Mpumalanga 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 Mpumalanga (MP) for the years 2007/08 to 2009/10.

Total HIV and TB spending in Mpumalanga

At the time of the NASA assessment, as of October 2008, 455 000 people in Mpumalanga were HIV-positive, with the number of new infections per day (109) exceeding the number of deaths each day (92)[1]. The National Household Survey of 2008 noted that the province's HIV prevalence rate had increased from 14.1% in 2002, to 15.2% in 2005 and to 15.4% in 2008[2].

The 2009 ANC survey by the Department of Health revealed that on a sample of 32,861 women attending 1,447 antenatal clinics across all nine provinces, 29.4% of pregnant women were living with HIV. The HIV prevalence at antenatal clinics in MP, which stood at 34.7%, was higher than the national figure and the second highest after KZN. However, this represented a decrease from the 2008 figure of 35.5%. The recent ANC survey (2011) found that MP's HIV prevalence amongst the general population as 23.94 in 2010 and increasing to 24.11 in 2011. MP is now just under KZN's prevalence rate of 24.7% (ANC, 2011). According to the ASSA provincial modelling, there were 482,288 people living with HIV in MP in 2011.

At the time of the NASA assessment, in 2009/10, MP had 23 hospitals and two Community Health Centres accredited to provide antiretroviral therapy in the province[3]. In 2008/09, 38,129 patients were on ART, of which 35,257 were adults and 2,872 were children[4]. The number of patients on ART rose significantly over the period, from nearly 27,001 in 2007 to 70,310 in 2009/10. The target for people accessing ARVs in 2009/10 was 42,431 and this was surpassed by 66%[5]. Uptake was expected

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[1] http://www.metam.co.za/documents_v2/File/RedRibbon_2009/Provincial%20HIV%20and%20AIDS%20statistics%20for%202008.pdf

[2] Based on the *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey*, 2008, quoted on *Avert Health HIV&AIDS Statistics for South Africa*.

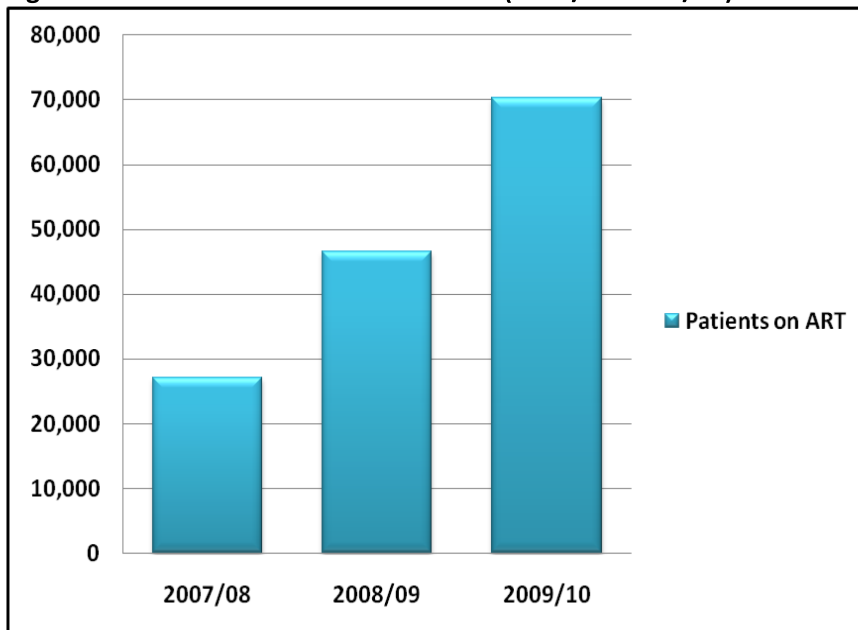
[3] MP Budget Overview 2009/10

[4] MP Budget Overview 2009/10

[5] MP Budget Overview 2010/11

to grow further due to the increase (effective 1 April 2010) in the CD4-count threshold for ARV eligibility for TB co-infected patients and pregnant women, (i.e. from 200 to 350cells/m^3),and triple-therapy provided to all children born with HIV. Figure 1~~Figure 1~~ shows the number of patients on antiretroviral treatment for the years 2007/08 to 2009/10. The ASSA Provincial modelling estimated 132,174 people on ART in MP in 2011, and the DORA targets indicated 189,481 on ART in 2012/13.

Figure 1: MP Number of Patients on ART (2007/08-2009/10)



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

The AIDS Spending Assessment in Mpumalanga (MP) 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. The study found that in 2007/08, Mpumalanga (MP) spent R368.4 million on HIV/AIDS and TB, increasing by 51% to R555.9 million in 2008/09, and reaching R642.9 million in 2009/10. Bearing in mind that the business sector was reluctant to share their expenditure, these may be underestimations to some degree. Although a proportion of the USA (PEPFAR) funds are missing from the total figures, it is estimated that approximately 80% of the provincial spending data has been captured.

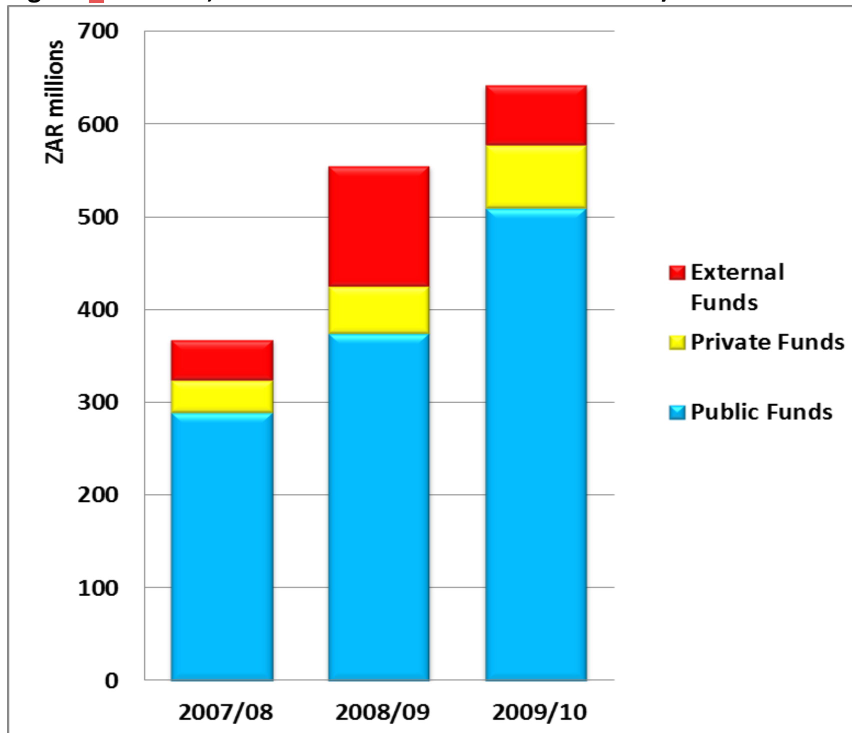
Sources of HIV/AIDS and TB funding in Mpumalanga

In 2009/10 in MP, public sources contributed 79.4% of total HIV/AIDS and TB funds (R510.3 million), while external contributed 10.1% (R65 million) while 10.6% (R67.6 million) was from private sources. See Figure 3~~Figure 2~~. The bulk of external funds emanated from bilateral organisations with a dramatic increase in funding from 2007/08 (R43 million) to 2008/09 (R112 million). However, this amount decreased in 2009/10 to R58 million. The governments of the United States (USG) and the Netherlands made notable contributions. Multilateral contributors included the European Union (EU) and UNAIDS.

The private sector spending also increased steadily over the three-year period, from R35 million in 2007/08 to R51 million in 2008/09, and again to R67.5 million in 2009/10. The majority of this spending came via medical aid schemes. In 2007/08, medical aid contributions amounted to approximately R35 million. These increased to R49.3 million in 2008/09 and to R66.5 million in 2009/10. Together, employee and employer contributions to these private medical schemes

averaged 9.5% of the total HIV/AIDS and TB spending over the three-year period under review in MP.

Figure 32: Public, Private and External Sources for HIV/AIDS and TB in MP (2007/08 – 2009/10)



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

According to Treasury, the government spending on HIV/AIDS in MP had increased significantly again to reach R650million 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 Mpumalanga

Overwhelmingly, government acted as the funding agent for HIV/AIDS and TB expenditure in MP. In 2009/10, 80.3% of funds were managed by government entities (including SASSA); 31.7% by provincial departments, and 48.7% by national government. The private sector managed 17.4% of the total funds, whilst the external sector controlled only 2.2% in 2009/10.

The public funds managed by provincial funding agents include Voted Funds from the Department of Health (DOH) and the Department of Social Development (DSD), as well as some other workplace programmes in other provincial departments. The public funds managed by national government were the Conditional Grants (CG) for HIV/AIDS, which were transferred to the provincial Departments of Health (DOH) and Education (DOE).

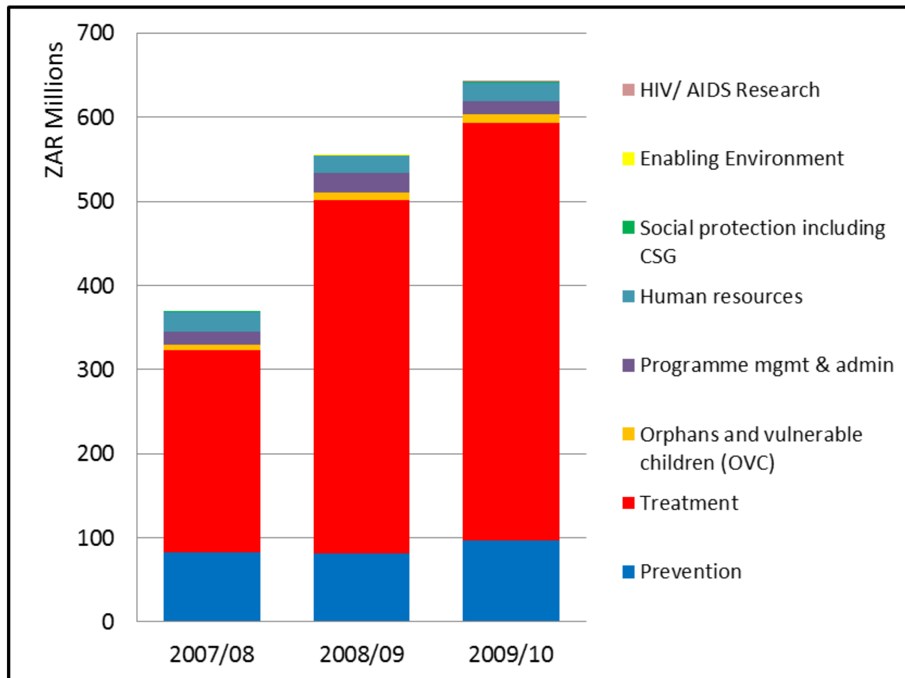
The bilateral organisations and NGOs primarily controlled externally sourced funds. These included monies from the USG and Netherlands government, and the EU.

HIV/AIDS and TB activities in Mpumalanga

The majority of HIV/AIDS and TB funds in MP were spent on treatment in all three years. Note that the 'treatment' category includes not only antiretroviral therapy (ART) but also home-based care

(HBC), TB treatment, palliative care, in-patient care, other opportunistic infections treatment and so on. Figure 5~~Figure 3~~ shows the spending breakdown by activities.

Figure 5~~3~~: HIV/AIDS and TB activities undertaken in MP – all sources (2007/08 – 2009/10)



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

Total treatment spending in MP increased as a share of the total HIV/AIDS and TB expenditure from 65.1% (R240 million) in 2007/08, to 75.6% (R420 million) in 2008/09 and to 77.2% (R497 million) in 2009/10. Prevention was the second-largest consumer in all three years, but decreased slightly from R82.7 million (22% of total HIV/AIDS and TB spending) in 2007/08 to R81.3 million (14.6%) in 2008/09, and then increased to R97million (15.1%) in 2009/10. Of concern is the relatively low spending on other categories, such as support for orphans and vulnerable children (OVC), research and human and legal rights activities, each of which had very small allocations of less than 2% throughout the period.

Whilst public and private funds were used primarily for treatment, the spending focus of external funds was more varied – split between prevention, research, treatment and co-ordination/programme management primarily. Public funds also served to finance social protection (through a portion of the Child Support Grant), to which private and external sources did not contribute.

> **Prevention activities**: The increase in prevention spending in 2009/10 was largely driven by increased expenditure on HIV Counselling and Testing (HCT) (formerly referred to as VCT or Voluntary Counselling and Testing), community mobilisation and behaviour change communication (BCC). In 2007/08, the largest component, approximately R21.4 million, was spent on vulnerable and accessible populations, followed by community mobilisation (R14.4 million), youth in school (R12 million) and HCT (R8.4million). In 2008/09, the focus shifted towards HCT (19% of total prevention), youth in school (19%) and BCC (13.3%). Expenditure on PMTCT increased over the three-year period, from R761 thousand in 2007/08 to R2.63 million (an increase of 246%) in 2008/09 and to R5.6 million (114% increase) in 2009/10.

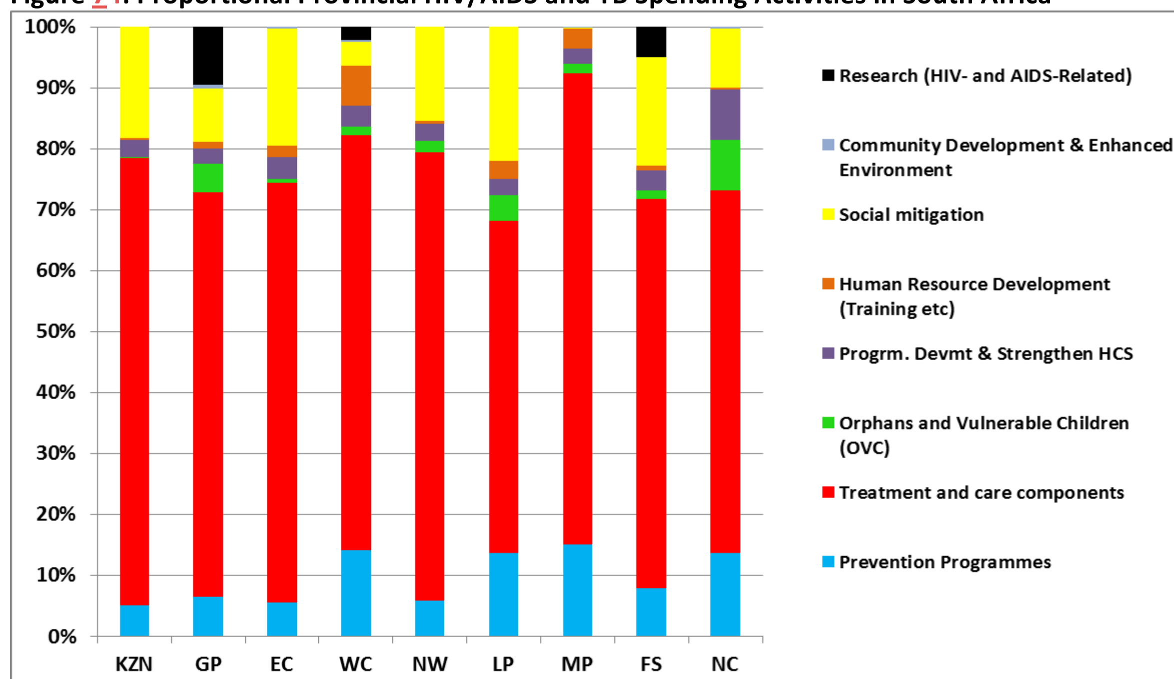
Treatment activities: In 2009/10, there was an 18% increase in treatment activates, bringing the total expenditure on treatment to R497 million. Of this amount, antiretroviral therapy (ART) took the bulk of spending: R244 million (or 49.2%) in 2009/10. However, it is noted that "treatment not disaggregated" represents the estimates of medical aid spending which could be assumed to be primarily for ART, so including this increases the ART proportion to 65.3% of the total treatment activities in 2009/10. In-patient TB treatment also increased steadily from R50 million in 2007/08 to 65.8 million in 2008/09 and to R77 million (15.5% of the total treatment spending) in 2009/10. The estimated out-patient TB treatment[6] spending also increased, from approximately R7 million in 2008/09 to R8.7 million in 2009/10.

Activities for OVC: Very little was spent on programmes specifically servicing OVC in MP. Approximately R6.4 million was spent in 2007/08, increasing by 33% to R8.5 million in 2008/09, and by 17% to reach R9.9 million in 2009/10. Almost the entire amount was spent on family/home/community support programmes in all three years, primarily delivered through NGOs.

Figure 7

~~Figure 4~~ shows the proportional spending of all provinces. Treatment was a major consumer in all provinces. MP's expenditure on OVC support, social mitigation, research and human and legal rights activities was minimal compared to the other 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 74: Proportional Provincial HIV/AIDS and TB Spending Activities in South Africa



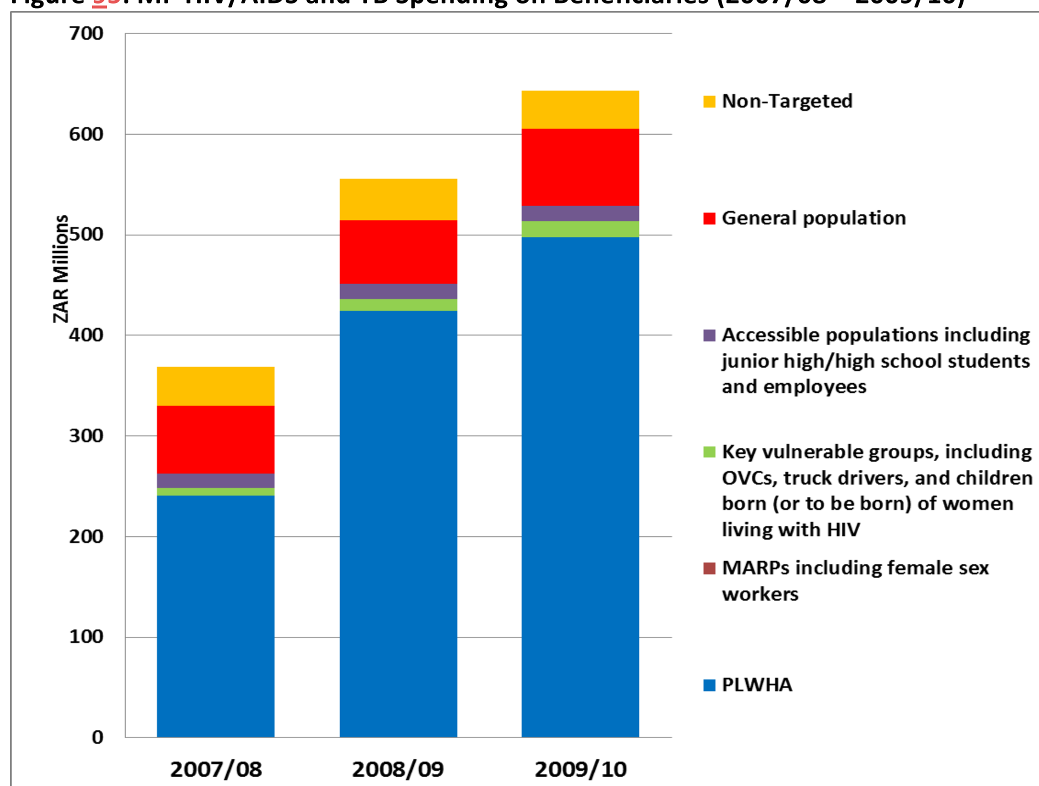
Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

[6] The TB out-patient costs are limited drug costs and did not include uniforms, salaries, etc., as these are embedded in the primary health care spending and could not be disaggregated.

The beneficiaries of HIV/AIDS and TB services in Mpumalanga

Throughout the period, people living with HIV/AIDS (PLWHA) took the majority of the HIV/AIDS funds as the beneficiary group of the large spending on ARVs, home-based care (HBC), other treatment spending and social protection spending. Spending on programmes targeted to PLWHA increased from 65.4% of total expenditure (R240.8 million) in 2007/08 to 76% in 2008/09 and to 77% (R497.7 million) in 2009/10. In all three years, a very small portion went to 'most-at-risk populations (MARP) with only 0.1% of the total each year. The only MARP identified were commercial sex workers (CSW). There was no identified expenditure on men who have sex with men (MSM) and intravenous drug users (IDUs). Of the total expenditure, only 2.1% went to key vulnerable groups including OVC, prisoners, truck drivers and children born (or to be born) of women living with HIV: R7.66 million in 2007/08, R11 million in 2008/09, and increased in 2009/10 to R15.9 million. The amount spent on prisoners decreased from R45 000 to R26 800 in 2008/09, but increased again to R92 000 in 2009/10. Spending on accessible populations (such as learners in school through the DOE Life-skills programme, and health care workers through the post-exposure prophylaxis) decreased from 3.8% in 2007/08 to 2.7% of the total spending in 2008/09, and further reduced to 2.3% in 2009/10. This is cause for concern as the DOE life-skills programme is the primary intervention targeting youth-in-school.

Figure 95: MP 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 services in Mpumalanga

In MP, the major service provider was the DOH HIV and AIDS / STI / TB Unit (HAST), delivering R261 million in services (or 41% of the total) in 2009/10. The second largest category of service provider constituted non-governmental organisations (NGOs) and community-based organisations (CBOs) that were responsible for 21% of the total expenditure in 2009/10. Public hospitals constituted the third largest service provider, delivering 17%, or R107 million, of services in 2009/10. The total

spending by NGOs and CBOs increased from R82.7 million in 2007/08, to R177.6 million in 2008/09, but decreased in 2009/10 to R172.6 million.

Mpumalanga Department of Health spending on HIV/AIDS and TB

In 2009/10, 68% (R289.9 million) of the DOH's HIV/AIDS and TB expenditure was sourced from the Conditional Grant (CG) and the remaining R261 million from Voted Funds. The MP DOH has increasingly allocated funds from its own budget (voted funds) for HIV/AIDS and TB.

MP DOH primarily used the CG funds for ART and the Voted Funds for TB in-patient treatment. In 2007/08, Voted Funds were also used for some HIV/AIDS activities – HBC, TB out-patient treatment, condoms, treatment for sexually transmitted illnesses (STIs), social mobilisation, training and programme management.

Overall, the DOH over-spent its HIV/AIDS (CG and Voted) budget by 1% in 2007/08. There was then under-spending of approximately 4% and 17% in 2008/09 and 2009/10 respectively, which was primarily driven by the under-spending of the allocated Voted funds, since the Conditional Grant (CG) was absorbed completely:

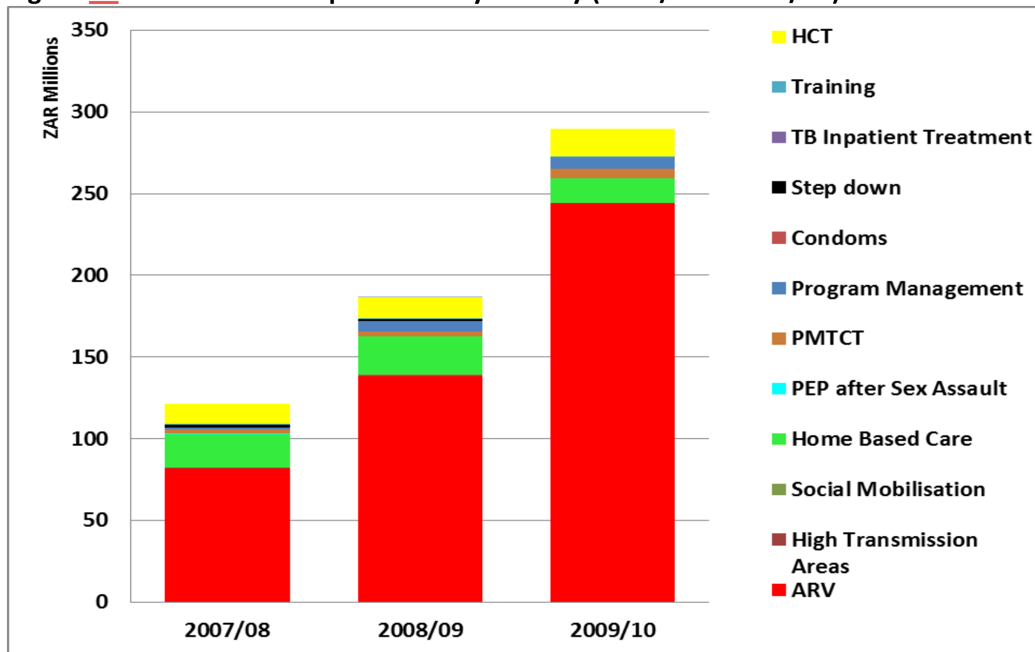
The DOH Voted Funds were over-spent by 2% in 2007/08 and under-spent by 18% in 2008/09, and under-spent again by 16% in 2009/10.

The DOH absorbed all the allocated Conditional Grant funds in 2007/08, although these were over-spent by 5% in 2008/09 and under-spent by 2% in 2009/10.

In all years, the main HIV/AIDS activities funded by the DOH, including both the CG and the Voted Funds, were ART, TB in-patient treatment and HCT. ART took up 33% (or R83 million) of the total DOH HIV/AIDS funds in 2007/08, 48.7% (R141 million) in 2008/09 and 57.7% (R244 million) in 2009/10.

In addition, the MP DOH allocated an increasing amount of funds from its own voted budget for TB treatment in line with the national DOH Enhanced TB Control Strategy. TB in-patient treatment expenditure accounted for 40.8% (R50.8 million) of total Voted Funds in 2007/08, 50.3% (R65.7 million) in 2008/09 and 54.2% (R 77.1 million) in 2009/10 –increasing by an overall 51% from 2007/08 to 2009/10. Figure 10~~Figure 6~~ outlines the MP CG expenditure by activity.

Figure 10~~6~~: MP DOH CG Expenditure by Activity (2007/08 – 2009/10)

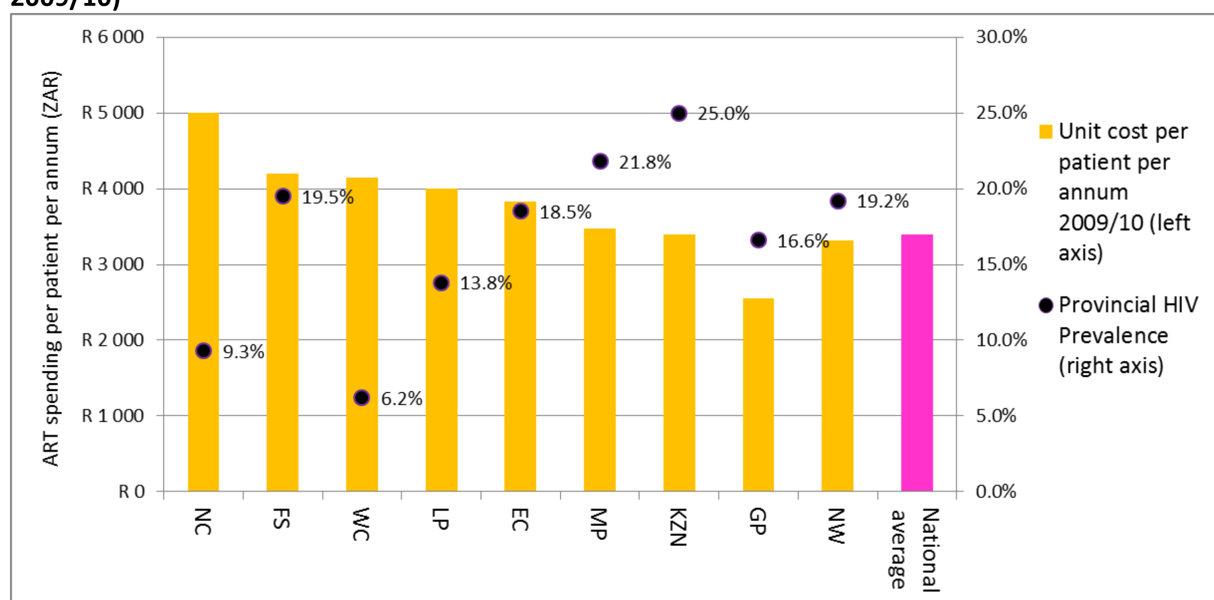


Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

MP DOH Expenditure on Antiretroviral Treatment

Total spending on the ART programme by the MP DOH increased steadily to reach R244 million in 2009/10, which reached 70,310 public patients. As expected, the antiretroviral drugs consumed a large portion of the spending: R98.7 million (40% of the total ART spending) in 2009/10, followed by laboratory costs at R95 million (30% of the total). Due to increased uptake of ART, expenditure on the drugs increased significantly from R32 million in 2007/08 (by 69%) to R54.5 million in 2008/09, and again increased substantially by 81% to reach R98.7 million. Laboratory costs rose by 81%, from approximately R31 million in 2007/08 to R55 million in 2008/09. In 2009/10, a further increase of 71% occurred, bringing the expenditure on laboratory costs to R95.4 million. It was noted that there was considerable misuse of laboratory forms, resulting in some non-HIV tests being labelled as HIV/AIDS laboratory costs. Moreover, the continuing use of the more expensive ELISA tests despite their discontinuation (according to the National DOH directive in favour of the Rapid Tests) also contributed to the increase in the laboratory bill for MP DOH. Salaries and wages increased at a far lower rate over the three years from R10.3 million in 2007/08 to R29 million in 2009/10. This raises concern that the staffing component for the ART programme is not expanding at the same rate to match the demand for the drugs and tests. Figure 12~~Figure 7~~ shows the provincial DOH ART costs per patient against the provincial HIV prevalence rates.

Figure 127: 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 the HIV/AIDS and TB response beyond health sector: The dominance of the DOH in the response to HIV/AIDS should be balanced with increased spending on integrated HIV/AIDS services in all the other departments, particularly the DSD and DOE. The Mpumalanga Provincial AIDS Council (MPAC) is housed in the MP DOH and its budget has been embedded in that of the DOH. This has resulted in activities of the PAC not being tangible. Some regarded it as inactive and not sufficiently multi-sectoral, which should be its core mandate. Insufficient financing and political mandate may be limited its effectiveness.

Avoid crowding out by ART spending: Spending on ART has increased dramatically and will continue to do so, especially with the recent increase of the CD4 eligibility to 350 cells/ m^3. Therefore, it is critical for the DOH and other departments to ensure that prevention spending, and the other key activities (mitigation, research, etc.) are not crowded out.

Increase priority given to prevention: It is vital that budgets be increased for those key prevention interventions that have been shown to have the greatest impact. Male circumcision, PMTCT, condom distribution and, potentially, the microbicides currently under development, could significantly reduce HIV transmission rates.

Conditionalising TB funds: due to the increasing demand for TB treatment, both in-patient and out-patient, ring-fencing the Voted funds for these might help protect these funds from being used on non-TB related activities. At the same time, greater spending on TB prevention (prophylaxis) would also reduce the TB treatment costs.

Prioritise personnel appointments: Failure to appoint and retain permanent staff in MP has resulted in activities being delayed or halted when new management takes office. Handover of portfolios is inadequate, resulting in poor monitoring and evaluation of programmes, as well as insufficient planning and co-ordination with other stakeholders.

Improve co-ordination within and between the Departments: Lack of communication and programme co-ordination within the departments on HIV/AIDS activities proved to be a deterrent in addressing the epidemic. In addition, some departments lamented the lack of co-ordination between departments, resulting in duplication of activities and wastage of resources. Improved co-ordination would free up excess funds for use in needy areas.

Use NASA findings for new Provincial Strategic Plan and Operational Plans: It is strongly suggested that the next PSP incorporates a detailed costing component that will guide future allocations. It is equally important that the findings of this NASA analysis inform the development of the new PSP, highlighting areas needing additional attention, and thus informing allocative decisions.

Improve accuracy and frequency of data collection on expenditure: The finance managers, together with programme managers, need to stipulate clear guidelines to be followed for capturing and coding financial data, to enable more effective budget monitoring and cost-efficient service delivery. Programme managers need to be empowered to access their programme's financial expenditure records, so as to better manage their monthly expenditure against their budgets. Ultimately, it is 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 MP.

Build capacity around data collection and analysis, and planning. There is urgent need for capacity-building in financial data management, analysis and utilisation in planning, within the public, private and NGO sectors. In addition, 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 in improving their own costing and budgeting skills, and should provide feedback as to why the total requested amounts cannot be approved and how these service providers could adjust their plans accordingly.

Increase transparency of funding of external sources: Funding of activities by external sources does not appear to be well co-ordinated in MP. It was apparent that the DOH knew only of those funds which came through the DOH, due to the general resistance by many of the development partners and businesses to sharing their current expenditures and 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 address funding gaps in a sustained and aligned manner, so as to reduce overlap and gaps in key areas.

Prioritise partnership with business sector and encourage their greater contribution: Businesses lamented that they are unable to collaborate with the Departments, which have their own unresolved issues. Their contribution should be encouraged and better coordinated. In addition, 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. CEGAA recommends the development of legislation for mandatory reporting by businesses on their HIV expenditure, to allow for easy tracking of gaps within the business sector and for government to identify which areas it should support if the need arises.