Western Cape 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 Western Cape (WC), for the years 2007/08 to 2009/10.

Total HIV and TB spending in Western Cape

At the time of the NASA assessment, as of October 2008, 298,000 people in WC were HIV-positive, with the number of new infections per day (73) exceeding the number of deaths each day (23)1. The National Household Survey of 2008 noted that the WC HIV prevalence rate had increased to 3.8% from 1.9% in 20052. However, there was a significant decline from the 2002 prevalence rate of 10.7%. The HIV prevalence rate in WC compared positively to the national figure, at 16.9 % in 2009. The provincial prevalence rate therefore nearly doubled, compared to the 2001 estimate of 8.6%.3 The recent ANC survey (2011) found that WC's HIV prevalence amongst the general population as 18.2% in 2011. According to the ASSA provincial modelling, there were 273,113 people living with HIV in WC in 2011.

The number of clients tested by the WC public health sector in the years 2007/08, 2008/09 and 2009/10 was 266,682, 353,959 and 397,707 respectively.

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 2011 ANC survey noted WC HIV prevalence among antenatal women increased from 16.9% in 2009 to 18.5% in 2010 and subsequently decreased to 18.2% in 2011.[4]

At the time of the NASA assessment, in 2009/10, the WC had 81 ARV-accredited sites, an increase from 66 in 2008/95. The number of patients on ARVs has increased over the past five years. The

[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 in *Avert Health HIV&AIDS Statistics for South Africa.*

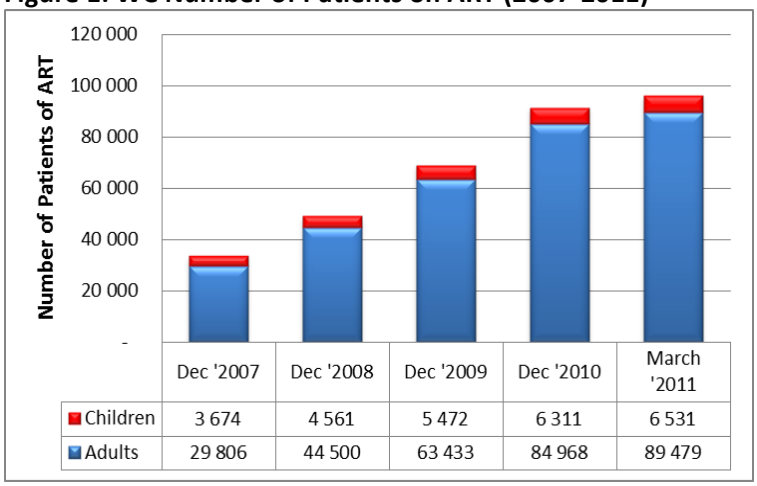
[3] Based on Department of Health's "National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2009", quoted in *Avert Health HIV&AIDS Statistics for South Africa.*

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

[5] Western Cape Department of Health Annual Report 2007/8 and 2009/10.

number of patients on ART rose steadily, from nearly 33,480 in 2007 to 96,010 as of March 2011. This was partly due to the recent increase (effective 1 April 2010) in the CD4 count threshold for ARV eligibility for TB co-infected patients and pregnant women from 200 to 350 cells/m3, and triple therapy provided to all children born with HIV. Figure 1 shows the number of patients on antiretroviral treatment (ART) for the years 2007-2011. The ASSA Provincial modelling estimated 110,339 people on ART in WC in 2011. The DORA targets estimated the number of ART patients in care for WC to be 135,000 in 2012/13, 151,800 in 2013/14 and 167,256 in 2014/15.

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



	Dec '2007	Dec '2008	Dec '2009	Dec '2010	March '2011
Children	3 674	4 561	5 472	6 311	6 531
Adults	29 806	44 500	63 433	84 968	89 479

Source: Information provided by WC DOH

The AIDS Spending Assessment in the Western Cape 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, WC spent R551.9 million on HIV/AIDS and TB, increasing by 54% to R849 million in 2008/09, and reaching R1.04 billion in 2009/10. Bearing in mind that not all the data on 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 large proportion of the USA (PEPFAR) funds is missing from the total figures, it is estimated that approximately 90% of the provincial spending data has been captured.

Sources of Funding for HIV/AIDS and TB Activities in the Western Cape

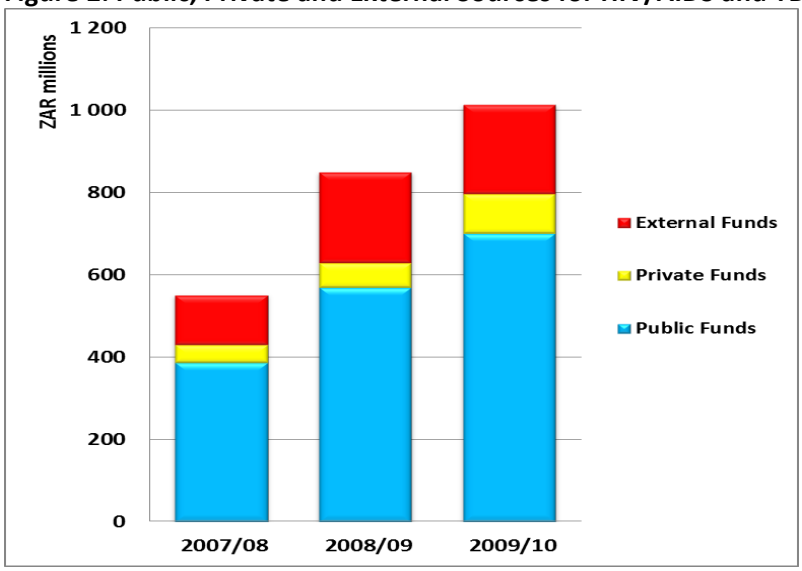
In 2009/10 in WC, public sources contributed a total R700.6 million (69.1%) to the total spending on HIV/AIDS and TB, increasing from R377.4 million in 2007/08 and R568 million in 2008/09. External sources contributed the second largest share (21.4%) amongst the three sectors, although the flow of money from external sources fluctuated over the study period. Multilateral organisations were responsible for large shares of outside funding, totalling R217 million in 2009/10. The key sources of multilateral aid were the Global Fund for AIDS, TB and Malaria (GFATM) and the European Union (EU).

Bilateral aid increased over the three-year period from R19 million in 2007/08 to R68 million in 2009/10, while external foundations fluctuated. In 2007/08, they contributed R5.2 million, R3.12 million in 2008/09 and R3.8 million in 2009/10. The USA and Belgium were the key bilateral contributors.

The private sector contributed the least amongst the three sectors, only 9.5% in 2009/10. Even so, private spending has increased substantially each year, by 36% in 2008/09 and by 61% in 2009/10, i.e. from R44 million in 2007/08 to R96 million in 2009/10. Most private spending comes from medical aid schemes: R25.3 million was provided by employees with a matching amount from

employer contributions. Together, employee and employer contributions made up 5% of the total HIV/AIDS spending in WC in 2009/10. The contribution from the business sector was very small, less than 1% of the total HIV/AIDS spending.

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



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

According to Treasury, the government spending on HIV/AIDS in WC had increased significantly again to reach R755,496 million for Department of Health and Department of Education 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 the Western Cape

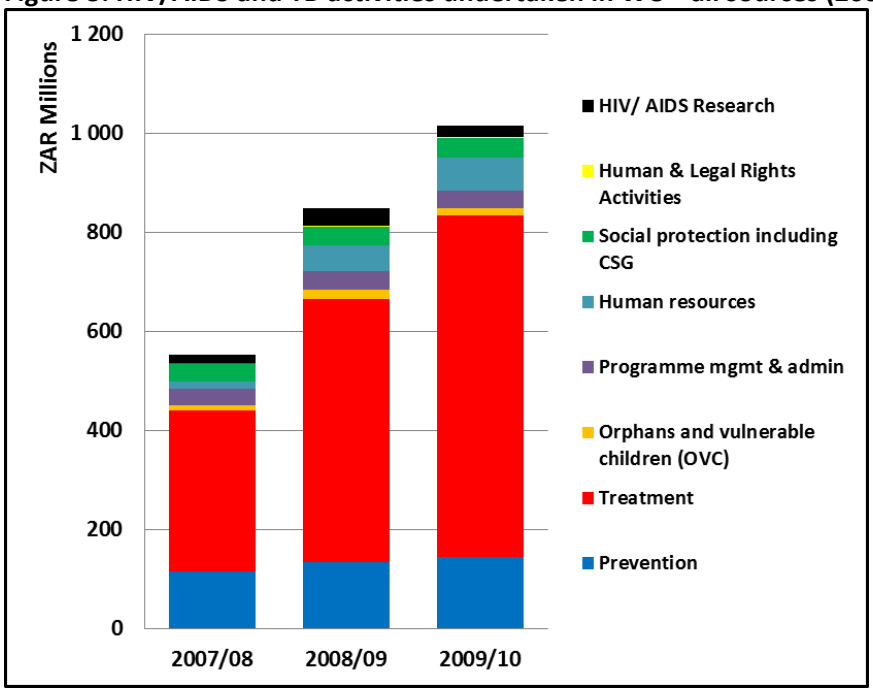
Overwhelmingly, government acts as the funding agent for HIV/AIDS and TB expenditure in WC. In 2009/10, 81% of funds were managed by government entities (including SASSA); 33% by provincial departments, and 43% by national government. The public funds managed by provincial funding agents include: Voted 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 are the Conditional Grants (CG) funds for HIV/AIDS, which are transferred to the provincial Departments of Health and Education.

The provincial government also primarily controlled externally sourced funds. These included the money from the GFATM, the EU, and the Government of Belgium, but excluded the funds from PEPFAR which were managed by their own agents.

HIV/AIDS and TB Spending Activities in the Western Cape

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

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



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

Expenditure on treatment grew from R326 million (59% of total activities) in 2007/08 to R690 million (or 68%) in 2009/10. Prevention was the second largest consumer in all three years, and although increased in nominal terms each year, has decreased proportionally from 21% (2007/08) to 16% (2008/09) and again to 14% (2009/10) of the total activity spending. A total of R143 million was spent on prevention in WC in 2009/10. Of concern is the relatively low spending on other categories, such as OVC support, research and human and legal rights activities, which each had very small allocations of less than 3% throughout the period.

Public funds and private funds are being used primarily for treatment, while the spending focus of external funds is more varied – split between prevention, research, treatment and co-ordination/programme management primarily. Public funds also serve to finance social protection and social services, to which private and external sources do not contribute.

- **Prevention**: Overall, funds on prevention activities in WC increased steadily by 17% to R134 million in 2008/9, and by 7% to R143 million in 2009/10. This increase was driven largely by greater spending on HCT (now termed HIV Counselling and Testing – HCT). In 2007/09, the largest component was spent on prevention of mother-to-child transmission (PMTCT) (R31.7 million), followed by HCT (R26 million) and Community Mobilisation (R22 million). In 2008/09, the focus shifted more towards HCT (26%), Community Mobilisation (19%) and PMTCT (18%).

- **Treatment**: There was a significant growth in treatment spending in WC, which grew from R326 million in 2007/08 to R690 million in 2009/10. Antiretroviral therapy (ART) was the largest expenditure, consuming R361.8 million (or 52.4%) in 2009/10. In-patient TB treatment took an increasing share of treatment funds, starting at R3.6 million in 2007/08 and rising to R174 million in 2009/10, or 25.24% of the total. Outpatient TB treatment[6]

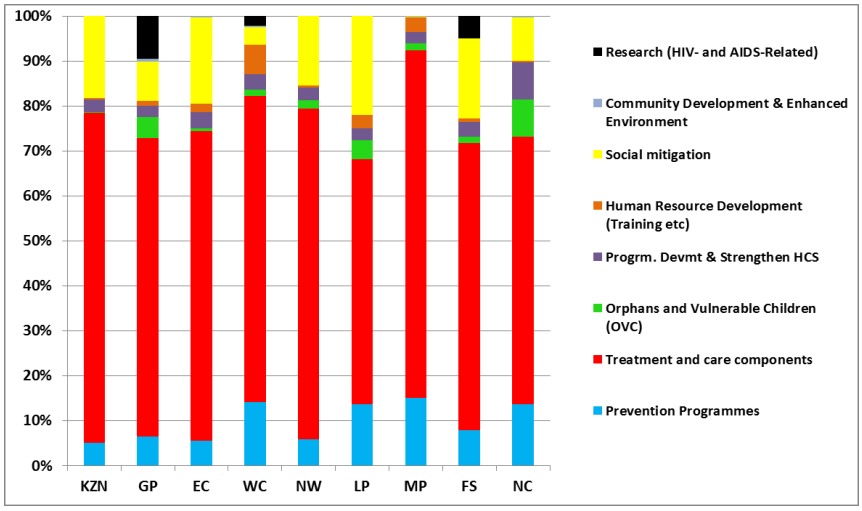
[6] These are drug costs and do not include uniforms, salaries, etc. as these are embedded in the primary health care spending and could not be disaggregated. Moreover, TB outpatient costs are said to be costed at sub-district level; therefore it was difficult to track the expenditure from district level upwards.

spending also increased from approximately R13 million in 2007/08 to R19 million in 2009/10.

- **Activities for OVC**: Very little was spent on programmes specifically servicing OVC: only R9.8 million in 2007/08, increasing by 103% to R19.9 million in 2008/09. However, in 2009/10, the expenditure for OVC activities decreased to R14.6 million. Almost the entire amount was spent on family/home/community support programmes in all three years.

Comparing WC's spending activities to those in other provinces; **Error! Reference source not found.** shows that treatment was a major consumer in all provinces. WC conducted a variety of activities as compared with other provinces, with a slightly larger proportion on prevention and capacity building.

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



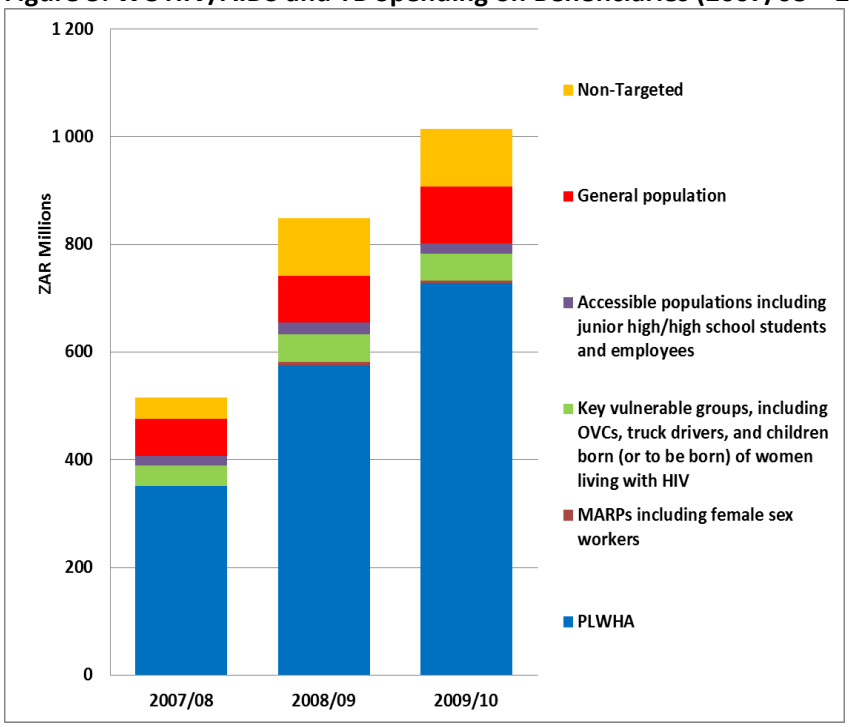
Source: SA NASA (2012), UNAIDS, SANAC, CEGAA.

Beneficiaries of HIV/AIDS and TB Spending in the Western Cape

People living with HIV/AIDS (PLWHA) were the main beneficiaries of HIV/AIDS and TB spending in WC in all three years, mainly from the high ART and TB treatment expenditure. The amount benefitting PLWHA increased from R357.5 million (or 65% of total expenditure) in 2007/08 to R728.8 million (or 72%) in 2009/10. In 2009/10, a very small portion (0.37%) 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). Just 4.91% of total expenditure went to key vulnerable groups including OVCs, truck drivers and children born (or to be born) of women living with HIV (the latter benefitting from PMTCT). Spending on accessible populations – such as learners in school or college, and health care workers – decreased from 3% of total expenditure in 2007/08 to 1.98% in 2009/10. See

Figure 5.

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

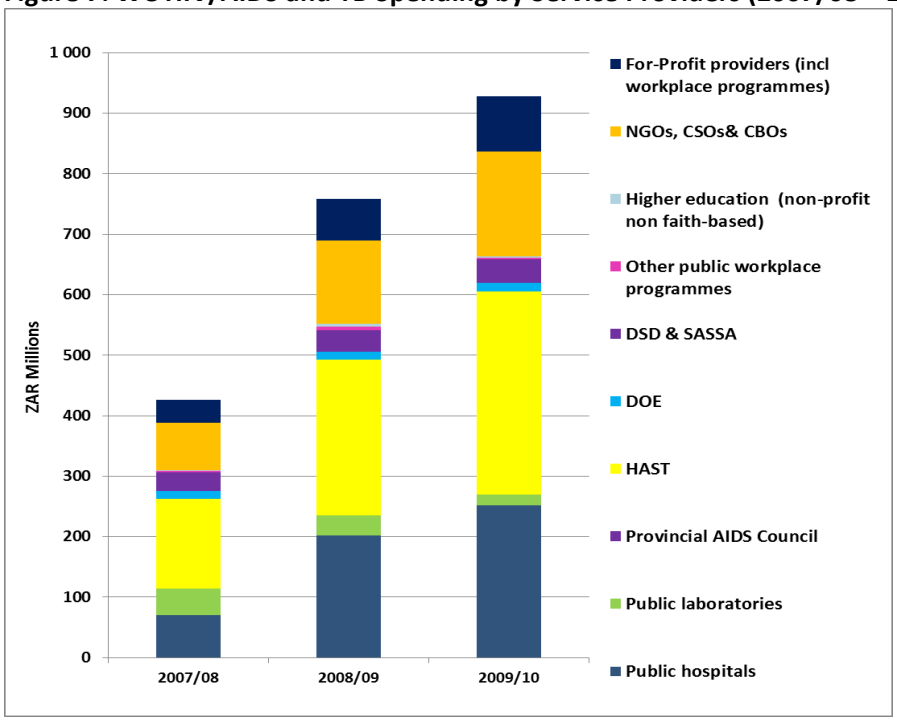


Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

Providers of the HIV/AIDS and TB Services in the Western Cape

Figure 7 notes the WC provider spending. The major service provider was the DOH HIV/AIDS, STI & TB Directorate (HAST), delivering R335 million in services (or 33% of the total) in 2009/10. Public hospitals provided 25%, or R252 million, of services in 2009/10. The third largest provider was constituted by CBOs, CSOs and NGOs, which were responsible for 17% of the total expenditure.

Figure 7: WC HIV/AIDS and TB Spending by Service Providers (2007/08 – 2009/10)



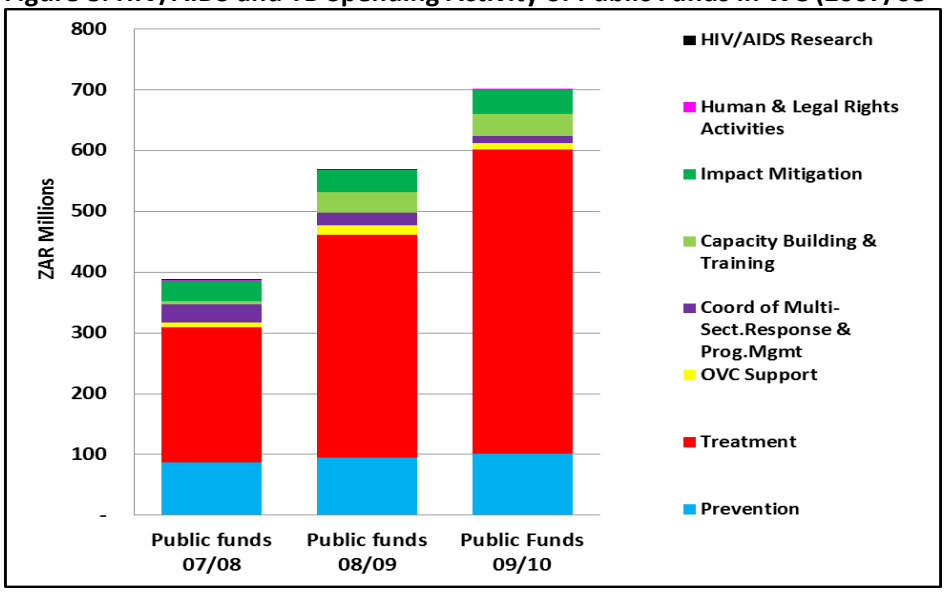
Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

Western Cape Department of Health spending on HIV/AIDS and TB

In 2009/10, 69% (R383 million) of the DOH's HIV/AIDS and TB expenditure was sourced from the Conditional Grant (CG) and the remaining R193 million from Voted Funds. The WC DOH has increasingly allocated funds from its own budget for HIV/AIDS and TB (i.e. Voted Funds).

Overall, the DOH over-spent its HIV/AIDS budget by 1% in 2007/08 and by 8% in 2008/09. The Department then slightly *under-spent* by approximately 0.5% in the 2009/10. On Voted Funds, the DOH has over-spent by 6.4% in 2007/08, over-spent by 0.79% in 2008/09 and *under-spent* by 1.44% in 2009/10. The DOH absorbed all the allocated Conditional Grant funds In 2007/08 and in 2009/10, but in 2008/09 over-spent by 11.37%.

Figure 8: HIV/AIDS and TB Spending Activity of Public Funds in WC (2007/08 – 2009/10)

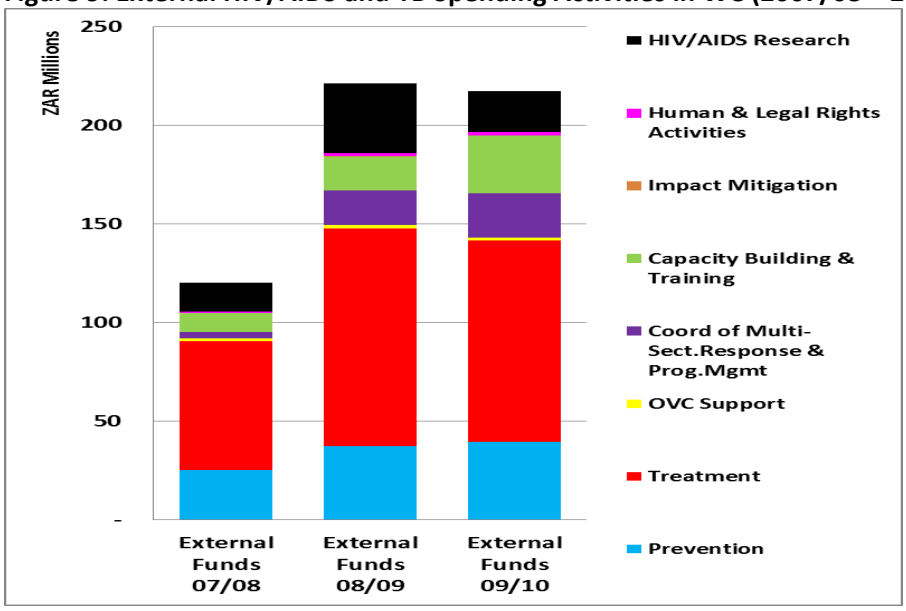


Source: SA NASA (2011), UNAIDS, SANAC, CEGAA.

The great majority of the CG funds were used for ARVs each year (75% in 2009/10), while the rest of the CG was primarily used for PMTCT, HCT and Step-down Care. This indicates the DOH's policy decision to use the CG for the ART programme primarily, to meet the escalating demand.

Because the CG was used primarily for the ART programme, the Voted Funds (from the Equitable Share) are extremely important for other key prevention and treatment activities. The largest slice of the Voted Funds was spent on TB in-patient treatment. For example, R174 million (or 90% of DOH Voted Funds for HIV/AIDS) went to TB in-patient treatment in 2009/10. Approximately 90% of Voted Funds for HIV/AIDS and TB was spent by hospitals. In comparison to external activities spending, public spending on research was minimal; an area external fund played a pivotal role in WC. Coordination of the multisectoral response and capacity building /training was mostly funded by external funds in compared to public funds. See **Figure 9**.

Figure 9: External HIV/AIDS and TB Spending Activities in WC (2007/08 – 2009/10)



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

Western Cape DOH Expenditure on Antiretroviral Treatment

Total spending on the ART programme by the WC DOH increased steadily to reach R286 million in 2009/10. In all three years, ARV drugs and wages consumed much of the budget. As expected, ARV drugs consumed a large portion of the money: R96.35 million (34%) in 2009, followed by Wages and Pensions with 30% (R85.4 million). The drugs cost R75.7 million in 2007/09, but this amount increased substantially by 25% to R94.7million in 2008/09 due to increased uptake of treatment. The third highest expenditure from the ART fund was on Laboratory Costs. These costs rose substantially, from approximately R20.5 million in 2007/08, growing by more than 100% to R57 million in 2009/10.

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/AIDS needs to be balanced with increased spending on integrated HIV/AIDS services in all the other departments, particularly the DSD and DOE. During the years of the NASA assessment, the public Wellness programmes for civil servants were only just developing, so increased spending on these will also be an important part of a larger effort to enhance integration and mainstreaming. Spending on OVC support, community development, enabling environment, and human and legal rights activities was also low in the WC. These activities are all critical elements in an integrated response that would attempt to meet all the needs of both individuals and communities in handling the impact of HIV/AIDS on their lives.

The WC PAC is housed in the WC DOH and its budget has been embedded in the DOH budget. This has resulted in activities of the PAC not being tangible. Some regarded the PAC as inactive and not sufficiently coordinating a multi-sectoral response, which should be its core mandate. Importantly, the PAC has been allocated its own funding for the next financial year (2011/12), and hopefully it will actively facilitate a more multi-sectoral response to HIV/AIDS in the province.

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. In addition, attention must be paid to other treatment requirements, such as treatment of opportunistic infections, in-hospital care, HBC and palliative care. These should be funded from the Voted (ES) Funds, since the CG is being used primarily for ART. The DOH should use the Voted funding stream to ensure adequate financing of prevention activities.

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 and, potentially, the microbicides currently under development, could significantly reduce HIV transmission rates. According to the Modes of Transmission Study (HSRC, 2010), the bulk of new infections are occurring between heterosexual married couples who have multiple concurrent partners – not in the traditionally defined MARPs. Prevention campaigns should be aimed at this group in particular. Hopefully, the DOH's launch of the HIV Counselling and Testing (HCT) campaign (2010) will raise awareness and willingness to change behaviour while also increasing access to treatment.

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

Conditionalising TB funds would help protect these funds from being used on non-TB related activities.

Improve Co-ordination amongst the Departments: Some departments reported a lack of co-ordination between departments, resulting in duplication of activities and wastage of resources. Improved co-ordination would free up funds to be channelled to priority areas.

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. Therefore, funding for NGOs and CBOs should be increasing, especially if the WC wishes to achieve its PSP Goal of improving the lives of PLWHA through palliative care and HBC. It is suggested that the DOH and DSD increase and standardise the stipends paid to NGO volunteers, as well as harmonise their funding and reporting requirements for recipient organisations.

Use NASA findings for new PSP: 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 analysis inform the development of the new PSP, highlighting areas needing additional attention.

Increase transparency of funding of external sources: Funding of activities by external sources does not appear to be well co-ordinated in the province. 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 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.

Advocate for greater contribution from the business sector: Greater commitments from the business sector and increasing their provision of services for employees would increase funding available and reduce the burden on the public health care system. 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 know where to contribute if the need arises.

Improve Coding and Usability of the Current Public Financial Accounting Systems: The public Basic Accounting System (BAS) does not disaggregate the DOE and DSD HIV/AIDS spending activities in detail. Therefore, DSD managers reported difficulty in monitoring their HIV/AIDS-specific spending. Sometimes this caused misclassification of expenditure data by the financial officers, and so the reports may incorrectly reflect the programmes' budgetary progress, leading to inefficiencies and under- or over-spending. The DOE and DSD HIV-related spending should be better disaggregated and coded.

On the other hand, the BAS coding used by the DOH has a high degree of detail and disaggregation, allowing for clear HIV-related spending broken down by different activities and by the provider of the service. However, the software programme is not user-friendly for the district and provincial programme managers in some instances, and they are unable to utilise the system outputs for their planning and budget management purposes.

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. 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.

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 the public, private and NGO sectors.

Centralise and institutionalise HIV/AIDS expenditure data collection: It is ultimately critical for improved expenditure tracking systems to be institutionalised, with detailed HIV coding, and for these to be populated by *all actors* in the HIV/AIDS field in WC. Effort will be required to develop these systems, and the SABCOHA Bizwell[7] online system could provide a user-friendly interface. Efforts should also be made to estimate the "hidden" spending embedded within the general public services (health and others), so as to measure the true cost to public institutions. The information should be centralised and managed by SANAC and the PACs to ensure improved co-ordination and alignment of overall efforts. The household out-of-pocket expenditure should be collected in the next expenditure tracking exercise.

[7] http://www.bizwell.co.za/html/index.htm