

Project Identification Document

(PID)

for

Equity in Integrated Primary Health Care

"The *EQUITY* Project"

Project Number 674-0320

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ACRONYMS

| | |
|---------|--|
| AIDS | Acquired Immuno-Deficiency Syndrome |
| ARC | Agricultural Research Council |
| BASICS | Basic Institutional Strengthening for Child Survival |
| CHC | Community Health Committees |
| CHW | Community Health Worker |
| CPSP | Country Program Strategy Plan |
| CS | Child Survival |
| CSIR | Council on Science and Industrial Research |
| CSM | Condom Social Marketing |
| DFA | Development Fund for Africa |
| DHA | District Health Authorities |
| DHS | Demographic and Health Survey |
| DNHPD | Department of National Health and Population Development |
| DPT | Diphtheria, Pertussis, Tetanus |
| EU | European Union |
| ENHR | Essential National Health Research |
| EPI | Extended Program of Immunization |
| EQUITY | Equitable Integrated Primary Health Services |
| FP | Family Planning |
| FSN | Foreign Service National |
| GDP | Gross Domestic Product |
| GNU | Government of National Unity |
| HDD | Health Development Division (USAID/SA) |
| HIV | Human Immuno-deficiency Virus |
| HIS | Health Information System |
| HMIS | Health Management Information System |
| HSRC | Human Sciences Research Council |
| HST | Health Systems Trust |
| IEC | Information, Education and Communication |
| IEE | Initial Environmental Examination |
| IET | Information, Education and Training |
| IMR | Infant Mortality Rate |
| IPPF | International Planned Parenthood Federation |
| MCH | Mother and Child Health |
| MEC | Member of Executive Committee |
| MEDUNSA | Medical University of South Africa |
| MER | Monitoring and Evaluation Review |
| MMR | Maternal Mortality Rate |
| MOH | Ministry of Health |
| MRC | Medical Research Council |
| NACOSA | National AIDS Council of South Africa |
| NHS | National Health System |
| NGO | Non-Governmental Organization |
| ODA | Overseas Development Administration |
| OR | Operations Research |

ACRONYMS

| | |
|-----------|--|
| ORS | Oral Rehydration Salts |
| ORT | Oral Rehydration Therapy |
| OSD | Office of Social Development |
| PID | Project Identification Document |
| PHC | Primary Health Care |
| PP | Project Paper |
| PSC | Personal Services Contract |
| RDP | Reconstruction and Development Program |
| REDSO/ESA | Regional Economic Development Services Office for East and Southern Africa |
| RH | Reproductive Health |
| RSA | Republic of South Africa |
| SAG | South African Government |
| SMT | Strategic Management Team |
| STDs | Sexually-Transmitted Diseases |
| TA | Technical Assistance |
| TB | Tuberculosis |
| UCT | University of Cape Town |
| UNDP | United Nations Development Program |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| USAID/SA | USAID Mission to South Africa |
| USAID/W | USAID Washington |
| WHO | World Health Organization |

I. EXECUTIVE SUMMARY

The Equity in Integrated Primary Health Care Project (the EQUITY Project) is a proposed seven year, \$50 million assistance effort that will facilitate the South African Government's (SAG's) efforts to resolve what may be its largest public health challenge. The formidable task is to provide integrated primary health services to all South Africans by rectifying the inequities in the provision of health services brought about and supported by apartheid.

Problems related to child survival, reproductive health, STDs/HIV/AIDS, and tuberculosis (TB), frequently addressed through primary health care, are as serious for the underserved population in South Africa as for the populations in other sub-Saharan countries.

The underlying problem is a highly fragmented, uncoordinated, and inefficient health system that has historically placed strong emphasis on high-technology curative care, and relatively little attention to serving the African population in the rural areas and the townships. The need is to restructure, strengthen coordination, and increase the efficiency and effectiveness of the public-sector delivery system. It is only through success in these efforts that the SAG can bring about equity and access to services for the majority of the population -- a population that is largely black African, often rural, with particularly vulnerable sub-groups, including women of reproductive age, children, and adolescents.

The EQUITY Project will support the SAG's efforts to restructure the health system to be more efficient and effective, and better able to provide essential, equitable, quality health services to the entire population, particularly those currently underserved. The EQUITY Project will provide support to make the restructured system operational in a focus province. Concurrently, it will assist central and provincial administrations in utilizing the lessons learned in the focus province to replicate the system nationwide. The project will also build the capacity of MOH headquarters to plan and implement the program of integrated primary health care services nationwide.

In assisting the SAG to operationalize the restructured system down to the community level, the project will strive to achieve six major outputs over a seven-year period: (1) increase access to a package of essential, integrated primary health care services in the focus province; (2) develop an effective referral system in the focus province to maximize access to needed health care services; (3) enhance public-sector capacity to manage an integrated primary health care program down to the community level; (4) improve the efficiency and effectiveness of PHC service delivery in the focus province; (5) institutionalize the capacity for effective PHC training at all levels; and (6) improve the information base for decision making, program development and management.

II. PROGRAM FACTORS

A. Conformity with South African Government (SAG) Programs

The new Government of National Unity (GNU) has inherited a sophisticated health care delivery system that devotes 75% of the national health care budget to a tertiary health care system effectively serving less than 20% of the population. In view of the current environment of fiscal constraints and unlikely budget increases, Ministry of Health policy emphasizes restructuring of the health system in order to extend health care services to the majority of the population disadvantaged under apartheid. This may involve increased efficiency and/or reduction of services at the tertiary level. This will allow for the reallocation of resources to develop and expand integrated primary health care, and to improve preventative and promotive health care which will enhance health care services to under-served populations in townships, former homelands and rural areas.

GNU health policy is evolving rapidly as new leaders from the previously disenfranchised majority take the reins of administration. The most current policy formulation in the health sector is "Health Priorities of the Reconstruction and Development Program" (October 1994), which lists 23 priority areas (see section III.A for the listing). Extensive dialogue between the Ministry of Health and USAID has resulted in identification of the highest priority areas and the degree of their overlap with USAID priorities and capabilities. These areas are the restructuring of the national health administration, the development of new provincial health structures, and the expansion of maternal and child health services through improved primary health care facilities.

The EQUITY PID has been reviewed by the Special Adviser to the Minister of Health who confirms the MOH's support for the project. Furthermore, the Special Adviser has discussed details of the PID with officials of the RDP office (a section of the President's office), who also support the project.

B. Relationship to USAID Guidelines and Mission Strategy

The EQUITY Project is being initiated as a response to the United States Government's commitment to support GNU efforts to restructure a health system distorted by apartheid and extend services to the disadvantaged majority. The GNU priorities and USAID's experience overlap substantially in a number of areas. USAID's recently revised strategic objectives in Population, Health and Nutrition are to:

- reduce high levels of infant and child mortality;
- address the unmet need for contraception;
- respond to the needs of women and adolescents for reproductive health care and ensure reproductive choice; and
- devote resources to combatting STDs/HIV/AIDS and tuberculosis (TB).

All of the preceding are major health problems in South Africa.

USAID/South Africa's current post-elections development strategy is "to increase the majority population's political, economic and social empowerment." A key Mission priority is to assist the new democratic government to restructure and unify racially-based apartheid institutions to achieve equity in the provision of services and distribution of resources.

Based on a comprehensive review of recent South African health sector assessments, other studies and reports, USAID/South Africa and the Ministry of Health of the GNU concluded that service provision or focussed technical assistance in areas such as child survival, reproductive health, or HIV/AIDS, without major attention to organization and management of the delivery system, would result in ineffective or unsustainable health care. Therefore the Mission decided to support the GNU's efforts to restructure and unify national and provincial administrations, and develop an integrated primary health care system.

In the coming months the Mission will finalize a new Country Program Strategy Plan (CPSP). Development of this project will parallel the development of the CPSP in many respects, ensuring that the project paper fully addresses health sector strategy/CPSP issues. The analytical process for the development of this project will, in fact, mirror the methodology for development of CPSP health sectoral analysis (the CPSP is scheduled for submission to USAID/W in August of 1995). In both cases, basic work to be carried out will include: (i) analysis of the health sector's situation/status as well as the host country's sectoral objectives and policies, (ii) analysis of host country and other donors' activities, and (iii) implications for USAID sector strategy. It is also anticipated that this health project and the sector strategy will coincide in focus and time frame. The EQUITY Project will be USAID's primary health intervention and the centerpiece of the strategy. Further, this project is envisaged to have a seven year timeframe, due to its institutional restructuring focus, so there will be a close match with the duration of the strategic plan.

The analytical process for both the CPSP and this project has already begun. As noted above, a thorough review of health sector assessments, funded by other donors and South African organizations, has been carried out by the PID design team (see the reference section of this PID). This literature review and interviews with health sector stakeholders identified problems, discussed later in this document, and enabled the design team to formulate a range of potential project-funded interventions, for which USAID has experience and a competitive advantage, needed to address key health sector constraints. Next, the design team met with senior Ministry of Health officials and discussed SAG priorities and health sector objectives. This analytical process focussed on SAG priorities included in the Reconstruction and Development Program (RDP). These discussions resulted in the matching of RDP priorities and opportunities for USAID assistance which form the analytical base for this PID (see Section III.A).

In a separate Monitoring, Evaluation and Reporting (MER) exercise, the project purpose

and performance indicators were reviewed for consistency with the Mission's program performance plan and future APIs. Although project objectives will be further developed during the design of the project paper, it is believed that performance indicators included in this PID are appropriate for measurement and results reporting. A further assessment of project objectives and potential outputs indicated that attainment of desired results is in the Mission's manageable interest. At this early stage in CPSP development, it appears that the project purpose proposed in this PID can be achieved within Mission funding and staffing constraints, and therefore, represents a viable program outcome or strategic objective, depending on how the CPSP objective tree evolves.

The basic concept of the EQUITY Project is included in USAID/SA's July 1994 Action Plan. As the project paper and CPSP are developed, USAID's role in assisting the health sector will be more clearly defined. However, it is already clear that the EQUITY Project responds to the GNU's and USAID's high priorities for primary health care, HIV/AIDS, population planning, and maternal and child care. Thus there is a clear rationale for the further development and implementation of the EQUITY Project.

C. Other Donors

With the exception of a comprehensive family planning program, the apartheid government provided poor basic services to the disenfranchised majority. As a result, the burden for the provision of health care services fell heavily on local and national private organizations. Community organizations, churches, and corporations have raised funds to support local health care facilities, on a level of magnitude that is unique in the developing world. Such private support channeled through non-government organizations is strongest in urban townships, and weakest in rural areas and former homelands. The Independent Development Trust, a parastatal foundation, has funded the building or upgrading of about 300 clinics and the procurement of medical equipment.

During the apartheid era, virtually no international or bilateral donor agencies supported health programs in South Africa. Since 1992, the majority of current activities are in the form of program planning and research rather than active interventions. The Kaiser Family Foundation is supporting an excellent program of research focusing on health systems management and primary health care, and is preparing to conduct a nationwide survey on access to health care. The initial work of UNICEF and WHO has concentrated largely on agreements and protocols, and their programs probably will focus respectively on children and women, and primary health care. The European Union (EU), one of the largest potential donors in the sector, is developing support for a large-scale program of training for district primary health care workers, and is equally interested in the areas of family planning and reproductive health, and STDs/HIV/AIDS. British ODA is also working with the SAG to develop an overall management strategy for the health sector, and plans to begin work in early 1995. The Japanese Government is planning to provide health care buildings and medical equipment in three provinces. Other governments will be providing funding on a much smaller scale, probably concentrating on the government priority of primary health care. Since most of these activities are in the planning stages, it will be necessary to actively exchange information with other major donors during the

conduct of project feasibility studies. Of the donor organizations identified above, the most important for collaboration are the Kaiser Family Foundation, the EU, and ODA. Preliminary discussions have already taken place, and coordination will continue to ensure that available resources will be used effectively in meeting South Africa's health needs.

III. PROJECT DESCRIPTION

A. Perceived Problem

1. Introduction

The major public health challenge for South Africa is to provide basic health care to all South Africans, and, at the same time, rectify the inequities in the provision of health services brought about or supported by apartheid. In order to respond to this problem, the MOH has identified 23 priority areas (sub-problem areas) within the RDP, upon which the SAG will focus, and upon which it is asking donors and NGOs to focus as well. USAID has interviewed other international donors, representatives of foundations and NGOs, reviewed reports of health assessments and analyses, and commissioned a study to review and accumulate all recent studies and reports on the health sector. Additionally, extensive consultations with the MOH served to articulate health sector priorities in relation of the GNU to USAID's strengths and comparative advantage in supporting health systems development. Based on conclusions from these interviews and reviews, the priority areas to which USAID will be able to most effectively contribute were identified.

Although the priority areas presented in the table have been grouped by the MOH into six sub-groups, all of the areas fall loosely within the general area of restructuring issues/problems or specific health issues/problems. Priority areas where USAID assistance might impact fall into both general areas. However, as will be seen in following sections, USAID's impact in all of the 16 priority areas will come about through a partnership with the SAG in assisting to restructure the health system. Following is the RDP list of priority areas, with a second column that indicates those areas where the proposed project may have an impact (see following discussions in Sections III.B and III.C, and the complete RDP health priorities document in Annex D).

TABLE 1

RDP Priority Areas for Addressing the Problem of Basic Health Services and Inequities in Service Delivery

| Priority Problem Area | Opportunities for USAID Project Assistance |
|---|---|
| Restructuring and Shifting of Resources | |
| 1. Fragmentation | Directly Assist |
| 2. Community Participation | Directly Assist |
| 3. Rural Health Services | Directly Assist |
| 4. Curative Emphasis | Directly Assist |
| 5. Human Resource Development | Directly Assist |
| 6. Traditional Healers | Directly Assist |
| 7. Emergency Health Services | Will Not Assist |
| Nutrition | |
| 8. Undernutrition | Lesser Extent Assist |
| Maternal and Child Health | |
| 9. Preventive and Promotive Services for Children | Directly Assist |
| 10. Reproductive Health | Directly Assist |
| 11. Reproductive Rights | Lesser Extent Assist |
| Specific Diseases and Conditions | |
| 12. Sexually Transmitted Diseases and HIV/AIDS | Directly Assist |
| 13. Chronic Diseases (TB only) | Lesser Extent Assist |
| 14. Care for the Aged | Will Not Assist |
| 15. Disability | Will Not Assist |
| 16. Mental Health | Will Not Assist |
| 17. Substance Abuse (Adolescent emphasis) | Lesser Extent Assist |
| 18. Occupational Health | Will Not Assist |
| 19. Adolescent Health | Directly Assist |
| Drug and Technology Policies | |
| 20. Drug Policy | Will Not Assist |
| 21. Technology Policy | Will Not Assist |
| Information and Research | |
| 22. Health Information Systems | Lesser Extent Assist |
| 23. Health Research | Directly Assist |

2. Specific Problems and Constraints

In order to highlight the nature of the RDP priority areas, primary health care problems associated with child survival, reproductive health, and STD/HIV/AIDS are briefly reviewed below; and then the over-arching problem of restructuring and shifting resources to enable the SAG to respond to the basic health problem of equity is discussed. While the ultimate impact of the project will be to assist SAG in better service delivery of integrated primary health services and better health for the historically under-served populations, SAG can only achieve this by successfully restructuring and developing an efficient and effective health delivery system.

Child Survival, Reproductive Health, and STD/HIV/AIDS - Health Problems

Child Survival

The infant mortality rate (IMR) among African children reflects the inequities of the past health system and the scarcity or absence of basic health services, as do the other indicators of health that follow. The IMR rate among African children is nearly 10 times higher than that of white children. The life expectancy of African and colored children at birth is 10 years less than that of white children. In 1986 the major causes of child mortality were intestinal infection (particularly diarrhoeal disease), acute respiratory infection and nutritional disease. These were responsible for well over one quarter of infant deaths among African and colored people. While diarrhoeal disease is the major cause of death among 1-4 year old African and colored children, only 4% of white children in this age category die from it. Tuberculosis is a major cause of death and disease. In 1990, 74,283 cases of tuberculosis were identified, and of these, African and colored children accounted for 98%. As with many other countries, early weaning of babies and low birth weight are both identified child survival problems. While breast feeding is sustained for longer periods in rural areas, the duration of breast-feeding is declining.

Reproductive Health and Family Planning

The quality and effectiveness of reproductive health services vary, but most importantly, they often fail to provide health care in a sensitive, supportive, and caring manner. The most common causes of maternal mortality are sepsis, hypertension and hemorrhage. The contribution of complications from illegal abortions and obstructed labor to the maternal mortality rate (MMR) is unknown, but the evidence indicates that illegal abortions are a significant contributor.

Between 31% and 66% of women in rural areas give birth at home. The main reasons cited for home births relate to inaccessibility of services and lack of transport. The most commonly used types of contraception among African women are injectable contraceptives (35%) and the pill (12%). There remains, among some groups, a belief that family planning was used by previous governments to impede growth of black

populations while there was a pronatalist orientation towards the white population, and therefore family planning still may have strong negative connotations for some groups.

Two of the main contributors of morbidity and mortality among adolescents are pregnancy and sexually transmitted diseases, yet health programs specifically targeting the youth are virtually non-existent.

While family planning has been a sensitive issue in the past, the SAG now has the opportunity to develop effective maternal and child health care services -- as part of the PHC service package -- that will meet the needs of clients to space and/or limit births so that the family's quality of life will improve. The benefits of family planning are clear. For example, spacing births at least two years apart will improve the health of both the mother and the child; and a smaller family size typically means that children will attain higher levels of education, and in turn will be more productive members of society. These and other positive outcomes indicate the importance of family planning in achieving both family and national objectives.

STD/HIV/AIDS

South Africa has recognized that it has a potentially serious problem because of the extent to which STDs/HIV/AIDS has taken hold. Recent estimates indicate that the number of HIV infected people doubles every 8 months, and that 550 people are infected with the virus every day. The highest incidence is among the 20-24 year age group. Projections indicate that between 18% and 24% of the adult population will be HIV infected; that the cumulative death toll will be 2.3 million; and that there will be about 1.5 million AIDS orphans. The STD surveillance system in the country is totally inadequate. A township based study found that 20% of adolescents over 15 years old are treated at least once annually for an STD, and 10-15% of women attending family planning clinics have STD infections.

Restructuring - the Health System Delivery Problems

In view of the significance of the health problems just identified, and the fact that the current health care delivery system cannot respond adequately to these problems, the SAG has developed the "Plan for Reconstruction and Development." It is the reconstruction of the health system, herein frequently referred to as "restructuring" or "responding to the problem of fragmentation," to which the SAG is giving priority.

Historically, South African public health services have been arranged in three tiers. The national structure was the Department of National Health and Population Development (DNHPD). (The Population Development element has already been transferred to the Ministry of Welfare and Population Development, and the health component is now called the Department of Health.) Its budget funded its own administrative and executive services as well as the three "Own Affairs" departments for each of the disadvantaged groups (African, Indian and Colored) and the ten former "homelands." Consequently, there are now 14 Departments of Health. The second tier was comprised of the four

provincial health departments that are funded directly from the central treasury. The third tier consisted of 800 local authorities that are responsible for providing primary, preventive, and some curative care. At the health program level there are several vertical programs such as TB, family planning, nutrition and dental services. Preventive, rehabilitative and curative services are provided separately and have received their funding from different health authorities. Communication between the various tiers and within the tiers was generally poor, rendering the services structurally, functionally, and politically fragmented. In addition, there is a sharp division between the public and private services, with both working simultaneously but not in coordination.

The health care delivery system is currently undergoing a major restructuring, to respond to a variety of identified problems. In addition to the fragmented organization of the health system, the RDP outlines a number of MOH organizational constraints and restructuring problems: communities are seldom involved in the planning, managing, delivering, monitoring, and evaluation of health services; at the understaffed rural clinics personnel are often poorly trained and lack skills to manage the services; due to the inadequacies of local primary health care facilities, patients travel long distances and inundate overcrowded hospitals; the training of doctors and nurses has a clear curative, hospital-based bias; the reorientation and restructuring of the health system will require a new understanding and skills in PHC at all levels of the health delivery system; there is clearly a need for implementation of programs aimed at PHC reorientation and management training; and cultural aspects of popular and folk healing methods have been ignored by the South African biomedical-biased health care system. Yet, traditional cultural beliefs and practices are widely held among rural and urban South Africans, alongside the increasing acceptance of modern medicine practices.

As indicated earlier, health service data are collected in many different forms by a variety of health service providers. The data are often not analyzed and hence not used to evaluate the health services in terms of equity, effectiveness, and efficiency. Similarly, no feedback is provided to providers and managers at different levels so that they can be made aware of both performance and problems, and thus have information on which to base corrective actions.

Further, the priorities for health research have not contributed to reducing a fragmented health system. Generally health research priorities have been left to the discretion of individual researchers and their interests. These priorities have largely been disease-related and not aimed at national policy formulation or health services reform.

The GNU has indicated that there will be no proportional increase in funding available to the public health sector. Thus, the SAG and its development partners must work to shift resources within the sector to provide additional resources for PHC. This becomes one of the principal challenges in achieving RDP objectives in health.

3. Summary

The RDP presents a broad agenda for improving basic health services and redressing the

inequities of service delivery within the current South African health system. Through close scrutiny of these areas and discussions with representatives of the SAG, USAID/South Africa has identified areas where project resources can provide significant impact in assisting South Africa's efforts to bring about an equitable, integrated system of basic health services needed to address the health problems noted above. The major project emphasis will be on assisting the SAG to develop an effective delivery system for providing these services. The project goal, purpose and outputs that will guide the project and reflect success, are discussed in the following sections.

B. Project Goal and Purpose

1. The project goal is to achieve equitable access to quality health care for all South Africans.
2. The project purpose is to support the development of a system for the provision of integrated primary health care services to under-served populations.

C. Expected Achievements

1. Introduction

As discussed in Section III.A., the fragmentation of the system under apartheid resulted not only in inequitable access to health care but also to tremendous inefficiencies in the health system. Large segments of the population, in particular the rural African population and those in squatter settlements, often lack the most basic services, due to a lack of adequate facilities and trained staff. Where services are available, they are often of a lesser standard than those available to other segments of the population.

The SAG has recently embarked on a program to consolidate the present fragmented health system into a unified system from national to community level. At the same time, the health care system has to deal with the very real implications resulting from the SAG's decision to expand the provincial structure from four to nine provinces. In addition, the Department of Health has made the decision to stress the district level as the focus of its efforts to improve access to PHC services. Taking these factors into account, the restructuring program will place a much greater emphasis on preventive and promotive health care, rationalize the delivery of curative health care to make it more cost-efficient, decentralize the new restructured health system to bring about greater involvement of communities in determining their health care needs, and make a reasonable standard of health care available to all South Africans, in particular to those residing in the rural areas and squatter settlements and those most at risk -- women, children, and adolescents.

2. Project Approach

South Africa offers unique challenges for provision of USAID support in the health

sector. The health care system ranges from being able to support heart transplants to **not** being able to reduce high levels of infant and maternal mortality for some population groups. There are also a number of capabilities that need to be developed in order for South Africa to bring about the unified, equitable and cost-efficient health system that is envisioned. The recently released draft of "The Health Priorities of the Reconstruction and Development Program" (Annex D) identifies many of these gaps and what needs to be done in each priority area. The EQUITY Project responds to those needs and priorities.

The EQUITY Project will support the SAG's efforts to restructure the health system to become more effective and efficient, and better able to provide essential, equitable health services to the entire population. However, as USAID resources are limited, the project will concentrate its support on those priority areas of the RDP (a) that are not already being supported in a major way by other donors and (b) where USAID has considerable experience and is felt to have a comparative advantage in relation to other development agencies. The project will take a capacity-building and systems development approach. It will assist the SAG to change and strengthen its health system so that quality essential services can be made available to all South Africans, particularly those currently under-served.

Several possible approaches were considered for the scope and implementation strategy of the EQUITY Project. Since USAID's resources for the health sector are limited, it seems clear that if the project were implemented on a national scale, its content would have to be limited to a single "vertical" program, and thus might not achieve a sustainable impact. Similarly, implementing the project in several of the nine provinces doesn't add much to the impact and would be difficult to manage. Thus, of the three options considered, the strategy selected is to work in a "focus province," and ensure that sufficient project and SAG support is available to expand the successes in the focus province to the other provinces over a very short time frame.

The focus project approach has several advantages. More specifically, the project will provide the support needed to make the new system fully operational in a selected province; and assist the SAG, as well as the provincial administrations, in utilizing the lessons learned in this province to replicate the system nationwide. This may involve publications, conferences, workshops, observational travel and staff exchanges. The Project will also build the capacity of the national DOH to plan and implement the program of integrated primary health services nationwide. Furthermore, the focus province approach will make project implementation manageable and provide measurable impact.

The project becomes national in purpose, since the activities undertaken successfully in the focus province are transferred quickly to the other provinces, as appropriate. The SAG can generate the resources to expand effective systems and mechanisms in the other provinces. One important example of the national scope is the high priority for upgraded training for rural health nurses. Thus, the EQUITY Project will begin by assisting the SAG to develop an appropriate national curriculum, will help to coordinate the

development of the training program in the focus province, and will help to ensure that training resources are utilized in the other provinces to implement the training there. While all nine provinces may not have adequate training institutions themselves, a plan will be developed to ensure that training is available at other training institutions.

An essential ingredient to project success in achieving SAG's objectives is to develop a dynamic linkage among the focus province, the national DOH, and the other eight provinces that will reap the benefits of lessons learned. The MOH already has a strategic management team, which includes national and provincial leaders, for restructuring and developing health administration. This is a critical element of the project design, and will include mechanisms to involve all of the provinces in the planning and implementation steps to ensure that project activities and interventions will be relevant and effective in achieving the SAG's objectives. The focus province will be selected based on criteria mutually agreed by the SAG and USAID/SA, and will likely involve all of the provinces in the selection process. Similarly, officials from all of the provinces will be involved frequently in selecting project activities and helping to devise effective ways to implement them. For example, numerous workshops and seminars will be held that focus on various restructuring and system-building strategies, and eventually on how to implement program successes in the other provinces. This dynamic linkage between the DOH, the focus province, and the other provinces will provide a mechanism for ensuring that the provinces, with guidance from the DOH, can adapt and transfer lessons learned quickly. The development of this linkage will ensure that the influence of the EQUITY Project is much broader in its impact on the under-served populations of South Africa than would be the case if all of the lessons learned and successes were limited to only the focus province.

After due consideration, USAID/SA has decided that the EQUITY Project should have a life of seven years. The rationale for this decision is that EQUITY is an institutional development project, and will require a longer period to ensure that project efforts will be sustainable and that the SAG can provide needed continuity when USAID support ends. This decision also acknowledges that the first year of the project (i.e., counting from the time of authorization) will not really be part of the implementation period, since the long-term technical assistance team will not yet be in place to assist with large-scale implementation. A mid-project evaluation will be conducted in the fourth year, to ensure that the project is on track and that necessary mid-course adjustments can be made so that project objectives will be achieved (also see Section III.H).

3. Project Outputs

It is expected that the MOH will have completed its design of the new structure for the national health system by the start of the EQUITY Project. In assisting the SAG to operationalize this new system down to the community level, the project will strive to attain six major outputs over a seven year period. In the focus province, the project will: (a) increase access to a package of essential primary health care services; (b) put in place a functioning referral system to maximize access by all members of the public to basic primary health services, and the range of other available health care services; (c) increase

the effectiveness and efficiency of health care delivery; and (d) institutionalize a capacity for reorienting and training staff, at all levels, in primary health care. In both the focus province and at the central level, the project will (a) enhance the public sector's capacity to manage an integrated primary health care program down to the community level in both the public and private sectors, and (b) improve the information base for decision making, program development and management. The essential package of primary health care services, as defined here, consists of maternal and child health and reproductive health services, and includes special attention to STD/HIV/AIDS and tuberculosis control. While services in all of these areas entail both preventive and curative components, the project will place particular emphasis on the preventive and promotive aspects of the program. It is not expected that the project will support the actual delivery of services and commodities at the clinic level, except as part of research or pilot activities to determine more effective ways to deliver these services.

Output 1: Increased access to an integrated package of PHC services in the focus province.

At present, there is no single structure for delivery of essential primary health care services, and preventive and promotive services for mothers and children are weak. With regard to family planning, the current mixture of options, choice and counselling appear to be idiosyncratic and inadequate, with special services to teenagers and young adults virtually non-existent. It will require unusual sensitivity to nurture confidence within black communities in order to develop a sound population program. There needs to be a renewed focus on women in development and a multi-sectoral approach to reproductive health, family planning, and population programs (Sai, et al., pp. 2-3).

While there are many primary health care sites, they are very unevenly distributed and most still deliver a limited range of PHC services. Few private sector clinics and hospitals provide such services. In almost all cases, the staff at the delivery sites are primarily trained to deliver curative services and have little understanding of or commitment to the delivery of primary health care. The restructuring of the health system is intended to draw the different health authorities, as well as the private sector, into one unified health system at all levels -- central, provincial and district -- and to provide an "integrated" package of PHC services. "Integration" here does not mean that all personnel are trained to deliver all PHC services, but that all delivery sites have the capability to provide this range of services.

The project will support the SAG's efforts to increase the availability of an integrated package of PHC services by:

- providing technical assistance in the development of the administrative structures for provincial and district health authorities in the focus province;
- supporting operations research and pilot schemes for determining the most effective ways to;

- (a) involve the private sector and NGOs in primary health care, and outreach services including the possible development of a social marketing program for certain PHC commodities such as condoms, ORS, and weaning foods;
 - (b) integrate traditional healers into the health system;
 - (c) mobilize community involvement in the health system;
 - (d) improve the quality of rural services, including better access for rural dwellers to PHC as well as secondary services (see section III. C. 2.);
 - (e) make services more available to the under-served population by developing effective ways to deliver services, e.g., reallocate or bring health personnel to under-served areas and develop more effective ways for community based delivery of services; and
 - (f) address the specific informational and service needs of particularly vulnerable groups, such as adolescents.
- supporting the training (including on-the-job training and PHC reorientation) of health care workers, at all levels of the health system, on the essential package of PHC interventions, in the focus province;
 - supporting the development of appropriate IEC materials and programs on reproductive health, STD/HIV/AIDS, TB and other MCH interventions;
 - providing support to ensure that the range of reproductive health services, including all approved contraceptive methods, are readily available at all appropriate service sites;
 - supporting an outreach screening program for TB in both the public and private sectors and the development of standardized treatment protocols.

Output 2: An effective referral system in place in the focus province

South Africa's peripheral hospitals tend to be ill-equipped and poorly staffed, with better health facilities, skills, and technology concentrated in the large city hospitals and the private sector. The unplanned and checkered distribution of front line clinics in the townships and rural areas, the lack of private sector alternatives, and the generally poor hospital service in these areas have caused over-utilization and crowding in the large city hospitals. This results in poorer quality treatment due to the pressure on the staff and facilities and the under-utilization of facilities at the periphery.

With the establishment of a unified health system, the opportunity exists for the establishment of a uniform referral system. Such a system can serve to ensure the most

effective utilization of available facilities and services at all levels. To function properly, however, the services at the periphery must be accessible and perceived to be of satisfactory quality.

The project will assist in the development and implementation of a referral system at primary, secondary and tertiary care levels in the focus province. In accomplishing this the project will support:

- an assessment of the current referral system in the focus province, including how referrals are handled within the private sector;
- observational tours to other countries with successful referral systems to examine how referral systems operate in these countries;
- technical assistance, workshops, and studies leading to the design of a model referral system for the focus province;
- the development of an effective communications network to aid in the operationalization of the referral system;
- research to determine how to most effectively link the private sector into the referral system;
- development and implementation of an IEC program for both health workers and communities about the new referral system and how it is to work; and
- periodic evaluation of the system and modification, as necessary, to develop an effective model for replication in other provinces.

Output 3: An enhanced capacity to manage the integrated primary health care program at central level and in the focus province.

Management training has assumed a position of importance in the health sector in South Africa. There is widespread realization that the managerial skills required - to deal with the planned organizational changes, the integration and devolution of services, a greater emphasis on a PHC approach, an implicit decentralized delivery system with a district focus, and the emphasis on increased efficiency and equity - are seriously lacking. Some progress is being made with two of the country's public health schools developing short courses in health management for senior managers. Much more, however, will be required for the system to be effectively restructured and operationalized.

The project will assist the SAG in enhancing its health management capacity by:

- providing technical assistance to design a management development strategy and assist in managing the process of change within the health system;

- supporting the development of appropriate management courses and programs that can serve to address such areas as managing organizational change, budgeting and financial management, costing and economic analysis;
- supporting the delivery of these courses to senior and mid-level managers, in the focus province and at the central ministry level;
- once evaluated and proven effective, supporting the institutionalization of a capacity to continually update and deliver health management training in appropriate training schools, universities or management institutes.

Output 4: Increased efficiency and effectiveness of PHC service delivery at the provincial level and below.

The SAG is well aware that, owing to the historical development of the health care system and the multiple authorities at national and provincial level (including the former homelands), there are many inefficiencies in the current system. Similarly, there are many opportunities for improved mechanisms and systems that will ensure increased access to integrated PHC services by the underserved population. While some of the major issues will be addressed within approximately the next year as the SAG shifts the responsibility for health service delivery to the provinces and lower levels, many opportunities will remain at the provincial level, and especially at the district level, for improved efficiency and effectiveness. For example, by integrating PHC services, a number of so-called "vertical" programs (e.g., tuberculosis, STDs/HIV/AIDS) will be eliminated; while many of the staff from these vertical programs will continue to be involved in integrated PHC services, the resulting services will operate more efficiently than when they were administered separately. To accomplish increased efficiency and effectiveness the project will:

- Streamline program implementation by integrating previously separate health interventions into an integrated PHC delivery system;
- Assist in rationalizing the use of both physical and human health care resources by devising strategies for reallocating resources previously restricted to serving one population group; and
- Assist in developing a strong and effective service delivery mechanism at the district level, in accordance with SAG priorities.

Output 5: Institutionalized capacity for PHC training

The need for training of service delivery staff at all levels within the province has been discussed in Section C.3.1. To provide for both sustainability and for the expansion of the PHC program throughout South Africa, it will be necessary to institutionalize the capacity

for PHC training in SA institutions. In accomplishing this the project will:

- support in-country as well as overseas training of staff of selected training institutions in PHC curriculum development, training of trainers, training evaluation, the preparation of training plans, and their implementation;
- support the development of training in communications skills for effective health education and promotion related to the implementation of PHC programs, including appropriate skills for post-abortion counselling;
- provide training to update the knowledge of training staff on the principal PHC interventions, including family planning, nutrition, STD/HIV/AIDS and TB.

Output 6: Improved information base for decision-making, program development, and management

Due to the fragmented health care institutions, there are no uniform reporting requirements and no integrated national health information system. Health services data generated by different providers are not collected or analyzed so that equity, efficiency and effectiveness can be assessed. Epidemiological data are scattered among the various departments and authorities involved in the provision of different services, making it difficult to comprehensively assess data and determine the health needs of communities.

Likewise, data collected on health personnel do not allow for manpower planning, deployment of health care personnel or the evaluation of employment policies, productivity or appropriateness of training. Available financial data are collected in a way that does not make possible the evaluation of health programs in terms of cost-effectiveness, efficiency, or equity at the local, provincial and national levels. There has also been a lack of periodic provincial and national level health surveys.

Until South Africa has a national health information system, it will continue to have difficulty in: monitoring the health status of all South Africans; adequately assessing the existing health services; evaluating the effectiveness of interventions; comparing the health status of communities, thus enabling the system to monitor the needs of the underserved population; monitoring the trends in health status, disparities in health status, access to and cost of services; determining health priorities and setting national health goals and objectives relevant to the needs of the people; and developing policies based on valid and reliable health data.

Without a system that provides current and reliable data both on health status and on the operation of the health system, it will be extremely difficult to reshape and manage a unified health system either at the provincial or national level. Although the SAG is receiving assistance from WHO in the development of the national health information system (HIS), the EQUITY Project will:

- support two national level demographic and health surveys, one at the start of the

project (funded by central funds) and one in year five (funded by EQUITY);

- assist the focus province to implement the HIS at the various levels of the health system, including training of health personnel in utilization of the information collected; and
- provide substantial financial and technical assistance at the national level to facilitate the sharing of lessons learned in the focus province from the implementation of the various components of the health system and from the operations research within the focus province.

D. How It Will Work

The EQUITY Project will be one of USAID/South Africa's first bilateral projects with the SAG. Thus, many of the answers to questions on roles, responsibilities and administrative arrangements will be obtained during PP design. However, several things are already clear:

- The SAG will take the leadership role in implementing the MOH restructuring program. It will therefore be responsible for overall programmatic guidance and direction, and overseeing all aspects of direct assistance to the MOH, and for ensuring that the assistance conforms to SAG policies and regulations, regarding bilateral assistance arrangements. The SAG will also ensure that its mutually agreed contributions to the project are fully met. SAG responsibilities also include monitoring of project implementation to ensure that USAID-financed project resources (e.g., technical assistance through USAID's prime contractor and project commodities) are effectively utilized in accomplishing the project purpose. The SAG will also be responsible for selecting the focus province for the project, based on criteria mutually developed and agreed to by the SAG and USAID.
- USAID/South Africa will be responsible for managing all USAID-funded project inputs, including technical assistance provided by the prime contractor and its subcontractors and/or sub-grantees; all project procurement; and any USAID-funded assistance provided through centrally- or regionally-funded projects and other assistance mechanisms external to the bilateral grant agreement. The Mission will also ensure that all appropriate USAID regulations and programmatic guidance are followed, and that project performance is effectively monitored and evaluated. USAID/SA will also be responsible for approving and coordinating all REDSO/ESA and USAID/W assistance related to the project.
- Global Bureau support will be requested to assist in the project design and provide support to the MOH during the project design period and procurement process for technical assistance, as well as to deliver limited assistance in parallel with project implementation. Global will therefore have the responsibility of coordinating this assistance through USAID/SA.

As noted above, many of the detailed responsibilities and mechanisms for the Mission's first bilateral grant agreement will have to be worked out between the SAG and USAID/South Africa once this PID has been approved. In addition, a number of studies and/or assessments will be completed in the process of developing the Project Paper. All of these efforts will contribute to clarifying how the project will actually work.

E. Implementation Arrangements

Since the project includes several major components both at the national and provincial levels, and because of the unique need for strong coordination at both national and provincial levels (including with the focus province), implementation efforts will be complex. Implementation of the project includes provision of technical assistance, both local and international, training and workshops, observational travel for national, provincial, and district officials, operational research, and the procurement of certain commodities. All this has to be coordinated carefully, both within the target province and at the national level to ensure maximum project efficiency and effectiveness and overall success.

Implementation will require a full-time project team, resident in the focus province to coordinate with provincial officials to implement project activities in the province. Project activities at the national level will require full-time TA team presence to maintain coordination with national officials, to coordinate the strong linkages with the other provinces, and to provide a strong liaison with the USAID Health Development Division. Because of the senior nature of this position, it should be the Chief of Party's position.

During the analysis and Project Paper design phase, several options for project implementation will be explored in depth, with a final decision made by the time the PP is finalized. It is clear that South Africa has significant organizational and human resources in many of the technical specialty areas covered under this project, and therefore, as much as possible, South African institutions and staff will be utilized to implement project activities.

The Global Bureau has been requested to assist in a number of areas related to the project through centrally funded mechanisms. Global will hopefully assist by fielding analysts for the PP design. Due to the urgent need of the MOH for support to its restructuring program, Global assistance has also been requested to provide quick start assistance through existing buy-in projects such as Demographic Health Surveys (936-3023), BASICS Project (936-6006), Pathfinder (936-3062) and INTRA (936-3031). Preliminary discussions between the Mission and Global indicate that the prospects for centrally-funded support are good.

As the preparation of the Project Paper proceeds, one important issue needs to be kept in focus. The Ministry of Health is in the lead. The project can only assist the MOH to effectively implement its restructuring program in order to deliver better primary health care to the disadvantaged majority. Therefore, the redesign assumes that the SAG will have enough of the design and initial steps of the restructuring process underway at the

national and provincial levels to permit the aggressive implementation of the project. Soon after the approval of the PID there needs to be discussions with SAG representatives to arrive at a clear understanding of what restructuring has to take place in the focus province and the appropriate time frame. If the agreed-upon initial steps cannot be achieved, then the USAID-financed procurement of project inputs may need to be held up, and possible redesign of either the overall project or selected project elements considered. [See also Sections IV.C. and IV.F. for related discussions of this issue.]

The overall implementation mechanism to provide long- and short-term technical assistance cannot be described in detail at the PID stage, since there are a number of factors that can only be adequately assessed during the PP design. For instance, the roles and responsibilities of the MOH, USAID and a technical assistance contractor cannot be fleshed out until a detailed technical/institutional analysis of the MOH is carried out. Additionally, it will not be possible to determine whether the currently envisaged project inputs will be sufficient to achieve sustainable primary health care until a comprehensive assessment of all health sector stakeholders, donors and other contributors is completed during the PP design. For example, the role of NGOs, as key players in the delivery of health care services, must be carefully examined and appropriately integrated into the project design. Other important issues, such as the lack of water and basic sanitation, will have an impact on the selection and prioritization of project interventions, and will be investigated in the project paper.

However, it is likely that one "umbrella" institutional contractor (or consortium of organizations) will be given responsibility to assist the MOH on most or all aspects of the project. Such a contractor would provide a project team to manage the delivery of assistance on a day-to-day basis, as well as make sub-contracts (or sub-grants) for technical assistance, observational tours, and whatever else is necessary to implement the project. The contractor would also directly contract with NGOs for specific project activities, and directly procure any commodities that are required for the project. If this option were chosen, it is possible that the prime contractor would be either a U.S.-based or South African-based institution/consortium; in any case the prime contractor would sub-contract with appropriate South African institutions to carry out many of the activities. South African leadership is a critical element in the SAG's strategy to ensure sustainability of the efforts undertaken in the EQUITY Project so all aspects of project planning, the procurement process and administrative arrangements for implementation must be developed maximize local participation to the greatest extent practicable.

The concept of an umbrella implementation entity, with responsibility for the delivery of all project inputs, provides an important component in attaining project objectives. A single management unit will facilitate effective oversight and management of the project implementation by the MOH and USAID.

Another issue that may affect implementation arrangements is the extent to which the Mission decides to continue support for the HIV/AIDS prevention activities which it has funded under the Community Organization and Leadership Development (COLD) Project since 1992. These include eight small grants to NGOs, a PASA with the Centers for

Disease Control (CDC) for grant management, and a buy-in to the AIDSCAP project for technical assistance to grantees. COLD funding will continue through FY95. The Mission is inclined to continue a small grants program under the Equity Project, in partnership with the MOH. However, the extent of this program and responsibility for its management must be carefully considered during the project technical analyses.

F. USAID/SA Support Requirements

USAID/SA's OYB funding level has risen dramatically in the past year, resulting in an increased workload and additional management burden. The Mission must currently track several hundred separate obligations -- the vast majority of which are individual grants to NGOs, requiring Mission management at all levels to spend considerable amounts of time on day-to-day implementation actions. Therefore, in order to allow the Mission to supervise the EQUITY Project effectively and ensure successful implementation by maintaining strong coordination with government officials and the project team, it will be necessary to keep the Mission management burden to a minimum, while still retaining effective monitoring and control of the project.

The Project will be managed by the Health Development Division (HDD) of the Office of Social Development (OSD). Due to the complexity of the project and the wide array of technical skills required for its oversight and monitoring, additional management resources may be required. This can only be determined during the project analysis, as the detailed project design develops. The PP design team will recommend any additional management resource requirements, their nature, duration, and source.

G. Estimated Cost and Methods of Financing

1. USAID Funding

USAID plans to contribute a total of \$50 million to the EQUITY Project. The majority of project activities will be undertaken by the institutional contractor (or consortium), including technical assistance, training, observational tours and operations research. The \$50 million includes all costs that the contractor incurs in providing and/or managing those activities, as well as any commodities to be procured. The PP design team will assess the feasibility of awarding the prime contract through an 8(a) or Gray Amendment set-aside, and recommend an appropriate mode of competition. Other contracts or similar agreements will be awarded through appropriate mechanisms, in accordance with the laws and regulations governing USAID assistance. As noted earlier, given the wealth of expertise within South Africa, local firms and/or local specialists will be utilized to the fullest extent possible to provide the necessary services.

2. Host Country Contribution

The host country government is expected to contribute at least 25 percent of the total cost of the project. Thus in the EQUITY Project, the SAG will contribute at least \$16.67 million to the project. This is expected to result largely from in-kind contribution of

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personnel and programmatic resources (e.g., staff salaries, overhead, vehicles and transport costs, commodities) which are directly related to project implementation. It may also include contributions from other organizations that are collaborating with the project in carrying out priority activities (e.g., field support costs for the second Demographic and Health Survey). Given the magnitude of SAG resources that will support EQUITY Project implementation, the SAG total is expected to greatly exceed the 25 percent requirement. A careful assessment of the nature and amount of the SAG's contribution will be made during the Project Paper development.

Following is an estimated preliminary budget for the project:

Technical Assistance:

| | |
|---|--------------|
| National & Provincial DOHs | \$2,500,000 |
| Focus Province | 33,000,000 |
| Other Provinces (incl dynamic linkages) | 2,000,000 |
| Evaluations and Audits | 500,000 |
| Subtotal: | \$38,000,000 |

Training including observational travel:

| | |
|---|--------------|
| National & Provincial DOHs | \$1,000,000 |
| Focus Province | 7,000,000 |
| Other Provinces (incl dynamic linkages) | 3,000,000 |
| Subtotal: | \$11,000,000 |

Commodities Subtotal: \$1,000,000

TOTAL \$ 50,000,000

H. Monitoring and Evaluation

Monitoring

Project activities will be monitored on a day-to-day basis by the prime contractor; periodic progress reports will be submitted to the SAG and USAID in accordance with contractual provisions. The USAID HDD Chief and his staff will also conduct frequent site visits to the focus province to monitor progress in the field; and will hold periodic (e.g., monthly) review meetings with selected prime contractor staff and SAG representatives. To provide broad oversight of project implementation and policy guidance, a project Strategic Advisory Committee (SAC) will be established, including representatives of at least the following entities: the national DOH, provincial health

authorities, USAID/South Africa, the prime contractor, and selected representatives from key SA organizations involved in project implementation. This committee will meet at least twice a year to review both project progress and implementation problems (based on contractor and DOH reports and statistics and other relevant information), and to recommend possible courses of action that can be taken to resolve such problems. The SAC may meet more frequently during the early stages of project implementation.

Evaluation

Using USAID central funds, a nationwide demographic and health survey will be conducted during the first year of the project. Using centrally funded G Bureau technical support, a situational analysis of the health sector will be conducted in the focus province in late FY95 or early FY96. This latter study will analyze in detail those aspects of the health system that will be specifically addressed by the project, e.g., the referral system, management training needs, and current PHC training capacity. There will also be specific assessments conducted to examine the management and informational needs of the central ministry as they relate to identified project outputs. All of this information will, in effect, provide a baseline for measuring achievement of project objectives. Once these studies and assessments are completed, the project will modify and refine the targets and progress indicators for the various outputs of the project.

There will be two major evaluations of the project, a mid-term "process" evaluation conducted during year four and a final impact evaluation conducted during year seven. The mid-term evaluation will measure and document progress attained in meeting project objectives, problems encountered, USAID's, MOH's, and institutional contractor's management of the project, as well as recommend modifications in project design to enhance project success. The final impact evaluation will document what the project has actually achieved and provide the basis for consideration of a follow-on project, should USAID consider continuing its assistance to this sector. It will draw on assessments and evaluations of various components of the project that have been conducted, as well as the results of a second DHS that will be conducted in year five and a second situational analysis that will be conducted in year five or six. Additional special assessments or surveys also may be conducted during year seven as deemed necessary for this evaluation.

IV. OTHER CONSIDERATIONS

A. Social Considerations

1. Social - Cultural Context

Social determinants that influence health outcomes in South Africa are very much linked to the legacy of apartheid. Apartheid is the system of legalized and institutionalized race discrimination and segregation in South Africa. The defining characteristics of apartheid are:

- The hierarchical ordering of the economic, political, and social structures on the basis of race, identified by physical characteristics, such as skin color. The white

minority, comprising 13 percent of the population, held absolute power and controlled virtually all economic resources. The disenfranchised majority, including Black, Coloured, and Indian communities, held no real political power and only meager economic resources.

- Discrimination against black Africans, and to a lesser extent coloreds and Indians, who were excluded from many of the civil, political, and economic rights enjoyed by whites, such as the vote, freedom of movement, and the right to certain jobs or own property in much of the country.
- Segregation of the races in many spheres of life: they lived in separate areas, went to separate schools and universities, used separate buses and trains; there was little social mixing; sexual relations and inter-marriage across the color line were illegal.
- The legalization and institutionalization of this hierarchical, discriminatory and segregated system, through laws enacted and enforced by the government.

In the sixties, apartheid took on the face of separate development. Instead of claims about biological or genetic differences, arguments for racial separation were based on cultural or ethnic differences and the right of each group to maintain their identity.

Apartheid has resulted in a health care system biased towards expensive tertiary care that benefits only a small minority. Infant mortality rates for Africans range from 70-130 per 1000 live births (comparable to Bangladesh); for whites the rate is 12 per 1000 live births for whites. The table below shows other baseline health indicators at the national level.

Table 2

| Characteristic | African | Colored | Asian | White |
|--|-----------------|---------------|---------------|----------------|
| Population (Millions) ^a (percent) | 29.0 (75.5%) | 3.2 (8.6%) | 1.0 (2.6%) | 5.0 (13.5%) |
| Per Capita Educational Expenditure 1988 ^a | R276 | R1,358 | R2,226 | R3,080 |
| Per Capita Health Expenditure 1987 ^a | R95 | R339 | R356 | R596 |
| Life Expectancy 1985 ^b | 62 | 61 | 67 | 71 |
| Infant Mortality Rate 1988 ^a | 80 | 46 | 19 | 12 |
| Percent of Death Before 5 years 1987 ^b | 23 | 16 | 7 | 2 |
| Total Fertility 1988 ^a | 3.9 | 3.0 | 2.4 | 1.8 |
| ^a SAIRR Survey 1989/90 ^b Health Trends in South Africa, Department of National Health and Population Development, 1988. | | | | |

The first column of figures provide a stark statement of what is consistently referred to as the unserved or under-served population, under apartheid. It is to this legacy that the government is attempting to bring equity through its new Reconstruction and Development Program. During PP development, a social soundness analysis to better understand social factors influencing health provision and health seeking behavior will be undertaken.

2. Beneficiaries

The beneficiaries of the proposed project are the unserved and underserved health service users of South Africa. Specifically, the project plans to improve the health status of mothers, children, and youth of the disadvantaged black population. Service providers, including traditional health practitioners, alternative potential health service providers, non-governmental organizations, and the health private sector are also likely to benefit from the project. The social soundness analysis will examine how these different groups will benefit from the EQUITY Project. In addition, the social soundness analysis will look at (a) potential adverse consequences (and suggest mitigating actions) for any groups from reforms supported by the EQUITY Project, (b) likely spread effects of benefits of the project, and (c) project impact on equity.

3. Participation

Participation during the PID process included health officials from GNU, including officials representing RDP, and non-governmental organizations. During PP development, the Mission plans to involve stakeholders through the use of local experts in

doing the technical, institutional, social, and economic analysis. Wider participation will be sought through focus groups interviews and a "health conference" of academics, practitioners, service users, and beneficiaries either at the national level or at the provincial level. In addition, the team will involve stakeholders in conducting rapid participatory assessments at the provincial level.

4. Socio-Cultural Feasibility

Genuine political goodwill to focus attention and resources on providing integrated primary health care to the previously underserved and unserved populations exists in South Africa. GNU is undertaking analysis and policy discussions with grassroots women's organizations, health workers, academics and policy makers, with the most recent policy discussion being a women's health policy conference held in December 1994. The GNU is committed to addressing the underlying socio-economic determinants and intermediate behavioral determinants to produce positive health outcomes.

Social issues, as discussed in 1-3 above, will be viewed against the technical aspects of the project in order to better identify what is feasible for the project to accomplish.

5. Impact

The project is planned to contribute to improvements in people's health status, implying not only social changes but also changes in people's behavior. Social soundness analysis during PP development will help project planners, implementers, and community members and leaders understand and deal with the opportunities and consequences of the proposed Equity project. The social soundness analysis will also provide a systematic approach to measure the changes taking place, evaluate changes, determine which changes are significant, and, more importantly, outline steps a community might take to enhance the positive and minimize the negative aspects of change. In addition, the process should strengthen a community's ability to respond positively to change.

B. Economic Considerations

1. General Economic Performance

South Africa's economy with a GDP of over \$117 billion in 1993 is more than four times the size of the economies for the rest of southern Africa. The economy grew rapidly through the 1960s, averaging 6% real GDP growth from 1960 to 1965 and 5.3% real GDP growth from 1965 through 1970. Beginning in the 1970's, however, the economy's annual growth rate declined to 3.9% for the first half and 3% for the last half of the decade. During the 1980's, the annual growth rate fell to less than 1.5%. For the period 1990-1993, real GDP has declined at annual rate of 0.7%. Thus, while growing in aggregate terms since 1960, the underlying rate of economic growth has continuously declined. Simultaneously, the capital-intensity of production has risen from an average 2.04 in the early 1960s to 2.82 for the period 1981-1993. Real per capita GDP increased

until 1981; however, from 1981 through 1993, real per capita GDP has declined from R8,859 to R6,629 (1990 prices). As a result, South Africa's real per capita income now roughly corresponds to what it was in 1965.

At the same time that growth declined, inflation increased. From 1960 through 1971, inflation averaged approximately 2.5% per annum, but with a slight upward trend over this period. Beginning in 1972, however, inflation increased and averaged just over 13% through 1993. Unlike other African countries, South Africa is not in a perpetual balance of payments crisis with a consequent shortage of foreign exchange. Nevertheless, at the end of 1993, South Africa's gross foreign reserves equalled between one and two months of imports or 2.9 percent of GDP.

Given this long term stagnation, the economy's recovery, which began in 1993, is a welcome development for the new Government of National Unity. GDP is expected to grow 2 percent in 1994 and positive growth is foreseen by most economists over the next 2 to 3 years. Business expectations are running high and foreign investment has begun to flow back into South Africa. The prospects for at least a short-term improvement in growth are good given the fact that the economy has an estimated excess capacity of over 6 percent of potential GDP. For the longer term the Government of National Unity faces significant challenges in raising growth rates high enough to accomplish positive improvements in per capital income. The process of revitalizing the economy will be further complicated by the need to redress the economic and social inequities that they have inherited.

2. Budgetary Considerations

a. Overall Government Budget

Expenditure and lending in South Africa's Consolidated Budget, i.e., including all levels of government, rose from R25.9 billion in 1983 to R111.3 billion in 1992 corresponding to 28.3% of GDP and 32.5% of GDP, respectively (see Annex F for tables supporting this section).¹ The increase in expenditures relative to GDP occurred primarily after 1990. Prior to that time, expenditures remained fairly constant as a share of GDP. Concurrent with the increase in expenditures, the consolidated budget deficit also increased. In 1983, the deficit was R2.9 billion or 3.2% of GDP; this figure rose to R8.0 billion (5.4% of GDP) by 1988, then declined to R2.2 billion (0.8% of GDP) in 1990. The consolidated deficit increased to R12.1 billion (3.9% of GDP) and R15.4 billion (4.5% of GDP) in 1991 and 1992, respectively. While consolidated figures are not available for 1993 and 1994, the central government budget deficit equaled 7.6% of GDP and approximately 6.6% of GDP for these years. The revised 1994 budget announced in June, 1994, projected a deficit of approximately 6.3% of GDP. This is

¹*This section uses the South African fiscal year which runs from April through March. Thus, reference to a given year, e.g., 1983, refers to the fiscal year beginning in that year and extends through March of the following year.*

likely to be overly optimistic due to poorer growth performance than projected.

Within the consolidated budget, social services, i.e., education, health, housing and community services, and social security and welfare, have been the largest recipients of resources, with over 37% of expenditures annually from 1983-1986 (over 10% of GDP), then rising to over 39% for the rest of the 1980s (11-12% of GDP), and 40.9% and 42.4% of total expenditures (12.8% and 13.7% of GDP) in 1991 and 1992, respectively. Health has consistently received between nine and ten percent of total expenditures, or roughly 25% of the consolidated social service expenditures. For 1993 and 1994, health expenditures in the national budget, including Ministry of Works expenditures for the construction of hospitals and clinics, equalled 2.05% and 1.57% of total expenditures. The discrepancy between the national share and the consolidated budget share illustrates the importance of provincial and local governments in the provision and financing of health services.

b. National Health and Population Development Budget for 1993 and 1994

In June 1994, the Government of National Unity announced its first budget that was a modification of a previously approved budget running through March 1995. The national Health and Population budget has typically been divided into eight programs: administration, primary health care, health care, population development, medical services, health protection against environmental aspects, social welfare, and auxiliary and associated activities.

The overall national health budget for 1993 totalled R2.26 billion while that for 1994 totalled R1.66 billion. The decline in the national budget results from the shifting of responsibility for medical services to the provincial level. Table 3 summarizes the change and composition of the new budget compared to that of 1993.

The new budget places a significantly increased emphasis on social welfare and population development -- the only programs to receive increases in real terms, and an increased emphasis on health aspects of the environment, and primary health care.

The second table below presents budgetary information related to the areas where EQUITY proposes to work. As seen from this information, the Government of National Unity has increased expenditures in these areas, thus demonstrating their shared concern or problems in these sub-sectors.

Table 3

| National Health and Population Budget, Percent Change and Shares, 1993 - 1994 | | | | | |
|--|-----------------------|--------------|--------------|------------------|------------------|
| Program | % Change 1993 to 1994 | | | Share in 1993 | Share in 1994 |
| | Expenditures | Trans. | Total | | |
| Administration | -15.2 | n/a | -15.2 | 3.72% | 4.30% |
| Primary Health Care | -1.8 | 8.9 | 3.4 | 27.22% | 38.40% |
| Health Care | 6.4 | 10.7 | 6.5 | 7.22% | 10.50% |
| Medical Services | -100.0 | -100.0 | -100.0 | 28.28% | 0.00% |
| Population Development | 14.3 | n/a | 14.3 | 1.03% | 1.61% |
| Social Welfare | 4.2 | 98.2 | 57.0 | 1.24% | 2.66% |
| Health Aspects of the Environment | 3.6% | 5.2% | 4.0% | 4.64% | 6.59% |
| Auxiliary & Associated Services | 10.3 | -3.5% | -1.1% | 26.64 | 35.95% |
| Total | -16.8 | -33.8 | -26.7 | 100.00% | 100.00% |

Table 4

| Selected Areas of Interest to EQUITY in the National Health Budget | | | | | |
|--|--------------------|-----------|-------|---------------|---------------|
| Program | % Change 1993-1994 | | | Share in 1993 | Share in 1994 |
| | Expenditures | Transfers | Total | | |
| Primary Health Care: | -1.8 | 8.9 | 3.4 | 27.22% | 38.40% |
| <i>Communicable Disease Control</i> | 1.0 | 2.9 | 1.2 | 2.37% | 3.27% |
| <i>AIDS</i> | -1.2 | 4.1 | 0.6 | 0.96% | 1.32% |
| <i>Family Planning</i> | -6.4 | n/a | 5.4 | 6.61% | 9.50% |
| Population Development | 14.3 | n/a | 14.3 | 1.03% | 1.61% |
| Nutrition | 118.3 | -4.3 | 0.2 | 19.71% | 26.92% |
| School Health Services | 3.6 | n/a | 3.6 | 1.09% | 1.54% |

c. Economic Issues

The key economic issue surrounding the Government's efforts to promote a more efficient and equitable health care system will revolve around the cost, financing and sustainability of the revised system. Currently, there are no clear figures of the portion of the population receiving health services. The following table looks at the implied annual cost to the national budget of expanding service coverage to the full population for different assumed levels of current coverage. Given the importance of provincial and local financing, the full cost of expanding coverage could easily be 4 to 5 times the levels shown. In the best case examined below, an 11% increase in the health budget would be required. In the worst case, a 66.7% increase would be required. Given the need to reduce the fiscal deficit and the need to expand a number of social services in addition to health, these examples clearly illustrate the need to rationalize the current system and create a more effective and more efficient system.

Table 5

| Example of Possible Costs of Expanding Health Services | | | | |
|--|------------------------|--|-----------------------|--------|
| Total Health Budget - 1994 (R Millions) | | 1,658.339 | Population (Millions) | 42.350 |
| % Population Served | Per Capita Expenditure | Health Budget Required to Serve 100% of Population | | |
| | | R Millions | % Increase | |
| 60% | 65.26 | 2,763.8 | 66.7% | |
| 70% | 55.94 | 2,369.1 | 42.9% | |
| 80% | 48.95 | 2,073.0 | 25.0% | |
| 90% | 43.51 | 1,842.6 | 11.1% | |

The estimates presented above assume that there is no increased effort at cost recovery/user fees in the health sector. An increased cost recovery/user fee effort would ease the need for increased budgetary votes. User fees have also proven crucial in other health systems for maintaining an efficient, effective and consumer driven health system. For these reasons, EQUITY will be prepared to assist the government in examining issues and options surrounding health care economics and financing in order to promote a sustainable and equitable system.

d. Project Paper Analysis

The economic analysis for the project paper will need to more clearly identify the costs of increasing the coverage of South Africa's health care system. The Project Paper's Technical Analysis will identify the expected impact of the proposed system modifications on key health indicators, once the modified package of services is identified and extended nationwide. The changes in those indicators will form the basis for estimating the benefit flow resulting from the project. Together with the direct costs of this project, such information will provide the basis for a full economic analysis of EQUITY.

C. Institutional Considerations

South Africa's health system is still extremely fragmented. There is a multiplicity of health authorities, including national, provincial, homeland, and local authority health services, as well as an extensive private sector and many NGOs. Coordination between and among all of these is extremely poor, resulting in serious gaps in service delivery. This is especially true at the primary level in the rural and semi-urban areas. It is, therefore, difficult for most of the population to obtain even basic health care, as the system is mainly focused on curative care for the affluent, mainly white, urban dwellers.

Health care in many rural areas, particularly primary health care, falls significantly below the standards for this kind of care that have been achieved in some nearby African countries.

This fragmentation has resulted in considerable inefficiency, duplication of services, and all-round poor utilization of the resources being expended on health. While South Africa apparently has sufficient hospital beds for the entire population, the location of these facilities is not appropriate to meet the demand. Also, the checkered location of clinics in the rural and former homeland areas is such that they do not provide an adequate foundation for development of a comprehensive national primary health care system. Reallocation of facilities, personnel and finances, as well as future investment in infrastructure will be required. In the interim, however, it may prove necessary for the government to place greater reliance on NGO provision of services in underserved areas. There already is a precedence set for NGOs to receive government funding to support provision of services in such areas. In reality, however, there is a limited number of such organizations that would be able to play such a role. This raises a question about the capacity of the NGO sector to adequately fill this gap and the consequent need to examine other possible ways to provide the underserved with access to at least essential services. The development of a more effective referral system is seen as one possibility.

The SAG has declared that the present fragmented health system will be restructured into a unitary state health service, with a single National Department of Health and provincial and district health departments. In line with this, strategic management teams already have been established in each province, drawing from the health authorities located in each. These teams are responsible for the integration of services within the national health system and for rationalizing the various health authorities within each province. The provinces themselves have only recently been created and there is still some uncertainty about whether or not their administrative structures are yet in place. To date, however, the teams have identified provincial priorities and strategies for integrating their provincial health authorities, but have yet to develop structures for the new provincial and district health authorities. Nor have they devised a plan for developing a "district" health system, with emphasis on integration of primary and secondary care at this level, although the EC is apparently planning to assist the SAG to do this. This "district" health system is expected to form the basis of the new health system by bringing together all existing health services under a single "district" health authority.

Unifying the system, however, is not expected to put an immediate end to the unequal allocation of health resources. This will require a concerted shift of both financial and human resources from the tertiary to the primary health sector, as well as within the tertiary and secondary health sectors. In 1991/92 only 5% of the health care budget was spent on primary health care, compared with 43% which was spent on academic complexes. Furthermore, the public tertiary sector is very heavily subsidized by the government, with less than 5% of the costs being recovered from user charges. With the expectation that the budgetary resources will remain basically the same for the public sector health system, the SAG wants to explore ways to more effectively utilize those resources it already has as well as means by which to increase the level of cost recovery,

especially in the tertiary sector. Similar problems are found with respect to personnel and facility utilization. For example, there has been a significant under utilization of major provincial hospitals formerly reserved for whites while the hospitals for blacks are still mostly overcrowded and understaffed. Although all 246 provincial hospitals are now open to all races this type of problem still persists.

In addition to the poor distribution of facilities, many are beset with inadequate physical resources - lack of a means of communication, transport, refrigeration, and supplies of medicine. This is especially true of the front line clinics in the rural areas. Visits by doctors are often infrequent and many clinics lack nursing staff and staff trained to provide a range of essential services. There are also serious deficiencies in physical facilities, with lack of water and electricity posing the most serious problems.

There is also a problem in the area of health personnel. This is primarily manifested in the shortage of nurses in the system, in an imbalance in the distribution of doctors and allied health personnel between urban and rural areas and across some geographic regions, and in the lack of importance placed on and therefore under utilization of support personnel, such as nurses aids and community health workers. This situation is exacerbated by the type of training that health personnel have received, in particular the training of doctors and nurses, which strongly promotes a medical hierarchy with a curative, hospital-based, urban bias. The SAG recognizes this as a major problem and has plans to reorient the entire health system, including service provider and physician training, to one that focuses on primary health care. It intends that nurses and doctors will be trained to be more community responsive and to have a strong grounding in PHC knowledge and management skills. It also intends that all service delivery sites will be capable of providing the range of primary health care services. At this time, however, the training capacity is insufficient to achieve these objectives.

D. Experience with Similar Projects

This project is the Mission's first comprehensive health program. Since 1992 the Mission has had an HIV/AIDS prevention program under the Community Outreach and Leadership Development (COLD) Project, funded at approximately \$3.5 million per year. Due to the restrictions of the Comprehensive Anti-Apartheid Act of 1986, as amended, USAID was prohibited from working with the government or any organization funded or controlled by the government. Therefore, the HIV/AIDS prevention program was implemented entirely through non-government organizations. Currently, under the South African Democratic Transition Support Act of 1993, and with the certification by the President of free and fair elections, the Mission can undertake direct project activities with the Government. Fortunately, most of the top leaders of the Ministry of Health, as well as many in the Reconstruction and Development Program, are prior directors of non-government organizations, and have substantial working relationships with Mission staff.

E. Design and Approval Strategy

The PID will be submitted to USAID/W for review and approval in December 1994.

Pending approval of the PID, USAID/South Africa will finalize the design and prepare the PP for authorization before the end of FY 95. A crucial part of this process will be the analyses to be undertaken before and during the PP design. Attached to this PID are scopes of work for several analyses to be done; these will be further refined and additional scopes of work will be finalized during November and December, 1994.

It will be necessary to complete at least a first, solid draft of all of the important analyses before the initiation of the PP design. These include the technical analysis, institutional analysis, financial and economic analyses, and social soundness/gender analysis.

REDSO/ESA staff will continue to assist the mission with preparation of the scopes of work for the analyses, and will provide staff for some of the actual analyses, perhaps including the social soundness and gender analysis and the economic analysis. The Mission will request Global Bureau assistance (or contract directly) to conduct the other analyses, as much as possible utilizing local South African expertise as team members. The Mission will assist with gathering CVs and bio-data for potential South African candidates for these analyses.

It is anticipated that the project analyses will be undertaken during January and February, 1995. By the time the analyses are completed, on/about the end of March, it is hoped that PID approval will have been received from USAID/W, to enable the Mission to proceed directly with the PP design.

The actual PP design will then begin around mid-March and run through April and perhaps into May, as required. As with the PID design, the Mission will rely on REDSO/ESA to provide the bulk of the technical expertise necessary for the design, including specialists in Health Care Financing, Family Planning, Child Survival and Health Care Policy, and AIDS, as well as PDO support. The Mission will also request support from the Global Bureau, particularly in the field of HIV/AIDS. Of course, the PP design team will include the Mission's own health staff and other support offices. Finally, the team will include several local health specialists, probably including some of those experts who will be involved in preparing the analyses.

It is anticipated that the PP will be completed in June or July, to be reviewed and approved in time for obligation before the end of the fiscal year. It is anticipated that the primary obligation mechanism will be a Handbook 3 bilateral grant between the USG and SAG, with a minimal amount to be obligated through Handbook 13 grants with NGOs or AID direct contracts for specific elements of the overall project. USAID/SA hereby requests an ad hoc delegation of authority to approve the PP and authorize the project in the field.

F. USAID Policy Issues

Restructuring: The SAG has initiated the restructuring process. This includes developing a single National Department of Health from 14 separate departments under

apartheid. The restructuring also includes developing the 9 provincial departments, including the linkages between these departments and the district level health authorities. Very substantial progress has already been made by the strategic management groups who have undertaken these complicated tasks. Additional work to be completed includes defining the boundaries of districts, defining and then setting up the new or changed administrative structures to accommodate restructuring. These structures include equitable personnel systems, staff training, and reallocation of resources. Clearly, the continuing SAG efforts at restructuring are going to be demanding and complex. If the SAG is unsuccessful in aggressively launching restructuring at the national, provincial and district levels, the assistance and potential impact of the EQUITY Project could be severely limited. The complexity and scope of this issue is discussed in IV. C. and the implications that difficulties in restructuring might impose on project development and implementation are reviewed in III. E.

Management: Given the rapid growth of USAID/South Africa's program budget, management workload is an important project design criteria. Monitoring and impact measurement, given the diverse nature of the activities included under each project, are also important design considerations. Therefore, the current design must attempt to minimize the number of obligations and other transactions, such as contracts and grants, to the greatest extent practicable. This might be achieved by utilizing a single bilateral obligation with the SAG for all or most of the funds authorized under the project, and, if possible, a prime contract for the implementation of coordinated project activities.

Impact Monitoring: USAID/South Africa is increasing efforts towards measuring program impact, as evidenced by the current Monitoring and Evaluation Review effort. The goal is to examine Mission strategic objectives and program outcomes, and establish impact indicators across the program portfolio. For monitoring and impact measurement reasons, project inputs and outputs should be clearly defined and linked in support of the project purpose. Project activities will be designed to be cohesive and focused on a well defined beneficiary group, with sufficient baseline data and information systems to measure implementation progress and program impact against a set of measurable indicators.

Strategy: The Mission does not have an approved CPSP. Although a comprehensive "Strategy Concept Paper," similar in many ways to a CPSP, was developed in March 1993, this document does not include health as an area of strategic focus. Therefore, the obvious question arises as to how this project can be developed in the absence of a strategic framework to provide direction in selecting activities and measuring impact. On the other hand, the USG and USAID have an unwavering commitment to support the democratic government in addressing key development constraints detailed in the RDP.

In view of the wide range of constraints detailed in the RDP, the SAG has made a request for USAID assistance to deliver improved health care services to the majority population. In responding to the urgent need of the SAG, USAID health care technical specialists and the Office of Social Development have reviewed a large body of recent health sector

analyses, and subsequently, have measured RDP focus areas against USAID's known areas of comparative advantage in delivering assistance.

The result of this analysis and discussions with the Ministry of Health have specified USAID interventions to provide integrated health care services in a focus province, and to strengthen MOH central's capacity to plan and deliver integrated primary health services nation-wide. This approach offers the advantages of delivering timely assistance, within the limitations of USAID funding, under a manageable and measurable working-model project. The working-model project offers the further advantage of replication and expansion of an improved provincial health care system on a nation-wide basis. The question is whether USAID/South Africa will: (i) deliver timely assistance under the currently identified approach, by designing the project now with the sector analyses currently available, or (ii) wait until a formal CPSP has been developed within the next year. As discussed in II. A., there is a clear fit between the thrust of the EQUITY Project and currently stated development objectives of the Mission. Consequently, there appears to be little, if any, advantage in waiting for the formal USAID/W approval of the CPSP.

Sustainability: Resources for the health sector are limited. Whether the SAG will be able to maintain the systems developed in the focus province, as well as replicate the lessons learned in the focus province throughout the country, is an important question. The project will have the resources needed to make the new unified health structure operational within the focus province. Nevertheless, USAID and the central and provincial governments will have to be sensitive to the cost implications related to sustaining the systems put in place.

The SAG is working under the assumption that no additional financial resources will be made available for restructuring the new health system. This includes the provision of essential health services to the currently under-served population. MOH will need to demonstrate efficiency and effectiveness in utilizing the quite substantial resources already devoted to health. These efforts will include the generation of additional resources through user fees or other health financing schemes. The project will support these activities in the focus province. The expectation is that systems improvements (e.g., cost accounting, management) and health financing schemes will be applicable for the national health system as a whole. To the extent that efficiency and effectiveness efforts are successful in the focus province, the financial sustainability of South Africa's health program will be enhanced.

There is also the issue of technical sustainability, to which the EQUITY Project will contribute. One of the principal objectives of the project is to develop and institutionalize the indigenous capacity for provision of technical and management training. It is expected that by project end such a capacity will have been developed in the focus province and in the process of being transferred throughout the country.

Project assistance will facilitate the sharing of lessons learned in the focus province. Sharing and what is being called "dynamic linkages" will take place with both the central

government and other provinces. However, the project will lack the resources needed to actually operationalize new systems in the other provinces. This expansion will be contingent upon resources being available either from the SAG or from other donors. The cost of replicating developed systems will be far less than the initial development. Also, being able to rationalize the system to efficiently and effectively utilize resources, will help to provide additional funding to offset the cost of expansion of the systems in the other provinces.

Reproductive Health and Family Planning: Family planning and reproductive health remain sensitive areas in South Africa. It is believed by many observers that the major motivation for family planning and the Population Development Program, especially in the 1960s and 1970s, was the white community's concern about being swamped by the larger numbers of the black population.

Reproductive health and family planning still remain important areas for contributing to the health and well being of South Africa's disenfranchised populations (including adolescents), and as important components of USAID's development program. It will require, as earlier referenced (section III. C.) "unusual sensitivity both of a new democratic government and whatever support from foreign donors to nurture confidence within black communities in order to develop a sound population program" (Sai et al, p. 2).

While the preceding history and reference to the importance of sensitivity are both important to remember, they should serve as guides and not deterrents to including family planning and reproductive health as integral elements of integrated primary health services. Close collaboration with the communities within the focus province, as delivery systems are developed, will provide the project with the opportunity to participate in placing the important areas of family planning and reproductive health within a positive context of empowerment, free choice and better health.

NGOs: Non governmental organizations have played an essential role in grass roots contacts and organization. During apartheid, health-focused NGOs served as political activists as well as health educators and providers of services. They have demonstrated their capacity to reach, develop trust, and work with communities. NGOs have an important role to play in the reconstruction development program for health. As the SAG begins the reconstruction of the health system, NGOs serving as extensions of the health system into communities can serve a pivotal role.

The SAG needs to demonstrate its ability to reach and provide services to the historically underserved. The project can play an important role, working with the provincial system, to help the government define and implement complementary roles in ensuring integrated primary health services do reach the hard to reach populations. Not only do NGOs have a role to play in reaching the geographically hard to reach, but they have demonstrated their ability to reach difficult to reach subgroups such as adolescents.

In the process of preparing for and writing the PP, it is anticipated that a major role will

be developed for NGOs. This will require analysis of the available NGOs in the focus province, their past experiences in the health sector, and the development of potential roles within the provincial system. The anticipated involvement of NGOs also means that mechanisms will need to be developed to fund NGO participation. All of this will need to be done in concert with national and provincial MOHs, to ensure that the long-term sustainability of NGO participation is taken into account. MOH central has stated that it does not want NGO activities undertaken that it cannot support eventually, and this is consistent with USAID's interest in attempting to ensure sustainability of its development activities.

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VI. Annex A. Preliminary Logical Framework

Please NOTE that the logical framework is in process of review and further development. However, the current framework will provide a general conceptualization of the Project

The EQUITY Project: Preliminary Logical Framework

| Narrative | Verifiable Indicators | Means of Verification | Assumptions |
|---|--|--|--|
| <p>Program Goal Broader objective to which this project contributes:</p> <p>Equitable access to quality health care for all South Africans</p> | <p>Measures of Goal Achievements:</p> | | <p>Assumptions</p> |
| <p>Project Purpose: To support the development of a system for the provision of integrated Primary Health Care services to under-served populations.</p> | <p>Conditions that will indicate purpose has been achieved: End of project status:</p> <ol style="list-style-type: none"> 1. Functioning sustainable integrated PHC system in place in the focus province. 2. More efficient and cost effective delivery of PHC services in the focus province. 3. Capacity at the national level to plan and manage the PHC system established. 4. An established framework for effectively transferring lessons learned in focus province to other provinces. | <ol style="list-style-type: none"> 1. Two DHS - one at the beginning of the project and one in five years. 2. Three situational analyses - one at the beginning of the project, one in four years, and one at the end of the project. 3. Potential linkage of above information to MEDUNSA national data base to be explored. | <p>Affecting purpose-to-goal links:</p> <ol style="list-style-type: none"> 1. Restructuring of the health system from national level to province and districts. 2. Adequate financing of health from the central budget - no reduction in absolute funding and constant or increase in proportion of budget to health. 3. Democracy and governance changes are in place and functioning at the national, provincial and district levels. 4. Public service restructuring accomplished (need further investigation here) |

EQUITY Project

| Outputs: | Magnitude of outputs necessary and sufficient to achieve purpose: | | Affecting output-to-purpose links: |
|--|---|---|---|
| <p>1. Increased access to an integrated package of essential PHC services in the focus province.</p> | <p>1.1 Number of sites with package of services. 1.2 Number of staff trained in package of services. 1.3 Increase in the number of clients using essential primary health services.</p> | <p>1.1 Situation analyses 1.2 MOH statistics 1.3 Special focus surveys</p> | <p>1.1 Adequate funding for PHC at provincial level. 1.2 Reallocation of human and financial resources in the focus province. 1.3 Appropriate counterpart assigned at provincial and national levels.</p> |
| <p>2. Effective referral system in place in the focus province.</p> | <p>2.1 Referral system developed and implemented. 2.2 Increased number/percentage of people referred to next higher level</p> | <p>2.1 MOH referral system records. 2.2 Guidelines in place and being followed.</p> | |
| <p>3. Enhanced capacity to manage the integrated primary health care program at central level and in the focus province.</p> | <p>3.1 Management structure and operating guidelines developed and implemented at provincial and district levels.</p> | | <p>3.1 By the end of the project there will be adequate distribution of peripheral health sites, participating in the referral system. 3.2 All identified referral entities (e.g., NGOs, work based clinics/hospitals, and mission health centers, as well as MOH sites) are willing to participate in the referral system.</p> |

EQUITY Project

| | | | |
|---|--|--|--|
| <p>4. Health financing schemes developed to support the provincial primary healthcare program.</p> <p>5. Institutionalized capacity for PHC training.</p> <p>6. Improved information base for decision-making program development and management.</p> | <p>4.1 Various schemes designed</p> <p>4.2 Several schemes pilot tested in province</p> <p>5.1 Training curriculum designed and developed</p> <p>5.2 Training schools using new curriculum</p> <p>6.1 DHS being used</p> <p>6.2 Ops research taking place</p> <p>6.3 HIS functioning</p> <p>6.4 Number of observation tours</p> <p>6.5 Number of training courses conducted</p> <p>6.6 Lessons learned in province replicated in other provinces</p> | | |
| <p>Inputs: Activities and Types of Resources:</p> | <p>Level of Effort/Expenditure for each activity:</p> | | |

Annex B. Initial Environmental Examination

TO BE E-MAILED BY MARIA BEEBE FOLLOWING DEC 20 DISCUSSIONS WITH AFRIC BUREAU ENVIRONMENTAL OFFICER REGARDING NEW FORMAT.

Annex C. SAG Health Priorities of RDP

TO BE ATTACHED.

Annex D. Letter of Request for Assistance

INCLUDED IN DHL AND MAILED COPIES

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