Gauteng Provincial AIDS Spending Assessment Brief (2007/08-2009/10)

April 2013

SANAC and UNAIDS commissioned the national and provincial HIV/AIDS and TB spending assessments (NASA and PASAs).The overall goal of NASA is to contribute to the strengthening of comprehensive tracking of actual spending from all sources that comprises the national response to HIV/AIDS and TB in South Africa, to leverage both technical and financial support for the development, implementation, management, monitoring and evaluation of the national HIV/AIDS and TB response. The overall aim of the assessment was, in its initial phase, to implement an AIDS Spending Assessment in Gauteng Province (GP), for the years 2007/08 to 2009/10.

Total HIV/AIDS and TB spending in Gauteng

Between 2001 and 2008, the number of people with HIV/AIDS in Gauteng increased by 178 000. Following 2008, the number slowed down somewhat. HIV prevalence rates declined from 13.1% in 2004 to 11.7% in 2008. Gauteng registered the first negative prevalence growth rate for people with HIV/AIDS of -0.5% in 2005, and this fell to -2% in 2008. The recent ANC survey (2011) found that GP's HIV prevalence amongst the general population as 28.7% in 2011, a decrease from 30.4% in 2010. GP has the fifth highest prevalence after KZN, MP, FS, and NW. According to the ASSA provincial modelling, there were 1,215,856 people living with HIV in GP in 2011.

The ART programme has swelled in numbers since its inception in 2004. The DHSD reported that the number of people on ART increased from 185,126 in 2008/09 to 263,602 in 2009/10.[1] The number of ART sites grew to 206 in 2010/11. The Department aims to have 440,000 adults on ART by the end of 2010/11, and 35,210 children on ART.[2] The ASSA Provincial modelling estimated 422,081 people on ART in GP in 2011. The DORA targets estimated the number of ART patients in care for GP to be 1, 042,000 in 2012/13, 1,150,500 in 2013/14 and 1,271,000 in 2014/15.

The AIDS Spending Assessment in Gauteng sought to capture all public, external (donor) and business sector contributions to the HIV/AIDS and TB response in the province, in 2007/08, 2008/09 and 2009/10. It excluded household and individual contributions (out-of-pocket expenditure), including their payments made to traditional healers. This may be a large component of the total spending on HIV/AIDS and TB in the province, and should be included in future spending assessments.

In 2007/08, Gauteng province spent R1.353 billion on HIV/AIDS and TB, increasing by 30% to R1.754 billion in 2008/09, and reaching R2.28 billion in 2009/10. Bearing in mind that not all the external funds could be captured at the provincial level, and that the business sector was reluctant to share

[1] Gauteng Department of Health and Social Development 2009/10 Annual Report.
[2] Gauteng Provincial Treasury. 2011/12 Budget Statement 2.

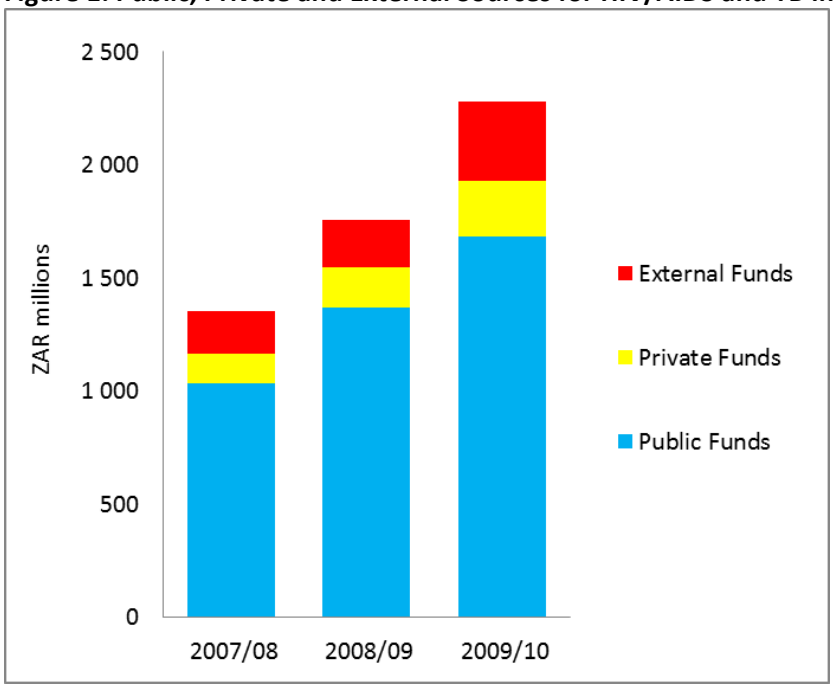
their expenditure, these may be underestimations to some degree. Although a proportion of the PEPFAR funds are missing from the total figures, it is estimated that approximately 85% of the provincial spending has been captured.

When adjusting for total population size, Gauteng spent approximately R204 per person in 2009/10, which sits mid-range among the South African provinces.

Source of funds for HIV/AIDS and TB in Gauteng

In 2009/10, public sources contributed 74% of total HIV/AIDS and TB funds, while external and private sources contributed 15% and 11% respectively. The contribution from public funds has remained approximately 75% throughout the study period.

Figure 1: Public, Private and External Sources for HIV/AIDS and TB in Gauteng (2007/08 – 2009/10)



Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.
*These figures include a proportion of the Child Support Grant, and some of the PEPFAR funds (those that could be validated).

Privately-sourced funds have increased steadily, from R130 million in 2007/08 to R245 million in 2009/10. Most private spending comes from medical aid schemes: R112 million was estimated to have been contributed by employees with a matching amount from employer contributions. Together, employee and employer contributions made up 10% of the total HIV/AIDS spending in 2009/10.

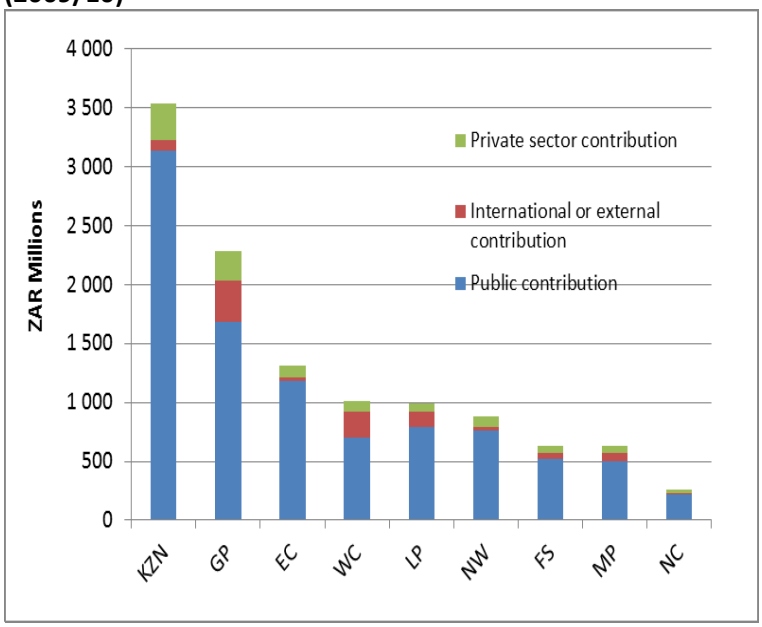
In 2008/09 the contribution from external funds increased by just 9%, and then in the following year it jumped by 71% to R350 million.

External sources contributed 15% of total funds in 2009/10. Bilateral organisations were responsible for the largest portion of externally-sourced HIV/AIDS and TB funding, totaling R289 million in 2009/10 or 13% of total expenditure. The largest contribution was from the Government of the United States (USG), while other large bilaterals included Japan, France, Sweden and the United Kingdom. Multilateral organisations contributed R34 million in 2009/10, the key sources were the European Union and the Global Fund, which contributed a total of R23.5 million and R10.5 million

over the three years respectively. Smaller amounts were also contributed by UNAIDS, UNHCR and UNODOC. Other external foundations contributed a smaller amount, namely R27 million.

Figure 2 provides a comparison to HIV/AIDS and TB spending in other provinces.[3] It shows that HIV/AIDS and TB spending in 2009/10 in Gauteng exceeded spending in all the other provinces, excepting KZN.

Figure 2: HIV/AIDS Spending in South African Provinces – Public, Private and External Sources (2009/10)



Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

According to Treasury, the government spending on HIV/AIDS in GP had increased significantly again to reach R 2,2 billion in 2012/13, excluding other discretionary and hidden spending (provincial voted funds and in-patient costs). The recent Annual Planning Tool should be able to indicate the total provincial spending, including the development partners' contributions.

Agents of the HIV/AIDS and TB funds in Gauteng

Government mainly acts as the funding agent for HIV/AIDS and TB expenditure in Gauteng. In 2009/10, 74% of total funds were managed by government entities (including SASSA and other public entities)—21% by provincial departments and 44% by national government. Approximately 15% each year was controlled by private funding agents, primarily private for-profit organisations, i.e. businesses.

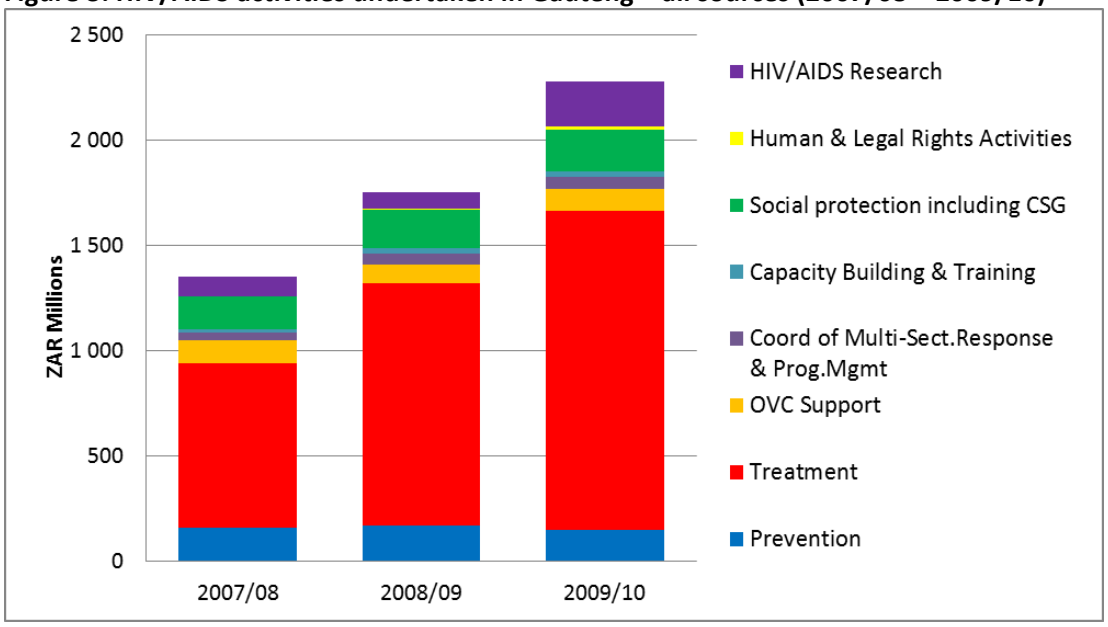
Externally-sourced HIV/AIDS and TB funds were primarily managed by bilateral organisations (73% in 2009/10) and NGOs (19% in 2009/10). Essentially aid from foreign governments was mostly being controlled and allocated to various activities by those bilateral agencies themselves, while much of the multilateral aid (from the EU and GFATM) was placed in the control of public departments.

Activities the money is spent on in Gauteng

The majority of HIV/AIDS and TB funds in Gauteng were spent on treatment in all three years. **Figure 3** shows the breakdown by activities.

[3] **Figure 2** excludes PEPFAR spending which was not confirmed by recipient partners.

Figure 3: HIV/AIDS activities undertaken in Gauteng – all sources (2007/08 – 2009/10)



Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

In 2009/10, treatment took 66% of all the funding (noting that treatment was not only ART but also included home-based care, palliative care, TB treatment, etc., followed by social protection including the Child Support Grant (9%) and HIV/AIDS and TB research (9%). Only 6% of funds were spent on prevention activities in 2009/10, and 5% on services for orphans and vulnerable children (OVC). While expenditure on treatment increased from R781 million to R1.15 billion between 2007/08 and 2009/10, spending on prevention decreased from R162 million in 2007/08 to R147.6 million in 2009/10. Gauteng has relatively large expenditure on research (compared to the other provinces) due to the concentration of research institutions in Johannesburg and Pretoria. Of concern is the relatively low spending on other categories, such as OVC support (5%), capacity building (training) (1%) and human and legal rights activities (1%).

Table 1: Categories of HIV/AIDS and TB Spending in Gauteng (ZAR)

Activity	(ZAR)	total	(ZAR)	of total	(ZAR)	total
& Prog.Mgmt	38 011 137	3%	54 004 252	3%	57 423 713	3%
Social protection including CSG	157 061 625	12%	180 686 152	10%	197 573 389	9%
Human & Legal Rights Activities	20 453 394	2%	6 278 099	0%	15 334 914	1%

Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

Public funds and private funds were primarily being used to fund treatment, while the bulk of funds from external sources went towards research activities. Public funds also served to finance social protection and social services, to which private and external sources did not contribute.

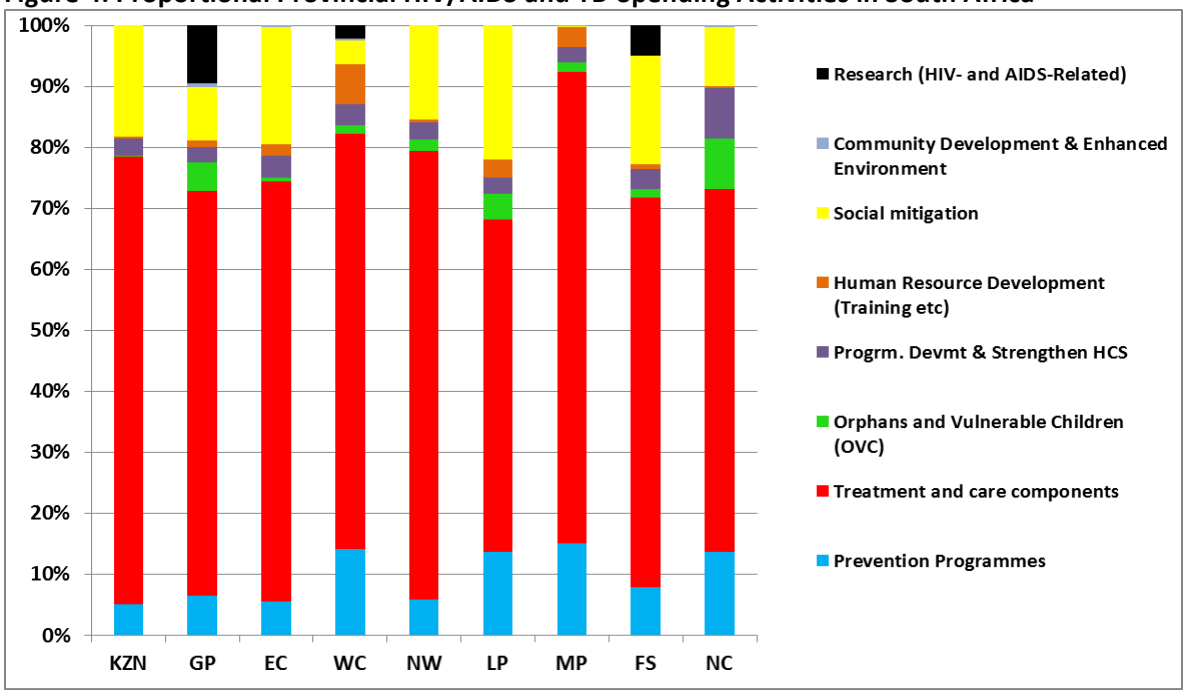
- **Prevention**: Overall, funds spent on prevention activities dropped from R161.8 million in 2007/08 to R147.1 million in 2009/10, largely driven by a 71% cut on expenditure on programmes for youth in school in 2008/09. In all three years, the main prevention activity was workplace programmes, which consumed 40% of the prevention budget in 2009/10. R21.8 million (or 15% of the total prevention activity budget) went to PMTCT in 2009/10 while another 16% was spent on male condoms (R23.4 million).

- **Treatment**: Spending on treatment and care has climbed steadily, growing by 48% in 2008/08 and by 31% in 2009/10. ART consumed approximately 50% of total spending every year, totaling just over R1 billion in 2009/10, of which R763 million came from public sources, and around R224 million was estimated from private medical aids. In-patient TB treatment took an increasing share of treatment funds, starting at R22.3 million in 2007/08 (or 3%) and rising to R198.4 million (or 13%) in 2009/10. This may be partly due to the increasing number of cases of Multi-Drug Resistant (MDR) TB. The other key treatment activity was home-based care (HBC). However expenditure on HBC declined from 16% of total treatment spending in 2007/08, to 8% in 2009/10, and was primarily provided by NGOs. Expenditure on VCT (or HCT) was captured under the treatment category at the request of the province, as per their strategic plan. The HCT spending steadily increased from R18 million in 2007/08, to R27 million in 2008/09, and R37 million in 2009/10 – forming only 2% of the total treatment spending in each year.

- **Activities for OVC**: a total of R105.6 million was spent on activities for OVCs in 2007/08, decreasing to R88.4 million in 2008/09, and rising again to R104.7 million in 2009/10. These were generally family and home support, provided through NGOs delivering HBC services.

Figure 4 shows the proportional spending of all provinces. Treatment was a major consumer in all provinces. Research was a dominant activity in Gauteng Province, Western Cape and Free State. Social mitigation was well-funded in KwaZulu-Natal, Free State, Limpopo, Eastern Cape and Gauteng Province.

Figure 4: Proportional Provincial HIV/AIDS and TB Spending Activities in South Africa



Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

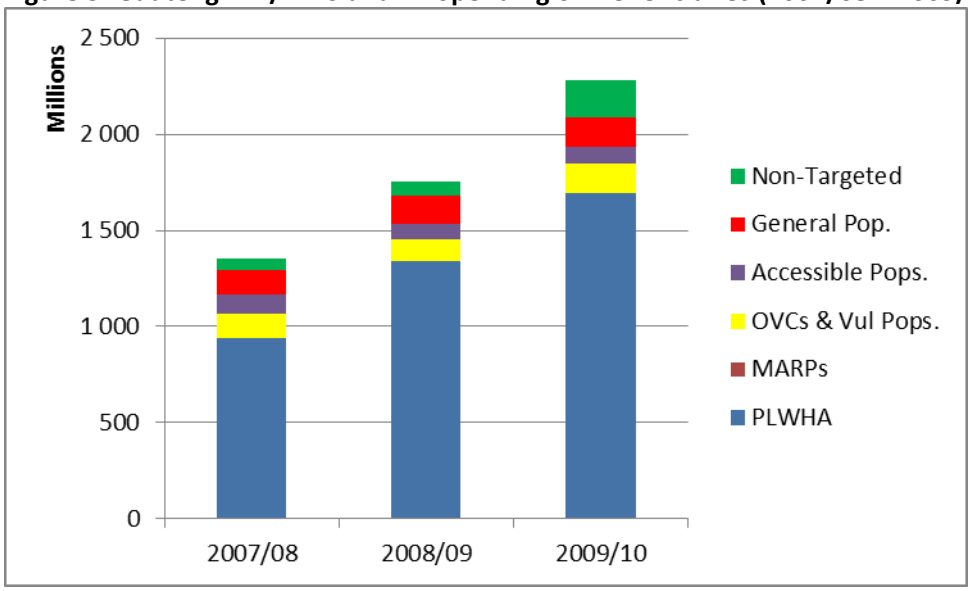
The beneficiaries of HIV/AIDS and TB spending in Gauteng

Figure 5 shows the amount of expenditure targeted to each of the six main categories of beneficiaries of HIV/AIDS and TB services in Gauteng. People living with HIV/AIDS (PLWHA) were the main beneficiaries of HIV/AIDS funding in Gauteng in all three years, primarily due to ART and HBC spending, 77% in 2009/10. The total amount spent on PLWHA totalled R1.01 billion million in 2007/08, reaching R1.75 billion by 2009/10. Approximately 88% of spending on PLWHA in 2009/10 was for treatment and care, while the remaining share was for various impact mitigation activities.

In 2009/10, a small portion 4.5% was targeted to key vulnerable groups including OVCs, truck drivers and children born (or to be born) of women living with HIV, and just 0.12% went to most-at-risk populations (MARPS) such as commercial sex workers (CSW), men who have sex with men (MSM) and intravenous drug users (IDUs). Most of the spending targeted to vulnerable groups and MARPs was for prevention activities. However, for OVCs, one half of total expenditure in 2009/10 was spent on OVC support activities, one quarter for prevention and the remaining for treatment and care.

Only 3.7% of the total spending in 2009/10 went to accessible populations, such as learners in school or college, and health care workers.

Figure 5: Gauteng HIV/AIDS and TB Spending on Beneficiaries (2007/08 – 2009/10)



Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

Service Providers for HIV/AIDS and TB in Gauteng

Public hospitals were the largest service provider, delivering R589 million in services (or 26% of the total) in 2009/10. Public clinics provided 17%, or R378 million, of services in 2009/10. The third largest provider was NGOs, CSOs and CBOs which were responsible for 16% of the expenditure. For-profit providers (mainly medical aids) also played an important role, delivering 11% of services in 2009/10.

The largest change over the three-year period was to public clinics, whose share of total services increased from 5% in 2007/08 to 17% in 2009/10. This suggests the increasing role they are playing with the decentralisation of the delivery of HIV/AIDS and TB services.

Gauteng Department of Health and Social Development spending on HIV/AIDS and TB

Health Services

In 2009/10, 85% of the DHSD's health services spending on HIV/AIDS and TB was sourced from the Conditional grant (R671 million) and the remaining 15% from Voted funds. The amount of Voted Funds allocated for HIV/AIDS and TB declined from R195 million in 2007/08 to R119 million in 2009/10.

Including both Conditional Grant and Voted Funds, DHSD *overspent* by 5% in 2007/08, followed by two years of *underspending*. In 2008/09, 18% of the total DHSD health services' HIV/AIDS budget was not spent; this amount increased to 25% (or R265.8 million) in 2009/10. Spending on the Voted Funds and Conditional Grant funds varied:

- In 2007/08, the Department completely spent the Conditional Grant but *overspent* on Voted Funds (by 15% or R25.7 million).
- In 2008/09, 6% of the Conditional Grant was not spent and 48% of Voted Funds were left unspent.
- The situation worsened the following year: in 2009/10, R218.7 million, or R25%, of Conditional Grant funds were unspent and 28% of the Voted Funds (R47.2 million) were also unspent.

The two main HIV/AIDS activities funded by DHSD, including both the CG and the ES, in all years were antiretroviral drugs (ARVs) and TB in-patient treatment. ARVs took up approximately 60% of the total DHSD HIV/AIDS funds each year and totaled R593 million in 2009/10.

The next largest share was for TB in-patient treatment (mainly for MDR TB) which consumed an increasing amount, from 4% in 2007/08 to 20% in 2009/10, totaling R198.3 million.

The activities for which the funds were used and the main service providers were different for the Voted Funds compared to the Conditional Grant funds. In essence, the hospitals are providing ARVs (funded mainly through the CG) and TB in-patient treatment (funded mainly through Voted funds).

CG Funds:

- The great majority of the CG funding was used for ARVs each year (85% in 2009/10). The rest of the CG was primarily used for VCT, PMTCT and Step Down Care. CG expenditure on VCT and Step Down Care have more than doubled between 2007/08 and 2009/10.
- The main service provider for the DHSD was public hospitals, who spent approximately 60% of total Conditional Grant funds in 2009/10. The role of clinics as service providers for CG-funded programmes has grown over the period, from 13% to 28%, importantly decentralizing the ART services.

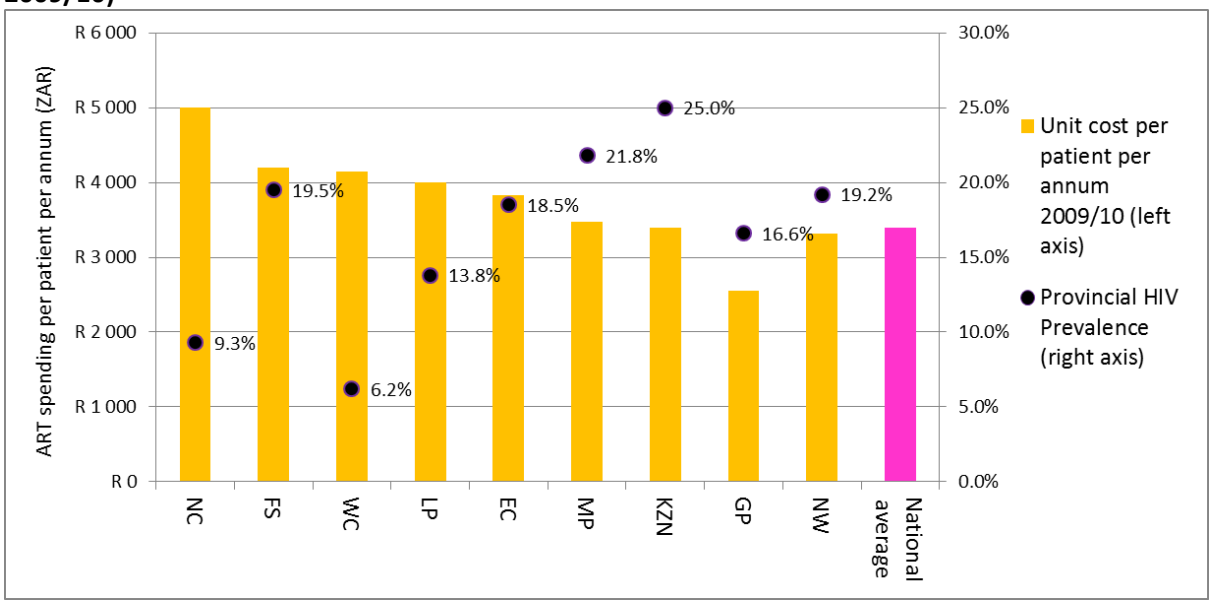
Voted Funds:

- Voted funds were mostly used for TB in-patient treatment: R198.3 million in 2009/10 (or 62% of DHSD Voted funds for HIV/AIDS and TB).
- Voted Funds were also used to pay for HBC, which received R42.1 million in 2009/10, or 13% of total Voted funds. It is noted that voted expenditure on HBC has declined over the period, from R44.3 million in 2007/08.
- Voted Funds were mainly channeled to NGOs and hospitals, the latter being the main service provider, averaging 61% of total Voted funds.
- Notably approximately 20% of DHSD Voted funds were delivered by NGOs in 2009/10. Only a small portion of Voted funds were spent by clinics—approximately 6%.

DHSD's Expenditure on Antiretroviral Treatment

Total spending on the ART programme by Gauteng DHSD has increased steadily to reach almost R593 million in 2009. As expected, ARV drugs consume a large portion of the money: R346 million (or 58%) in 2009. The majority of ARV expenditure is attributed to public hospitals as the service provider, followed by clinics. The role of clinics in delivering ARV treatment has increased, from 15% in 2007/08 to 34% in 2009/10. At the same time the share of total ARV expenditure by hospitals has declined, from 75% in 2007/08 to 58% in 2009/10. Using the all the costs coded as ARV in the Basic Accounting System (BAS) and the total number of active patients receiving ART as provided by the DHSD, the rough annual per patient unit cost decreased from R2,837 in 2008/09 to R2,551 in 2009/10, which was lowest amongst all the provincial public ART unit costs. **Figure 6** depicts the comparison between ART unit cost per patient per annum and provincial HIV prevalence rates.

Figure 6: Provincial DOH Public ART cost per patient per annum (ZAR) and HIV Prevalence (%, 2009/10)



Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

DHSD's Social Development Services Spending on HIV/AIDS and TB

Total expenditure by the Social Development Services of DHSD on HIV/AIDS activities fell by 18% in 2008/09. HIV/AIDS expenditure continued to drop in 2009/10 by 5%, to R137.1 million. In all three years, the vast majority of the funds (all but approximately 2%) were transferred to NGOs who acted as the service providers for various activities, including HBC. Through the three-year study period, the amount spent on PLWHA support has dropped drastically, while the amount spent on home-based care has increased. In 2007/08, R108.2 million is spent on support activities for people living with HIV and AIDS. By 2009/10, this amount has declined to less than R3 million. Simultaneously, the spending on HBC has grown from R37.5 million in 2007/08 to R103.4 million in 2009/10, making up 75% of total DSD HIV/AIDS spending.

Gauteng's Department of Education spending on HIV/AIDS

The spending on the Lifeskills programme by the Department of Education dropped from R44 million in 2007/08 to R26 million in 2008/09. It remained essentially at this level for 2009/10 as well. This is of concern as it is the primary programme targeting adolescents and youth in school.

Recommendations

The following are recommendations to improve planning and service delivery, allocative decisions, and financial management systems, based on the findings of the NASA:

Expand the HIV/AIDS response beyond health sector: The dominance of the DHSD in the response to HIV/AIDS needs to be balanced with increased spending on integrated HIV/AIDS services in all the other departments, particularly the DSD and DOE. Spending on OVC support, community development, enabling environment, and human and legal rights activities needs to be increased in GP.

Increase priority given to prevention: It is vital that budgets are increased for those key prevention interventions that have been shown to have the greatest impact. Medical male circumcision and, potentially, the microbicides being developed, could significantly reduce HIV transmission rates. PMTCT, condoms and PEP remain effective interventions to be expanded.

Expand DOE's interventions: The DOE interventions are the main ones targeting youth in school and therefore their expenditure should be expanded.

Prioritise TB prophylaxis: Spending on TB prophylaxis would contribute to a decrease in the DHSD's spending on TB treatment, and greatly enhance the wellbeing of PLWHA.

Avoid crowding out by ART spending: While recognizing the preventative effects of scaled-up ART access, it is also critical for the DHSD and the other departments to equally ensure that prevention spending, and the other key activities (mitigation, research, etc.) are not crowded out. In addition, attention must be paid to the other treatment requirements, such as treatment of opportunistic infections, in-hospital care, HBC and palliative care.

Increase support to NGOs and CBOs: CBOs are providing valuable HBC and other services, which offer critical support for PLWHA. Funding for NGOs and CBOs should therefore be increasing, and DHSD should be offering suitable NGOs three-year contracts, based on performance.

Use NASA findings to inform the development of the new PSP: The findings presented here will indicate if the GP PSP priorities were in fact funded accordingly. It is strongly suggested that the new PSP have clear, realistic and measureable objectives and targets that can be accurately costed to guide future allocations.

Increase transparency of funding by external sources: Development partners must be more transparent about what they are funding in the province, as well as what they intend to commit in the longer term, in order to foster a harmonised and integrated response that is guided by the provinces' priorities. This will enhance the government's ability to measure future funding requirements, and to address funding gaps in a sustained and aligned manner, so as to reduce overlap and gaps in key areas.

Build human resource capacity around data collection analysis and planning: There is urgent need for capacity- building in data management, analysis and utilisation in planning, within both the public and NGO sectors.

Improve accuracy and frequency of data collection on expenditure: The finance managers, together with programme managers, need to stipulate clear guidelines that should be followed for financial data capturing and coding, to enable more effective budget monitoring and cost-efficient service delivery. The financial data should be linked to output indicators in one consolidated M&E system.

Centralise and institutionalise HIV/AIDS expenditure data collection: It is ultimately critical for improved expenditure tracking systems to be institutionalised, with detailed HIV-coding, and for these to be populated by *all actors* in the HIV/AIDS field in Gauteng. The information should be centralised and managed by SANAC and MSAU, to ensure overall improved co-ordination and alignment of all efforts.

Improve intergovernmental budget planning: Greater engagement of the district level public service providers in managing their expenditure according to their available budgets, including easy access to the BAS records for improved programme management.

Advocate for greater contribution from business sector: Greater commitments from the business sector, and increasing their provision of services for employees, would increase available funding and also reduce the burden on the public health care system.