Northern Cape 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 the Northern Cape (NC) for the years 2007/08 to 2009/10.

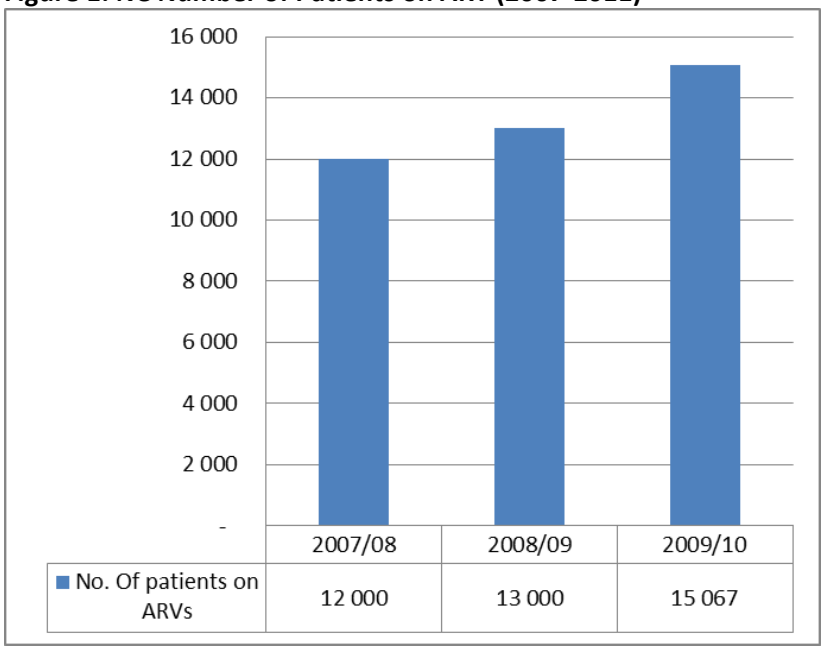
Total HIV/AIDS and TB spending in Northern Cape

The recent ANC survey (2011) found that NC's HIV prevalence amongst the general population as 17.0% in 2011, the lowest of all provinces. According to the ASSA provincial modelling, there were 76,966 people living with HIV in NC in 2011. The 2011 ANC survey noted NC HIV prevalence among antenatal women increased from 17.2% in 2009 to 18.4% in 2010 and subsequently decreased to 17.0% in 2011.[1]

Figure 1 shows the number of patients on antiretroviral treatment (ART) for the years 2007-2011. The ASSA Provincial modelling estimated 28,711 people on ART in NC in 2011. The DORA targets estimated the number of ART patients in care for NC to be 28,600 in 2012/13, 39,505 in 2013/14 and 47,307 in 2014/15.

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

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



Source: Information provided by NC DOH

The AIDS Spending Assessment in the Northern Cape (NC) 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. The Assessment excluded household and individual contributions (out-of-pocket expenditure), as well as 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.

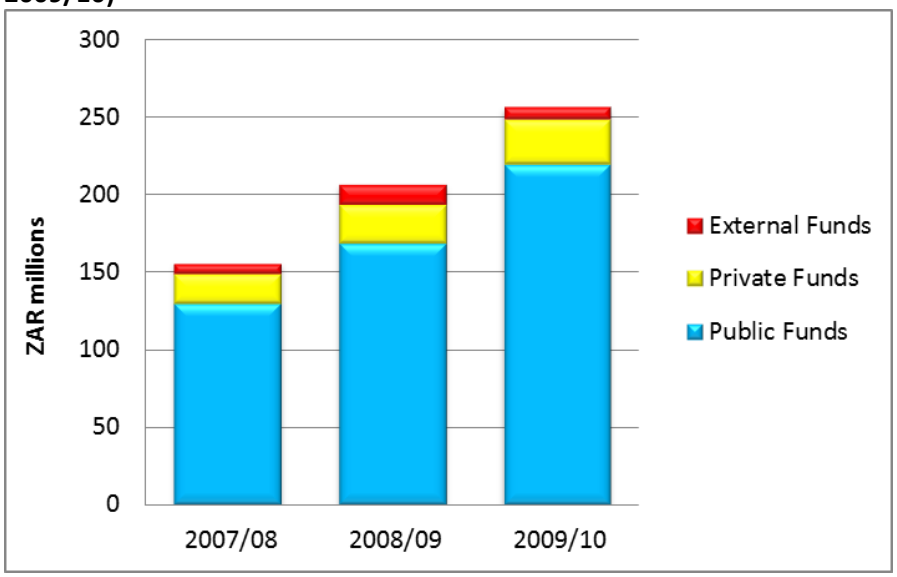
In 2007/08, the Northern Cape spent R155.9 million on HIV/AIDS and TB, increasing by 32% to R205.9 million in 2008/09. In 2009/10 the amount increased again by 24% to reach R256.2 million. Bearing in mind that not all the external funds could be captured at the provincial level, and that the business sector was reluctant to share their expenditure, these may be underestimations to some degree. Although a proportion of the PEPFAR funds is missing from the total figures, it is estimated that approximately 85% of the total provincial spending has been captured.

When adjusting for total population size (1.1 million), the Northern Cape spent approximately R223.6 per person on HIV/AIDS and TB in 2009/10, making it the third highest spending province *per capita*, after KwaZulu-Natal (KZN) and North West (NW).

Sources of funding for HIV/AIDS and TB in the Northern Cape

In 2009/10, public sources contributed 86% of total HIV/AIDS and TB funds, while private and external sources contributed 11% and 3% respectively. The contribution from public funds averaged 84% throughout the three-year period. **Figure 2** shows the sources of HIV/AIDS and TB funds in NC

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



Source: SA NASA (2012), UNAIDS, SANAC, CEGAA.
NB: These figures include a proportion of the Child Support Grant, and some of the PEPFAR funds (those that could be validated).

While the contribution from private funds has remained steady at about 12% of total HIV/AIDS and TB expenditure, the contribution from external funds jumped from R6.5 million in 2007/08 to R12.6 million in 2008/09, due to a large injection of multilateral aid, and then dropped again in 2009/10 to R7.9 million. As a result, external sources peaked in 2008/09 at 6% of total expenditure.

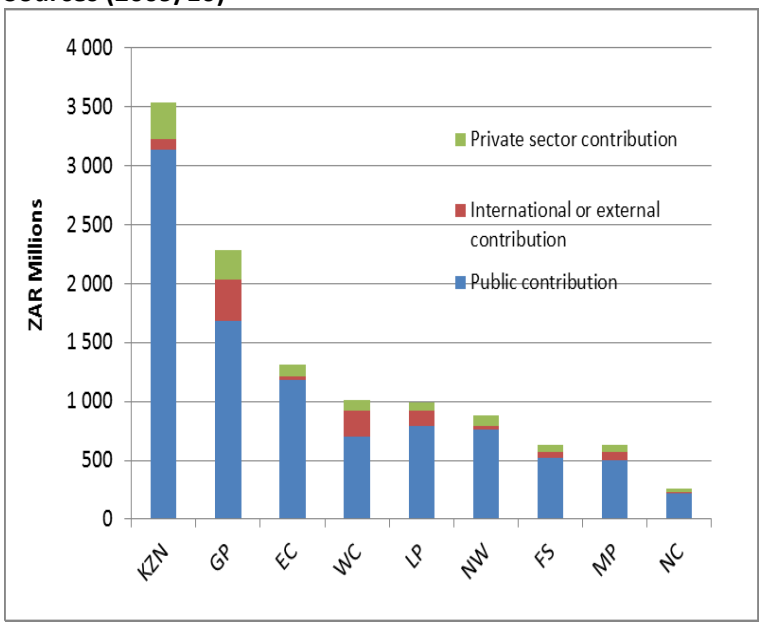
Multilateral organisations were important contributors of external funds, totaling R23.2 or 4% of total expenditure over the three-year period. The primary multilateral donor was the European Union (EU), which contributed nearly R21 million between 2007/08 and 2009/10. The Global Fund for AIDS, Tuberculosis and Malaria (GFATM) was another multilateral contributor, totaling R2.4 million over the same period.

Private sources – which include For-Profit businesses, Not-For-Profit NGOs and some out-of-pocket expenditure (OOPE) in payments of employees to medical insurance schemes – have each increased substantially, rising from R19 million in 2007/08 to R29 million in 2009/10. Total expenditure sourced from the private sector grew an average of 29% each year, and the majority of the spending came from Not-for-Profit Funds or NGOs, totaling nearly R40 million over the three-year period (5.5% of total HIV/AIDS and TB spending in the Northern Cape in 2009/10). In contrast, the contribution of the business sector was less than 1% of the total HIV/AIDS and TB funding in the province[2].

[2] Because many (For-Profit) businesses could not provide Northern Cape data, their proportion may be underestimated.

Together, employee and employer contributions made up 5% of the total HIV/AIDS spending in 2009/10, and 45% of total private HIV/AIDS and TB spending. In 2009/10, it was estimated that employees and employers each contributions around R7 million to Medical Insurances for HIV/AIDS treatment services.

Figure 3: HIV/AIDS and TB Spending in South African Provinces – Public, Private and External Sources (2009/10)



Source: SA NASA (2012), UNAIDS, SANAC, CEGAA.

According to Treasury, the government spending on HIV/AIDS in NC had increased significantly again to reach R299 million 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 the Northern Cape

As the entities which receive and send on funds to the service providers, funding agents have power in determining the spending priorities in the province. Overwhelmingly government acts as the funding agent for HIV/AIDS and TB expenditure in the Northern Cape. In 2009/10, 86% of funds were managed by government entities (including South African Social Security Agency - SASSA), 12% by private funding agents and only 2% by external funding agents. With regard to external funds, the money from the GFATM was channeled to the Department of Health (DOH) as the principal recipient and funding agent. The DOH also served as the funding agent for some of the funds contributed from the EU, the rest were managed by the EU office. For PEPFAR funds, the funding agent was coded as the United States (US) bilateral agent.

Looking only at publicly sourced HIV/AIDS and TB expenditure in NC, in 2009/10, national government acted a funding agent for 56% of the funds, provincial government for 34% and the balance (10%) were managed by SASSA and other public funding agents. The public funds managed by provincial funding agents include Voted Funds from the DOH and Department of Social Development (DSD), as well as some other workplace programmes in other provincial departments. The public funds managed by national government are the Conditional Grant funds for HIV/AIDS for

DOH and the Department of Education (DOE) as well as the funds channelled to SASSA for social security grants. Given that the national DOH, DOE or Treasury determine how the CG funds can be spent, central government is coded as the funding agent, according to NASA methodology.

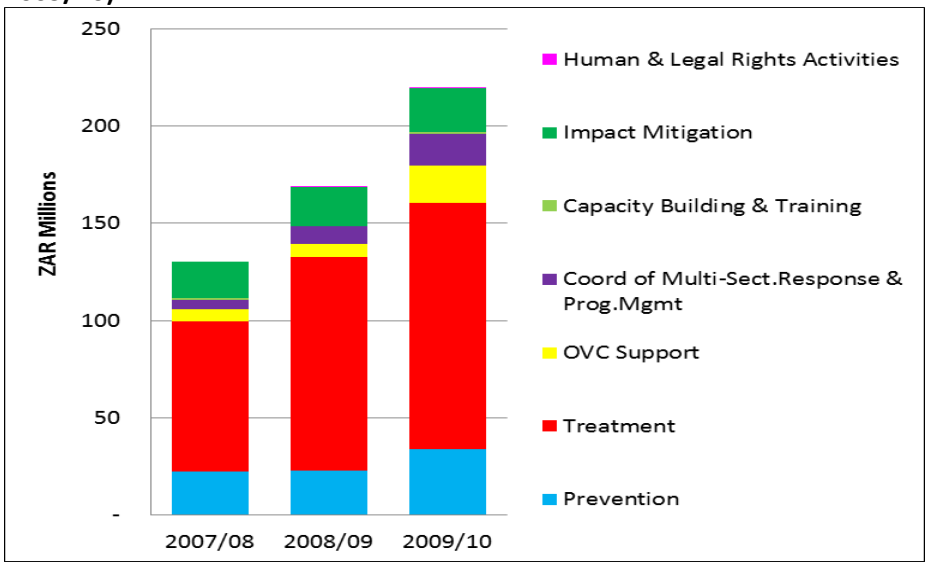
Externally-sourced HIV/AIDS and TB funds were primarily managed by multilateral funding agents (given the size of the contributions from the EU) and NGOs. Multilateral organisations served as the funding agent for 74% of the total external funds in 2009/10 while NGOs were the funding agents for 18%.

Turning to HIV/AIDS funds sourced from the private sector, NGO's managed a large portion (57%) these funds, followed by those managed by the medical insurance companies[3].

HIV/AIDS and TB spending activities in the Northern Cape

The majority of HIV/AIDS and TB funds in the Northern Cape were spent on treatment activities in all three years. Note that the treatment category does not refer only to anti-retroviral therapy (ART) but also includes home-based care (HBC), palliative care, TB treatment etc.

Figure 4: HIV/AIDS and TB Spending Activity of Public Funds in the Northern Cape (2007/08 – 2009/10)



Source: SA NASA (2012), UNAIDS, SANAC, CEGAA.

In 2009/10, 60% of the total funds went to treatment, followed by prevention (14%) and social protection including a portion of the Child Support Grant (10%). Activities for orphans and vulnerable children (OVC) and Programme Management each received 8% of total funds in 2009/10.

Notably, spending on prevention in the Northern Cape has grown less quickly than spending on treatment. Expenditure on treatment rose from R97.5 million in 2007/08 to R152.4 million in 2009/10, while expenditure on prevention only grew from R24.8 million in 2007/08 to R35.1 million in 2009/10.

Expenditure on social protection which was primarily a portion of the Child Support Grant (CSG) estimated to be benefitting OVC grew from R19.3 million to R24.7 million over the period. In

[3]The private employer medical aid programme spending is coded the following way: in terms of funding sources, one half is sourced from employees (i.e. out-of-pocket) and one half is from employers (i.e. private other); in terms of funding agents, the entire amount is controlled by the employer (i.e. private other).

addition, spending on OVC support activities more than doubled in the same period, amounting to R21.2 million by 2009/10.

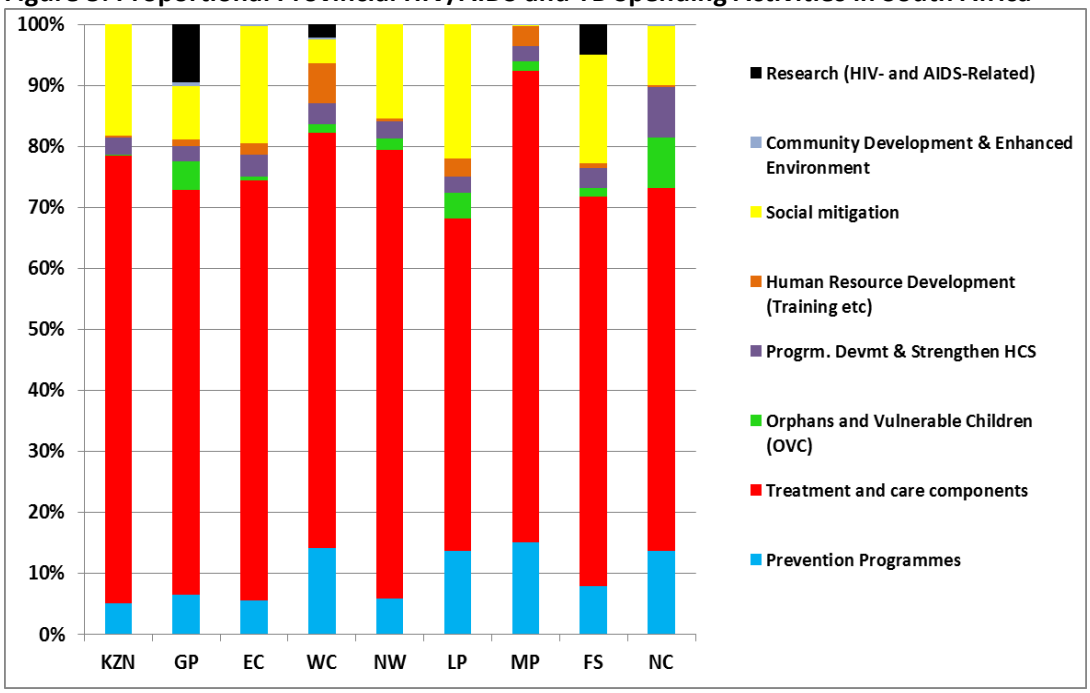
For all three sources (public, private and external), the primary activity was treatment. Comparatively more of the private funds were spent on programme management, than was the case for public and external funds. A sizable slice of public were used for social protection to which only a small amount of external funds were allocated. The spending within the categories is broken down below:

- **Prevention:** Overall, funds spent on prevention activities rose from R33.3 million in 2007/08 to R49.3 million in 2009/10. The largest prevention activities were HIV Counselling and Testing (HCT), previously referred to as Voluntary Testing and Counselling (VCT), programmes for youth in school, and Prevention of Mother-to-Child Transmission (PMTCT). In 2009/10, HCT received 46% of total preventions funds, PMTCT received 17% and 11% of total prevention funds were spent on programmes for youth in school. R6.1 million was spent on male condoms over the three-year period, compared to R4.8 million spent on female condoms.

- **Treatment**: Spending on all treatment and care has climbed steadily, growing by 42% in 2008/09 and by 10% in 2009/10. Antiretroviral Therapy (ART) consumed over half of total funds every year, totaling R202 million over the three years, and peaking at R77 million in 2009/10 to reach just over 15,000 public patients. NC is the province lowest number ART patients in the country. Expenditure on Home-based Care (HBC) rose from R31 million (32% of total treatment spending) in 2007/08, to R47 million in 2009/10 (31%). In-patient and out-patient TB treatment each took approximately 4% of treatment spending each year.

- **Activities for Orphans and Vulnerable Children (OVC)**: R8.5 million was spent on activities for OVC in 2007/08. This amount rose by 14% in 2008/09, and then more than doubled to R21.1 million in 2009/10. Almost the entire amount was spent on family/home/ community support programmes, primarily delivered through NGOs. It is important to note that some NGOs which receive funding for their HBC programmes also included OVC in those programmes. Therefore, the amounts here may be an underestimation. In addition, the Child Support Grant, a portion of which was captured under the Mitigation component, also benefits many OVC, although it was not possible to obtain exact details from SASSA and so an estimated portion based on the provincial HIV prevalence and child poverty rates was applied.

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



Source: SA NASA (2012), UNAIDS, SANAC, CEGAA.

Beneficiaries of HIV/AIDS and TB spending in Northern Cape

People living with HIV/AIDS (PLWHA) took the majority (73% over the three year) of the total HIV/AIDS funds as the beneficiary group of the large treatment spending. The amount spent on PLWHA totalled R115 million in 2007/08, and increased to R175 million by 2009/10, of which approximately 86% was for treatment and care activities, and 13% was used for impact mitigation (including the CSG). The small amounts remaining were used for prevention, programme management, and programmes to create an enabling environment for combatting HIV/AIDS.

In 2009/10, nearly 12% of total expenditure was targeted to key vulnerable groups including OVC, truck drivers and children born (or to be born) of women living with HIV, and less than 1% 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).

Approximately 2% of total spending in 2009/10 went to accessible populations, such as learners in school (through the Department of Education's Lifeskills programme) and health care workers (through post-exposure prophylaxis services).

Most of the spending targeted to vulnerable groups and MARPs was for prevention activities. However for OVCs and other key vulnerable groups, 70% of total expenditure in 2009/10 was for activities targeted for OVC support specifically, the remainder going to prevention programmes for other vulnerable groups.

Providers of services for HIV/AIDS and TB in the Northern Cape

The HIV/AIDS/STI Unit (HAST) within the DOH was the largest service provider, delivering R117 million in services (or 46% of the total spending) in 2009/10. The second largest provider was constituted by NGOs, CSOs and CBOs which were responsible for 29% of the 2009/10 expenditure. DSD and SASSA also played an important role, delivering 11% of services in 2009/10. Interestingly, public hospitals were only the fourth largest service provider of HIV/AIDS and TB services.

Northern Cape Department of Health Spending on HIV/AIDS and TB

Total HIV/AIDS and TB expenditure by the DOH increased steadily over the period, rising by 38% in 2008/09 and again by 30% in 2009/10, to reach a total of R151.7 million on HIV/AIDS and TB control. This included all the spending of HAST, district offices, hospitals and clinics and other directorates within DOH.

Approximately 80% of the funds were sourced from the CG (almost R114 million in 2009/10), with the remainder coming from Voted Funds (R37 million in 2009/10). The size of the Conditional Grant (CG) for HIV/AIDS increased by 24% in 2008/09 and again by the same amount in 2009/10.

The amount of Voted Funds allocated for TB specifically remained consistently 4% of total DOH HIV/AIDS and TB expenditure (including Voted and CG funds) while the amount of Voted Funds for HIV/AIDS specifically increased through the period as a share of the total, from 8% in 2007/08 to 21% in 2009/10. This was primarily due to a large jump in Voted Funds for HIV/AIDS in the middle year, from R6.7 million in 2007/08 to R21.3 million in 2008/09. This may have been due to overspending on the CG being moved onto Voted Funds.

In total (CG and Voted Funds together), the Department failed to spend 24% of its total HIV/AIDS and TB budget in 2007/08. In 2009/10, the per cent underspend was reduced to 3%. Over the three-year period, a total of R56.4 million of Voted and CG funds for HIV/AIDS and TB was left unspent, which were primarily unspent allocated Voted Funds, since the CG was better absorbed.

With regard to the Voted Funds, the spending was better with the funds allocated to TB specifically than those Voted Funds allocated to HIV specifically. However, over the three-year period, spending rates improved significantly.

The two main HIV/AIDS activities funded by the DOH in all years, including the CG and Voted Funds, were antiretroviral therapy (ART) and home-based care. ART took up approximately 57% of the total DOH HIV/AIDS funds over the three-year period and amounted to R77 million in 2009/10. The next largest share was for HBC which consumed approximately 17% of total expenditure.

The majority of total DOH funds was spent by the Metro and District Services facilities – approximately 72% in 2009/10. NGOs were the second largest service provider, responsible for 21% of total spend in 2009/10. Hospitals were responsible for 6% of total spend in 2009/10, with the remaining services provided by HAST and Clinics.

HAST, the hospitals, Metro and District Services, and NGOs were all receiving both Voted Funds and the CG for HIV/AIDS and TB expenditure. However, the clinics did not receive any Voted Funds for HIV/AIDS and TB expenditure.

On the whole, Metro and District Services were primarily delivering ART, while NGOs were delivering home-based care and PICT. The hospitals were mainly delivering TB in-patient treatment and ART.

The activities and service providers for the Voted Funds differed when compared to the Conditional Grant funds, as described below:

DOH Conditional Grant Funds:

- The greater portion of the CG funding was used for ART each year (67% in 2009/10). The portion of the CG used for Programme management costs rose from 6% in 2007/08 to 14% in 2009/10, while the share spent on HBC dropped from 14% in 2007/08 to 7% in 2009/10.

The remaining CG was primarily used for PMTCT, HCT and High-transmission Area (HTA) interventions (primarily for truck drivers and CSWs).

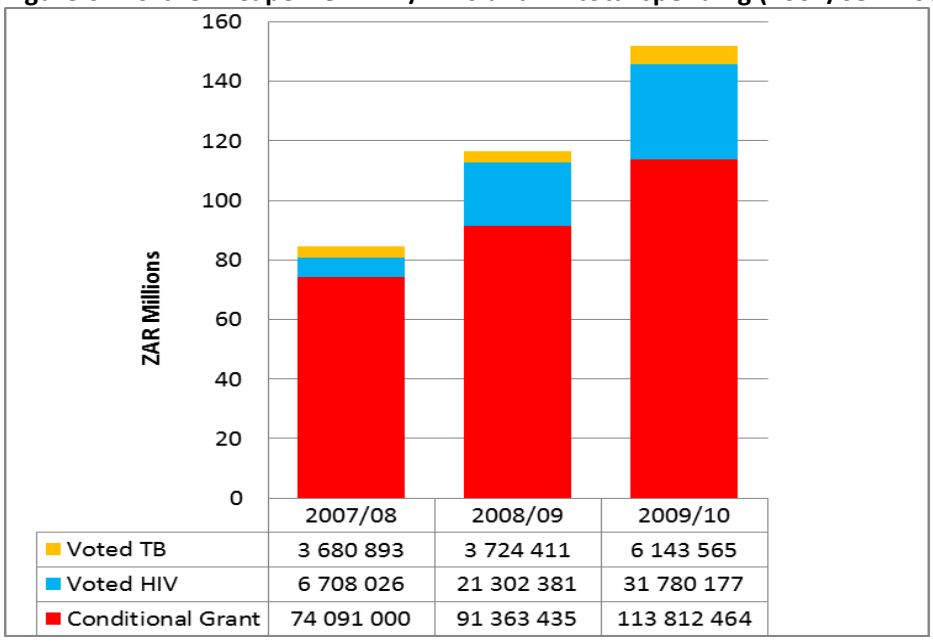
- The main spender of the DOH CG was Metro and District Service facilities, which spent approximately 97% of total Conditional Grant funds in 2009/10.

DOH Voted Funds:

- The NC DOH primarily used Voted Funds for TB in-patient treatment, HCT and HBC, as well as ART. In 2007/08 and 2008/09, the Department spent approximately R3.6 million of Voted Funds on TB in-patient treatment each year. This amount rose to R6 million in 2009/10. In 2009/10 the amount of Voted Funds allocated to HBC also shot up to R21 million, or 56% of total Voted Funds expenditure. A substantial portion of the Voted Funds was also allocated for VCT, approximately 23% over the three-year period.

- The main provider of HIV/AIDS and TB services funded through Voted Funds was NGOs, who spent over 60% of Voted fund for HIV/AIDS and TB over the three-year period. Hospitals were another major provider of services financed from Voted Funds, spending nearly 19% of total Voted Funds over the study period, primarily for in-patient TB treatment.

Figure 6: Northern Cape DOH HIV/AIDS and TB total spending (2007/08 – 2009/10)



	2007/08	2008/09	2009/10
Voted TB	3 680 893	3 724 411	6 143 565
Voted HIV	6 708 026	21 302 381	31 780 177
Conditional Grant	74 091 000	91 363 435	113 812 464

Source: SA NASA (2012), UNAIDS, SANAC, CEGAA.

DOH Spending on Antiretroviral Treatment in the Northern Cape

Total spending on the ART programme by the DOH increased steadily from R44.4 million in 2007/08 to R75.4 million in 2009/10. The amount spent on human resources costs (wages, pensions etc.) has remained approximately R8 million each year. The amount spent on the antiretroviral (ARV) drugs has risen from R17 million in 2007/08 to R27.5 million in 2009/10, but has remained consistently about 36% of total expenditure. Laboratory costs as a share of total expenditure dropped in the middle year and then increased again, to R28%. In 2008/09, 'other costs' increased significantly, to over 40% of total spending and included such cost components as uniforms, transport, etc. However, some expenses could have been incorrectly classified.

Calculated on all the costs coded as "ART" in the DOH Basic Accounting System (BAS) and the total number of active patients receiving ART as provided by the DOH (15,067), the rough annual per

patient unit cost for ART treatment increased from R3 700 in 2007/08 to R5 649 in 2008/09. In 2009/10, the unit cost then fell slightly to R5 007. This was found to be the highest in the country, and the DOH attributed this to their high transport and infrastructural costs in delivering ART in the rural areas.

DSD spending on HIV/AIDS and TB in Northern Cape

Total expenditure by the Department of Social Development (DSD) on HIV/AIDS activities amounted to R14.3 million in 2007/08, and then fell slightly by 4% in 2008/09. In 2009/10, there was a marked increase as total expenditure rose by 60% to R21.9 million.

Each year, approximately one quarter of the total expenditure was transferred to NGOs for the provision of home-based care, while the remaining funds were used by the Department for Programme Management and Administration costs, which was higher than for other provinces. In 2009/10, the amount transferred to NGOs jumped from R3.6 million in 2008/09 to over R6 million, while expenditure on programme management and administration climbed from R10.2 million in 2008/09 to R15.9 million in 2009/10. In all three years, the DSD underspent on its HIV/AIDS budget, with a total of R12.3 million was left unspent over the three years. On average, the DSD underspent by 34% on Programme Management and Administration costs each year, and underspent by 13% on transfers to NGOs for home-based care.

DOE spending on HIV/AIDS programmes in Northern Cape

Spending on the Life-Skills programme by the Department of Education (DOE) decreased steadily over the three-year period, driven largely by the drop in Voted funds. In 2007/08, total expenditure was R6 million, dropping to R3.8 million by 2009/10. The DOE *overspent* on the CG funds (by 17% in 2007/08, 0% in 2008/09 and 1% in 2009/10) and *underspent* on the Voted funds allocated for the Lifeskills programme (by 63% in 2007/08 and by 75% in 2008/09). In 2009/10, zero funds were allocated from Voted Funds for HIV/AIDS. Over the three-year period, the DOE over spent by R681 500 on CG funds and failed to spend R5.45 million in Voted Funds for the HIV/AIDS Lifeskills programme.

Recommendations

Based on the findings of the NASA, the following recommendations are offered towards improve planning and service delivery, allocative decisions and financial management systems:

Expand the HIV/AIDS response beyond health sector: The dominance of the DOH in the response to HIV/AIDS and TB should 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 should be increased in the Northern Cape and which could be best provided through NGO services. Increasing the scope of the wellness programmes would also facilitate greater integration of the response.

Increase priority given to prevention: Spending on prevention in the Northern Cape has grown at a slower rate than increases to the overall HIV/AIDS and TB budget. In order to reduce the number of persons needing treatment, 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 currently under development, could reduce HIV transmission rates significantly. PMTCT, condoms and post-exposure prophylaxis (PEP) remain effective interventions to be expanded.

At the same time, expanding access to ART will also reduce the levels of infectivity of HIV-positive patients, according to recent research findings.

Expand DOE's interventions: The DOE interventions are the main programmes targeting youth in school and therefore warrant expanded expenditure.

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

Avoid crowding out by ART spending: While recognising the preventative effects of scaled-up ART access, it is equally critical that the DOH and the other departments ensure that prevention spending, and the other key activities (mitigation, research, etc.) are not crowded out. In addition, attention must be paid to 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.

Use NASA findings to inform the development of the new PSP: The findings presented here will indicate whether or not the Northern Cape Provincial Strategic plan (PSP) priorities were appropriately funded. It is strongly suggested that the new PSP has 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 should 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 province's 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 to be followed for financial data capturing and coding, so as to enable more effective budget monitoring and cost-efficient service delivery. The financial data should be linked to output indicators in a single consolidated Monitoring and Evaluation (M&E) system.

Centralise and institutionalise HIV/AIDS expenditure data collection: 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 the Northern Cape. The information should be centralised and managed by SANAC and HAST, to ensure improved co-ordination and alignment of all efforts. The provincial departments should be planning for this routine data collection and identifying their capacity and skills requirements.

Improve intergovernmental budget planning: Greater engagement of district-level public service providers is needed in managing their expenditure according to their available budgets. In order to improve programme management, there must be user-friendly access to the BAS records.

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