KwaZulu Natal 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 KwaZulu Natal Province (KZN), for the years 2007/08 to 2009/10.

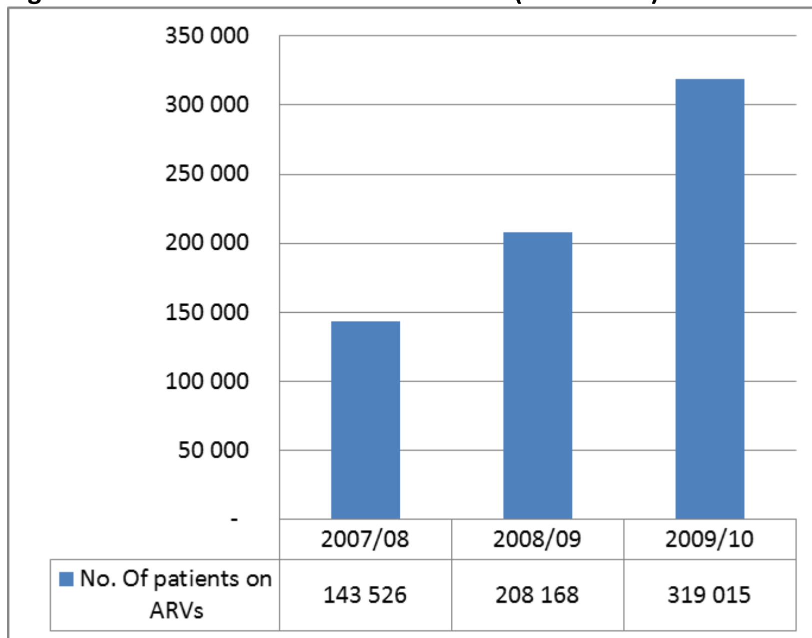
Total HIV and TB spending in KZN

The recent ANC survey (2011) found that KZN's HIV prevalence amongst the general population as 39.5% in 2010 and 37.4% in 2011, the highest of all provinces. According to the ASSA provincial modelling, there were 1,576,025 people living with HIV in KZN in 2011. The 2011 ANC survey noted KZN HIV prevalence among antenatal women was 39.5% in the years 2009 and 2010. It decreased to 37.4% in 2011.[1]

Figure 1 shows the number of patients on antiretroviral treatment (ART) for the years 2007-2011. The ASSA Provincial modelling estimated 512,497 people on ART in KZN in 2011. The DORA targets estimated the number of ART patients in care for KZN to be 755,175 in 2012/13, 915,175 in 2013/14 and 1,059,472 in 2014/15.

[1] The National Antenatal Sentinel HIV and Syphilis Prevalence Survey, South Africa, 2011, National Department of Health

Figure 1: KZN Number of Patients on ART (2007-2011)



Source: Information provided by KZN DOH

The AIDS Spending Assessment in KZN 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, KZN spent R2.163 billion on HIV/AIDS and TB, increasing to R3.191 billion in 2008/09 and reaching R3.534 billion in 2009/10. This constituted an increase of nearly 48% in 2008/09, driven largely by public sector spending on ART.

Remembering that not all the external funds could be captured at the provincial level, and that the business sector was reluctant to share their expenditure, these are underestimations to some degree. Although the large PEPFAR funds are missing from the total figures, it is estimated that approximately 80% of the provincial spending is captured. It is however, important to note that the KZN total expenditure was underestimated because data from business entities, research institutions and some international organizations was not available at provincial level.

Source of funds for HIV/AIDS and TB in KwaZulu Natal

In 2007/08, public sources contributed 80.5% of total HIV/AIDS and TB funds while external and private sources contributed 11.1% and 8.4% respectively. There was a significant increase of HIV/AIDS and TB funding in 2008/09 driven primarily be greater flows from public sources. By 2009/10, 88.7% of total expenditure was from public sources. For nominal figures see **Table 1**

Table 1: Sources of all HIV and TB Spending in KZN (ZAR, 2007/08 - 2009/10) - Further disaggregated

Sources		2007/08	Share of total	2008/09	Share of total	2009/10	Share of total
	Central public funds	1 735 405 68[illegible]	80%	2 511 048 73[illegible]	79%	3 135 017 36[illegible]	89%
sources	Provincial	0	0%	118 632	0%	0	0%
	Local and other public funds	6 511 607	0%	11 981 605	0%	0	0%
	For Profit funds	5 249 582	0%	6 326 272	0%	380 000	0%
sources	Out of pocket funds	80 825 497	4%	112 970 015	4%	151 318 036	4%
	Not For Profit funds	14 864 454	1%	18 248 519	1%	2 710 015	0%
	Private financing sources n.e.c.	79 924 343	4%	113 495 915	4%	151 318 036	4%
	Bilateral	125 401 411	6%	250 855 028	8%	56 716 631	2%
sources	Multilateral	103 204 864	5%	149 035 139	5%	35 942 796	1%
	External foundations	11 694 988	1%	16 996 259	1%	415 288	0%
Totals		**2 163 082 429**	100%	**3 191 076 122**	100%	**3 533 818 163**	100%

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

NB: Because 2009/10 was added to the study scope after primary data collection for the previous two years was completed, the 2009/10 data collection did not include visits to municipalities. This likely account for the drop in funds sourced from 'Local and other public funds' as reflected in 1. For the same reason, not all the external and private sources of funds were captured and thus are underestimated above.

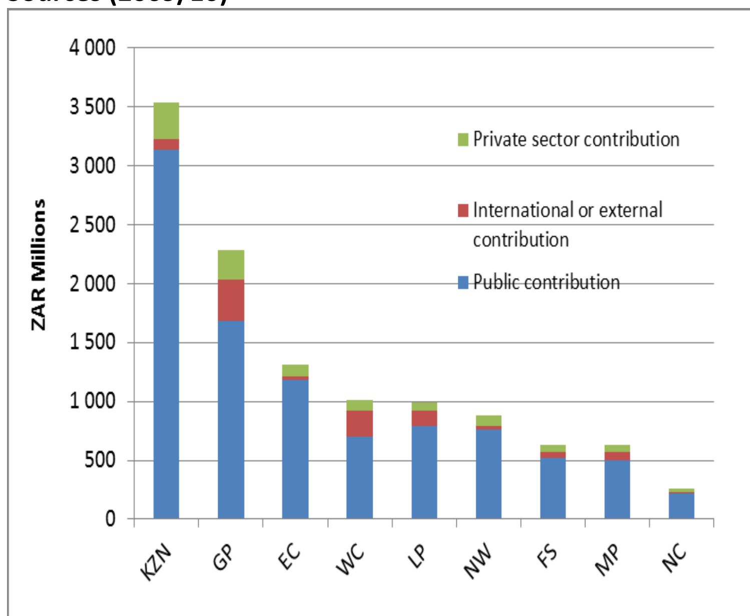
The total external aid to KZN increased dramatically by 74% from R240.3 million in 2007/08 to R416.9 million in 2008/09. However, in 2009/10 the funding flows from external sources dropped markedly again by 78% to only R93.1 million. This may have been partly due to limitations in collecting primary data for 2009/10. Multilateral aid has been dominated by contributions from the Global Fund, which peaked at R127 million in 2008. Total multilateral aid then dropped by 76% in 2009/10, largely due to an 80% decrease in funding from the Global Fund. Note that the spending of the UN agencies was only being captured in the national NASA, so they are not represented here. Bilateral funds have been driven by aid from the Netherlands which peaked at R157 million in 2008/09 and then dropped to R33million the following year. The USA has also been a large contributor, providing 34% of total bilateral aid in 2009/10. The third largest bilateral donor has been the UK who contributed R23 million (or 9% of total bilateral aid) in 2008/09.

Private sources—which include for-profit businesses, not-for-profit NGOs and out-of-pocket funds—have increased each year, by 39% in 2008/09 and by 22% in 2009/10. Because most (for-profit) businesses could not provide KZN data, their proportion captured here is very small. A large part of private source funds come from individuals (out of pocket funds), making up approximately 45% of total private sources.

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

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

Figure 2: HIV/AIDS and TB 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 KZN had increased significantly again to reach R2.4 billion 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 KwaZulu Natal

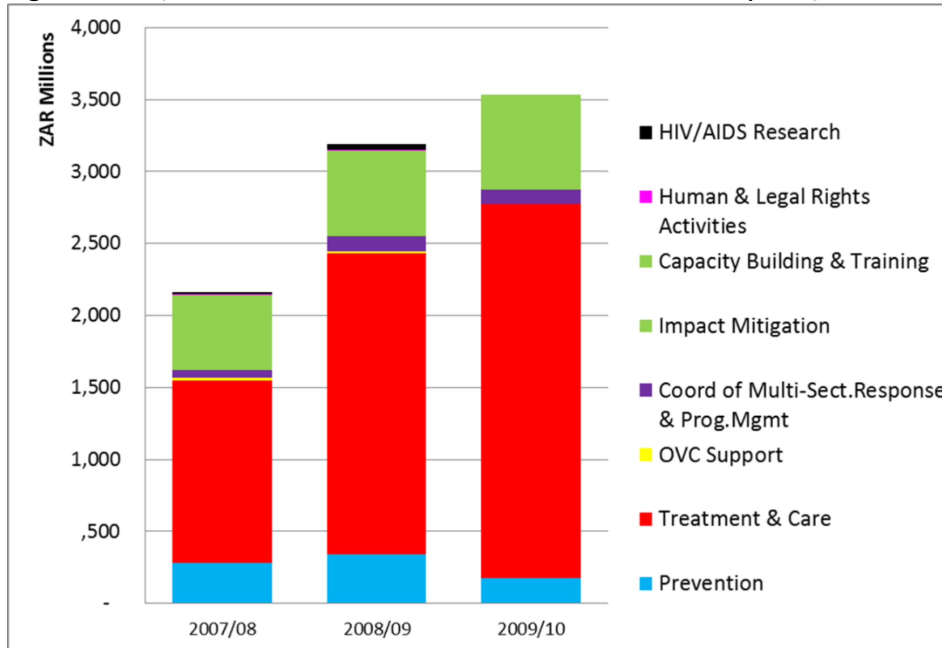
Government mainly acts as the funding agent for HIV/AIDS and TB expenditure in KZN. Funds sourced from public entities the agents include, national, provincial and district governments. In 2009/10, national government acts a funding agent for 42% of the funds, provincial government for 37% and the balance (21%) are managed by District DOH and other local government funding agents. According to the NASA methodology, provincial government is the Funding Agent for Voted ES funds, and national or central government is the Funding Agent for conditional grant funds. Not surprisingly, the amount of public sector funds managed by non-public sector entities is negligible.

Externally-sourced HIV/AIDS and TB funds were primarily managed by the bilateral agencies, NGOs and District DOH. In the first two years, the EU monies were controlled by the EU itself, and thus are coded as multilateral funding agent. However in 2009/10, the EU funds primarily moved through DOH to NGOs; thus the coding of this money changed to District DOH as the funding agent. The money from the Global Fund was managed by provincial government as the funding agent.

Activities the money is spent on in KwaZulu Natal

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

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



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

In 2009/10, the funds went to treatment (73%), followed by social protection including the Child Support Grant (18%), and followed by prevention (5%) and programme management and administration (3%). On the whole, this picture was the same for all three years, except for 2009/10 when the share of funds spent on prevention activities dropped from 11% to 5% between 2008/09 and 2009/10. Of concern is the relatively low spending on other categories, such as mitigation, research and enabling environmental activities.

Prevention:

Overall, funds spent on prevention activities dropped by 48% in 2009/10, largely driven by cuts in budgets for VCT, youth in school and BCC activities. Spending on both BCC and PEP has been steadily declining over the three years. BCC dropped by an average of 67% each year, and PEP by an average of 25% each year. The largest slice of prevention funds continued to go to PMTCT: 48% in 2007/08, 32% in 2008/09 and 68% in 2009/10. VCT activities funded by DOH are categorized as treatment since they are initiated by the provider, and thus are not included in this graph. The VCT expenditure of R113 million (or 33%) in 2008/09 was sourced from PEPFAR and Health Alliance International. This VCT share dropped to barely 1% in 2009/10, due largely to the bulk of PEPFAR funds not having been verified and therefore excluded from this analysis It is also worth noting that prevention activities targeted at youth (both in and out of school) received R19 million (7%) in 2007/08 and then R36 million (11%) in 2008/09, but were cut completely in 2009/10.

Treatment:

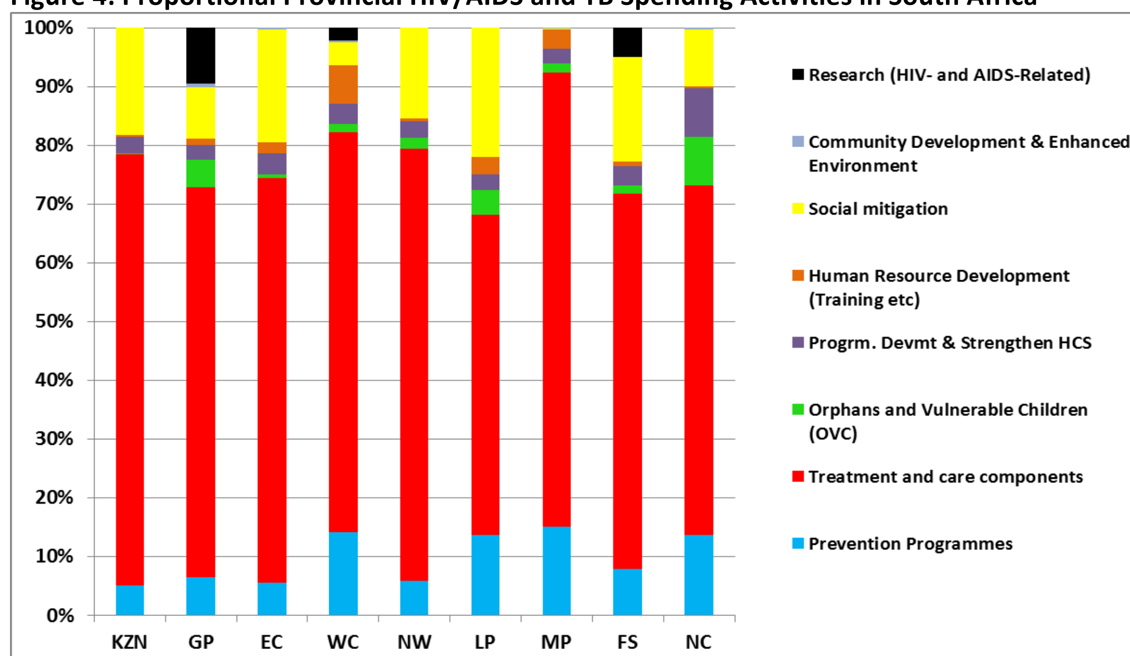
Overall, spending on treatment is climbing steadily, growing 65% in 2008/08 and by 25% in 2009/10. (Not surprisingly, ART makes up the bulk of spending: R920 million (or 35%) in 2009/10. TB treatment—both in and out patient—is taking an increasing share of treatment funds, starting at 10% in 2007/08 and rising to 25% in 2009/10 (R651 million). This may be partly due to the increasing number of cases of Multi-Drug Resistant TB. Other treatment activities such as home-based care remained relatively constant over the three-year period, although increasing somewhat in 2009/10. It is noted that there is very little expenditure on palliative care and step-down care.

Activities for OVC:

Spending on OVC support programmes was between R14 million and R16.5 million in 2007/08 and 2008/09, and then dropped dramatically by 78% in 2009/10 to only R3.7 million (largely due to the conclusion of the EU contract and reduction in the Global Fund grant monies). As a result, over the three-year period, OVC activities have narrowed to only family/home and community support interventions, and other initiatives (such as basic health care, institutional care and education) have been cut. In 2009/10, all but 8% of the spending goes to community support programmes.

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.

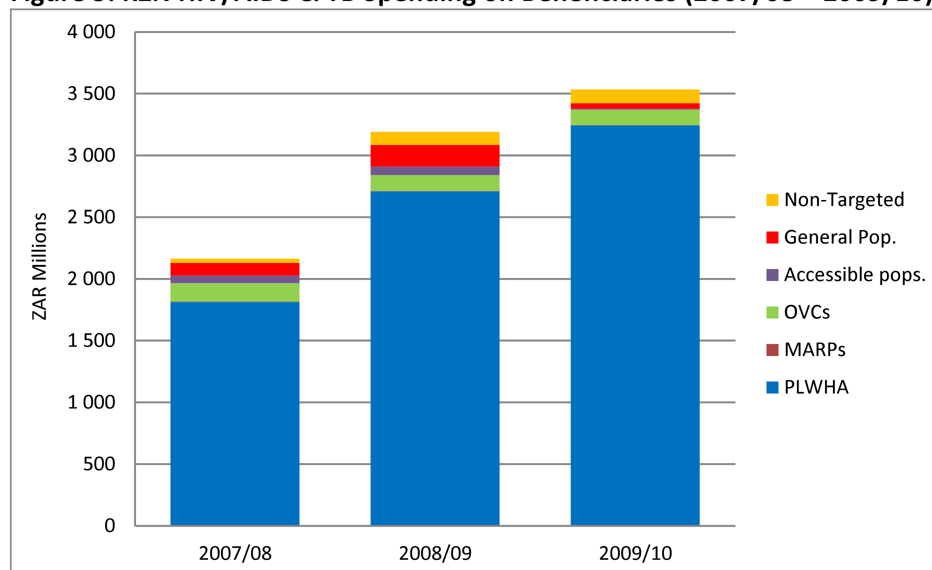
The beneficiaries of HIV/AIDS and TB spending in KwaZulu Natal

Throughout the period, people living with HIV/AIDS (PLWHA) took the majority of the HIV/AIDS funds due to being the beneficiary of the large spending on ARVs. In 2009/10, 92% of spending was on programmes targeted to PLWHA and 4% to OVCs.

The amount targeted to the general population (mostly prevention activities) declined in 2009/10 from R176 million to R46 million. In 2009/10, much smaller allocations also went to MARPS (0.05%) such as commercial sex workers (CSW), men-who-have-sex-with-men (MSM) and intravenous drug users (IDUs) and just 0.18% to accessible populations, such as children in school or college, health care workers and the police and military forces.

Figure 5 shows the amount of expenditure targeted to each of the six main categories of beneficiaries of HIV/AIDS and TB services in KZN.

Figure 5: KZN HIV/AIDS & TB Spending on Beneficiaries (2007/08 – 2009/10)[3]



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

Service Providers for HIV/AIDS and TB in KwaZulu Natal

The public sector hospitals accounted for the largest share of the provision of HIV/AIDS services in KZN in all three years. The Rand value of services provided by public hospitals more than doubled from R557 million in 2007/08 to R1.14 billion the following year. The biggest providers are therefore public hospitals and DSD (49% and 20% of spending in 2009/10 respectively), the latter being for the delivery of the Child Support Grant. Both have taken on an increasing role through the 3 year period.

CBOs, CSOs and NGOs accounted for around 10% of spending in 2008/09, yet they also provide an important range of services particularly with regards to OVCs and other mitigation efforts. Notably the amount spent by NGOs, CBOs and CSOs declined by 58% in 2009/10, while the amounts spent by public laboratories and HAST remained steady (at approximately R90 million and R110 million respectively).

KwaZulu Natal Department of Health spending on HIV/AIDS and TB

Overall HIV/AIDS spending by KZN DOH has increased dramatically over the period, increasing 50% in 2008/09 and by 45% in 2009/10. In particular the conditional grant (CG) increased by 37% in 2008/09 and then by a huge 140% in 2009/10.

The Voted funds also increased significantly in 2008/09 by 65%, but then actually dropped by 30% in 2009/10. This may indicate that the province has had to redirect more of its Equitable Share funds to other health priorities, leaving the conditional grant to cover the HIV/AIDS services. Of concern, as shown later, is that while the CG was primarily used for the delivery of ART, the ES funds were also used for a range of other necessary HIV services (such as media communications, PMTCT, home-base care, etc.) which may now be underfunded due to the recent trends.

The two main HIV/AIDS activities funded by DOH, including both the CG and the ES, in both years were antiretroviral drugs (ARVs), taking up 65% of the total DOH HIV/AIDS funds in 2009/10. The amount of ARV expenditure went up from R362 million in 2007/08 to R919.8 million in 2009/10.

[3] We have made an assumption that 100% of TB patients have HIV/AIDS but research suggests it is closer to 70% co infection rate. This would suggest that the expenditure on PLWHA is 30% overestimated here.

Meanwhile, spending on PMTCT fell from R130 million (17% of the total) in 2007/08 to R119.6 million, or just 8% of the total two years later.

Spending on nutritional support related to ART in 2008/09 (R36 million) was about 5 times higher than what was spent in the previous year. Further, spending on VCT climbed quickly from R26 million in 2007/08 to R213 million in 2009/10, when it consumed 15% of the total budget.

Results show that only about 6% of total HIV spending went to HBC each year, although there was a significant increase from R53 million to R83 million in 2009/10. Prevention through communication is another area of concern with R10 million spent in 2008/09 and zero spent the following year.

CG Funds:

The CG was mainly spent on the ART programme in both years. The ART programme took up 83% of the total CG HIV/AIDS spending in 2007/08, increasing to 93% (or R902 million) in 2009/10. In 2008/09, ARV spending consumed all but 2% of the DOH CG budget. This indicates the DOH's policy decision to use the CG for the ART programme primarily, to meet the escalating demand. It is therefore important that the ES voted funds are being strategically directed towards the other critical prevention, mitigation and treatment (other than ART) services.

Voted Funds:

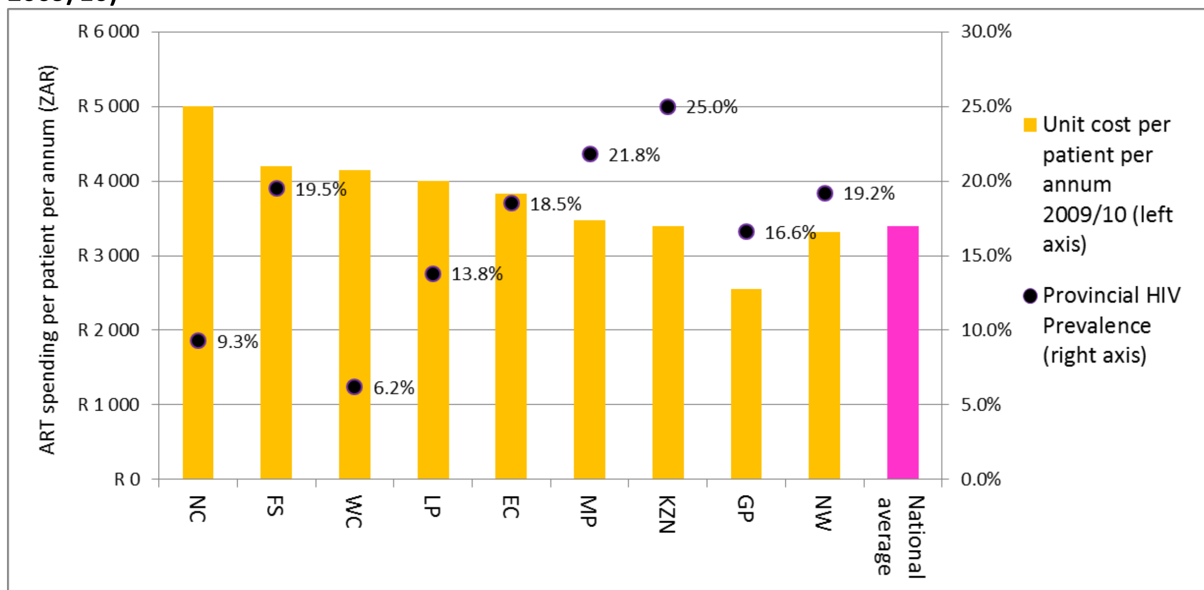
Importantly the KZN DOH allocated increasing ES funds to HIV/AIDS from just over R406 million in 2007/08 to R581 million in 2008/09, representing an increase of 30%. Unfortunately, Voted funds were reduced again by 32% to R440 million in 2009/10. In 2007/08, Voted DOH funds were devoted mainly to PMTCT (30%), Step down care (16%), and ARVs (15%). A significant slice (13%) also went to TB/HIV Combination Management in 2007/08 as well.

When the total amount of Voted funds jumped by 30% in 2008/09, it enabled an increase in allocations for most activities across the board. The shares to each activity remained largely similar to the previous year's budget, except for TB/HIV Combination Management, which dropped to nearly zero, and VCT which expanded considerably to now take up 18% of the total in 2008/09. In 2009/10 when the amount of Voted funds was cut by 30%, the activities which were primarily affected were ARVs, ARV nutrition, PEP & OPEP, and Communication & Prevention—these activities saw their shares of the total drop significantly. The amount of Voted funds allocated to ARVs dropped by 88%. It is likely that this due to a switch being made to rather fund ARVs from the CG instead of Voted Funds; DOH CG spending on ARVs increases substantially in 2009/10. Also important to note that Voted funds allocated for ARV nutrition dropped in 2009/10, after a large jump the previous year when it consumed 6% of the total.

DOH's Expenditure on Antiretroviral Treatment

ARV drugs are the largest component in the delivery of the ART services in KZN, consuming R585 million or 54% of the total ART budget in 2009/10. Wages were the next largest, and tests and reagent became a large share in 2009. Interestingly, the 'Other' component is made up of overhead costs such as transport, administration, and maintenance, as well as capital investment in equipment or infrastructure, and yet these form a very small proportion of the total ART costs (less than 1%). The 'other' overhead and capital investments in the delivery of the ART services by DOH are very small compared to the drugs, wages, tests and other medical supplies. They have been reducing over the years, dropping from R10.8 million in 2007/08 to R3.3 million in 2009/10. This could imply that the ART services are increasingly being integrated into the general health care services and thus these costs are being absorbed into the general facility overheads. **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.

Key Recommendations

Integrated Response

The dominance of the DOH in the response to HIV/AIDS needs to be balanced with increased spending on integrated HIV/AIDS services in all the other departments, particularly DSD and DOE. During the years of the NASA assessment, the public wellness programmes for civil servants was only just developing, so increased spending on these will also be an important effort to integrate services across the public sector.

Increased spending on prevention interventions that have greatest impact is necessary. Male circumcision and potentially the microbicides being developed could significantly reduce HIV transmission rates. According to the Modes of Transmission Study (HSRC, 2010), the bulk of the new infections are occurring between heterosexual married couples who have multiple concurrent partners – not the traditionally defined MARPs. Prevention campaigns need to be aimed at this group in particular. The DOH's recent launch of the counseling and testing campaign (2010) will hopefully raise awareness and willingness to change behavior while also increasing access to treatment.

The impact of the DOE spending on Life Skills training and other BCC efforts should be measured so as to ascertain their strengths and areas needing strengthening or improved targeting.

Spending on TB prophylaxis will decrease the DOH's spending on TB treatment, and greatly enhance the lives of PLWHA. The DOH's recent commitment (2010) to Isoniazid preventive therapy (IPT) is thus an important contribution. TB management spending, particularly for more integrated TB and HIV/AIDS services are equally important.

Spending on ART has increased dramatically and will continue to do so, especially with the recent increase of the CD4 eligibility to 350 cells/mm3. Therefore there it is critical for the DOH and the other departments to 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 OI treatment, in-hospital care, HBC and palliative care. These should be funded from the voted (ES) funds, since the CG is being used solely for ART. The DOH should therefore not be reducing its ES allocations, and ensure that the total allocated budgets are absorbed effectively.

CBOs are providing valuable HBC and other services, which ease the burden on the public health care system when patients fail their treatment. Funding for NGOs and CBOs should be increasing, not decreasing. It is suggested that the DOH and DSD increase and standardise the stipends paid to NPO volunteers, as well as harmonise their funding and reporting requirements for recipient organisations.

Spending on OVCs, social mitigation efforts, community development, enabling environment and research is low in KZN, although some research spending is missing (e.g. CAPRISA). These activities are all critical elements in an integrated response that would attempt to meet all the needs of both individuals and communities in their handling of the impact of HIV/AIDS on their lives.

It is also recommended that the findings of this analysis inform the development of the new PSP, highlighting areas needing additional attention.

Human Resource and Infrastructural Development

There is urgent need for capacity building in data management, analysis and utilisation in planning, within both the public and NOG sectors.

In order for the public health sector to attract skilled health workers at district level, the government should consider an Occupational Specific Dispensation (OSD) programme which offers preferential salary scales for scarce human skills. This may require increased district budget allocations and a transparent selection of qualified and experienced professionals. In addition, task shifting to nurses and other cadre of health workers would greatly improve the chances of posts being filled.

Additional resources are required for infrastructural development of health facilities that are overburdened with the delivery of ART. Decentralisation to clinics is important but will require sufficient infrastructure and Human resources.

Costing, Budgeting and Disbursements

The provincial HIV/AIDS strategic plan (PSP) had not been costed so the expenditure captured in this process could not be measured against the resource requirements so as to ascertain the funding gap. This implies that the implementation of the PSP has been undertaken without any indication of how much it will cost for the all the departments and services providers. This has hindered their ability to budget and plan adequately, and to predict their future resource requirements. It is strongly suggested that the next PSP have a detailed costing component that will guide future allocations.

Greater engagement of the district level public service providers in the development of their budgets with the national and provincial DOH managers would assist them to improve their own costing and budgeting skills, and should provide feedback as to why the total requested amounts cannot be approved and how to adjust their plans accordingly. If the financial demands from the districts cannot be met due to limited resources, alternative strategies are required, with regular dialogue, oversight, and support between district and provincial officials. There is also need for greater dialogue with the national level, particularly in determining priorities so as to reflect the provincial needs.

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 routine collection and utilisation of spending data to ascertain actual unit costs of the various services would be valuable to the implementers and to the country and region in improving the availability of valid costing data, for future projections.

Improving the disbursement rates and timings from the national treasury to provincial departments and from provincial to district offices, would enhance their efficient spending of their funds according to their Business Plans.

DSD should consider incorporating the fees of the audit in the total allocation to NPOs, and transfer these funds prior to the audit, so as to enable them deliver the audited report on time.

External and Business Sector Contributions and Coordination

Funding of activities by external sources does not appear to be well coordinated in the province. Although there is a donor forum group, it was not possible for the research team to meet with them as they kept postponing their meetings. It was not clear if the provincial AIDS coordinator was involved in these groups, but it was apparent that the DOH only knew of those funds which came through the DOH, due to the general resistance of many of the development partners and businesses to share their current expenditures and their future long-term commitments. This does not foster a harmonised and integrated response which is guided by the provinces' priorities. Nor does it 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.

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

Although the KZN NASA could not capture the spending of private medical insurance companies in KZN, the national NASA will capture these. Nevertheless, improved monitoring and regulation of the private health care sector would ensure the most cost-efficient usage of resources, as well as the cross-subsidisation between the private and public sectors.

Financial Information Systems

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 KZN. Efforts should be made to capture any 'hidden' spending that is embedded within the general public services (health and others). In addition, those entities that provide national level services should provide province-specific spending data, such as large corporations, bilateral and multilateral agencies, and public facilities such as correctional services, the Social Security Agency, blood backs, laboratories etc. The information should be centralised and managed by SANAC and the PACs, to ensure overall improved coordination and alignment of all efforts.

Planning for NASA

Recommendations to the other provinces that may assist in the planning of their NASAs:

Thorough awareness raising among all departments, external partners, NGOs and businesses of the NASA process, its purpose and the data requirements is essential to ensure the understanding, buy-in and collaboration of all actors involved in the HIV/AIDS field. This should be driven by the Provincial AIDS Coordinator with support from SANAC, the Department of Public Services and Accountability (DPSA), the provincial treasury and UNAIDS.

Letters of permission and access should be prepared well in advance for the research team, that allows them entry to all the departments and other stakeholders.

Once the senior management of all the involved actors have been informed and given their formal permission to access the data, it is also important for this permission to be filtered down to the lower staff members, particularly those that manage the expenditure data, so as to ensure their timeous release of the data.

Key finance officials from each department should attend the introductory training on NASA classifications and data collection and coding. This will greatly facilitate their understanding of the data requirements and therefore ensure valid data is provided with the required level of disaggregation. In addition, it will facilitate the institutionalisation of the collection of HIV/AIDS expenditure data on a routine basis.

Generally the respondents cannot complete the data collection forms unassisted (self-completed). They are meant to be semi-structured interview schedules, and data collectors require extensive training in the NASA classifications for their accurate completion.

It usually takes more than 2 or 3 visits by the data collectors to obtain all the data required from a single organisation or department. This greatly increases the time and costs incurred in the process, and every effort should be made by the Field Supervisors to prepare the respondents electronically and telephonically, so that the physical visit secures the data required, as quickly as possible.

Any gaps or inconsistencies in the data collection forms must be rectified in the field as soon as possible.

All actors (including both those that provided data and those that did not) should participate in a validation meeting that seeks their feedback on the validity of the data and obtains their assistance to improve the data and fill any gaps.