended US\$ 15,5 million in 1996 and slightly US\$ 14 million in 1997 on its National HIV/AIDS programme. About US\$ 88,967 (Rand 409,950) was spent on salaries and incentives. Figure 4 displays the expenditures of the National HIV/AIDS programme in FY 1997 by area.

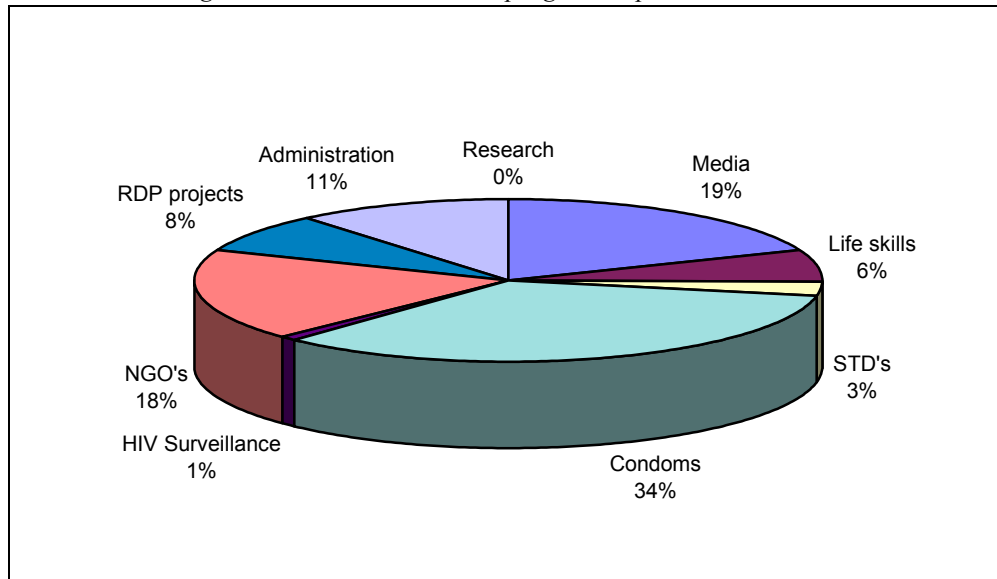
As can be seen from figure 4, one third of the total was expended on condoms, almost one fifth on media campaigns, but insignificant proportions went to HIV surveillance and research. However, 18 per cent of funds were expended through national NGOs of which some are supported for research activities pertaining to HIV/AIDS. The percentage of funds expended through NGOs is significantly lower than in fiscal year 1996 (27 per cent).

In 1996, US \$ 11.7 million was received in support from the EU and US \$ seven million from Belgium. In 1997 the donor support came from the EU at US\$ 221,443 and USAID for US\$ 4 million.

### **Department of Health- Directorate of Maternal, Child and Women's Health**

The Department of Health, directorate of MCWH, is in the process of reorienting their strategies toward integrated and client-based health services. Areas on which the MCWH directorate has focussed its resources

Figure 4. National HIV/AIDS program, expenditures, 1997



are training programmes for midwives and health workers, next to an expansion of integrated services in PHC, such as improved ante-, peri- and neonatal care, child health, infertility treatment and family planning.

In fiscal year 1997, the Department of Health spent R 6,231,179 (US\$ 1,352,290) on its MCH programme. This programme is basically vertical and covers many issues, except pure service delivery which is done by the provincial health departments (Klugman *et al.*, 1998, p. 26).

### **Department of Welfare and Population Development-National Population Unit (NPU)**

The former Chief Directorate for Population Development (CDPD), was restructured into the National Population Unit (NPU), within the Department of Welfare in 1997. The CDPD is associated with the apartheid regime and was mainly aimed at reducing fertility and promoting the small family norm and some IEC activities. These IEC activities were targeted at women and adolescents and aimed at promoting Family Planning.

The newly formed NPU has as its main task the integration of population and development interrelationships into South Africa's development policies, plans and legislation in all sectors and levels of government.

Through advocacy and training on population issues other government departments and agencies are familiarized on the significance of population for developmental issues, and the aims of the new national population policy and implementing mechanisms.

The NPU has spent a total of US\$ 1,829,000 on research, training and policy development in 1997.

### **Intersectoral collaboration**

One of the goals of the new population policy is the progressive integration of population issues into all aspects of development planning and resource allocation. Although much has still to be done, some successful initiatives has been launched. One of the most notable examples is the so-called Working for Water Programme, which was initiated in 1996 by the Department of Water Affairs and Forestry. Although it is essentially a public works initiative it contains elements of employment creation, poverty reduction, women's empowerment, health and HIV/AIDS education.

The Working for Water program takes a holistic approach to development, i.e. environmental, social and health needs are addressed simultaneously.

More specific aims of the project are:

- reduction of water consumption and environmental conservation by clearing alien water consuming plants in water catchment areas;
- a sustainable productivity of farmland;
- protection of biological diversity and ecological stability;
- employment creation, literacy and skill training, especially for women;
- improvement of the welfare of marginal groups, e.g. the poor, disabled, youth and women;
- reduction of crime and unemployment;
- creation of secondary industries and training in management of business and self-employment;
- reduction of racial tensions through multi-ethnic youth work groups;
- creation of community social services, e.g. crèches for employed women;
- health improvement, through employment and through an emphasis on training in e.g. health and HIV/AIDS prevention;
- last but not least, awareness building and training of people in primary health, HIV/AIDS, sexual health, nutrition, child care/parenting, drug abuse, sexual abuse, community development, sustainable environmental.

Many Government departments and agencies are involved in this integrated programme: Department of Water Affairs & Forestry, Department of Agriculture and Land Affairs, Department of Environmental Affairs and Tourism, Public Works, Department of Trade & Industries, Department of Health and local government bodies i.e. municipal councils. The programme focuses on the integration of the line functions of the several government departments. As a community based programme local community groups and local farmers are also involved. The CBD programmes of the Planned Parenthood Association of South Africa are being integrated with the Working for Water programmes in Eastern Cape (Kouga), Western Cape (Soutkraal) and in Free State (Golden Gate).

#### *Funding of the Working for Water program*

The WfW programme is funded through the water conservation programme, but also receives funds through Department of Water Affairs' Poverty Relief Fund, but also received grants and awards from external donors such as World Wildlife Fund, Finland, Norway, Netherlands, USAID, IDRC-Canada, UNFPA, the European Union, and various national partners such as Rand Water, South African National Parks, the Sugar Association of South Africa and various South African conservation agencies.

Until November 1997 there were 38 projects across South Africa under the programme, providing jobs for over 8,000 people, half of which were held by women. The budget for 1997/8 was R 100 million. At the end of 1997, the Department of Finance provided an additional grant of R 150 million from the Poverty Relief Fund, after which the total programme grew to 240 WfW projects and (temporary) jobs for 42,000 people. The 1997/8 government budget for this programme was approximately R 100 million (US\$ 21,7 million). In November 1997 an additional R 150 million (US\$ 32,5 million) was allocated by the Department of Finance from the government's Poverty Relief Fund. A year later, R 250 million (US\$ 54,3 million) was allocated by the Minister for Water Affairs and Forestry. The possibility of securing multi-year government Poverty Relief funding for the programme is envisaged, in the twenty year strategic plan.

### **4.3 | Role of national NGOs**

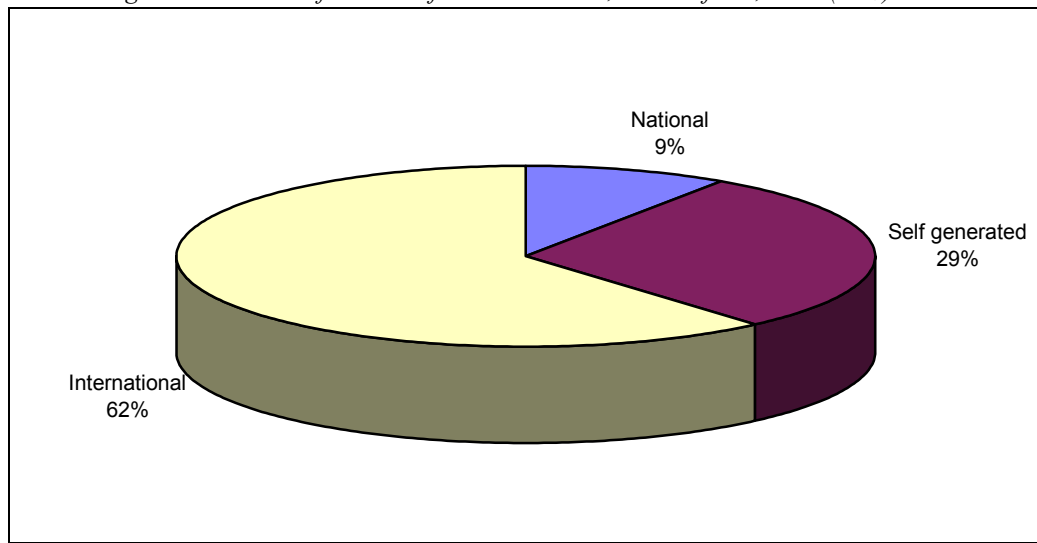
There are over 5000 NGOs in South Africa, but this number includes many small community based organizations and associations. Although quite a number address issues pertaining to health, women, youth or HIV/AIDS, the number of NGOs that play a significant role in reproductive health is small however. The major South African NGOs working in the field of population and reproductive health are the Planned Parenthood Association of South Africa (PPASA), the Women's Health project of the University of Witwatersrand, the Reproductive Health Research Unit based at the Chris Hani Baragwanath hospital in Soweto. Other important NGO groups are the National Progressive Primary Health Care Network. Less significant players are the AIDS Consortium, the Center for Health Policy, the Health Systems Trust, Reproductive Rights Alliance and the Society for Family Health.

The main focus of South African NGOs is the quality of services, advocacy and counseling. Some of them have a pioneering function, and tackle sensitive subjects such as gender violence or work with special target groups (e.g. youth or commercial sex workers). NGOs can play a pioneering role, they can focus their activities on special target groups, or in special areas, e.g. in the field of STD, HIV/AIDS activities, and basic research and population and development policy analysis.

As to the sources of income of national NGOs, it is evident that they are still very much dependent on funding from international donors (figure 5).

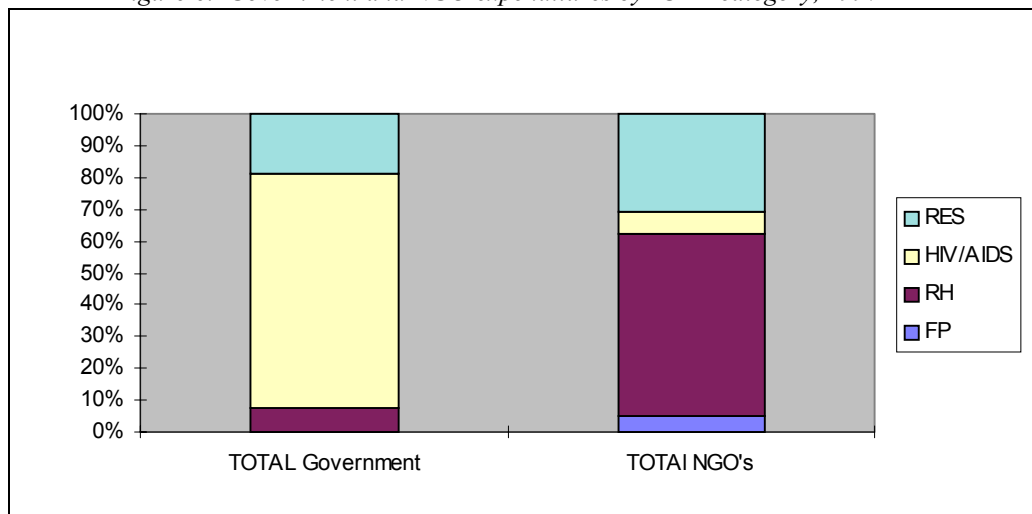
Of the total income of US\$ 4,712,569 for fiscal year 1997, 62 per cent was from international sources and nine per cent from national sources. A significant amount (29 per cent) consisted of self-generated income. This was many due to the PPASA, which generated 42 per cent of its income, mostly contract income from the South African Department of Health for the implementation of projects.

Figure 5. Sources of income of national NGOs, South Africa, 1997 (US\$)



Source: RF 1997 Domestic database

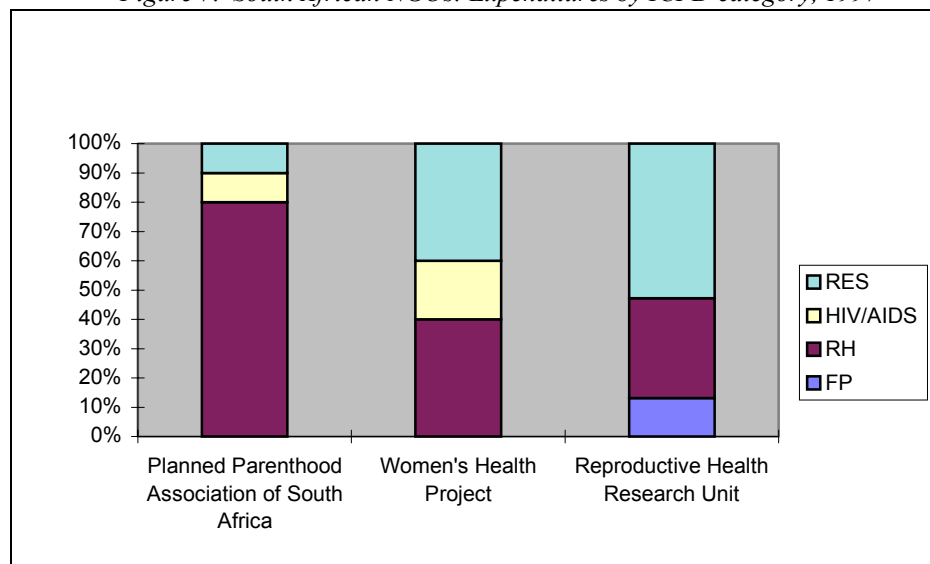
Figure 6. Government and NGO expenditures by ICPD category, 1997



When we compare the total expenditure made by government departments and NGOs respectively (figure 6), it becomes evident that, in financial terms, the emphasis of government involvement is on HIV/AIDS prevention while the NGOs are active in reproductive health activities and research. However, it should be noted that the government contracts out activities in the field of family planning and IEC projects, e.g. through the PPASA. Although only two per cent of the total national expenditures made in the field of population activities goes via national NGOs, their activities do supplement the government.

In figure 7 the total expenditure for FY 1997 of the three major South African NGOs working in the field of reproductive health are shown.

Figure 7. South African NGOs: Expenditures by ICPD category, 1997



Source: RF 1997 Domestic database

The figure shows that the emphasis of activities differs among the three most important NGOs active in the field of reproductive health.

### **Planned Parenthood Association of South Africa (PPASA)**

The PPASA aims at promoting cost-effective sexual and reproductive health services for disadvantaged communities. The pilot projects are intended to be duplicated by government if successful. PPASA main programmes include:

- CBD social marketing of contraceptives;
- Reproductive health education;
- Reproductive health services for adolescents ;
- Life skills and sexuality training for teachers, parents and women;
- Promoting the involvement of men in reproductive health;
- Advocacy and lobbying.

The PPASA receives financial support from international donors as well as from local sources. The success of PPASA is reflected in the increasing income which grew from US\$ 416,000 (Rand 2.3 million) in 1994 to US\$ 1,355,375 (Rand 7,5 million) in 1996. In 1997 total income from all sources amounted to US\$ 2.6 million (PPASA, 1998). This includes donations, contract income and other self-generated income.

In 1996 PPASA received a total of US\$ 891,469 (Rand 4,938,889) in donations which increased to US\$ 1.5 million (Rand 8,360,176) in 1997. The main international donors are DFID (slightly over half a million US\$ in 1997), UNFPA (US\$ 343,000 in 1997), IPPF (US\$ 180,000) and NORAD (US\$ 100,000). National sources of funding include the South African government (US\$ 36,000 from the Department of Health), private donors and corporate social investment programmes (US\$ 270,000 in 1997).

### **Women's Health Project**

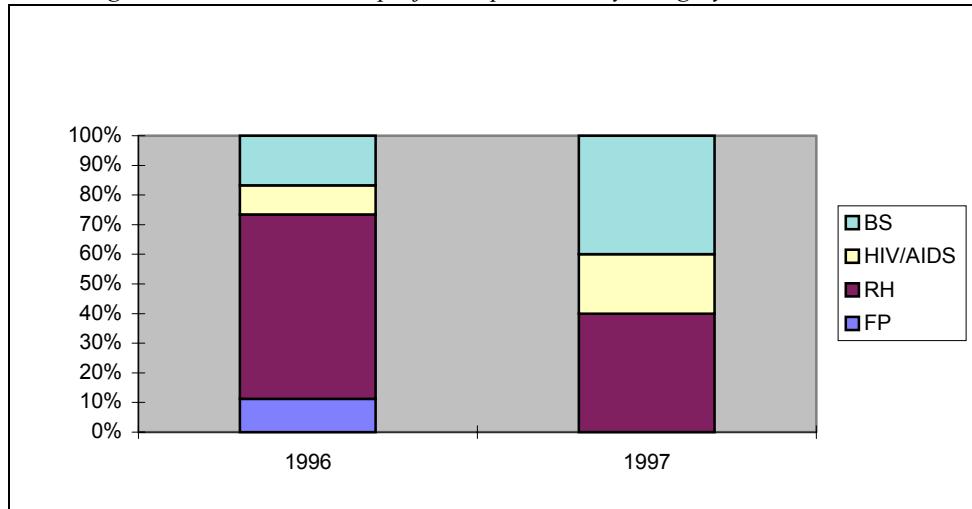
The Women's Health Project (WHP) is an independently funded national NGO based in the Department of Community Health of the University of the Witwatersrand in Johannesburg. The WHP started in 1991, has a multidisciplinary staff with backgrounds in medicine, policy, social sciences, management and administration. The WHP is mainly involved in research on reproductive health and policy, strengthening public reproductive health services, development of educational materials, IEC, training, consultancy, advocacy and international networking.

In implementing its activities the WHP collaborates with the Department of Health, South African and international groups working in reproductive health. Several of the issues currently addressed by the WHP are:

- maternal mortality and women health;
- abortion;
- cervical cancer and screening;
- STD's, HIV/AIDS;
- health systems management and implementation;
- improvement of health services;
- population policy.

Total expenditures of the WHP in 1996 were US\$ 421,591 and increased to US\$ 715,742 in 1997. The division of total expenditures over the four ICPD categories is shown in figure 8. Most work is done in the field of reproductive health and basic research, with relatively lesser attention to HIV/AIDS and family planning.

Figure 8. Women's Health project, expenditure by category, FY96 and FY97

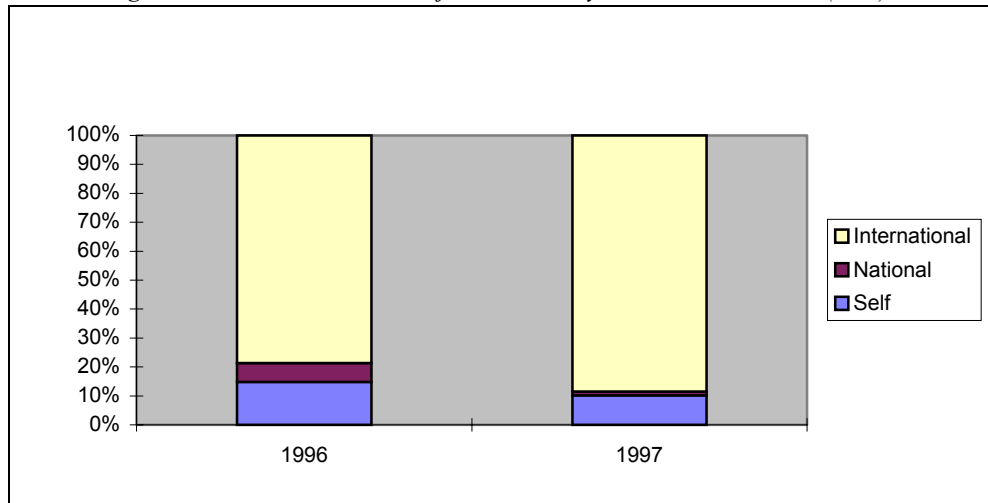


Source: RF 1996 and RF 1997 domestic database

The WHP received most funding from international donors, e.g. UNFPA, the Carnegie Corporation, WHO, DFID, Oxfam (UK), Terre des Hommes (Switzerland) and ICCO (Netherlands). Some South African NGOs support WHP work, but no income came from government sources.

Figure 9 shows the WHP sources of income in 1996 and 1997.

Figure 9. Women's Health Project, income by source, 1996, 1997 (US\$)



Source: RF 1996 and RF 1997 domestic database

### Reproductive Health Research Unit (RHRU)

The Reproductive Health Research Unit (RHRU) is based at the Chris Hani Baragwanath Hospital in Soweto, Johannesburg, the largest hospital in the world. It is a joint project of the Department of Obstetrics and Gynaecology, Chris Hani Baragwanath Hospital and the University of Witwatersrand and the Greater Johannesburg Metropolitan Council. The RHRU activities cover four areas, i.e. research, clinical, training and policy and advocacy. It currently has projects in e.g. Soweto, Johannesburg and the squatter settlement Orange Farm.

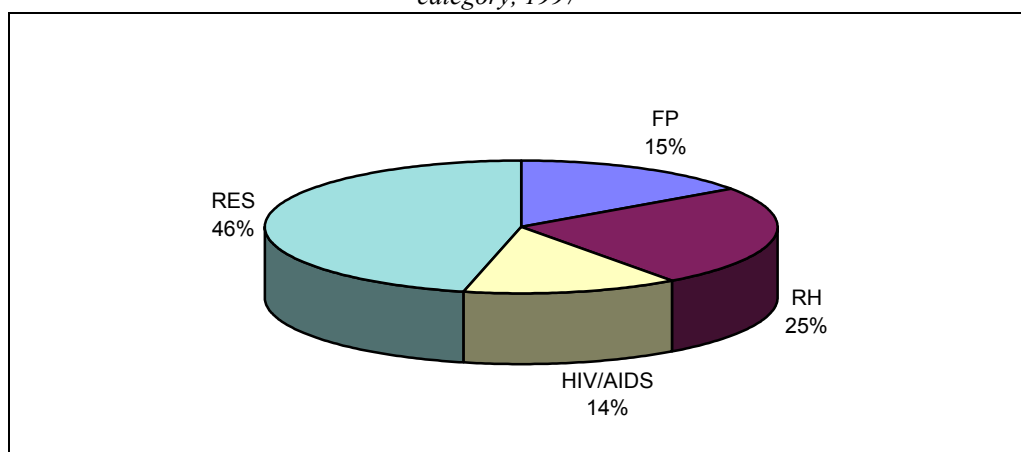
The objectives of the RHRU are to undertake reproductive health research impacting on policy, develop alternative models for reproductive health service delivery, provide technical expertise, train health personnel in reproductive health issues and develop national and international linkages in reproductive health research.

The RHRU gets most of its funding from international sources. In 1997 the main donors were the British DFID, UNFPA, WHO, UNAIDS, IPPF and the Kaiser Family Foundation. National funding sources represented a mere five per cent of total resources available.

Figure 10 displays the expenditures in 1997 by category. While research claimed almost half of RHRU resources, with less spent on reproductive health, family planning and HIV/AIDS activities.

It should be noted here that apportioning RHRU expenditures over the four ICPD categories is rather difficult as their several projects fall within different categories. For instance, the 'Reproductive Health Education Package' or the 'Reproductive Health Research Methods Course' include RH and HIV/AIDS elements. The distribution in the figure above is therefore tentative. For clarity, RHRU projects and programmes are listed below (table 9).

Figure 10. Reproductive Health Research Unit: expenditures by ICPD category, 1997



Source: RF 1997 domestic database

Table 9: Reproductive Health Research Unit: projects, 1997

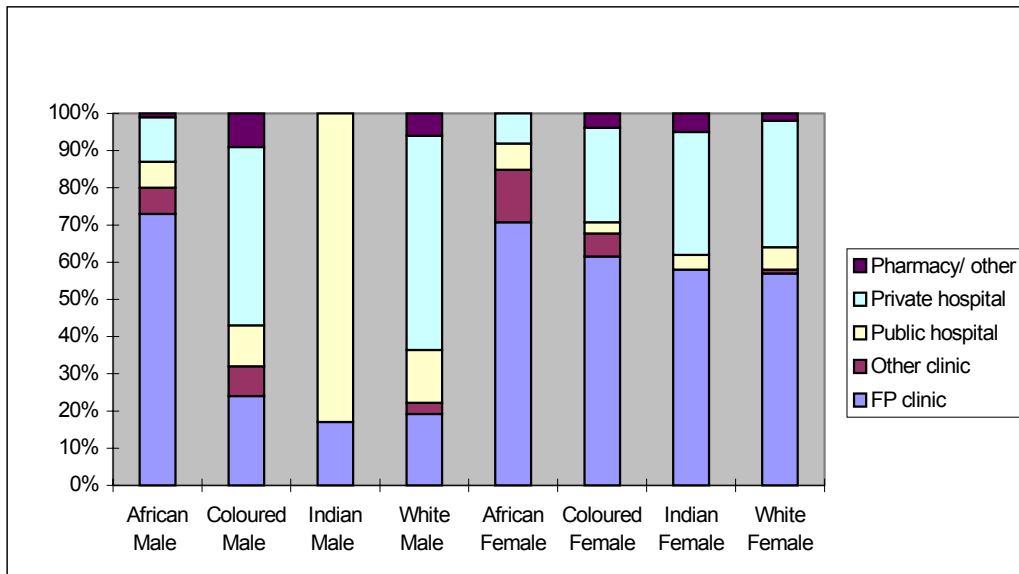
	Total expenditure Rands
Maternal mortality study	450.000
Expanding contraceptive choice	420.000
Microbicide study	400.000
RH research methods course	200.000
Female condom study	300.000
Termination pregnancy meetings	100.000
Male programme	100.000
RH education package	240.000
RH materials package	157.000
<b>Total</b>	<b>2.367.000</b>

#### 4.4 | Role of Private Sector

Measuring the contribution of South Africa's private sector to reproductive health is difficult, due to problems of categorization and inadequate budget lines. The private sector does have a large role to play, be it in funding NGO projects in reproductive health and through the delivery of services.

A survey in 1993 (McIntyre *et al.*, 1995, p. 21) found that over half of the general health expenditure from private sources is funded from medical schemes for private sector employees, followed by out-of-pocket payments (23 per cent) and medical schemes for civil servants (14 per cent). The UNFPA has estimated that the private sector took up two thirds of all spending on health in 1995. There is a wide discrepancy between expenditure on health between the private and public sector. Medical schemes spent fifteen times more per patient than the government spends on a person using public health services, while only 17 per cent of the population belongs to medical schemes (UNFPA PRSD, 1998).

Figure 11. Source of contraceptive advice by gender and ethnic group



Source: CASE survey, 1995

The National Household Survey of Health Inequalities, prepared by the Community Agency for Social Security (CASE) and conducted in 1994, indicated that most Africans rely on the public health service (82 per cent in rural areas and 68 per cent in urban areas), while the large majority of whites and Indians rely on private health care. Coloureds make use of public (45 per cent) and private (55 per cent) health care, almost to the same degree in urban and rural areas (Hirschowitz *et al.*, 1995).

As to family planning, when seeking advice on contraception, the majority tend to go to family planning clinics. Whites and coloured make more use of private doctors and pharmacies (Figure 11).



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## 5. Concluding remarks

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### 5.1 | ICPD and the South African population programme

The change from the *apartheid* government to the Government of National Unity (GNU) coinciding with the process of ICPD forms a watershed for South Africa's population policy. Population issues are now increasingly incorporated into the South African government's development policies, the guidelines of which are formulated in the 1998 Population Policy. Keywords are now sustainable development, equity, integration, community driven development, multi-sectoral involvement of civil society and health services for all.

The government of South Africa is implementing a policy of integration and decentralization of health services, and is committed to health sector reform. The restructuring of the administrative and health systems has made the tracking of resource flows for population and reproductive health a complex task.

### 5.2 | Implications for data collection on resource flows

Due to problems of measurement as a result of the current situation in South Africa, the data presented here should not be treated as absolute but rather as indicative of the current trends in spending on population and reproductive health.

A number of points in connection with tracking resource flows for population activities should be mentioned here:

- the central government expenditure is undergoing decentralization, with a shift of planning, implementation and management for health services devolved to the nine provinces under the federal state structure;
- some government departments cannot disaggregate their financial data so as to identify population budget lines;
- Under the Medium Term Expenditure Framework system there are sectoral task teams, but these only use broad aggregate categories (health, education, welfare *et cetera*). Therefore, exact breakdowns to RH categories are not possible;

- Some relevant government resource flows for population activities are allocated through sectoral departmental budgets other than the Departments of Health or Welfare and are thus difficult to identify (e.g. the Department of Water Affairs involvement in the Working for Water Programme, which includes a population component);
- the category codes at national and provincial level are not always compatible with reproductive health categories used in by the Resource Flows project; the same is true for information on medical schemes;
- at district level there is no reliable information on how much is spent and on what activities;
- local level budgets such as those of the metropolitan councils consist of resources from higher administrative levels (provincial, national) and from own revenue (local taxes), so data are needed from different administrative levels;
- government funds for co-operative projects of metropolitan councils and NGOs go from the province through the local metropolitan councils to the NGOs, there is no direct provincial funding to NGOs;
- new initiatives are taken, e.g. the traffic police department who visit schools for training on traffic rules are requested to provide IEC on sex education as well. Such integrated initiative obviously complicates tracking resource flows.

Considering the fact that budget lines and expenditure categories vary between administrative levels and between provinces and a new financial information system is still not in place, developing a system with standardized definitions, categories and budget lines would greatly benefit the planning, budgeting and monitoring process of the health sector (Valentine, 1998).

At present, because the four ICPD categories of population activities are not used consistently, if at all, information on expenditures on these activities can only be gleaned from other sources to arrive at rough estimates. Existing public sources providing a basis for estimates are for instance Budget Reviews, Auditor General Reports, the Medium Term Expenditure Framework and the Provincial Expenditure and Revenue Reports. Private sector sources are for example the Registrar of Medical Schemes Report and the Reserve Bank national income consumption estimates (Valentine, 1998). These sources however all have their own idiosyncrasies, refer to different years and are not always compatible.

**What is the way forward?**

Next to continuing collecting information through mail enquiries to the main NGOs and Government Departments involved in Reproductive Health we need to collect information on:

- budgets and expenditures on the provincial level;
- national allocations to provinces;
- where possible, estimates of local government expenditures;
- private spending and users fees;
- medical schemes;
- corporate sector programmes.

The collection of a broader range of data at different administrative levels would require more inputs in terms of time and personnel. In the future the local consultant responsible for collecting the data could maybe work with a small team of data collectors on the provincial level. Such a team could consist of university researchers and/or civil servants at provincial level. Even if this implies a greater data collection effort and costs, the use of these additional sources is necessary if we aim at measuring resource flows for population activities more accurately.



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## Annex I. Persons contacted

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Mr. Achmet Dangor	Health Consultant for UNFPA, Pretoria

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Ernst Spaan and Steve McGarry were observers.