Evaluation of the EU Development Cooperation with South Africa With Regard to Poverty Reduction Through Health Services

(EU2008, 2008)

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Date of Delivery:	24 August 2011

Abstract

In this paper, the effectiveness of EU development assistance to South Africa with regard to poverty reduction through improved health services is examined. Overall country-wide indicators indicate that poverty has indeed been reduced during the past decade. For the health indicators, the evidence is mixed, but points more often than not in a negative direction. Detailed analysis of an EU development project, namely the Partnerships for the Delivery of Primary Health Care (including HIV/AIDS), suggests that even though the program did not achieve its full potential, it did have positive effects on health services and poverty reduction. Furthermore, it seems that factors such as non-EU development assistance, HIV/AIDS, the economic situation, and skills shortage also have an effect on the level of poverty and the possibilities for its reduction in South Africa. It is recommended to focus more on the gathering and availability of data, both on the program-level and the country-level. Moreover, it should be a priority to make sure that the money committed actually does reach the final beneficiaries.

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ACP	African, Caribbean and Pacific Group of States
DAC	Development Assistance Committee
DOH	Department of Health South Africa
EC	European Commission
EU	European Union
GDP	Gross Domestic Product
HBC	Home Based Care
HPCSA	Health Professions Council of South Africa
IMCI	Integrated Management of Childhood Illness
MDG	Millennium Development Goal(s)
MIP	Multi-Indicative Program
NPMU	National Programme Management Unit
NPO	Non-profit Organisation
ODA	Official Development Assistance

OECD	Organization for Economic Cooperation and Development
OVC	Orphans and Vulnerable Children
PDPHCP	Partnerships for the Delivery of Primary Health Care Program
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission
PMU	Programme Management Unit
PPMU	Provincial Programme Management Unit
PPP	Public Private Partnership
SA	South Africa
SMMEs	Small, Medium and Micro Enterprises
TB	Tuberculosis
TDCA	Trade, Development and Cooperation Agreement
UN	United Nations
UNDP	United Nations Development Program
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
ZAR	South African Rand

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1. Introduction

International cooperation between the European Union (EU) and South Africa has occurred and still occurs in many forms. Among these are multilateral cooperation in the form of the Cotonou Agreement with the African, Caribbean and Pacific Group of States (ACP) or bilateral cooperation through the Trade, Development and Cooperation Agreement and the various Country Strategy Papers. Currently, the EU supplies 70% of the external assistance available to South Africa, which makes the EU South Africa's most important development partner (European Commission, 2006). Moreover, about 80% of the foreign direct investments in South Africa stem from Europe (European Commission, 2006).

Seeing that the European Union has directed considerable funds and efforts towards South Africa over the past decades, and considering that in times of financial and economic crises EU Member States as well as their citizens seem to become more reluctant to give development aid, it becomes crucial to evaluate the EU development cooperation with South Africa. Consequently, this study will try to answer the following research question:

To what extent has the EU co-operation with South Africa with regard to poverty reduction through improved health services been effective?

South Africa is in many respects a special case and certainly not the typical recipient country of development aid. Although South Africa is classified as 'upper middle-income country' (The World Bank Group, 2011d), it still receives development assistance from several countries and international organisations, the EU being one of them. Nevertheless, constituting 1.3% of the domestic budget and 0.3% of the nation's GNP, foreign aid is not a very substantial source of capital for the country and South Africa is considerably less dependent on aid than other African countries (European Commission, 2002a).

South Africa's economy is relatively strong, especially when compared to other African countries. Between 2000 and 2008, it had an annual GDP growth of about 4% (The World Bank Group, 2010a). The World Bank describes South Africa's economic policy prior to the financial crisis as "largely successful" (The World Bank Group, 2010b). However, while the South African economy has been relatively strong and stable over the recent years, the same cannot be said about its society. In the Country Strategy Paper 2003-2005 widening income inequality, slow growth, high and rising unemployment and the HIV/AIDS pandemic have been identified as the main challenges for South Africa in the medium term (European Commission, 2002a). In the Country Strategy Paper 2007-2013 the HIV/AIDS pandemic and high unemployment are highlighted as main challenges which are assumed to lead to poverty, inequality, crime and political instability (European Commission, 2006). Life expectancy still hovers at about 52 years (The World Bank Group, 2011).

When it comes to the country's human rights culture, a similar paradox arises: Despite being ranked as 'Free Country' by FreedomHouse and having a progressive constitution, it seems that "36% of the population has never heard of the Bill of Rights, 29 % do not know its purpose and 59% do not know

where to seek help in the event of abuse“ (European Commission, 2002a; FreedomHouse, 2010). This is especially (although not exclusively) important in the context of xenophobia and racism which still prevail to a large extent in South African society, even more than two decades after the end of the Apartheid regime.

The paper is structured as follows: At first, a theoretical framework is provided in which the variables poverty reduction and health services are introduced and their mutual relationship is explained. This is a necessary precondition for the operationalisation of the variables and the comparison between theory and reality at a later stage. After this, the methodology of the study is presented, including the research question, research design, methods of data collection and analysis, and the case selection. The next step is the operationalisation of the main variables. For each variable it is explained what is to be included or excluded in the concepts, what the practical limitations are (e.g. with regard to the availability of the data) and which specific indicators are used to measure the variables. This is especially important for the quantitative part of the empirical analysis where the indicators are actually measured and compared over time. The empirical analysis is presented in Chapter 4. Here the focus is on establishing whether or not the EU development objectives under consideration have been fulfilled and whether this can be attributed to the EU intervention. The first part consists of a quantitative as well as a qualitative analysis. For the quantitative analysis indicators for poverty and health services are compared (approximately) before and after the EU intervention to get a picture of their developments over time on the national scale. Because this is rather general information, the quantitative data is complemented by qualitative data on a specific EU development intervention, namely the Partnerships for the Delivery of Primary Health Care Program. Here, data is gathered from the annual reports and a questionnaire sent to NPO personnel involved in the program. This ensures the inclusion of a top-down as well as a bottom-up perspective on the program. Finally, the qualitative insights are summarised in a results or policy chain connecting the EU intervention to improved health services and poverty reduction. The role of the EU in the attainment of the goals is assessed by looking at other factors which could have had an influence on poverty reduction, too, such as non-EU development aid, HIV/AIDS, economic developments and skills shortage. The report ends with a conclusion and policy recommendations.

2. Theoretical Framework

This chapter offers the theoretical framework of the study. It helps to understand and define the main variables of the study and their mutual relationships. Moreover, it lays the foundation for the operationalization of the concepts. Additionally, a strong theoretical framework allows us to compare theoretical expectations with what as actually happened at a later stage in the study.

In the following a definition of poverty and poverty reduction is given. Moreover, theories on how to reduce poverty as well as the theoretical link between health services and poverty are be provided. It is shown that the mechanisms behind poverty reduction are far from being fully understood, but that poverty reduction can often be linked to factors such as economic growth and a good policy environment. These theories inform actual policy interventions aimed at the reduction of poverty, which vary greatly. Finally, access to and quality of health services is defined and it is shown that there is a two-way link between poverty reduction and health services.

The definition of poverty by the UN is the most prevalent **definition of poverty**:

> "*(…)[P]overty is a denial of choices and opportunities, a violation of human dignity. It means lack of basic capacity to participate effectively in society. It means not having enough to feed and clothe a family, not having a school or clinic to go to, not having the land on which to grow one's food or a job to earn one's living, not having access to credit. It means insecurity, powerlessness and exclusion of individuals, households and communities. It means susceptibility to violence, and it often implies living on marginal or fragile environments, without access to clean water or sanitation*"

(Gordon, 2005)**.**

In the scope of the United Nations Millennium Development Goals, poverty reduction has been translated into a quantitative goal, which is to „halve, between 1990 and 2015, the proportion of people whose income is less than one dollar a day" (United Nations, 2010). In order to measure poverty (reduction), the UN uses the following MDG indicators:

1) Proportion of population below $1 (1993 PPP) per day
2) Poverty gap ratio [incidence x depth of poverty]
3) Share of poorest quintile in national consumption
(UN Development Group, 2006)

While widely accepted, the view of poverty reduction by the UN does not remain undisputed. Collier & Dercon (2006) for example find that the UN's high focus on reduction in poverty as a measure of development (especially within the framework of the Millennium Development Goals) comes with a certain price. Firstly, because it shifts the focus to measuring poverty, not enough attention is paid to how poverty arises. Secondly, it creates the illusion that 'solving' poverty ultimately comes down to

redistribution which is portrayed as costless (which is not the case). Finally, exaggerated focus on short-run reduction in poverty may have at best neutral and at worst negative consequences in the long run (Collier & Dercon, 2006). Moreover, Hulme & Shepherd (2003) criticize that the UN's definition and measurement "encourages the conceptualization of the poor as a single homogeneous group whose prime problem is low monetary income and has lead policymakers and their advisors to search for 'the policy' that increases the income of 'the poor'".
However, despite the costs that come with this view of poverty, it does bring the benefit of making poverty measurable. Especially in the area of international politics where promises are as easily made as forgotten and broken, and where vagueness and ambiguity may be a politician's best friends, this is a benefit that should not be dismissed too easily.

While there has been much attention in the literature on the topic of poverty reduction, no grand theory capable of explaining the incidence of poverty has been developed (see for example Hulme & Shepherd, 2003). Nevertheless, many **factors related to poverty,** and the reduction of it, have been identified.
There is, for example, a high tendency to relate poverty reduction to economic growth. Dollar and Kraay (2002) even claim that the two are related on a one-to-one basis. However, other studies suggest that this relationship is not as straightforward as one might assume (Donaldson, 2008; Olsen & Nomura, 2009). Dagdeviren et al (2002) for example claim that growth alone is never sufficient to reduce poverty because it is distribution-neutral and, similarly, Fosu (2010) holds that the influence of growth on poverty depends on the income distribution profile of a given country. More specifically, Fosu claims that income inequality has a twofold effect on poverty: on the one hand increased inequality leads to increased poverty and on the other hand, increased inequality lessens the positive effect that increased income has on the reduction of poverty. This importance of income inequality is also stressed by Yao (2000) who conducted a study on the development of rural poverty in China and concluded that rising income inequality had a decisive negative effect on poverty reduction in China and that "(w)ithout rising income inequality, China would have been able to eliminate poverty more or less by now".
Another factor that is often named in relation to poverty reduction and growth is the presence of a good and conducive policy environment. Agenor et al (2008) for example find in their study "the importance of combining increases in aid with reforms aimed at improving the management of public resources, to maximize their impact on growth and poverty reduction." Bastiaensen et al. (2005) stress that the eradication of poverty "requires the promotion of institutional change". Leftwhich and Sen (2011) also argue that institutions matter for poverty reduction and growth, but they qualify this statement by stressing the importance of the ways in which different institutions in different sectors interact with each other as well as the importance of the development of extra-institutional organisations in different sectors which interact with the institutions and thereby strengthen them. Furthermore, Collier and Dollar (2001) hold that the quality of economic policy is essential for poverty reduction, and they, too, see an important role for foreign aid which "can accelerate the process". Crespin (2006) adds to this view by stressing the local dimension of poverty reduction by claiming that "an important part of poverty reduction is supporting the building of more effective governance systems from the bottom-up, and this includes supporting local initiatives that address deprivations directly". Against these studies, stands Hyden (2007) who claims that "prevailing assumptions in the international development policy

community about improved governance as a principal mechanism to reduce poverty in Africa rests more on faith than science". According to him, the fact that most of the people who live in extreme poverty live and try to solve their problems 'outside the system' results in the de facto ineffectiveness of policies through formal institutions. Mwangi & Markelova (2009) summarise most of these views and findings quite nicely by emphasising the multidimensionality of poverty in which institutions as well as power relations and the political context play an equally pivotal role.

All of these relationships are essential when deciding on actual **policy interventions** to combat poverty. An important consideration in this respect is that Fan et al (2008) find in their study into different types of government expenditure on agricultural growth and rural poverty reduction in Thailand, that it is not only the absolute size of the government spending that determines its effect on poverty reduction, instead "it is the composition of the spending that has differential effects on growth". Of course, the choice of policy should always heavily depend on the country's particular situation. When Dercon (2009) for example focused on the role of agriculture in poverty reduction in the Sub-Saharan African region, his conclusion was that "the role of agriculture is likely to be very different in different settings, depending on whether a country can take advantage of manufacturing opportunities, whether it is dependent on others for its natural resources, or whether it is landlocked and with few natural resources of its own". Still, Dercon does think that focusing on agriculture could be a promising road out of poverty.

A very attractive solution for governments is the "vision of a business model for poverty" (Goldsmith, 2011). This is a vision of a situation in which lifting people out of poverty can be an activity which covers its own expenses and can even yield a profit. This idea is mainly advocated by the private sector (see for example Shell Foundation, 2005). In his examination of some of these initiatives, Goldsmith (2011) however finds that "poverty-fighting commercial enterprises are usually helped by charitable or public organizations. That unremunerated help, whether monetary or in kind, appears to be critical to success on the 'double bottom line'". In other words, without unremunerated help from external organisations, the activities would probably not be financially sustainable after all.

Another policy approach to poverty reduction is through more inclusive citizenship, especially targeted towards the inclusion of the poor. Hickey (2010), however, found out that these approaches do not succeed in changing the underlying determinants of poverty and though they may include some useful aspects, they are not in themselves a sufficient approach against poverty.

Peters et al (2008) claim that successful policies to reduce poverty should include "concerted efforts to reach the poor, engaging communities and disadvantaged people, encouraging local adaptation, and careful monitoring of effects on the poor". Hulme & Shepherd (2003) propose that the choice of a poverty reduction policy should depend on the relative prevalence of transient and chronic poverty in a specific country. When there is relatively more transient poverty (rather than chronic poverty) in a country, there should be a focus on improving the transition period from poverty into non-poor status, including for example social safety nets, temporary unemployment allowances, social grants, micro-finance, and skills acquisition programs. If a country is, however, characterised to a large extent by the existence of chronic poverty, poverty reduction policies should include redistribution of assets, reduction of social exclusion, investments in physical infrastructure and long-term social security (Hulme & Shepherd, 2003). Moreover, Kirigia et al (2005) stress that particular types of poverty reduction

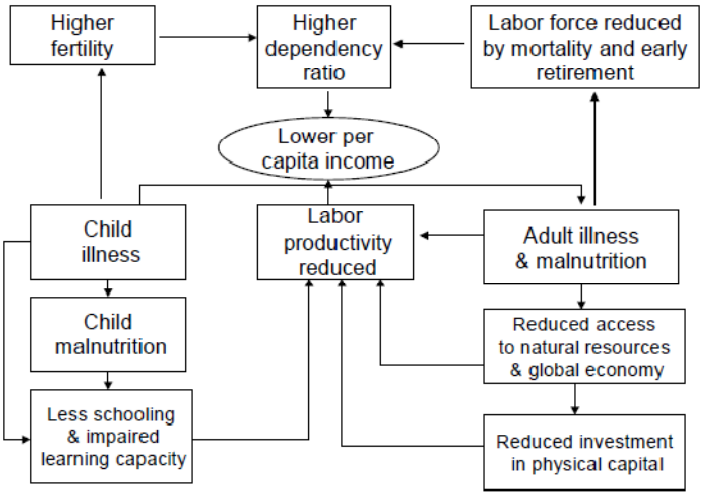
policies focusing specifically on women (such as access to education, improved living environment, better family planning services) can have positive effects on the women's ability to access health services. This then has positive effects with regard to poverty reduction for both these mothers and their children.

Finally, then, poverty reduction has also been analysed in relation to **health services**. Within this concept, quality of health care and access to health care play a very important role. These are the two aspects stated in the EU's development objectives for South Africa with regard to health care (see Chapter 3.4.1). Nevertheless, it is difficult to find a comprehensive and straightforward definition of the two. Andersen (2005) has defined access to health care as "the actual use of personal health services and everything that facilitates or impedes the use of personal health services". Andersen's Health Behaviour Model which is based on this definition is widely used in the literature (see for example Sibley & Weiner, 2008). In their study on the rural perspective on health care, Stamm et al (2007) emphasise that access to health care is a multifaceted concept, "in terms of not just the distance to the doctor's office, but also the distance to a specialist or a hospital or inaccessibility of a public service because of economies of scale". Of course, the focus on rural aspects of poverty is also important in many developmental settings. With regard to quality, it becomes apparent that many studies use the concept and also measure it, but do not provide a clear definition. The Institute of Medicine does, however, provide a definition, namely that quality is "the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge" (Institute of Medicine, 2011). Furthermore, Stamm et al (2007) hold that quality health care should encompass "preventive, restorative, and rehabilitative care, regardless of the area of health care". Quality and access are closely interrelated and intertwined. In order words: it would not make sense to focus on the one while neglecting the other.

Poverty reduction and health services seem to be closely related. Peters et al (2008) claim that the **relation between access to health services and poverty is a two-way relationship**: whereas financial limitations can make access to health services difficult or even impossible, at the same time delayed or non obtained health care can lead to worsened health which in turn leads to income losses and increased spending on health. Put differently: "The relationship between poverty and access to health care can be seen as part of a larger cycle, where poverty leads to ill health and ill health maintains poverty" (Peters et al, 2008). The interconnectedness of poverty and health is also stressed by Agee (2010) who analysed the relationship between children's nutrition, mothers' access to health care and poverty and came to the conclusion that policies should focus simultaneously on improved health services and poverty reduction strategies.
Within the scope of this study, we are of course mostly interested in the **effect that improved health services can have on poverty**. In their study of several nationally representative surveys, van Doorslaer et al (2006) found out that too little focus is paid on out-of-pocket expenditure for health care. They claim that this type of expenditure poses an extra burden on households and thus aggravates poverty. Consequently, so they argue, policies aimed at poverty alleviation should "include measures to reduce such payments" (van Doorslaer et al, 2006). Moreover, health services also include reproductive and family planning services which tend to lead to lower fertility rates. As Allen (2007) claims, these lower

fertility rates lead to reduced population growth which help to reduce poverty. Moreover, having fewer children results in a decreased dependency ratio, meaning that the number of working-age adults rises in relation to the number of dependents (especially children and elderly) (see also Edouard, 2006). Another way in which family planning helps to reduce poverty is through its contribution to economic growth, via enhancements in people's health, productivity, education and skills. The idea behind this mechanism is that people benefit when scarce resources are split over a smaller number of people – which is the case when fewer babies are born (Allen, 2007).
These ideas can also be witnessed in the model developed by Ruger et al. Figure 1 portrays the different (mutual) relationships between illness and, inter alia, fertility rates, the dependency ratio and per capita income.

Figure 1: Channels linking illness to per-capita income



(Ruger et al, 2001 in Green & Merrick, 2005)

When talking about poverty reduction and health services in the Sub-Saharan African region, one cannot escape the topic of **HIV/AIDS**. It seems that in developing countries, the incidence of poverty and the prevalence of HIV/AIDS are positively correlated (Fenton, 2004). In fact this, too, is a relationship that works both ways. On the one hand poverty causes HIV/AIDS because poor people are more susceptible to infectious and sexually transmitted diseases due to various factors such as malnutrition and lack of access to health care. On the other hand, HIV/AIDS also causes poverty through the morbidity and mortality it inflicts, inter alia, on the working age population, affecting for example household income and service delivery (Fenton, 2004). In a more general sense, Over et al (1992) have examined the economic effects of fatal illness for households. Table 1 summarises these effects.

Table 1: Economic Effects of Fatal Illness in the Household

Timing of effect/ type of effect	**Before illness**	**During illness**	**Immediate effect of death**	**Long term effect of death**
Effect on	-Organisation of	-Reduced	-Lost output of	-Lost output of

production and earnings	economic activity -Residential location	productivity of ill adult -Reallocation of labour	deceased	deceased -Reallocation of land and labour
Effect on investment and consumption	-Insurance -Medical costs of prevention -Precautionary savings -Transfer to other households	-Medical cost of treatment -Dissaving -Changes in consumption and investment	-Funeral costs -Transfers -Legal Fees	-Changes in type and quantity of investment and consumption
Effect on household	-Extended family fertility	-Reduced allocation of labour to health maintaining activities	-Loss of deceased	-Poor health of surviving household members -Dissolution or reconstitution of household
Psychic costs		-Disutility of ill person	-Disutility of person -Grief of loved ones	

(Over et al, 1992 in Green & Merrick, 2005)

One type of health services is primary health care. This type of health care will be of importance later on in the study. In the Declaration of Alma-Alta, primary health care is defined as being "essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of selfreliance and self-determination" (World Health Organization, n.d.a).

Summary

In this chapter we have looked at the existing theories around poverty reduction and health services and their mutual relationship. The most important insight here is that poverty is a multidimensional concept which cannot be easily captured and measured. Accordingly, policy choices with the aim to tackle the incidence of poverty are not always straightforward, either, and depend on the type and definition of poverty. Theories around health services have also been examined and the two most important aspects, namely quality and access, have been highlighted. Moreover, we have seen that there is a mutual relationship between health services and poverty. While poverty can impede the access to and quality of health services, improved health services can have a positive effect on the reduction of poverty. Consequently, when mainly focusing on the impact of health services on poverty in the remainder of the study, the reverse relationship should also be kept in mind.

All of the above provides insights on how poverty could be influenced and how we might expect improved health services to impact positively on the reduction of poverty. This knowledge is used to better understand the mechanisms that govern the relationships between the actual EU intervention

under consideration and its influence on health services and poverty. Moreover, it will be useful at a later stage in the study to map and understand the discrepancies between theory and reality. Exactly how this "reality" will be assessed and analysed is explained in the next chapter.

3. Methodology

This chapter lays out the methodology of the study, including the research question, the research design, the methods of data collection and analysis, the case selection as well as the operationalisation of the study's main variables.

3.1 Research Question

The following research question has been identified:

To what extent has the EU co-operation with South Africa with regard to poverty reduction through improved health services been effective?

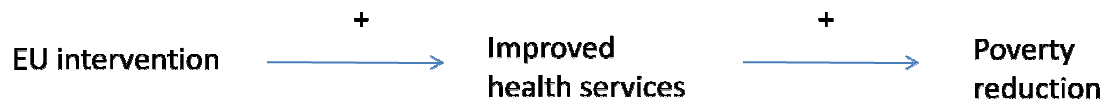
In order to answer the research question, two sub-questions have been identified:

1. To what extent have the goals with regard to poverty reduction through health services been achieved?
2. Which role did the EU play in the attainment of the goals?

While the first question investigates the goal attainment, question two focuses on the role of the EU in the attainment of these goals.

The research to be undertaken is an evaluative study. Moreover, it tries to investigate into the causal relationship between the EU development policy means (independent variable) and the objectives of EU development policy which are used here as outcome variable (dependent variable). To be more precise, the policy outcome is split into an intervening and a dependent variable. The idea is that the EU intervention leads to improved health services which in turn lead to poverty reduction (in the ways that have been explained earlier). Fig. 2 summarises this relationship.

Figure 2: Relationship between the variables "EU intervention", "improved health services" and "poverty reduction"



3.2 Research Design

The evaluation carried out can be classified as an external, independent, ex-post evaluation. Especially the fact that the evaluation is independent is an advantage and one of the characteristics that distinguishes it in a positive way from the evaluations carried out by the EU itself – as independence is a "prerequisite of credibility that is missing in the evaluation systems used by most governments, companies and development agencies" (Picciotto, 2003). In order to answer the research question outlined above, qualitative and quantitative desk research is conducted. Content analysis is undertaken in order to determine the objectives of the development cooperation between the EU and South Africa which serves as the dependent variable in the study. Moreover a questionnaire has been administered. The research is also in part case-oriented as a case in the study is included in the study, namely the Partnerships for the Delivery of Primary Health Care.

It should be noted that the words 'goal attainment study' and 'effectiveness study' are sometimes used interchangeably or in conflicting ways in the literature. In this paper, 'goal attainment' is used to describe whether the desired outcome has been achieved – irrespective of *how* these goals have been achieved. 'Effectiveness' is used to describe the role that the EU had in the achievement of the goals: Were the goals reached because of the EU development intervention? In other words: Was it indeed the independent variable which caused the dependent variable? In this paper, there is a focus on both goal attainment and effectiveness. Goal attainment is measured by using both quantitative and qualitative means. As regards the quantitative aspect, poverty is measured and compared at the beginning and at the end of the period 2002-2008. This specific period has been chosen because this is the period in which the Partnerships for the Delivery of Primary Health Care have been implemented. Moreover, indicators for health care are measured and compared at the beginning and the end of the period 2002-2008. This allows us to establish whether poverty has indeed been reduced and health care has indeed been improved over the specified period. With regard to the more qualitative aspects, there is a detailed investigation into the processes that occurred in the period 2002-2008 through tracking & tracing and the process analysis method by Hans Bressers. Here, the Partnerships for the Delivery of Primary Health Care Program (PDPHCP) are closely examined through the analysis of the annual reports as well as through a questionnaire. This allows us to say more about the actual influence of EU action on the outcome. Finally, the influence of other factors on the presumed relationship is analysed.
The unit of analysis of this research is South Africa as the effects of a specific policy intervention (the Partnerships on the Delivery of Primary Health Care Program) on South Africa are studied. However, it should be noted that the PDPHCP is not a South African policy but the result of the cooperation between the EU and South Africa. Despite the involvement of the EU, however, the policy is carried out on South African soil and mainly carried out by South Africans; therefore, the focus of the analysis will be on South Africa.

3.3 Data Collection /Analysis

3.3.1 Data Collection

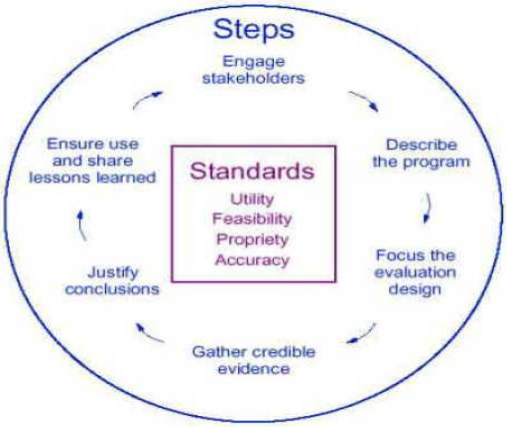
This research heavily depends on the identification and choice of objectives of development cooperation between the EU and South Africa as a basis for determining the dependent variable. Data on these objectives are gathered from policy documents from the EU and South Africa, such as the EU Treaties, EU policy strategy papers on development aid, trade agreements with the ACP and/or South Africa, and most importantly, the Country Strategy Papers with South Africa as well as Progress Reports and Evaluations of the Country Strategy Papers. The Country Strategy Papers and their evaluations do not only provide information on the intentions of the EU and the objectives of development cooperation. In addition to this, they also provide an analysis of the political and economic situation of South Africa as well as a short evaluation of past achievements. This, too, is an important source of information. However, especially the evaluations should be treated with caution because they are not provided by an independent source.

When it comes to the goal attainment part, extensive use are made of statistics, above all, to be able to compute the indicators identified in the next section. These statistics have been collected from diverse sources such as the South African government, the World Bank, the World Health Organization and the UN. This means that the goal attainment part of the research is mainly based on quantitative data. For the evaluative part of the study, the annual reports of PDPHCP have been used. This information is complemented by the information provided in questionnaires that have been sent to NPOs participating in the PDPHCP. Additionally, information from personal correspondence with these NPO contact persons is used. Moreover, all the sources indicated above have also been used when checking for the influence of possible other variables. Moreover, it is possible to use certain parts of the evaluations by the EU (for example in the Country Strategy Papers). Although they are not from an independent source, they are from a credible source. This means it should at least be possible to assume that the data communicated in these evaluations are truthful, even though the interpretations of these data might be biased. So if handled carefully, the evaluations by the EU can be used as a complementary qualitative source of data.

3.3.2 Data Analysis

By evaluation, we mean a “systematic and objective assessment of an on-going or completed project, programme or policy, its design, implementation and results” (International Development Evaluation Association, 2008). Moreover, evaluation should be seen as a process which generally involves the following steps:

Figure 3: The Evaluation Process



(International Development Evaluation Association, 2010)

One type of evaluation is policy evaluation or more specifically, development evaluation. One main characteristic of development evaluation is the fact that there is no such thing as a harmonised or standardised approach or methodology that is used by all or at least the majority of development evaluating organisations. Instead, each organisation, country or other institution develops and uses their own techniques. As Grasso (2010) points out, even though international development evaluation organisations have developed (such as the DAC Evaluation Network, the Evaluation Cooperation Group or the UN Evaluation Group), the standards used by these organisation differ amongst each other, and even "full harmonization across the individual members sometimes is elusive". There is however, a relative consensus on the terms and concepts used in development evaluations. The DAC Glossary of Key Terms in Evaluation and Results Based Management for example is widely used and is a comprehensive source of definitions of the main concepts used in development evaluation (International Development Evaluation Association, 2008).

Development evaluation serves a variety of goals, including being part of the checks-and-balance system, holding authorities responsible, provision of feedback and learning, and being a basis for decision-making and improving the quality of decision-making (Grasso, 2010; Picciotto, 2003). In this sense, Picciotto (2003) argues that it is imperative for development evaluations to measure more than just the inputs but rather concentrate on measuring the results, that is, outputs and outcomes.

An important concept with regard to evaluation studies, is *attribution*, which "refers to that which is to be credited for the observed changes or results achieved. It represents the extent to which observed development effects can be attributed to a specific intervention or to the performance of one or more partner taking account of other interventions, (anticipated or unanticipated) confounding factors, or external shocks" (International Development Evaluation Association, 2008). This, however, is very difficult due to the concentration of different activities and the complexity of the whole development enterprise. Consequently, many aid agencies only claim that they have *made a contribution to* a specific outcome rather than *achieved* that outcome on their own (Thomas, 2010). Thomas (2010) claims that there are certain common limitations to development evaluation studies – lack of resources, lack of harmonisation, data limitations, capacity constraints, evaluation not used – and that the combination of

these limitations results in the fact, that even after decades of development cooperation, it is still not possible to say if aid has made a difference, and if so, a negative or a positive one. Moreover, he holds that these inadequacies of development evaluation have important ethical implications, including "insufficient investments in needed development activities (…), misdirection of aid to less effective activities, and the burdens on citizens in both aid recipient and donor countries as a result of such misdirection" (Thomas, 2010).

Ultimately, a good evaluation is not enough in itself – it needs to be taken up and used by donor agencies and policy makers. The following four lessons learned summarise what makes an evaluation more influential:

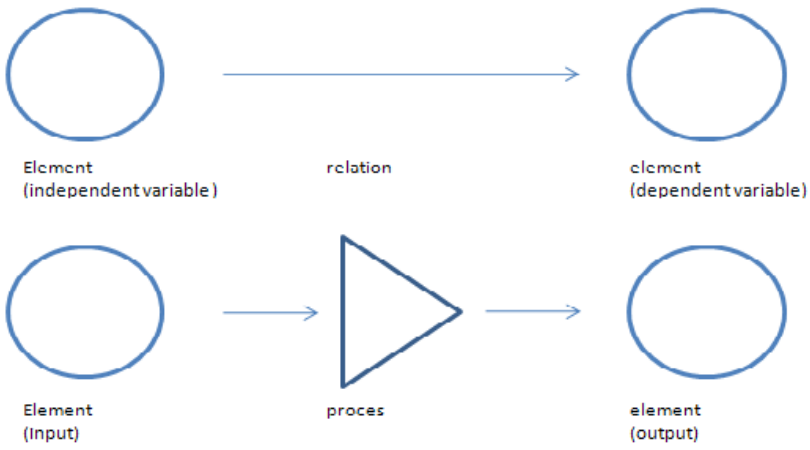
- The importance of a conducive policy environment;
- The timing of the evaluation;
- The role of the evaluation; and
- Building a relationship with the client and effective communication of the evaluation findings

(Independent Evaluation Group, 2004).

In the following a method of how to evaluate policy as it is laid out by Hans Bressers in his dissertation on the effectiveness of water quality policy will be presented (Bressers, 1984). This method is used later in the study to analyse the data gathered.

The starting point of the theory is to see society as a system consisting of processes, whereby a process is defined as "the entirety of activities and interactions which causes the relation between two or more elements of a system". Figure 4 shows a schematic display of the interrelations between the concepts 'relation', 'element' and 'process'. One can see that when there is a relation between two elements in a system, they can be seen as independent and dependent variable. They can also be seen as input and output and the relation between them can be explained by a certain process which is taking place. The different labelling of the elements (independent/dependent vs. input/output) becomes even more important when we distinguish between main processes and partial processes (which will be explained later).

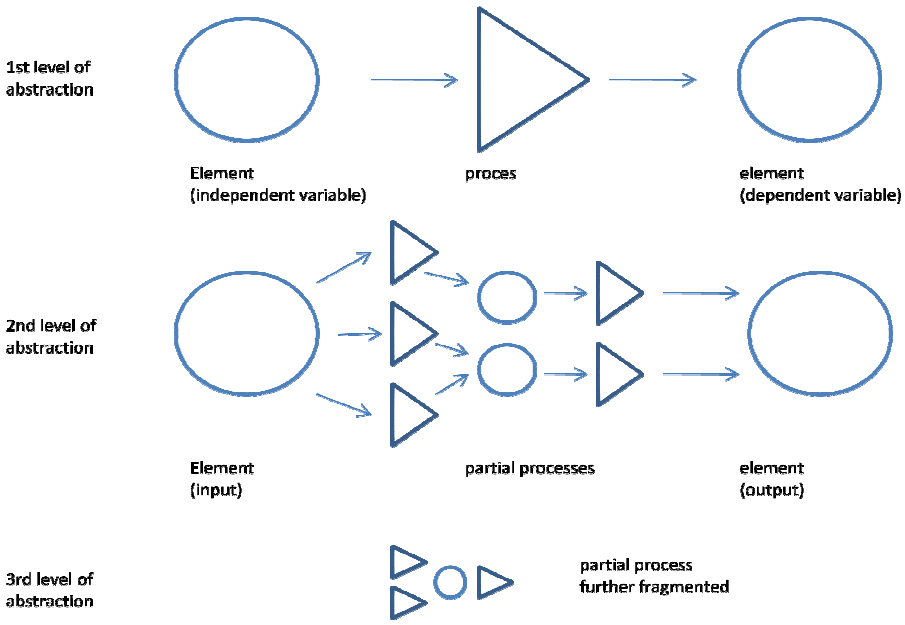
Figure 4: The role of the terms "relation" and "process" in models of reality



(Bressers, 1984)

There are then three ways to analyse a process. The first two are rather natural scientific in nature, while the last one is a rather humanistic approach. The first approach is already depicted in Fig. 3. Here the process hypothetically only consists of one single relation between dependent and the independent variable. The two variables will be operationalised so they can be measured and the statistical relationship between the two will be computed. This means that the process then remains a so-called 'black box' which is not opened. The opening of the black box takes place in the second approach. In this approach, the main process between the independent variable and the dependent variable will be fragmented into different partial processes between several input and output variables. Fig. 5 shows the schematic display. In this approach, the partial processes remain unopened black boxes.

Figure 5: The fragmentation of processes – graphical display



(Bressers, 1984)

As already noted above, the labelling of the elements plays an important role. If we analyse the main process, we talk about the relation between the independent and the dependent variable. The independent variable in that case is the (implementation of) the policy means. The dependent variable is the envisaged policy effects (the envisaged consequences of the policy, the envisaged outcomes).

If we analyse a partial process on the other hand we talk about the relations between inputs and outputs. The output of a policy means is for example a policy achievement. This policy achievement is then an input for another process which again has a specific output. If the policy theory is correct, this results chain will finally lead to the envisaged outcome, the dependent variable, as the last output of the processes chain.

However, analysing processes is only the first step of a policy evaluation. The second step is to assess the effectiveness of the policy. In other words: Did the policy actually cause the outcome or were third variables influential? Precisely the controlling for third variables is what distinguishes policy effectiveness or evaluation studies from simple goal attainment assessments. Bressers claims that the best method to test for the influence of other variable is to conduct an experiment. However, due to practical restraints experiments are often not feasible in social research. Deaton (2010) even holds that experiments "have no special ability to produce more credible knowledge than other methods" - amongst other things precisely because of those practical problems "that undermine any claims to statistical superiority". Bressers advises to complement the longitudinal study with the so-called 'modus-operandi method' by Michael Quinn Patton, which helps to identify the importance of possible third variables by considering the special characteristics of the consequences of these variables.

Based on this method by Hans Bressers, the following steps have to be undertaken in order to analyse the data gathered:

1. Identify main independent (policy means) and dependent variable (outcome)
2. Split main process up into partial processes (identification of intermediate (input/output) variables)
3. Analyse main process and partial processes
4. Assessment of effectiveness (controlling for other variables)

The idea is to construct a results chain that allows us to trace the input/output sequences in the chain from the policy means to the envisaged policy effects. Here it also becomes visible why a case study is such an important element in the study. The case study represents an important set of links in the results chain that will allow us to trace inputs and outputs on a lower level of abstraction.

In the following a short inventory of variables and their indicators is given. The independent variable in this study is the EU intervention. The intermediate variable is health services. For this, a set of indicators is developed (see section 3.5). The dependent variable is the envisaged situation, the development objective, in this case the reduction of poverty. As the EU does not provide measureable concepts or indicators of poverty, a set of indicators to measure poverty is be developed, too (section 3.5).
More intermediate independent and dependent variables of the partial processes (the inputs and outputs) will become clear at a later stage in the study, for example after having the analysis of the annual reports of the PDPHCP.

3.4 Case Selection

3.4.1 Poverty reduction through health services

The following section shows why the study focuses on the objective of poverty reduction through health services (including HIV/AIDS). This objective has been chosen because it is a very salient and high priority topic in the EU-SA Country Strategy Papers. Moreover, it combines the overarching goal of EU

development cooperation (poverty reduction) with the top priority goal of EU development cooperation with South Africa (provision of services) and a very important cross-cutting issue (HIV/AIDS).

In the search for the objective to focus on, it is wise to not only look at the country strategy papers with South Africa, but to start on a more general level. In this sense, it is helpful to start by taking the general EU development policy into consideration. We will first consider the importance of **poverty reduction as an objective of EU development cooperation**. Poverty Reduction as an important objective of development cooperation was and is laid down in the Treaties. Art. 177 of the Treaty Establishing the European Community stated the following:

> 1. Community policy in the sphere of development cooperation, which shall be complementary to the policies pursued by the Member States, shall foster:
>
> - the sustainable economic and social development of the developing countries, and more particularly the most disadvantaged among them,
> - the smooth and gradual integration of the developing countries into the world economy,
> - the campaign against poverty in the developing countries.

This idea was taken up in the Treaty on the European Union, where Art. 21.2 states:

> 2. The Union shall define and pursue common policies and actions, and shall work for a high degree of cooperation in all fields of international relations, in order to:
> (…)
> (d) foster the sustainable economic, social and environmental development of developing countries, with the primary aim of eradicating poverty

Furthermore, "the overriding objective of poverty reduction" is confirmed in the European Consensus which the Union's development policy (European Commission, 2006; European Union, 2006a). In addition to this, the Regulation 1905/2006 of the European Parliament and of the Council of 18 December 2006 also states poverty reduction as one of the main aims of EU development cooperation policy (European Union, 2006c). Finally, the European Union has committed itself strongly to the achievement of the United Nations Millennium Development Goals of which "eradicate extreme poverty & hunger" is the first of the eight goals to be achieved until 2015 (United Nations, 2010).
The EU's commitment to poverty reduction can also be witnessed by looking at the Cotonou Agreement on the cooperation between the EU and the ACP (including South Africa) which entered into force in 2003. Here the aim to eradicate poverty is the very first thing to be stated in the preamble and soon afterwards, Art. 1 on the objectives of the partnership states that the „partnership shall be centred on the objective of reducing and eventually eradicating poverty consistent with the objectives of sustainable development and the gradual integration of the ACP countries into the world economy" (European Union 2006b).
Moreover, if one takes a closer look at the cooperation between the EU and South Africa, one must also look at the Trade, Development and Co-operation Agreement (TDCA) which entered into force in 2004. Here, poverty reduction also holds a prominent role. The following is stated:

> "Development co-operation shall contribute to SA's harmonious and sustainable economic and social development and to its insertion into the world economy and to consolidate the foundations laid for a democratic society and a State governed by the rule of law in which human rights in their political, social and cultural aspects and fundamental freedoms are respected. Within this context, priority shall be given to supporting operations, which help the fight against poverty"

In the most recent evaluation of the development cooperation with South Africa by the EU in 2002, the advice is given that future programmes must "target poverty more directly" and of the six recommendations that are made, already the first states that "the focus of the next MIP should be more on poverty reduction, with a core theme of sustainable livelihoods as the basis of clearly measurable overall objectives (...)" (European Commission, 2002b).
Then, finally, there are also the country strategy papers which lay down the development cooperation between the EU and South Africa. The two most recent Country Strategy Papers of South Africa also give insights on the importance of poverty reduction. The Country Strategy Paper 2003-2005 states that the "overall objective of the SA-EC strategy for the period 2003-06 is to support the SA policies and strategies to reduce inequality, poverty and vulnerability and to mitigate the HIV/AIDS pandemic and its impact on society" (European Commission, 2002a). The Country Strategy Paper 2007-2013 reminds the reader that cooperation with South Africa is focused on political, economic as well as development objectives. The aim of the latter is to "reduce poverty and inequality in accordance with the Millennium Development Goals, promoting internal social stability as well as environmental sustainability" (European Commission, 2006).

All of the above show that poverty reduction is an extremely important and overarching objective of EU development cooperation in general and with South Africa in particular. This explains why the focus in this paper is on the objective of poverty reduction. However, poverty reduction in itself is still a much too broad topic. It needs to be further narrowed down. In order to do this, we will look at the two most recent Country Strategy Papers again in order to determine on which **objective to focus on within the overall objective of poverty reduction**[1]. The 2003-2005 Paper states that within this realm, "it will focus on four main objectives: equitable access to and sustainable provision of social services, equitable and sustainable economic growth, deepening democracy and regional integration and co-operation" (European Commission, 2002a). While the 2007-2013 states that the development objective is poverty reduction, it states that within the area of development cooperation it will focus on the promotion of pro-poor , sustainable economic growth, improvement of the capacity and provision of basic services for the poor and the promotion of good governance (European Commission, 2006). Table 2 gives an overview of the objectives as they are laid out (and ordered) in the Country Strategy Papers of 2003-2005 and 2007-2013[2].

[1] Here one should be careful as to clearly distinguish and not to confuse the variables "poverty reduction" and "improved health services". EU policy focuses, within the realm of poverty reduction, on the improvement of health services. This makes improving health services part of the EU's poverty reduction policy. However, because improving health services is a *means* to achieve the *aim* of poverty reduction, the two variables remain distinct.
[2] Note that it is assumed here that the order of the objective conveys information on their perceived importance, with those named first having top-priority.

Table 2: Comparison of the objectives of EU-SA development cooperation 2003-2005 and 2007-2013 and their relative importance

2003-2005	2007-2013
1. Equitable access to and sustainable provision of social services	2. To improve the capacity and provision of basic services for the poor
2. Equitable and sustainable growth	1. promote pro-poor, sustainable economic growth
3. Deepening Democracy	3. To promote good governance
4. Regional integration and co-operation	• Regional and continental cooperation
	• Science and technology
	• Land reform
	• Sustainable resource management
	• TDCA-related financial support, providing seed money for activities related to political, economic, trade, cultural and other forms of cooperation

(European Commission, 2002a; European Commission, 2006)

Next to these objectives within the overall objective of poverty reduction, there are also the so-called **'cross-cutting issues'**. These are objectives, too, which are to be paid attention to in all other areas of actions. Table 3 summarises the cross-cutting issues of the Country Strategy Papers of 2003-2005 and 2007-2013 and their respective order.

Table 3: Comparison of the cross-cutting issues of EU-SA development cooperation 2003-2005 and 2007-2013 and their relative importance

2003-2005	2007-2013
1. HIV/AIDS	3. HIV/AIDS
2. Capacity Building	4. Capacity Building
3. Civil Society and other non-state actors involvement	
4. Governance	5. Good Governance
5. Environment	2. The Environment
6. Gender	1. Gender
	6. Innovation

(European Commission, 2002a; European Commission, 2006)

Based on this comparison, it seems reasonable and important to focus on health services (including HIV/AIDS) within the realm of poverty reduction.

Having chosen the objectives of EU development cooperation which serve as the independent variable of the study, it is now also necessary to choose a concrete program carried out by the EU within these objectives.

3.4.2 PDPHCP

As a next step it is thus necessary to find a program which can serve as a case study. This program would have to fulfil four requirements. First, it would need to fit the selected objectives poverty reduction / services / health (including HIV/AIDS). Second, the time frame in which the program was carried out would need to be adequate for the evaluation purpose. Third, data would need to be available. Fourth, the program would need to be rather typical of an EU development program.

The Partnerships for the Delivery of Primary Health Care fulfil all of these requirements: It specifically addresses the selected objectives of EU development cooperation with South Africa, the program objective being "more accessible, affordable quality primary health care for the poorest communities in 5 target provinces" (DOH, 2006). The programme was carried out between 2002 and 2008, which means that it is recent but already a few years finished which means that its possible effects can already be measured. The PDPHCP website provides rich data on the background, objective, logframe and other details of the programme. Moreover, detailed annual reports are available on the website. Finally, the programme is a typical example of the Commission's Project Approach (European Commission, 2010). The case study serves as an illustration because it is a typical EU development program. More importantly, however, it conveys important information on the partial processes which connect the inputs to the outputs and the outcomes.

3.5 Operationalisation

For the actual empirical measurement, the main variables of the study need to be operationalised. In the case of EU intervention, the values of the variables are tied to certain years, whereas sets of indicators are developed for poverty reduction and health services.

3.5.1 EU intervention

The independent variable in this study is the policy intervention by the EU, more specifically the program implemented by the EU in South Africa, namely the Partnerships for the Delivery of Primary Health Care (including HIV/AIDS). The variable is operationalised as a dichotomous variable with the two values "intervention" and "no intervention". These two values correspond to the years in which the program has not yet been implemented (before 2002) and the years in which it was finished (2008 and later). The exact years from which the data are gathered, depend on the availability of the data. In any case, for the value "intervention", the year closest to 2008 will be chosen and for "no intervention" the year closest to 2002 will be chosen.

3.5.2 Poverty Reduction

The dependent variable of the study is poverty reduction. In order to measure poverty reduction, indicators by the UN and the World Bank are used. These two sources provide indicators such as percentage of the population below poverty line, poverty gap ratio, income share by lowest quintile or the multidimensional poverty index (United Nations Statistics Division, 2011a; United Nations Statistics Division, 2011b; The World Bank Group, 2011a; UNDP, n.d.). However, the data for these indicators are surprisingly scarce. The only indicators for which both an estimate near the year 2002 and near the year

2008 is available are 'population below national poverty line', 'poverty gap at $1,5 a day' and 'poverty gap at $2 a day'. Consequently, these are the indicators used in this study to measure poverty reduction.

3.5.3 Health Services

The following shows how this concept is measured – namely by using the following five groups of indicators: immunization coverage, mortality rate, case detection rate, expenditure and number of health personnel.

In order to develop a set of indicators that measures this concept, indicators are needed which meet the following three criteria: Firstly, data from before and after the implementation of the PHPCP must be available. Secondly, the indicator (or a similar indicator) must have been used in earlier studies. Thirdly, the set must cover all three types of indicators identified by Donabedian (see below).

With regard to the **types of indicators** to include, a main contribution was made by Donabedian in 1966 with his distinction between structure, process and outcome measures (Donabedian, 2005). By structure, Donabedian means settings in which the health care takes place, including also administrative processes. Facilities and equipment, financial aspects or qualifications of medical staff can be structure indicators. Process measures can include the completeness of information obtained through clinical history or diagnostic tests. Outcome measure can for example include mortality rates, survival rates or patient satisfaction (Donabedian, 2005). This threefold distinction is still used today (see for example Chiu et al 2007; Cooperberg, 2009). Generally, most quality evaluations use outcome indicators because they are easiest to report and measure. However, a main weakness of outcomes measures is that differences in these measures can be caused by factors other than the quality of the health care (Mant, 2001). In this sense, it is also problematic to use outcome measures as a basis for specific improvements as the specific problem which causes a negative outcome may be difficult (or impossible) to locate by solely looking at the outcome indicators (Rubin et al 2001). Process measures on the other hand have the advantage that they measure quality more directly (Mant, 2001). A main disadvantage, however, is that process measures are often specific to certain illnesses or treatments which makes it difficult to provide comprehensive summaries of process measures (Rubin et al 2001). Considering the above, it is of major importance to include at least one type out of the three indicators in the set of indicators that will measure health care.

Now that we have seen which types of indicators to include, we have to decide which indicators to include. In doing so, it pays to have a look at studies that concerned themselves with theoretical or actual quality assessment in order to see **which indicators have been used in these studies**.

In their study on the development and implementation of nationwide health care quality indicator system in Taiwan, Chiu et al (2007) provide a list of 138 indicators, including in-patient, emergency, out-patient and intensive care indicators. In their comparative study of four countries (Canada, England, New Zealand, and the United States), Hussey et al (2008) use 9 indicators which were selected on the basis on feasibility, scientific soundness, interpretability, actionability and importance. Another set of indicators, spanning ten aspects of quality, is used by Kipp et al (1994) in their study on primary health care services in Western Uganda. With regard to access to health care, there are many studies that operationalise access to health care as "perceived" access (Kirby, 2008; Montgomery et al 2002). Perceived access is then often measured by asking patients (see for example Kirby, 2008). In their study on the effects of neighbourhood residential instability on access to health care, Kirby & Kaneda (2006)

use various health care supply variables as indicators, including general practitioner density. This indicator is also highlighted by the UC Atlas of Global Inequality (2004) which also highlights health care spending as an indicator for access. Other indicators include whether patients have a "usual source of care" (Kirby, 2008) and the use of health care (conditional on the need for it) (Waters, 2002; Montgomery et al 2002; Sibley & Weiner, 2011). Finally, Rohde et al (2008) used a broad set of indicators to assess primary health care in 30 countries.

Most **available data** about health care in South Africa are based on data by the World Health Organisation. The WHO's Global Health Observatory Data Repository lists 140 health care-related indicators for South Africa for the years 1990-2011 (World Health Organization, 2011a). However, it is by far and long not the case that there is data available for every indicator and/or for all of the years. For South Africa in particular, data for whole groups of indicators are completely missing. And even if data is available, they tend to be rather out-dated. This is mostly the case because the data on South Africa is for the most part based on surveys from 2003 and earlier (World Health Organization, n.d.b).

Table 4 shows selected indicators from the sources indicated above[3], the availability of the data for these indicators and their Donabedian category. As can be seen in the Table 4, indicators from the studies by Hussey and Chiu are not represented well. This is mainly due to the fact that there was no data available for the indicators used in those studies.

Table 4: Selected health care indicators, their Donabedian category, their use in earlier studies and availability of data.

Category	Available Data	Hussey	Chiu	Kipp	Kirby	UCAtlas	Rohde
Outcome	Immunization coverage for diverse diseases			Immunization coverage			DPT3 coverage
	Diverse mortality rates (infants, neonates, adults)	Asthma mortality rate, infant mortality rate	Various mortality rates				Maternal mortality ratio
Process	Case detection rate for all forms of tuberculosis			Supervision			
Structure	Various health expenditure estimates			Community involvement		Health care spending	Health care spending (by governme nt)
	Case detection			Basic skills			

[3] The studies by Kirby (2008), Montgomery et al (2002), Sibley & Weiner (2011), Waters (2002) are not represented in the table because none of the indicators used in these studies can be used in this study (due to methodological limitations and lack of data).

	rate for all forms of tuberculosis			and knowledge of staff			
	Registered health personnel			Staffing	General practitioners per 1,000 PCSA residents	Numbers of doctors	

The combination of the three criteria thus leads to a set consisting of the following five groups of indicators: immunization coverage, mortality rate, case detection rate, expenditure and number of health personnel.

Summary

We have now seen the methodology of the study. While the research question and the research design seem quite straightforward and self-evident, the methods of data collection and analysis have to be chosen carefully. Both the limited availability of quantitative as well as qualitative data can be challenging and the data do not always stem from independent sources (and therefore require special consideration). Nevertheless it seems important as well as possible to include data from several different sources. The case selection seems relatively straightforward as well since poverty reduction is such an overarching aim of EU development cooperation (with South Africa), but the choice of health services is more discretionary as the more specific objectives of EU development cooperation and their prioritisation have changed over time. Moreover, the EU policies are not always clearly outlined and one has to be careful to clearly distinguish the different policy areas and objectives so as not to blur the demarcations between the different variables. The operationalisation of the main variables is problematic, too. While ample information exists on which indicators *should* be included in such an evaluation and on which indicators *have been* included in similar studies, the (un)availability of data has been the decisive factor in deciding which indicators to include. Nevertheless, it was possible to develop a comprehensive set of indicators which cover a wide, albeit not the full, range of the variables. Finally, the methodology of a study is a tool which is used to carry out the actual research in a scientific way. The following chapter presents the empirical analysis and its results.

4. Empirical Analysis

The purpose of the following chapter is to assess whether the objectives of EU development aid outlined above have been attained and which role the EU played in the attainment of the goals. This is done according to the methodological approach outlined in the previous chapter.

At first we turn to the goal attainment part in order to assess whether or not the objectives of EU development cooperation have indeed been achieved, that is, if health services have been improved and if poverty has been reduced. For this purpose quantitative as well as qualitative data are used. With regard to the quantitative data, indicators before and after the EU intervention are measured and

compared on a national scale. However, because these data on their own are insufficient to establish whether there really is a causal relationship or only a correlation, they are complemented by qualitative data. Qualitative data are gathered on a specific policy intervention, namely the Partnerships for the Delivery of Primary Health Care Program. The annual reports and a questionnaire sent to NPO personnel are analysed. These data are then used to create a policy chain that (supposedly) links the EU intervention to improved health services and poverty reduction.

As has already been mentioned earlier, an effectiveness study consists not only of a goal attainment part but also of an assessment of the actual role of the independent variable. Consequently, several factors other than the EU policy intervention will be examined in order to assess their possible impact on poverty reduction. The factors analysed are non-EU development aid, the HIV/AIDS pandemic, the economic situation and the shortage of skills.

4.1 Quantitative Measurement

The following sub-chapter presents the quantitative findings for the indicators for poverty reduction and health services respectively.

4.1.1 Poverty Reduction

With regard to poverty reduction, we can see that the numbers for all of the three indicators have improved in the period between the introduction of the EU intervention and its finalisation (or the years towards finalisation). Tables 5-7 show how the percentages for the three indicators have decreased over said period. The population that has an income below the poverty the national poverty line has experienced a decrease from 38% to 22% from 2002 to 2008. The poverty gap at 1.5$ and 2$ a day have decreased by similar percentages, namely 4.9% and 6% respectively.

Table 5: Population below national poverty line in 2000 and 2008

Indicator / Year	2008	2000
Population below national poverty line, percentage	22,0%	38,0%

(United Nations Statistics Division, 2011a)

Table 6: Poverty gap at $1.5 a day (PPP) in 2000 and 2006

Indicator / Year	2006	2000
Poverty gap at $1.5 a day (PPP) (%)	3.3%	8.2%

(The World Bank Group, 2011b)

Table 7: Poverty gap at $2 a day (PPP) in 2000 and 2006

Indicator / Year	2006	2000
Poverty gap at $2 a day (PPP) (%)	12.3%	18.3%

(The World Bank Group, 2011c)

Based on these indicators it can thus be concluded that poverty in South Africa has indeed been reduced over the period in which the EU actively intervened.

4.1.2 Health Services

In the following the estimates for immunization coverage, mortality rate, case detection rate, expenditure and number of health personnel for the period 2002-2008 are presented. The data all come from Global Health Observatory Data Repository except where stated otherwise (World Health Organization, 2011a).

The evidence for health care is not as clear as is the case with regard to poverty reduction. The estimates for immunization coverage indicate a negative development over the indicated period. The evidence for the mortality rates is mixed, with the adult mortality rate having increased and the children's rates having decreased. With regard to expenditure on health, the developments seem to have been positive, but the changes between 2002 and 2008 are minor. The case detection rate for all forms of tuberculosis has increased substantially. With regard to the number of health personnel, the number of dentistry personnel seems to have decreased while the number of physicians has increased, but the reliability of this estimation is questionable because different sources of data have been used.

Table 8 shows the development of the adult, infant and under-five mortality rates in 2000 and 2009. While the percentages for the children's rates have improved over the period (from 5.4% to 4.3% for infants and from 7.7% to 6.2% for under-fives), the adult's mortality rate has gone up. Between 2000 and 2009 the latter has increased from 41% to 49.6% which is an increase by 8.6%.

Table 8: Adult, infant and under-five mortality rates in 2000 and 2009

Indicator / Year	2009	2000
Adult mortality rate (probability of dying between 15 and 60 years per 1000 population)	496 (49.6%)	410 (41.0%)
Infant mortality rate (probability of dying between birth and age 1 per 1000 live births)	43 (4.3%)	54 (5.4%)
Under-five mortality rate (probability of dying by age 5 per 1000 live births)	62 (6.2%)	77 (7.7%)

The immunization coverage rates show differences, too. Unfortunately, the only disease for which the coverage has improved is neonatal tetanus. Here the coverage went up from 62% to 75% - an increase by 13%. The immunization coverage for Hib3, BCG, Measles, DTP3 and Hepatitis B have all decreased. It must be noted, however, that the percentages by which the coverage has decrease all stay within a range of 1% and 3%.

Table 9: Immunization coverage for selected diseases in 2002 and 2008

Indicator / Year	2008	2002
Neonates protected at birth against neonatal tetanus (PAB) (%)	75%	62%
Hib (Hib3) immunization coverage among 1-year-olds (%)	67%	68%

BCG immunization coverage among 1-year-olds (%)	81%	84%
Measles (MCV) immunization coverage among 1-year-olds (%)	62%	65%
Diphtheria tetanus toxoid and pertussis (DTP3) immunization coverage among 1-year-olds (%)	69%	70%
Hepatitis B (HepB3) immunization coverage among 1-year-olds (%)	67%	68%

Table 10 summarises the developments with regard to expenditure on health. It can be seen that general government expenditure on health (as percentage of total expenditure on health) has slightly increased between 2002 and 2008 by 1%, which could indicate greater government involvement in health care. The decrease in private expenditure on health (as a percentage of total expenditure on health) also by 1% between 2002 and 2008 would point in the same direction, namely that the financial burden of health care has shifted slightly from the household to the government.
The other two indicators seem to contradict each other. While per capita total expenditure on health has gone up (indicating that more is spent on health care), total expenditure on health as a percentage of GDP has decreased (indicating that less is being spent on health care). This is explained by the fact, that South Africa's GDP has increased between 2002 and 2008 (OECD, n.d.a) – meaning that although the expenditure as a percentage of the GDP has declined, more money is spent in absolute terms.

Table 10: Selected types of health expenditure in 2002 and 2008

Indicator / Year	2008	2002
General government expenditure on health as a percentage of total expenditure on health	39.7%	38.7%
Private expenditure on health as a percentage of total expenditure on health	60.3%	61.3%
Per capita total expenditure on health at average exchange rate (US$)	459	210
Total expenditure on health as a percentage of gross domestic product	8.2%	8.7%

The case detection rate for all forms of tuberculosis has improved between 2002 and 2008 by 12%, as can be seen in Table 11.

Table 11: Case detection rate for all forms of tuberculosis in 2002 and 2008

Indicator / Year	2008	2002
Case detection rate for all forms of tuberculosis	72%	60%

The comparison of number of health personnel between 2004 and 2010 is problematic, not only because data on most types of health personnel is lacking, but especially because the data stem from two different sources. The numbers presented in Table 12 would suggest that the number of dentistry personnel has experienced a decrease by 38,4% and the number of physicians an increase by 3,4%. The data in 2010, however, stems from Health Professions Council of South Africa while that 2004 data stems from the WHO. Unfortunately, the HPCSA is not explicit enough about their definitions of the different types of health personnel. It would therefore be advisable not to attribute too much importance to this comparison.

Table 12: Number of dentistry personnel and physicians in 2004 and 2010

Indicator / Year	2010*	2004
Number of dentistry personnel	3445	5995
Number of physicians	36003	34829

* data from the Health Professions Council of South Africa (HPCSA, n.d.).

In conclusion, it can be said that there cannot be an easy and unambiguous answer as to whether health care has improved over the period in which the EU intervention has taken place. Health care has improved in some aspect and it has become worse in others. It is in any case not warranted to say that health care has in fact improved after the intervention by the EU.

Summary

With regard to the quantitative data, the results are thus rather mixed. While poverty seems to have improved, the picture for health services is not quite as bright. This means that the quantitative data does not confirm the hypothesis that the EU intervention has led to poverty reduction via improved health services. Whereas the relationship between the independent and the dependent variables is as expected, the intermediate variable does not fit the expectation. One explanation for this could be that the EU intervention has led to poverty reduction via mechanisms other than health services. Dollar & Pritchett for example argue that aid is fungible (The World Bank, 1998). This means that even though it might be tied to a specific sector (for example the health sector), it will inevitably have the effect of general budget support. In this sense, the EU development aid intended for the health sector could have had positive effects on poverty reduction via other mechanisms such as economic stimuli. Yet another explanation could be that EU intervention is not the independent variable, but that other factors explain the relationship. Unfortunately, the points of time for which data is gathered seem imprecise enough to allow for such a coincidence. Yet another explanation could be the indicators included in the study. Take the mortality rates for example: The decrease in the infant and under-five mortality rates leads us to think that health services did not improve and thus do not have a positive effect on poverty reduction. However, a decreased mortality rate could also be the consequence of decreased poverty because more children can survive when there is more money for food, medicine and decent housing, sanitation etc. At the same time, when more children survive, this means that the family income has to be distributed over more family members which can drive families (nominally or actually) into poverty. Put differently, because of the limited choice of indicators to be included in the study, there is the possibility that the available data misrepresent the actual situation. Because with only the quantitative data, it would not be possible to go beyond these speculations, it is necessary to include qualitative data as well. For this purpose, we zoom in from the national scale to a specific EU policy intervention, namely the Partnerships for the Delivery of Primary Health Care Program. Chapter 4.2 presents the qualitative measurement.

4.2 Qualitative Measurement: PDPHCP

For the qualitative measurement a specific EU policy intervention as been selected, namely the Partnerships for the Delivery of Primary Health Care Program, Including HIV/AIDS (PDPHCP). The PDPHCP is a program by the South African Department of Health in cooperation with the European

Union. The cooperation is based on the Trade, Cooperation and Development Agreement, the Regulation 1726/2000 on development cooperation with South Africa and the Country Strategy Paper 2003-06 which all focus on the reduction of poverty and within this aim on the improvement of health services. In total, the European Union committed EUR 50 million to the program for the period 2002-2008 (DOH, 2006). For the actual implementation of the program, five provinces were selected, namely Gauteng, KwaZulu-Natal, Eastern Cape, Western Cape and Limpopo. The overall objective of the program is **"(m)ore accessible, affordable quality primary health care for the poorest communities"** in the five target provinces (DOH, 2006). A distinguishing aspect of the PDPHCP is that it involves the communities in which it wants to reach people by establishing partnerships with community-based non-profit organisations. These organisations are the main channels via which primary health services are delivered to the people. Through the PDPHCP they are strengthened by receiving training and funding.

In the following, the effect of the PDPHCP on health services and on poverty reduction is examined. This is done by analysing the program's annual reports on the one hand and by analysing the results of a questionnaire on the other hand.

4.2.1 Annual Reports

Four annual reports are available on the website of the PDPHCP, namely the reports about the periods 2004/05 (DOH, 2008b), 2005/06 (DOH, 2008c), 2006/07 (DOH, 2008d) and 2008 (DOH, 2008e). These reports offer insights about what has (not) been achieved in the five provinces[4] during the respective years. In the following an overview of these annual reports will be presented, with regard to the NPOs involved, the staff, the training of the staff, the expenditure, the outputs, the problems encountered, and the outcomes.

NPOs

For the actual delivery of the services, partnerships with non-profit organisations are formed. Such "grass-roots" organisations are community-based and help enhance the capacity-building and ownership of the program within the community. In order to be eligible for the PDPHCP, however, NPOs has to fulfil certain criteria, such as the appointment of a minimum of five staff members and having a Board of Directors (DOH, 2008b). Both the staff members and the community care workers employed by the NPOs will then undergo a training. Initially, 225 NPOs applied for funding by the PDPHCP (DOH, 2008b)[5]. In 2005/06 already a total number of 302 NPOs was funded through the PDPHCP (DOH, 2008c). This number increased a little when compared to the number of NPOs funded in 2006/07 which was a total of 343 (DOH, 200d). Table 13 gives an overview over the number of NPOs funded per province and how this changed from 2005/6 to 2007/08.

[4] Later on in the program, it was decided to expand the PDPHCP to other provinces (North West, Northern Cape, Free State and Mpumalanga), too (DOH, 2008d). The annual report for 2008 includes data on all 9 provinces (2008e). Note, however, that the additional provinces are not included in this analysis, due to the fact that not enough data are available, especially not for the years prior to 2008.

[5] For an overview of the criteria according to which the NPOs were selected, see Appendix A.

Table 13: Number of NPOs funded per province in 2005/06, 2006/07 and 2007/08

Province/ Year	Western Cape	Limpopo	KwaZulu-Natal	Gauteng	Eastern Cape	Total
2005/06	56	69	52	70	55	302
2006/07	79	89	52	68	55	343
2007/08	79	201	61	66	55	462

(DOH, 2008c; DOH, 2008d; DOH, 2008e)

While the number of NPOs in the Eastern Cape and KwaZulu-Natal did not change between 2005/06 and 2006/07, it decreased slightly in Gauteng. The Western Cape and Limpopo on the other hand experienced an increase between 2004/05 and 2005/06, by 23 and 20 NPOs respectively. Interestingly, though, this change in numbers of NPOs did not translate into a change of numbers with regard to the community care workers employed at the NPOs. The total number of these carers remained 4025 between 2005/06 and 2006/07 and the distribution of the carers per province did not change either. A possible explanation for this phenomenon could be that the available (and already trained) carers were seconded to the newly contracted NPOs instead of new carers being employed. However, the whole idea behind the community care workers is that they are community-based rather than mobile, so this might be an unlikely scenario. Another explanation could be that the numbers are wrong because they had not been updated. In any case, the annual reports do not provide any answer to this issue.
The most significant change with regard the amount of NPOs is the increase in the number of NPOs in Limpopo between 2006/07 and 2007/08. While the number of NPOs funded in the other provinces remained relatively stable in the same period, Limpopo more than doubled its number from 89 to 201. Not only the increase in itself is unusual, but also the total number of NPOs funded in 2007/08 exceeds the numbers in all the other provinces by far. Surprisingly, the annual report 2007/08 only mentioned that a call for proposals was issued and consequently the eligible NPOs received funding, which was a total number of 201 (DOH, 2008e). It does neither mention the unusual increase nor any reasons for it. However, if one takes a closer look, one notices that in 2007/08 suddenly five instead of three districts in Limpopo participated in the PDPHCP and NPOs in this districts are eligible for funding (DOH, 2008d; DOH, 2008e). The increase in participating districts could well be a reason for the striking increase in the number of NPOs.

Staff

One main road via which the PDPHCP contributes to poverty alleviation is through employment. Therefore it is important to look at the staff that has been taken on by the program. This includes both the staff working at the Programme Management Units as well as those working at the NPOs. Of course, taking on staff necessary to carry out a program, could be seen as input variable. This is certainly the case. However, because of the number of people that gained employment because of the program (+/- 2000), it can and should be considered as output variable, too. And so it is treated indeed in this case.

The overall structure that connects the provinces is formed by the National Programme Management Unit (NPMU), which was established in March 2004. Also in 2004, all program officer posts were filled and 98% of the posts in the provincial structures were filled (DOH, 2008b). Consequently, the Provincial

Programme Management Units (PPMU) were established. Table 14 gives an overview over the personnel appointed in the provinces in 2005/06. Note that this table displays the numbers of employees appointed at the management units, not those working for the NPOs.

Table 14: Personnel appointed in the provinces 2005/06 and 2006/07[6]

Province/ Position	NPMU	PPMU Eastern Cape	PPMU Gauteng	PPMU KZN	PPMU Limpopo	PPMU Western Cape	Total
Director	1	1	0 (1)	1	1	0	**4 (5)**
Deputy Director	2	1	2	1	2	1	**9**
Assistant Director	0 (1)	4	3	4	3	4	**18 (19)**
Chief/Senior Professional Nurse	0	0	3	0	0	18	**21**
State Accountant	0	1	1	1	1	0	**4**
Chief Community Liaison Officer	0	3	0	3	3 (2)	4	**13 (12)**
Senior Administration Clerk	1	4	4	4	4	4	**21**
Senior Consultant	2	0	0	0	0	0	**2**
Junior Consultant	4 (3)						**4 (3)**
Total	**10**	**14**	**13 (14)**	**14**	**14 (13)**	**31**	**96**

(DOH, 2008c; DOH, 2008d)

The data shows that not many and no major changes have occurred with regard to the positions of the staff appointed at the provinces. This can be interpreted as a good sign, because stability and sustainability with regard to employment is an important objective of the program. Moreover, there are some differences between the provinces with regard to which positions they filled and with how many people. While Gauteng and Western Cape have three and 18 senior professional nurses, respectively, the other provinces have none. Similarly, while Gauteng has no chief community liaison officer, the other provinces all have two to four. Nevertheless, almost all provinces have filled eleven to 14 posts in total. The only exception to this is the Western Cape which filled 31 posts in total. It would be interesting to know why this is the case. Especially when considering that we have just seen that the number of NPOs funded (and therefore coordinated by the PPMU) in the Western Cape is not higher than in the other provinces. Unfortunately, the annual report 2004/05 does not offer an explanation as to why this is the case. It only states that the Western Cape "appointed a large amount of personnel" (DOH, 2008b). Another aspect in which the Western Cape stands out from the rest is the number of meetings held. While the other programme management units held 11 (Limpopo), 19 (Gauteng and Eastern Cape), and 27 (KwaZulu-Natal) meetings in 2004/05, this number accumulated to 394 in the Western Cape (DOH, 2008c).

[6] The numbers for 2006/07 are in brackets, if the numbers changed.

With regard to what has changed compared with the situation before the program, the total number of staff appointed at the provinces (96) can be seen as an absolute gain, as none had been employed by the program before the program started. This is different for the staff members at the NPOs. Here we do not know what the situation was before the program started.

Table 15 shows the number of staff appointed at the NPOs since the beginning of the program. This number excludes the community care workers but includes project managers, coordinators, administrative staff and professional staff employed by the NPOs (DOH, 2008c).

Table 15: Number of staff members appointed at NPOs in 2005/06 and 2006/07

Province/ Year	Western Cape	Limpopo	KwaZulu-Natal	Gauteng	Eastern Cape	Total
2005/06	154	208	112	164	195	833
2006/07	237	320	156	230	195	1138
2007/08	301	585	128	202	114	1330

(DOH, 2008c; DOH, 2008d; DOH, 2008e)

The data show an overall increase in the total number of staff employed by the NPOs in the five provinces, which is very positive in terms of employment opportunities in the communities. The development have been especially positive in the first years, between 2005 and 2007: no negative changes have occurred. Between 2006/07 and 2007/08, however, the staff numbers have decreased in KwaZulu-Natal, Gauteng and Eastern Cape. In Gauteng, this could be explained by a decrease in the number of NPOs funded. In the Eastern Cape, however, this number stayed the same and in KwaZulu-Natal it even increased between 2006/07 and 2007/08. The annual reports provide no straightforward explanations for these developments. Eastern Cape, however, reported major problems with regard to the cash flow of funds (DOH, 2008e) which could have translated into the quitting of some care workers because they did not get paid anymore.
The significant increase in the number of NPOs in Limpopo is probably the explanation for the increased number of employees in Limpopo in 2007/08.

Training

A very important factor through which the functioning and quality of the program is guaranteed, is the training of staff. Initially, 13 different courses were offered for the staff at the PPMUs, including for example an introductory training, trainings on MS Excel, Project management, partnership agreements and leadership. With the exception of the introductory training in which staff from the NPMU and every province participated (a total of 115 participants), not one other training was taken by all provinces. The participation in the training varies strongly with regard to the number of provinces and the number of participants per province. In the 59-days training for HBC, only Limpopo participated, but with 75 participants, which is the highest number of participants from one province in a training. Gauteng, Limpopo and Western Cape all participated in a training on finance, but while Gauteng and Limpopo both had 2 participants, Western Cape had 35 (DOH, 2008b).

The trainings that were offered in the consecutive years included some of the trainings offered in the beginning, but also included, inter alia, trainings on report writing PHC management, powerpoint, business writing skills, palliative care and communication. Again, the amount of trainings per province differed significantly (with the Eastern Cape having participated in four different trainings and the Western Cape having participated in 22 different trainings) as did the number of staff attending the trainings (DOH, 2008c).

Expenditure

The funding for the program is disbursed via the National and Provincial Departments of Health to the national, provincial and local levels (DOH, 2006).

In the first year in which the program was actually carried out, namely 2004/05, a total amount of ZAR 28,739,727 was spent. As the budget for that year was ZAR 56,913,472, this means that only 50.5% of the budget was spent (DOH, 2008b). The annual reports do no explain why 45.5% of the available money was not spent[7]. Moreover, the annual reports are not always as clear as one might wish on what constitutes the budget and what constitutes the expenditure. The annual report states both the amount of ZAR 28,739,727 and the amount of ZAR 23,707,803 as the total expenditure. However, in some sections it becomes clear that the latter amount is the amount spent under work plan 2, while that other seems to really be the total expenditure. Moreover, in several places ZAR 56,913,472 is states as the total budget disbursed, but in another figure, this amount is stated to be ZAR 51,881,547. The only clear thing seems to be that there is a major discrepancy between the budget and the expenditure. Table 16 shows the total budget disbursed vs. the total of expenditures for the years under review.

Table 16: Total Budget Disbursed vs. Total of Expenditures, ZAR

Year	Budget	Expenditure	% of budget spent
04/05	56 913 472	28 739 727	50.5
05/06	ca. 130.000.000	60 511 232	46.5
06/07	198,093,981	215,686,360	108.9
07/08	155,000,000	76,041,867	49.1

(DOH, 2008b; DOH, 2008c; DOH, 2008d; DOH, 2008e)

As can be seen, the same seems to be true for 2005/06 as for 2004/05 (DOH, 2008c): of the budget of ca. ZAR 130,000,000 only ZAR 60,511,232 was spent[8]. In 2007/08 again something similar has occurred. Here ZAR 76,041,867 of the budget of ZAR 155,000,000 has been spent. In all three cases only about half of the budget had only been spent.

Clearly then, it can be seen, that 2006/07 was a special year in this regard. Of the budget of ZAR 198,093,981 an amount of ZAR 215,686,360 was spent, which amounts to a surprising 108.9% of the budget. The most straightforward explanation would of course be that a (albeit small) part of the

[7] From the responses to the questionnaires it will become clear that this was probably due to the fact that the money was often disbursed late. Therefore it could not be spent in the planned way, which resulted in a surplus at the end of the year.

[8] The annual report only offers a diagram in which the precise amount is not indicated.

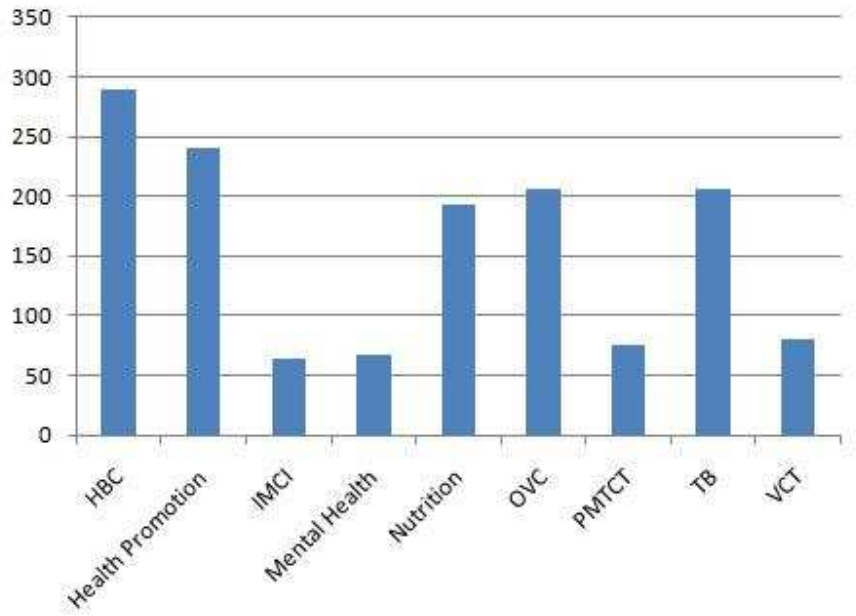
unspent amounts from the previous years have finally been spent. Unfortunately, however, the annual reports offer no explanations to this phenomenon.

Outputs

The PDPHCP helps NPOs to provide primary health care in their communities. Primary health care, however, involves a wide range of different services. In the case of the NPOs participating in the PDPHCP, these services involve, inter alia, victim empowerment, HBC, hospice, OVC, rehabilitation, counselling and support, nutrition, mental health, advocacy for safe circumcision, and health promotion (DOH, 2008c; DOH, 2008d). Figure 6 shows the distribution of the types of PHC services provided by the NPOs in the period 2006/07.

Figure 6: Distribution of Types of PHC Services Delivered by 313 NPOs[9]

(Number of NPOs and Type of PHC service)



(DOH, 2008d)

Table 17 provides an overview over the service provision and utilisation in the period 2005/06 in the provinces Western Cape, Limpopo and KwaZulu-Natal.

Table 17: Service Utilisation in Western Cape, Limpopo and KwaZulu-Natal in 2005/06.

Indicator	Western Cape	Limpopo	KwaZulu-Natal
Median number of carers	817	828	783

[9] 313 NPOs does not correspond to the number of NPOs previously mentioned for the period 2006/07. This is probably due to the fact that not all NPOs reported data on this topic.

Number of home visits	661060	n/a	24280
Number of patients visited	51346	83636	9578
Average number of visits per patient	13	1.4	n/a
Median number of visits per day per carer	4	n/a	n/a

(DOH, 2008c)

Unfortunately, for this period, all the data for the Eastern Cape and Gauteng lack and not all of the data for the other three provinces have been reported. What can be seen, though, is that despite similar numbers of care workers, the numbers of home visits are significantly different for the Western Cape and Kwa-Zulu Natal. However, based on the available data, it is not evident where these difference stem from and it is not possible to make other comparisons.
The data on service utilisation for the period 2006/07 are available for all five provinces and more comprehensive. Table 18 summarises these data.

Table 18: Service Utilisation per Province in 2006/07.

Province	**Number of NPOs**	**Number of Beneficiaries per Day**	**Median Daily Number of Beneficiaries per NPO**	**Number of Carers**	**Median Number of Carers per NPO**	**Median Daily Number of Beneficiaries per Carer**
Eastern Cape	55	3559	40	1161	14	2.9
Limpopo	84	7430	44	742	17	2.6
KwaZulu-Natal	44	5848	70	685	20	5.5
Gauteng	66	7003	29	994	12	2.4
Western Cape	68	6366	65	364	16	4.1
Total	**317**	**11129**	**49**	**3946**	**15**	**3.3**

(DOH, 2008d)

The data show that there are significant differences between the provinces with regard to every aspect of the service delivery. Unfortunately, the annual reports offer no explanations as to why these differences exist.

Problems

The Annual Reports also list those aspects of the (implementation of) the program which were problematic. In the year 2004/05, for example, the following areas were listed as the main challenges of the program: the late start of the program, the centralised procurement system, the poor understanding of the procurement system and the lack of capacity and support in some of the provinces (DOH, 2008b).

One year later, a completely different set of challenges was outlined, including the non-existence of norms and standards for NPO service delivery, poor integration of services at (sub-) district levels, poor referral systems, lack of coordination, lack of human resources for the management of NPOs on the ground (DOH, 2008c). Unfortunately, for the period 2006/07 such a concise list of challenges does not exist (DOH, 2008d). In the period 2007/08, the main challenges included that the demand outweighed the available resources, the availability of funds, the alignment of the PDPHCP budget with the national budget, the integration into the DOH and the quality of the data (DOH, 2008e). Looking at these lists of problems and challenges, it is difficult to find a common denominator as each list seems to point out different aspect than the other. It seems most likely that this is due to the fact that in each phase of the implementation of the program, different problems were encountered. Moreover, it might also be interpreted as a positive sign that the same problems are not complained about over and over again – maybe because they have been solved in the meantime.

Outcomes

The Annual Reports also list the effects of the PDPHCP on skills development, poverty alleviation, unemployment, women empowerment, and SMMEs within the health sector. Here, the PDPHCP is assumed to have a positive effect on all aspects, due to the employment and training of staff and carers (skills development and unemployment), the use of a modified PPP model which turns health NPOs into SMMEs within the health sector and the overrepresentation of female staff and carers within the NPOs (women empowerment) (DOH, 2008c; DOH, 2008d, DOH, 2008e).

For the purpose of this paper, the effects of the PDPHCP with regard to health services and poverty reduction are of course of particular interest. The PDPCHP is assumed to contribute to the reduction of poverty in the provinces mainly through the employment of the staff and carers (NPOs were obliged to appoint at least 5 staff members and pay them at least ZAR 1000 per month, carers were entitled to a job description and job contract and many are paid) (DOH, 2008c; DOH, 2008d). With regard to improved health services, the following benefits are identified: improved referral systems between health facilities and communities and homes, improved default tracing for chronic diseases, more involvement of the communities in health services, improved health literacy, improved quality, and improved access (DOH, 2008d).

However, despite these findings, the annual reports do not mention any effects of the PDPHCP on poverty alleviation through improved health services, such as the mechanisms that relate improved health to poverty reduction, as mentioned in Chapter 2.

Summary

To sum up, the annual reports have offered us the opportunity to look at the PDPHCP from a top-down perspective. Several angles were included in the reports which shed different lights upon the program. Seeing how many NPOs were funded and supported by the program and how this number increased in the course of the program, the program can be assumed to have had a positive effect on the communities, in terms of for example better access to health care, self-sufficiency, and employment opportunities. The same holds true for the staff employed because of the program. Especially the number staff employed at the NPOs is significant. Not only has the number of staff been relatively stable, it has also increased over the years, which is very positive. The annual reports offer no information,

however, on what will happen when the EU funding will eventually cease. If one looks at the trainings offered to the employees, it seems that they were able to choose from a diverse set of relevant and important trainings. If one takes a closer look, however, it becomes apparent that most trainings were attended only by a very small amount of people and that the attendance of trainings differs substantially per province. It seems that there is much room for improvement here. Especially because the training of the staff is such an essential requirement for the success of the program. And additionally, the further education of the staff would increase their employability after the end of the program. With regard to the expenditure, the annual reports are a rather difficult source. The numbers offered are difficult to compare over the years, due to differential labelling and the use of the same labels for different types of expenditure. Nevertheless it becomes clear from the reports that most of the years, only about 50% of the budget have been spent. This could be a sign of the absence of major corruption or of the fact that the program has performed below its potential. However, the annual reports offer no explanation whatsoever. With regard to the provision of services by the NPOs, the picture seems positive as a wide range of services is delivered. Moreover, these services seem relevant and important to the needs of the communities. Unfortunately, again the annual reports fail to provide explanations for apparent questions, for example why there are such significant differences between the provinces with regard to almost every aspect of the service delivery. With regard to the problems encountered, it is difficult to identify a common denominator or to detect certain developments over time. It seems that the reports summarise problems as they were encountered on the go, but without identifying deep-rooted structural weaknesses of the program. Finally, when it comes to the outcomes of the program, the annual reports list many positive effects, such as skills development, women empowerment, SMMEs etc. Moreover, several improvements with regard to health services are identified. However, even though the PDPHCP is assumed to have contributed to poverty reduction, it is assumed to have done so mainly through the creation of employment. Even though this is portrayed as such an important variable in the annual reports, it should actually be seen as a positive by-product – rather than as an intended achievement. Namely, instead of the creation of employment, the PDPHCP set out to make primary health care for the poor more accessible and of good quality (DOH, 2006). That is, to improve health care by focussing on the two aspects quality and access. These are exactly the two aspects which we would expect to be improved according to the theory. These improvements could then have led to the reduction of poverty. The annual reports, however, do not offer any clues which would support any of the mechanisms outlined in the theoretical background section through which we would have expected the program to have contributed to poverty reduction via improved health services.

The annual reports provide important data and information which are essential for a better understanding of the PDPHCP and its implementation. However, they also leave many blank spots. In order to get even better insights into what actually happened, a questionnaire was sent to several individuals involved in the implementation of the PDPHCP. The responses are presented in the next sub-section.

4.2.2 Questionnaires

In order to fill in the missing pieces of the annual reports and to get more insights into the information provided in the reports, a questionnaire has been conducted among several NPOs that participated in the PDPHCP. The NPOs were selected from a list published on the website of the PDPHCP (DOH, 2008a) which listed the contact details of all NPOs participating in the PDPHCP, which accumulated to a total

number of 625 NPS listed. However, only those NPOs for which e-mail addresses were listed were selected for the questionnaire. This slimmed down the number to 118 NPOs to whom an introductory e-mail was sent. In this e-mail the contact persons of the NPOs were asked to provide information on the PDPHCP and if they were willing to answer a question. However, of the 188 e-mails sent, 66 did not reach the recipients due to mail delivery failure. This is probably due to the fact that the list is a little out-dated as it was last updated in 2008. Of the 52 NPOs that can be assumed to have received the e-mail, 10 responded. Of these 10 respondents 1 indicated that they had never participated in the PDPHCP, 3 forwarded the message to another person but were never heard from again and 6 indicated that they were willing to fill in the questionnaire. Consequently, the questionnaire was sent to them and 3 of them returned the filled-in questionnaire[10]. Despite several attempts to follow-up on the promises made, this number could not further be increased. In the questionnaire, the respondents were asked about professional details and information about the implementation of the PDPHCP within their organisation. Finally, there was also a section consisting of non-obligatory questions in which participants could state their opinions on some broader issues surrounding health care and poverty in South Africa[11]. Unfortunately, with this method of contacting informants, only NPOs could be reached. However, because these NPOs work in such a locally confined setting, they do not have a network or regular contact with other NPOs. It is therefore not possible to ask them about comparisons with other provinces and other aspects of 'the bigger picture'. Consequently, efforts were made to contact the NPMU and the PPMUs, the South African Department of Health, **the Delegation of the European Union to South Africa**, and EuropeAid. However, not much useful information came from this, due to the fact that some contact details were not known, websites with information did not work, e-mails were not answered and constant referrals to other people were made because the person contacted was not the one in charge. Therefore, the reader should keep in mind that the following responses only reflect the perspective of NPOs – and only a few of the many that actually participated[12].

Personal & Professional Details

Two of the three NPOs represented in the questionnaire responses are based in Gauteng and the third in Limpopo. The three NPOs are active in the fields rehabilitation, health and home-based care. They are involved in the delivery of services, training, supervision, support and provision of home-based case. The contact persons who filled in the questionnaires (and whose opinions and experiences are represented therein) are a centre manager, a trainer/manager and a program manager. The PDPHCP in Gauteng started for both NPOs in 2006 and for the Limpopo NPO in 2005. Two contact persons state that they do not know whether this was later than scheduled, while one of the Gauteng contact persons states the assumption that the program probably had a late start due to it being worked on the by Department of Health.

[10] With regard to this questionnaires, there is the danger that those NPOs who replied and filled in the questionnaire are structurally different from those who did not (e.g. they might have more money and resources and are therefore easier to reach and they might also have more staff which allows them to make some time to fill in the questionnaire). It seems, however, that these bias will not be of great consequence as even the NPOs who did respond reported difficulties with regard to money and funds.

[11] For the complete questionnaire see Appendix B.

[12] For a tabular overview of the responses given in the questionnaire see Appendix C.

PDPHCP

The contact persons report that the **most difficult things in the start up** of the program were the late funding (which resulted in a loss of staff), community mobilisation and community ownership and confusion about how the program should be run. The **most difficult aspects of the finalisation** of the program, however, were the reporting (here the workload increased and became more difficult), the disrespectful treatment of the NPOs, and again, the later funding, which had deteriorating effects on both the delivery of services and certification of trainees. The contact persons stated that the **most positive effects of the PDPHCP** were employment, health care for sick people, the community involvement and the partnerships with NPOs (which resulted in more health services through which many lives could be improved and saved). With regard to the **most negative effects of the PDPHCP**, one person stated that there were none. The others name the negative role of officials which had negative effects on the community and the communities' unwillingness to take responsibility as well as the fact that not much capacity was given to the communities (in terms of time and resources). Two out of three think that the PDPHCP had a positive **effect on the health care in their province** while the third even thinks that the effect was very positive. As reasons for this they name the PDPHC has led to job creation, PHC for sick people, training of care workers, education on health issues and an extended reach of the health services provided. With regard to the **effects of the PDPHCP on the health care in South Africa**, two think that these were positive while the third does not know. Again, two out of three think that the PDPHCP had a positive **effect on poverty reduction in their province**. Their reasons to think this are that the employment created by the PDPHCP is a remedy for poverty-related problems and that when people are cared for by health programs, they are able to work which also results in the reduction of poverty. The third, however, thinks that it had no such effect because training of care workers and visits to families could not reduce poverty. With regard to the **effects of the PDPHCP on the reduction of poverty in South Africa**, the picture looks similar: two think that the effects were positive while one does not know. When asked which **aspects of the PDPHCP they would improve**, the respondents named the clearer communication of plans, the understanding of the program by officials, the delivery of funding on time, the awarding of certificates as promised, logistical improvements with regard to the training, to have an integrated rural development project with health at its centre, to have projects that involve the community and community ownership, the respect given to NPOs and that the opinions and experiences of the NPOs should be taken into account. As regard the **role of the EU** two think that it was good and one does not know. They would **improve the EU's role** by randomly select participating NPOs for site visits, by having integrated rural development projects and by involving the EU officials more.

Non-Obligatory Questions

The respondents were asked what are, in their opinion, the **main reasons for poverty** in South Africa. They answered that there are not enough companies to absorb the different levels of available skills, that there are insufficient pioneers of business, the (resulting) unemployment, the laziness of individuals, high illiteracy rates, high drop-out rates, the (resulting) poor education, the land is not worked by people, dependency on government grants and the HIV/AIDs pandemic which weakens the people. With regard to the **main problems with regard to health care** in South Africa, they named the discrepancies between the law and what is actually implemented, the fact that government officials often write reports about things they do not know anything about, the inadequate funding by the government

(resulting in brain drain), the diseases such as HIV/AIDS, diabetes and high blood pressure, teenage pregnancies, the insufficient number of medical facilities and the insufficient number of staff to work them – resulting in an overburdening and a low quality of health care, corruption, the poor management of the health sector and the person who currently holds the position of National Health Minister. Their solutions **how to improve the health care** in South Africa, include having an integrated rural development, and the training and hiring of more medical staff by the government, a more competent management for the health sector and the prosecution of corruption and mismanagement. Their proposals **how to reduce poverty** in South Africa, include to have people work the available land, the motivation of children, income-generating projects for communities and long-term job creation strategies such as improving education and recruiting people to be educated in the most necessary fields. The respondents think that the factors that have led to the **improvement of health care in South Africa during the past decade** are the training of nurses and use of lay counsellors for the education about HIV/AIDS and other diseases, HBC for the education of families about immunization of their children and the involvement of more NPOs in the health sectors (which has led to improved access to health care). They think that the remuneration of HBC workers and government grants for the older people have led to the **reduction in poverty in South Africa during the past decade**.

Summary

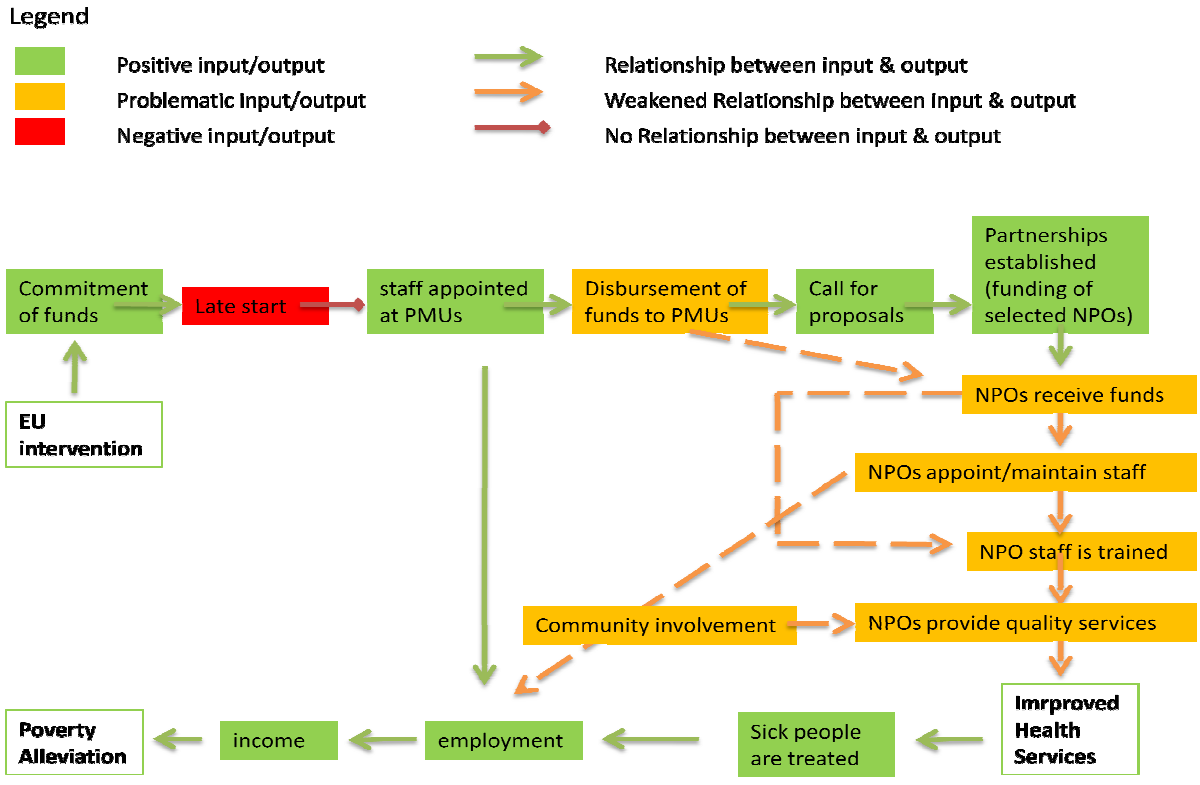
The first notion that must be made here is a note of caution not to see the responses presented above as representative. Only a very small percentage of NPOs involved participated in the questionnaire. Therefore, the insights gained through the questionnaires must instead be seen as information complementary to the annual reports. Nevertheless, they prove to be very useful in this function. For example they offer explanations as to why the first annual report was issued only in 2004 (because of the late start of the program) and as to why often only about 50% of the budget was spent (because the funding often arrived late and the money could therefore not be spent). Moreover the questionnaires provide insights on the perceived success and positive effects of the programme. Here the positive effects for the sick people who now receive treatment as well as the increased employment opportunities and their positive economic effects on the households stand out. Moreover, the positive effects of the program on health care and poverty reduction are felt. Here gain employment is one of the ways via which this was achieved, but this time not the only one. Rather some of the mechanisms outlined in the chapter on the theoretical background turn up, including the explanation how better care for sick people can result in alleviation of poverty by enabling the sick to work and gain income instead of spending the family savings. Of course, the responses also shed light on the perceived weaknesses and problems of the program. One respondent was for example very sceptic as to whether the PDPHCP had any effects at all beyond the positive effects on health care in the province. Among the weaknesses of the program was of course the late funding but also difficulties in the communication between the government officials and the workers on the ground as well as the disrespectful treatment of the latter by the former. The non-obligatory part of the questionnaire is helpful with regard to getting to know the respondents' opinion on the importance of health services in the reduction of poverty. No one mentions health services deficiencies as a reason for the existence of poverty in South Africa. And more importantly, no one mentions improvement of health services when asked about the best strategies to reduce poverty. Thus, while it is recognised that the PDPHCP has had a positive impact on

poverty, and this not only via employment but also via improvements in health care, the participants do not seem to think that improving health care is the main road to poverty alleviation.

4.2.3 Results

In the following, a results chain will be presented and explained, linking the main independent variable (EU intervention) via the main intermediate variable (improved health services) to the main dependent variable (poverty reduction). In order to be able to form this chain, the results from the annual reports have been combined with the insights gained from the questionnaires. Consequently, the following input/output variables have been identified as the most important steps between the main variables: 'commitment of funds', 'late start', 'staff appointed at PMUs[13]', 'disbursement of funds to PMUs', 'call for proposals', 'partnerships established (funding of selected NPOs', ' NPOs receive funds', 'NPOs appoint/maintain staff', 'NPO staff is trained', 'NPOs provide quality services', 'community involvement', 'sick people are treated', 'employment', and 'income'. The time order of the variables has mainly been derived from the information in the annual reports, while the information on how well (or not) the steps were carried out was mainly taken from the questionnaire responses. Figure 7 shows a schematic display of the relations between the variables.

Figure 7: Policy Chain of the PDPHCP, connecting "EU intervention", "Improved Health Services" and "Poverty Reduction"



[13] The notion 'PMU' includes both the National Programme Management Unit (NPMU) as well as the Provincial Programme Managment Units (PPMUs).

The chain starts with a positive input variable, namely the **commitment of funds.** This is based on the respective Country Strategy Papers and the Multi-Annual Indicative Frameworks. The next input/output, however, was negative: the **late start** of the program. The late start could be witnessed by the fact that the first annual report only appeared in 2004 and was also evident in the responses by the NPO contact persons. Although the PDPHCP officially is a six-year program starting in 2002 and ending 2008, it actually took off only in 2004. The first annual report, however, only marginally mentions the late start. Based on the problems encountered so far, the report proposes to "conduct a review of the programme implementation with regard to the start dates (...) because nothing happened between 2002 late 2003" (DOH, 2008b). Therefore, as long as the program did not actually start, the EU intervention cannot really said to have taken place – hence the red arrow between 'late start' and the next variable which indicates the missing relationship between the variables. However, one must be careful to conclude that really nothing happened in those years. One NPO contact person indicated that the years 2002-2004 were "all about identifying funders for the construction, building, recruiting human resource etc" (NPO contact person, personal communication, June 2011). Nevertheless, even if some things did happen in those years, it must have been too less. In any case, it made the European Health Advisor Ian Ralph write: **"**At the beginning of the programme it seemed as if there was very little hope" (DOH, 2008b).

Eventually, however, the program did start. With regard to the **staff appointed at PMUs**, the annual reports indicate that there do not seem to have been any major problems. Although some individuals have resigned and not every post could immediately be filled, overall everything seems to have gone well and no major changes have occurred throughout the years. According to the questionnaire responses, the **disbursement of funds to PMUs**, however, has been problematic at times. This can be assumed to be the reason for the fact that three out of four times only half of the available budget was spent, which could be seen in the annual reports (but for which no explanation was offered there). Of course this had negative consequences for the flow of cash and the activities that depend on it. Here it should be noted that the surpluses at the end of the years could also be interpreted as a sign of the absence of major corruption. However, it is not clear whether the surpluses existed in the form of actual money on the site, or whether it was only theoretical in nature (because it had not been transferred by the EU) and could thus not possibly have been used for corruption even if the intention had been there. More information would have been necessary to go beyond speculations here. Nevertheless, what can be concluded from the information at hand, is, that the disbursement of funds was indeed problematic.

The **call for proposals**[14] on the other hand seems to have gone smoothly in all provinces. The annual reports as well as a copy of such a call for proposals show that a clear set of expectations which the NPOs had to fulfil and a clear set of indicators against which the NPOs would be evaluated was developed and used. Soon, the **partnerships were established** and the funding of the selected NPO could begin. As becomes apparent from the annual reports, many partnerships were established in all of the provinces, and the number of NPOs funded increased over the years. Similarly, the respondents do not mention any difficulties with regard to the call for proposals and the establishment of the partnerships.

[14] See Appendix A for the evaluation criteria for the selection of NPOs.

A consequential problematic input/output variable then follows: whether or not (and when) the **NPOs received the funds**. Even though the annual reports are mainly silent on this topic, the NPO contact persons reveal major problems with regard to this aspect. And, as already mentioned, the fact that the budget was often not nearly fully spent supports this point, too. Because of the importance of this specific link in the chain, several other consecutive input/output variables are affected, too. The questionnaire responses reveal that the **appointment and maintenance of staff** at the NPOs was jeopardised by the unavailability of funds because the NPOs cannot pay them (in time) and sometimes this even resulted in the loss of staff. The same holds for the **training of the staff**, which cannot take place or can only take place for some of the staff when not enough money is available. This can also be evidenced in the annual reports where huge differences with regard to the variety of trainings attended as well as with regard to the amount of people that attended the trainings are reported. One contact persons reported that the certification of the trainings that were actually carried out also became problematic. This again can be assumed to have important consequences for the provision of **quality services by the NPOs**. However, no quality indicators or evaluations were included in the annual reports, so there is no hard data to support this. Nevertheless, it seems a logical and reasonable assumption, partly supported by the claim of one respondent that underfunding of health care and all its consequences leads to a lower quality of health care. Simultaneously, the quality of the services provided by the NPOs is also influenced by **involvement of the communities** in which the services are delivered. One NPO contact person reports that community ownership is problematic and that communities are unwilling to take responsibility. This can have deteriorating effects on service delivery. For the **improvement of health services** this means, that it depends on the extent to which the inputs before were problematic. Put differently, the policy chain has not been broken in any place, but because of several problems the chain has been weakened and the outputs are not as strong as they could have been. But based on the annual reports and especially the responses from the questionnaires we should conclude that a substantial improvement has nevertheless been achieved. Even though the program's full potential has probably not been realised.

The fact that health services have indeed been improved opens up the possibility that this had a beneficial effect on the reduction of poverty. At the point where services are provided, **sick people receive treatment** which they would not have received if the program had not been in place. That this actually happened on quite a large scale can be witnessed in both the annual reports and the questionnaire responses. In economic terms, this means for example that these individuals can participate in the labour market again and that they are more productive. In Figure 7 this is summarised under **employment**. Moreover, employment is also enhanced by the appointment of staff at the PMUs and the NPO. This additional mechanism is stressed predominantly in the annual reports as the main way via which the PDPHCP has contributed to poverty alleviation. It is also mentioned in the questionnaires along with the other mechanism summarised under employment. In short, all of this means benefits for the households in terms of **income**. The evidence from the annual reports and the responses from the questionnaires also indicate that poverty has been reduced (to a certain extent) by the PDPHCP through income via employment.

In summary, this means that we have now seen how the EU intervention (via many intermediate input/output variables) has led to improved health services which have led to poverty reduction. We

should, however, not forget, that the PDPHCP probably has not realised its full potential due to several problems in the intermediate stages. Additionally, even though there is evidence for most steps from the annual reports and the questionnaire responses, some steps and their problems have been inferred from logical reasoning.

We have now, according to Bressers's method (as explained above) identified the main independent and dependent variables, we have split up the main process up into partial processes and we have analysed these partial processes. The remaining step is now to have a look at other factors, except health services, that could have contributed to a decrease (or increase) in poverty in South Africa. For this purpose we zoom out from the individual project to the national scale again.

4.3 Controlling for other variables

Having examined the attainment of the goals from a quantitative as well as a qualitative perspective, we must now turn to the role of the EU in the attainment of the goals. It is in this step where the difference between a goal attainment study and an effectiveness study lies. Four factors (other than EU development aid in the form of the PDPHCP) that could have had an influence on the reduction of poverty in South Africa are assessed. These factors could influence poverty and its reduction in both a positive and a negative way. Note that in this case the focus is on the reduction of poverty as the end goal and final dependent variable. It would be very difficult to find factors that have influenced poverty through health care without analysing them as deeply as in the case of the PDPHCP. Because another in depth analysis of the sort already conducted is not possible here, the focus is on broader factors, such as non-EU development aid, HIV/AIDS, the economic situation, and skills shortage.

4.3.1 Non-EU development aid

South Africa has long been a recipient country of development aid. Table 19 gives an overview over the amounts of ODA that South Africa received in the years 2001-2007.

Table 19: Official development assistance and official aid (current US$)

Year	Value
2007	794,140,000
2006	720,440,000
2005	680,350,000
2004	628,110,000
2003	641,250,000
2002	504,570,000
2001	427,830,000

(UNData, 2011a)

The table shows a continuous increase in the ODA received. Of course, South Africa receives development aid from several sources, in the form of bilateral as well as multilateral assistance. Table 20 shows South Africa's top five donors in 2008/09.

Table 20: Top five donors of gross ODA (2008-09 average) in USD million

Country	USD m
United States	451
EU institutions	159
Germany	130
United Kingdom	93
Netherlands	43

(OECD, n.d.b)

The fact that the EU is in second place in terms of ODA given, would suggest that the EU development aid is a very important factor. If one looks at the amounts spent, however, one sees that the amount spent by the US is almost three times as much. Furthermore, only the combined amount of the UK and Germany already exceeds the amount spent by the EU. Nevertheless the EU's ODA to South Africa represents 25% of all ODA to South Africa (European Commission, 2002a). Still, that leaves 75% to be spent by other parties and on other projects which can reduce (or increase) poverty in many different and additional ways. If put in this perspective, the EU's contribution is certainly important but it is one among many. It is also important to know that the external assistance that South Africa receives constitutes only about 2% of the annual government budget (Schneider & Gilson, 1999). There is therefore much room for the South African government to take action to reduce poverty on their own.

4.3.2 HIV/AIDS

HIV/AIDS is named in the questionnaires as one of the reasons for poverty in South Africa. It is generally considered to be a great impediment to social and economic development progress (European Commission, 2002a; European Commission, 2006) because it reduces the population, the life expectancy, the economically active proportion of the population (including the loss of experienced personnel) and increases the number of orphans (European Commission, 2002a, European Commission, 2006). Green and Merrick (2005) outline findings that support the view that HIV/AIDS not only leads to a loss in GDP; it also undermines human capital formation, the intergenerational transmission of productive capacity and the schooling of children. Through all of this, HIV/AIDS is a major contributor to poverty.
Overall, the developments with regard to HIV/AIDS are negative. Table 21 shows three indicators which underline this.

Table 21: Selected HIV/AIDS indicators

Year	People living with HIV, 15-49 years, %	Number of deaths due to AIDS	AIDS orphans (one or both parents)
2009		310000	
2007	18.1	350000	1,400,000

2005		350000	1,100,000
2003		300000	690,000
2001	16.9	220000	400,000

(UNData, 2011b; WHO, 2011b; UNData, 2011c).

With regard to the number of people living with HIV, one can see it has increased by 1.2% between 2001 and 2007. The same holds true for the number of deaths due to AIDS between 2001 and 2007. Even though the number has decreased after 2007 (from 350000 to 310000 in 2009), the number is still much higher than it was back in 2001. Unsurprisingly, then, the number of AIDS orphans has also experienced an increase between 2001 and 2007. As Table 21 shows, there were 1,000,000 more AIDS orphans in 2007 than in 2001.

These numbers could be interpreted in such a way that they prove that health care and poverty reduction interventions (such as the PDPHCP) have failed. But they could also be interpreted to show that some positive effects have been achieved – despite the major negative influence of HIV/AIDS. In other words: Every time a step is made forward in the direction of poverty reduction, there is always the HIV/AIDS pandemic and its consequences, ready to push back hard in the opposite direction.

4.3.3 Economic situation

South Africa is placed among the group of upper middle income countries (The World Bank Group, 2011d) and, overall, South Africa has achieved macro-economic stability over the past years (European Commission, 2006). Table 22 lists four economic indicators and their developments over the past decade.

Table 22: Selected economic indicators, 2000-2008

Year	GDP Growth (annual %)	Employment-to-population ratio (%)	Unemployment rate, total (%)	Youth employment rate (15-24 years), (%)
2008	3.1	41.1	23	
2007	5.1	41.0	23	46.9
2006	5.3	39.3	26	
2005	5.0	38.7	27	
2004	4.9	39.1		
2003	3.1	36.5		56.5
2002	3.7	37.3		56.5
2001	2.7	38.7		

(UNData, 2011d; UNData, 2011e)

GDP growth has increased from 2,7% in 2001 to 5.3% in 2006. It has decreased, however, coming down to 3.1% in 2008, as a consequence of the global economic crisis and its consequences also being felt in South Africa (European Commission, n.d.). Nevertheless, the other indicators have all undergone a positive development. Despite some variability between 2001 and 2006, the employment-to-population ration has increased from 38.7% in 2001 to 41.1% in 2008. The total unemployment rate has decreased

by 4% to 23% in 2008. And although the youth employment rate is still disproportionately high, it has decreased by almost 10%, from 56.5% in 2002 to 46.9% in 2007.

However, this only shows one side of the South African economy. For example, despite the decrease in unemployment rates, the high unemployment remains one of South Africa's most pressing social problems (European Commission, 2006). If one takes a closer look at the South African economy, one will see that the economy would be better classified as a dual economy, with "sophisticated physical infrastructure as well as financial, IT and telecommunication services, side by side with extreme levels of poverty and exclusion" (European Commission, 2002). More troublesome still, is the fact that the border separating these two economies, also runs along racial lines. As a legacy from the Apartheid regime, business is highly concentrated in specific geographic areas and inaccessible to most ethnic groups, especially black South Africans (European Commission, 2006). With a Gini coefficient[15] of 0.6, South Africa is one of the most unequal societies in the world (Landman, 2003).

A note of caution should be made with regard to the possibility that economic growth could be cause by external aid given to South Africa. If that would be the case, we should be cautious with regard to the actual differences between the factors "non-EU development aid" and "economic situation". However, as we have seen above, external assistance accounts for only a very small percentage of the South African budget and therefore we may assume that its influence, despite possibly present, is not too strong on the economic situation.

The economic indicators show that many positive things have taken place in South Africa and that its economy certainly holds the potential to be a major factor in the reduction of poverty. However, bearing in mind how widespread and deep inequality in South Africa is, we should be cautious to assume that increases in national wealth will translate into decreases in poverty for all. One should not forget that these economic indicators cannot tell us whether the poor really benefit, or whether it is the case that the already wealthy get wealthier and the poor remain the same or are even worse off. So again, the economic developments are positive and bear positive promises but in themselves, considering inequality in South Africa, they cannot tell us whether they really have helped reduce poverty.

4.3.4 Skills Shortage

When asked about the main problems with regard to health care in South Africa, one respondent to the questionnaire answered that health personnel migrated to other countries because of better pay and working conditions. This "Brain Drain" exists in almost all sectors of the South African economy where skills exist but are not compensated well. Brain Drain can be beneficial when it allows some South Africans to go abroad and earn money to send back to their relatives – which at the same time opens up workplaces for those staying back. Brain Drain becomes dangerous, however, when an insufficient number of people to carry out certain tasks and activities remain in South Africa. In South Africa, the

[15] The Gini coefficient measures the extent to which a given society is unequal. It varies from zero to one, zero indicating a perfectly equal society and one indicating a perfectly unequal society (World Bank, 2011e).

latter seems to be the case in South Africa, where the export of skills is a major contributor to unemployment (European Commission, 2006) and has major negative effects on the whole economy.
Moreover, the lack of some skills has more than only economic consequences. A major threat is for example the "unavailability of sufficient quantities of skilled personnel" in the South African health sector, which cannot completely be compensated by the increasing number of community health workers (UNAIDS, 2008). Gavin et al (2009) claim that at least 25% of South African born doctors and 4% of nurses are working abroad.
Unfortunately, brain drain is not the only reason for the existing skills shortage. The HIV/AIDS pandemic is a major impediment to sustainable numbers of health personnel as well. Gavin et al (2009), for example, have found a 20% HIV prevalence rate among health works aged between 18 and 35 years.
There is the recognition that "insufficient absolute numbers of health personnel have been identified as one of the key impediments in the improvement of health systems performance worldwide" (Lehmann, 2008). And with this comes an additional way in which skills shortage (next to its negative consequences for the economy) contributes to poverty.

Summary

One should note that these factors are not isolated. They may not only influence poverty but also be influenced by it themselves. Brain drain and HIV/AIDS are prime examples of factors which can be caused by poverty and in turn can have a strong negative impact on poverty. (And sometimes the same is argued for development aid). Moreover, the factors may be influenced by each other. Non-EU development aid, HIV/AIDS and skills shortage can all have an impact on the economic situation. The economic situation can in turn influence the amount of non-EU development aid, the spread of HIV/AIDS and the shortage of skills – to name only a few of the ways in which the factors may influence each other. Additionally, the factors may be influenced by EU development aid and may influence it as well. If the economic situation improves, for example, less EU development aid may be given. At the same time, the EU might not be very strong in their help to improve the conditions for health personnel as long as they migrate to the EU and are a welcome addition to the European workforce.
We can see that these relationships are complex and heavily intertwined. Therefore it is extremely difficult, if not impossible, to determine which factor has had exactly what share in the reduction of poverty. Nevertheless, it is important to map these third variables and understand the mechanism through which they impact poverty.

5. Conclusion & Policy Recommendations

In this paper we have looked into the effectiveness of EU development cooperation with South Africa with regard to poverty reduction through improved health services.

The first sub-question to be addressed was: **To what extent have the goals with regard to poverty reduction through health services been achieved?**
With regard to the theoretical background, we have looked at the existing theories around poverty reduction and health services and their mutual relationship. We have found poverty to be a multidimensional concept which is difficult to capture and measure. Furthermore, we have seen that there is a mutual relationship between health services and poverty. While poverty can impede the access to and quality of health services, improved health services can have a positive effect on the reduction of poverty.
As regards the study's methodology, both the limited availability of quantitative as well as qualitative data have been identified as challenges. Still, it was possible to include data from different sources. Another challenge concerned the operationalisation of the main variables. Despite the abundance of information on which indicators to be included in an evaluation, the (un)availability of data has been the decisive factor in deciding which indicators actually to include. Nevertheless, it was possible to develop a comprehensive set of indicators which cover the variables to a reasonable extent.
The next step was then to actually measure the main variables in order to assess whether or not the objectives of EU development cooperation have indeed been achieved, that is, if health services have been improved and if poverty has been reduced. As a first step, quantitative data were analysed in order to assess the country-wide developments in the period 2002-2008.The data here are rather mixed: On the one hand, the poverty indicators show that poverty has indeed been reduced during the period under review. On the other hand, the health indicators point more often into a negative than a positive direction. This means that the quantitative data does not confirm the hypothesis that the EU intervention has led to poverty reduction via improved health services. Whereas the relationship between the independent and the dependent variables is as expected, the intermediate variable does not fit the expectation. There are many possible explanations why this is the case, but looking at the quantitative data only will not be enough to solve the puzzle. Therefore we have turned from quantitative to qualitative data and from the national scale to the project level. More specifically, we turned to the Partnerships for the Delivery of Primary Health Care Program as an example of an EU development intervention. At first the annual reports of the Program have been analysed. What stands out right at the beginning, is the fact that the first annual report was only written in 2004/05, even though the program was scheduled to start in 2002. The analysis of the reports shows that the major points of action were carried out fine. Positive aspects include the funding of an increasing number of NPOs, the employment of an increasing number of staff, the provision of trainings for the staff and the provision of a diverse range of services. Furthermore the program is claimed to have had a positive impact on women empowerment, SMMEs, and skills development. However, the annual reports leave

many blank spots and often offer no or insufficient explanations for obvious questions. For example, they do not explain why often only 50% of the budget is spent, why many of the trainings where only attended by small numbers of staff or why there are differences with regard to almost every aspect of the service delivery per province. Additionally, the reports are at times confusing and hard to compare over the years (especially with regard to the expenditure). Moreover, their accounts of both problems encountered and achievements made seem rather ad-hoc. A major point in case is the fact that the annual reports promote the employment of staff as the main way via which the PDPHCP has contributed to poverty reduction. This may be true, but it was not the way it was planned, as initially, the PDPHCP set out to reduce poverty via the improvement of the access to and quality of primary health care. In summary, it can thus be said that the annual reports are strong with regard to describing what has happened (although not without weaknesses) but weak with regard to offering explanations and identifying deep-rooted and structural problems. In other words, they remain rather superficial.

In order to get even better insights into what actually happened, a questionnaire was sent to contact persons of NPOs who participated in the PDPHCP. Their responses constitute the second source of qualitative data used in this study. Firstly, a note of caution must be made as only a very small percentage of NPOs involved participated in the questionnaire. Therefore, the insights gained through the questionnaires must be seen as information complementary to the annual reports instead of representative data. Still, they provide essential insights and answer a few questions that the annual reports could not. Moreover the questionnaires provide insights on the perceived success and positive effects of the programme. The PDPHCP is indeed felt to have had positive effects on both health services and poverty reduction. And while employment is also named as a factor through which this has been achieved, this time it is not the only one. Rather, some of the mechanisms outlined in the chapter on the theoretical background turn up which explain how better care for sick people can result in alleviation of poverty by enabling them to work and gain income instead of spending the family savings. Among the weaknesses of the program was of course the late funding but also difficulties in the communication between the government officials and the workers on the ground as well as the disrespectful treatment of the latter by the former.

The non-obligatory part of the questionnaire shed light on the perceived importance of health services for poverty alleviation. No one seems mentions health services deficiencies as a reason for the existence of poverty in South Africa. And more importantly, mentions improvement of health services when asked about the best strategies to reduce poverty. Thus, while it is recognised that the PDPHCP has had a positive impact on poverty, and this not only via employment but also via improvements in health care, the participants do not seem to think that improving health care is the main road to poverty alleviation.

The results from the annual reports and the questionnaires enabled us to create a policy chain connecting the main variables of the study to each other. In this chain, the main intermediate variables as well as their strengths and weaknesses are highlighted. It seems that the qualitative evidence with regard to the PDPHCP suggests that even though the program did not achieve its full potential, it probably did have some positive effects on health services and poverty reduction.

The second step of an effectiveness study, after having assessed whether the goals have been achieved, was then to look into whether there were other factors than the independent variable which could have had an effect on the dependent variable. The second sub-question was: **Which role did the EU play in**

the attainment of the goals? It seems reasonable to assume that non-EU development assistance, HIV/AIDS, the economic situation, and skills shortage did also have an effect on the level of poverty and the possibilities for its reduction in South Africa. Because EU development assistance makes up only a small part of the overall development assistance to South Africa, we can assume that other development partners, who probably also have focused on poverty reduction, also had an impact. HIV/AIDS has such a major negative impact on every aspect of South African society and economy that it is always to be considered a strong force with a very negative impact on poverty. With regard to the economic situation, we have seen very positive developments which could have impacted positively on poverty reduction. However, given the level of inequality in South Africa, this need not necessarily be the case and effects could have been neutral or even negative. Furthermore, the existent shortage of skills in South Africa has negative effects on poverty through both its negative consequences on the economy as well as through its negative consequences on the health of South Africans (in the case of skills shortage in the health sector). Moreover, we were able to see that these third variables are also related among themselves and that these relationships are complex and heavily intertwined. Therefore it is extremely difficult, if not impossible, to determine which factor has had exactly what share in the reduction of poverty. To answer the second sub-question, we can conclude that the EU development aid probably did play a role in the reduction of poverty in South Africa. However, we must also conclude that there were also many other factors at work, pulling both in the negative and in the positive direction.

Finally, a last note of caution must be made. Due to the late start of the program it is difficult to attribute any findings in the 2008-data to the PDPHCP. Even though the first annual report was issued in 2004/05, some NPOs reported that they only received funding in 2006, and one contact person even stated that his NPO started the program only in 2009 (NPO contact persons, personal communication, June 2011). In the most extreme cases it may thus be very difficult or even impossible to be able to attribute any changes found to the policy intervention.

The following recommendations are suggested: There should be much more emphasis on the gathering and availability of data. This holds true both at the program-level as well as the country-level. The widespread unavailability of data throughout the whole study makes it very difficult to make sound conclusions. More generally, it makes evaluations of programs such as the PDPHCP almost impossible. This should be reason for concern for the European Union in particular, as it should be of utmost importance to be able to prove that its Member States' (and therefore their citizens') money is spent on actions which are effective. Moreover, it is hard to learn lessons from and consequently improve these sorts of programs when they cannot be properly evaluated. Another concern for the EU should be to make it a priority to make sure that the money committed does actually reach the final beneficiaries in time. While failing to do this severely threatens the effectiveness of a program such as the PDPHCP, it can also reflect negatively upon the EU and could thereby threaten future endeavours of cooperation. A final recommendation would then be to keep running these sorts of programs as they do seem to have positive effects on not only health services and poverty reduction, but also community involvement and community empowerment, the strengthening of NPOs, and women empowerment.

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7. Appendix

A. Evaluation Criteria for the Selection of NPOs

Financial & Operational Capacity	Relevance	Methodology	Sustainability
Does the applicant and partners have sufficient experience of project management?	How relevant is the proposal to the objectives and one or more of the priorities of the call for proposals?	Are the objectives proposed appropriate, practical and consistent with the objectives and expected results?	Is the action likely to have a tangible impact on its target groups?
Does the applicant and partners have sufficient technical expertise (notable knowledge of the issues to be addressed)?	How relevant is the proposal to the particular needs and constraints of the target country/countries or region(s)?	How coherent is the overall design of the action? (in particular, does it reflect the analysis of the problems involved, take into account external factors and anticipate an evaluation?)	Are the expected results of the proposed action sustainable?
Does the applicant have stable and sufficient sources of finance?	How clearly defined and strategically chosen are those involved (intermediaries, final beneficiaries, target groups)?	Are the partners' level of involvement and participation in the action satisfactory?	
	Does the proposal contain specific elements of added value, such as innovative approaches, models for good practice, promotion of gender equality and equal opportunities, environmental protection?	Is the target groups' and final beneficiaries' level of involvement and participation in the action satisfactory?	
		Is the action plan clear and feasible?	
		Does the proposal contain objectively	

		verifiable indicators for the outcome of the action?	

(NPO contact person, personal communication, June 2011)

B. Questionnaire sent to contact persons of NPOs participating in the PDPHCP

Personal & Professional Details

Your Name:

Name of organisation:

Province (in which organisation is active):

Work field of organisation (e.g. health care):

PDPHCP

What was the role of your organisation in the PDPHC?

What was your personal role in the PDPHCP?

When did the program start?

Did the program start later than initially planned? If so, why?

What were the most difficult things in the start-up of the program?

What were the most difficult things in the finalisation of the program?

What do you think were the most positive effects of the PDPHCP?

What do you think were the most negative effects of the PDPHCP?

Which effect do you think the PDPHCP had on the health care in your province?

Very negative	Negative	No effect	Positive	Very positive	Don't know

Why do you think the PDPHCP had the effect you indicated?

Which effect do you think the PDPHCP had on the health care in South Africa?

Very negative	Negative	No effect	Positive	Very positive	Don't know

Which effect do you think the PDPHCP had on the reduction of poverty in your province?

Very negative	Negative	No effect	Positive	Very positive	Don't know

Why do you think the PDPHCP had the effect you indicated?

Which effect do you think the PDPHCP had on the reduction of poverty in South Africa?

Very negative	Negative	No effect	Positive	Very positive	Don't know

Which aspects would you improve in the PDPHCP? Why?

How would you evaluate the role of the EU in the PDPHCP?

Very bad	Bad	Neutral	Good	Very good	Don't know

How could the role of the EU be improved?

Non-Obligatory Questions

What do you think are the main reasons for poverty in South Africa?

What do you think are the main problems with health care in South Africa?

What do you think are the best strategies to improve health care in South Africa?

What do you think are the best strategies to reduce poverty in South Africa?

What do you think are the main factors that have contributed to improved health care in South Africa during the past decade?

What do you think are the main factors that have contributed to the reduction of poverty in South Africa during the past decade?

Please state any additional comments you might have.

C. Overview of the Responses given in the Questionnaire

Answer / question	1	2	3
Province?	Gauteng	Limpopo	Gauteng
Work Field?	Rehabilitation	health	HBC
Role of NPO?	Service delivery	Training, supervision and support HBC	Provision of HBC
Personal Role?	Centre manager	Training / Managment	Program Manager
Start?	2006	2005	2006 (funding from 2006-2011, renewal of contract on yearly

			basis)
Late Start? Why?	Don't know	Don't know	-program probably started later than originally planned, probably because the program was being worked on by the DOH (i.e. how it would work, who was eligible to receive funding) -lot of confusion when program started on which reports were needed (e.g. financial, statistical)
Difficult in start-up?	Late funding -> loss of staff	-community mobilisation -community ownership	-confusion about how the program should be run
Difficult in finalisation?	Late funding -> (involuntary) surplus at the end of each year -> bad for service delivery & some trainees did not receive certificate	-question unclear	-reporting (work became more and more difficult) -NGOs were not treated with respect by DOH officials
Positive effects?	-employment -HC for sick people at home	-partnership/working with communities	-NGO previously not funded now received funding -> more health services were provided -> many lives were touched and changed, lives were saved
Negative effects?	-negative role of officials -> negative effects on community and political structures	-communities unwilling to take responsibility -not much capacity given to community (e.g. time and resources)	None
PDPHCP -> HC (province)	Positive	Positive	Very Positive
Why?	-job creation -PHC for sick people	-training of care workers -communities were educated on health issues	-more people could be reached with health services
PDPHCP -> HC (country)	Don't know	Positive	Positive
PDPHCP -> PR (province)	Positive	No effect	Positive

Why?	-employment -> remedy for poverty-related problems	-training of HBC workers and visits to families could not reduces poverty -instead: community projects such as farming and bread making to generate employment and income	-when people are cared for by health programs, they are able to recover and return to work -> poverty reduction -if this is not the case: people would die or stay sick, not being able to work for their families and draining the economic resources of their families
PDPHCP -> PR (country)	Positive	Don't know	Positive
Improve PDPHCP? Why?	-communication of plans -understanding of program by officials -delivery of funding on time -trainees should receive promised rewards at the end of the training -logistical improvements with regard to training (reimbursement of travels costs, refreshments during training)	-have an integrated rural development project with health at its centre -projects that involve community and community ownership	-respect given to NGOs -clearer communication about how the program should be run / the expectations -opinions/experiences of NGOs should be taken into account
Role of EU?	Don't know	Good	Good
Improve role of EU?	-randomly select participating NPOs for site visit and get their side of the story	-Integrated rural development projects	-more involvement of by EU officials
Why Poverty in SA?	-not enough companies to absorb the different levels of skills available in SA (i.e. unskilled, semi-skilled, skilled) -not enough pioneers of business, can only take few people -laziness of individuals	-high illiteracy rate -schools have high drop-out rates (children not motivated) -people don't work the land -people are dependent on government grants -HIV/AIDS weakens	-unemployment -poor education

		people	
HC problems in SA?	-discrepancies between law and what is implemented in reality -government officials write reports about things they never witnessed themselves -inadequate funding by government -> brain drain because of better pay abroad	-diseases (HIV/AIDS, TB), diabetes, high blood pressure -teenage pregnancies	-not enough medical facilities & not enough personnel to work them -> the ones that exists are overburdened -> low quality care -corruption -> resources for health care are not spent on health care -poor management in the health sector -> changes that need to happen do not happen -it matters who is the National Health Minister (he can block or initiate change)
How improve HC in SA?	-	-integrated rural development	-government must train & hire more medical staff -more competent management for the health sector -corruption and mismanagement must be prosecuted
How PR in SA?	-	-people to work the available land -motivate children to be more ambitious -income-generating projects for communities	-long-term job creation strategies: improving education, recruiting people to be educated in the most necessary fields (nurses, doctors, teachers, social workers, technical fields)
Why improved HC in SA?	-	-Training and use of lay counsellors to educate about HIV/ AIDS and other diseases - HBC to educate families about immunization of	-involvement of more NGOs in the health sector -> improved access to health care

		children	
Why PR in SA?	-	-HBC workers get remunerated -government grants for the older people	Don't know
Additional comments	-	-	-