Limpopo 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 Limpopo Province (LP), for the years 2007/08 to 2009/10.

Total HIV/AIDS and TB spending in Limpopo

The development and delivery of Primary Health Care (PHC) services to a population of about 5.2 million people in a predominantly rural province is challenging. Access to health care facilities is made difficult in the deep rural areas due to the topography of the province, poor road infrastructure, poverty and cultural factors. Nevertheless, the Department of Health in Limpopo continues to deliver universal access to PHC services, which includes collaboration with traditional health practitioners. According to the 2009/10 DOH Annual Report for Limpopo, PHC utilisation rates in the Province increased from 2.7% to 3.2%, which is still below the national norm of 3.5%. The number of clinics providing 24-hour services increased by about 10% from 2008/09 to the second quarter of 2009/10. In addition, the Department reported an increase of 392 clinics in the Province offering a comprehensive PHC package in the second quarter of 2009/10. Despite these achievements, the Province experiences challenges relating to a shortage of nurses, doctors and allied health professionals. The Limpopo DOH increased the number of sites of HIV and AIDS care, treatment and management programmes from 49 sites in 2008/09 to 65 sites in 2009/10[1].

According to the recent 2011 ANC survey, HIV prevalence rate in LP is estimated at 21.4% in 2010 and 22.1% in 2011.[2] According to the ASSA provincial modelling, there were 409,161 people living with HIV in LP in 2011. HIV prevalence amongst antenatal clinic (ANC) attendees in LP declined significantly from 21.5% in 2007 to 20.7% in 2008, and increased to 21.4% in 2009, 21.9% in 2010 and 22.1% in 2011. [3] Limpopo remains the third-lowest province affected by the HIV epidemic, after the Western Cape (18.2%) and the Northern Cape (17.0%). The ASSA Provincial modelling estimated

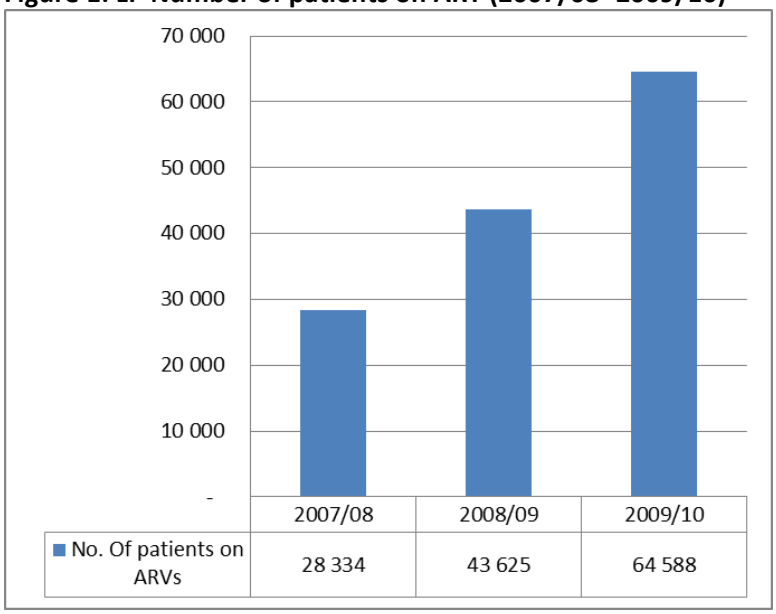
[1] DOH Annual Health Report, Limpopo 2009/10

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

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

120,842 people on ART in LP in 2011. The DORA targets estimated the number of ART patients in care for LP to be 188, 410 in 2012/13.

Figure 1: LP Number of patients on ART (2007/08- 2009/10)



Source: Information provided by LP Department of Health

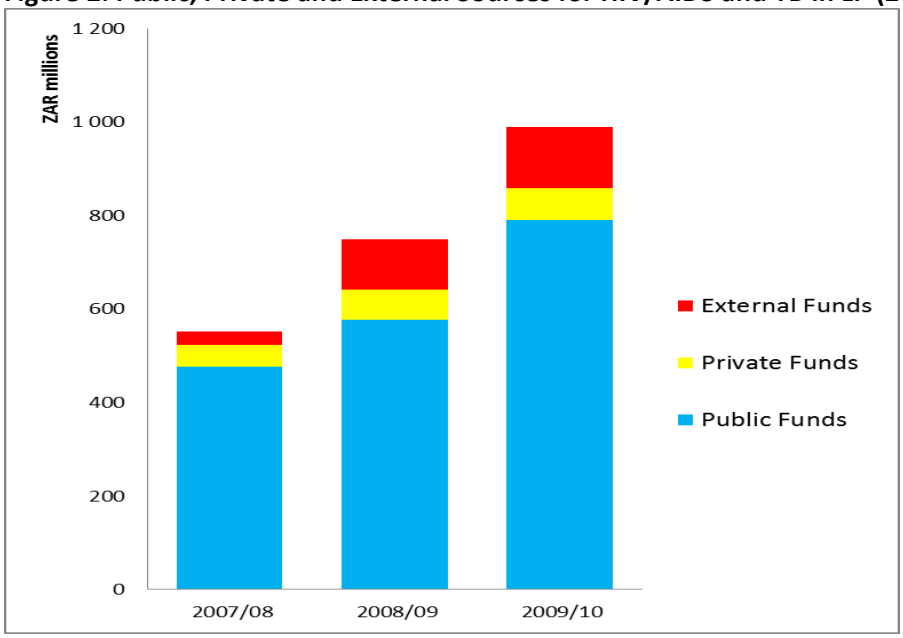
The AIDS Spending Assessment in LP sought to capture all public, external (donor) and business sector contributions to the HIV/AIDS and TB response in the province, in 2007/08, 2008/09 and 2009/10. Household and individual contributions (out-of-pocket expenditure) were excluded.In 2007/08, LP spent R552 million on HIV/AIDS and TB, increasing by 35.4% to R747.7 million in 2008/09, and reaching R988.4 million 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 their details of their expenditure, these may be underestimations to some degree. Although a large proportion of the PEPFAR funds is missing from the total figures because they could not be validated, it is estimated that approximately 85% of the provincial spending has been captured.

When adjusting for total population size, LP spent approximately R144.6 (US$ 19.30) per person in 2009/10, which sits mid-range among the South African provinces, but falls behind Botswana, Swaziland and Lesotho.

Sources for HIV/AIDS and TB activities in Limpopo

In 2009/10, public sources contributed 80% of total HIV/AIDS and TB funds, while the external sector contributed 13%. Private sources accounted for only 7% of expenditure in 2009/10. **Figure 2** provides a graphical presentation of the sources.

Figure 2: Public, Private and External Sources for HIV/AIDS and TB in LP (2007/08 – 2009/10)



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

Public sources increased from R 476.5 million in 2007/08, to R576.8 million in 2008/09, and further increased by 37% to R789.2 million in 2009/10. In 2008/09, externally sourced funds increased to R107 million (14% of the total) and increased again in 2009/10 to R130 million (13% of the total).

Multilateral organisations were responsible for large shares of external funding: totalling R67.8 million in 2009/10. The two key sources of multilateral aid were the European Union (EU) and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM), which contributed a total of R51 million and R84 million over the three years respectively.

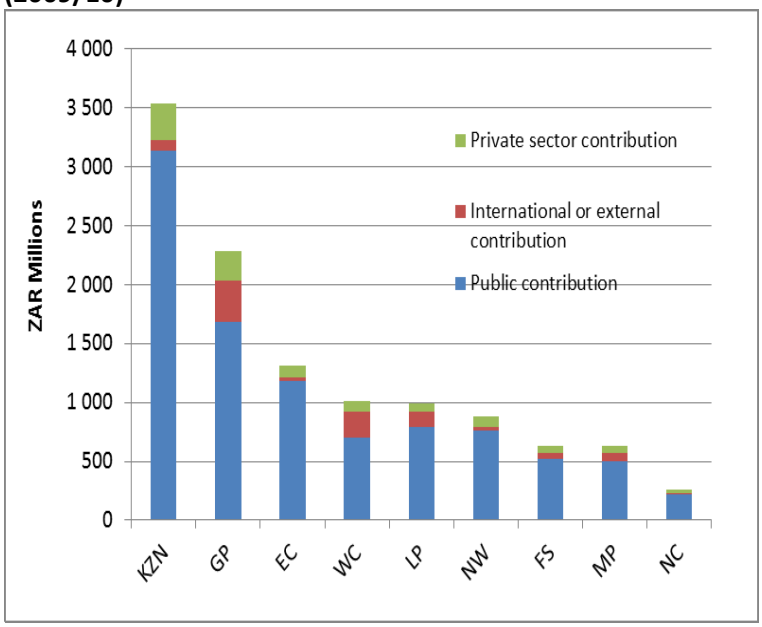
Bilateral aid amounted to R54 million in 2009/10, while external foundations contributed the lowest amount of R7.2 million. The Government of Ireland gave a total of R12.8 million over the three years, while the United States provided R77.6 million during this period.

Private sources contributed the least amongst the three sectors, growing from R46.9 million in 2007/08 to R68.6 million in 2009/10 (7% of total expenditure on HIV/AIDS and TB in LP). Most private spending came from medical aid schemes: R30.6 million was provided by employees with a matching amount from employer contributions in 2009/10. Together, employee and employer contributions made up 6% of the total HIV/AIDS spending in 2009/10. The business sector was unwilling to share their expenditure data on HIV/AIDS and TB in LP; those companies that did provide this information contributed less than 1% of the total spending on HIV/AIDS and TB across the years.

Figure 3 provides a comparison to HIV/AIDS and TB spending in other provinces.[4] It shows that HIV/AIDS spending in 2009/10 in Gauteng exceeded spending in all the other provinces, excepting KZN.

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

Figure 3: 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 LP had increased significantly again to reach R915 million 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 HIV/AIDS and TB funds in Limpopo

Overwhelmingly, it is government that acts as the funding agent for HIV/AIDS and TB expenditure in LP. In 2009/10, 86% of funds was managed by government entities (including the South African Social Security Agency: SASSA) – 19% by provincial departments, and 45% by national government. The public funds managed by provincial funding agents include Voted Funds from the DOH and DSD, as well as some other workplace programmes in other provincial departments. The public funds managed by national government were the Conditional Grant funds for HIV/AIDS allocated to the DOH and DOE. Given that the national Department determines how these funds can be spent, central government is coded as the funding agent, according to NASA methodology.

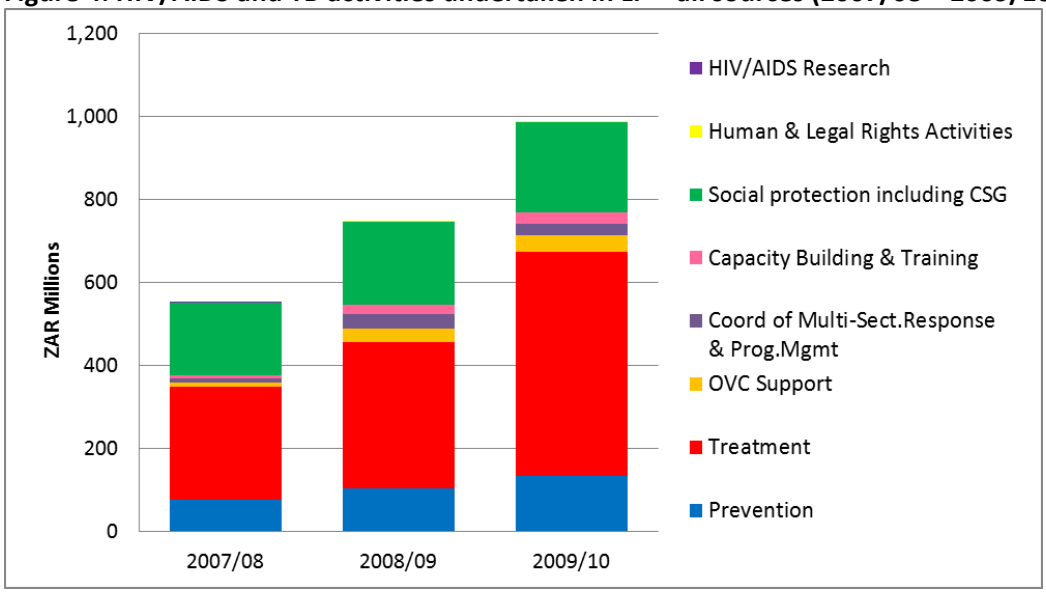
HIV/AIDS funds sourced from the private sector, which were primarily the estimated contribution from medical aid schemes, were managed primarily by private employer medical aid schemes, with some of the private funds managed by NGO agents, mainly through corporate social investment (CSI) from the business sector.

Externally sourced HIV/AIDS and TB funds were managed primarily by the provincial and bilateral governments (47% and 39% respectively in 2009/10). The USA contribution for NGO-based support was mainly for care and treatment, and was managed by the bilateral source (USA government). The EU contribution supported NGOs providing home-based care (HBC) and was channeled via the provincial DOH, as was the Global Fund contribution to NGOs.

Activities the money for HIV/AIDS and TB in Limpopo was spent on

The majority of HIV/AIDS and TB funds in LP were spent on treatment in all three years. In 2009/10, the funds went to treatment (54%), followed by social protection including the Child Support Grant (22%), and followed by prevention (14%). Expenditure on treatment increased steadily from R273 million to R538 million between 2007/08 and 2009/10, and by 53% from 2008/09 to 2009/10. Note that "treatment" refers not only to antiretroviral therapy (ART,) but also includes other treatment such as palliative care, HBC and TB treatment. Prevention also increased from R76 million in 2007/08 to R134 million in 2009/10, with a significant increase of 28% from 2008/09 to 2009/10. Of concern is the relatively low spending on other categories, such as OVC support, research and human and legal rights activities.

Figure 4: HIV/AIDS and TB activities undertaken in LP – all sources (2007/08 – 2009/10)



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

Funds from all the three sources (public, private and external) were overwhelmingly being used to fund treatment activities. Small proportions of funds from external sources went towards prevention and enabling environment activities. Public funds also served to finance social protection and social services and some prevention activities, to which private and external sources did not contribute. The thematic categories are further broken down as follows:

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- **Prevention**: Overall, funds spent on prevention activities increased by 28% in 2009/10, largely driven by a 131% increase in spending on PMTCT, despite the cost of ARVs for mothers being captured under ART. After increasing in 2008/09 to R9.3 million, spending on PMTCT increased dramatically to R21.5 million in 2009/10 (or 16% of the total prevention spending). In 2009/10, the largest slice (27%) of prevention funds went to HIV/AIDS Counselling and Testing (HCT), with 19% being directed to other prevention activities which could not be disaggregated.

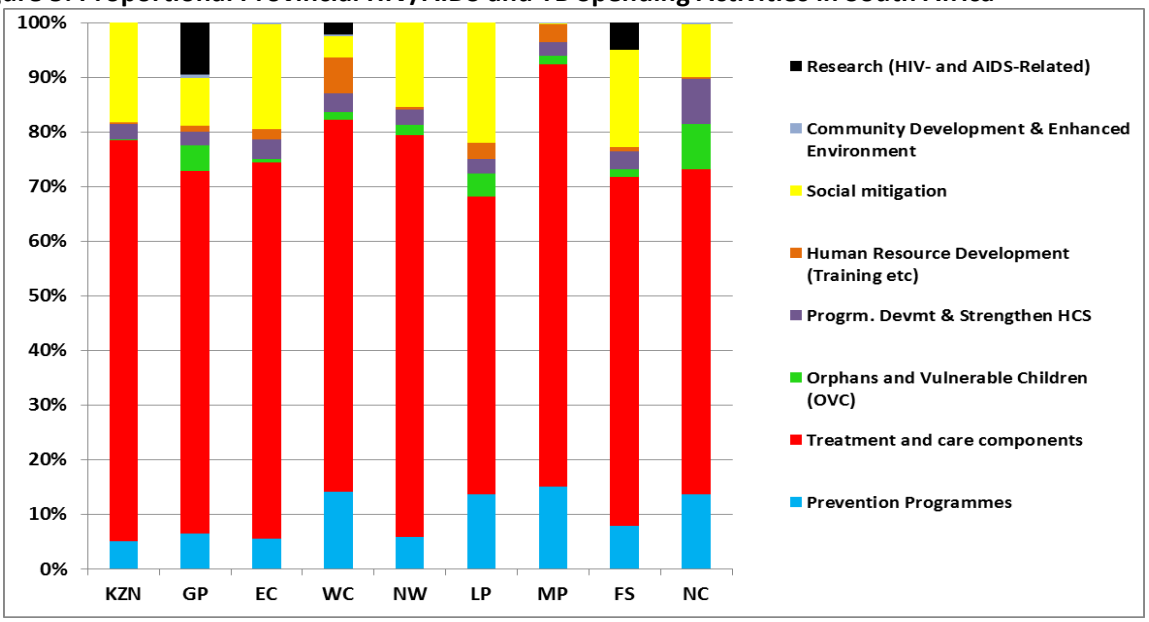
- **Treatment**: Overall, spending on treatment climbed steadily, growing by 29% in 2008/08 and 53% in 2009/10. Not surprisingly, ART makes up the bulk of spending: R261.7million (or 49%) in 2009/10. TB treatment – both in- and out-patient – took an increasing share of treatment funds, starting at R27.4-million in 2007/08 and rising to R82.4 million in 2009/10,

or 15% of the total treatment spending. Also, although funding for HBC had increased in 2008/09 to R120.3 million, in 2009/10 it was reduced to R116.6 million.

- **Activities for orphans and vulnerable children (OVC)**: In LP, increasing amounts of HIV/AIDS funds were spent on programmes specifically servicing OVC: R9.5 million was spent in 2007/08, increasing by nearly 236% to R31.9 million in 2008/09, and by 31% to R41.8 million (4% of the total spending on HIV/AIDS and TB). The entire amount was spent on family/home support programmes.

Figure 5 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 with no investment recorded in Limpopo. Social mitigation was well-funded Limpopo in KwaZulu-Natal, Free State, Eastern Cape and Gauteng Province. However, Limpopo proportional spent a huge amount on prevention compared to Eastern Cape, North West, KwaZulu-Natal, Free State and Gauteng.

Figure 5: Proportional Provincial HIV/AIDS and TB Spending Activities in South Africa



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

Beneficiaries of the HIV/AIDS and TB spending in Limpopo

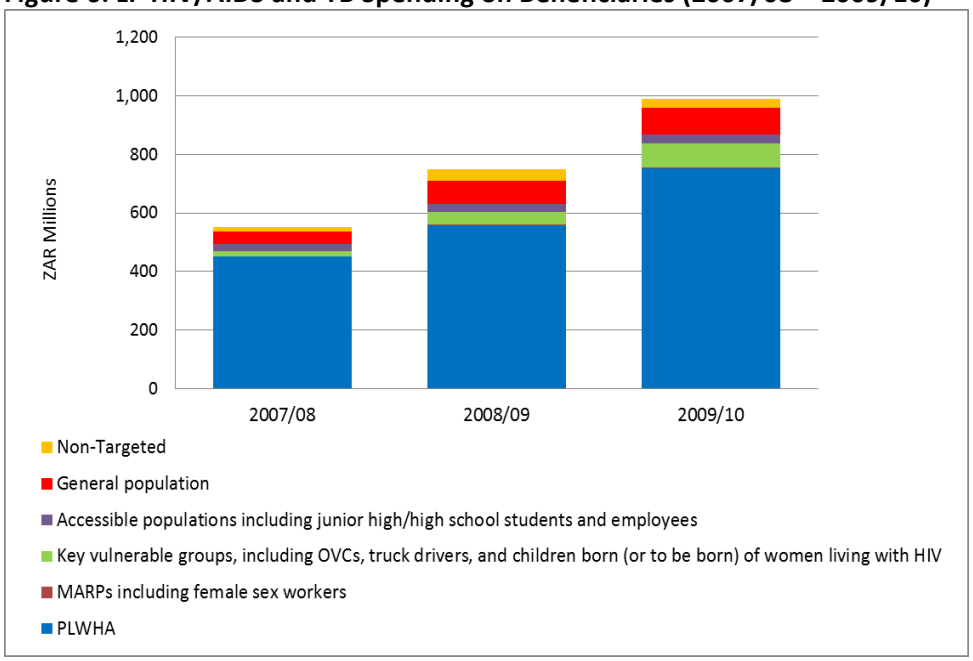
Throughout the period, people living with HIV/AIDS (PLWHA) took the majority of the HIV/AIDS funds as the beneficiaries of the large spending on ART. In 2007/08, PLWHA benefited from R450 million, and this allocation reached R753.5 million (76% of total spending) in 2009/10.

In 2009/10, a very small portion (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), and just 8.34% went to key vulnerable groups including OVC, truck drivers and children born (or to be born) of women living with HIV.

Only 3.02% of the total spending in 2009/10 went to accessible populations, such as learners in school or college (primarily through the DOE's Conditional Grant for its Life-Skills programme), and health care workers (through post-exposure prophylaxis).

In 2009/10, approximately 71% of spending on PLWHA was for treatment and care, and 29% was for various impact mitigation activities. Other activities shared only 10% of the total amount benefiting PLWHA. In essence, PLWHA benefited mainly from treatment and care activities, while the general population, MARPs, other vulnerable populations and accessible groups benefited mainly from prevention activities. OVC and vulnerable populations benefited mainly from OVC support (51%) as well as prevention activities (44%).

Figure 6: LP HIV/AIDS and TB Spending on Beneficiaries (2007/08 – 2009/10)



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

Service Providers of HIV/AIDS and TB in Limpopo

The Directorate for HIV/AIDS and TB (HAST) in the Department of Health and Social Development (DOHSD) was the largest service provider, delivering R398.8 million in services (or 40% of the total) in 2009/10. The workplace co-ordinators greatly assisted with HIV/AIDS spending in their programmes, but in total this amounted to only 2% of the total HIV/AIDS and TB spending in LP. The Department of Education (DOE) accounted for 3% of the total share in same year. The second-largest service provider was SASSA, delivering 25%, or R246 million, of services in 2009/10. This was the estimated share of the Child Support Grant that was benefiting orphans and children affected by HIV/AIDS. The third-largest provider was constituted by NGOs, CSOs and CBOs, which provided 21% or R203 million altogether in the same year. For-Profit providers accounted for only 6% amongst the private sector, and these were primarily the medical insurance companies. It is also noted that the survey response from the business sector was low, so their contribution is likely to have been underestimated here.

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

In 2009/10, 71% of the DOHSD's HIV/AIDS and TB expenditure was sourced from the Conditional Grant (CG) (R402.1 million) and the remaining R41.3 million came from Voted Funds. The amounts of Voted and CG funds varied in relation to each other throughout the period; CG had been increasing throughout the three years, while Voted Funds decreased in 2008/09 by 54% and then increased by 85% in 2009/10. On the other hand, CG funds increased by 38% and 71% in 2008/09 and 2009/10 respectively.

Overall, the DOHSD underspent its total HIV/AIDS budget by 14.8% in 2007/08, underspent by approximately 5% in 2008/09, and underspent slightly again by 2.9% in 2009/10.

- DOHSD *overspent* on its voted budget by double in 2008/09, and underspent by 10% and 24% in 2007/08 and 2009/10 respectively.

- In contrast, in 2007/08, DOHSD *underspent* on its CG budget by 15.8%, but spent 100% of its CG budget in 2008/09 and 2009/10).

The majority of the CG funds were used for ART each year (64.3% in 2009/10), while the rest of the CG was used primarily for HCT and HBC.

The largest slice of the Voted Funds was spent on TB out-patient treatment. For example, R 28.3 million (or 67% of DOH Voted funds) went to TB out-patient treatment in 2009/10.

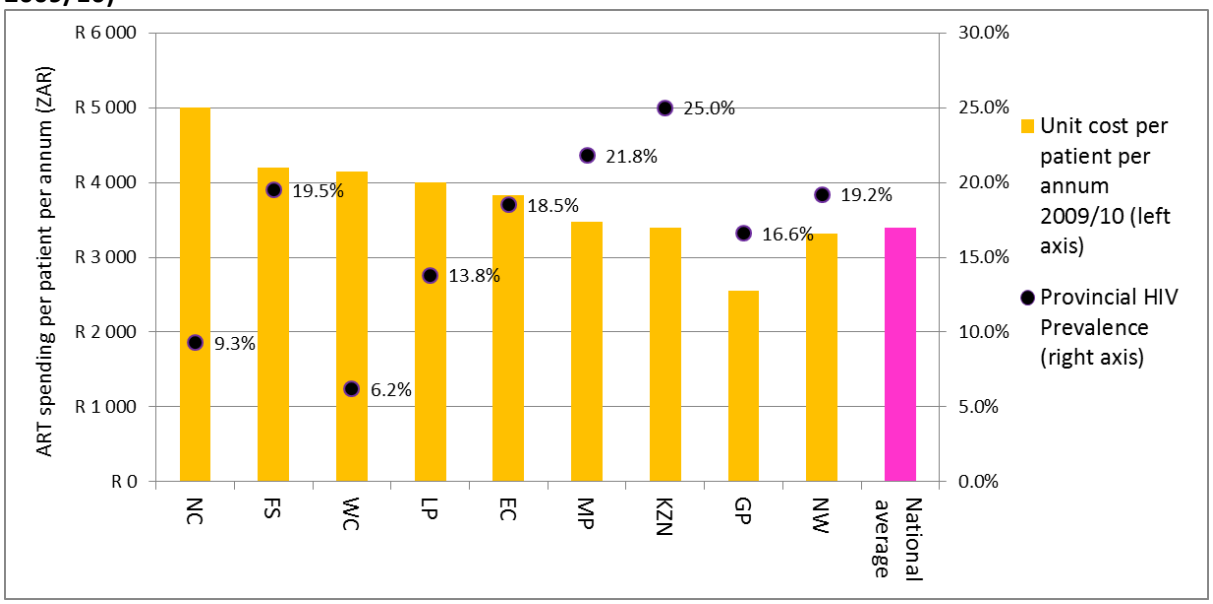
In essence, HAST was providing ART (funded mainly through the CG) and clinics were providing TB out-patient treatment (funded mainly through Voted Funds).

DOHSD's Expenditure on Antiretroviral Treatment in Limpopo

Total spending on the ART programme by the DOHSD increased steadily to reach close to R258.4 million in 2009. As expected, ARV drugs consumed a large portion of the money: R134 million (52%) in 2009. The majority of ART expenditure was attributed to HAST as the service provider. This suggested that the DOHSD was increasingly using the Directorate as the cost centre for expenditure, rather than attributing it to the clinic or hospital directly providing the service.

It is noted that laboratory costs were rising substantially, from R36.2 million in 2008/09 to more than double in 2009/10 (R83.2 million). This may have been due to the bills from the National Health and Laboratory Services (NHLS) not being paid in 2008/09 and being rolled over to 2009/10. As a result, laboratory costs were also consuming a much larger share of total ART programme costs: 32% in 2009/10. Despite rising laboratory costs, the average unit cost (per patient per annum) fell from R3,631.06 in 2007/08 to R2,668.21 in 2008/09, but rose again to R4,001.87 in 2009/10. This is likely to be due to NHLS laboratory bills being unpaid in 2008/09 and rolled over to 2009/10, which disproportionally increased the 2009/10 unit cost. To reduce delivery costs, decentralisation and task-shifting are recommended, while the new tender prices for the new WHO regimen (2010) will further reduce the unit costs. **Figure 7** depicts the comparison between ART unit cost per patient per annum and provincial HIV prevalence rates.

Figure 7: Provincial DOH Public ART cost per patient per annum (ZAR) and HIV Prevalence (%, 2009/10)



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

Key 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 response beyond health sector: The dominance of the DOH in the response to HIV should be balanced with increased spending on integrated HIV services in all the other departments, particularly the DSD and DOE.

Increase priority given to prevention: Public prevention spending is not increasing adequately and proportionally, it is too low compared to that of HIV treatment and care. It is vital that budgets are increased for those key prevention interventions that have been shown to have the greatest impact. Male circumcision and, potentially, the microbicides being developed, could significantly reduce HIV transmission rates.

Prioritise TB prophylaxis: Spending on TB prophylaxis would contribute to a decrease in the DOH's spending on TB treatment, and greatly enhance the lives of PLHIV. TB management spending, particularly for more integrated TB and HIV services, is equally important.

Measure and expand the impact of DOE interventions: 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. Since it is the key programme for youth, it is important to expand its impact as far as possible.

Avoid crowding out by ART spending: Spending on ART has increased dramatically and will continue to do so, and therefore long-term sustainability, greater ART efficiencies are required. For instance, the DOH should secure tenders for lower drug prices, and ensure increased task-shifting, step-down care and clinic-level delivery. Limpopo NASA Final Report Page 7.

Increase support to NGOs and CBOs: CBOs are providing valuable HBC and other services, which ease the burden on the public health care system when patients fail their treatment. More funds are needed for HBC, step-down care and palliative care and this can be best provided through NGOs.

Use NASA findings for new PSP: It is strongly suggested that the LP PSP have a detailed costing component that will guide future allocations. It is important that the findings of this analysis inform the development of the forthcoming PSP, highlighting areas needing additional attention.

Improve accuracy and frequency of data collection on expenditure: The routine collection and utilisation of spending data to ascertain actual unit costs of the various services would be valuable to the implementers, as well as to the country and region, in improving the availability of valid costing data for future projections.

Increase transparency of funding of external sources and business contributions: Funding of activities by external sources does not appear to be properly co-ordinated in the Province, while some of the development partners and businesses do not share their current expenditure data and their future long-term commitments. This dynamic does not foster a harmonised and integrated response that 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.

Advocate for greater contribution from business sector: 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 system.

Build HR capacity around data collection and 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.

Centralise and institutionalise HIV 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 field in LP. The expenditure tracking should include out-of-pocket expenditure (OOPE) which was missing from this study.

The Provincial AIDS Council should begin the process of planning their next NASA or routine expenditure tracking survey, and should identify the skills and resources required to institutionalise the process within the province.