

**Republic of South Africa
South African National AIDS Council
(SANAC)**



**NATIONAL AIDS SPENDING ASSESSMENT Plus (NASA+)
HIV and TB SPENDING: 2021/22 – 2023/24**

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THIS REPORT PRESENTS A COMPREHENSIVE ASSESSMENT OF PUBLIC, PRIVATE, AND INTERNATIONAL RESOURCE FLOWS FOR HIV IN SOUTH AFRICA OVER THE PERIOD 2021/22 TO 2023/24. IT AIMS TO INFORM STRATEGIC PLANNING, RESOURCE ALLOCATION, AND SUSTAINABILITY OF THE NATIONAL HIV RESPONSE.

South African National AIDS and TB Assessment (NASA+) Report

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Abbreviations

ABYM	Adolescent boys and young men
AGYW	Adolescent girls and young women
AYP	Adolescents and young persons
AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral therapy
ARV	Antiretroviral
ASC	AIDS Spending Category
BAS	Budget Accounting System (South African government's accounting system)
BP	Beneficiary Population
CDL	Chronic disease list (used by medical insurance schemes)
CEGAA	Centre for Economic Governance and Accountability in Africa
CG	Conditional grant
CHAI	Clinton Health Access Initiative
CMS	Council of Medical Schemes
COS	Community Outreach Services
COP	Country Operational Plan (PEPFAR)
C&T	Care and treatment
DCT	Data Consolidation Tool
DBE	Department of Basic Education
DCS	Department of Correctional Services
DOD	Department of Defense
DOH	Department of Health
DHE	Department of Higher Education
DSD	Department of Social Development
DSD	Differentiated service delivery
DS-TB	Drug-sensitive tuberculosis
DR-TB	Drug-resistant tuberculosis
DTG	Dolutegravir
EA	Expenditure analysis (PEPFAR data)
EID	Early infant diagnosis
ER	Expenditure Report (PEPFAR data)
EU	European Union
FE	Financing entity
FAP	Financing agent – purchaser
FSW	Female sex workers
GAM	Global AIDS Monitor (formerly GARPR)
GBV	Gender-based violence
GoSA	Government of South Africa
GDP	Gross Domestic Product
GDI	Gross domestic income
GF	Global Fund to Fight AIDS, Tuberculosis, and Malaria
HEAIDS	Higher Education HIV/AIDS Programme
HE ² RO	Health Economics and Epidemiology Research Office
HIV	Human Immunodeficiency Virus
HOP	PEPFAR Head Quarter's Operational Plan
HPV	Human papillomavirus
HSS	Health systems strengthening
HTA	High transmission area
HTC	HIV testing and counselling
HTS	HIV testing services
IP	Implementing partners
MDR-TB	Multi-drug resistant tuberculosis
MSM	Men who have sex with men
NASA	National AIDS Spending Assessment

ND	Not disaggregated
NDOH	National Department of Health
NDP	National Development Plan
n.e.c.	Not elsewhere classified
NGO	Non-governmental organisation
NHA	National Health Accounts
NHLS	National Health Laboratory Service
NPO	Non-profit organisation
NSP	National Strategic Plan for HIV, TB and STIs
OOP	Out-of-pocket payments
OOPE	Out-of-pocket expenditures
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	(US) President's Emergency Plan for AIDS Relief
PF	Production factor
PMB	Prescribed minimum benefits (for medical insurance schemes)
PR	Principal recipients
PUDR	Progress Update & Distribution Reports (of Global Fund principal recipients)
PWID	People who inject drugs
PLHIV	People living with HIV
PMTCT	Prevention of mother-to-child transmission
PrEP	Pre-exposure prophylaxis
PS	Provider of services
PxQ	Price multiplied by quantity
REV	Financing revenues
RTT	Resource Tracking Tool (NASA)
SAG	South African Government
SANAC	South African National AIDS Council
SANBS	South African National Blood Services
SBCC	Social behaviour change communication
SDM	Service delivery modality
SHA	System of Health Accounts
SCH	Financing schemes
SPES	Social protection and economic support
STI	Sexually Transmitted Infection
TB	Tuberculosis
UN	United Nations
UNAIDS	Joint United Nations Programme on AIDS
UNGASS	United Nations General Assembly on HIV/AIDS
USD	United States dollar
USG	United States government
VMMC	Voluntary medical male circumcision
WB	World Bank
WHO	World Health Organisation
WITS	University of Witwatersrand
ZAR	South African Rand (local currency)

Foreword

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Message from SANAC CEO

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Executive Summary

This National AIDS Spending Assessment Plus (NASA+) report presents a comprehensive analysis of HIV and TB-related expenditures in South Africa for the 2021/22 to 2023/24 financial years. Conducted using UNAIDS' revised NASA 2020 methodology and led by SANAC with technical support from CEGAA, the assessment provides a detailed overview of resource flows across public, private, and international sources, tracing funds from financing entities to final service delivery and beneficiaries.

Key Findings

Total Expenditure and Financing Trends

South Africa has spent a total of ZAR 42.4 billion, ZAR 42.7 billion, and ZAR 41.7 billion on Human immunodeficiency virus (HIV) and Tuberculosis (TB) in 2021/22, 2022/23, and 2023/24 respectively; with HIV accounting for 92.48%, 92.08%, and 91.89% (ZAR 39.2 billion, ZAR 39.3 billion, and ZAR 38.3 billion) and TB 7.52%, 7.92%, and 8.11% (ZAR 3.2 billion, ZAR 3.4 billion, and ZAR 3.4 billion) in 2021/22, 2022/23, and 2023/24 respectively. Despite minor annual fluctuations, overall HIV spending remained relatively stable. Government funded most of this response, increasing its share to 76% in 2023/24, while international contributions decreased to 21%, and private sector investments remained limited (2–3%).

Resource Allocation by Programme Area

Care and treatment consistently received over 70% of total HIV expenditure across the three years, underscoring the country's commitment to sustaining antiretroviral therapy (ART) for over 6.2 million people. Prevention spending rose from 9% to 11% from 2021/22 to 2023/24, with notable investments in male circumcision, condom distribution, Pre-Exposure Prophylaxis (PrEP), and adolescent girls and young women (AGYW) programmes. However, funding for key populations (KPs), including sex workers (SWs), Men who have Sex with Men (MSM), inmates, and People who inject drugs (PWID), remained at just 1% over the three-year period.

Spending by Beneficiary Population

Over the three-year period, most of the funds (73–75%) were directed towards People Living with HIV (PLHIV), reflecting the continued focus on treatment. The general population saw a modest increase in prevention spending, while allocations for vulnerable and key populations remained disproportionately low despite their higher risk profile.

Efficiency Gains and Cost Drivers (2023/24)

A reduction in Antiretroviral (ARV) prices particularly with the scale-up of dolutegravir (DTG)-based regimens and the implementation of differentiated service delivery models contributed to a 21% under-expenditure against initial ART budgets. However, these savings were partly offset by a 12% increase in diagnostic costs and a 46% rise in contracted services. Spending on personnel remained the largest cost driver, particularly within public sector delivery.

Financing Gaps and Alignment with the National Strategic Plan

Encouragingly, the gap between available resources and the estimated needs outlined in the NSP for HIV, TB and STIs 2023–2028 is relatively small. While some key prevention programmes were somewhat underfunded, these were limited in number, and overall, only minor resource misalignments were observed. South Africa has done an impressive job in aligning investments with national priorities, and these efforts should be commended and built upon in the years ahead.

Data Quality and Methodological Rigor

The NASA+ achieved high data quality standards, with 100% of transactions derived from verified expenditure reports and over 95% of public and international funding captured. However, limited data from private-for-profit sectors and gaps in expenditure disaggregation by production factors remain areas for improvement.

Conclusions

South Africa has demonstrated strong leadership in financing and sustaining its HIV and TB response, with a growing share of domestic funding and continued investment in treatment and system strengthening. However, persistent underfunding of prevention, KPs, and TB—combined with rising input costs and reliance on donor support for some interventions—pose risks to sustainability and equity. The institutionalization of routine expenditure tracking, integration of donor-funded programmes into public planning, and strategic resource reallocation will be essential to meet the NSP 2023-2028 goals and sustain the gains achieved.

1. Introduction and background

1.1. South African HIV and TB situation

South Africa has the largest population of people living with HIV (PLHIV) globally, with an estimated 8 million PLHIV, according to the 2024 UNAIDS estimates. Despite the high burden of HIV, the South African HIV Behavioural, Sero-status and Media (SABSSM VI) survey reported a decline in HIV prevalence, from 14.0% in 2017 to 12.7% in 2022¹. This reduction is attributed to several key factors, including decreased new infections, increased numbers of HIV-negative births, a reduction in AIDS-related mortality, and natural aging of the population.

New HIV infections dropped from 164,000 in 2022/23 to 146,784 in 2023/24. While HIV-related deaths declined to 44,534, compared to 92,129 reported in the past decade². Data from the Thembisa Model Version 4.8 (2025 estimates) show that South Africa has a substantial HIV burden to grapple with, with an estimated 8 million people living with HIV in the country as of 2024. While 6.2 million people are estimated to be on antiretroviral treatment, South Africa has achieved the first of the UNAIDS' 95-95-95 targets, with 95% of PLHIV aware of their status, whilst 71% (5.4 million) of PLHIV have viral suppression, and approximately 77% of diagnosed PLHIV are currently on ART (UNAIDS, 2023)². The key findings from a national survey result published in 2022 also showed increased viral suppression (81% in 2022 vs. 62% in 2017)¹, particularly among women (83%) compared to men (79%), but lower among younger adults (70%) and men aged 25–34 (66%). Despite this progress, challenges remain in initiating approximately 1.1 million additional people on treatment, especially within male and child populations².

To address the ART initiation gap, 100 high-volume healthcare facilities across the country have been prioritized to improve ART coverage. The programme has expanded HIV self-screening to over 800 sites, and 91% of clinically stable patients on ART have been transitioned to Differentiated Models of Care. These facilities span all nine provinces and are being supported through several key initiatives, which include establishing and operating effective Nerve Centres³, providing supportive ART supervision, implementing continuous quality improvement, using data to enhance performance, and shifting away from a compliance-focused reporting approach².

The incidence and mortality of tuberculosis (TB) in South Africa increased significantly before 2009, largely due to the impact of HIV⁴. However, the expansion of antiretroviral therapy (ART) has played a critical role in reversing this trend. Between 2015 and 2022, TB incidence declined by 49%, from 552,000 to 280,000 cases, with a more pronounced reduction among people living with HIV (PLHIV) compared to HIV-uninfected individuals (51% vs. 46%)⁴. TB-related mortality also decreased by 17%, from 65,000 in 2015 to 54,000 in 2022, with a 31%

¹ Zuma, K., Simbayi, L., Zungu, N., Moyo, S., Marinda, E., Jooste, S., North, A., Nadol, P., Aynalem, G., Igumbor, E. and Dietrich, C., 2022. The HIV epidemic in South Africa: key findings from 2017 national population-based survey. *International journal of environmental research and public health*, 19(13), p.8125

² National Department of Health, Annual Report 2023/24, Republic of South Africa. 2024: <https://www.health.gov.za/annual-reports/>

³ Never Centres - Refer to centralized hubs or coordinating bodies that manage, monitor, and support the implementation of HIV-related programs and interventions.

reduction among PLHIV. In contrast, mortality among HIV-uninfected individuals increased by 15%, from 20,000 to 23,000 deaths⁴. Overall, South Africa achieved a notable 53% decline in TB incidence over this period. By the end of 2022, TB treatment coverage reached 77% for the first time—surpassing the global average of 71%—and the estimated number of people missing from TB care fell to 65,705⁴. Despite these advancements, 56% of the population continues to face financial barriers in accessing TB treatment. In 2023, TB treatment coverage was estimated at 74%, based on 2022 incidence data. The same year saw a 12% increase in TB testing, with nearly 2.8 million individuals tested. Although the number of laboratory-confirmed TB cases remained steady compared to 2022, the positivity rate declined further to 7.0% in 2023, reflecting improved screening efforts⁴.

In response to this co-epidemic, South Africa developed its fifth National Strategic Plan (NSP) for HIV, TB, and STI 2023–2028, aimed at removing obstacles to accessing healthcare and social services. Building on insights from the previous NSP 2017–2022, it introduces a renewed and urgent emphasis on addressing inequalities among individuals who are not receiving adequate treatment and care, while infected with HIV, TB and STIs. The plan also integrates mental health services and social support, recognizing the strong connection between HIV, TB, STIs, sexual and gender-based violence (SGBV), human rights violations, inequalities, and mental health.

The National Department of Health's HIV, STI, and TB program (NDoH) is responsible for developing and guiding policies, strategies (such as Universal test and Treat, 1.1 million strategy, etc) interventions and implementation aimed at preventing and treating HIV and STIs. It also provides technical support and capacity building to healthcare facilities and coordinates donor efforts to achieving the UNAIDS 95-95-95 targets. The NDoH 2023/24 annual report underscores South Africa's achievements while highlighting persistent challenges, particularly among children and men, necessitating targeted interventions to further combat the epidemic. Additionally, the NSP incorporates viral hepatitis, a frequently overlooked but highly prevalent infection linked to HIV and STIs.

There remains strong multisectoral commitment to combating HIV and TB. Effectively addressing these epidemics requires a well-coordinated and targeted strategic program for HIV, TB, and STIs, supported by substantial financial investment to protect lives and sustain livelihoods.

The funding for implementing the current NSP primarily depended on the South African government's (SAG) capacity to generate domestic revenue, supplemented by additional financial support from international sources, and private sector (non-for-profit and for-profit organisations). Though the private sector is believed to contribute an important proportion towards the fight against HIV and TB, it is still not clear about the exact contribution that they have in South Africa. This uncertainty may be because the corporate sector's HIV and TB response is not as structured as with the government's response where it is easy to understand and access government's programmes and services. Consequently, the South African National AIDS Council (SANAC) structures that coordinate the multisectoral response to HIV do not have a clear and in-depth knowledge and understanding of how the private

⁴ National TB Recovery Plan, Version 3.0, National Department of Health, South Africa, 31 May 2024.

sector HIV and TB response is structured and how significant it may be. SANAC has been embarking on the establishment of Provincial Private Sector Forums to ensure a strong private sector coordinated response towards the epidemic.

1.2. Social-economic and health indicators in South Africa

1.2.1 Socio-economic situation in South Africa

The South African government's (SAG) response to the epidemic is crucial in fulfilling its constitutional duty to deliver quality healthcare for all. Economic challenges have been seen in recent years. Gross Domestic Product (GDP) growth slowed to 0.6% in 2023 (from 1.9% in 2022), driven by electricity shortages, transport issues, and lower global prices for gold and platinum. Agriculture and mining declined, while manufacturing grew slightly⁵.

South Africa is among the most unequal countries globally, with a Gini coefficient ranging between 0.63 and 0.67, highlighting the stark divide between the rich and the poor. The National Treasury's Budget Review and Economic Outlook (2025)⁶ statements confirm that the nation grapples with a high unemployment rate, currently around 32.1%, while youth unemployment is alarmingly high at approximately 39%. About 21.6% of the population lives in poverty, with many people depending on informal employment that offers low and unstable earnings⁴. In contrast, well-paying and skilled jobs often require access to quality education and influential networks. The National Treasury forecasts that real GDP will grow by 1.9 percent in 2025, following a downward revision of the 2024 growth estimate to 0.8 percent. This revision stems from a contraction in GDP during the third quarter, largely due to weak performance in the agriculture and transport sectors. However, fourth-quarter data indicate a recovery, driven by increased consumer spending as inflation eases and the implementation of the two-pot retirement system begins (further discussed in Chapter 4).

Between 2025 and 2027, GDP growth is expected to average 1.8 percent. This medium-term growth will be supported by rising household consumption, fuelled by increased purchasing power, gradual job recovery, and growing household wealth. Continued investment in renewable energy and progress in addressing structural challenges are also anticipated to boost investment levels. Achieving stronger economic growth and job creation will depend on enhanced collaboration with the private sector in energy and transport, swift implementation of structural reforms, reduced regulatory barriers, and expanded infrastructure investment.

The household consumption and inflation have both declined, and the rand depreciated by 12.4% between 2023 and early 2025. The fiscal deficit remains at 4.6% of GDP, and the current account deficit has widened due to a rise in imports and a decline in exports. The outlook is more uncertain due to the USG tariffs imposed on SA.

⁵ Economic Outlook, African Economy, 2024. Driving Africa's Transformation: The Reform of the Global Financial Architecture. African Development Bank Group. URL: www.afdb.org/en/knowledge/publications/african-economic-outlook.

⁶ National Treasury, Budget Review and Economic Outlook, 2025: <https://www.treasury.gov.za/documents/National%20Budget/2025/review/FullBR.pdf>

To achieve sustained economic expansion without triggering inflation or excessive debt, it is essential to boost potential growth. A key factor in this is improving productivity, how efficiently resources are utilized within the economy as it plays a major role in driving long-term growth trends. Access to healthcare is uneven, with high-quality private care available to the wealthy, while the majority rely on an overburdened and underfunded public system. Social grants reach over 18 million citizens and provide some relief, but they are insufficient to close the economic gap. Rural areas experience greater hardship, facing limited job prospects and poor service delivery⁶.

1.2.3 The National Response to HIV/AIDS

The HIV response in South Africa reflects a combination of governmental commitment and collaborative efforts with various multi-sectoral partners. Over the years, South Africa has geared itself through policymaking and resource allocation to combat the HIV epidemic, contending with the highest number of PLHIV globally, characterized by high prevalence rates and a significant disease burden.

The South African government's successive NSPs for HIV, TB, and STIs, including the most recent NSP (2023 – 2028), align with international and regional responsibilities, commitments, and targets pertaining to HIV, TB, and STIs, aiming to steer priority actions for government, civil society, development partners, and the private sector. Importantly, the government has allocated considerable financial resources to support these efforts. The 2021 South African National AIDS Spending Assessment incorporating TB (NASA+)⁷, covering 2017/18 to 2019/20 financial years, revealed that the country's HIV and TB expenditure ranged between R22 billion and R26 billion respectively, with government contributions accounting for between 72% and 66%, respectively. Additionally, the investment case for HIV (2023) projected the total annual cost of the HIV program to be between R24.7 billion and R26.0 billion, if there was no scaling up or down of any HIV interventions (Jamieson et al, 2023)⁸.

South Africa's national HIV response is resource intensive as in its nature is designed as a comprehensive, evidence-based, and inclusive approach, addressing both prevention and treatment needs while tackling structural and social barriers. Prevention strategies are focusing on expanding HIV testing, providing pre-exposure prophylaxis (PrEP), promoting medical male circumcision, and implementing harm reduction programs for key populations⁹, along with launching targeted awareness campaigns. Universal access to treatment is being ensured by facilitating early diagnosis, initiating immediate ART, and strengthening community-based healthcare to improve adherence. Efforts are directed to addressing stigma, discrimination, and gender-based violence (GBV) to reduce social and structural barriers to care.

⁷ The "+" sign denotes the addition of TB in the NASA exercise.

⁸ Jamieson L, Meyer-Rath G, Kubjane M, Johnson L: South African HIV Investment Case - Full Report. 2023 Update. December 2023. Available from <https://www.heroza.org/wp-content/uploads/2024/01/HIV-Investment-Case-2023-Full-Report-v1.2.pdf>

⁹ Sex workers and their clients, trans-gender and gender-diverse people, men who have sex with men (MSM), persons who use drugs (PWUD), people in prisons and other closed settings, and people living with HIV (PLHIV).

The healthcare system is continuously strengthened by integrating HIV services, improving supply chain and training the workforce to enhance service delivery. Targeted interventions are prioritizing AGYW, SWs, MSM, PWID, and prisoners, ensuring tailored prevention and treatment approaches. Community engagements remain vital, with peer-led programs, mental health services, and social support initiatives playing a key role in improving outcomes for PLHIV. All these efforts require sustainable financing which could be secured through various means, such as mobilizing domestic and international resources, efficiently allocating public funds, and fostering public-private partnerships to maintain progress.

There has been a modest improvement in the distribution of both male and female condoms. HIV testing capacity has grown steadily, allowing more individuals to learn their status, while the rate of new HIV-positive diagnoses has been declining. Additionally, HIV self-screening services have expanded to over 800 facilities to better reach key populations. Approximately 91% of clinically stable ART patients—over 2.8 million people—have been transitioned to Differentiated Models of Care (DMoC). Despite these gains, the biggest challenge lies in meeting the second 95 target, which concerns getting people onto treatment. Around 1.1 million individuals still need to be initiated on ART. To address this, the ART sub-programme launched the “1.1 million strategy,” also known as the “Close the Gap” campaign, aiming to initiate an additional 1.1 million people on treatment by the end of 2025². This initiative is focused on improving both initiation and retention in care to help close the gap in the second 95 target.

The country’s commitment to regular NASA exercises and routine expenditure monitoring, undertaken by SANAC and NDOH, underscore the importance of monitoring the utilization of HIV funds and their outcomes over time. To this end, effective resource tracking emerges as a crucial policy consideration for all stakeholders. Therefore, SANAC has initiated another round of the NASA to cover the period 2021/22 to 2023/24.¹⁰ The resulting data will inform the development of sustainability plans and the mid-term review of the NSP for HIV, TB & STIs 2023 to 2028. Development partners will also leverage the data in their planning processes. Information will also feed into other important reports, such as the Joint United Nations Programme on HIV/AIDS (UNAIDS) Global AIDS Monitoring (GAM) Report. In addition, the NASA exercise is very important in identifying the financing gap(s) and providing essential information to determine where efficiencies can be made given the scarce financial resources to ensure universal access to HIV and TB care.

2. The National AIDS Spending Assessment+ in South Africa

2.1. Objectives and scope of the NASA+ in South Africa

NASA+ Objectives

The primary objective of this NASA+ exercise was to collect data on HIV and TB expenditures in South Africa for the period 2021/22, 2022/23, and 2023/24, applying the South Africa public financial years, using UNAIDS' NASA methodology, with updated classifications (2024).

Specific objectives were:

1. To track the allocation of HIV/AIDS and TB funds, from their origin down to the end point of service delivery, among the different financing sources (public, private, or external) and among the different providers and beneficiaries (target groups) and compile a comprehensive National AIDS Spending Assessment (NASA+) Report for the period 1 April 2021 to 31 March 2024.
2. To implement a methodology for systematic monitoring of HIV financial flows at national and provincial levels using the NASA methodology in South Africa.
3. To adapt the NASA methodology, classification, and tools to the South African context, including central as well as subnational financing.
4. To build national level capacity for systematic monitoring of HIV/AIDS financing flows using the NASA methodology, with a view to a yearly, fully institutionalized NASA, using the Basic Accounting System-Reloaded (BASLY-R) tool.
5. To conduct an HIV and TB spending assessment focusing on public and development partner (external) resources and including private (both for-profit and not-for-profit) entities known to be contributing to HIV activities.
6. To identify and measure the flow of resources for HIV by the funding entity (FE), revenue (REV), financing scheme (SCH), financing agent-purchaser (FAP), service provider (PS), the service delivery modality (SDM), function/ intervention (ASC), cost components (factors of production, PF) and beneficiary populations (BP).
7. To prepare a report of expenditure trends that will inform the development of Sustainability Plan and a mid-term review of the National Multisectoral Strategic Plan 2023-2028.

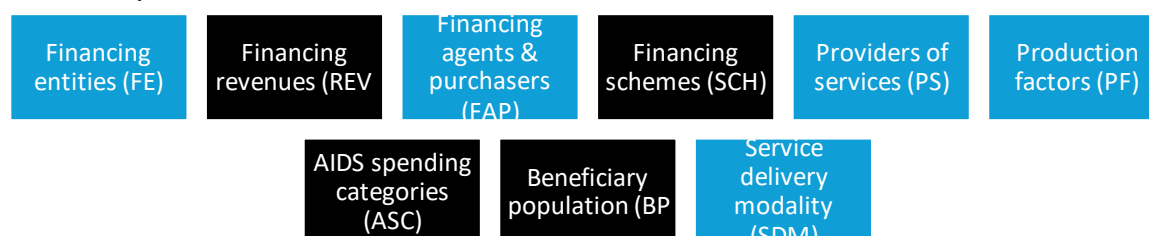
Furthermore, apart from the vectors addressed in this assessment, this NASA also provided answers to the following additional questions:

- a. What have been the trends in HIV expenditure over the past years: from 2007/08 to 2023/24?
- b. Were adequate resources allocated to achieve the NSP targets for 3 years under assessment, compared to their estimated resources needed? Were there financing gaps (or surpluses) experienced for any interventions?
- c. What was spent on key interventions to reach one person? How do these units of expenditure compare with the estimated unit costs applied in the costing of the NSP?
- d. Are these services providing value for money?
- e. Where have technical efficiencies been achieved, or where could savings be made? have economies of scale been achieved?
- f. Was the spending on ART per ART client equitable across sub-national regions?

NASA+ methodology and scope

This South African NASA+ covered three years from 2021/22, 2022/23 to 2023/24, using South Africa public financial years, and included funding from public, external, and private sources for HIV and TB interventions. The assessment was conducted using UNAIDS' revised NASA 2020 methodology and was led by SANAC with technical support from the Centre for Economic Governance and Accountability in Africa (CEGAA). While the Terms of Reference (TOR) specified that STI expenditure should be incorporated, the CEGAA team had reservations about the value-add of including STI expenditures. This was because estimating STI expenditure posed significant challenges due to limited data on the types and frequency of STI incidences and their treatments. Additionally, these treatments were relatively inexpensive and meant that estimating their expenditure required substantial effort for a relatively minor amount of spending in a constrained time frame.

The assessment was conducted at both the national and provincial levels. The approach to data collection and presentation adhered to the programmatic disaggregation outlined in the NASA guidelines. To facilitate international comparability, NASA amounts and figures are presented both in the South African Rand and the United States (US) Dollar. All vectors within the NASA framework were applied in line with NASA 2024 guidelines. The vectors/variables covered by this NASA were:



NASA vectors definitions:

Financing vectors:

- ✓ Financing entities (FE) refers to economic units providing the resources to the schemes (used by the agents).
- ✓ Financing revenues (REV) are mechanisms to provide resources to financing schemes (used by the agents).
- ✓ Financing schemes (SCH) are modalities through which the population access the services.
- ✓ Financing agents & purchasers (FAP) are economic units that operate the schemes. They collect revenue, pool financial resources, pay for the service provision, and take programmatic decisions (allocation and purchase modalities).

Provision vectors:

- ✓ Providers of services (PS) are entities that engage in the production, provision, and delivery of HIV services.
- ✓ Production factors (PF) are inputs/resources (labour, capital, natural resources, "know-how," and entrepreneurial resources) used for the production of ASC.

Use / consumption vectors:

- ✓ AIDS spending categories (ASC) are HIV-related interventions and activities.

- ✓ Beneficiary segments of the population (BP) are populations intended to benefit from specific activities (e.g. key population groups such as men who have sex with men, injecting drug users, etc.)
- ✓ Service delivery modality (SDM) – a new variable in NASA 2020 which indicates the modality of the service provided.

By recreating every financial transaction according to the NASA vectors, and presenting our analysis thereof, we were able to answer the following questions and to:

- Describe the funding flows for HIV & TB in South Africa such as Who paid for HIV & TB services? Who pooled funds? What funding schemes were used?
- Who purchased the HIV and TB services?
- What mechanisms / schemes allowed payment (such as insurances)?
- Who were the providers of HIV&TB services in South Africa?
- What HIV&TB services were available, and what was the expenditure on these? What were their modes of delivery?
- Who were the beneficiaries of the HIV&TB spending in South Africa?
- What were the key cost drivers, the production factors, of the HIV&TB spending in South Africa?

NASA preparatory activities

- There was an establishment of the steering committee comprising of governmental institutions (SANAC, relevant government departments), private sector, civil society organizations and cooperating partners to provide guidance and oversight of the activity as well as mobilize partners – create demand and support the NASA Resource Tracking Team for data collection- The NASA reference group.
- SANAC prepared and sent out formal letters to institutions requesting access to their financial expenditure records.
- CEGAA in turn drafted a letter of introduction stipulating its obligated role in the NASA exercise and this was sent to the respective stakeholders for buy-in purposes to provide required data.
- CEGAA presented a Power Point presentation on NASA principles and methodology to the NASA reference group as a way of sensitizing the stakeholders on the kind of data CEGAA required to expedite the NASA processes.
- A full sensitization workshop was initially planned to sensitize all stakeholders in the HIV and TB fraternity in one meeting, since not all stakeholders were represented in the NASA Reference Group. However, due to restrictive timelines and budgets, this was delayed in the process to serve as a validation meeting for preliminary results. SANAC and CEGAA sensitized each stakeholder individually and provided guidance on the required information and format.
- CEGAA undertook a mapping exercise of all actors involved in the HIV and TB response in South Africa at national and provincial levels and developed a comprehensive database with updated contact details of all the stakeholders which was reviewed, updated and approved by SANAC.
- CEGAA reviewed the standardized UNAIDS NASA data collection tools and developed the data collection plan and presented these to the NASA reference group for approval.

2.2. NASA study design

CEGAA employed the principles enshrined in the universal standardized UNAIDS NASA (2024) principles and guidelines to conduct this NASA exercise.

2.2.1 Study population

The study population for the NASA exercise comprised of financing entities, financing agents and providers of HIV and TB goods and services in the public, private and external sectors and stakeholders in the HIV and TB fraternity both at national and provincial levels.

2.2.2 Sampling approach

CEGAA, in collaboration with SANAC, established a comprehensive database comprising all stakeholders involved in the HIV field, categorized as financing entities, financing agents/purchasers, and service providers. This database encompassed various entities such as development partners, government ministries, Non-Governmental Organisations (NGOs) (both international and local), Civil Society Organisations (CSOs), as well as private sector organizations including businesses and health insurance companies (medical aid schemes). All primary sources of funding (public, private, and international) and entities managing these funds in South Africa were automatically included (without following a sampling method), adopting a census approach. However, service providers underwent purposive sampling by strata to ensure representation across different levels and sizes of providers, aiming to capture approximately 90% of all HIV and TB expenditures in the country. The selection criterion for service providers was guided by input from the SANAC and the NASA reference group.

2.2.3 Data collection

The CEGAA NASA expert oversaw and supervised the data collection process, implementing rigorous quality control measures to ensure accurate tool application and data quality. The NASA data collection template was utilized for primary data collection. Recognizing the limitations of self-administered questionnaires in yielding high-quality data, the NASA team conducted both virtual and face-to-face interviews with respondents.

The initial phase of data collection adopted a top-down approach, extracting expenditure data from donor expenditure reports and government budgets. This approach focused on external funds, private sector and public grants allocated for the HIV response in South Africa. For instance, data from the Basic Accounting System (BAS) provided expenditures from all identified public departments, with the health and education expenditures also disaggregated by province, while the PEPFAR Expenditure Report datasets provided the United States Government (USG) expenditure. Most of the Global Fund spending in the country was sourced from Global Fund Principal Recipients' (PRs) datasets. Further, the UN agencies and other international NGOs and foundations also provided their expenditure data.

Although the private for-profit response might have been weak, we were able to obtain all the private spending on health insurances, with data from the Council for Medical Schemes (CMS), which made up a large portion (+95%) of private sector spending.

The bottom-up approach involved tracking expenditures directly from service providers' financial records, especially at provincial level. This included capturing data from both governmental departments' expenditure accounts (which manage public funding) and private

sector entities, whether they are for-profit or not-for-profit organizations. The process of gathering this data required the NASA team to perform extensive fieldwork across provinces to ensure comprehensive coverage of service providers. Data collected from such provinces was triangulated with what was collected at national level to ensure completeness and avoid double-counting.

In addition, during fieldwork, the team conducted in-depth interviews with key personnel within all non-governmental that are beneficiaries to DOH and provincial departments such as PDSO, PDOH, PDOE, correctional services, among others. These interviews targeted individuals in strategic roles, such as Directors, Programme Managers, Finance Directors, and Finance Officers. These personnel are critical because of the institutional memories, regarding financial activities, including budget allocation, management of funds, and expenditure reporting responsibilities.

Furthermore, the assessment focused on collecting performance indicators for key HIV and TB interventions. These indicators were used to evaluate the efficiency of the expenditure, with a particular focus on comparing costs against the outputs or outcomes achieved (i.e., using unit expenditure as a benchmark). By comparing expenditures to performance, the NASA+ team was able to assess whether funds were being used efficiently to achieve the intended health outcomes.

This combination of data collection, document review, and efficiency analysis provided a detailed picture of how funds for HIV and TB were allocated and spent across all sectors, ensuring that both public and private funding streams were accounted for.

2.2.4 Data capturing and processing

Significant steps were undertaken during data capturing and processing for the NASA+, and these included mapping funding sources, identifying all domestic and international contributions such as government and donor funding, including private sector investments to track financial inputs for HIV, TB, programs. Expenditures were captured and consolidated using the NASA data consolidation tool (DCT). Quality control and validation processes were implemented internally to ensure data accuracy. Data triangulation was a key component of this approach, allowing for cross-checking of information from different respondents (funding entities, agents, and service providers). This process involved reconstructing the full transaction using the nine NASA vectors, thereby minimizing double counting and avoiding incomplete transactions. The cleaned and completed DCTs were then imported into the NASA Resource and Tracking Tool (RTT) for analysis.

2.2.5 Analysis

The imported data were consolidated by the RTT, which also identified any coding or data errors that required correction. The RTT was also essential in aggregating and in creating financing flow diagrams. It also generated the full dataset in Excel spreadsheets that were used to undertake the bulk of the analysis, and to create graphical illustrations and tables.

2.2.6 Quality control

CEGAA implemented the following steps to ensure data quality and accuracy:

- Classification Verification:

- Conducted a thorough review of the classification of spending inputs according to specified categories.
- Cross-checked the classification against established guidelines and criteria.
- Identified any misclassifications or discrepancies and rectified them.
- Data Mapping Validation:
 - Validated the accuracy of data mapping from various sources to the appropriate categories.
 - Ensured that the data mapping was consistent and followed the predefined rules and guidelines.
 - Identified any deviations or mapping errors and provided recommendations for correction.

For accuracy and consistency, the CEGAA NASA+ expert checked the capturing of all the transactions daily to troubleshoot potential inconsistencies and provided guidance on standardized data coding entries in the Resource Tracking Tool. The RTT's control board also indicated where there were discrepancies that needed to be adjusted or fixed.

Preliminary findings were presented to the Reference Group and key stakeholders for review. The final validation process involved a thorough review by key stakeholders, including NDOH, SANAC, Global Fund Principal Recipients, Council of Medical Schemes, principal recipients of the Global Fund, PEPFAR, CSOs, and the United Nations agencies.

The UNAIDS Global Centre conducted an external review to ensure quality, accuracy, and alignment of the NASA analysis and presentation with global standards. This review process was applied to the preliminary results, including Data Consolidation Tool (DCT) and Resource Tracking Tool (RTT) outputs, following the completion of data analysis in the Excel files. The review also covered the draft Power Point slide-deck, and the initial findings report. These steps were crucial to validate methodologies and findings before finalizing the documents.

Findings are presented in South African Rand (ZAR), with some of the key tables and matrices converted to United States dollars (USD) in appendix, to allow for international dissemination and comparability. The South African Reserve Bank annual average USD: ZAR exchange rates were applied as follows:

Exchange rates (USD:ZAR)	1USD
1 April 2021 to 31 March 2022 Annual Average	R 14.78
1 April 2022 to 31 March 2023 Annual Average	R 16.38
1 April 2023 to 31 March 2024 Annual Average	R 18.46

2.3. Overview of the data included in NASA

This NASA+ has achieved an impressive level of coverage, successfully capturing the vast majority of HIV and TB-related spending across South Africa. Specifically, 98% of public funding from both national and provincial departments was included, as well as 95% of international funding, primarily sourced from PEPFAR, the Global Fund, and relevant UN agencies as reported by NGOs. Approximately 90% of NGOs, research agencies, and other

service providers were accounted for through the databases of the NDOH, DSD, PEPFAR, and the Global Fund. All private medical insurance expenditures for HIV and TB were comprehensively captured, with data collated by the Council of Medical Schemes. While it was more challenging to quantify the full extent of funding from research agencies and universities, it is estimated that about half of the spending by key institutions was reported via PEPFAR. Response rates were somewhat lower among businesses and universities, representing a minor gap in an otherwise robust dataset.

Regarding donor funding for TB, all Global Fund TB module expenditures were fully captured, and PEPFAR funds allocated for TB/HIV activities were included in the analysis. We also made efforts to obtain TB spending data from USAID and CDC that did not flow through PEPFAR; however, these data were not provided due to a US Government stop work order, which limited our ability to capture the full scope of donor contributions in this area.

It is important to note that the CMS did not report members' shortfalls—out-of-pocket expenses (OOPE) incurred when scheme benefits were insufficient—which means that some private sector HIV and TB spending by households is not reflected in this analysis. As a result, total private expenditure on HIV and TB may be understated, given that OOPE can represent a significant financial burden for medical scheme members.

For additional context, it is now understood that approximately 70% of medical research in South Africa is funded by the US Government's National Institutes of Health (NIH), with an estimated annual contribution of R6.65 billion¹¹. This substantial investment underscores the critical role of international research funding in the country's health sector.

The quality of the NASA data can be measured by the degree to which primary expenditure data have been collected, or if budgets, estimations or secondary data sources were used. Every transaction is labelled accordingly, and Table 1 below provides a summary of these quality control indicators. The South African NASA collected 100% expenditure data (as opposed to budgetary / commitments or estimates) in all three financial years and the data were obtained from expenditure reports, while 100% of transactions were from primary sources in all years. In the case of the production factors, there were a few transactions (3% or less) that needed some adaption or estimation. These confirm the quality and accuracy of NASA data presented here.

Table 1: Quality of data captured in the NASA assessment

SA NASA Data quality/sources	2021/22	2022/23	2023/24
Overall type of NASA data:			
Based on budgets	0%	0%	0%
Expense reports	100%	100%	100%
Transaction source type:			
Primary source certificate	100%	100%	100%

¹¹ <https://bhekisisa.org/health-news-south-africa/2025-04-24-we-do-the-sums-the-nih-funds-350-million-r6-65-billion-of-research-in-sa/>

2.4. Limitations of the study

The NASA+ analysis was subject to the following limitations and assumptions, which are important to acknowledge for the interpretation of results:

1. Limited Data from Private-for-Profit Sector

Despite repeated engagement efforts, the response rate from private-for-profit businesses was exceptionally low—only 3%. As a result, their financial contributions to HIV and TB responses could not be included in the analysis, except for expenditure data from medical aid schemes, as reported by the Council for Medical Schemes (CMS).

2. Partial Insights from Medical Aid Schemes

The CMS data captured payments made by medical schemes to private healthcare providers for patients officially registered as living with HIV under the Prescribed Minimum Benefits (PMB) list. However, several limitations affected this dataset:

- Contributions from employers or individuals toward these schemes (i.e., insurance premiums) could not be determined.
- The specific services accessed by members were not detailed.
- Consequently, it was assumed that individuals living with HIV received a standard package of care and treatment (not further disaggregated), and that TB patients received treatment for drug-sensitive TB.

3. Insufficient Data Disaggregation

Some organizations were unable to provide data at the level of disaggregation required by NASA. In cases where spending could not be broken down by specific production factors, the expenditures were classified as "Production Factor not disaggregated." This limitation affected approximately only 7% of total expenditure in the 2023/24 financial year, which indicates good quality of the rest of the data.

4. Inconsistent Fiscal Year Alignment

Development partners operate on different fiscal calendars, which sometimes created challenges for aligning data with the South African public fiscal year. While most data were adjusted accordingly, this was not feasible for PEPFAR's Expenditure Reporting (ER), which follows the U.S. government fiscal year. For this reason, NASA used the PEPFAR 2022 expenditure report for the South African 2021/22 fiscal year. This method has been consistently applied in previous NASA exercises, and, over time, the resulting misalignment is considered negligible.

5. Exclusion of Indirect or 'Hidden' Expenditures

No estimates were made for the DOH's indirect or embedded HIV-related expenditures. Examples include:

- Treatment of opportunistic infections or STIs provided by the Department of Health (DoH).
- The portion of nurse salaries in primary health care settings allocated to HIV services, where salaries were not specifically attributed to HIV, noting that there is no recent SHA to provide some estimate into these shares.
- These indirect costs, often covered by general health budgets, are not reflected in the analysis and thus under-represent the public sector's contribution to HIV services.

6. Gaps in TB Expenditure Data

Similar limitations regarding the DOH shared expenses in the delivery of TB services were faced. For instance, nurse time devoted to TB screening in clinics was not estimated, nor were expenditures for TB wards in general hospitals, as such costs could not be identified in the BAS (Basic Accounting System) records. Only spending in specialized TB hospitals was included, and it was assumed that these expenditures related exclusively to the treatment of drug-resistant TB (DR-TB).

7. Quality Over Completeness

The decision not to estimate certain indirect or 'hidden' expenditures was intentional, aimed at preserving the accuracy and reliability of the NASA+ data. While this enhances the credibility of the data presented, it also means that some departmental contributions (mainly DOH) are likely slightly under-reported. Nonetheless, these omitted amounts are considered minor compared to the overall HIV-specific public spending.

8. Exclusion of Out-of-Pocket (OOP) Expenditures

The scope of this NASA did not include direct household or individual expenditures, such as out-of-pocket payments. While some of these costs may be captured indirectly through private insurance contributions, their full extent remains unknown. Given that HIV treatment is freely provided to people living with HIV (PLHIV) in South Africa, missing OOP costs are assumed to be relatively small. However, they may still place a disproportionate financial burden on poorer households.

9. Provincial Data Limitations

The ability to disaggregate expenditure by province was restricted to public sector data and medical schemes. PEPFAR, Global Fund and other international partners datasets lacked provincial identifiers, limiting the depth of the sub-national analysis and weakening insights at the provincial level.

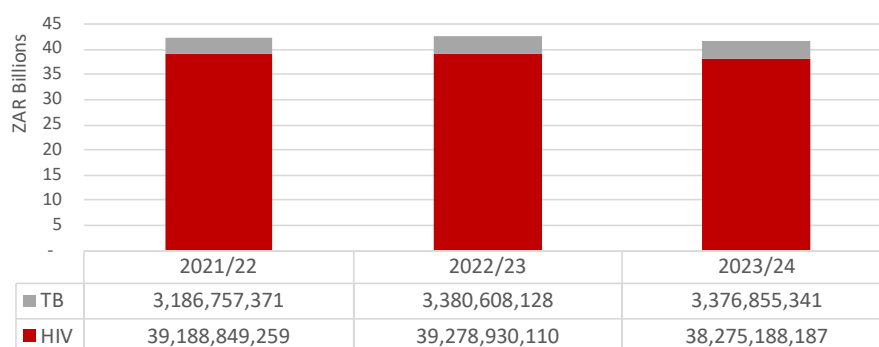
3. Key NASA+ HIV Findings

3.1. Total picture – all HIV and TB sources (financing entities)

The overall expenditure on HIV and TB in South Africa remained relatively stable over the three fiscal years, fluctuating around ZAR 42–43 billion annually. While there is a slight decline in total spending from ZAR 42.37 billion (US\$ 2.87 billion) in 2021/22 to ZAR 41.65 billion (US\$ 2.26 billion) in 2023/24, the proportion of spending between HIV and TB has remained relatively consistent, with HIV consistently receiving the larger share. HIV spending peaked slightly in 2022/23 at ZAR 39.28 billion (US\$ 2.40 billion) but then slightly dropped by 3% to ZAR 38.27 billion (US\$ 2.07 billion) in 2023/24. In contrast, TB spending showed a modest increase of 4.9% from 2021/22 to 2022/23, rising from ZAR 3.19 billion (US\$ 215.61 million) to ZAR 3.38 billion (US\$ 206.39 million), before slightly decreasing to ZAR 3.38 billion (US\$ 182.93 million), in 2023/24. Overall, while TB funding remained relatively stable, the decline in HIV spending drove the overall reduction in total expenditure. (Figure 1 below).

The progressive depreciation of the South African Rand against the US Dollar has a significant impact on the interpretation of financial trends when expressed in USD. Thus, when interpreting year-on-year changes, especially in USD, it is essential to distinguish between real expenditure variations and exchange rate effects. The overall trend in domestic currency (ZAR) gives a more accurate reflection of spending levels, whereas trends in USD are more sensitive to currency market fluctuations.

Figure 1: Total HIV and TB expenditure in South Africa (2020/21-2023/24, ZAR)



3.2. Historical trends in HIV spending (2013/14-2023/24)

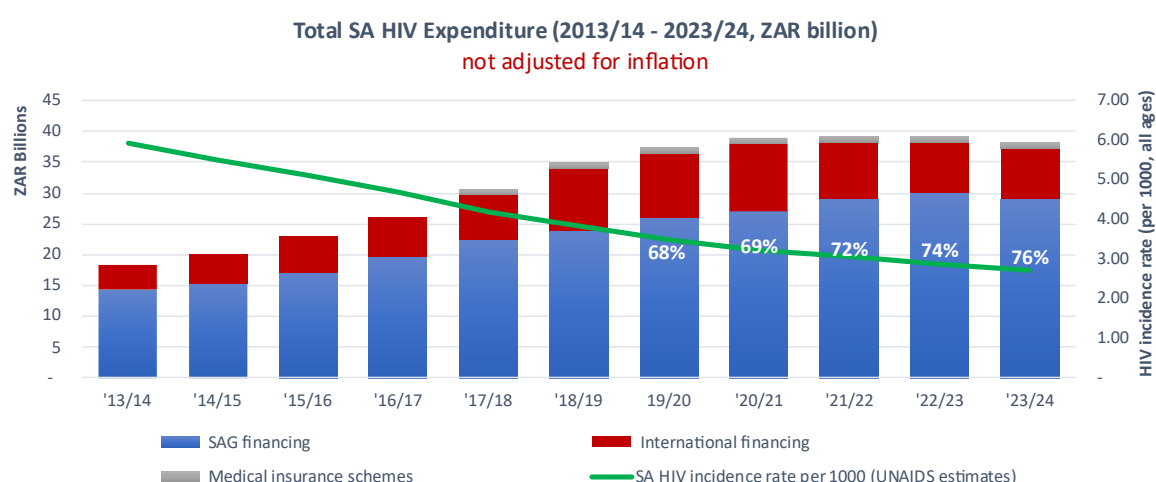
Figure 2 illustrates total HIV expenditure in South Africa from 2013/14 to 2023/24, and demonstrates an evolving financing landscape with increasing reliance on domestic funding. From 2013/14 to 2016/17, the expenditure tracking exercises focused only on the three major funding sources. The South African government (SAG), PEPFAR, and the Global Fund without including private sector contributions. This limited scope may have understated total spending during those years.

The analysis shows a clear upward trend in total HIV expenditure in South Africa between 2013/14 and 2023/24, reaching around ZAR 40 billion annually in recent years. This increase

has been driven primarily by domestic government funding (SAG financing), supplemented by international funding and contributions from medical insurance schemes. Over the same period, the HIV incidence rate (new infections per 1,000 population) steadily declined from above 5.5 in 2013/14 to below 3.5 in 2023/24. This inverse relationship suggests that sustained and increased investment in the HIV response has contributed significantly to reducing new HIV infections, demonstrating the positive impact of continued financial commitment on epidemic control

Additionally, governments are increasingly committing to universal health coverage (UHC), integrating HIV and TB services into public healthcare systems to ensure sustainability. Since HIV and TB treatments require long-term funding, The South African government (SAG) often cover these costs, whereas donors typically focus on providing funding support to the government to cover shortfalls and other short-term projects.

Figure 2: Historical trends in HIV expenditure in South Africa (2013/14 – 2023/24, ZAR billions)



DATA SOURCES:

2013/14 SA Investment Case expenditure tracking (undertaken by R4D & CEGAA).

2014/15-2016/17: SA expenditure tracking (undertaken by R4D, CEGAA, HE²RO & NDOH).

2017/18-2019/20: NASA+ (undertaken by CEGAA & HE²RO).

2021/22-2023/24: current NASA+ (undertaken by CEGAA).

3.3. HIV financing entities, revenues, schemes and agents/purchasers (2021/22-2023/24)

Between 2021/22 and 2022/23, overall HIV spending increased slightly in nominal terms by +0.2%, from ZAR 39.18 billion to ZAR 39.27 billion, before decreasing slightly by 3% in 2023/24 to ZAR 38.27 billion.

The SAG covered around three-quarters of the total HIV expenditure each year. The public funding grew both in nominal and proportional terms, rising from ZAR 29.07 billion (74%) in 2021/22 to ZAR 29.97 billion (76%) in 2022/23 and maintaining a strong share of 76% in 2023/24, despite a slight nominal dip generally on total HIV spending between the years. International funding decreased from ZAR 9.23 billion in 2021/22 to ZAR 8.26 billion in 2023/24, reflecting a proportional drop from 23% to 21% of total spending on HIV in the

country. Private and insurance-based contributions fluctuated moderately, increasing from ZAR 889 million in 2021/22 to ZAR 1.04 billion in 2022/23, then falling slightly to ZAR 1.02 billion in 2023/24, increasing their share from 2.3%, 2.7% and 2.7%, so even though slight reduction (-1.5%) in nominal amount, their share of total remained same because the total also decreased slightly. Within international sources, PEPFAR remained the dominant contributor, consistently accounting for 19–21% of total HIV funding. The Global Fund’s allocation dropped notably in 2022/23, from ZAR 926 million (in 2021/22) to ZAR 681 million (26%) before recovering to ZAR 933 million in 2023/24. The GF maintained a consistent 2% share of the total funding throughout the study period, despite the low spending in 2022/23 that is primarily due to it being the first year of the new GF grant cycle (GC6). It is common for GF spending to be lower during the initial year of a grant implementation, largely because of several contributing factors likely due to the start of a new grant cycle. (Figure 3).

Figure 3: Financing entities contributions to HIV in South Africa (2020/21 – 2023/24), ZAR billion, %)

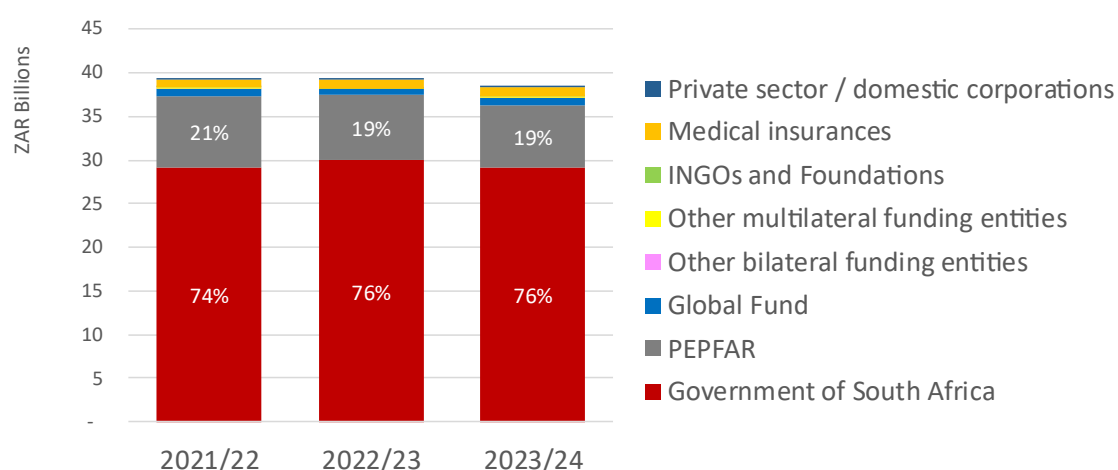


Table 2: Financing entities contributions to HIV in South Africa (2021/22 – 2023/24, ZAR, %)

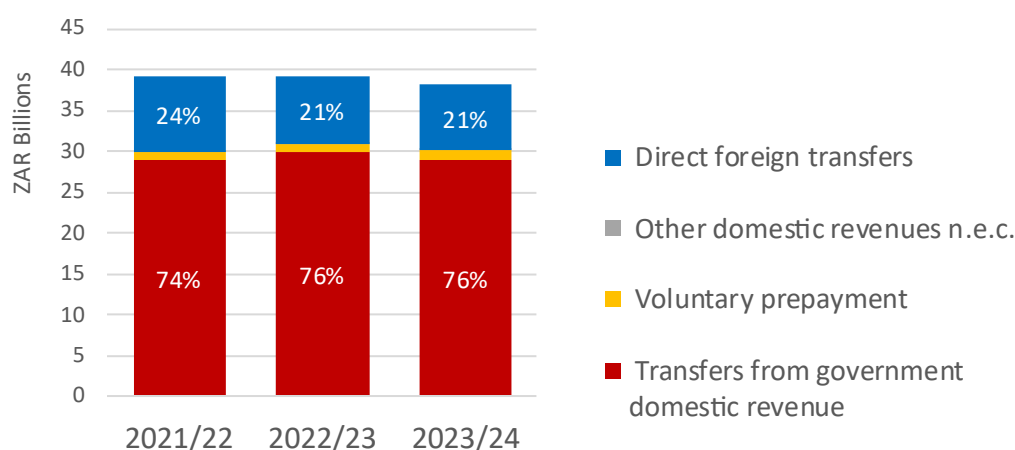
HIV Funding Entities (ZAR)	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
Government of South Africa	29,068,994,920	29,974,849,507	29,074,644,515	74%	76%	76%
PEPFAR	8,216,515,262	7,470,234,250	7,162,583,331	21%	19%	19%
Global Fund	926,399,287	681,020,602	933,509,576	2%	2%	2%
Other bilateral funding entities	6,495,978	12,406,659	18,087,000	0.0%	0.0%	0.0%
Other multilateral funding entities	77,658,964	96,374,350	58,450,972	0.2%	0.2%	0.2%
INGOs and Foundations	3,005,662	504,057	486,476	0.0%	0.0%	0.0%
Medical insurances	889,346,480	1,043,107,979	1,026,902,624	2.3%	2.7%	2.7%
Private sector / domestic corporations	432,706	432,706	523,694	0.0%	0.0%	0.0%
Total HIV (ZAR)	39,188,849,259	39,278,930,110	38,275,188,187	100%	100%	100%

Table 3: Financing entities contributions to HIV in South Africa (2021/22 – 2023/24, USD, %)

HIV Funding Entities (USD)	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
Government of South Africa	1,966,779,088	1,829,966,392	1,575,007,829	74%	76%	76%
PEPFAR	555,921,195	456,058,257	388,005,598	21%	19%	19%
Global Fund	62,679,248	41,576,349	50,569,316	2%	2%	2%
Other bilateral funding entities	439,511	757,427	979,794	0.0%	0.0%	0.0%
Other multilateral funding entities	5,254,328	5,883,660	3,166,358	0.2%	0.2%	0.2%
INGOs and Foundations	203,360	30,773	26,353	0%	0%	0%
Other international entities	31,392	-	-	0.0%	0.0%	0.0%
Medical insurances	60,172,292	63,681,806	55,628,528	2%	3%	3%
Private sector / domestic corporations	29,276	26,417	28,369	0.0%	0.0%	0.0%
Total HIV (USD)	2,651,509,691	2,397,981,081	2,073,412,144	100%	100%	100%

Figure 4 illustrates the revenue (REV) mechanisms that support financing schemes. In 2021/22, 2022/23, and 2023/24, the transfers from government domestic revenue accounted for 74%, 76%, and 76% of total revenue, respectively. Meanwhile, most international financing came from direct foreign transfer revenues, contributing 24% in 2021/22 and 21% in both 2022/23 and 2023/24. Voluntary prepayment revenue constituted 2% in 2021/22 and 3% in both 2022/23 and 2023/24.

Figure 4: Financing revenues for HIV (2021/22 - 2023/24, ZAR, %)



The revenues indicate the mechanisms through which the financing entities (sources) fund the services. Since the bulk of funding was from government sources, then these are distributed via transfers from central government. Most of the international financing entities distribute funds via direct foreign transfers, but not all – some are through government transfers (such as GF funding to NDoH). In terms of the schemes, which are the financing arrangements through which people obtain health services, Table 4 indicates that in 2023/24 the bulk (78%) of HIV financing are channelled through government schemes, mostly central government schemes. Most of the international entities' financing flows via the resident foreign agencies' schemes (19% of total). Only 1% of HIV financing went through non-profit organisations which shows a decline from the previous assessment which was reported at 3%.

Table 4: HIV financing entities and their financing schemes (2021/22 - 2023/24, ZAR)

HIV Financing Entities and their Financing Schemes (ZAR)	2021	2022	2023
FE.01 Public Entities	29,068,994,920	29,974,849,507	29,074,644,515
SCH.01 Government schemes and compulsory contributory health care schemes	29,068,994,920	29,974,849,507	29,074,644,515
FE.02 Domestic Private Entities	889,779,186	1,043,540,685	1,027,426,317
SCH.01 Government schemes and compulsory contributory health care schemes			90,988
SCH.02 Voluntary payment schemes	889,779,186	1,043,540,685	1,027,335,330
SCH.02.01 Voluntary insurance schemes	889,346,480	1,043,107,979	1,026,902,624
SCH.02.01.98 Voluntary insurance schemes not designated for specific purposes	889,346,480	1,043,107,979	1,026,902,624
SCH.02.02 Not-for-profit schemes (including resident foreign agencies schemes)	432,706	432,706	432,706
SCH.02.02.01 Not-for-profit organisation schemes	432,706	432,706	432,706
FE.03 International Entities	9,230,075,153	8,260,539,917	8,173,117,355
SCH.01 Government schemes and compulsory contributory health care schemes	495,942,142	562,720,179	721,917,105
SCH.02 Voluntary payment schemes	8,681,655,601	7,667,786,746	7,417,201,157
SCH.02.02 Not-for-profit schemes (including resident foreign agencies schemes)	8,395,735,215	7,558,133,899	7,285,192,128
SCH.02.02.01 Not-for-profit organisation schemes	8,274,020,386	7,423,607,561	7,191,953,250
SCH.02.02.02 Resident foreign agencies schemes	121,714,830	134,526,338	93,238,878
SCH.02.03 For-profit organizations schemes	285,920,386	109,652,847	132,009,029
SCH.04 External schemes (non-resident)	52,477,410	30,032,992	33,999,093
SCH.04.02 Voluntary schemes (non-resident)	52,477,410	30,032,992	33,999,093
Grand Total	39,188,849,259	39,278,930,110	38,275,188,187

The financing agents and purchasers (FAPs) are the economic units that operate the schemes. They collect revenue, pool financial resources, pay for the service provision, and take programmatic decisions (allocation and purchase modalities). They are therefore important 'drivers' of the response. Because the bulk of the HIV financing in South Africa comes from government revenue, these were mostly managed by public departments (77% in 2023/24), while 19% were managed by PEPFAR agencies (these agencies determine the use of their contributions). The other FAPs were responsible for the remaining small amounts (Figure 5 and Table 5 provide details).

Figure 5: Financing agents & purchasers for HIV services (2021/22 - 2023/24, ZAR)

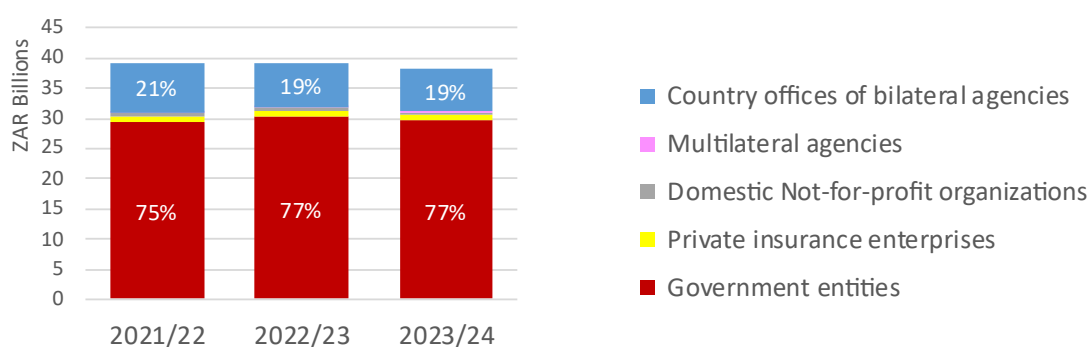


Table 5: Financing agents & purchasers for HIV services (2021/22 - 2023/24, ZAR, %)

HIV Financing Agents and Purchasers (ZAR)	2021/22	2022/23	2023/24	% 2021/22	% 2022/2	% 2023/2
Government entities	29,437,877,745	30,314,629,860	29,570,371,735	75%	77%	77%
Private insurance enterprises	889,346,480	1,043,107,979	1,026,902,624	2%	3%	3%
Domestic Not-for-profit organizations	565,785,133	357,946,334	457,994,693	1%	1%	1%
Multilateral agencies	79,324,639	93,011,687	57,335,803	0.00	0.00	0.00
Country offices of bilateral agencies	8,216,515,262	7,470,234,250	7,162,583,331	21%	19%	19%
Total	39,188,849,259	39,278,930,110	38,275,188,187	100%	100%	100%

Table 6: Financing entities and their agents & purchasers for HIV services (2021/22 - 2023/24, ZAR)

Financing Agents with their Financing Entities (ZAR)	2021	2022	2023
FE.01 Public Entities	29,068,994,920	29,974,849,507	29,074,644,515
FAP.01.01 Territorial governments	29,068,994,920	29,974,849,507	29,074,644,515
FE.02 Domestic Private Entities	889,779,186	1,043,540,685	1,027,426,317
FAP.01.01 Territorial governments			90,988
FAP.02.03 Domestic Private insurance For-profit orga	889,346,480	1,043,107,979	1,026,902,624
FAP.02.05 Domestic Not-for-profit organizations	432,706	432,706	432,706
FE.03 International Entities	9,230,075,153	8,260,539,917	8,173,117,355
FAP.01.01 Territorial governments	368,882,825	339,780,353	495,636,233
FAP.02.05 Domestic Not-for-profit organizations	565,352,427	357,513,628	457,561,987
FAP.03.02 Multilateral agencies managing external re	79,324,639	93,011,687	57,335,803
FAP.03.99 Other international financing agents n.e.c.	8,216,515,262	7,470,234,250	7,162,583,331
Grand Total	39,188,849,259	39,278,930,110	38,275,188,187

Note: The small amount R91k in 2023, was a donation from companies to SANAC - interesting and could be an example to encourage govt to source more from businesses.

3.4. Providers of HIV services in South Africa

Figure 6 shows that public or government service providers continue to dominate HIV service provision in South Africa, accounting for the largest share of total expenditure, rising from 75% in 2021/22 to 77% in 2023/24. This reflects strong reliance on the public health system for service delivery. These providers are funded mainly by both the South African government and the important contribution from international partners, underscoring their central role in the national HIV response. Local NGOs represent the second-largest group of service providers, though their share has declined slightly from 21% in 2021/22 to 18% in 2023/24. Most of their funding comes from international sources, with only negligible contributions from the government. Expenditure on for-profit providers remained stable at 3% over the 3 years.

Figure 6: HIV service providers (2021/22-2023/24, ZAR)

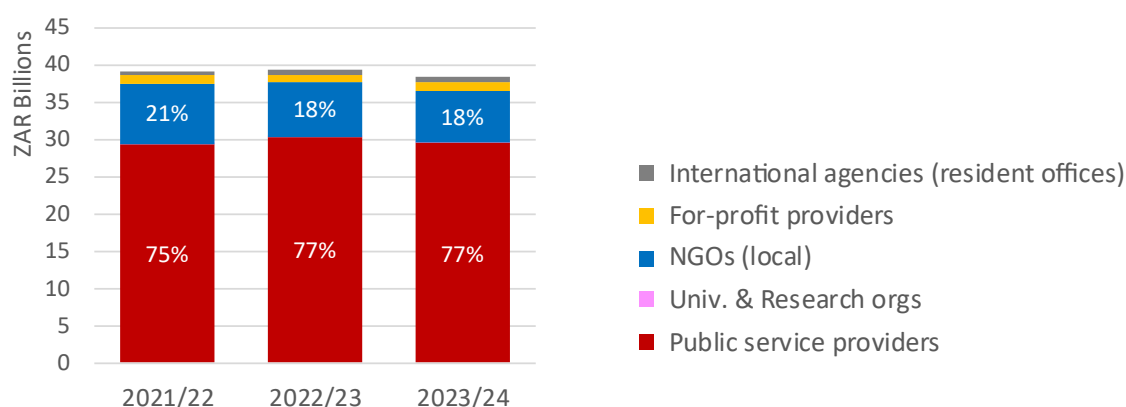


Table 7: HIV providers of services per sector (2021/22-2023/24, ZAR)

Providers of HIV Services per Sector (ZAR)	2021/22	2022/23	2023/24	% 2023/24
PS.01.01 Governmental organizations	29,346,529,147	30,222,390,818	29,494,395,081	77.1%
Clinics/Hospitals	22,001,388,971	23,808,249,007	23,245,584,737	60.7%
Pharmacies	-	8,190,000	11,999,000	0.0%
Schools and Universities (public)	298,616,491	240,327,690	250,955,723	0.7%
Other public departments (DOH, DSD, DBE, SANAC etc.)	7,046,523,685	6,165,624,121	5,985,855,621	15.6%
PS.01.02 Parastatal organizations	49,121,463	142,148,670	130,062,407	0.3%
Labs	14,365,318	8,305,954	13,337,040	0.0%
Research institutions	34,756,145	133,842,716	116,725,367	0.3%
PS.02.01 Non-profit providers	8,080,584,899	7,223,507,358	6,893,308,489	18.0%
NGOs (non-faith-based)	8,039,658,360	7,198,350,315	6,883,150,383	18.0%
NGOs (faith-based)	40,926,539	25,157,042	10,158,106	0.0%
PS.02.02 Profit-making private sector providers	1,153,481,589	1,131,151,315	1,127,058,111	2.9%
Hospitals (profit-making private)	188,777,361	204,661,836	240,153,962	0.6%
Clinics (profit-making private)	866,818,343	838,450,746	786,748,662	2.1%
Research institutions (profit-making private)	4,434,000	982,800	-	0.0%
Consultancy firms (profit-making private)	84,590,640	87,055,933	83,785,565	0.2%
Profit-making providers not disagg.	8,861,246	-	16,369,922	0.0%
PS.03 International providers	559,132,161	559,731,950	630,364,099	1.6%
Multilateral agencies	109,661,380	87,599,776	78,797,538	0.2%
International NGOs and foundations	375,208,095	420,489,670	485,713,927	1.3%
International research centers and other for-profit	21,785,277	21,609,512	31,853,542	0.1%
Other International providers – in country offices n.e.c.	52,477,410	30,032,992	33,999,093	0.1%
Grand Total	39,188,849,259	39,278,930,110	38,275,188,187	100%

Table 8: HIV financing agents/ purchasers and their service providers (2021/22 - 2023/24, ZAR)

Providers of services with the financing agents/purchasers (ZAR)	2021/22	2022/23	2023/24	% 2023/24
FAP.01 Public sector	29,437,877,745	30,314,629,860	29,570,371,735	75%
PS.01.01 Governmental organizations	29,259,551,503	30,128,833,860	29,383,801,733	75%
PS.02.01 Domestic Non-profit providers	178,326,242	185,796,000	186,570,002	0%
FAP.02 Domestic Private sector	1,455,131,613	1,401,054,314	1,484,897,317	4%
PS.02.01 Domestic Non-profit providers	565,785,133	357,946,334	457,994,693	1%
PS.02.02 Domestic For-profit private sector providers	889,346,480	1,043,107,979	1,026,902,624	2%
FAP.03 International purchasing organizations	8,295,839,902	7,563,245,936	7,219,919,134	21%
PS.01.01 Governmental organizations	86,977,644	93,556,958	110,593,347	0%
PS.01.02 Parastatal organizations	49,121,463	142,148,670	130,062,407	0%
PS.02.01 Domestic Non-profit providers	7,336,473,524	6,679,765,023	6,248,743,794	19%
PS.02.02 Domestic For-profit private sector providers	264,135,109	88,043,335	100,155,487	1%
PS.03.02 Multilateral agencies	109,661,380	87,599,776	78,797,538	0%
PS.03.03 International not-for-profit organizations and foundations	375,208,095	420,489,670	485,713,927	1%
PS.03.04 International research and other for-profit	21,785,277	21,609,512	31,853,542	0%
PS.03.99 Other International providers – in country offices	52,477,410	30,032,992	33,999,093	0%
Grand Total	39,188,849,259	39,278,930,110	38,275,188,187	100%

3.5. HIV/AIDS spending activities (programme areas and interventions)

The NASA classification system provides a comprehensive list of interventions, grouped into eight programme areas. All collected data were cross walked (matched) to these AIDS Spending categories (ASC) and are presented in this section. The following figure 7 shows how funds flowed from financing entities (FE) to programmes areas (ASC) and to which beneficiary populations (BP).

The NASA analysis found that most of South Africa's HIV spending was consistently directed towards HIV care and treatment, which accounted for over 70% of total expenditure each year. This highlights the country's strong commitment to sustaining treatment access for people living with HIV, with the largest ART programme in the world. Meanwhile, Prevention spending fluctuated both in nominal value and as a share of total HIV expenditure, shifting from 9% in 2021/22 and in 2022/23, before rising to 11% in 2023/24. However, despite a 20% increase over the three years, prevention still accounts for a relatively modest portion of overall HIV spending. HIV testing and counselling (HTC) increased slightly, representing around 3–4%, ensuring continued early diagnosis and linkage to care. Programme enablers and systems strengthening also held a steady increase share of 8–9%, supporting the systems and capacity needed to deliver services effectively.

Other areas such as social protection and economic support comprised around 4–5% of spending, contributing to the broader goal of mitigating social and economic vulnerabilities related to HIV. Although relatively small in proportion, development synergies, social enablers, and HIV-related research together accounted for less than 2% of total spending annually. These areas, though modest in financial terms, play an important supporting role in advocacy,

community engagement, human rights protection, etc. It is important to note that spending on research is likely underestimated in this assessment due to limitations in data availability. Specifically, PEPFAR's expenditure reporting did not disaggregate research-related spending, which may have been embedded within broader programmatic activities such as prevention, treatment, or health systems strengthening. Additionally, efforts to clarify or obtain more detailed information were hindered by the U.S. government's Stop Work Order in January 2025, which restricted access to key data sources and engagement with relevant stakeholders during the assessment period. As a result, the actual level of investment in HIV research may be higher than what is captured in this report. However, it is likely to be significantly impacted by the withdrawal of research funding from the US Government.

Overall, the data reflects a balanced HIV response that prioritizes treatment, with some increasing prevention efforts, while maintaining essential investments in systems strengthening and supportive services.

Figure 7: Total HIV spending per programme area (2021/22 - 2023/24, ZAR)

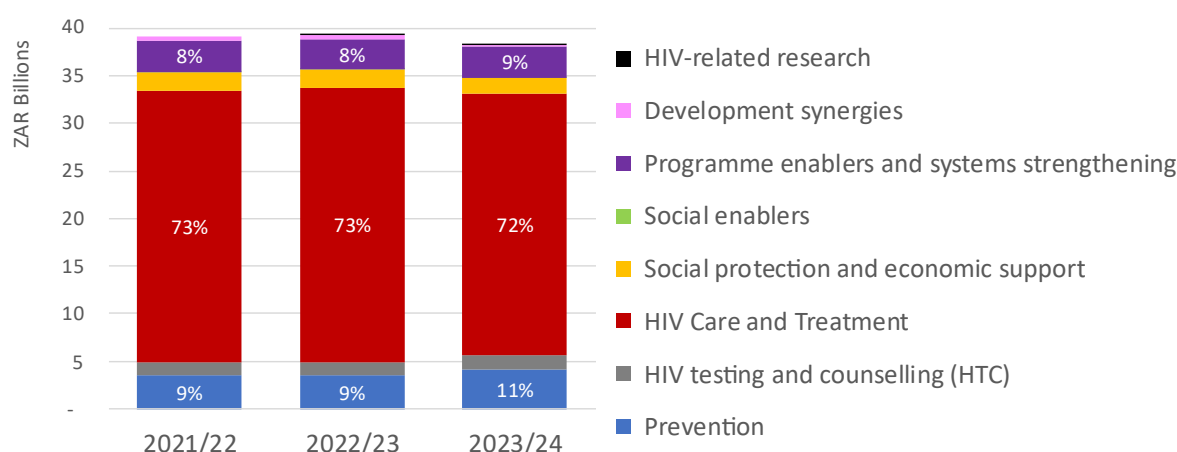


Table 9: Total HIV spending per programme area (2021/22 - 2023/24, ZAR, %)

Total HIV spending per programme area (ZAR)	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
Prevention	3,591,219,091	3,519,238,139	4,203,121,076	9%	9%	11%
HIV testing and counselling (HTC)	1,257,150,416	1,375,165,609	1,404,158,397	3%	4%	4%
HIV Care and Treatment	28,600,812,542	28,865,834,421	27,465,903,193	73%	73%	72%
Social protection and economic support	1,919,040,616	1,894,377,838	1,667,513,466	5%	5%	4%
Social enablers	7,100,807	8,323,029	11,536,658	0.0%	0.0%	0.0%
Programme enablers and systems strengthening	3,319,390,648	3,167,488,549	3,277,928,723	8%	8%	9%
Development synergies	494,135,138	447,739,805	231,328,909	1%	1%	1%
HIV-related research	-	762,720	13,697,765	0%	0%	0%
Total HIV spending (ZAR)	39,188,849,259	39,278,930,110	38,275,188,187	100%	100%	100%

Note that C&T is more than just the ART programme. HTC sub-categories include the testing for KPs, and therefore spending on KP testing should be included in HTC (and not prevention). However, where a package of KP services is delivered and the specific spending on their testing cannot be disaggregated, then they are all included under Prevention (but should not be double counted in both). Note that 'Programme Enablers and systems strengthening includes Programme management & Administration, and other enablers: planning & coordination, Information Systems, PSCM improvements, lab

strengthening, building health workers capacity. Each of these programme areas are broken down into more detail later.

Figure 8 shows the provincial distribution of HIV spending by programmatic area in 2023/24, highlighting some clear trends and variations. Across most provinces, HIV Care and Treatment dominates the spending, as would be expected as being primarily responsible for the delivery of the ART programme, consistently accounting for the largest proportion (over 70%), KZN and GP took the largest shares of all the provincial funding (excluding non-disagg), which reflects their greater burden of disease and large numbers of PLHIV. Spending on HIV testing and counselling (HTC), programme enablers and systems strengthening also feature moderately across provinces while spending on HIV prevention varied modestly across provinces but remains relatively low (10% or less in all provinces) compared to treatment. Notably, a substantial share of prevention spending also appears under the "Not disaggregated" category, reflecting prevention activities funded by international partners that are not reported at the provincial level.

Overall, while treatment remains the backbone of the HIV response, it is important to note that only spending from the public sector and medical insurance was disaggregated by province, while international partners' spending was not split geographically. As a result, a significant portion of the overall HIV expenditure appears under the category "Not disaggregated", which includes most of the international financing from PEPFAR, the Global Fund, and other partners. This explains the high proportion of spending in this category, especially for programmatic areas like systems strengthening, development synergies, and research, which were mainly funded by international partners. This limitation in disaggregation should be considered when interpreting provincial comparisons.

Figure 8: Provincial HIV expenditure per programme area (2023/24, ZAR billion)

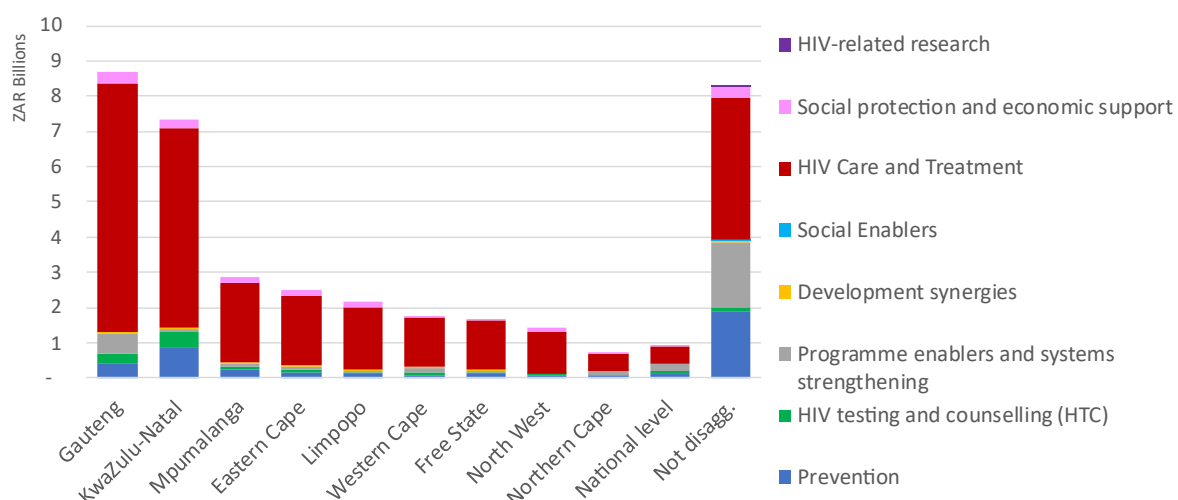
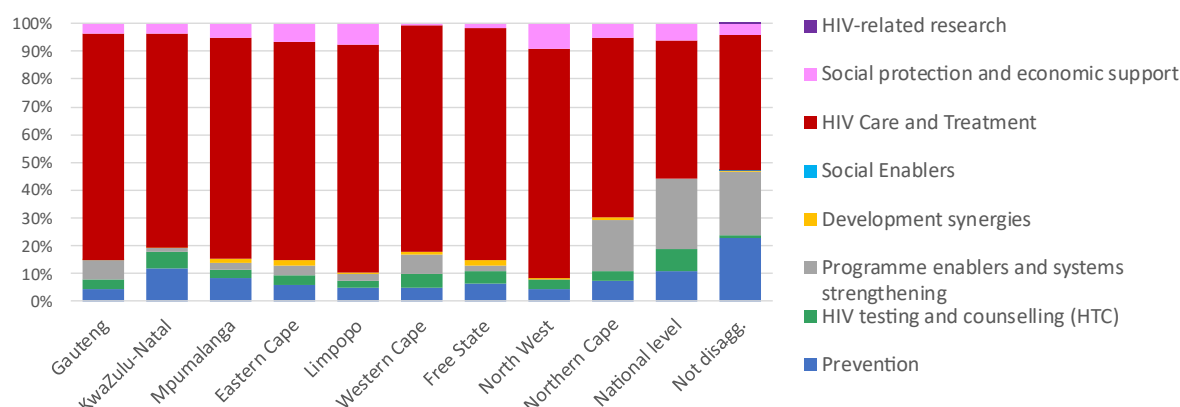
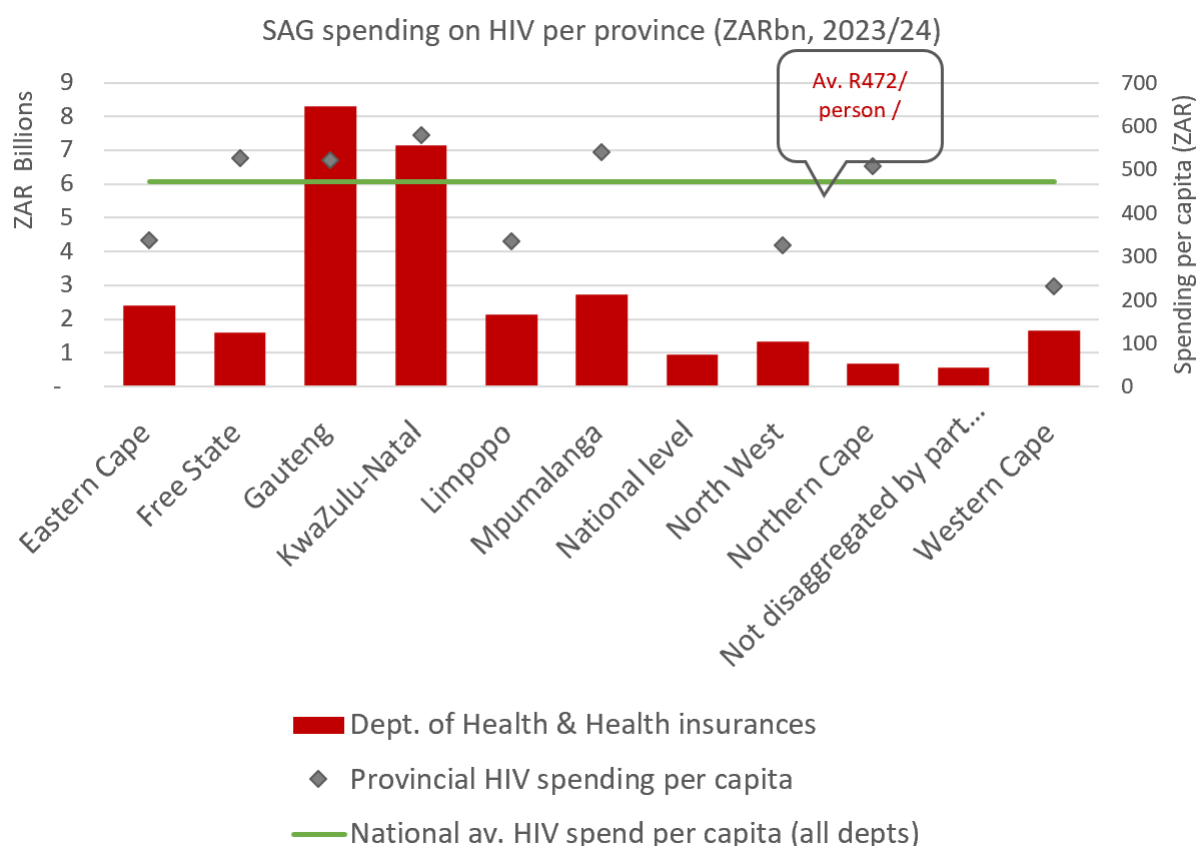


Figure 9: Proportions of provincial HIV expenditure by programme area (2023/24, %)



NOTE: 88% of the total HIV spending has been disaggregated by provinces. This analysis includes only most public funds (98%) that have been disaggregated at the provincial level, along with insurance expenditures. However, it does not fully reflect the actual provincial distribution due to the lack of geographic breakdowns from PEPFAR and the Global Fund.

Figure 10: SAG and Health insurances spending on HIV per province and per capita (ZAR and %, 2023/24) of financing entities' contributions to HIV programme areas (2023/24, %)



To calculate the per capita HIV spending by province, we divided the total HIV-related public health expenditure for each province by its respective population (Figure 10). This analysis

provides a clearer picture of how HIV funding is distributed on a per-person basis, highlighting regional disparities in resource allocation.

To assess the alignment between HIV prevalence and per capita HIV spending across South African provinces, we can compare the latest available HIV prevalence data (HSRC, 2022) with per capita spending figures. This comparison helps identify provinces where resource allocation may not correspond to the burden of disease, highlighting areas that may require advocacy for increased HIV resources.

Province	HIV Prevalence (%) (HSRC, 2022)	HIV Spending Per Capita (ZAR)	Notes
KwaZulu-Natal	16	580	✓ High prevalence & high per capita spending — aligned
Mpumalanga	17.4	541	✓ Highest prevalence with strong per capita spending — appropriate
Free State	15.6	526	✓ Highest prevalence with strong per capita spending — appropriate
Gauteng	11.9	521	⚠ Moderate prevalence, but very high spending (urban load?)
Northern Cape	8.9	507	⚠ Higher spending relative to prevalence — possible overfunding?
Eastern Cape	13.9	337	✗ High prevalence but low per capita spending — underfunded
Limpopo	13	335	✗ High prevalence with low per capita spending
North West	11.2	325	✗ Lower per capita spend despite moderate prevalence
Western Cape	7.4	232	✓ Low prevalence and lowest per capita spend — aligned

Key Insights

Alignment:

KwaZulu-Natal, Mpumalanga, and Free State show good alignment — high prevalence and above-average per capita spending.

Moderate Overspending or Inefficient?

Northern Cape and Gauteng show relatively high per capita spending despite having lower or moderate HIV prevalence. This might be due to urban service costs or special programs, but it's worth reviewing efficiency.

Potential Underfunding (Advocacy Targets):

Eastern Cape: 13.9% prevalence, but only R337 per capita

Limpopo: 13.0%, R335 per capita

North West: 11.2%, R325 per capita

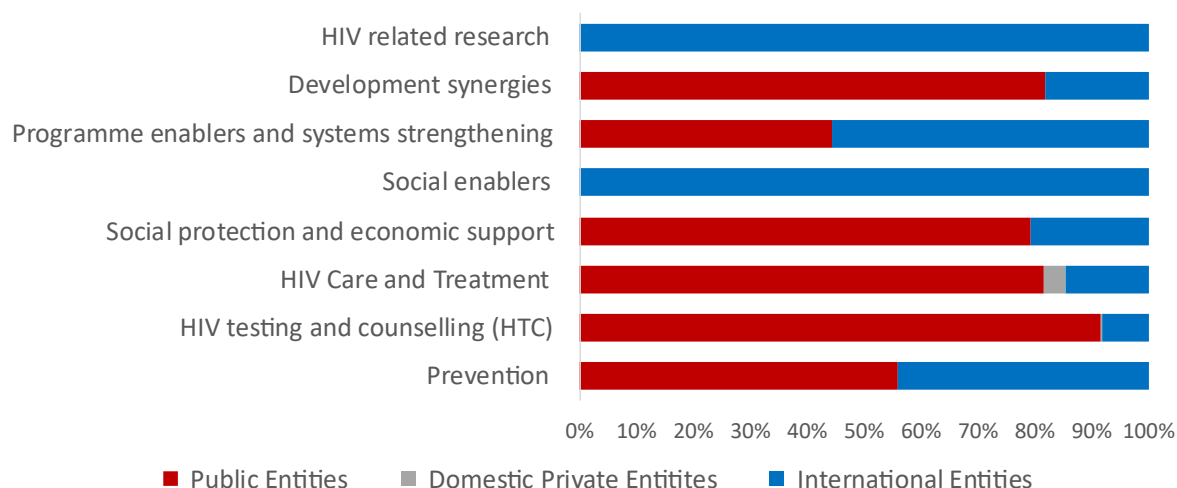
These are all above the national average prevalence but receive below-average per capita funds.

To ensure equitable and effective HIV service delivery, advocacy efforts should prioritize increased resource allocation to provinces with high HIV prevalence but comparatively low per capita spending, specifically the Eastern Cape, Limpopo, and North West. These provinces face a significant disease burden yet receive below-average funding, risking gaps in prevention, treatment, and care. Provincial business planning processes should use this data-driven evidence to align budgets with need, while also assessing spending efficiency in better-resourced but lower-prevalence areas such as Gauteng and the Northern Cape. A more balanced allocation will support national HIV targets and improve health outcomes

The figure 11 highlights the varying degrees of reliance on international aid across different HIV programme areas. HIV-related research, social enablers are entirely funded by international entities, as well as programme enablers and systems strengthening relying on

international funding, with over 60%, underscoring a high dependence on external support for these important components of the response. Similarly, prevention rely significantly on international funding, with over 40% of resources coming from external partners.

Figure 11: Proportions of financing entities' contributions to HIV programme areas (2023/24, %)



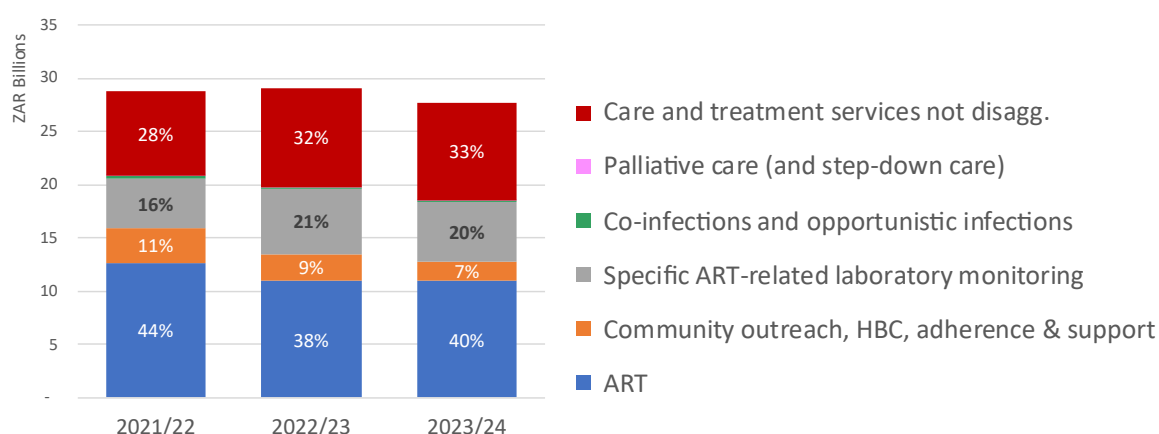
3.5.1. Spending on care & treatment activities

HIV care and treatment (C&T) continue to dominate South Africa's HIV spending, accounting for over 70% of total HIV expenditure across the three years. This high allocation is directly linked to the country's large HIV burden, with an estimated 8 million people living with HIV in 2024¹². The NASA data reveals that Antiretroviral Therapy (ART) alone absorbs the largest share within this category, making up 40% of the total care and treatment budget in 2023/24. Despite being the largest component, ART spending declined in nominal terms by 13 % in 2022/23, and stabilised in nominal terms between 2022/23 and 2023/24 reaching ZAR 10.9 billion in 2023/24 despite the persistent high demand for treatment across the country. However, this slight decline in ART spending was accompanied by a positive programmatic outcome: the number of patients on ART and remaining in care increased from 5.4 million in 2022/23 to 5.5 million in 2023/24, maintaining 94% of the national treatment target in both years. Provinces have attributed this achievement to differentiated targeted testing and treatment strategies implemented in the province. In addition, fewer patients were started on treatment than expected because the HIV positivity rate declined. This meant there were fewer new HIV-positive individuals needing treatment, contributing further to the reduced spending. This suggests that the reduction in expenditure may reflect improved efficiency and effective resource utilization, rather than diminished service delivery. It may also point to economies of scale achieved through optimized procurement, reducing ARV prices (as shown later in the efficiency section), decentralization of services, or better integration into the public health system.

¹² UNAIDS estimates 2024

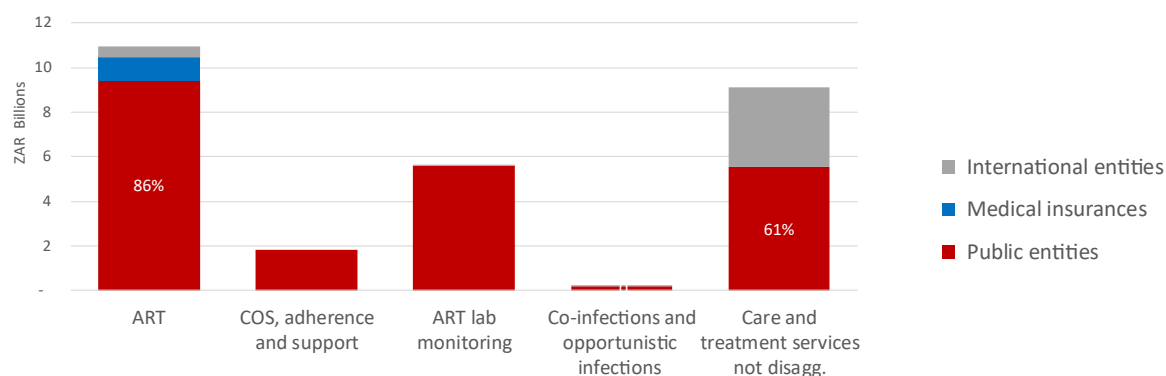
Similarly, the most significant decrease in expenditure is seen in community outreach, home-based care, and adherence support, which fell from ZAR 3.25 billion in 2021/22 to ZAR 1.83 billion in 2023/24, indicating a possible shift in focus or funding constraints in community-level services. In contrast, spending on ART-related laboratory monitoring remained stable, representing around 20% of the care and treatment expenditure in both 2022/23 and 2023/24 up from 16% in 2021/22, highlighting continued investment in routine clinical monitoring. A third of the spending (33%) in 2023/24 falls under non-disaggregated care and treatment services, reflecting mainly the clinical services in the PEPFAR expenditure dataset, which could not be disaggregated by specific activities. The scale of investment in care and treatment underscores the critical importance of sustaining life-long ART for millions, regular clinical monitoring, and community-based support systems to retain patients in care.

Figure 12: A deeper dive into spending on HIV care & treatment (2021/22 - 2023/24, ZAR, %)



Note that C&T not disaggregated includes PEPFAR's "C&T: HIV Clinical services" category which is not specifically ART-related, but covers a number of activities including HIV & TB case finding, linkage to ART, retention and viral suppression, TB activities, as well as some Cervical cancer interventions. But the expenditure is not disaggregated into any of these activities and therefore can only be labelled as C&T not disagg in NASA.

Figure 13: Financing entities' contribution to care and treatment activities (2023/24, ZAR, %)

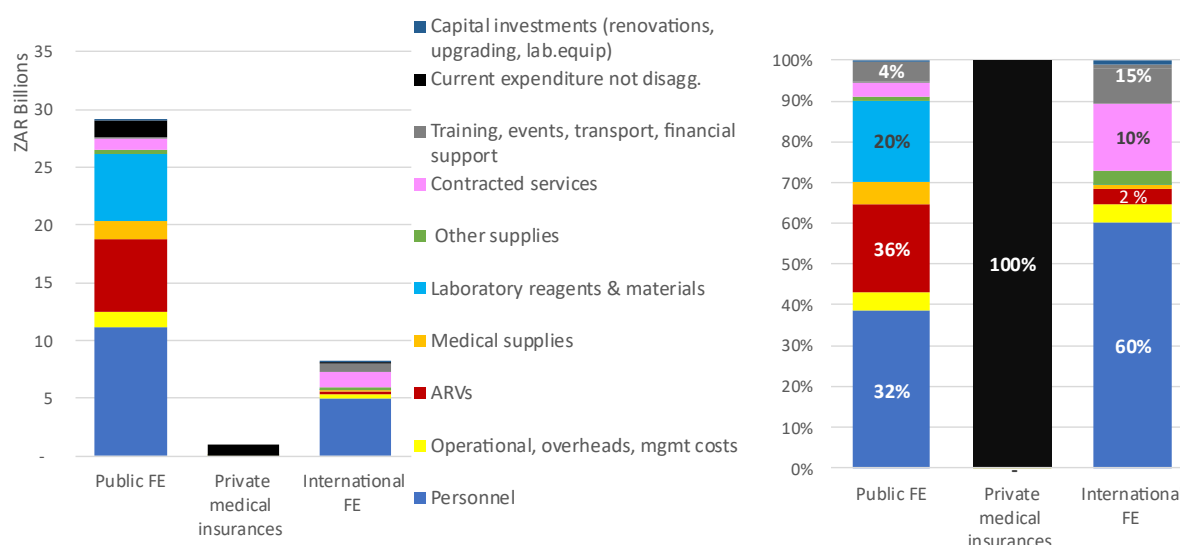


The blue bar in the Figure 13 represents the private sector's (medical insurance schemes') expenditure on HIV-positive patients within private healthcare. The Council for Medical Schemes (CMS) in South Africa reported the HIV-related expenditures of all registered private voluntary medical insurance schemes. These expenditures were based on members who were either officially registered as HIV-positive under the Chronic Disease List (CDL) for Prescribed Minimum Benefits (PMBs), or those who submitted claims marked as HIV-related, even if they were not formally registered as HIV-positive. Since the specific types of interventions covered were not detailed, it is assumed that most of these costs were associated with ART, although a smaller portion could possibly be allocated to treating other opportunistic infections (OIs).

Public financing entities accounted for approximately 76% of total C&T expenditure. Most of their spending was directed toward personnel costs, representing around 39% of total C&T spending. Additional priorities included antiretroviral drugs (ARVs) and laboratory reagents, making up 17% and 15% of total spending respectively. This reflects the public sector's strong focus on delivering direct treatment services and maintaining the health system infrastructure.

International financing entities contributed around 21% of the total C&T spending. Their funding emphasized personnel (13%), contracted services (4%), and training, events, transport, and financial support (2%), indicating a strategic orientation toward supporting human resources, technical assistance, and program delivery through implementing partners.

Figure 14: Financing entities' spending on C&T activities by production factor (2023/24, ZAR, %)

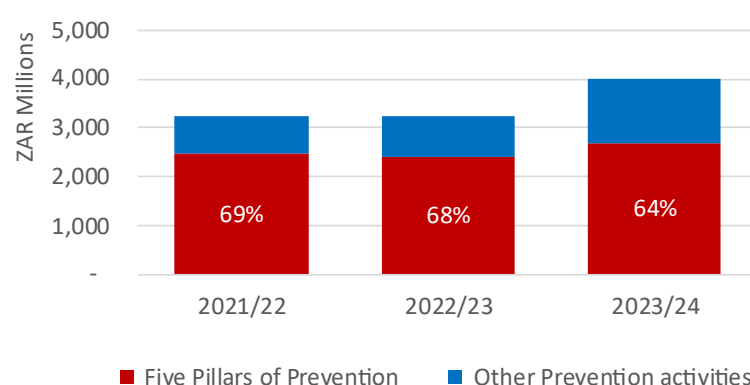


3.5.2. Spending on prevention activities

The overall spending on HIV prevention increased by 19%, rising from ZAR 3.59 billion in 2021/22 to ZAR 4.20 billion in 2023/24, forming 11% of total HIV spending. Despite this increase, the share of spending on the Five Pillars of Prevention declined from 69% to 64% of total prevention spending. Within prevention, voluntary medical male circumcision (VMMC) spent the largest proportion, accounting for 25%, 30% and 24% of the total over the three years. Condom distribution for the general population also saw a significant rise in both

absolute terms and proportion, increasing from ZAR 462 million (13%) in 2021/22 to ZAR 729 million (17%) in 2023/24. Pre-exposure prophylaxis (PrEP) made up 7%, 9% and 8% across the years. Spending on prevention for adolescent girls and young women (AGYW) and services for key populations declined in both amount and proportion, each dropping to 7% by 2023/24. Meanwhile, spending on "Other Prevention Activities" grew sharply, making up 36% of the total in 2023/24 indicating either new interventions or expanded programming, including PMTC 9%, the department of basic education (DBE) life skills programme that targeted children and youth 6% and human papillomavirus (HPV) vaccination 5%. HPV vaccine is specifically aimed at preventing adolescent girls and young women (AGYW) from contracting both HIV and cervical cancer. As such, it forms part of the government's broader efforts to prioritize the health and well-being of AGYW. The remaining smaller activities such as social behavior change and communication (SBCC), community mobilization, PEP, and others collectively accounted for approximately 6–8% of total prevention spending.

Figure 15: Spending on HIV prevention interventions (2021/22 - 2023/24, ZAR million)



* Five Pillars: Prevention for AGYW, services for key populations, condoms, VMMC and PrEP.

Table 10: Spending on HIV prevention activities (2021/22 - 2023/24, ZAR)

HIV Prevention interventions (ZAR)	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
Five Pillars of Prevention	2,484,189,072	2,410,607,107	2,691,714,790	69%	68%	64%
Prevention for AGYW	459,165,232	326,856,172	304,745,482	13%	9%	7%
Services for key populations	425,604,941	321,086,330	335,985,288	12%	9%	8%
Condoms for gen.population	462,492,688	388,369,215	729,101,929	13%	11%	17%
VMMC	890,713,475	1,049,885,904	989,078,061	25%	30%	24%
Pre-Exposure Prophylaxis (PrEP)	246,212,736	324,409,486	332,804,031	7%	9%	8%
Other Prevention activities	1,107,030,020	1,108,631,032	1,511,406,286	31%	32%	36%
PMTCT	310,064,748	321,937,930	357,317,025	9%	9%	9%
Activities for vulnerable and accessible populations	-	16,332,111	43,287,464	0%	0%	1%
Prevention for children and youth (excl. for AGYW)	275,687,375	237,796,406	250,196,988	8%	7%	6%
SBCC	86,782,150	140,448,766	164,233,403	2%	4%	4%
Community mobilization	47,597,576	84,963,486	115,697,807	1%	2%	3%
Wellness programmes in the workplace	2,548,062	852,475	204,170	0%	0%	0%
Post-exposure prophylaxis (PEP)	13,529,874	15,920,005	20,453,171	0%	0%	0%
Other Prevention activities not disagg	31,937,710	25,454,615	31,766,262	1%	1%	1%
Other prevention activities n.e.c	-	-	314,524,508	0%	0%	7%
Prevention activities not disaggregated	115,228,206	72,576,160	13,730,197	3%	2%	0%
HPV vaccination	223,654,318	192,349,077	199,995,290	6%	5%	5%
Total Prevention spending (ZAR)	3,591,219,091	3,519,238,139	4,203,121,076	100%	100%	100%

Figure 16 illustrates the proportional contributions of various financing entities to different HIV prevention activities in 2023/24. The total HIV prevention spending amounted to ZAR

4.20 billion, with public financing entities contributing 58% (ZAR 2.43 billion) and international entities contributing 42% (ZAR 1.76 billion). Public funding prioritized condom distribution for the general population (30% of public prevention spending), VMMC (20%), PMTCT (15%), and prevention for children and youth (excluding AGYW) (10%). In contrast, international funders concentrated their support on VMMC (28%) of total international prevention spending), PrEP (18%) prevention for AGYW (17%), key populations (10%), and notable allocation to other prevention activities not elsewhere classified (18%) including primary HIV prevention and sexual violence from PEPFAR. Smaller activities such as SBCC, community mobilization, and PEP together represented around 9% of public and 5% of international prevention funding.

Figure 16. Financing entities' contributions to HIV prevention activities (2023/24, ZAR, %)

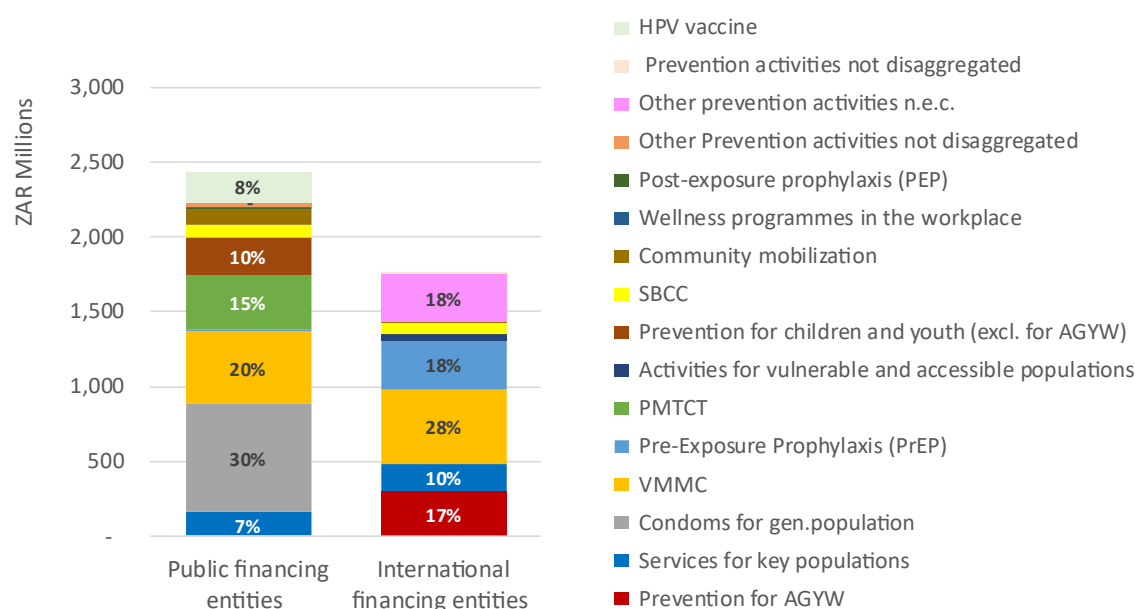


Figure 17 indicates the relative reliance on external funds for each prevention intervention, highlighting those almost entirely dependent, such as PrEP and interventions for AGYW and other vulnerable populations – raising concern about the sustainability of these should external funds reduce. VMMC and key population interventions are approximately half reliant on international funds and thus also at risk.

Figure 17. Financing entities' contributions to HIV prevention activities (2023/24, %)

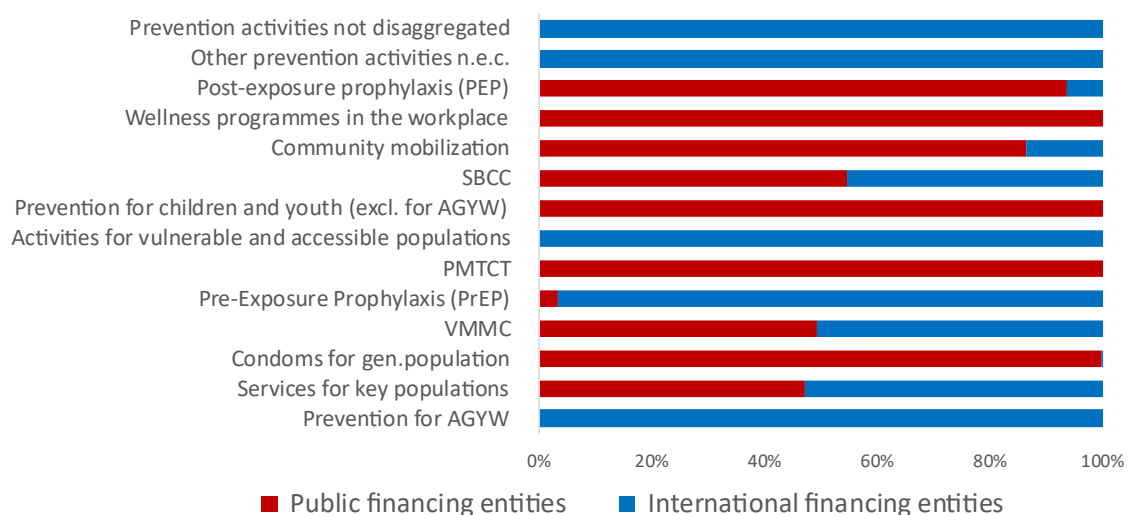
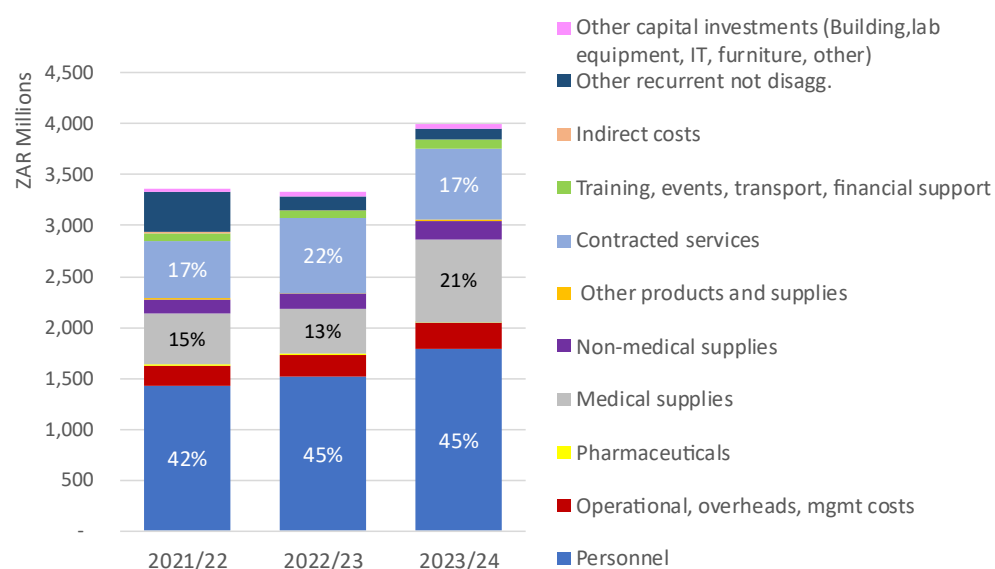


Figure 18 shows that personnel costs consistently dominated HIV prevention spending, accounting for 42% in 2021/22 and rising slightly to 45% in both 2022/23 and 2023/24, underscoring the labour-intensive nature of prevention services. Medical supplies emerged as a growing cost driver, increasing from 15% in 2021/22 to 21% in 2023/24, likely reflecting expanded procurement of prevention-related commodities such as condoms and devices for VMMC. Contracted services also constituted a significant share, peaking at 22% in 2022/23 before settling at 17% in 2023/24, highlighting the role of outsourcing to deliver key prevention interventions. Meanwhile, operational, overhead, and management costs remained stable at 6–7%, and non-medical supplies held steady at 4% annually. The “other recurrent costs not disaggregated” dropped from 12% to 3%, possibly due to improved expenditure tracking. Overall, the data shows a shift toward more direct, tangible service delivery inputs such as personnel and supplies, with modest growth in training and logistics support.

Figure 18. HIV prevention spending by production factor (2021/22-2023/24, ZAR)



3.5.3. Spending on HIV testing and counselling

The spending on HTC, also known as HIV testing services (HTS), increased modestly over the three-year period, from ZAR 1.26 billion in 2021/22 to ZAR 1.40 billion in 2023/24, reflecting an overall rise of approximately 12% in nominal terms. This growth was primarily driven by a steady increase in public financing, which rose from ZAR 1.02 billion in 2021/22 to ZAR 1.29 billion in 2023/24 accounting for 92% of total HTC spending in the most recent year. In contrast, international financing for HTC declined sharply by over 50%, from ZAR 234 million in 2021/22 to ZAR 115 million in 2023/24, indicating a significant shift towards domestic funding responsibility. Contributions from domestic private entities remained negligible, consistently below ZAR 500,000 annually.

In terms of programmatic focus, the bulk of HTC spending was directed towards voluntary testing for the general population, which increased from 71% in 2021/22 to 77% in 2023/24, reinforcing a strong emphasis on widespread testing access. Only a small share of resources was allocated to key and vulnerable populations, with HTC for MSM showing growth from 0% to 1.5%, while services for sex workers, PWID, and inmates together remained below 5% in 2023/24. Testing for pregnant women (through the PMTCT sub-programme), which accounted for 3.1% in 2021/22, no HTC spending was specifically labelled as part of PMTCT program but may have been included in the public PMTCT prevention spend or under HTC not disaggregated in 2023/24. Additionally, non-disaggregated HTC spending made up a sizable proportion of 17% in 2023/24 highlighting persistent gaps in expenditure reporting that didn't provide disaggregated information on beneficiaries' groups of HTS. Overall, the presented data signal a continued prioritization of general population testing, growing reliance on public funding, and only gradual progress in reaching key and vulnerable groups through dedicated funding.

Figure 19. HTC spending by target population (2021/22 - 2023/24 ZAR, %)

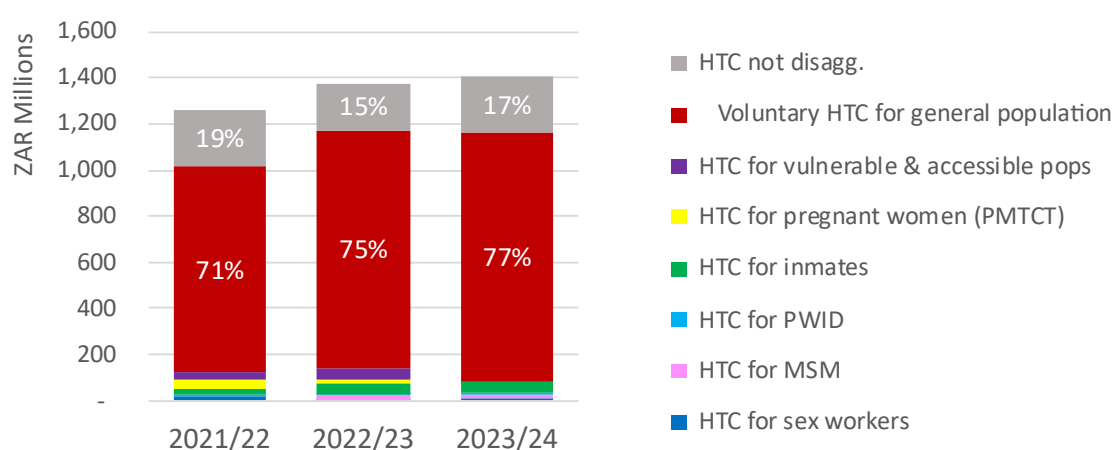
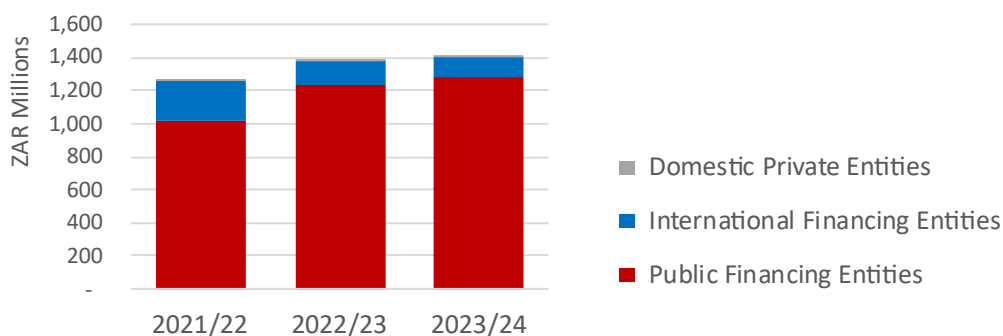
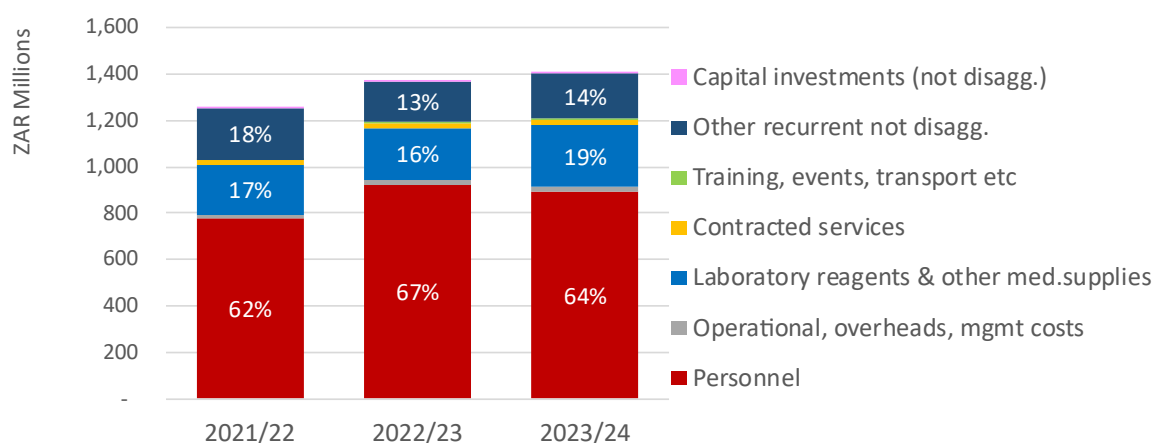


Figure 20. Financing entities for HIV testing and counselling (2021/22 - 2023/24, ZAR million)



The main cost driver for HIV testing and counselling (HTC) services across the three years was personnel, consistently accounting for the largest share of HTC spending (62%) in 2021/22, rising to 67% in 2022/23, before slightly dropping to 64% in 2023/24. This decline in 2023/24 appears to reflect a reduction in salary spending from public funds, possibly due to efficiency gains through increased self-testing and other differentiated models of delivery. The second-largest expenditure was on laboratory reagents and other medical supplies, which grew steadily from 17% in 2021/22 to 19% in 2023/24, indicating growing investment in essential testing materials. Another important component was "other recurrent costs not disaggregated," which accounted for 14% in 2023/24.

Figure 21. HTC expenditure by production factor (2021/22 - 2021/23, ZAR, %)



3.5.4. Spending on Programme Enablers and System Strengthening

The total spending on Programme Enablers and System Strengthening remained relatively stable over the three-year period from 2021/22 to 2023/24. The largest share of spending consistently went to Programme Administration and Management, which accounted for 83% in 2021/22, 80% in 2022/23 and 81% 2023/24, which concerningly results in limited proportions for other systems strengthening efforts. Strategic Information and Strategic Planning and Coordination were the next significant areas of investment, representing 10%, 14% and 13% respectively throughout the period. Public System Strengthening held a steady share of 4% annually, while Community System Strengthening accounted for 2% each year.

In terms of financing sources for programme enablers and systems strengthening, international entities contributed just over half, 56–62% of total spending over the period, while public financing entities contributed between 44% and 38%.

Figure 22. Programme enablers and systems strengthening sub-activities (2021/22 - 2023/24, ZAR)

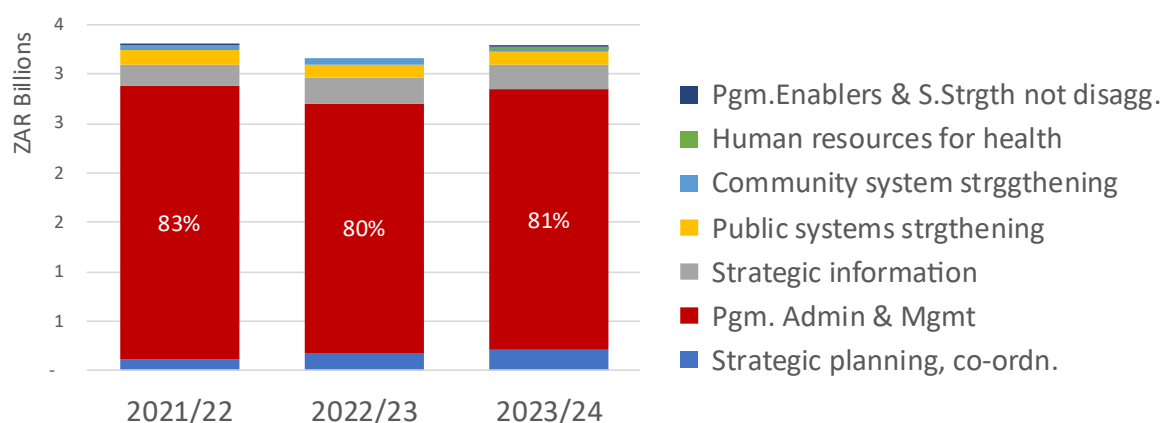
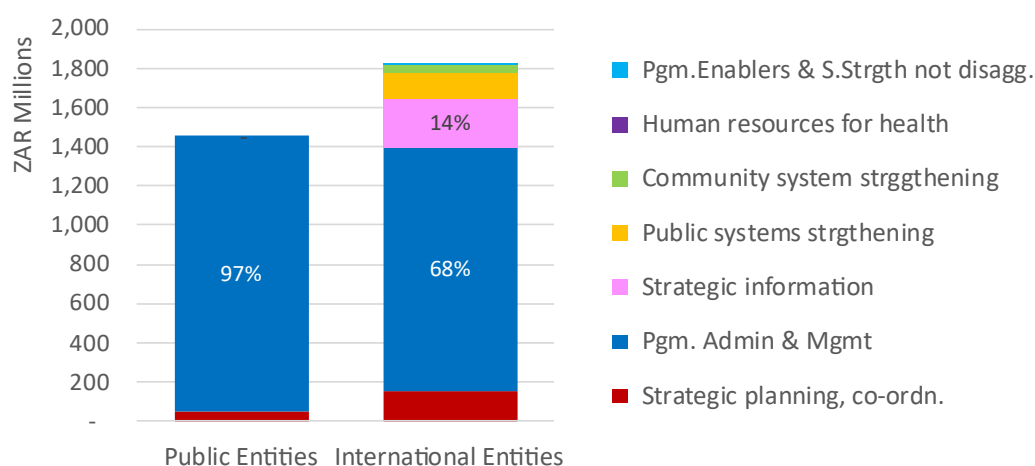


Figure 23. Programme enablers and systems strengthening activities by financing entity (2023/24, ZAR)



3.5.5. Spending on the other HIV programme areas

Figure 24 shows the expenditure on the other HIV programme areas, indicating the contributions of public and international financing entities to:

- Social protection and economic support (which includes OVC support).
- Social enablers.
- Development synergies.
- HIV-related research.

The spending on HIV Research, Development Synergies, and Social Protection & Economic Support remained modest, collectively accounting for just 6% of total HIV expenditure annually. Among these, Social Protection dominated, making up most of the spending though

its allocation declined slightly over the three years, with around 85–90% of the combined total with the majority of this allocated to non-OVC activities (81–84%), while support for OVC accounted for (16–19%) of the social protection spending. Development Synergies (Formative education to build-up an HIV workforce and Reducing gender-based violence) saw a sharp decline (over 50%), mainly due to reduced contributions from private and international sources, while HIV Research, though increasing, remained negligible in spending share. Spending on social enablers, including human rights activities and advocacy was negligible over the three-year period, reflecting minimal investment in these critical areas.

In terms of financing, public entities were the primary funders of Social Protection, covering 74% by 2023/24, while international donors played a leading role in Development Synergies and social enablers and fully funded HIV Research. Despite their relatively small share, these areas support long-term sustainability and impact of the HIV response, warranting ongoing attention to ensure alignment between investment levels and strategic importance.

Figure 24. Interventions for social protection, social enablers and development synergies (2021/22-2023/24, ZAR million)

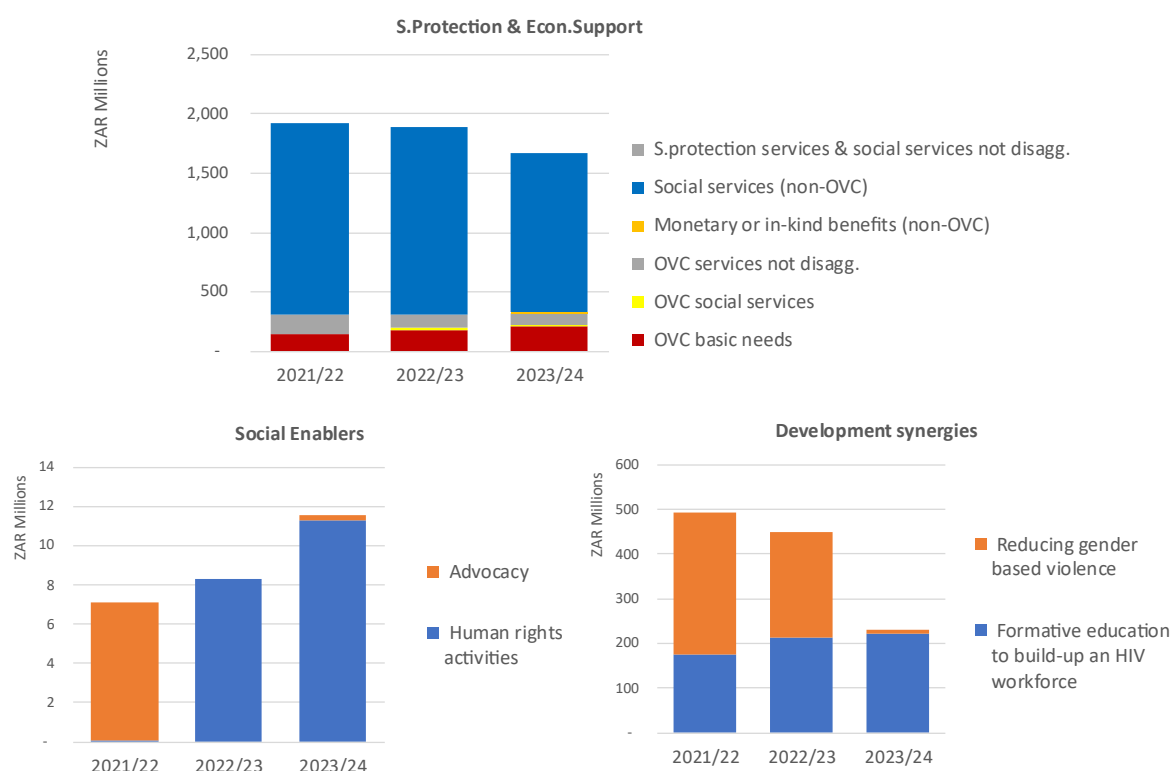
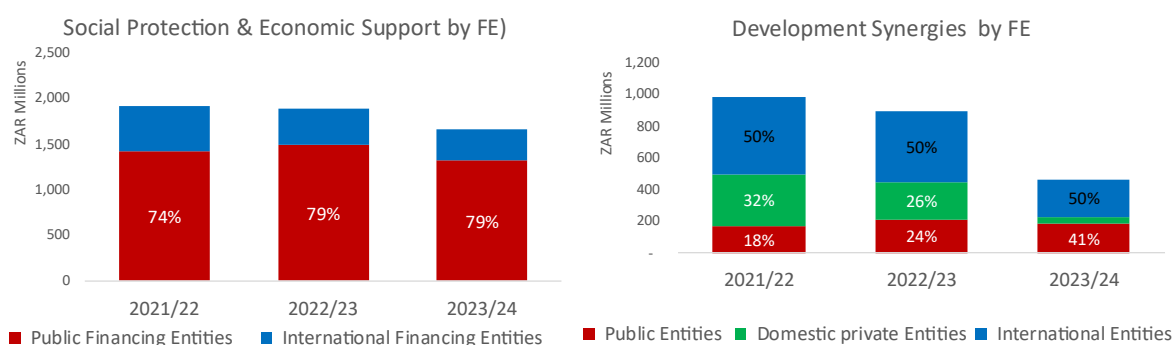


Figure 25. Financing entities for social protection, and development synergies (2021/22 - 2023/24, ZAR)



* PUBLIC funds are mainly DSD HIV, OVC and family community / children's services

3.6. Beneficiaries of overall HIV spending

An analysis of HIV expenditure distribution across beneficiary populations from 2021/22 to 2023/24 reveals a consistent prioritization of PLHIV, who accounted for approximately 73% to 75% of total HIV-related spending over the three-year period. This sustained allocation reflects an ongoing commitment to treatment and care for PLHIV.

Notably, there was a modest relative increase in expenditure directed toward the general population, rising from 8% in 2021/22 to 10% in 2023/24. This shift may indicate an emerging focus on broader HIV prevention initiatives beyond high-risk groups.

Conversely, key populations—comprising sex workers, MSM, PWID, and inmates of correctional facilities remained critically underfunded, receiving only 1% of total HIV spending throughout the period. Despite being among the most vulnerable and high-risk groups, investment in their targeted interventions has remained stagnant and minimal. Spending on vulnerable yet more accessible populations held relatively steady, with 7% allocated in 2021/22 and 6% in both subsequent years. Additionally, 9% to 10% of total HIV expenditure fell under the "not applicable" category, encompassing interventions not attributable to any specific beneficiary group.

Overall, while there are marginal shifts in allocation trends, the data in Figure 26 highlights a persistent underinvestment in key populations, underscoring a critical gap in addressing the needs of those most at risk and frequently underserved.

The pie chart on the right breaks down the 1% spending to key populations receiving HIV services. Sex Workers make up the largest share at 48%, followed by inmates at 19%, MSM at 13%, and PWID at 9%. An additional 11% of the funding is allocated to KPs that are not disaggregated, while transgender (TG) individuals receive minimal representation.

Figure 26: Total HIV spending by beneficiary population (2021/22-2023/24, ZAR million)

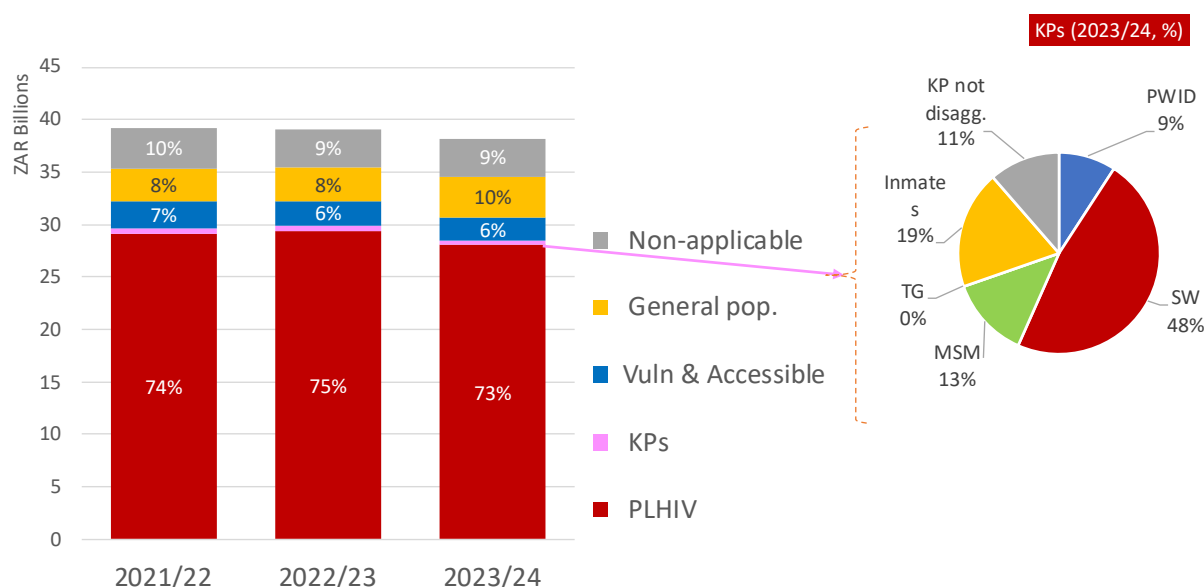


Table 11: HIV spending by sub-beneficiary population (2021/22-2023/24, ZAR, %)

Beneficiaries	2021	2022	2023	% of total exp. (2023/24)	% of sub-category (2023/24)
BP.01 People living with HIV	28,910,877,290	29,187,772,350	27,823,220,218	73%	
Adult and young people living with HIV	1,232,608,186	1,357,699,469	1,564,116,901	4.1%	6%
Children living with HIV	15,860,404	117,866,084	93,527,713	0.2%	0%
People living with HIV not disaggregated	27,662,408,700	27,712,206,798	26,165,575,604	69%	94%
BP.02 Key populations	546,632,131	485,827,457	468,485,363	1%	
Persons who Inject drug users (PWID)	57,814,904	53,023,170	42,891,328	0.1%	9%
Sex workers (SW)	194,450,630	124,693,602	222,460,430	0.6%	47%
Gay men and other men who have sex wi	80,596,676	115,950,917	61,014,454	0.2%	13%
Transgender/Trans	1,894,190	3,684,949	-	0.0%	0%
Inmates of correctional facilities (prisoner	66,585,136	85,404,674	88,788,207	0.2%	19%
Key populations not disaggregated	145,290,594	103,070,144	53,330,944	0.1%	11%
BP.03 Vulnerable, accessible and other targ	2,598,054,011	2,386,677,801	2,121,054,340	6%	
Orphans and vulnerable children (OVC)	635,025,489	578,924,104	521,867,862	1%	25%
New borns with un-determined HIV statu	38,471,246	18,515,657	-	0%	0%
Adolescent girls and young women	613,649,135	368,217,129	417,822,778	1%	20%
People attending STI clinics	-	15,079,399	17,151,996	0%	1%
Employees	2,548,062	852,475	204,170	0.0%	0%
Vulnerable, accessible population not dis	1,308,360,077	1,405,089,037	1,164,007,534	3%	55%
BP.04 General population	3,058,829,565	3,205,468,420	3,954,950,155	10.4%	
General adult population	920,494,745	1,044,154,218	983,621,122	2.6%	25%
Children and Youth	333,971,334	243,879,949	260,013,685	0.7%	7%
General population not disaggregated	1,804,363,486	1,917,434,254	2,711,315,348	7.1%	69%
Non applicable (ASC which do not have a s	3,820,626,594	3,624,314,103	3,566,767,783	9%	
Grand Total	38,935,019,590	38,890,060,132	37,934,477,858		

3.7. HIV Services Delivery Modalities (SDM)

HIV services delivery modalities (SDM) refer to the ways and means of providing HIV prevention, testing, treatment, and care services to the people who need them. In South Africa, there are two main types of HIV service delivery modalities: facility-based and community-based. Facility-based services are provided by health facilities, mainly the ART centre and laboratories in public hospitals. On the other hand, community-based services are mostly provided by community-based organizations, including peer groups, and outreach workers, that operate outside the formal health system and offer HIV services in community settings, such as homes, communities, and hotspots.

In 2023/24, facility-based interventions represented the largest share of HIV spending, accounting for 65% of the total, while only 12% of spending was directed toward services delivered at home and community settings, reducing from 15%. Delivery modalities that were not disaggregated constituted 14% of spending, highlighting limitations in data classification from certain sources.

Interventions labelled as "SDM non-applicable" is used for transversal interventions such as program enablers, systems strengthening, research, and development synergies, accounted for 9% of total HIV expenditure. This spending pattern remained largely consistent with previous years.

Table 12: Spending on service delivery modality (2023/24, ZAR)

Service delivery modalities	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
SDM.01 Facility-based service modalities	23,692,133,590	25,488,941,502	24,890,576,244	60%	65%	65%
Health Facility-based: Outpatient	23,210,096,446	25,028,448,852	24,384,393,429	59%	64%	64%
Health Facility-based: Inpatient	188,777,361	204,661,836	240,153,962	0%	1%	1%
Non-health facility-based	293,259,784	255,830,814	266,028,853	1%	1%	1%
SDM.02 Home and community-based service	5,729,040,678	5,115,335,372	4,593,831,019	15%	13%	12%
Community-based: center	146,975,751	177,529,448	208,343,182	0%	0%	1%
Community-based: outreach	3,800,000	3,800,000	62,551,188	0%	0%	0%
Community-based: home-based	3,333,949,316	2,600,273,209	1,932,561,879	9%	7%	5%
Home and community-based not disag.	2,181,895,029	2,314,115,667	2,390,374,769	6%	6%	6%
Other Home and community-based n.e.c.	62,420,581	19,617,048	-	0%	0%	0%
SDM.03 Self-service by the client	-	22,714	187,286	0%	0%	0%
SDM.05 Non applicable (ASC which do not have a spe	3,820,626,594	3,624,314,103	3,534,492,054	10%	9%	9%
SDM.98 Modalities not disaggregated	5,947,048,397	5,050,316,419	5,256,101,583	15%	13%	14%
Grand Total	39,188,849,259	39,278,930,110	38,275,188,187	100%	100%	100%

3.8. Production factors of overall HIV spending

Figure 27 presents the production factors for the total HIV spending in the country. The biggest cost driver in the HIV response being personnel accounting for 41%, 40% and 42% respectively for 2021/22, 2022/23, and 2023/24, followed by medical products and supplies account for 37% in 2021/22 and 38% for the later years respectively. Recurrent expenditure not disaggregated accounted for the third largest share representing 11%, 9% and 7% respectively over the study period. A closer analysis of the "Medical Products and Supplies" category reveals that two key cost drivers dominated this area in the 2023/24 financial year: ARVs, which accounted for 45% of spending in this category, and laboratory reagents and

materials, which represented 40%. While both items exhibited a fluctuating trend over the past three years, their significant share highlights their critical role in the HIV response. In 2023/24, South Africa's high expenditure on antiretroviral therapy amounting to 17% of total HIV spending and on laboratory reagents and materials (15%) reflects the country's substantial HIV burden and the ongoing need for sustained treatment and diagnostics capacity.

Figure 27: Total HIV expenditure by production factor (2021/22 - 2023/24, ZAR, %)

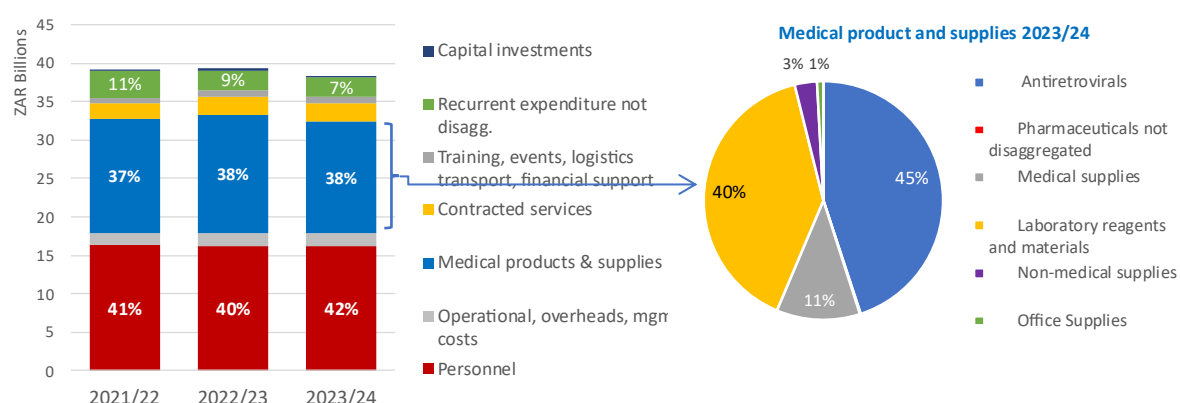


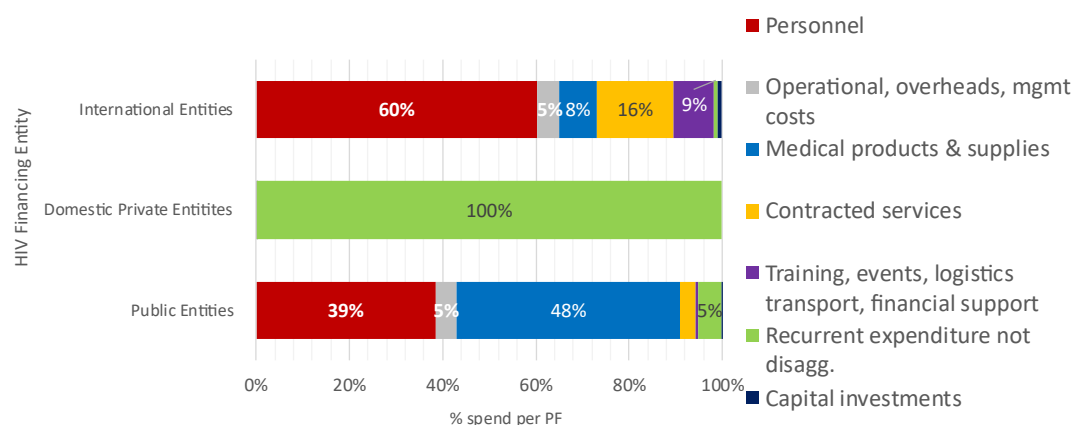
Table 13: Total HIV expenditure by production factor (2021/22-2023/24, ZAR million)

Production Factors of HIV spending (ZAR)	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
Personnel	16,307,440,887	16,220,757,453	16,145,683,332	42%	41%	42%
Operational, overheads, mgmt costs	1,537,987,698	1,681,269,052	1,698,052,888	4%	4%	4%
Medical products & supplies	14,943,625,032	15,369,972,517	14,586,558,552	38%	39%	38%
Contracted services	1,970,373,886	2,334,222,775	2,336,615,746	5%	6%	6%
Training, events, logistics transport, financial	763,760,362	851,922,894	831,666,737	2%	2%	2%
Recurrent expenditure not disagg.	3,508,272,633	2,645,076,280	2,527,193,514	9%	7%	7%
Capital investments	157,388,761	175,709,139	149,417,416	0%	0%	0%
Total HIV (ZAR)	39,188,849,259	39,278,930,110	38,275,188,187	100%	100%	100%

In 2023/24, the distribution of HIV spending across production factors varied significantly by financing entity. Among public entities, the largest share of expenditure was allocated to medical products and supplies, accounting for 48% of total public HIV spending, followed by personnel costs at 39%. This reflects the strong role of government in sustaining treatment and care, particularly through procurement of antiretroviral medicines and the staffing of health facilities. It is important to note that public sector salary contributions to HIV services may be underestimated, as personnel in primary health care (PHC) facilities often deliver integrated services and are not specifically designated under HIV programmes. Consequently, their proportional contribution to HIV service delivery was not fully accounted for. By contrast, international entities spent most of their HIV resources on personnel costs (60%), while allocating only 8% to medical products and supplies, likely due to their focus on technical assistance, capacity strengthening, and community-based service delivery. A further 16% of internationals' expenditure went toward contracted services, including implementation support and outsourced interventions, with 9% directed to training, events, logistics, transport, and financial support. These figures highlight the complementary roles played by external partners in human resources, technical support, and program implementation.

Similarly, operational, overhead, and management costs were modest 5% for both financing streams—indicating relatively efficient administrative spending. The domestic private entities, primarily consisting of insurance schemes, did not report disaggregated data by production factor; 89% of their expenditures were captured under "recurrent expenditure not disaggregated", making it difficult to assess their actual spending components.

Figure 28. HIV financing entities' production factors (2023/24, %)

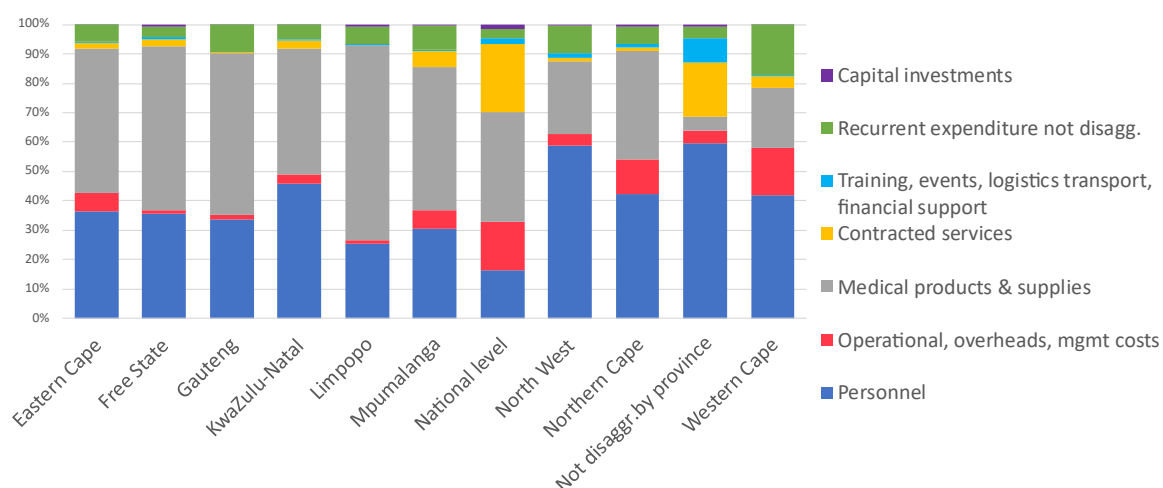


The provincial analysis of HIV spending by production factors for 2023/24 is based on data from the public sector and health insurance schemes only. Other financing sources did not report spending disaggregated by province and are therefore excluded from this breakdown. Medical products and supplies, along with personnel, were the primary cost drivers in most provinces (Figure 29). Medical products and supplies represent the largest spending category in all provinces except the Northern Cape, Western Cape and North West, accounting for approximately 40–60% of total HIV expenditures. This reflects the significant investment in antiretroviral treatment and related consumables across the health system. Personnel costs follow closely, making up around 30–45% in most provinces. The Northern Cape, Western Cape and North West provinces allocated a notably higher proportion to personnel, exceeding 50%, indicating a heavier reliance on human resources for service delivery in those regions.

Other spending categories show more modest shares and vary by province, while the operational, overhead, and management costs ranged from around 5–20%, with higher proportions observed at the national level and in the North West, the recurrent expenditure not disaggregated was prominent in the Western Cape, accounting for a sizable portion of spending, indicating gaps in expenditure breakdown. Contracted services¹³ and training-related costs are relatively higher at the national level and in "not-disaggregated by province" or unspecified provincial allocations, suggesting these functions are more centralized.

Figure 29. Provincial HIV spending by production factor (2023/24, %)

¹³ The contracted services from public spending include mainly the outsourced services like Transport & Operational Logistics, Facilities & Infrastructure Maintenance, Professional & Contracted Services and IT, Data & Communication Systems



4. Adequacy of Funding, Prioritisation, Sustainability and Efficiency Gains

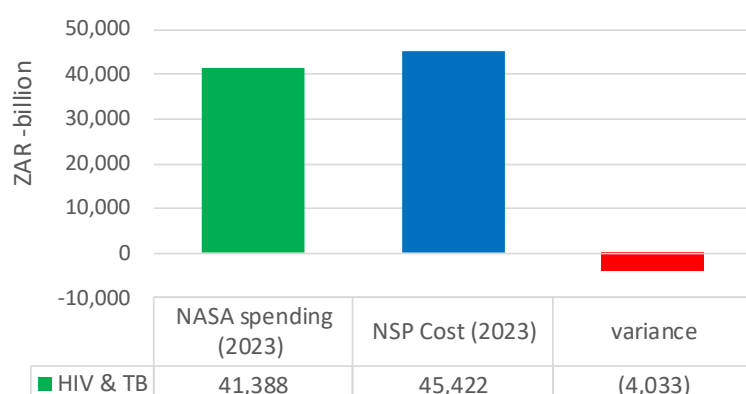
This analysis compares the estimated resources outlined in South Africa's National Strategic Plan for HIV, TB and STI for the fiscal year 2023/24 with actual expenditures reported through the NASA for the same year. The objective is to evaluate the extent to which financial allocations toward HIV and TB interventions align with the priorities and targets set out in the NSP. The comparison is limited to those interventions for which both NSP cost estimates and actual NASA expenditures were available and comparable.

The most recent NSP for HIV, TB, and STIs covers the period from 2023/24 to 2027/28 and projects an estimated implementation cost of ZAR 45.4 billion for HIV and TB-related interventions in its first year. In comparison, the NASA recorded actual expenditures for HIV and TB of ZAR 41.7 billion for 2023/24, suggesting a possible overall financing gap of approximately 9%, for both HIV and TB interventions.

Focusing specifically on HIV-related interventions, the NSP projected a total requirement of ZAR 41.6 billion for 2023/24. However, NASA data indicate actual spending reached only ZAR 38.3 billion, resulting in a possible financing shortfall of about 8%. This small possible gap entails that South Africa has been mostly managing to mobilise resources for its extensive HIV programme. Similarly, for TB-related interventions, the NSP estimated a resource need of ZAR 4.6 billion, while recorded expenditures amounted to ZAR 3.3 billion. This translates to a more substantial potential gap of 27%, pointing to a potential misalignment between projected resource needs and actual spending. However, further examination of the costing assumptions

and methodology used in the NSP is essential to determine the accuracy and details of this potential gap.

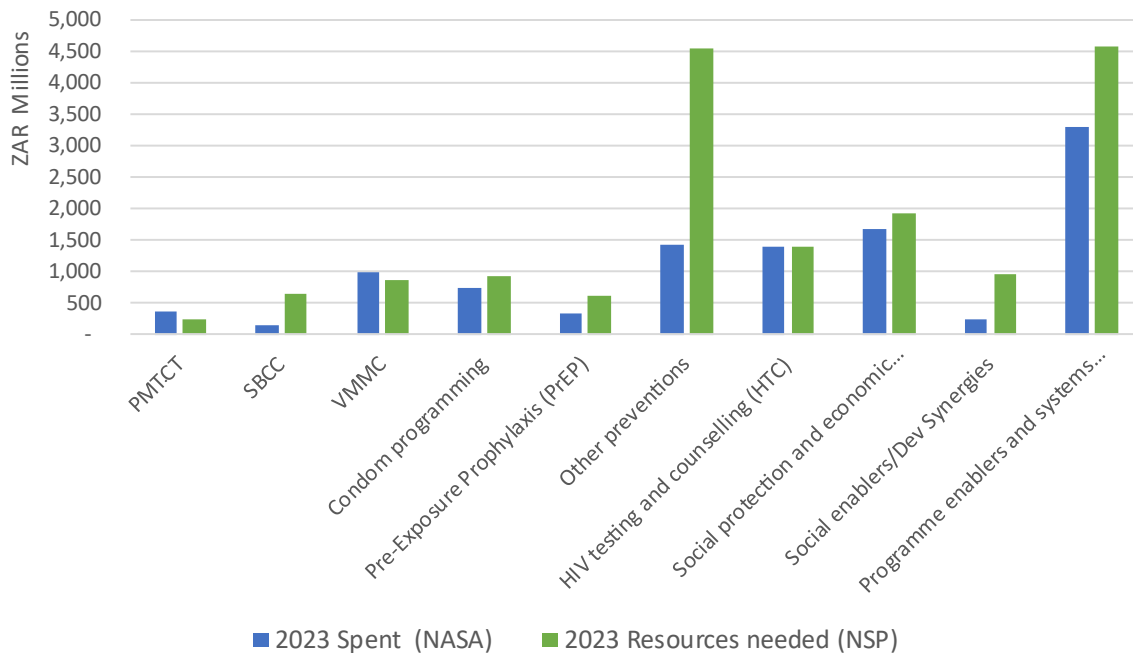
Figure 30. Comparison of HIV and TB spending with estimated NSP costs for HIV & TB (2023/24, ZAR)



4.1. Adequacy and prioritization of past expenditure

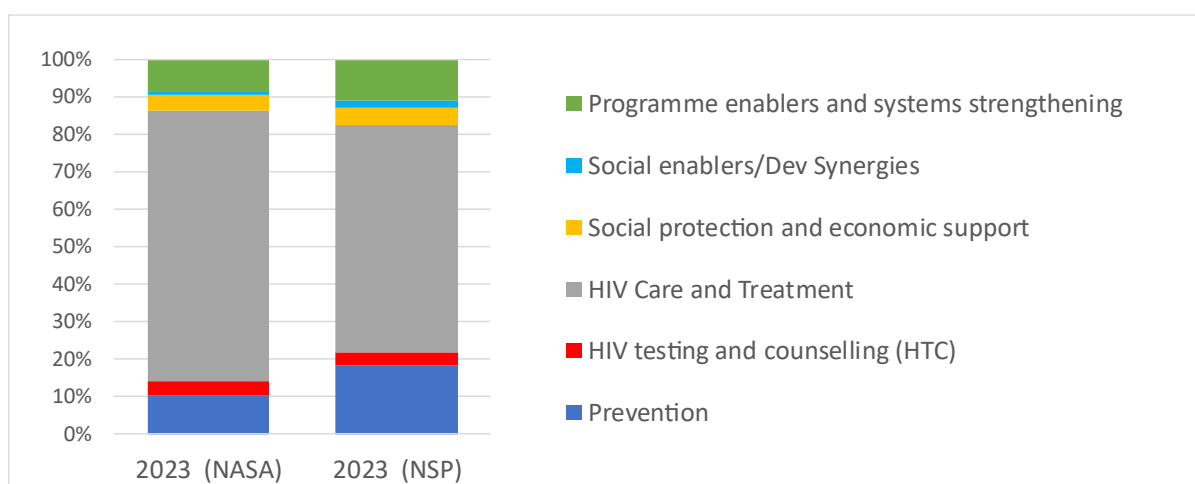
Figure 31 below compares 2023 HIV spending across key programmatic areas against the estimated resource needs outlined in South Africa's NSP for HIV, TB and STIs-2023-2028. The analysis reveals possibly significant funding gaps in several prevention programs, including SBCC, PrEP, and other prevention interventions, with shortfalls ranging from 47% to over 70%. This suggests that critical prevention efforts may be severely underfunded, potentially compromising the country's ability to curb new infections. Similarly, Social Enablers and Programme Enablers show notable gaps of 74% and 28%, respectively, which may undermine supportive systems needed for effective implementation. Social protection also exhibited a gap of 14%, which could affect efforts to mitigate the socio-economic drivers of HIV. On a more positive note, spending on HTC and VMMC were closely aligned with NSP estimates (near 1% surplus), and area like Condom Programming demonstrated smaller gaps under 20%, indicating relatively better alignment. The NSP other preventions include mainly Community-based and community-led outreach Integrated school health services, while NASA include mainly HPV and prevention not disaggregated.

Figure 31: Comparison of HIV spending with estimated NSP costs – excluding ART (2023/24, ZAR millions).



A proportional comparison between the 2023 NASA and the NSP estimated resource needs provides insight into the prioritization of intervention areas and allocative efficiencies (Fig.32). HIV Care and Treatment is closely matching its proportion in the NSP estimates. This suggests more accurately aligned with strategic prioritization and confirms that treatment continues to be a central focus of the national response. HTC also shows a proportional alignment between actual spending and NSP projections. Prevention, on the other hand, reveals a notable discrepancy. While the NSP assigns it a significantly larger share of resources, NASA data shows a much smaller proportion of actual spending. This shortfall suggests that prevention was under-prioritized in practice, which could undermine long-term epidemic control efforts. Social Protection and Economic Support and Social Enablers/Development Synergies were also underfunded relative to their planned allocation in the NSP. Their minimal representation in NASA spending reflects a lower degree of prioritization than anticipated, despite their importance in addressing structural and socio-economic drivers of HIV. Conversely, Programme Enablers and Systems Strengthening received a slightly lower share of actual expenditure compared to NSP plans.

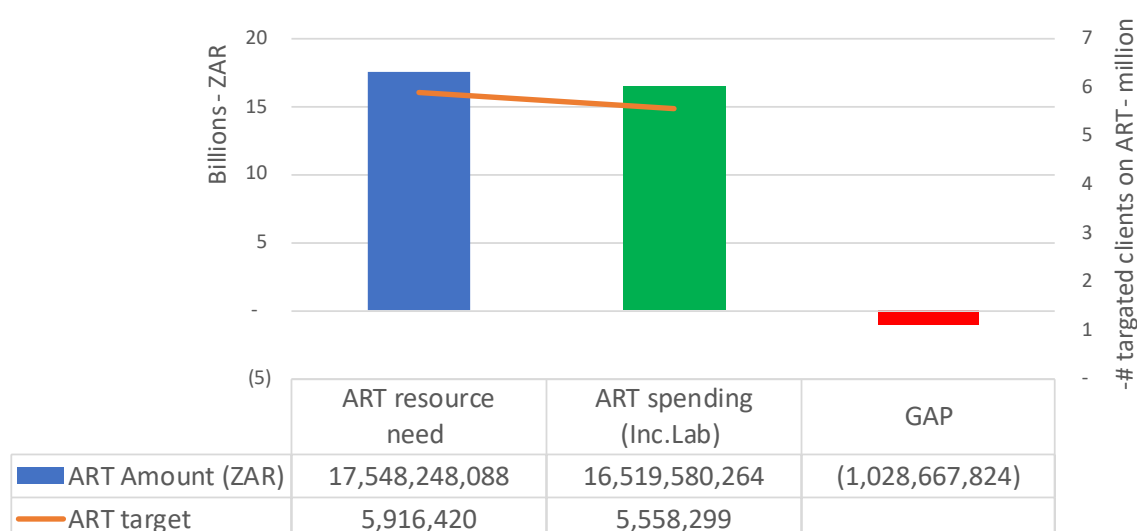
Figure 32: Proportional NSP cost estimates versus expenditure (2023/24, %)



Note: The high proportion of spending on Care and Treatment (C&T) in the 2023 NASA may reflect the inclusion of PEPFAR-funded research activities, which are not separately labeled in expenditure reports and likely classified under C&T. Since these research investments may not be fully captured in the NSP cost estimates, the comparison could be misleading. Thus, it cannot be conclusively stated that there was over-investment in C&T.

For ART specifically, excluding all other 'care and treatment' expenditures (which exceed ART costs), the comparison indicates that the NSP's estimated ART costs for 2023/24 were slightly higher (6%) than the actual ART spending (Figure 33). However, this discrepancy does not necessarily point to a funding gap—it may instead reflect the achievement of cost efficiencies, such as reduced ARV prices (see Fig 33) and fewer patients were started on treatment than expected because the HIV positivity rate declined which contributing further to the reduced spending.

Figure 33. Estimated NSP ART costs and realised expenditure (2023/24, ZAR)



4.2. Areas of potential technical efficiencies

For specific interventions, the unit of expenditure per output has been calculated to highlight where efficiency gains may have been made over the three-year period. Similarly, variations in units of expenditure between provinces may indicate equity or inequity in resource distribution, and/or areas where further savings could be made. The analysis is limited to interventions where discrete outputs can be directly attributed to the expenditure, such as DOH's ART, VMMC, HTC, and condom programmes, which are presented here, split by production factor to show the main cost drivers for each intervention. This simple analysis does not attempt to evaluate the many factors which may influence technical efficiencies.

Department of Health- ART programme

Figure 34 illustrates the DoH annual per-person expenditure on ART (in Rand, left axis), broken down by key cost components. It also shows the number of individuals remaining on ART at the end of each year (right axis), with the blue trend line reflecting a steady annual increase of 3% over the three-year period. The average cost per ART patient declined by 5%, from R3,516 (US\$238) in 2021/22 to R3,349 (US\$205) in 2022/23, and by a further 11% to R2,972 (US\$161) in 2023/24, closely aligning with the NSP's estimated unit cost of R2,966. This downward trend was largely driven by a 24% reduction in ARV costs (reaching USD 64 per person per annum by 2023/24) and a 17% decrease in personnel expenses, likely a result of scaling up differentiated models of ART delivery, which streamline service provision. However, these savings were partially offset by a 12% rise in the cost of diagnostic reagents (reaching USD 54 per person per annum by 2023/24) and a 46% increase in spending on contracted external services. To realize greater economies of scale amid growing ART patient numbers, it will be essential to negotiate lower laboratory costs and continue to promote wider adoption of DTG-based ARV regimens.

Figure 34: DOH ART spending per person on ART by production factor (2021/22-2023/24, ZAR)

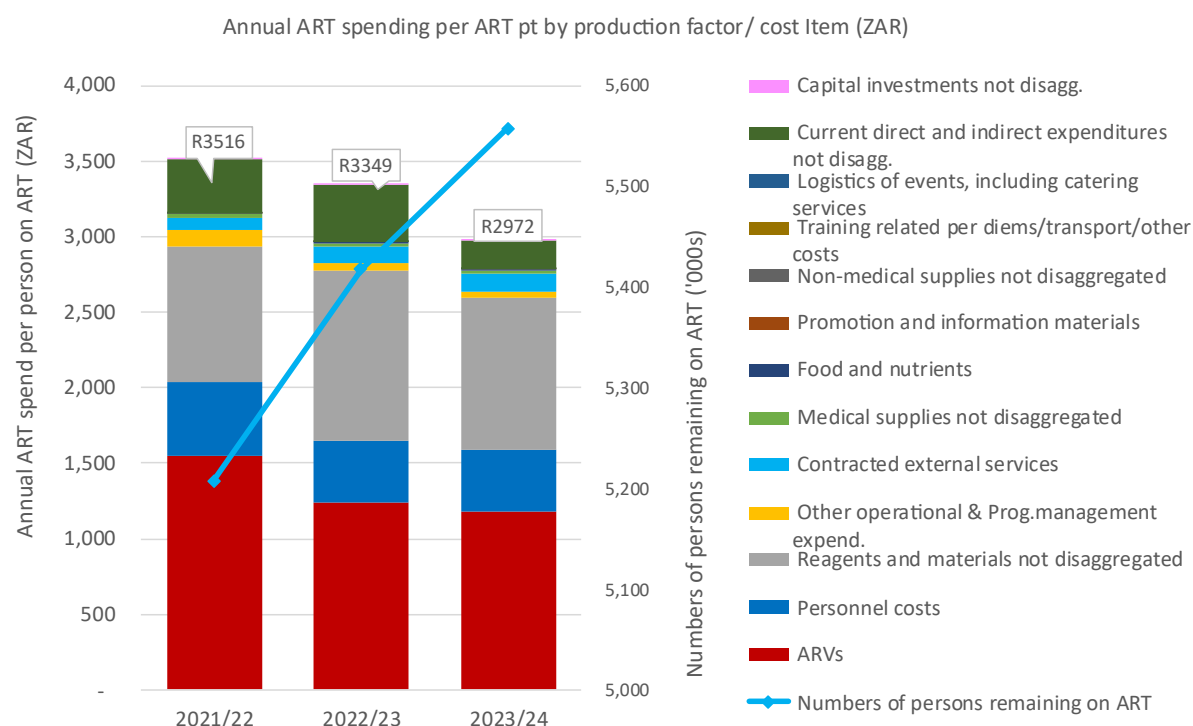


Table 14: Spending per person on ART by production factor (2021/22-2023/24, ZAR million)

Spending per person on ART by production factor (cost item)	2021/22 (ZAR)	2022/23 (ZAR)	2023/24 (ZAR)	2023/24 USD
ARVs	1,544	1,236	1,179	63.84
Personnel costs	495	415	410	22.23
Reagents and materials not disaggregated	895	1,128	1,003	54.34
Other operational & Prog.management expend.	112	42	44	2.37
Contracted external services	81	111	118	6.39
Medical supplies not disaggregated	25	26	25	1.37
Food and nutrients	2.8	4.2	3.7	0.20
Promotion and information materials	0.0	0.0	0.1	0.01
Non-medical supplies not disaggregated	0.0	0.0	0.4	0.02
Training related per diems/transport/other costs	0.3	1.5	2.4	0.13
Logistics of events, including catering services	0.1	0.4	0.5	0.03
Current direct and indirect expenditures not disagg.	359	385	185	10.01
Capital investments not disagg.	1.3	1.2	1.2	0.07
DOH spending per person remaining on ART (ZAR)	3,516	3,349	2,972	161.00

An analysis of SAG HIV C&T relative to the number of people living with HIV (PLHIV) per province, indicates that an average of R3,105 was spent per PLHIV in 2023/24 and, apart from North West, Eastern Cape and Northern Cape, all provincial spend per ART patient were close to this average – implying equity and similar efficiencies across provinces. KwaZulu-Natal and Gauteng recorded the highest total spending on C&T (over R5 billion and R6 billion, respectively), reflecting their large HIV burdens and large ART patient populations. KwaZulu-Natal, possibly due to high volumes of ART patients, had achieved one of the lowest per-person spending on ART at around R2,787, suggesting the possibility of economies of scale in service delivery. In contrast, the Northern Cape reported the highest per person spending on ART, reaching approximately R4649, which is far above the national average. This likely reflects higher unit costs of service delivery due to geographic dispersion and smaller patient volumes. These provincial discrepancies highlight the importance of assessing not just total expenditure but also efficiency and equity in resource use across regions. (Figure 35 below).

Figure 35. SAG spending on HIV C&T by PLHIV per province (2023/24, ZAR)

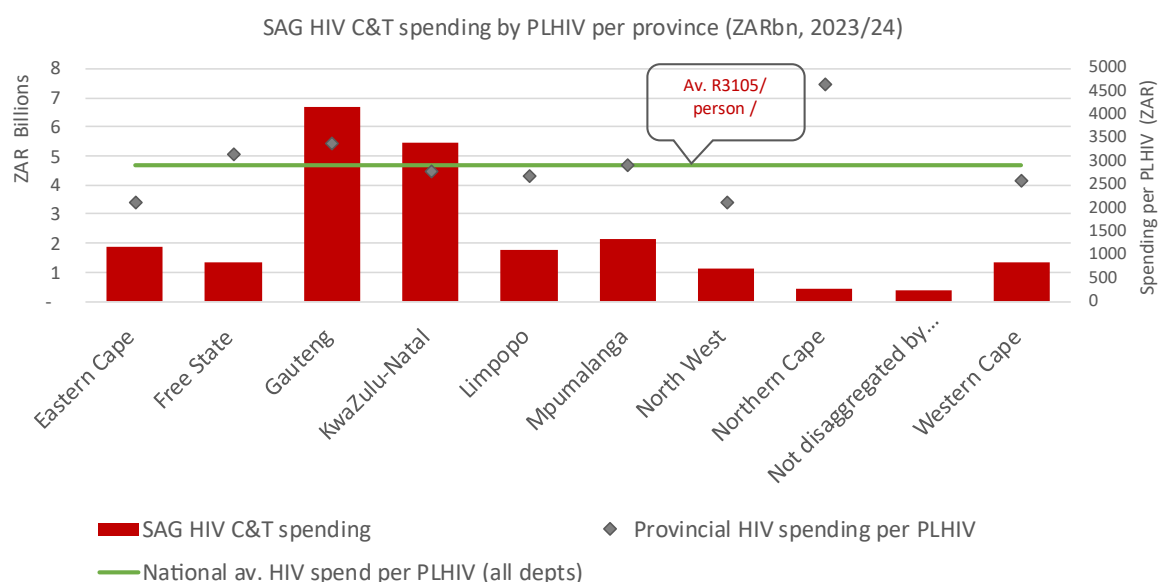
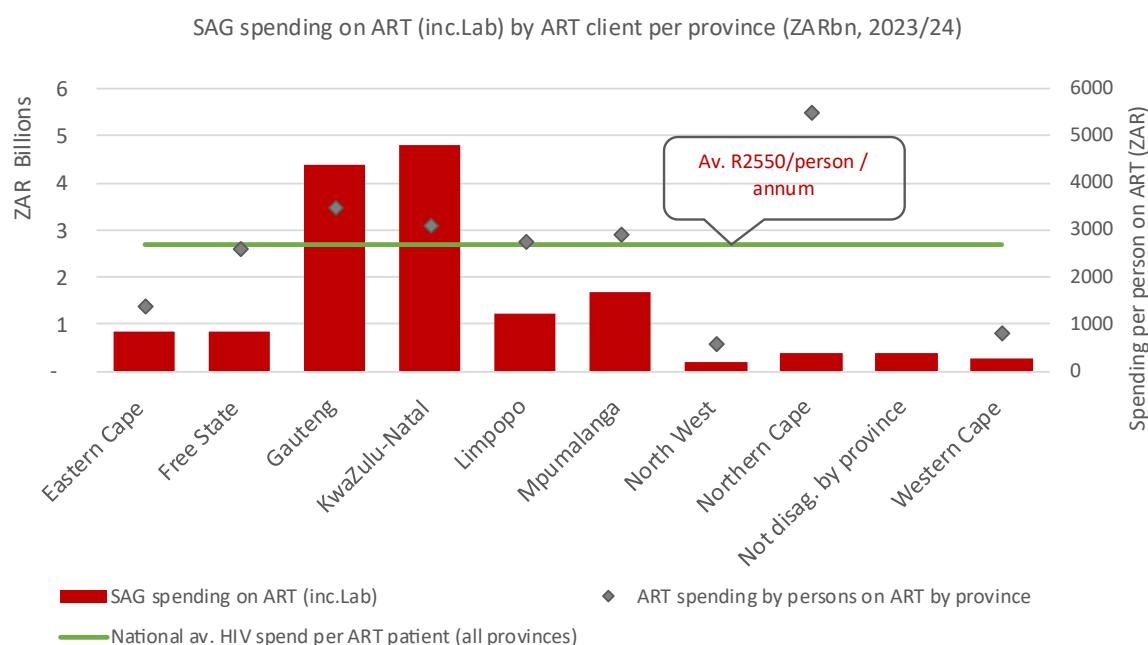


Figure 36 focuses specifically on ART expenditures relative to the number of people remaining on ART (TROA). This analysis allows for benchmarking ART program costs across provinces, identifying outliers where spending per ART client is unusually high or low. This can inform resource reallocation, highlight potential cost-saving opportunities, and support efforts to standardize care quality and efficiency.

Figure 36. SAG spending on ART vs. TROA Numbers per Province (2023/24, ZAR)



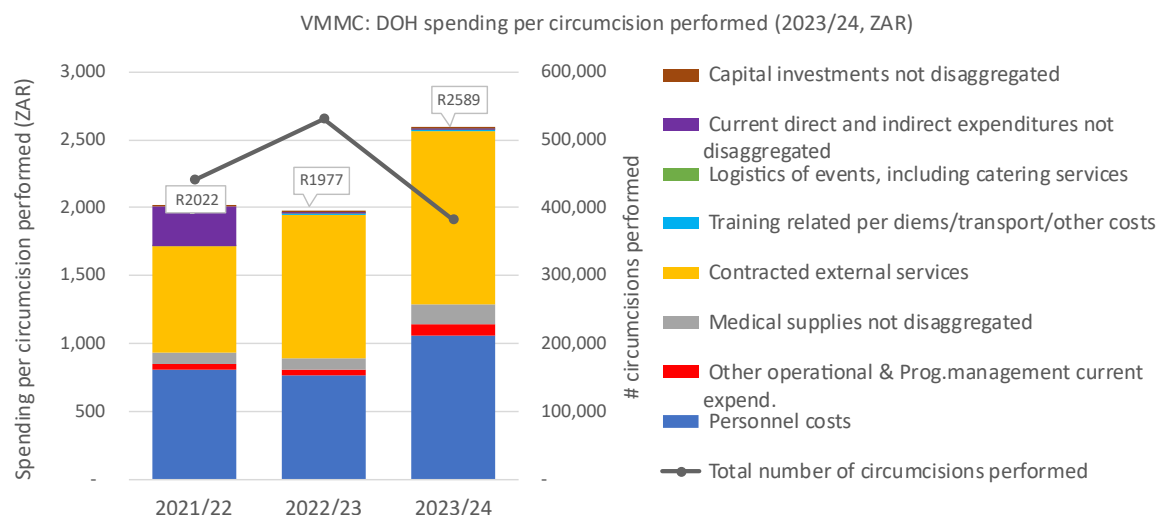
Department of Health - Voluntary Medical Male Circumcision programme

The VMMC programme appears to have encountered inefficiencies in scale over the reviewed period. As shown in the figure 37, while the total number of circumcisions increased in 2022/23, they dropped again in 2023/24 by approximately 18%, potentially undermining programme efficiencies. The average cost per VMMC performed declined by 2%, from R2,022 (US\$137) in 2021/22 to R1,977 (US\$121) in 2022/23, then increased and by 31% to R2,589 (US\$140) in 2023/24.

Despite relatively stable total expenditure, the cost per circumcision remained high, with no clear evidence of cost-efficiency gains. Notably, contracted external services¹⁴ and personnel costs continue to dominate spending, and their share does not appear to decrease in line with reductions in circumcision volumes. This suggests that much of the spending is either fixed or not adequately responsive to service uptake. Moreover, persistent spending on medical supplies and operational categories like logistics and training, despite fewer procedures being performed, raises concerns about resource optimization. The health department may need to revisit service delivery models, consider volume-based costing strategies, and enhance demand generation efforts to improve efficiency and cost-effectiveness.

¹⁴ the contracted services from public spending include mainly the outsourced services like Transport & Operational Logistics, Facilities & Infrastructure Maintenance, Professional & Contracted Services and IT, Data & Communication Systems

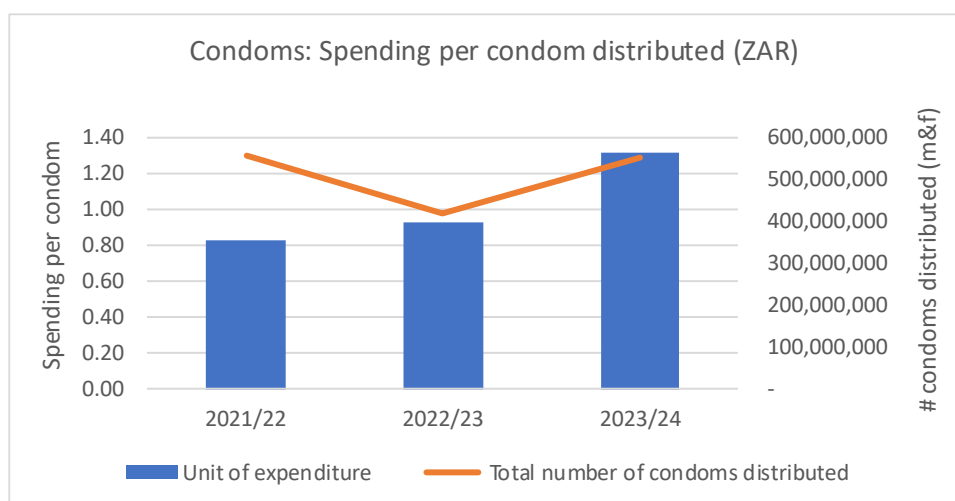
Figure 37. DOH spending per male circumcision (2021/22-2023/24, ZAR)



Department of Health- Condoms programme

Figure 38 illustrates trends in the DOH expenditure on condoms between 2021/22 and 2023/24, with a focus on unit cost per condom distributed and the total number of condoms distributed annually. Noting that the analysis reflects spending on commodities only as the production factor, which may result from limitations in the breakdown of production factors (PF), particularly the lack of personnel and other recurrent costs. In 2021/22, with over 559 million condoms distributed at a unit cost of ZAR 0.83, the programme demonstrated strong cost-efficiency. However, in 2022/23, distribution dropped by 25%, while the unit cost rose by 12%, indicating reduced scale and higher per-unit spending. By 2023/24, although distribution nearly returned to 2021/22 levels, the unit cost surged by 41.9% to ZAR 1.32, and total spending increased by 87.8%, far outpacing distribution growth. This trend reflects declining economies of scale, where increasing costs are not matched by proportional increases in output, possibly due to procurement of higher-cost condoms or inefficiencies in supply or pricing, highlighting the need for more detailed cost breakdowns to better assess efficiency.

Figure 38: DOH spending per condom distributed (2021/22-2023/24, ZAR)



Department of Health- HIV testing services

The NDOH reported a continued rise in the number of clients tested for HIV, including antenatal clients, increasing from approximately 17.6 million in 2021/22 to over 20 million in 2023/24. Over the same period, total HTC spending rose from R1.2 billion to R1.4 billion, with the cost per client tested only slightly increased, averaging around R70 per test across the three years. This stability, in the context of rapidly rising testing volumes, is somewhat surprising as greater volumes of test kits and reagents could have led to decreased prices and economies of scale, but this does not appear to have occurred.

Personnel costs remained the largest share of HTC spending, and increased slightly which might have been due to annual salary inflation-related increases. The proportion of spending on test kits and medical supplies remained steady, suggesting limited change in procurement costs. Meanwhile, non-disaggregated and indirect costs such as office supplies and capital investments remained moderate and reduced slight in the second year. There might have been improved efficiency through more optimized service delivery models, such as expanded use of community health workers and/ or self-testing, and more streamlined operations.

Figure 39. DOH spending per client tested (2021/22-2023/24, ZAR)

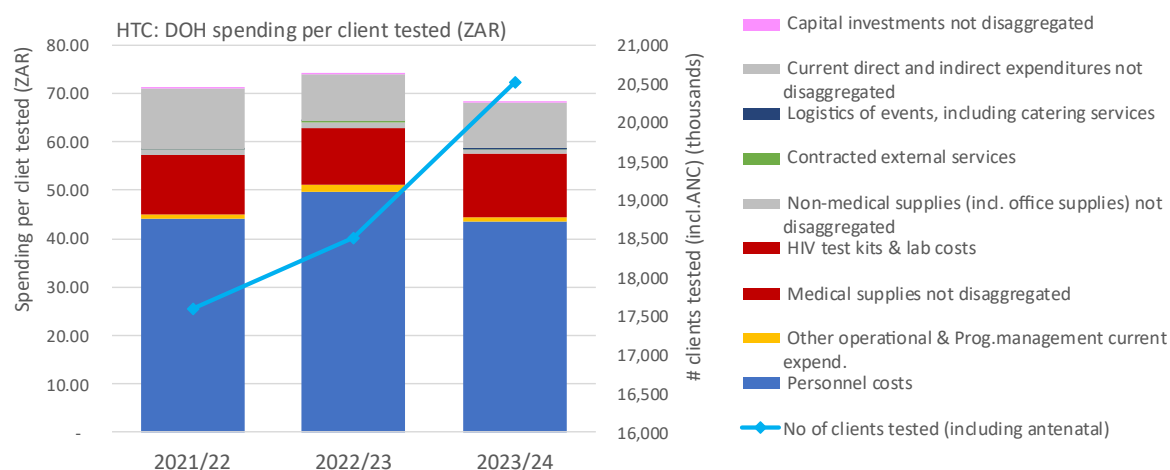


Table 15: Summary of DOH's expenditure versus outputs (2021/22-2023/24, ZAR)

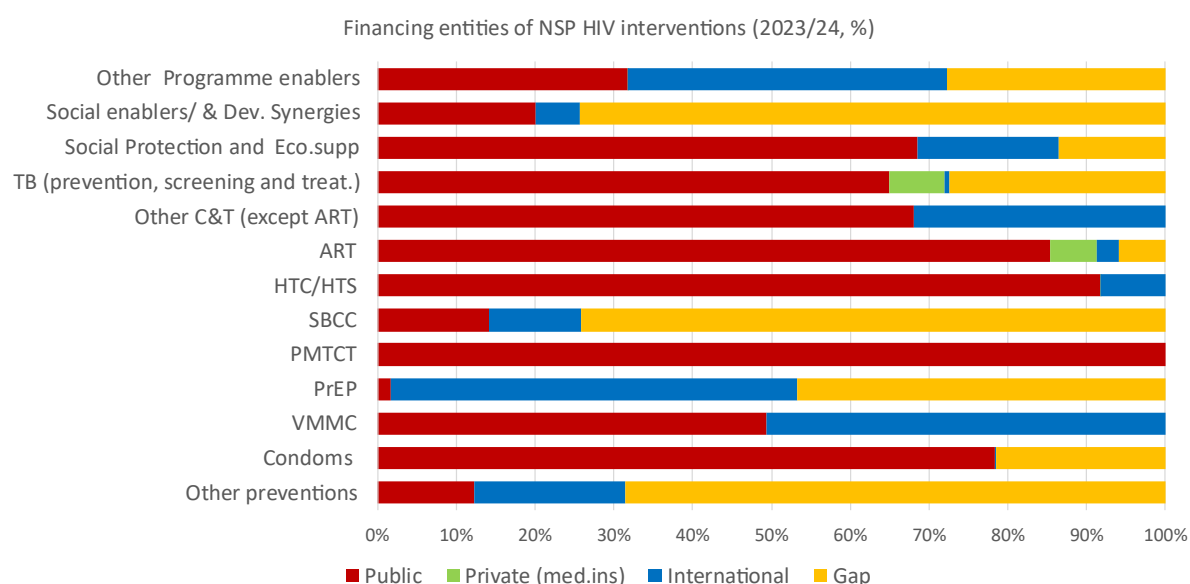
DOH programme unit/spend (ZAR)	2021/22	2022/23	2023/24
ART			
ART Spending	18,309,476,644	18,146,766,771	16,519,580,264
ART patients remaining in care (TROA)	5,207,831	5,418,394	5,558,299
ART unit spend	3,516	3,349	2,972
Condoms (male & female)			
Condoms Spending	462,492,688	388,369,215	729,101,929
Condoms distributed	559,632,694	418,321,580	554,043,106
Condom unit spend	0.83	0.93	1.32
VMMC			
VMMC spending	890,713,475	1,049,885,904	989,078,061
VMMC performed	440,419	531,153	381,970
VMMC unit spend	2,022.42	1,976.62	2,589.41
HTC			
HTC spending	1,257,150,416	1,375,165,609	1,404,158,397
Tests performed	17,598,704	18,516,584	20,516,584
HTC unit spend	71.43	74.27	68.44

Financing entities of NSP HIV interventions: sustainability issues

The Figure 40 provides a comparative analysis of the different financing entities contributions to the NSP interventions estimated costs in 2023/24, and their potential funding gaps, highlighting potential sustainability risks in the event of shifts or reductions in funding from development partners.

This analysis underscores the critical role of international funding in sustaining several HIV intervention areas, particularly in prevention and support services. However, the visible potential funding gaps in certain key areas (such as PrEP, SBCC and TB services) raise concerns about past funding shortfalls for those interventions, and the future potential impact of reduced donor funding on the NSP's ability to maintain and scale up critical HIV interventions. Strengthening domestic financing, exploring innovative funding mechanisms, and enhancing program efficiencies will be vital to mitigate these risks and ensure sustainable HIV response efforts.

Figure 40: Proportional contributions of financing entities and potential funding gap per NSP intervention (2023/24, %)



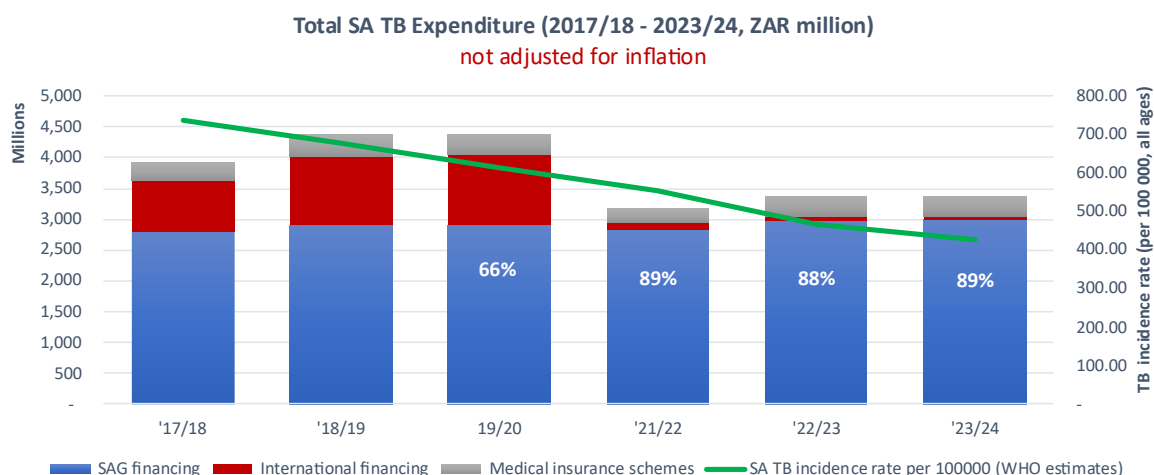
Note: The NSP other preventions include mainly Community-based and community-led outreach Integrated school health services, while NASA include mainly HPV and prevention not disaggregated

5. Key NASA+ TB Findings

The figure 41 illustrates South Africa's total tuberculosis (TB) expenditure from 2017/18 to 2023/24 (in ZAR millions), alongside the estimated TB incidence rate per 100,000 population (WHO estimates).

Between 2017/18 and 2023/24, South Africa's total TB expenditure fluctuated, peaking around 2018/19 and 2019/20 at over ZAR 4 billion before declining and stabilizing above ZAR 3 billion in the later years. While overall funding decreased slightly, there was a notable shift in the composition of financing: the share of domestic funding (SAG financing) increased substantially from 66% in 2019/20 to 89% by 2021/22 and remained high thereafter, reflecting stronger national ownership of the TB response. At the same time, international financing appeared to decline markedly, though this may be partially explained by data limitations specifically, TB spending may be underestimated in this assessment, as some data from USAID and CDC that did not flow through PEPFAR were not made available due to a U.S. Government stop-work order. This limitation affected the ability to fully capture the extent of donor contributions to TB-related activities. Contributions from medical insurance schemes remained minimal throughout the period. Importantly, this shift in funding occurred alongside a steady decline in the estimated TB incidence rate, from over 600 to just under 500 cases per 100,000 population, indicating progress in TB control despite changes in the funding landscape.

Figure 41: Proportional contributions of financing entities and potential funding gap per NSP intervention (2023/24, %)

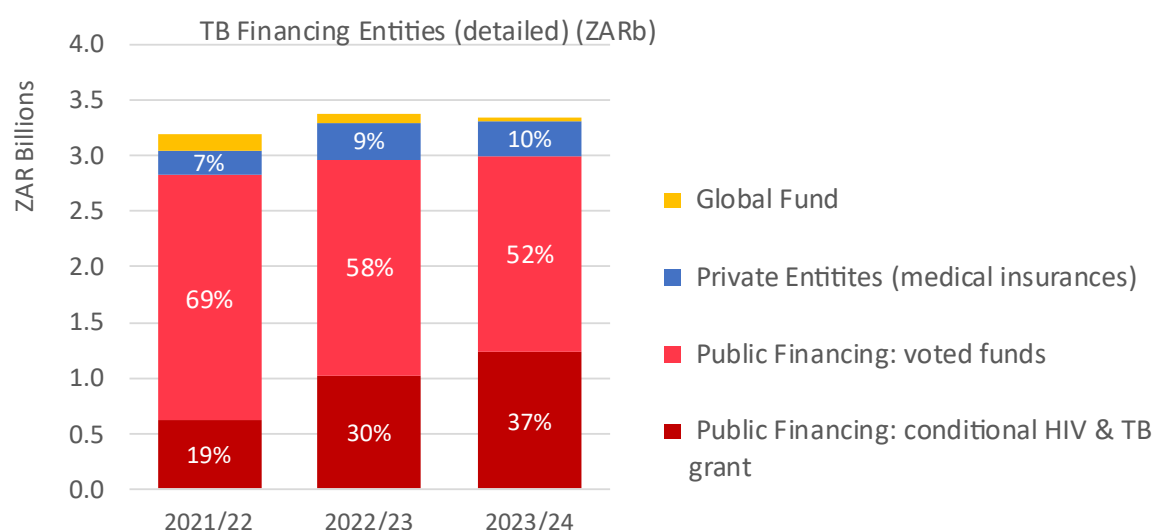


Note: We expect total TB spending to have decreased because the cost of DR treatment has been massively reduced and they no longer need 18mths of hospitalization

Total TB expenditure in South Africa remained relatively stable over the period 2021/22 to 2023/24 with annual totals of R3.19 billion, R3.38 billion, and R3.34 billion respectively. Public funds, combining both voted funds and the Conditional HIV & TB Grant, consistently formed the bulk of TB spending contributing between 89% and 93% with a combined total of R2.8 billion in 2021/22 rising to R3.0 billion in 2023/24. Within this, a growing share was attributed to the Conditional Grant, which increased from 19% of total funding in 2021/22 to 37% in 2023/24. In contrast, the share of voted (Equitable Share) TB funds declined from 69% to

52% over the same period, and some DOH voted spending on personnel in public PHC and general hospitals that deliver TB services might have been missed. Private medical insurance provided a modest but gradually increasing share, rising from 7% to 10%, while donor contributions from the Global Fund decreased significantly, dropping from 4% in 2021/22 to just 1% in 2023/24, averaging around R3.3 billion annually, with a slight increase from R3.2 billion to R3.4 billion before levelling off.

Figure 42: TB financing entities (2021/22-2023/24, ZAR billion)

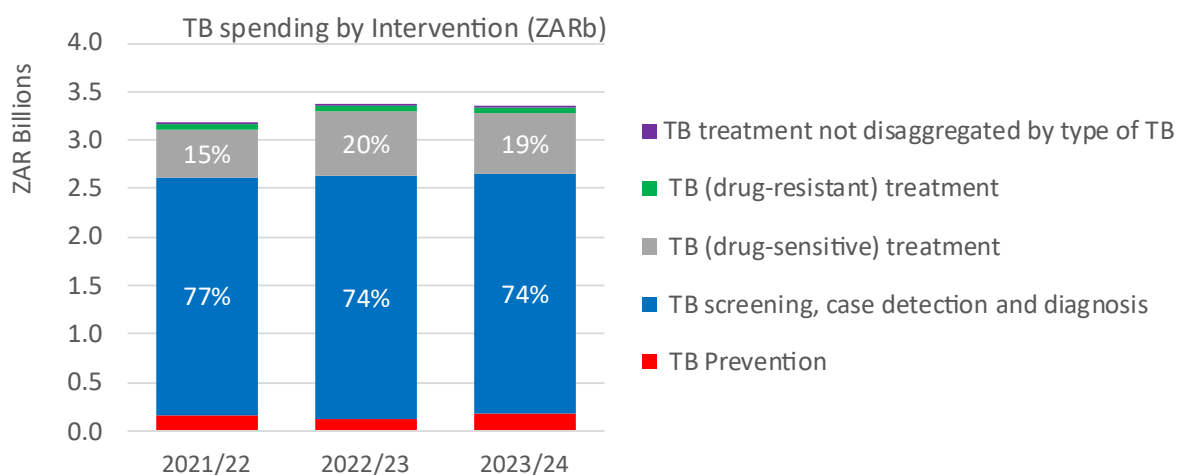


Most of the TB expenditure 74% to 77% was consistently directed toward TB screening, case detection, and diagnosis, underscoring a strong and sustained emphasis on identifying persons with TB. Investment in drug-sensitive TB treatment rose from 15% in 2021/22 to 20% in 2022/23, before slightly declining to 19% in 2023/24, reflecting continued prioritization of treatment coverage. TB prevention accounted for a modest 3–5% of total spending across the three years, while drug-resistant TB treatment maintained a stable share at 2% annually. Minimal expenditure was allocated to program management and non-disaggregated treatment categories, each contributing less than 1% of total TB spending.

Through these investments in the TB response, South Africa has achieved a 53% decline in TB incidence over this NASA period. Importantly, TB treatment coverage reached 77% for the first time by the end of 2022 surpassing the global average of 71% and the estimated number of people missing from TB care fell to 65,705¹⁵.

¹⁵ National TB Recovery Plan, Version 3.0, National Department of Health, South Africa, 31 May 2024.

Figure 43: TB expenditure per intervention (2017/18-2019/20, ZAR billion)



Compared with the NSP TB cost estimates, the total TB spending was lower than anticipated by 27%. Examining the specific interventions, Figure 44 shows some alignment of resources to need, except for larger shortfalls for screening and case findings (NASA may have missed some outreach case detection efforts), and especially for the drug-resistant (DR-TB) treatment. The bulk of DR-TB used to be for hospitalization and the expensive 18months treatment, which are no longer required and appear not to be being picked up by BASLY and NASA. In the public expenditure records, all TB medicines are labelled as such with no distinction between DR or DS drugs, which makes it impossible for NASA to separate these. Nevertheless, compared to the previous NASA findings of DR-TB treatment spending, huge savings have been made due to the shorter, cheaper DR-TB treatment options, but NDOH could explore further if there has been underspending given the incidence of MDR and XDR TB cases.

Figure 44: TB spending versus estimated resources needed (2023/24, ZAR)

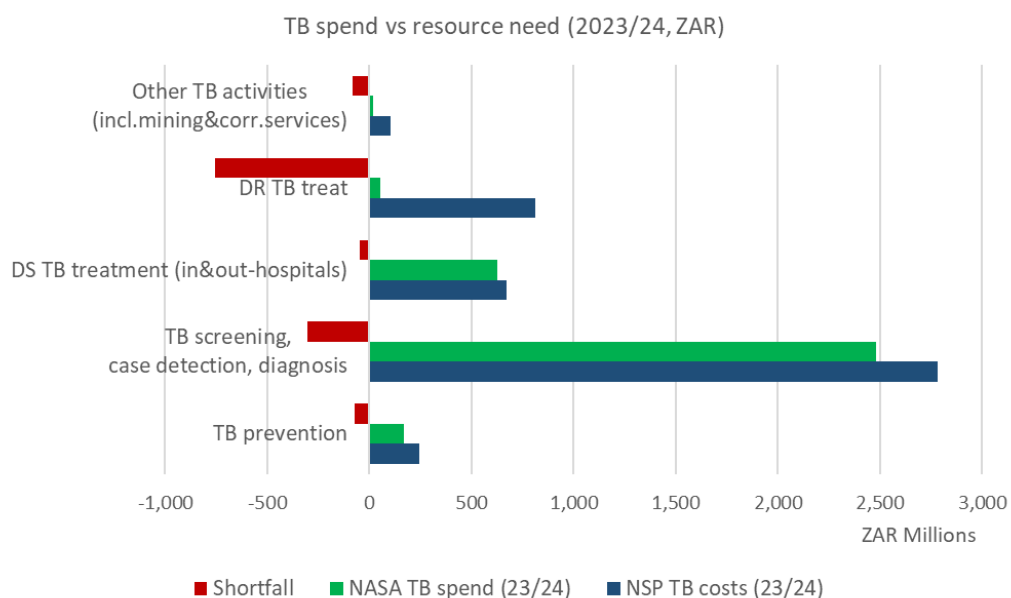
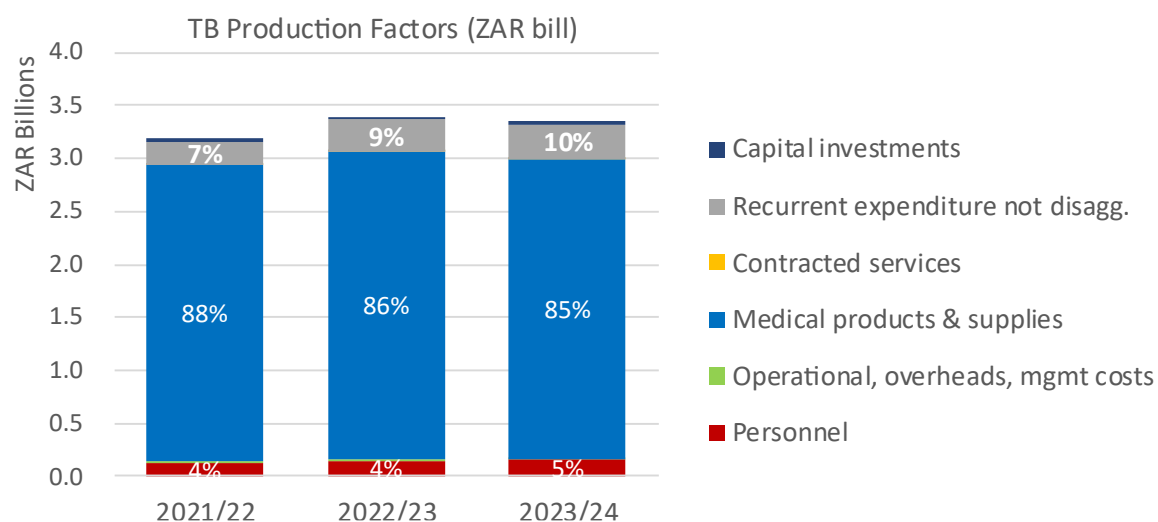


Table 16: TB financing entities (2021/22-2023/24, ZAR, %)

Total TB spending per intervention by FE	2021/22	2022/23	2023/24	% 2023/24
FE.01 Public Entities	2,822,147,255	2,970,010,001	2,994,517,656	90%
TB prevention	157,514,608	114,640,820	170,446,276	5%
TB screening, case detection and diagnosis	2,463,131,666	2,517,189,105	2,478,422,814	74%
TB care and treatment	177,976,794	310,705,480	327,301,152	10%
TB activities not disaggregated	11,503,772	14,880,282	7,457,004	0%
TB Programme enablers	12,020,414	12,594,314	10,890,410	0%
FE.03 International Entities	137,769,843	93,743,530	25,615,603	1%
TB care and treatment	137,769,843	93,743,530	25,615,603	
FE.02 Domestic Private Entities	226,840,273	316,854,596	324,446,353	10%
TB care and treatment	226,840,273	316,854,596	324,446,353	10%
Grand Total	3,186,757,371	3,380,608,128	3,344,579,612	100%

Between 2021/22 and 2023/24, most of the TB spending in South Africa, about 85% to 88% was allocated to medical products and supplies. Personnel costs accounted for a small but gradually increasing share, rising from 4% to 5%. Recurrent expenditure not disaggregated by type also grew modestly, from 7% to 10%. All other production factors, including operational costs, contracted services, training, and capital investments, consistently represented 1% or less of total spending each year.

Figure 45: TB expenditure by production factors (2021/22 – 2023/24, ZAR Billion)



6. Recommendations

The findings from the 2021/22–2023/24 NASA+ exercise offer important insights into the financing and spending dynamics of South Africa’s HIV and TB response. Overall, the results highlight the remarkable success of the country’s HIV programme particularly the strong and sustained commitment by the South African government, which now funds approximately 70% of the response through domestic resources. This is a significant achievement and a clear demonstration of national leadership. Encouragingly, the gap between available resources and the estimated needs outlined in the NSP for HIV, TB and STIs 2023–2028 is relatively small. While some key prevention programmes were somewhat underfunded, these were limited in number, and overall, only minor resource misalignments were observed. South Africa has done an impressive job in aligning investments with national priorities, and these efforts should be commended and built upon in the years ahead.

The recommendations below draw on current NASA+ results and build on lessons from the previous NASA (2017–2020), offering strategic actions to enhance efficiency, equity, sustainability, and impact across the HIV and TB response.

1. Strengthen Coordinated and Transparent Resource Planning

All financing entities and service providers public, private, and development partners—must commit to transparent, timely, and coordinated planning, budgeting, and expenditure reporting for HIV and TB programmes. Enhanced alignment of data systems and accountability mechanisms will prevent duplication of effort and foster better intersectoral collaboration and efficiencies aligned with NSP strategic priorities.

2. Close Funding Gaps Through Sustainable Resource Mobilization

Despite increases in domestic funding and successful funding of the ART programme, some financing gaps persist particularly for TB, some prevention such as PrEP and SBCC, and key population interventions. These shortfalls should be addressed through:

- Greater integration of donor-funded programs into national priorities to supplement funding gaps.
- Increased domestic resource mobilization, including through fiscal reforms aligned with National Health Insurance (NHI) goals.
- Development and implementation of a clear transition plan for donor-dependent interventions, particularly for key population and community-based services.

3. Prioritize Underserved and High-Risk Populations

Spending on key populations—including MSM, sex workers, PWID, and inmates remains critically low at just 1% of HIV spending, despite elevated HIV risk in these groups. Targeted, adequately funded interventions must be scaled up to meet equity and effectiveness standards.

4. Improving Equity in Provincial HIV Resource Allocation and Aligning Provincial HIV Budgets with Disease Burden.

An important consideration for improving equity and impact in HIV financing is the alignment of provincial budgets with the actual burden of disease. While provinces such as KwaZulu-Natal, Mpumalanga, and Free State exhibit strong alignment between high HIV prevalence

and per capita spending, others—namely the Eastern Cape, Limpopo, and North West—face relatively high HIV prevalence but receive below-average funding. These discrepancies suggest potential underfunding and should be addressed through targeted advocacy and more evidence-informed provincial planning. Conversely, spending efficiency should be reviewed in provinces like Gauteng and the Northern Cape, where per capita allocations are high despite lower prevalence rates. Ensuring that resources are both sufficient and appropriately distributed across provinces is essential for sustaining progress and achieving the equity goals of the NSP for HIV, TB and STIs 2023–2028.

5. Rebalance the Prevention-Treatment Investment Mix

Care and treatment continue to dominate HIV spending (over 70%), yet prevention remains underfunded, despite persistently high HIV incidence. A strategic shift is needed to:

- Increase funding for proven prevention interventions (e.g., condoms, PrEP, VMMC, AGYW programs, and SBCC).
- Prioritize funding for community-based prevention and social enablers approaches that address structural drivers of infection.

6. Enhance Efficiency Through Strategic Procurement and Delivery Models

The observed reduction in ARV costs partly due to DTG adoption demonstrates potential for efficiency gains. Further savings can be realized by:

- Scaling up use of DTG-based ARV regimens nationwide.
- Negotiating better rates for laboratory services and diagnostics.
- Expanding differentiated service delivery (DSD) models to reduce personnel and facility costs without compromising service quality and health outcomes.

7. Capturing Hidden Costs: Strengthening HIV Expenditure Estimates.

To strengthen future estimates and provide a more accurate picture of the public sector's contribution to HIV services, it is recommended that efforts be made to systematically capture and quantify indirect or 'hidden' expenditures related to HIV. This includes costs such as the treatment of opportunistic infections and STIs provided by the Department of Health, as well as the proportion of staff salaries (e.g., nurses in primary care) attributable to HIV services when these are not explicitly coded in financial systems. In the absence of recent System of Health Accounts (SHA) data, a practical approach would be to conduct targeted costing studies or time-and-motion analyses to estimate the share of general health expenditures that support HIV-related activities. Additionally, engaging with facility managers and financial officers to allocate a proportion of overheads and shared costs based on service utilization statistics or expert consensus can help approximate these hidden expenditures. Developing and applying standardized allocation methodologies, as recommended in international costing guidelines, will not only improve the comprehensiveness of NASA reports but also provide the South African Government with stronger evidence of domestic co-financing for Global Fund commitments

8. Further enhance the Institutionalization of NASA and Annual Expenditure Reviews

South Africa has already achieved routine expenditure tracking using the BASLY tool and the NASA framework. Additionally, the NDOH and PDOHs undertake quarterly expenditure and performance reviews of the HIV and TB conditional grants. Thus SANAC and NDOH have

successfully led the institutionalization of expenditure tracking and use the data in their Situation Room online portal as well as their performance monitoring. Steps to further enhance these achievements and ensure the optimal use and impact of the data could include:

- Institutionalize annual NASA reviews within SANAC and relevant government departments.
- Regularly link expenditure data to outputs and outcomes to enable real-time analysis of value-for-money.
- Build provincial capacity for expenditure tracking and interpretation, and integrate NASA findings into NSP mid-term and end-term reviews.

9. Strengthen Engagement of Private Sector and Research Institutions

Private sector and academic contributions remain significantly underreported, limiting the full picture of resource flows. A structured approach should be developed to:

- Encourage routine reporting from medical schemes, employers, and private providers.
- Improve coordination with universities and research entities to capture HIV- and TB-related research investments.

10. Support Community Health Systems and Social Contracting

Community service delivery plays a critical role in both prevention and treatment. Government should:

- Support sustainable financing for community-led NGOs and community health workers (CHWs), guided by social contracting frameworks.
- Align transition plans with the NHI rollout to ensure continuity of community-level services.

11. Ensure Long-Term Sustainability Through Integrated Health Financing

With the anticipated scale-up of NHI, the government should:

- Safeguard and increase allocations to HIV and TB within the broader health budget.
- Ensure NSP objectives are explicitly integrated into NHI planning to prevent the marginalization of vertical programs.
- Consider the most efficient means of funding HIV and TB prevention efforts, since many of these are not typically included in the benefits package of health insurance schemes.

8. APPENDICES

8.1. Additional NASA tables

i. Total HIV expenditure by Financing Entities (2021/22-2023/24, USD, %)

Funding Entities (USD)	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
Government of South Africa	2,157,722,745	2,011,285,684	1,737,224,386	75%	77%	77%
PEPFAR	555,921,195	456,058,257	388,005,598	19%	18%	17%
Global Fund	72,000,618	47,299,398	51,956,944	3%	2%	2%
Other bilateral funding entities	439,511	757,427	979,794	0.0%	0.0%	0.0%
Other multilateral funding entities	5,254,328	5,883,660	4,914,773	0.2%	0.2%	0.2%
INGOs and Foundations	203,360	30,773	26,353	0%	0%	0%
Medical insurances	75,520,078	83,025,798	73,204,170	3%	3%	3%
Private sector / domestic corporations	29,276	26,417	28,369	0.0%	0.0%	0.0%
Total HIV and TB (USD)	2,867,091,112	2,604,367,414	2,256,340,386	100%	100%	100%

ii. Revenue by Financing Entities (2021/22-2023/24, ZAR, %)

HIV Financing Entities and their Revenues (mechanisms for financing services) (ZAR)	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
FE.01 Public Entities	29,068,994,920	29,974,849,507	29,074,644,515	74%	76%	76%
REV.01 Transfers from government domestic revenue	29,068,994,920	29,974,849,507	29,074,644,515	74%	76%	76%
FE.02 Domestic Private Entities	889,779,186	1,043,540,685	1,027,426,317	2%	3%	3%
REV.05 Voluntary prepayment	889,346,480	1,043,107,979	1,026,902,624	2%	3%	3%
REV.06 Other domestic revenues n.e.c.	432,706	432,706	523,694	0.00	0.00	0.00
FE.03 International Entities	9,230,075,153	8,260,539,917	8,173,117,355	24%	21%	21%
REV.07 Direct foreign transfers	9,230,075,153	8,260,539,917	8,173,117,355	24%	21%	21%
Total	39,188,849,259	39,278,930,110	38,275,188,187	100%	100%	100%

iii. Public departments managing HIV and TB funds (2021/22-2023/24, ZAR, %)

Depts. Managing Public HIV & TB Funds (ZAR)	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
NDOH	30,073,233,304	31,067,829,717	30,355,362,161	94%	94%	95%
SANAC	36,486,748	60,062,555	48,847,248	0.00	0.00	0.00
DEPARTMENT OF BASIC EDUCATION	238,312,375	217,192,406	217,666,988	1%	1%	1%
HIGHER EDUCATION AND TRAINING	37,375,000	20,604,000	32,530,000	0.1%	0.1%	0.1%
CORRECTIONAL SERVICES	47,372,969	56,250,584	54,507,292	0.1%	0.2%	0.2%
SCIENCE AND INNOVATION	33,505,246	35,808,051	37,230,191	0.1%	0.1%	0.1%
SOCIAL DEVELOPMENT	1,424,856,532	1,487,112,195	1,323,018,289	4%	5%	4%
Total Public Funding (ZAR)	R 31,891,142,175	R 32,944,859,508	R 32,069,162,170	100%	100%	100%
Total Public Funding (USD)	\$ 2,157,722,745	\$ 2,011,285,684	\$ 1,737,224,386			

iv. HIV Financing Schemes (2021/22-2023/24, ZAR)

HIV Financing Schemes	Column Labels	2021	2022	2023
Row Labels				
SCH.01 Government schemes and compulsory contributory health care schemes		29,564,937,062	30,537,569,686	29,796,652,608
SCH.01.01 Government schemes		29,564,937,062	30,537,569,686	29,796,652,608
SCH.02 Voluntary payment schemes (other than Household out-of-pocket payments)		9,571,434,787	8,711,327,432	8,444,536,486
SCH.02.01 Voluntary insurance schemes		889,346,480	1,043,107,979	1,026,902,624
SCH.02.02 Not-for-profit schemes (including resident development agencies)		8,396,167,921	7,558,566,605	7,285,624,834
SCH.02.03 For-profit organizations schemes		285,920,386	109,652,847	132,009,029
SCH.04 External schemes (non-resident)		52,477,410	30,032,992	33,999,093
SCH.04.02 Voluntary schemes (non-resident)		52,477,410	30,032,992	33,999,093
Grand Total		39,188,849,259	39,278,930,110	38,275,188,187

v. *Production Factors with their Financing Entities (2021/22-2023/24, ZAR, %)*

FE x Production Factors of HIV (2023/24)	Public Entities	Domestic Private Entities	International Entities	% 2021/22	% 2022/23	% 2023/24
Personnel	11,210,241,234	0	4,935,442,099	39%	0%	60%
Operational, overheads, mgmt costs	1,323,495,797	473,694	374,083,397	5%	0%	5%
Medical products & supplies	13,919,765,418	0	666,793,135	48%	0%	8%
Contracted services	992,763,332	0	1,343,852,415	3%	0%	16%
Training, events, logistics transport, financial	130,391,748	50,000	701,224,989	0%	0%	9%
Recurrent expenditure not disagg.	1,430,438,693	1,026,902,624	69,852,198	5%	100%	1%
Capital investments	67,548,294	0	81,869,123	0%	0%	1%
Total HIV (ZAR)	29,074,644,515	1,027,426,317	8,173,117,355	100%	100%	100%

vi. *HIV spending by Production Factors (2021/22-2023/24, ZAR)*

Sum of Amount (ZAR)	Column Labels			
Row Labels		2021	2022	2023
PF.01 Current direct and indirect expenditures		39,031,460,498	39,103,220,971	38,125,770,770
PF.01.01 Personnel costs		16,307,440,887	16,220,757,453	16,145,683,332
PF.01.02 Operational and programme management		1,537,987,698	1,681,269,052	1,698,052,888
PF.01.03 Products and supplies (including medical)		14,943,625,032	15,369,972,517	14,586,558,552
PF.01.03.01 Pharmaceuticals		8,067,481,257	6,726,569,920	6,566,983,123
PF.01.03.01.01 Antiretrovirals		8,042,724,578	6,696,639,871	6,550,674,163
PF.01.03.01.03 Opioid substitution therapy (O)		5,847,016	4,939,785	6,666,534
PF.01.03.01.08 OI other than TB, Heps, cervical cancer drugs			43,899	187,762
PF.01.03.01.98 Pharmaceuticals not disaggregated		17,539,376	20,449,582	4,172,201
PF.01.03.01.99 Other Pharmaceuticals n.e.c.		1,370,287	4,496,784	5,282,463
PF.01.03.02 Medical supplies		1,478,111,831	1,699,451,247	1,646,563,133
PF.01.03.03 Laboratory reagents and materials		4,840,392,335	6,299,984,743	5,797,219,258
PF.01.03.04 Non-medical supplies		494,865,639	540,726,521	439,037,634
PF.01.03.05 Office Supplies		43,382,656	96,671,378	124,009,541
PF.01.03.98 Products and supplies (including medical)		210,761	128,911	128,911
PF.01.03.99 Other Products and supplies (including medical)		19,180,554	6,439,797	12,616,952
PF.01.04 Contracted external services		1,970,373,886	2,334,222,775	2,336,615,746
PF.01.05 Transportation related to beneficiaries		7,809,883	2,169,119	3,272,506
PF.01.07 Financial support for beneficiaries		8,723,976	9,613,938	2,848,174
PF.01.08 Training costs (including related per diem)		135,148,458	139,532,966	155,240,485
PF.01.09 Logistics of events, including catering services		84,690,088	119,475,670	120,663,545
PF.01.10 Indirect costs		527,387,956	581,131,202	549,642,028
PF.01.98 Current direct and indirect expenditures		3,481,352,006	2,612,758,497	2,478,463,421
PF.01.99 Other Current direct and indirect expenditures		26,920,627	32,317,783	48,730,093
PF.02 Capital expenditures		157,388,761	175,709,139	149,417,416
Grand Total		39,188,849,259	39,278,930,110	38,275,188,187

vii. Beneficiary populations with their Financing Entities (2021/22-2023/24, ZAR)

Beneficiary population by Financing Entities	2021/22	2022/23	2023/24
FE.01 Public Entities	29,068,994,920	29,974,849,507	29,074,644,515
BP.01 People living with HIV	23,539,978,123	24,274,586,965	22,943,122,410
BP.02 Key populations	136,616,162	169,037,710	207,722,613
BP.03 Vulnerable, accessible and other target population	1,427,404,594	1,487,964,670	1,323,222,459
BP.04 General population	2,326,917,473	2,630,962,996	2,957,390,148
BP.05 Non applicable (ASC which do not have a specific BP)	1,638,078,569	1,412,297,166	1,643,186,884
FE.02 Domestic Private Entities	889,779,186	1,043,540,685	1,027,426,317
BP.01 People living with HIV	889,346,480	1,043,107,979	1,026,902,624
BP.04 General population	432,706	432,706	432,706
BP.05 Non applicable (ASC which do not have a specific BP)			90,988
FE.03 International Entities	9,199,899,803	8,064,019,017	8,032,402,317
BP.01 People living with HIV	4,705,207,006	4,062,426,483	4,053,190,475
BP.02 Key populations	410,015,969	316,789,747	260,762,749
BP.03 Vulnerable, accessible and other target population	1,170,649,417	898,713,131	797,831,880
BP.04 General population	731,479,386	574,072,718	997,127,301
BP.05 Non applicable (ASC which do not have a specific BP)	2,182,548,025	2,212,016,937	1,923,489,911
Grand Total	39,158,673,908	39,082,409,209	38,134,473,148

viii. Service Delivery Modalities with their Financing Entities (2021/22-2023/24, ZAR)

Service Delivery Model with their Financing Entities	2021/22	2022/23	2023/24
FE.01 Public Entities	29,068,994,920	29,974,849,507	29,074,644,515
SDM.01 Facility-based service modalities	21,939,521,466	23,757,579,553	23,063,887,762
SDM.02 Home and community-based service modalities	4,983,434,614	4,375,237,987	3,588,329,675
SDM.05 Non applicable (ASC which do not have a specific SDM)	1,638,078,569	1,412,297,166	1,643,186,884
SDM.98 Modalities not disaggregated	507,960,272	429,734,801	779,240,193
FE.02 Domestic Private Entities	889,779,186	1,043,540,685	1,027,426,317
SDM.01 Facility-based service modalities	889,346,480	1,043,107,979	1,026,902,624
SDM.02 Home and community-based service modalities	432,706	432,706	432,706
SDM.05 Non applicable (ASC which do not have a specific SDM)			90,988
FE.03 International Entities	9,230,075,153	8,260,539,917	8,173,117,355
SDM.01 Facility-based service modalities	863,265,644	688,253,970	799,785,858
SDM.02 Home and community-based service modalities	745,173,358	739,664,680	1,005,068,638
SDM.03 Self-service by the client		22,714	187,286
SDM.05 Non applicable (ASC which do not have a specific SDM)	2,182,548,025	2,212,016,937	1,891,214,182
SDM.98 Modalities not disaggregated	5,439,088,126	4,620,581,618	4,476,861,391
Grand Total	39,188,849,259	39,278,930,110	38,275,188,187

ix. *Care and Treatment activities by Financing Entities (2023/24, ZAR)*

HIV Care and Treatment activities (2023/24)	Public entities	Medical insurances	International entities
ART	9,417,694,495	1,026,902,624	488,728,967
COS, adherence and support	1,832,056,962	-	-
ART lab monitoring	5,574,737,134	-	11,517,045
Co-infections and opportunistic infections	199,995,290	-	5,559,013
Care and treatment services not disagg.	5,545,776,041	-	3,547,385,450
Total Care and Treatment (ZAR)	22,585,805,385	1,026,902,624	4,053,190,475

x. *Care and Treatment spending by production factors and by Financing Entities (2023/24, ZAR)*

C&T by cost item (2023/24, ZAR)	Public FE	Private medical insurances	International FE	Total C&T spend
Personnel	11,210,241,234	-	4,935,442,099	16,145,683,332
Operational, overheads, mgmt costs	1,323,495,797	473,694	374,083,397	1,698,052,888
ARVs	6,252,572,224	-	314,410,900	6,566,983,123
Medical supplies	1,567,588,122	-	78,975,011	1,646,563,133
Laboratory reagents & materials	5,796,555,398	-	663,860	5,797,219,258
Other supplies	303,049,675	-	272,743,363	575,793,038
Contracted services	992,763,332	-	1,343,852,415	2,336,615,746
Training, events, transport, financial support	130,391,748	50,000	701,224,989	831,666,737
Current expenditure not disagg.	1,430,438,693	1,026,902,624	102,127,927	2,559,469,243
Capital investments (renovations, upgrading, lab.equ	67,548,294	-	81,869,123	149,417,416
Total C&T spending (ZAR)	29,074,644,515	1,027,426,317	8,205,393,084	38,307,463,916

xi. *Financing entities' contribution to prevention activities (2023/24, ZAR)*

HIV Prevention (ZAR, 2023/24)	Public financing entities	International financing entities	Domestic private entities	Total Prevention
Prevention for AGYW	-	304,745,482		304,745,482
Services for key populations	158,464,582	177,520,706		335,985,288
Condoms for gen.population	728,311,322	790,606		729,101,929
VMMC	488,405,195	500,672,866		989,078,061
Pre-Exposure Prophylaxis (PrEP)	10,582,604	322,221,427		332,804,031
PMTCT	357,317,025	-		357,317,025
Activities for vulnerable and accessible populations	-	43,287,464		43,287,464
Prevention for children and youth (excl. for AGYW)	250,196,988	-		250,196,988
SBCC	89,796,000	74,437,403		164,233,403
Community mobilization	100,116,619	15,581,188		115,697,807
Wellness programmes in the workplace	204,170	-		204,170
Post-exposure prophylaxis (PEP)	19,162,608	1,290,563		20,453,171
Other prevention activities n.e.c.	-	314,524,508		314,524,508
Prevention activities not disaggregated	-	13,730,197		13,730,197
Total Prevention (ZAR)	2,234,323,376	1,768,802,410	-	4,003,125,786

xii. *Prevention by production factor (2021/22-2023/24, ZAR)*

Prevention by production factor	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
Personnel	1,424,108,975	1,509,888,996	1,788,424,725	42%	45%	45%
Operational, overheads, mgmt costs	192,407,699	219,756,689	251,610,391	6%	7%	6%
Pharmaceuticals	27,800,104	17,552,290	7,095,474	1%	1%	0%
Medical supplies	493,070,907	439,709,078	821,306,679	15%	13%	21%
Non-medical supplies	133,633,354	146,207,147	178,833,546	4%	4%	4%
Other products and supplies	22,362,222	6,798,083	12,263,392	1%	0%	0%
Contracted services	559,876,058	738,051,315	691,051,076	17%	22%	17%
Training, events, transport, financial support	73,672,458	70,632,908	99,496,440	2%	2%	2%
Indirect costs	5,611,539	1,308,949	-	0%	0%	0%
Other recurrent not disagg.	392,265,963	140,298,484	107,498,326	12%	4%	3%
Other capital investments (Building,lab equip	42,755,496	36,685,122	45,545,738	1%	1%	1%
Total Prevention spending (ZAR)	3,367,564,773	3,326,889,062	4,003,125,786	100%	100%	100%

xiii. HTC by production factor (2021/22-2023/24, ZAR)

HTC by production factor	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
Personnel	778,109,332	920,024,071	895,251,746	62%	67%	64%
Operational, overheads, mgmt costs	15,498,989	25,533,114	18,842,456	1%	2%	1%
Laboratory reagents & other med.supplies	212,470,677	220,074,454	266,517,477	17%	16%	19%
Contracted services	22,473,477	20,951,267	19,406,884	2%	2%	1%
Training, events, transport etc	2,552,784	6,731,408	5,909,884	0%	0%	0%
Other recurrent not disagg.	221,129,877	176,932,132	194,458,369	18%	13%	14%
Capital investments (not disagg.)	4,915,281	4,919,162	3,771,582	0%	0%	0%
Total HTC spending (ZAR)	1,257,150,416	1,375,165,609	1,404,158,397	100%	100%	100%

xiv. Social protection and economic support by production factor (2021/22-2023/24, ZAR)

S.Protection & Econ.Support by production factor	2021/22	2022/23	2023/24
Personnel	657,623,966	778,992,056	683,194,547
Contracted services	36377431.23	59428955.39	42027452.86
Logistics of events, including catering services	5741167.94	6999541.50	5808128.88
Current expenditures not disaggregated	1,112,701,011	925,874,059	810,749,477
Operational, overheads, mgmt costs	43,661,433	59,223,138	60,678,190
Products and supplies	33,705,765	41,901,277	46,267,232
Other recurrent not disagg.	4,809,767	689,647	-
Training, events, transport	20,821,453	16,425,371	5,496,608
Capital investments (not disagg.)	3,598,621	4,843,793	13,291,830
Total S.Protection & Econ.Support (ZAR)	1,919,040,616	1,894,377,838	1,667,513,466

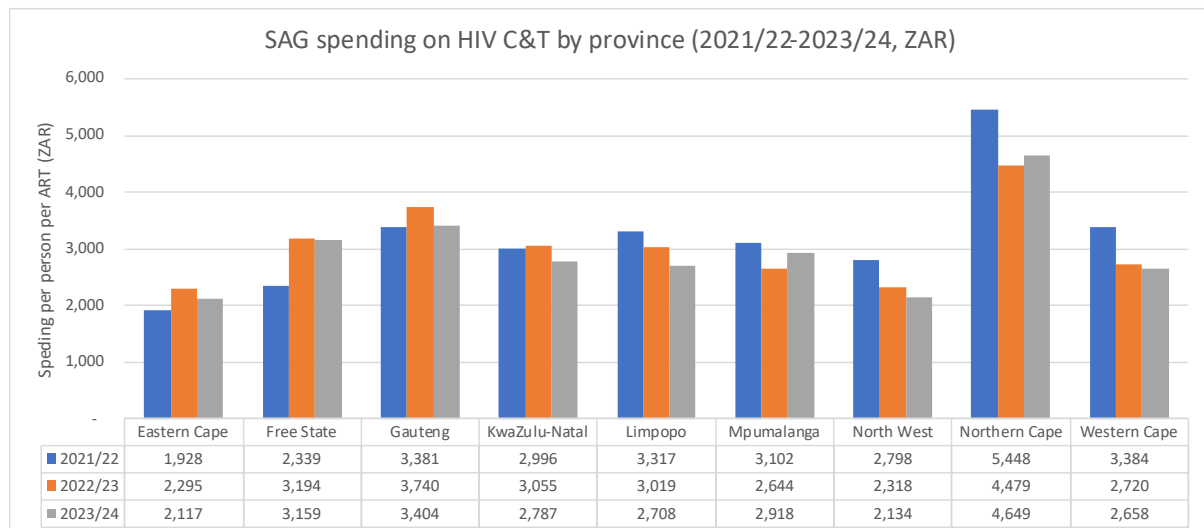
xv. Programme enablers and systems strengthening by production factor (2021/22-2023/24, ZAR)

Pgm.Enablers & S.Strgthening by PF	2021/22	2022/23	2023/24
Personnel costs	1,827,759,619	1,307,821,219	1,630,058,449
Contracted external services	323,157,628	359,702,481	357,831,913
Logistics of events, training costs	41,686,293	68,025,062	49,723,083
Indirect costs	521,419,541	578,853,825	548,864,739
Operational, overheads, mgmt costs	342,719,547	468,413,027	451,065,828
Medical & non-medical products and supplies	91,789,485	202,843,147	77,899,640
Current expenditures not disaggregated	157,061,626	136,546,033	138,021,773
Capital expenditures (not disagg.)	13796907.57	45283754.89	24463299.49
Total Pgm.Enablers & S.Strgthening (ZAR)	3,319,390,648	3,167,488,549	3,277,928,723

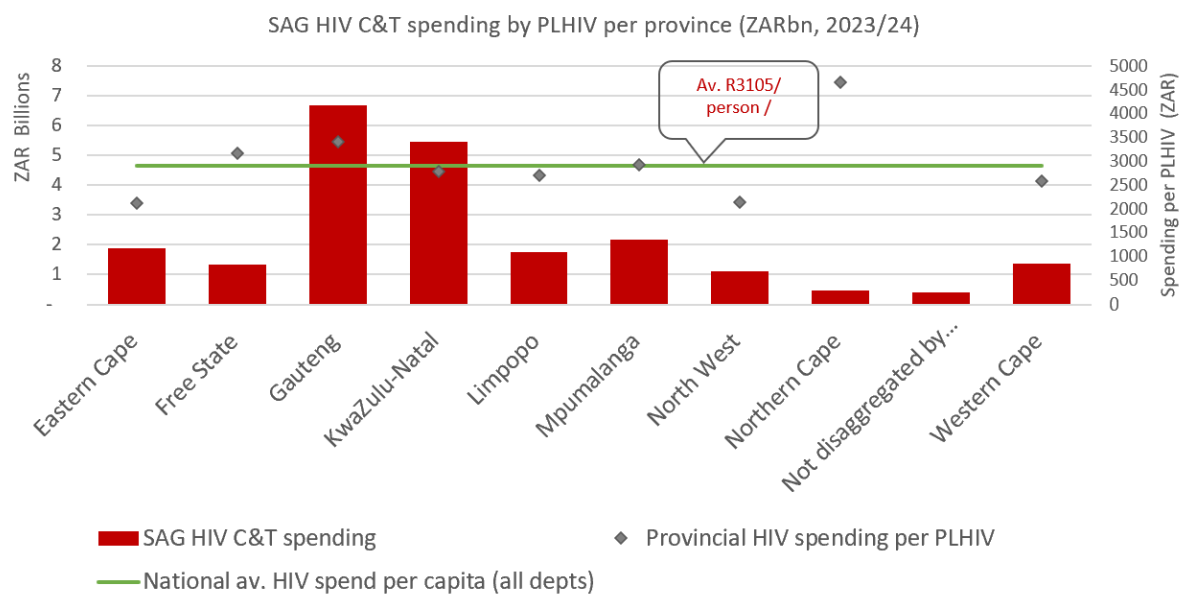
xvi. HIV service providers (2021/22-2023/24, ZAR)

HIV Service Providers (ZAR)	2021/22	2022/23	2023/24	% 2021/22	% 2022/23	% 2023/24
Public service providers	29,346,529,147	30,222,390,818	29,494,395,081	75%	77%	77%
Univ. & Research orgs	49,121,463	142,148,670	130,062,407	0.1%	0.4%	0.3%
NGOs (local)	8,080,584,899	7,223,507,358	6,893,308,489	21%	18%	18%
For-profit providers	1,153,481,589	1,131,151,315	1,127,058,111	3%	3%	3%
Multilateral agencies	109,661,380	87,599,776	78,797,538	0.3%	0.2%	0.2%
INGOs & Foundations	375,208,095	420,489,670	485,713,927	1.0%	1.1%	1.3%
International research centers and other for-profit	21,785,277	21,609,512	31,853,542	0.1%	0.1%	0.1%
International agencies in-country	52,477,410	30,032,992	33,999,093	0.1%	0.1%	0.1%
Total	39,188,849,259	39,278,930,110	38,275,188,187	100%	100%	100%

xvii. SAG spending per person on ART per province (2021/22-2023/24, ZAR)



xviii. SAG Spending on Care and Treatment by PLHIV per Province (2023/24, ZAR)



8.2. Statistics

PLHIV by Province - Thembisa 4.8

Province	2021	2022	2023	2024
Eastern Cape	868,300	880,368	893,175	905,292
Free State	418,713	419,544	420,817	421,695
Gauteng	1,898,260	1,930,740	1,963,580	1,994,720
KwaZulu-Natal	1,943,750	1,950,920	1,958,570	1,964,150
Limpopo	628,344	637,180	647,126	656,596
Mpumalanga	727,390	734,889	742,786	749,634
Nothern Cape	93,782	94,630	95,686	96,641
North West	508,178	513,143	518,459	523,107
Western Cape	493,153	507,466	521,844	535,653
	7,579,870	7,668,880	7,762,043	7,847,488

Population estimate by Province -MYPE

Provinces	2023
Eastern Cape	7,176,230
Free State	3,044,050
Gauteng	15,931,824
KwaZulu-Natal	12,312,712
Limpopo	6,402,594
Mpumalanga	5,057,662
Northern Cape	1,372,943
North West	4,155,303
Western Cape	7,176,230
Total	62,629,548