HIV/AIDS Financing

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There is a complex array of mechanisms through which resources destined for HIV/AIDS flow to provincial health departments, the key site of delivery of a number of HIV/AIDS prevention and care services. Much of this complexity has emerged in the last two years, as the national Department of Health (DoH) sought to establish alternative, perhaps more cost-effective modes of prevention, care and treatment at provincial level. Provinces have recently also prioritised and sought to increase the status of HIV/AIDS structures and the level of resources they receive.

National resources directed towards HIV/AIDS units in provincial health departments come from two sources: a 'top slice' of the national collected revenue and from national DoH budget. National resource flows are in two forms: application-based conditional grants and resources in-kind. The chapter looks at how national quantifies and identifies these resources and the mechanisms through which provinces are required to access them, and suggests that some of these resources seem to be inequitably distributed. Some provinces experience problems with the timing of resources and find them difficult to access.

Resources at a provincial level come either from a provincial health department budget or a combination of provincial health budgets and a 'top slice' of the province's equitable share. In most provinces these resources are not quantified on the basis of an intervention or spending strategies.

Units require considerable budget and business planning abilities to direct all these resources effectively. Given the lack of coherent strategic plans within provincial HIV/AIDS units, these skills seem to be lacking. As many of the interventions being introduced at provincial level are new, well functioning and activity sensitive financial control and monitoring systems need to be put in place to evaluate and improve the interventions and the spending patterns behind them. The structure of the financial information management systems is such that detailed activity reporting is very difficult.

Many resource management challenges arise because HIV/AIDS management structures in their present form are new. In many cases institutional memory has been lost over the years through a lack of continuity of staffing.

The alternative modes of delivery require a huge increase in the involvement of Non-Government Organisations (NGOs). NGOs working in this field are usually quite small and newly formed. The Public Finance Management Act (PFMA) provisions, in effect, mean that only financially competent NGOs can receive transfers of public resources. For these new delivery modes to be successful, innovative ways have to be found to both resource NGOs and simultaneously build-up their financial competencies.

This chapter looks at how resources are being directed toward identified interventions and projects. Some of the incentives that are in place to promote efficiency in spending are considered. Budgets are examined to determine how they are related to need, spending capacity and the project costs by looking at budgeting and control processes. In the case of in-kind resource support, consideration is given to how these are matched to the needs of the delivery agency.

Mechanisms for funding the provincial response to HIV/AIDS

Introduction

Over the last decade both provincial and national government have financed HIV/AIDS activities at the provincial level, the main focus of health service delivery. The national level has tended to fund specific interventions in the realms of prevention and support for People living with AIDS (PWAs) and other affected groups, while provinces have financed clinically based prevention and care responses - the latter mainly through treating opportunistic diseases and providing palliative care. The national level has probably taken on these funding responsibilities because provincial health delivery and financing has been in the process of transformation since 1994. In addition, HIV/AIDS prevention and support represented a new challenge for provinces, for which they have had to develop capacity. Until relatively recently, demand for care has been limited.

In relation to budgeting and resource management, preventative and support interventions have tended to be resourced through funds specifically **designated** for HIV/AIDS, while care interventions have been funded from the routine delivery budgets of health regions, districts and hospitals (what can be termed **non-designated** resources). Where care and clinically based preventative responses e.g. TB and STD services, have required a change in treatment protocols, this change may have been supported using designated funds.

As the epidemic matures, expenditure requirements are spreading to include not only prevention and social mobilisation, but care and support. Since 1999 the impact of the epidemic is becoming clearer and the government has begun to emphasise the need for routine public delivery institutions to mainstream HIV/AIDS interventions, as well as recognising that the epidemic can only be dealt with by drawing heavily on civil society resources. The advent of the Community and Home Based Care and Support (CHBC) interventions, a formal element of the National Integrated Plan (NIP) -

discussed in some detail later - represents the most focused attempt to mobilise civil society resources.

A number of problematic features have recently come to characterise the context in which HIV/AIDS is resourced. At both national and provincial level, spending on HIV/AIDS has been rapidly prioritised over the last few years and significant resources have been shifted towards it; the need for the routine delivery system to respond to care requirements is seen as key. These shifts are occurring in a context of institutional restructuring in which provincial resources have been redistributed across provinces and provinces have largely been given autonomy over these resources. Although government HIV/AIDS strategies have been revisited over time, the institutions through which responses are being resourced have tended to be excluded from consideration.

An analysis framework centred on 'resource streams' was developed to look at how resources are being directed towards identified interventions and projects. Resource streams are resource flows that start from a relatively large pool of public funds, are attached to a particular activity-defined purpose, quantified, given a particular physical and institutional form and controlled as they move from the source to final spending agent or project implementor.

The chapter is structured as follows:

- A description of the institutional and structural context in which HIV/AIDS budgeting and spending occurs, including the management tools used by AIDS structures
- The application of a 'resource streams' framework to the main streams of funding, national and provincial, respectively
- A consideration of how the funding streams measure up to the assessment criteria mentioned above.

Unless otherwise specified, five provincial case studies, as well as research on the national DoH, underpin this analysis.[1] The provinces selected - largely on availability of data - were KwaZulu-Natal (KZN), Gauteng, Northern Province, Eastern Cape, and the Free State. Research was conducted via interviews with key programme and finance staff, both from health departments and treasuries, as well as the study of internal policy documents and business plans. Unfortunately, difficulty with accessing staff and collecting data make the level of detail and understanding uneven across provinces.

HIV/AIDS health units at national and provincial levels

National level

The national DoH has set up a structure at chief directorate level to co-ordinate the government's response to HIV/AIDS within the health sector. The HIV/AIDS Chief Directorate is involved in initiating projects at provincial level, providing resource inputs to these projects and giving them technical support.

Provincial level

Provincial health departments have set up specialised units to manage designated HIV/AIDS activities and their funding. The status of these units has generally been upgraded since late 2000, except for Gauteng, which has enjoyed its current status for three years. Units have either been upgraded to directorate level or there is a stated intention to do so. This increase in stature reflects the political priority given to the epidemic and the advent of a large national programme, the National Integrated Plan (NIP).

There are two types of provincial HIV/AIDS units, those that co-ordinate strategies within the health department (or **health-based** units) and those that co-ordinate strategies both within health and between departments (or **interdepartmental** units). KZN and Gauteng have interdepartmental units. For historical reasons, health-based strategies include non-school based education and information interventions and social mobilisation activities. Interdepartmental strategies give more emphasis to the role of health departments in facilitating other government departments to develop HIV/AIDS responses. Such facilitation occurs through the provision of policy development and planning support and resources to run interventions.

In the past, the HIV/AIDS clinical prevention and public awareness programmes were run somewhat independently of routine public health delivery bodies. For example, district offices through their clinics would run awareness campaigns, or HIV/AIDS counselling initiatives. However, the advent of the new interventions in care (Home Based Care (HBC[a]) and Prevention of Mother-to-Child-Transmission (PMTCT)) and the combination of voluntary counselling and testing (VCT), has necessitated involving hospitals and clinics in running these programmes. These new interventions are more complex, more dependent on participation of existing delivery structures, and more resource-intensive. As a consequence of this change, line managers of districts and regions, such as district managers and CEOs of health district complexes (districts and regional hospitals) are becoming more important to HIV/AIDS service delivery. Accordingly, there are moves to decentralise budgets to them.

a HBC is used to represent the health component of the broader CHBC approach which involves both Health and Social Development Departments.

Provincial units make use of a number of resource mobilisation and management tools, such as strategic plans, business plans, activity budgets and financial reports.

Except in the case of Gauteng, provinces do not have discursive documents explaining their ***strategies***, although sometimes they describe their individual ***activities*** in explanatory documents.

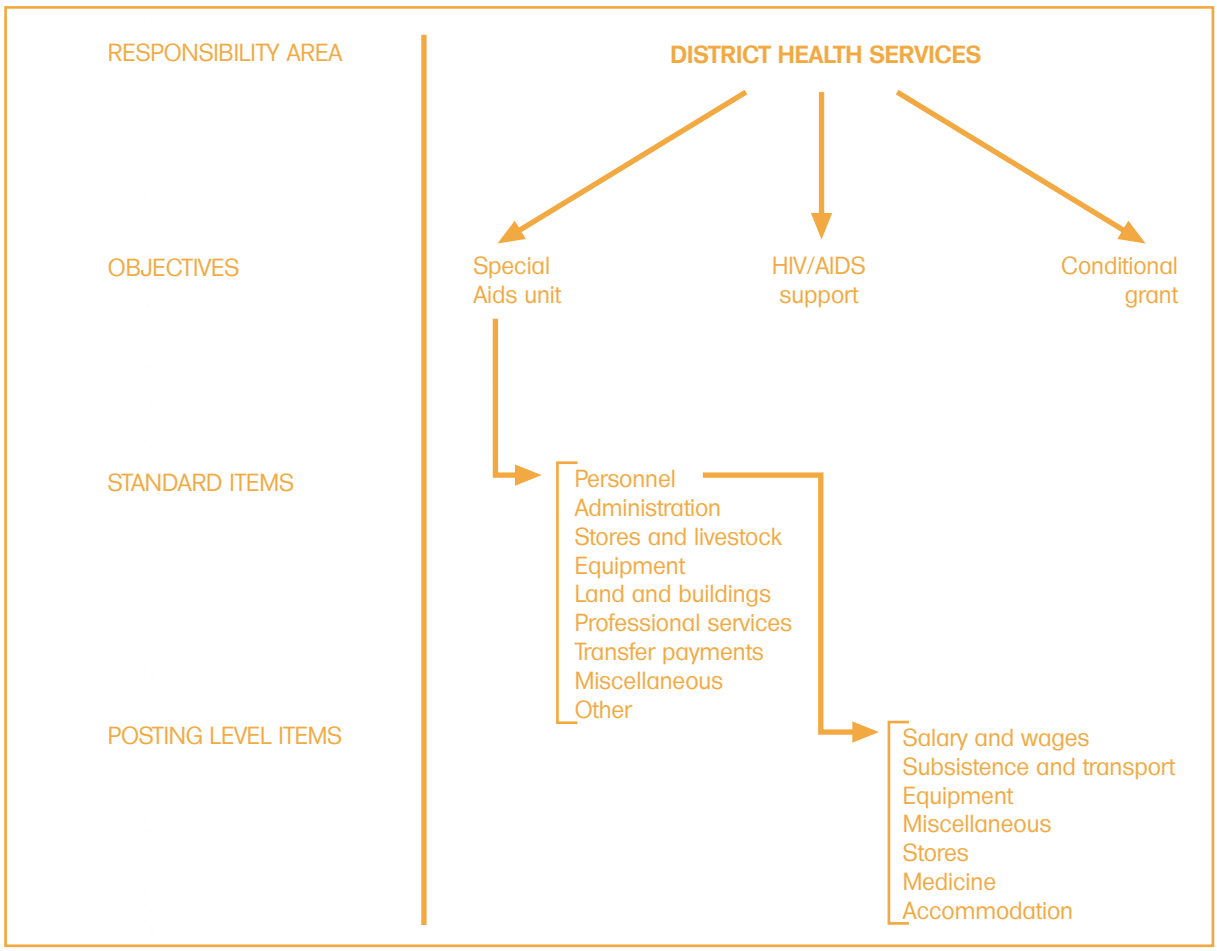
Business plans that exist at various levels are the best way to glean a unit's strategic responses. A number of provinces have unit-wide business or operational plans but some of these are deficient; only Gauteng appears to have a usable business plan.

For strategic and project planning, as well as management and reporting, units generally use some kind of activity budget related to their business plans. Deficiencies in business plans are naturally passed onto their associated budgets. At the time of study, Gauteng was the only province with a comprehensive, functional activity budget.

The formal financial management used by provinces is structured, with local variations, in terms of the following hierarchical categories, with each one wholly containing the next:

- Responsibility code which refers to the programme or the main structure in which HIV/AIDS unit budget is located e.g. District Health
- Objective code which refers to the utilisation of funds within a Programme e.g. for HIV/AIDS Support
- Standard or Economic Classification Line Item
- Posting Items which are sub categories of Standard Items.

Figure 1: Structure of financial information management system as applied by KwaZulu-Natal

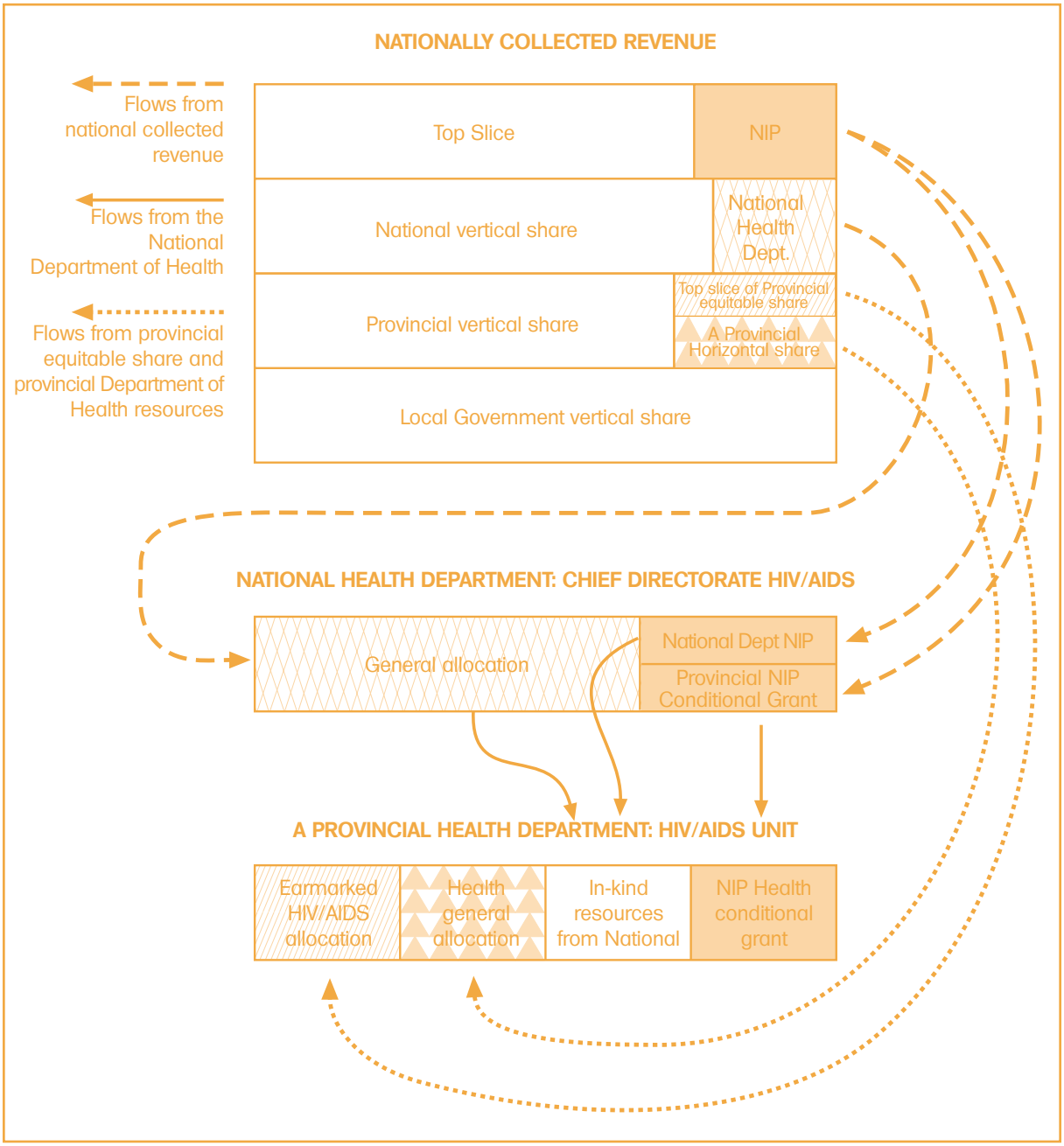


This system does not allow for tracking of funds used for discreet ***activities*** (e.g. HBC). The lowest level of aggregation possible in the system (which could be used to show expenditure by activity) is the 'Objective' code. The system can only comfortably handle a limited number of these codes. To minimise the number of codes in use, a range of expenditure items (HBC, TB, HIV integration, IEC (Information, Education and Communication) etc.) are assigned to a single code. This practice gives rise to a high level of activity aggregation, making it very difficult to use the formal system to track activities and thus generate activity budget reports. Units often have to run parallel reporting systems.

Funds to provinces from national level

Resource streams that flow from national level are either funded from a 'top slice'[b] of nationally collected revenue[c] or from national DoH's allocation from the national sphere's vertical share of nationally collected revenue (see Figure 2). The latter can also be referred to as national DoH's general allocation.

Figure 2: Resource Streams flowing to provincial HIV/AIDS Units



b At a generic level, a 'top slice' is an allocation of resources to a particular activity from a total pool of resources, before the pool is sub-divided into shares that go to activities that routinely receive resources from the pool.

c Other items funded from the top slice of nationally collected revenue include membership fees to international bodies and poverty relief.

Funds flowing from the national level to the provinces take two forms: conditional grants[d] or in-kind resources.[e]

Budgets for in-kind resource flows reside with the HIV/AIDS Chief Directorate which makes spending decisions, controls and is accountable for the expenditure. Provinces receive the goods and services resulting from this spending. There appear to be three main reasons behind the extensive use of these resource streams:

- Given that health budgets are subject to provincial discretion, this provides a way for the national Department to ring-fence health resources
- Provinces often lack the technical capacity to spend resources effectively
- Procurement of certain goods at the national level increases its economies of scale.

National Integrated Plan for HIV/AIDS (NIP)

The National Integrated Plan (NIP) for HIV/AIDS is the only HIV/AIDS set of activities funded from a top slice of the nationally collected revenue. The NIP started in 2000/01 and, at present, its total allocation is projected until the end of the 2002 Medium Term Expenditure Framework (MTEF) planning cycle (i.e. 2004/05). The NIP funds:

Conditional Grants: a set of three conditional grants going to the provinces, one grant going to each of the health, education and social development provincial departments.[f] In line with the programmatic structure of the NIP, the Health Conditional Grant consists of a HBC component and a VCT component. The grants can only be used to fund the direct running costs of the programmes, and not the personnel and administrative costs incurred by provincial departments in terms of the NIP programmes.

In-Kind Grants: the set-up and administrative costs of the NIP for the national departments participating - health, social development and education. The national departments have taken on funding some of the direct provincial costs through in-kind resource flows from their NIP allocations e.g. Assistant Director and Administrative Assistant posts for NIP programmes. In terms of this funding, the provinces run the appointment process, but national must verify the selection decisions. In the health sector, the HIV/AIDS Chief Directorate provides job descriptions for the posts which can be negotiated by the provincial units, although national has the final say. The appointees

d Transfers of money from the national sphere to other spheres that are conditional on certain nationally defined services being delivered or on compliance with nationally specified requirements.

e Resources that are transferred in kind i.e. actual goods or services rather than in the form of cash.

f See Chapter 8 "Mainstreaming HIV/AIDS" : The National HIV/AIDS and STD Strategic Plan for South Africa (2000-2005) and the National Integrated Plan (NIP) for more details.

have short-term contracts (one to two years) with the national DoH; it is envisaged that in the future the staff will simply be taken over by the provinces.

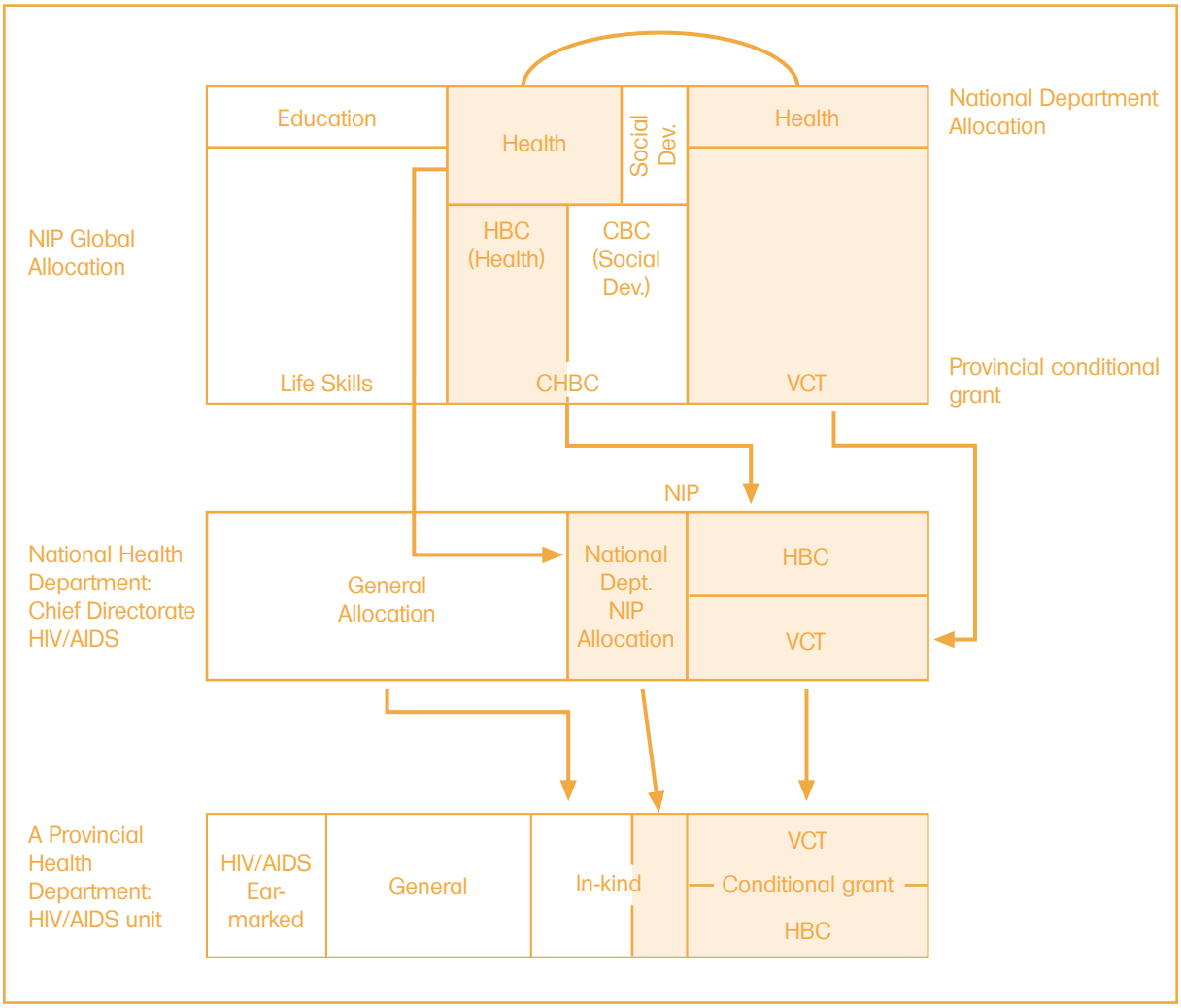
The national DoH bears overall responsibility for the NIP, and houses the national co-ordinator, the co-ordinators for HBC and VCT and consultants for the Life Skills programme. This concentration in health reflects the historical origins of the programmes that make up the NIP. The main decision-making body for the NIP is the National Steering Committee (NSC), which consists of one chief director from each of the national departments involved, and the overall National NIP Co-ordinator who plays the role of secretariat.[2]

Determining the quantities

The global amounts for the NIP budgeted over the first three years were not based on a thorough needs-assessment or costing, and emerged from consultations between the national Treasury and the three national departments.

The NSC ratifies all decisions but the national Treasury and the national NIP Programme Co-ordinators feed into these decisions.

Figure 3: Division of the NIP fund into National and Provincial allocations



- The global amount is split into programme element allocations (Life Skills, VCT and CHBC). In the first two years (2000/01 and 2001/02), half went to Life Skills and the other half was shared between CHBC and VCT. This pattern will continue in the third year, while from the fourth year (2003/04) onwards a large portion of the NIP global allocation will be shifted to the CHBC.
- The allocations to national departments to administer and support the Life Skills, VCT and CHBC programmes are subtracted from the total programme element allocations and given to the appropriate national departments based on the cost of their current and projected roles.
- At least for the third year and the years following, the remaining CHBC programme amount is then split into a health part (i.e. HBC) and a social development part. At the time of writing it is not known on what basis this split was made. National programme based co-ordinators and the national Treasury play an important role in achieving these splits. These three decisions result in four programme based amounts i.e. Life Skills, VCT, HBC and the social development part of CHBC.
- The four programme amounts are split horizontally into provincial conditional grant allocations. For the first two years of the NIP, it is not known whether the two components of the NIP Health Conditional Grant (CHBC and VCT) were separated before they were split horizontally into provincial allocations. The authorities used an array of indicators that seemed to measure need, capacity to run the funded programmes and a general commitment and capacity to run poverty targeted programmes. It is unclear how these measures were combined to determine the allocations. From the third year of NIP implementation i.e. 2002/03, the VCT component will be split according to provincial prevalence rates recorded in the 2000 Antenatal Survey, while the HBC component of CHBC will be split primarily on the basis of the number of people without medical aid by province.

Accessing procedures

To access the national grants, provincial DoHs are required to submit business plans for each component of the grant. The plans should be consistent with the programme guidelines issued by the national DoH. These guidelines include permitted expenditure items and project design elements e.g. provincial DoHs' administration and personnel items are not permitted. One of the key design requirements is that programmes be 'integrated' with each other, although provinces seem unclear exactly what this means. In relation to CHBC, the conception of integration seems be that the health and social development aspects of the programme should be jointly planned and managed, and spending should flow from some kind of unified budget. The

plans require both the approval of national and provincial heads of department before funds can be transferred. On the reporting side, provincial DoHs have to submit monthly reports to the national DoH, who in turn submit reports to the national Treasury.

In the first year of the NIP, 2000/01, conditional grant allocations were only made known in the second half of the year. In the second year, grant allocations were only made known just prior to the start of that year. In both these years no medium term projections for the subsequent two years of the MTEF were given. For the third year of the NIP, 2002/03, national authorities are attempting to improve the situation. Provinces will reportedly receive indicative allocations approximately 6 months before the start of the year and projections for the subsequent years of the MTEF will be made available at the start of 2002/03.

Provincial management of conditional grant spending

In terms of internal financial control of the conditional grant funds, the NIP Health Conditional Grants are taken into the provincial HIV/AIDS units' budgets in most cases. The financial information systems structure is such that is difficult to track the spending on the conditional grant components, and often on the grant as a whole. Frequently, the NIP Health Conditional Grant has not been given its own separate 'Objective' code. Provinces have attempted to get around this by placing the entire grant under a single Standard Item (itself under a general HIV/AIDS 'Objective' code). Two problems can arise here. Firstly, provinces cannot easily distinguish between VCT and HBC funds. Secondly, the used of an inappropriate Standard Item category can create confusion. In the Eastern Cape, this has created a block in the transfer of funds when the provincial Treasury questions the logical connection between the requested payment and the standard item. Where provinces have created a separate 'Objective' code for the conditional grants, they still have to devise a method for distinguishing between VCT and HBC funds. Provinces have tended to refrain from creating a separate 'Objective' code for each of the VCT and HBC components, as the system becomes unwieldy as more codes are added (see Figure 2).

National Department of Health's General Allocation (Conditional Grants and In-Kind Resources)

Conditional grant: Prevention of Mother-To-Child-Transmission Pilots

In June 2001 there was no information on the amount of funding the HIV/AIDS Chief Directorate planned to make available to provinces to fund PMTCT pilots, or of the form that the transfer would take. At the beginning of the 2001 financial year provinces were asked to develop and submit business plans for PMTCT programmes with budgets (but were not given a budget ceiling to guide them).

In October 2001 it emerged that a PMTCT Conditional Grant would be transferred to the provinces as part of the NIP funds,[g] but would not be funded from NIP funds. The 2001 National Adjustments Budgets states that the PMTCT is funded from 'savings' in the HIV/AIDS Chief Directorate.[3] The grants were apparently transferred in late October, but at the time of writing there was insufficient information to analyse how the provincial PMTCT conditional grant amounts were determined.

In-kind support

In-kind support covers four types of goods and services used by provincial HIV/AIDS units: NGO services, personnel, condoms, and technical services.

Funding of provincial NGOs

The HIV/AIDS Chief Directorate has set up a National NGO Funding Unit with its own budget to fund national and provincial NGOs, mainly for IEC activities. The National Funding Unit's capacity was increased in 2001 to improve the management of funds. Provincial NGOs formally apply to the Funding Unit for funding, the application first being vetted by provincial HIV/AIDS units before reaching the national office. The National Funding Unit's decision to fund a particular NGO seems to be based primarily on the strength of its application, the track record of the NGO and how the service on offer by the NGO complements the work of the provincial DoH and the other funded NGOs. In the awarding of funds, the National Funding Unit seems to rate the capacity of an NGO to spend effectively above such indicators such as provincial HIV/AIDS prevalence levels. Gauteng does not receive any of this funding, because the Funding Unit argues that the province sets aside enough of its own resources for this purpose and funds should rather be directed to provinces which have not done so.

Because of information asymmetries arising from the distance between the National Funding Unit and provinces, it relies on provinces to select and monitor the NGOs that the National Funding Unit funds. Provinces use the same structures and procedures to select and monitor these NGOs, as they do for those that they fund from their own resources. All provinces have set up NGO Funding Committees to vet applications, with vetting usually underpinned by departmental procedural requirements. They forward the applications they would like to see the national level fund and report to the National Funding Unit on the performance of these NGOs. The monitoring and support arrangements for NGOs vary across provinces with these responsibilities usually falling to a single designated person. KZN is testing a formal monitoring tool and looking at establishing a forum through which NGOs can share ideas and experiences. In the Northern Province and the Free State, a single person, the NGO Co-ordinator, undertakes the monitoring of NGOs, visiting sites, keeping in contact with NGOs and liaising with

g M Blecher, National Treasury, personal communication.

district HIV/AIDS co-ordinators on the delivery progress of grantees.[h]

The National Funding Unit has established a number of procedures to ensure that provinces fulfil their roles effectively:

- The Funding Unit has provided guidelines for provinces about the structures and procedures they could put in place for NGO selection and expenditure monitoring and control. The idea is that all provincially based NGOs funded by government, whether nationally or from provinces' own funds should be managed through these procedures. The transfer of public funds to NGOs is now also covered by the PFMA. The PFMA obliges departments to ensure that the NGOs they fund have proper financial management and control systems. In the absence of a written assurance from NGOs about these systems, the departments have to take measures to ensure that the money transferred is properly spent. These requirements upon NGOs can include: regular reporting procedures, audit requirements and submission of audited statements, regular monitoring procedures, scheduled and unscheduled inspection visits or performance reviews. The regulations also specify the reasons for which the department is permitted to withhold payment e.g. agreed objectives are not attained.
- As a number of provinces appear to deploy limited capacity to manage and monitor public funded NGOs in their provinces, the National Funding Unit requires that provinces submit an NGO funding programme plan. This is intended to force provincial units to take stock of their human and financial resources for funding NGOs and then develop a plan for NGO funding which lays out their funding priorties.

Funding of provincial posts

In addition to provincial posts funded from the national's NIP allocations, the HIV/AIDS Chief Directorate also funds salaries for a wide array of posts located in provincial HIV/AIDS units from its general allocation. Part of the national Government AIDS Action Plan (GAAP) budget goes to fund two co-ordinators in every province (two Assistant Director posts, for external (NGOs, CBOs and business) and internal liaison). GAAP is essentially a nation-wide social mobilisation and media campaign. The HIV/AIDS Chief Directorate also funds a PMTCT co-ordinator at assistant director level in each province.

h In Gauteng, the situation differs markedly, as regions and their staff are formally involved in monitoring and NGO selection is decentralised to regions through a multi-layered committee structure.

National procurement and distribution of condoms

The Chief Directorate procures and delivers male condoms to a number of primary sites in the provinces. The estimate of the total condom requirement in 2001/02 was based on a consolidation of estimates by each provincial condom co-ordinator. The co-ordinator's assessments considered the capacity of provincial health systems to distribute condoms and the demand for condoms.

In 2001 the HIV/AIDS Chief Directorate also introduced a Logistics Management Information System (LMIS) to make condom distribution to the primary delivery sites more efficient. Prior to the LMIS, sites were provided with an arbitrary monthly stock allocation which did not take into account actual needs. The intention of the LMIS is to ensure that sites never fall below a three-month 'minimum' stock level.

Since the implementation of the LMIS in April 2001, according to the HIV/AIDS Chief Directorate, the store has had a zero stock-out rate. However, some provincial plans for increasing condom availability and accessibility were not realised, and thus the provinces' estimates of condoms needed, turned out to be overly optimistic. Given this scenario, the estimated requirement for 2002 has been reduced from the 2001 estimate.

Gauteng procures additional condoms using its own resources. This seems to be because Gauteng is not completely confident that the national DoH can supply sufficient number of condoms and the political ramifications of condom shortages are very high. According to provincial officials, the demand for condoms is growing in the province and there is some uncertainty of the extent of this growth. Provincial procurement of condoms allows Gauteng to have a contingency supply.

Technical services

The HIV/AIDS Chief Directorate also provides a number of technical services to provinces in support of their programmes, especially those initiated by the unit. For instance, the Chief Directorate funds training in provinces for a host of activities and to a range of agents, some outside government e.g. in KZN, the HIV/AIDS Unit has reported that it intends to access nationally funded training for NGOs in project management.

Funds from provincial equitable shares

The provincial equitable shares arise from the horizontal division of provinces' vertical share of nationally collected revenue. Resources can flow to HIV/AIDS activities from a top slice of a province's equitable share or from a provincial DoH's general allocation which is drawn predominantly from the equitable share[i] (see Figure 2).

i A very small portion of a provincial DoH's general allocation may be funded by revenue generated by the province itself.

The funding streams which flow from provincial sources can all be classified according to their relationship to the activities of the provincial HIV/AIDS units and whether they are designated or non-designated HIV/AIDS funds. Three main streams have been identified:

- Provincial HIV/AIDS unit programme budget: Designated funding of HIV/AIDS unit programme through the provincial HIV/AIDS unit budget
- Other contributions to provincial AIDS unit programmes: Non-designated contributions to HIV/AIDS programmes by other sections of the provincial health departments
- Indirect spending in the routine delivery budgets caused by HIV/AIDS: Non-designated service delivery budgets impacted on by HIV/AIDS activities outside of provincial AIDS unit programmes.

Provincial HIV/AIDS Unit Budgets [4]

A unit budget is either sourced from a provincial DoH allocation or a combination of DoH allocation and a top slice from the province's equitable share.

Determining provincial HIV/AIDS units' total budgets[4]

In the five provinces, **health-based units** tend to be funded by the provinces from the provincial health department allocation in the five provinces. The HIV/AIDS unit allocations are determined in a number of ways.

- **Free State:** The director in charge of HIV/AIDS is centrally involved in a highly competitive, negotiated budgeting process in which allocations are based on 'crude costs, crude assessments of needs and current costs, and continuous political lobbying'.[j]
- **Northern Province:** Top management of the DoH determines global allocations to the HIV/AIDS Unit with limited input from the Unit directors. In this case, previous expenditure performance seems to be the overriding factor in determining the unit's allocation.
- **Eastern Cape:** The provincial Cabinet prescribes an amount the DoH should allocate to the HIV/AIDS. To date, this has occurred without an assessment of need, cost or ability to spend.

Gauteng and KZN have **interdepartmental units,** which historically have tended to be funded by a top slice of the provincial budgets determined by provincial Cabinets, although from 2001 they have also been funded by provincial DoH allocations. The interdepartmental units take on two broad groups of roles – those of health-based units and a role in facilitating and managing responses from other line departments. The two-stream funding of these units reflects this division, with health aspects tending to be funded

j Personal correspondence with director in charge of HIV/AIDS unit in the Free State.

by health department allocations and the intergovernmental aspects by an allocation from the general provincial budget.

- **Gauteng**, the longest established HIV/AIDS Unit, had undergone extensive costing and service demand estimation exercises in its initial stages and has been able to refine these over the years. Not only does it submit medium term expenditure and output projections for its activities to the provincial Cabinet, when the latter considers the total unit allocation, but it continually reports to the Cabinet on its progress, the demand for services and policy developments in South Africa and abroad.

The provincial DoH transfer is being used to fund interdepartmental HIV/AIDS interventions run by the DoH. The DoH does have costing information for its HIV/AIDS services, and thus possible outputs flowing from the transfer can be readily projected. The DoH, however, appears not to have weighed-up output against service demand in determining the amount transferred to the interdepartmental unit budget. Top health department managers made the decision and its seems as if the provincial Cabinet's top slice was adjusted to accommodate DoH's transfer. No special adjustment appears to have been made to the DoH's total allocation to accomodate the transfer from the DoH general budget to the interdepartmental unit budget, although the growth in the total DoH's allocation for this year was about a percentage point above last year's inflation.

- The more newly established unit in **KZN** used less extensive costing methods to determine the global amount. A number of new projects were only costed very crudely.

In 2001 the budget of a pre-existing interdepartmental unit (funded by a provincial Cabinet allocation) was amalgamated with the budget of a pre-existing health-type unit (funded directly by the provincial DoH), and both budgets were simply increased by a rate approximately equal to the rate of price inflation in the last year. A third amount, matching the national conditional NIP grants was added from the provincial DoH's allocation.

To ensure the allocations for interdepartmental units are sufficient, therefore, entails two separate planning processes based on clear notions about what each stream should cover. More research is required to determine whether this is the case. In KwaZulu-Natal the department's provision of an allocation which closely matches the NIP Health Conditional Grant amount suggests that the DoH appreciates that the NIP grant does not cover key administration, management and staffing costs associated with the implementation of NIP programmes. At the time of research, it was not clear on what this matching amount was to be spent.

Determination of detailed activity budgets

The five provinces studied used different methods for drawing up their detailed activity budget:






Gauteng: Gauteng's interdepartmental joint business planning process is the most sophisticated approach. Once the annual global unit allocation is determined, the interdepartmental HIV/AIDS Unit facilitates a planning meeting which includes all departments and key civil society sectors. In preparation for the meeting the unit adjusts the previous MTEF activity-based figures (on the basis of new costings and the new global allocation) and makes these available to departments. In theory the annual meeting serves to co-ordinate AIDS activities already being planned by departments and to work out which activities should be funded from the unit budget. Once these decisions have been made, departments do their detailed business plans for unit-funded activities and submit these to the unit for compilation into a unified annual plan. The head of the DoH vets the plan, taking into account the proposed interdepartmental split of resources and their delivery records.

Eastern Cape and Free State: The Eastern Cape and Free State used a combination of historical increments for pre-existing activities and crude costings for new activities to determine their activity allocations. These allocations are fitted into the pre-determined total budget allocation. Frequently the amounts linked to new or newly prioritised projects were based on judgements of the relative importance of likely spending demands of the new projects in relation to other project allocations and the global unit budget.

Northern Province: At the time of doing this research, the Northern Province lacked a workable activity budget as there was confusion over which business plans and associated budgets were valid.[k]

KwaZulu-Natal: In 2001 the KZN HIV/AIDS Unit Director asked activity co-ordinators in the unit to submit detailed plans and budgets in the absence of any guidelines on their budget ceiling. While this process may generate good costing information, the Unit Director has to now fit these business plans into the total unit allocation, which may lead to arbitrary activity budget cuts and necessitate replanning.

Provincial Funding of Nationally Directed Programmes

All provinces allocate amounts to VCT and/or HBC programmes in addition to the NIP Health Conditional Grants received by the provincial AIDS units from national. This raises issues of which funds flow to which parts of these programmes.

In KZN, the HBC part of the NIP Health Conditional Grant is managed separately from the amount the province itself allocated to HBC, each being spent on different sub-projects. The provincial HBC allocation appears to be based on some kind of activity budgeting and mainly covers established activities, with a few new ones added. The provincial money allocated to VCT is used for specific activities intended to complement the NIP conditional

k The Northern Province had appointed a Director to the HIV/AIDS unit, a newly created post, from outside of the province just before the research was concluded in the province.

grant-funded VCT activities. Similarly in the Eastern Cape, the additional VCT funds from the provincial HIV/AIDS Unit budget are linked to particular purposes separate from the conditional grant. In the Free State, the provincial amount allocated to HBC is supposed to serve as a buffer to absorb any over-expenditure on activities covered by the grant. The amount appears arbitrary.

In the Eastern Cape the provincially funded PMTCT activity line item has deliberately been inflated to act as a kind of contingency reserve for other HIV/AIDS interventions. The intention is to use the budget for unplanned spending on medicines that might arise from VCT.

NGO funding and transfer mechanisms

Provinces frequently have a particular fund for NGO funding, although the use of the fund varies from being restricted to certain activities to being quite open. In most provinces, it seems that NGOs can also be given grant funding from project/intervention funds.

In some provinces individual allocations to NGOs might be quite small e.g. KZN and Free State where the annual payments range from R5 000 to R25 000. The Free State has spread its funding over numerous NGOs (approximately 80 in 2001).

Transfers to NGOs usually occur in the form of annual grants which are often paid in instalments subject to adequate performance, financial control and reporting which is all specified in an agreement or contract between the NGO and the unit. KZN, in contrast, appears to have a highly bureaucratic system for releasing funds to NGOs. Each NGO submits receipts on work undertaken which are processed by the unit. Receipts go via the NGO Funding Portfolio Manager to the Chief Administration Clerk in the DoH. This long process often results in mistakes or delays. At the least, NGOs are paid 3 weeks to a month after submitting claims.

Contributions from sections outside of the provincial HIV/AIDS units

Bodies in a provincial health department, besides the HIV/AIDS unit, end up contributing resources from their own non-designated budgets to programmes run by the HIV/AIDS unit. For national NIP grant-funded activities, this is consistent with the requirement that NIP conditional grants not be used to cover department associated staffing and administration costs. The resource contributions might be:

- Incidental expenses e.g. time to attend training courses, transportation to courses, management time for attending courses
- Direct expenditure required for a particular activity e.g. setting up step-down facilities,[1] rendering STD control services, distributing

1 Facilities in which recuperative or palliative care is provided at levels of service below that of a conventional hospital ward.

condoms, administering HIV tests.

Where contributions support long-established interventions that have been mainstreamed for a number of years already e.g. TB and STD Management and Control, health bodies tend to budget fairly adequately for them. However, when contributions are required for new interventions, provincial HIV/AIDS unit directors tend to be concerned that contributions are insufficient.

Routine service delivery budgets impacted by AIDS

In 2001 the national Health Department estimated that provincial health departments collectively would spend nearly R4 billion on treatment and care of AIDS-related illnesses in 2001.[5] This figure excludes spending on prevention programmes. The estimate is based on demographic projection models and the costs of treatment and care currently observed in the public health sector. The estimate excludes the effects of alternative modes of HIV/AIDS service delivery on spending, and of rationing of HIV/AIDS care by provincial DoHs.[m] However, it is difficult to ascertain whether the figure has been divided by province or whether it has been projected in the future. If not, presumably the model can be adapted to produce provincial estimates and projects. If so, the model represents a useful budget planning tool for provinces.

Some of the challenges and issues with funding streams

National funding of provincial posts

The practice of funding provincial posts increases provincial capacity but can also create new difficulties:

- The staff are accountable to two, often opposing principals, the provincial units and the national DoH, raising problems for the management of the staff
- The shortness of the contracts on offer may deter better candidates, and discourage the province to invest in the development of the appointed staff
- When national terminates funding of salaries at provincial level, the provinces must undergo a time-consuming, bureaucratic process to shift these posts onto the provincial payroll and structure
- The provinces may not be able to afford the staff.

From the perspective of the provinces, the content of nationally funded posts in provincial offices seems to be decided on without reference to the provincial AIDS unit. For instance, in KZN, Assistant Director posts for VCT and HBC

m M Hensher, National Health Department

already existed before national informed the province it would pay for these portfolios. The AIDS Unit was unable to convince national to spend the available funds on other staff posts instead.

NGO grants

Application requirements and assessment: NGOs selected for funding must meet certain requirements to receive funding, including the submission of adequate business plans. These requirements allow the provincial co-ordinator and National NGO Funding Unit to monitor projects and be aware of potential problems, but they also slow the process down considerably from the perspective of the grantees. Where NGOs have difficulty fulfilling requirements, NGO capacity building projects, mentioned as a priority by all provinces, are meant to go some way in addressing this.

At the national level, the NGO Funding Unit seems to be predominantly concerned with identifying and funding provincial NGOs that can spend effectively, rather than distributing and disbursing funds to provinces on the basis of relative demand for public HIV/AIDS services. Given the shortage of experienced NGOs, this focus is probably correct, although this should be accompanied by programmes to build NGO capacity. Once strong enough NGOs emerge at the provincial level, the Funding Unit should move to distribute funds on the basis of the relative need for HIV/AIDS public services.

The exclusion of Gauteng from national NGO funding on the basis that they provide an adequate level for funding using their own resources is both unfair and provides a perverse incentive for them to cut their funding of NGOs.

Audit requirements: Audit costs are also a burden for smaller NGOs. Treasury requirements call for a chartered accountant to conduct the audit; the National Funding Unit and grantees have hit difficulties with fraudulent, very expensive, and time-consuming audits. To address the problem, the Directorate is considering the idea of appointing a chartered accountant to conduct all the grantee audits. How this would work has not been sorted out yet.

Limited grant oversight capacity at provincial level: The national NGO Funding Unit has stipulated that each province can recommend no more than 15 NGOs for a first reading or consideration by national. The national NGO Funding Unit has sufficient funds to supply more grants, but the capacity does not generally exist at the provincial level to manage the current number of grantees adequately. For example, the Free State and Northern Province each have a single person to monitor and support NGOs. The requirement that provinces submit a NGO funding programme plan is a rather blunt instrument to get provinces to deploy more capacity.

NGO payments: In some provinces, NGO payment systems are very cumbersome and costly to run e.g. receipt-based payment in KZN. Furthermore, at present, the national system can put provinces in a troublesome position. One province has reported that the approval of business

plans submitted by NGOs to national department has been slow in 2001. When the lengthy approval process at the national level delays payment of grants, provincial co-ordinators can become the middle-man in conveying NGO frustrations to the national level. (Furthermore, the lengthy approval process can have the effect of interrupting services.)

Conditional Grants

Information about allocations: The complications and delays in the approval of business plans disrupts implementation, especially in the first year (2000) of implementation of the NIP.

In 2001 provinces only received notice of their conditional grant allocations very close to the start of that year. This has two negative consequences. Firstly, detailed planning for non-HIV/AIDS health activities on the basis of complete resource envelopes can occur earlier than detailed HIV/AIDS planning, leading to co-ordination problems in planning. Secondly, detailed planning may be rushed in the limited time available before the start of the financial year. In addition, provincial departments were not provided with projections of their grant allocations for the subsequent years of the MTEF, making forward multi-year planning impossible. It seems that these problems will, however, be addressed for 2002 and subsequent MTEF years.

Project design and implementation requirements: Some provinces appear to be finding it difficult to integrate NIP projects in the manner prescribed in national policy documents. There is very limited integration of HBC projects being run through Health and those being run through Social Development at the level of administration of activities (e.g. through the integration of budgets).

Gauteng feels that the lack of progress is because the present budgeting and accounting system is not amenable to this type of interdepartmental integration. They feel that service delivery agencies should aim at providing services which are integrated from the user's perspective. i.e. by improving referral systems and creating complementary services. In this context, service providers must administer services separately on the basis of clearly defined roles and only conduct service delivery planning jointly.

Budgeting process

In some provinces, provincial prioritisation of HIV/AIDS has lead to the arrival of large amounts of money ring-fenced for HIV/AIDS. In the absence of a history of spending on HIV/AIDS, it is unclear how these amounts are meant to be translated into department/programme allocations. This often leads to a build up of activities/amounts to reach a preset target amount without proper costing and assessment of the capacity required to deliver these activities. The poor costing of projects, especially for new initiatives, can lead to poor total unit budget costing.

Other problems are evident with the budgeting process:

- Provincial AIDS units and the health finance sections may have different approaches to getting health regions and districts to start planning and budgeting conscientiously for HIV/AIDS services, especially the alternative prevention and care approaches. The sudden allocation of large amounts to a provincial AIDS unit may mean that established projects that are already meant to be covered by regional or district budgets are kept on the provincial HIV/AIDS unit budget, along with new ones, in a bid to minimise underspending. This may set up precedents in spending that disrupt the functioning of the unit budget and gives negative incentives to clinics and other health institutions to shift spending to units and not budget properly e.g. the Eastern Cape.
- Regions and districts are usually expected to contribute[n] to provincial HIV/AIDS unit interventions, although the expected contributions are not usually made explicit timeously in the budget process. The budget process is not providing for enough co-ordination and communication between the provincial HIV/AIDS units and the regions. Given the limitation of the financial management system, HIV/AIDS units can often not detect whether the districts has budgeted enough.
- Conditional grant business plans and provincial budgets and plans for the same activities (VCT and HBC) are drawn up separately and without reference to each other. Provincial unit plans may be drawn up without anticipation of conditional grants. One of the contributing factors behind this in 2000 and 2001 is that there were no MTEF projections on conditional grants, and provinces were informed of their allocation very late in their budgeting processes. This can result in:

  (a) 'double funding' of activities

  (b) doubling of effort if both sources used

  (c) no real sense of how slightly different sets of activities within the same basket, funded by different sources, align.
- In some provinces difficulties arise when the managers of individual interventions are required to develop their intervention budgets from the bottom-up while concurrently the total allocation is essentially handed to the unit in a top-down fashion. In the case of KZN in 2001, although the top-down process preceded the bottom-up, intervention managers were given no budget envelopes to guide them. As a result, when the individual intervention budgets are summed together they do not equal the total allocation. The bottom-up and top-down versions of the budget must then be reconciled – a slow process with high transaction costs and which likely leads to arbitrary cuts.

n The HIV/AIDS Units expect in-kind contributions from regions and districts. In-kind contributions obviously have financial implications and ultimately have to be budgeted for.

Financial management system and budget control

Firstly, the system does not allow for tracking of expenditure on particular projects and thus makes monitoring and control, vital when trying to pilot new services and mainstream them, very difficult. Secondly, this system also makes reporting on conditional grants difficult.

The following are examples of how the system causes difficulties for the provincial HIV/AIDS unit in planning and running programmes:

- The misallocation of conditional grants/project budgets to incorrect line items disrupts the flow of funds because the provincial HIV/AIDS unit cannot justify the expenditure authorisation if it is presented in an incorrect form
- In general, provinces have no capacity to track what expenditure is attributable to HIV/AIDS, e.g. there is no database ability to analyse pharmaceutical purchase trends. There appears to be no way to 'tag' HIV-related expenditure in the systems.

Conclusion

In regard to the flow of financial resources to provinces, the beginning of the NIP programme was marked by very poor signalling to provinces about the amount of resources they would receive in both short and medium term, making programme planning very difficult. Signalling seems set to improve. Given that the conditional grants cover neither the costs of administering the programmes nor the health personnel required to implement the programmes, whether provinces will be able find the resources required to fund significant parts of the programmes remains key. At present these funding decisions seem often to be left solely to the region, district and hospital managers. Some of these factors probably lie behind the limited spending that occurred on the NIP conditional grant by mid-year of 2001, although more investigation is required to pinpoint the precise reasons.[6]

Sometimes provinces are unable to utilise the contributions from national because of poor timing of their delivery or poor communication and planning regarding what the provinces need. This lack of usefulness may result from the physical form that resources take, the quantity and quality of the resource, and the time at which the resource arrives.

The rapid increase in the priority given to HIV/AIDS spending often leads to resourcing decisions which are divorced from an analysis of the ability to spend or an analysis of the costs of delivery. Resources could be locked out of more successful areas of health spending as a result.

The initial centralisation of support and funding for HIV/AIDS interventions is a valid response in the short term. However without adequate systems for monitoring and controlling spending and project implementation, there is a

danger that central units will not be able to play their role effectively. The lack of well functioning activity-based financial monitoring systems is a key weakness in this respect.

The interdepartment approaches used by some provincial HIV/AIDS units may hold potential for increasing the mainstreaming of HIV/AIDS interventions in that it gives departments some project experience and knowledge about the costs involved. However, without incentives and other institutions that force departments to start mainstreaming, the response could be slow.

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