# A Synopsis of the South African Provincial Strategic Plans and Budget Allocations for HIV/AIDS and TB

## Budget Policy Brief 7

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### 1. Introduction

The highest population of people living with HIV/AIDS is found in South Africa. It has the highest HIV prevalence of 17.9% [17.3% - 18.4%][1], with an estimated 6,100,000 [5,800,000 - 6,400,000] people living with HIV/AIDS. The South African government has over the years taken major steps to avert the disease through implementing health and HIV/AIDS policies, supported by increasing allocations from the national revenue. South Africa has aligned its policies with UNAIDS guidelines for the elimination of the pandemic globally. In the UNAIDS 2011-2015 strategic plan, a declaration was made to achieve the UNAIDS vision of, "Zero new HIV infections. Zero discrimination. Zero AIDS-related deaths."[2] The same strategy was adapted in the South African National Strategic Plan (NSP) 2012-2016. The aims of the NSP include a reduction in new HIV and TB infections and deaths caused by TB by 50%, Antiretroviral treatment for 80% of those in need of treatment, adherence and recovery for 70% of those already on treatment; 50% reduction of HIV and TB self-reported stigma, and ensuring an enabling environment and legal framework in order to promote and protect human rights.[3] The strategic objectives (SO) of the NSP for the years 2012-2016 are denoted in Table 1 below.

The same aims and strategic objectives were adopted by all South African provinces, namely the Eastern Cape (EC), the Free State (FS), Gauteng (GP), KwaZulu-Natal (KZN), Limpopo (LP), Mpumalanga (MP), the Northern Cape (NC), North West (NW), and the Western Cape (WC). They produced their own versions of strategic plans which were not far removed from the NSP, although the sub-objectives differed widely. In fact, the 9 Provincial Strategic Plans (PSP) were meant to reflect the provincial needs whilst collectively adding up to the national commitments.

1 UNAIDS (2012). South Africa Country Profile. Available from www.unaids.org/en/regionscountries/countries/southafrica/
2 Ibid.
33 SANAC.2013; Available on http://www.sanac.org.za/

## Table 1: NSP Strategic Objectives and Sub-Objectives

| **SO1: Address social and structural barriers to HIV, STI and TB prevention, care and impact** |
|---|
| 1.1 Mainstreaming HIV and TB and its gender- and rights-based dimensions into the core mandates of all government departments3 and all other sectors of the South African National AIDS Council (SANAC)<br>1.2 Addressing social, cultural, economic and behavioural drivers of HIV, STIs and TB, including the challenges posed by socialisation practices; living in informal settlements, as well as rural and hard-to-reach areas; migration and mobility; and alcohol and substance abuse<br>1.3 Implementing interventions to address gender norms and gender-based violence<br>1.4 Mitigating the impact of HIV, STIs and TB on orphans, vulnerable children and youths<br>1.5 Reducing the vulnerability of young people to HIV infection by retaining them in schools, and increasing access to post-school education and work opportunities<br>1.6 Reducing HIV- and TB-related stigma and discrimination<br>1.7 Strengthening community systems to expand access to services<br>1.8 Supporting efforts aimed at poverty alleviation and enhancing food-security programmes. |
| **SO2: Prevent new HIV, STI and TB infections** |
| **2.1** Maximising opportunities for testing and screening to ensure that everyone in South Africa is tested for HIV and screened for TB at least annually, and appropriately enrolled in wellness and treatment, care and support programmes.<br><br>**2.2**Increasing access to a package of sexual and reproductive health (SRH) services, including those for people living with HIV and young people, and conducting prevention activities in non-traditional outlets. The package includes medical male circumcision (for adults and neonates), and emphasis on dual protection, the provision of both male and female condoms, the termination of pregnancy and the provision of contraception.<br><br>**2.3**Reducing transmission of HIV from mother to child to less than 2% at six weeks after birth and less than 5% at 18 months of age by 2016. This includes strengthening the management, leadership and coordination of the prevention of mother to child HIV transmission (PMTCT) programme and ensuring its integration with maternal- and child health programmes. TB screening will be integrated into the PMTCT programme. In addition, screening and treatment of syphilis will be strengthened to eliminate neonatal syphilis.<br><br>**2.4** Implementing a comprehensive national social and behavioural change communication strategy with a focus on key populations. This aims to increase the demand and uptake of services, promote healthy behaviours, and address norms and behaviours that put people at risk for HIV, STIs and TB.<br><br>**2.5** Preparing for the potential implementation of future innovative, scientifically proven HIV, STI, and TB prevention strategies, such as pre-exposure prophylaxis (PrEP), new TB vaccines, and microbicides.<br><br>**2.6**Preventing TB infection and disease through intensified TB case finding, TB infection control, workplace/occupational health policies on TB and HIV, isoniazid preventive therapy (IPT), immunisation, prevention of multidrug-resistant TB (MDR-TB), and reducing TB-related stigma, alcohol consumption and smoking.<br><br>**2.7** Addressing sexual abuse and improving services for survivors of sexual assault. |
| **SO3: Sustain health and wellness** |
| **3.1** Reducing disability and death resulting from HIV and TB. This includes annual testing/screening for HIV and TB, particularly for key populations; improved contact tracing; early diagnosis and rapid enrolment into treatment; increased access to high-quality drugs; improved access to treatment for children, adolescents and youth; early initiation of all HIV-positive TB patients on ART; strengthened implementation of a patient-centred pre-ART package; early referral of all patients with complications; appropriate screening and treatment for cryptococcal infection; and strengthened screening and treatment of pregnant women for syphilis.<br><br>**3.2**Ensuring that people living with HIV and TB remain within the healthcare system, are adherent to treatment and maintain optimal health. The means to achieve this include the establishment of ward-based public healthcare (PHC) teams and regular communication using all appropriate media.<br><br>**3.3** Ensuring that systems and services remain responsive to the needs of people living with HIV and TB. This includes integrating HIV and TB care with an efficient chronic-care delivery system; expanding of operating hours of service delivery points; ensuring a continuum of care across service delivery points; strengthening quality standards; and adequate monitoring of drug resistance. |
| **SO4: Increase protection of human rights and improve access to justice** |
| **4.1** ensuring that rights are not violated when the interventions under the other three strategic Objectives are implemented, and that functioning mechanisms for monitoring abuses and vindicating rights are established.<br>**4.2** Reducing HIV and TB discrimination, especially in the workplace.<br>**4.3** Reducing unfair discrimination in access to social services. |

**Source: SANAC (2011). National Strategic Plan 2012-2016**

## 2. Summary review of the Provincial Strategic Plans for HIV/AIDS, STIs and TB

Unlike the other provinces which adopted the NSP SOs, Gauteng split SO1 into 2 parts, namely:

- SO1.A. Vulnerability to HIV and TB infections in youth and adults will be reduced through social, structural, and behavioural changes and
- SO1.B. Reduce social impacts of HIV and TB on people living with HIV (PLHIV) and TB and their households prioritizing children.

Despite the split, put together, the SO1A andSO1B represented the NSP SO1.

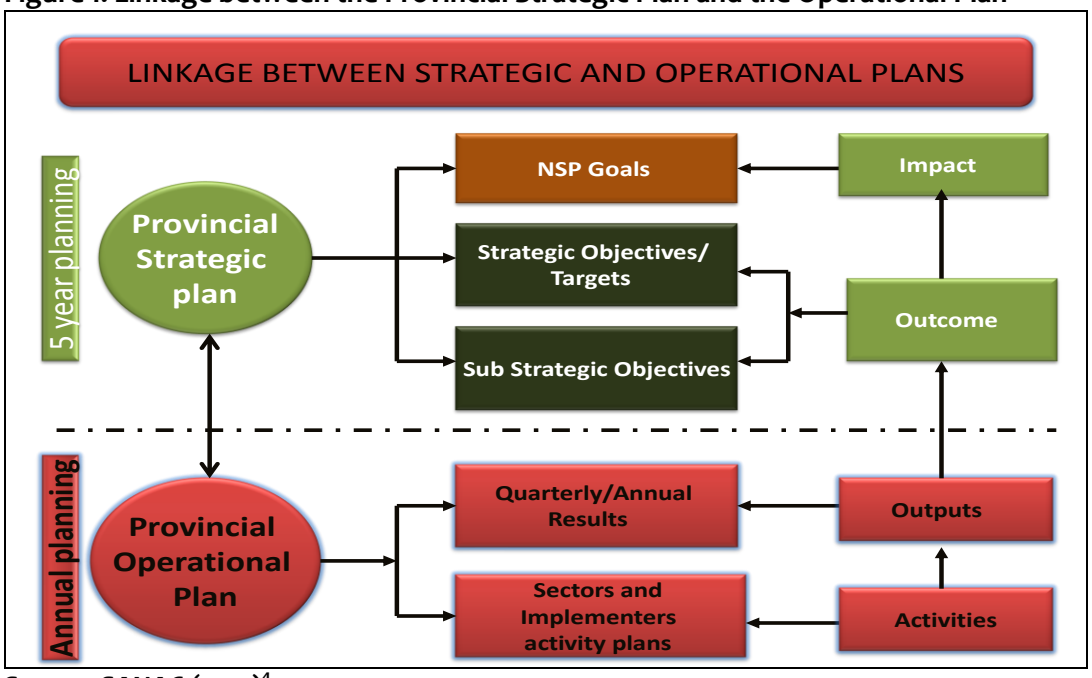
SO4 is a new objective in the series of NSPs and provincial governments had never dealt with related projects on human rights and access to justice. This resulted in less projects being planned and budgeted for by the government departments. A Strategic Objective 5 was added into the PSPs to represent other important factors relevant for the fight against HIV/AIDS and TB. These are referred to as Strategic Enablers, as noted in the NSP. Governance and institutional arrangements, monitoring and evaluation (M&E), communication and research activities are regarded as strategic enablers and were planned for under this strategic objective.

Costing is an important component of HIV/AIDS strategic planning to ensure that funding needs are understood and sufficient funding is allocated to achieve the strategic objectives of the PSPs. Strategic Development Consultants (SDC) and the Centre for Economic Governance and AIDS in Africa(CEGAA)conducted a costing exercise to determine the resource needs of the PSP Implementation Plans. The costing of Provincial Implementation Plans for HIV/AIDS, STIs and TB Report of SANAC, SDC and CEGAA (2012) identified some differences in PSP and NSP sub-objectives, with some provinces identifying their own sub-objectives and activities different from those in the NSP but somewhat supporting the broader strategic objectives identified.

The Provincial AIDS Councils (PACs) in South Africa are constituted by a combination of sectors including government departments, private sector and non-governmental organisations that come together to help mitigate HIV/AIDS within each province. During the compilation of the PSPs and the PSP Implementation Plans, all parties are meant to come together and shared responsibilities on the given mandate. Such structural arrangements are meant to avoid duplication of services which would result in inefficient supply, overfunding and/or underfunding of certain services. This end is however not always achieved as business tends to shy away from the inter-sectoral meetings. In the end, it is mostly government, NGOs and International NGOs that compile the PSPs and are given responsibility depending on their capabilities and their resource availability.

Figure 1 below shows the linkage between the NSP, PSP, and the Provincial Strategic Implementation (Operational) Plans.

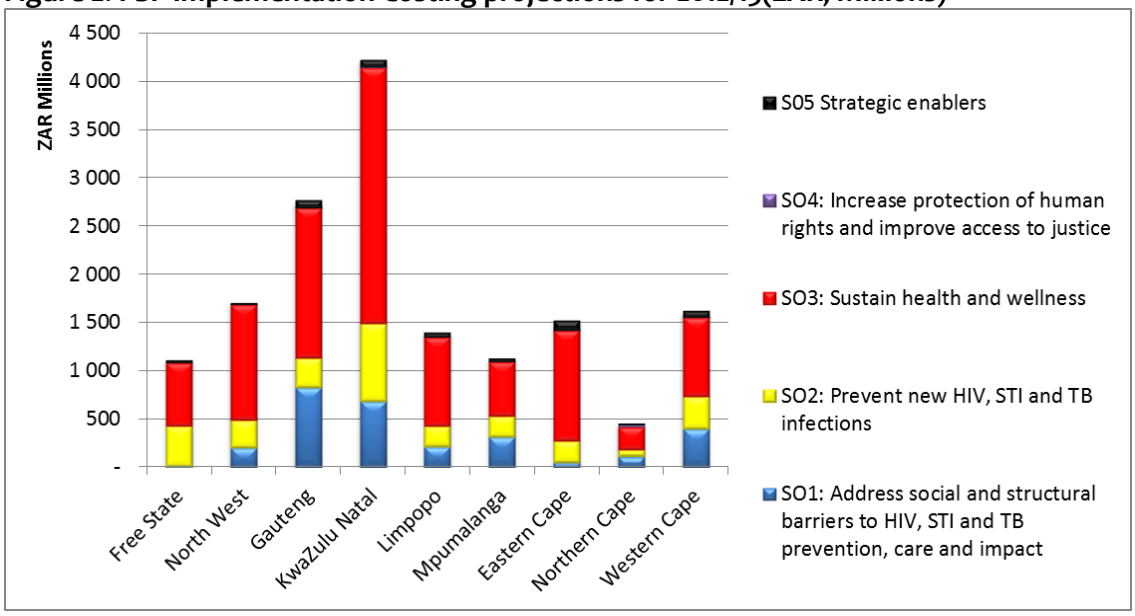
**Figure 1: Linkage between the Provincial Strategic Plan and the Operational Plan**




**Source: SANAC (2012)[4].**

The NSP was costed in September 2011 and following suit the PSP Implementation Plans were drawn up and costed by December 2012. Figure 2 shows the provincial costing projections for 2012/13. These, however, may not have translated into actual budgets for the provinces as only the government social sector (which includes Departments of Education, Social Development, and Health) expenditure information is publicly available and is regularly analysed.

**Figure 2: PSP Implementation Costing projections for 2012/13(ZAR, Millions)**




**Source: SANAC, SDC, and CEGAA 2012[5]**

4 South African National AIDS Council, SDC, and CEGAA (2012). Northern Cape Cost Analysis: Northern Cape Multi-sectoral Operational Plan.

[5]South African National AIDS Council, SDC, and CEGAA (2012). Costing Provincial Implementation Plans for HIV/AIDS, STIs and TB Report.

Table 2 gives a breakdown of the costing projection for all the provinces in the 3 year period (2012/13 – 2014/15).

**Table 2: PSP Implementation Plan Cost Projections (2012/13-2014/15, R'million)**

| R'million | 2012/13 | 2013/14 | 2014/15 | Total (2012/13 - 2014/15) |
|---|---|---|---|---|
| **EC** | 1 524 | 1 592 | 1 803 | 4 919 |
| **FS** | 1 112 | 1 153 | 1 275 | 3 540 |
| **GP** | 2 767 | 3 167 | 3 484 | 9 418 |
| **KZN** | 4 230 | 6 287 | 7 204 | 17 721 |
| **LP** | 1 398 | 1 591 | 1 815 | 4 804 |
| **MP** | 1 130 | 1 321 | 1 554 | 4 005 |
| **NC** | 454 | 558 | 644 | 1 656 |
| **NW** | 1 708 | 1 954 | 2 222 | 5 884 |
| **WC** | 1 624 | 1 842 | 1 875 | 5 341 |
| Total | 15 947 | 19 465 | 21 876 | **57 288** |

**Source: Data adapted from the SANAC, SDC, and CEGAA 2012report[6].**

Because of the unavailability of budget or expenditure figures from sectors outside of the public sector, and from other government departments outside of the social sector, it is difficult to ascertain whether the whole PSP costing projections were met. Apart from the National and Provincial AIDS Spending Assessments (NASA,PASAs) conducted by CEGAA and funded by the UNAIDS, detailed PSP expenditure has never been fully tracked. The last South African NASA was for the period 2009-2011, and included expenditure from government, NGOs, International NGOs, private business, and the community.

The costing exercise (Table 2 above) shows that there could be funding gaps for the PSP funding in 2012/13 and the later years, as only about R10,7 billion was allocated by the social sector government departments for HIV, TB and STIs from the national revenue in 2013/14, against R19,4 billion estimated in the PSP costing. Regular NASA/PASA exercises need to be conducted to fully understand spending trends and to develop appropriate funding plans. The NASA/PASA would assist in understanding the contributions made by other sectors to fight the HIV/AIDS epidemic, as part of the PSP/NSP objectives.

The next sections explore the provincial budget allocations for the 2013/14 financial year for the departments of Health (DOH), Social Development (DSD), and Education (DOE). These are the government departments tasked to work towards achieving the NSP's vision, goals, and objectives. Due to limited time and lack of funding to conduct PASAs, only government departments which have their expenditure information in the public domain (i.e. Provincial Expenditure Estimates Documents on the National Treasury Website) will be reviewed below.

## 3. Provincial HIV/AIDS budget allocations for 2013/14

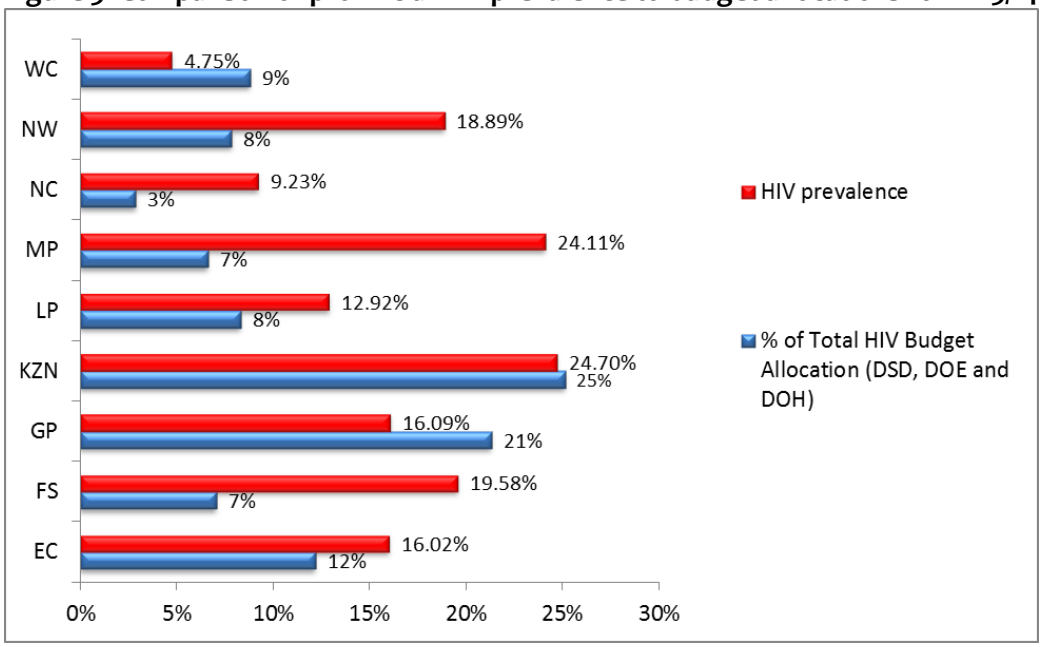
The social sector HIV/AIDS and TB allocations include the DOH Conditional Grant (CG) and Equitable Share (ES) for HIV/AIDS, DSD HIV/AIDS Equitable Share, and the DOE Life skills Conditional Grant. Most of the provinces have shifted their DOH HIV/AIDS activities fully onto the conditional grant resulting in some provinces having no sign of ES allocations in the provincial

[6]South African National AIDS Council, SDC, and CEGAA (2012). Costing Provincial Implementation Plans for HIV/AIDS, STIs and TB Report.

budget and expenditure statements. Only FS, GP, MP, NC still have equitable share allocations for HIV/AIDS.

Figure 3 below shows proportions of provincial HIV/AIDS budgets against the provincial proportions of HIV prevalence. This graph shows that in KwaZulu-Natal 24.7% of adults in KZN are HIV-positive and are supported by the largest share of the HIV/AIDS public funding of 25% of the total provincial HIV/AIDS budgets. The Free State Province has 19.58%HIV prevalence but has the second smallest share in HIV/AIDS public funding. This finding could assist in raising issues around equity, to ensure that needy provinces are given enough funds to finance their HIV/AIDS response. HIV/AIDS has been identified as one of key intervention areas for the health sector requiring prioritisation in funding and implementation. Such key intervention areas have been name "Non-negotiables" by the National Health Council and the National Department of Health, to ensure that provinces prioritise them in their implementation plans.

**Figure 3: Comparison of provincial HIV prevalence to budget allocations for 2013/14**




**Sources: National Treasury Provincial Expenditure Estimates Documents (2014), National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa (2012)**

Note: Eastern Cape (EC), Free State (FS), Gauteng (GP), KwaZulu-Natal (KZN), Limpopo (LP), Mpumalanga (MP), Northern Cape (NC), North West (NW), and Western Cape (WC), Department of Health (DOH), Department of Social Development(DSD) and Department of Education (DSD)

The following section discusses the un-audited provincial expenditure for the year 2013/14, also referred to as Revised Estimates of spending until audited figures are released. The provincial health HIV/AIDS services are provided through the District Health Services Programme, funded mainly through the CG from national government, the ES from the provinces and donor funding.

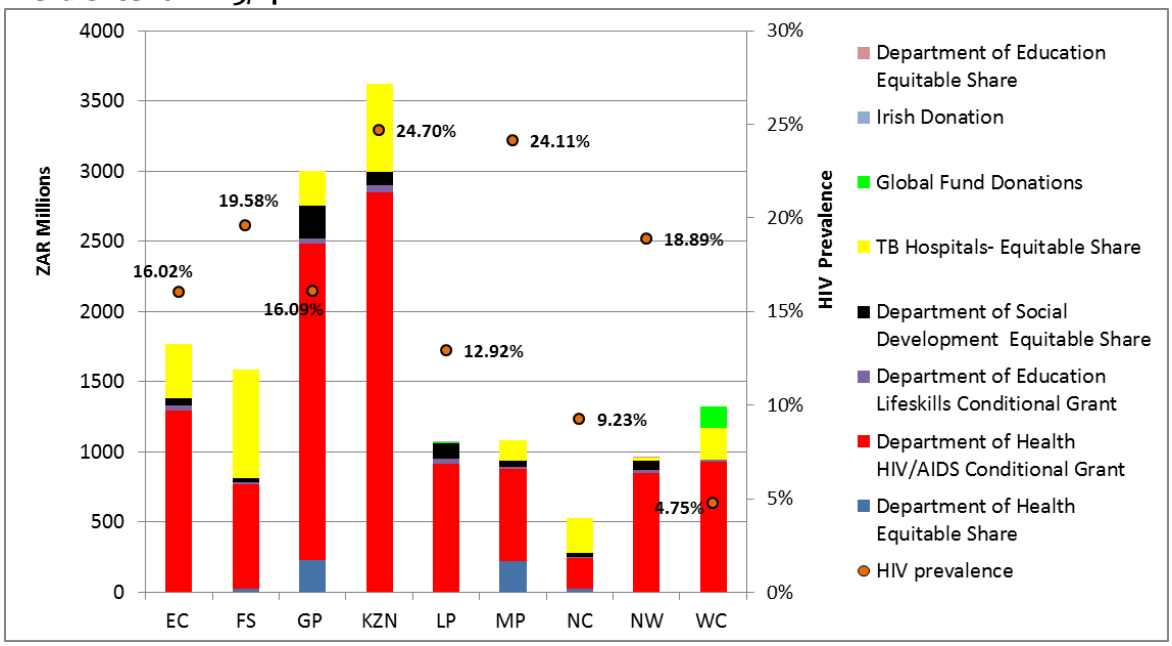
## 4. Provincial HIV/AIDS expenditure for the financial year 2013/14

As mentioned above, most of the provinces have shifted their DOH HIV/AIDS activities fully onto the CG funding resulting in some provinces having no sign of ES allocations in the provincial budget and expenditure statements. The provincial ES spending amounts are determined by deducting the CG from the total provincial HIV/AIDS spending within the District Health Services budget. The data to do these calculations can be attained from the National Treasury Provincial

Expenditure Estimates Documents[7]. Figure 4 and Table show that the DOH HIV/AIDS CG provided the largest contribution to HIV/AIDS expenditure in almost all provinces in 2013/14, except for the Free State where most of the money was spent on the TB Hospital CG.

In North West, the DOH HIV/AIDS CG provided 89% of the HIV/AIDS and TB funding, with very little contributions from other sources. Interestingly, the 2014/15 provincial budget statements show that Mpumalanga Provinces spent the largest amount of HIV/AIDS funding from the provincial ES amongst those provinces that allocate ES funds to HIV. The KZN social sector departments (DOH, DSD, and DBE) spent R3.62 billion on HIV/AIDS and TB Services (or 24% of total provincial HIV/AIDS and TB spending) followed by GP (R3.04 Billion or 20%) and LP (R1.77 billion or 12%). NC spent the least amount of R526 million, or 4% of the total HIV/AIDS payments by all provinces combined. Figure 4 shows proportional expenditure by the different HIV/AIDS and TB funding channels at provincial level.

**Figure 4: Nominal spending of the total Provincial HIV/AIDS and TB budgets against HIV Prevalence for 2013/14**




**Sources: National Treasury Provincial Expenditure Estimates Documents (2014).**

*Irish Donation assisted LP in the control and prevention of the spread of HIV and AIDS and gender mainstreaming.

[7] National Treasury Provincial Expenditure Estimates Documents (2014). Available on http://www.treasury.gov.za/documents/provincial%20budget/2014/4.%20Estimates%20of%20Prov%20Rev%20and%20Exp/Default.aspx.

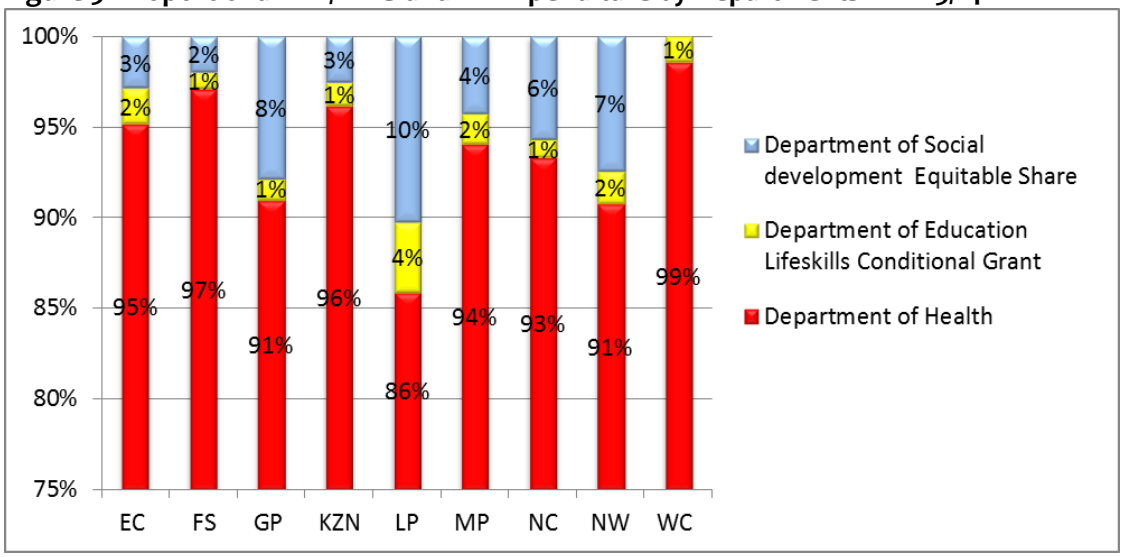
**Table 3:Nominal spending of the total Provincial HIV/AIDS and TB budgets for 2013/14 (ZAR, Thousands)**

| 2013/14 Revised Estimate | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **ZAR Thousands** | **EC** | **FS** | **GP** | **KZN** | **LP** | **MP** | **NC** | **NW** | **WC** |
| Department of Health Equitable Share | | 26 655 | 228 073 | | | 221 453 | 22 276 | | |
| Department of Health HIV/AIDS Conditional Grant | 1 295 620 | 742 984 | 2 258 483 | 2 852 072 | 911 867 | 654 267 | 223 532 | 853 127 | 927 547 |
| Department of Education Lifeskills Conditional Grant | 34 895 | 14 441 | 34 803 | 48 634 | 42 022 | 18 015 | 5 205 | 16 122 | 18 501 |
| Department of Social Development Equitable Share | 50 773 | 31 675 | 235 797 | 90 978 | 109 230 | 46 290 | 30 072 | 71 434 | |
| TB Hospitals- Equitable Share | 384 156 | 769 639 | 247 337 | 628 315 | | 140 137 | 245 808 | 20 375 | 224 937 |
| Global Fund Donations | | | | | 3 407 | | | | 155 005 |
| Irish Donation | | | | | 4 917 | | | | |
| Department of Education Equitable Share | | | | | | | | 1 051 | |
| **Total** | **1 765 444** | **1 585 394** | **3 004 493** | **3 619 999** | **1 071 443** | **1 080 162** | **526 893** | **962 109** | **1 325 990** |

**Sources: National Treasury Provincial Expenditure Estimates Documents (2014).**

Figure 5 shows the proportional spending of the total DOH payments in comparison to the DSD and DOE. Spending in all provinces was dominated by DOH with 90% and above of total HIV/AIDS and TB provincial funds, except for LP.

**Figure 5: Proportional HIV/AIDS and TB Expenditure by Departments in 2013/14**

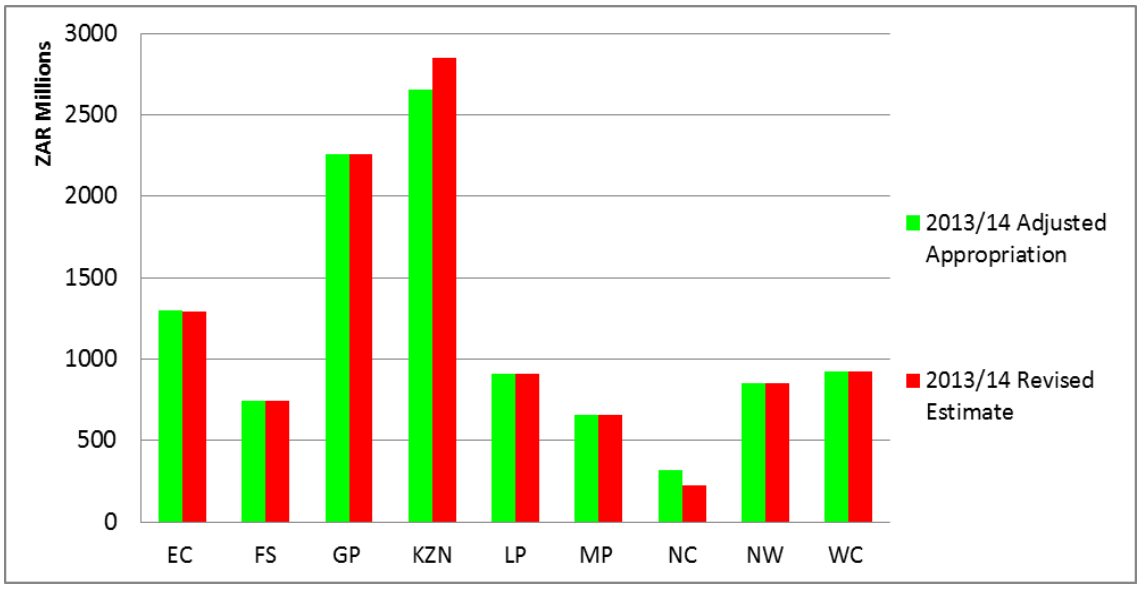



**Sources: National Treasury Provincial Expenditure Estimates Documents (2014).**

## 5. Absorption of the 2013/14 health HIV/AIDS budgets

Figure 6 below compares the adjusted appropriation and the revised estimate payments[8]for 2013/14[9] found in the provincial estimate documents on the South African National Treasury website. FS, GP, LP, MP and WC fully absorbed their DOH CG for HIV/AIDS. The rest nearly reached full absorption except for KZN who overspent on their allocation and Northern Cape who under spent.

**Figure 6: Provincial DOH HIV/AIDS Conditional Expenditure; Adjusted Appropriation versus Revised Spending Estimate for 2013/14 financial year (ZAR Millions)**




**Sources: National Treasury Provincial Expenditure Estimates Documents (2014).**

Table 4 shows provinces' absorption capacity by comparing the adjusted appropriation and the revised spending estimates. KZN overspent its 2013/14 combined social sector (DOH, DSD, and DOE) HIV/AIDS budgets by 4.8%. Northern Cape spent the smallest amount of money at 72,6% of the combined social sector HIV/AIDS budget.

[8]The revised estimate payments refer to payments made by spending agencies against the adjusted appropriations. Once finalized at the end of the financial year, these are referred to as 'final outcomes', and 'audited expenditure' once audited.

[9] National Treasury Provincial Expenditure Estimates Documents (2014). Available on http://www.treasury.gov.za/documents/provincial%20budget/2014/4.%20Estimates%20of%20Prov%20Rev%20and%20Exp/Default.aspx.

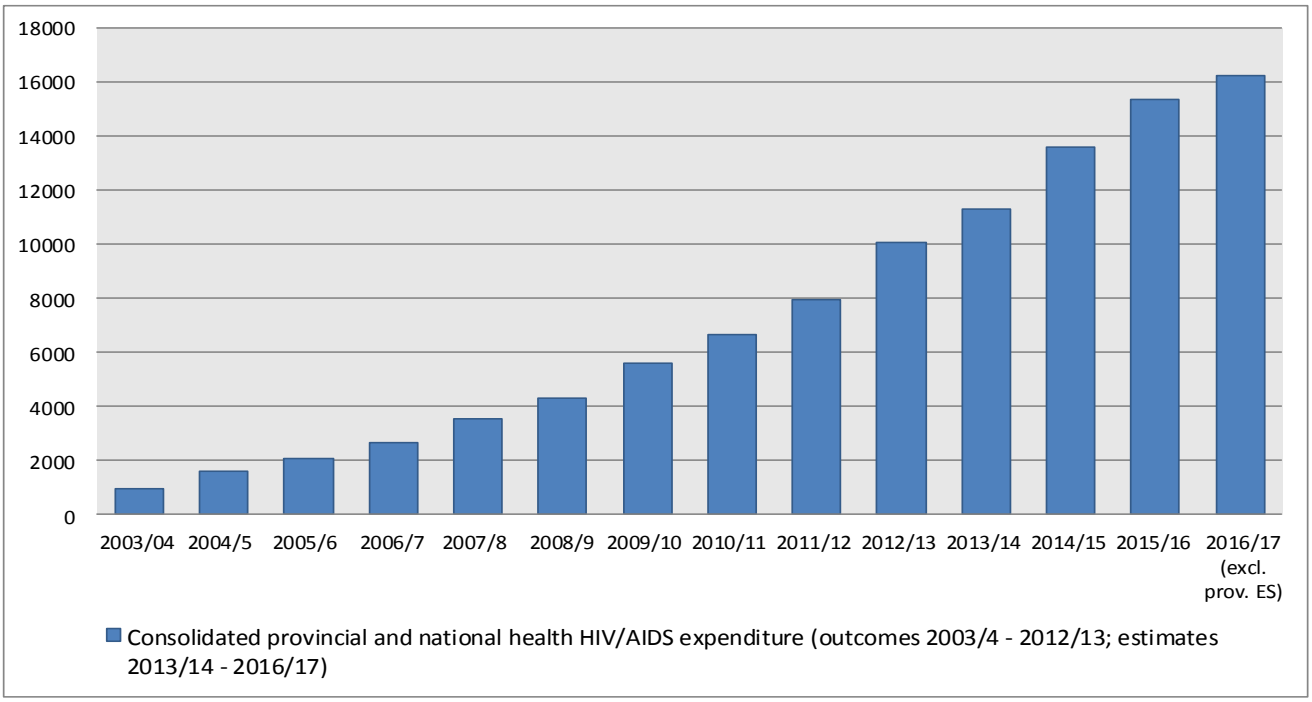
**Table 4: Provincial Total HIV/AIDS and TB Adjusted Appropriation versus Revised Estimate for 2013/14 (ZAR, Thousands)**

| Provinces; R'million | 2013/14 Adjusted Appropriation | 2013/14 Revised Estimate | Absorption % |
|---|---|---|---|
| EC | 1 780 | 1 765 | 99,2 |
| FS | 789 | 789 | 100,0 |
| GP | 2 872 | 2 776 | 96,7 |
| KZN | 3 454 | 3 620 | 104,8 |
| LP | 1 071 | 1 071 | 100,0 |
| MP | 853 | 859 | 100,7 |
| NC | 356 | 259 | 72,8 |
| NW | 942 | 942 | 100,0 |
| WC | 1 325 | 1 326 | 100,1 |
| TOTAL | 13 442 | 13 407 | 99,7 |

**Sources: National Treasury Provincial Expenditure Estimates Documents (2014).**

Despite the increasing budget allocations for HIV/AIDS and TB in the social sector of government, provincial departments are capable of absorbing the funds for their contributions in the implementation of the PSPs. There is however a pressing need to have all sectors, including other public sector departments other than the social sector, as well as the private sector share their plans, budgets, and expenditure records to be able to assess their contribution in the implementation of the PSPs. Figure 7 below shows the trends in HIV/AIDS budget allocations and spending in the health sector, demonstrating increased absorption capacity.

**Figure 7: Historical record of increasing health HIV and AIDS funding in South Africa, nominal figures, R'million. 2003/4 to 2012/13: budget outcomes; 2013/14 to 2016/17: budget estimates.**




**Source: Ndlovu & Meyer-Rath (2014)[10].**

[10]Ndlovu, N. & Meyer-Rath, G. 2014. *Reflecting on health, HIV/AIDS and TB budgets and services in South Africa: Review of the 2014 South African National Budget.* Budget Policy Brief 6. 11 June 2014.

## 6. Conclusion

The South African provinces strive to implement their PSPs through their PSIPs to mitigate the impact of HIV/AIDS and TB in the provinces. Funding for these diseases from government has drastically increased and provincial departments have demonstrated their capacity to spend these funds, as shown in Figure 7. However, there is increasing demand for sound reporting on both programme and budget performance. More financial and operational management capacity is required to ensure that provinces utilise available resources in a cost-effective and impactful manner. Health systems also need to be strengthened, including human resources for health and costing, budgeting and health financing research capacity within the government system.

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