Profile

The Impact of Global Health Initiatives on Access to Antiretroviral Therapy in South Africa

Annie Neo Parsons, Thubelihle Mathole and David Sanders
School of Public Health, University of the Western Cape

Introduction

South Africa's health funding does not rely on international donors – except in regard to HIV-related services. Donor aid was less than 1% of South Africa's overall health budget in 2007, but accounted for 26% of HIV and AIDS expenditure.[1] Though donor funding has dramatically increased since 2000, the South African government remains the largest source of HIV-related funding in South Africa.[2] The number of patients in need of antiretroviral therapy (ART) continues to grow, with South Africa's antenatal HIV prevalence standing at 29.3% in 2008.[3]

ART access is one element of South Africa's response to its HIV epidemic, and is also the most costly. Financially it is the largest component in the government's HIV and AIDS and STI Strategic Plan (NSP) for South Africa, 2007-2011 and attempts to meet a need that is unprecedented in scale.[4] The public sector had initiated a cumulative 678 550 patients on ART by December 2008; by April 2009 this was up to 781 478 patients.[5] Initial tardiness in initiating public sector ART, a shortage of health professionals in rural areas and difficulties in accrediting sites for treatment, have led to many facilities relying on civil society organisations (CSOs) funded by external donor support. Government's ability to replace such funds is limited and it faces significant challenges in meeting health equity goals and the growing HIV treatment demands of South Africa.

Two Global Health Initiatives (GHIs) provide the majority of external donor support for HIV-related services in South Africa: the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to fight AIDS, Tuberculosis and Malaria (GFATM). South Africa's status as a middle-income country has limited GHI activity, much of which focuses on a narrow number of global health concerns.[6] Almost all GHI funding for South Africa is HIV-related.[a] GFATM funds are channelled through national or provincial government departments, whereas PEPFAR directly funds both government and non-government organisations. As a result of the national public sector ART programme initiated in 2004, most CSOs providing HIV-related treatment operate at government facilities.[b]

South Africa still has a significant burden of unmet need for ART. Universal access to ART within five years was the goal of the government in 2004, but this was revised in 2008 to 2011.[7] Issues of access and levels of service delivery affect the ability of the public sector to address such need. The distribution and concentration of both government and donor-funded resources is an important step in ensuring equity.

This review arises out of a broader four-year European Union-funded INCO-DEV study at the School of Public Health, University of the Western Cape. The project aims to understand the impact of GHIs on the South African health system. Data collection has involved document analysis and individual interviews at national level, with further research at selected provincial, district and sub-district levels. Findings reflect fieldwork at national and sub-national levels from 2008-2010. Findings are time-bound as there are continual changes in the availability and specificity of global funding for health; this is indicated wherever applicable.

Findings

It was evident early on that the government faced three primary problems in delivering ART services: financing, human resources distribution and availability, and ensuring patient access to health care.[3] This three-way challenge is exacerbated by the reliance in South Africa on a physician-driven model for ART initiation, despite a shortage of physicians within the public sector.

Since 1994 South Africa's health policies have focused on ensuring equity in health care service delivery, financing and access to primary care, focusing on vulnerable groups and 'diseases of poverty'.[8] The National Treasury allocates funds

a South Africa's post-1994 public health sector focused on tuberculosis treatment, but initially did not directly address the country's growing HIV-related burden of disease. Subsequent efforts illustrate the associated costs of a mature HIV epidemic. GHI funding has largely concentrated on tuberculosis as part of the disease burden faced by people living with HIV and not as a separate disease entity.

b There are a limited number of independent CSO treatment sites. The majority work as part of the public sector.

for health care to provinces using equity-based formulae, principally the Provincial Equitable Share criteria. The District Health System is the main service delivery mechanism, in line with national guidelines. However, the federalist structure of South Africa's government gives provinces considerable autonomy in allocating funds. Concern over the inadequate allocation of funding by provinces to district ART programmes led to the dedication of funds per province for HIV treatment, with strict limits on use, and managed by the National Department of Health as a Conditional Grant.[9]

In 2008/9 South Africa's provincial departments of health spent R3.752 million on their District Health System HIV and AIDS sub-programmes (Table 1).[10,c] The National HIV and AIDS Conditional Grant accounted for 68.9%, with the remaining shortfall funded by each province's equitable share. The Conditional Grant was restricted to financing antiretrovirals, limited human resources and laboratory services.

Table 1: Provincial expenditure on HIV and AIDS, 2008/9

Province	HIV and AIDS sub-programme (R millions)	Conditional Grant 2008/9 (R millions)	Public Sector ART patients as of April 2009	Expenditure per ART patient	% Difference from average expenditure
Eastern Cape	R 396	R 301	79 846	R 4 960	3%
Free State	R 214	R 190	41 399	R 5 169	8%
Gauteng	R 707	R 541	190 442	R 3 712	-23%
KwaZulu-Natal	R 1 239	R 630	235 134	R 5 269	10%
Limpopo	R 257	R 234	51 566	R 4 984	4%
Mpumalanga	R 225	R 152	48 974	R 4 594	-4%
Northern Cape	R 113	R 91	12 279	R 9 203	92%
North West	R 332	R 205	64 925	R 5 114	7%
Western Cape	R 269	R 241	56 913	R 4 727	-2%
National	R 3 752	R 2 585	781 478	R 4 801	

Source: National Treasury, 2009;[10] Department of Health, 2010;[9] Department of Health, 2009.[5]

South Africa first applied to the GFATM in Round 1 and has received a total of three rounds of funding to both national government and specific provinces. By September 2008 the GFATM had approved US$ 228.7 million, of which only US$ 140 million had been disbursed.[11] PEPFAR funding for South Africa is considerably greater than that approved by the GFATM. PEPFAR allocated US$ 562 million for financial year (FY) 2008 alone,[12] of which 70% had been distributed by the end of the US government's fiscal year.[d] In addition, much of the GFATM funding was for support services such as home-based care. PEPFAR's allocation for HIV treatment services was around 49% of its total for South Africa in FY2008.

Most CSOs providing treatment-related services are funded by PEPFAR. These funds are over and above those of the Conditional Grant or provincial HIV/AIDS sub-programme expenditure. PEPFAR's allocation for ART-related services in FY2008 alone was equivalent to 83% of the South African government's 2008/9 Conditional Grant for HIV and AIDS and equal to 57% of provincial expenditure on HIV and AIDS sub-programmes (Table 2). The abilities of national and provincial government to impact on the use of donor funding vary considerably when such monies are channelled through CSOs.

Table 2: South African expenditure and PEPFAR allocation for HIV treatment services, 2008/9

Item	US$	Amount per ART patient (public sector)
Provincial expenditure on HIV and AIDS sub-programmes	454.2 million	US$ 581.25
National Conditional Grant for HIV and AIDS, 2008/9	313.0 million	US$ 400.54
PEPFAR allocation for HIV treatment services, FY2008	258.2 million	US$ 330.40
Total	712.4 million	US$ 911.65

Source: National Treasury, 2009;[10] Department of Health, 2010;[9] PEPFAR, 2010.[12]

Available spending allocations for the South African government and PEPFAR indicate that an overall US$ 712.4 million was available in 2008 for HIV treatment and services in South Africa. A 2007 costing for the 2007-2011 NSP estimated that providing a comprehensive, community-based care model by 2008 would involve in the region of US$ 521.7 million.[13]

The effects of such GHI financing on equitable access to ART in South Africa are difficult to estimate. GFATM funds are in theory easier for government to align with national policies, but the use of such funds is complicated by GFATM monitoring requirements. Ideally, externally-funded projects should concentrate where there is the greatest need in terms of service delivery and poverty. In theory, PEPFAR has the financial capacity to address the government's ART delivery problems – financing, human resources and geographical access. Many of the primary care facilities surveyed for the INCO-DEV project relied on staff provided by PEPFAR-funded CSOs. The location of PEPFAR-funded ART projects is therefore an important issue for ensuring equity of treat-

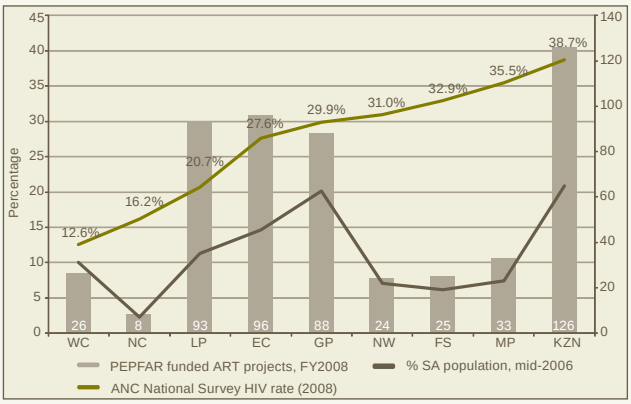
c ART services account for almost all District Health HIV/AIDS sub-programme activities.

d Donor funding cycles typically reflect those of the funder and not the recipient country. PEPFAR follows the U.S. Government's fiscal year (FY) of October 1 to September 30 of the following year. The South African government's fiscal year runs from April 1 to March 30 of the following year.

ment access for people living with HIV infection.[e]

Comparing the location of PEPFAR's 519 ART projects in FY2008 with the estimated antenatal HIV prevalence rate in each province for the same year shows the concentration of projects tended to reflect each province's relative population (Figure 1). This does not necessarily reflect need, however, as provinces with higher antenatal rates are more likely to have greater numbers of patients in need of HIV treatment services. Examining the number of projects per province also hides the relative distribution of services within each province.

Figure 1: 2008 concentration of PEPFAR funded ART projects by province, population and HIV prevalence



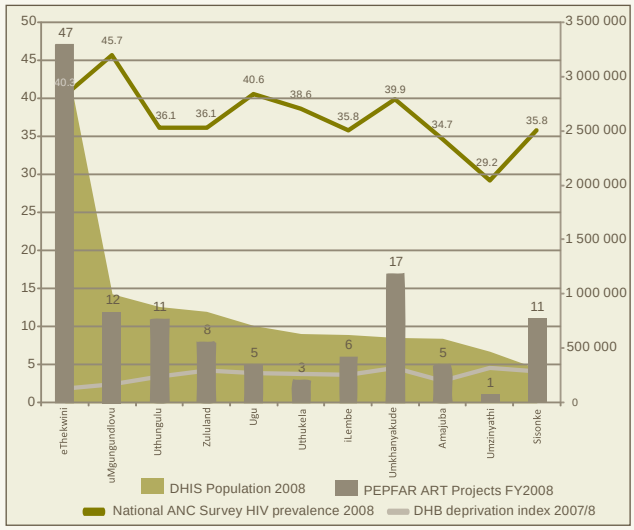
Source: PEPFAR, 2010;[12] Day et al., 2010.[4]

A more detailed view is possible when looking at the number of PEPFAR-funded ART projects in FY2008 for the 11 KwaZulu-Natal districts as shown in Figure 2. Except for eThekwini district the relative population of each district does not correlate with the number of ART projects. uMgungundlovu had the highest estimated HIV prevalence among women attending its antenatal services in 2008, but fewer projects than Umkhanyakude, which also had about a third less population in 2008.

Both CSO and government employees in KwaZulu-Natal interviewed for the INCO-DEV Project noted that lack of general infrastructure – as is often the case outside the major cities – is a significant barrier to delivering ART services. PEPFAR's initial funding plans exacerbated this trend by encouraging CSOs with existing projects to apply for funding. PEPFAR's Country Operational Plans (COPs) for South Africa encourage focused applications that report on specific programme components, dividing up a patient's 'continuum of care' into prevention, treatment and care.[12] INCO-DEV project interviewees noted that once funds are allocated it is possible to shift line items, but reports must reflect agreed targets at the end of each given period. Such a results-based model undermines the ability of CSOs and government to implement integrated and comprehensive programmes that

e PEPFAR funding for HIV treatment in FY2008 reflects allocated amounts, not actual expenditure.

Figure 2: Number of PEPFAR-funded ART projects by KwaZulu-Natal district, deprivation index, antenatal HIV prevalence and population, FY2008



Source: Day et al., 2010;[4] PEPFAR, 2010.[12]

address rehabilitation and care as well as treatment and prevention. Intersectoral actions to address the social determinants of health are also side-lined.

Conclusion

GHIs contribute a significant percentage of the funds spent on ART services in South Africa. But international donor commitments are always subject to global political and economic considerations. Both GFATM and PEPFAR announced new limits on their funding from 2009 and it is likely that these restrictions will continue for the foreseeable future. Neither funding source is assured, even once funding is allocated at central level.[f]

The South African government cannot, however, easily replace the extent of its external financing for ART. South Africa's ART programme will have initiated over a million patients by the end of 2010, with increasing efforts to ensure that those in need are able to access treatment. Sustainability is of particular concern as current protocols emphasize that patients initiated on ART must be maintained on medication for life.

The amount of money provided through PEPFAR to South Africa – even with a 10% reduction in funding levels from 2009 – must be considered when planning for the future.[g] Public sector health facilities' reliance on PEPFAR-supported services suggests that either government has under-budgeted

f Donors typically report on amounts allocated and amounts distributed; these often differ.

g In 2009 PEPFAR announced that it would provide once-off funding for South Africa's antiretroviral purchasing system to the amount of US$ 120 million over two years.

necessary expenditure or that certain areas are receiving higher levels of service delivery than the national average. Government efforts to ensure equity are substantially affected by donor funding.

The provision of services at primary care level remains a key area of concern in South Africa, with limited human resources and constrained funding for expanding services to those without sufficient access. Donor-funded projects are an important source of support for public sector ART services, though they may aggravate existing inequalities. GHI funding protocols also tend to fragment a patient's 'continuum of care'. Harmonising funding with government policies offers expanded ability to address such inequalities. However, this will involve the review of funding models to ensure comprehensive health services in poorly resourced areas over the long term.

In summary, South Africa must push for continued GHI funding of its ART programme. This should, however, involve a comprehensive and integrated approach that ensures funds address need across districts, services and time and are aligned effectively with national policy and priorities.

References

1 Organisation for Economic Co-operation Development. 2006 Survey on Monitoring the Paris Declaration, South Africa. Development Co-operation Directorate; 2007.

2 Schulz-Herzenberg C. A Lethal Cocktail: Exploring the Impact of Corruption on HIV/Aids Prevention and Treatment Efforts in South Africa. Pretoria: Institute for Security Studies; 2007.

3 National Department of Health. HIV and AIDS and STI Strategic Plan for South Africa, 2007-2011. Pretoria: South African National AIDS Council; 2007.

4 Day C, Monticelli F, Barron P, Haynes R, Smith J, editors. The District Health Barometer 2008/09. Durban: Health Systems Trust; May 2010.
URL: http://www.healthlink.org.za/publications/864

5 National Department of Health. National Strategic Plan for HIV and AIDS/ CCMT Monthly Statistics. Pretoria: National Department of Health; 2009.

6 Brugha R. Global Health Initiatives and Public Health Policy. In: Heggenhougen K, Quah SR, editors. International Encyclopedia of Public Health. San Diego: Academic Press; 2008: 72-81.

7 Bateman C. Public sector ART sites finding 'disturbing'. S Afr Med J. 2008; 98(4): 242-243.

8 Chetty KS. Equity Promoting Health Care Policies in South Africa. A literature review commissioned by the Health Systems Knowledge Network. Geneva: World Health Organization; 2007.

9 National Department of Health. Public Hearings on the Division of Revenue Bill, 2010. Presentation to the Standing Committee on Appropriations. 2010 Feb 25.

10 National Treasury. Health. Provincial Budgets and Expenditure Review: 2005/06 - 2011/12. Pretoria: National Treasury; 2009.

11 Global Fund for AIDS, Tuberculosis and Malaria. South Africa Grant Performance Report. Geneva: Global Fund for AIDS, Tuberculosis and Malaria; 2010.

12 PEPFAR. South Africa Fiscal Year 2008 Country PEPFAR Operational Plan. Washington DC: PEPFAR; 2010.

13 Cleary S, Blecher M, Boulle A, Dorrington R, Darkoh E, Bogopane-Zulu H. The Costs of the National Strategic Plan on HIV and AIDS and STIs, 2007-2011. 2007 Oct.