

# A review of health, HIV and TB resource allocation and utilisation in South Africa

2013/14 - 2020/21

## Authors

Nhlanhla Ndlovu<sup>i</sup>  
Kavya Ghai<sup>ii</sup>  
Nthabiseng Khoza<sup>iii</sup>  
Michael Chaitkin<sup>ii</sup>  
Sithabiso Masuku<sup>iv</sup>  
Gesine Meyer-Rath<sup>iv,v</sup>  
Teresa Guthrie<sup>ii</sup>

Timely and accurate data on spending trends are critical for policy, planning and programme management. Routine expenditure analysis can facilitate dialogue between national and sub-national actors to improve technical efficiency given the scarcity of public resources.

The South African Government, the United States (US) Government, and the Global Fund to Fight AIDS, Tuberculosis (TB) and Malaria each invest in health services in the country. Tracking resource allocation and utilisation is critical to understanding the extent of these investments.

This chapter shows trends in health, HIV and TB budgets (2013/14 - 2020/21) and expenditure (2013/14 - 2017/18) so as to inform the allocative efficiency and sustainability of the National Strategic Plan (NSP) for HIV, TB and sexually transmitted infections (STIs).

Budget and expenditure reviews were conducted to measure contributions from the South African Government and partners towards NSP objectives. Capacity was developed and built around an automated extraction tool for HIV and TB transactions in the public financial system. This tool was also used to consolidate available US Government and Global Fund data for 2014/15 through 2016/17, the three financial years following the last multi-year review of HIV and TB spending.

Government's health budget increased from R133.3 billion in 2013/14 to R205.4 billion in 2018/19 (12.3% of total budget), reflecting 2% real annual average growth. Within the health budget, the HIV and TB allocation increased at a real annual average rate of 7%, from R11 billion in 2013/14 to R20.7 billion in 2018/19. This may imply that HIV and TB are crowding out other health spending.

In 2016/17, the three largest contributors to HIV and TB spending were the South African Government (76%), the US Government (22%), and the Global Fund (3%). United States Government contributions increased from R4.2 billion in 2014/15 to R6 billion in 2016/17, although this amount may decrease in coming years. This analysis should inform the South African Government's efforts to mobilise additional resources for HIV and TB and to improve programme efficiency.

i Centre for Economic Governance and Accountability in Africa  
ii Results for Development  
iii South African National Department of Health  
iv Wits Health Consortium  
v School of Public Health, Boston University

## Introduction

Analysis of health spending includes determining trends for source of funds; level of funds; geographical and programmatic distribution; and cost drivers; this helps policymakers assess whether resources are reaching priority populations, interventions, and hotspot geographies. Analysis also helps with identifying potential opportunities to improve allocative and technical efficiency, and it stimulates more productive dialogue at multiple levels of the changing system.

It is also important to understand financial performance against the backdrop of programme performance. South Africa's mother-to-child HIV transmission rates dropped from 8% in 2008 to 2% in 2015, and then further to 1.5% in 2016.<sup>1</sup> The country continues to mount the world's largest HIV treatment programme, with more than 4.5 million people on antiretroviral therapy (ART) by the end of June 2018.<sup>2</sup> Partially as a result of this, life expectancy increased from 59.7 years (males) and 65.9 years (females) in 2015, to 61.1 and 67.3 years in 2018.<sup>3</sup> These achievements would not have been possible without the increasing political and financial commitment of the South African Government (SAG), combined with support from development partners.

Despite progress, annual new HIV infections were estimated at 270 000 in 2017, only a small reduction from the 280 000 reported in 2016. AIDS-related deaths increased<sup>a</sup> from 100 000 in 2016 to 110 000 in 2017.<sup>2</sup> Moreover, South Africa has the sixth-highest tuberculosis (TB) incidence in the world, with more than 450 000 new cases diagnosed in 2015 (0.8% of the population), and increasing numbers of multi-drug-resistant cases.<sup>2,4</sup> Tuberculosis remains a major cause of death<sup>5</sup> and a major public health threat, albeit with declining proportions of TB-related deaths among total deaths (down from 8.3% in 2014 to 6.5% in 2016).<sup>6</sup> Additionally, 60% of TB patients live with HIV, of whom 89% are on ART.<sup>7</sup> Strategic interventions and resources are needed to prevent and control TB among people living with HIV (PLHIV) and the general population.

This chapter examines financing for health, HIV and TB. A review was done of SAG expenditure and budget trends from 2013/14 to 2020/21 as well as a dissection of SAG, United States (US) Government, and Global Fund expenditure from 2013/14 to 2016/17, with a special focus on provincial programme spending and performance. This work builds on, and in some cases draws directly from, previous analyses of health and HIV budgets and expenditure.<sup>8-11</sup>

## Data sources and methodology

Information on the macro-economic outlook came from the International Monetary Fund 2018 and 2019 World Economic Outlook Reports<sup>12,13</sup> and the Statistics South Africa 2019 Quarterly Labour Force Survey.<sup>14</sup> Data sources for the SAG health, HIV, and TB budgets included the National Treasury's 2017/18 - 2019/20 Estimates of National Expenditure,<sup>15-17</sup> 2017/18 Estimates of Provincial Revenue and Expenditure,<sup>18</sup> the 2018/19 Budget Speech,<sup>19</sup> the 2018/19 Division of Revenue Act,<sup>20</sup> and the 2019/20 Budget Review.<sup>21</sup> These sources record SAG spending during 2013/14 - 2017/18 and budget estimates for 2018/19 - 2020/21. More detailed multi-sectoral and programmatic analysis of HIV and TB expenditure during 2014/15 - 2016/17 was based on data from the SAG's centralised Basic Accounting System (BAS), provided by the National Department of Health (NDoH). The study used descriptive analysis techniques in Excel, supported by quarterly review meetings with provincial HIV and TB management teams to validate financial and non-financial reports from the analysis. United States Government expenditure data were extracted from the Expenditure Analysis database of the President's Emergency Plan for AIDS Relief (PEPFAR), with some clarifications provided by a United States Agency for International Development (USAID) South Africa official. The Global Fund data came from Principal Recipients' progress updates and disbursement requests.

All budget and expenditure figures were converted into real terms based on consumer price index (CPI) information, using 2017 as the base year (Table 1).

Concurrent with the analytical process, an automated tool called BASLY<sup>b</sup> was developed and built to extract HIV and TB transactions from the SAG's Basic Accounting System (BAS), and capacity to use it was built within the national and provincial Departments of Health (DoHs). The NDoH and provincial DoHs are now using BASLY for their quarterly and annual reviews, with technical support from the Centre for Economic Governance and Accountability in Africa (CEGAA).

a The increase in AIDS-related deaths was not explained in the cited report, and possible reasons are not postulated in this chapter.

b BASLY is an Excel-based tool that automates several key steps of HIV and TB expenditure analysis. These include searching NDoH BAS records for every HIV- and TB-related transaction, extracting these into a common database, cross-walking the interventions and cost categories to reduced lists of common categories, and running detailed analyses on this dataset. The tool can analyse other expenditure data (such as from the US Government and Global Fund) along with the NDoH extract if they are arranged in the BAS output structure. The tool allows the government and partners to complete these steps in a few hours, compared with the weeks, or even months, previously required.

## Key findings

### South Africa's macro-economic outlook

During a period of global growth (3.7% in 2017 and 3.2% in 2018), South Africa's economy grew much more slowly (0.9% in 2017, 0.8% in 2018, and 0.9% (projected) in 2019),<sup>12,13</sup> with increasing unemployment, from 26.7% in 2017 to 27.1% in 2018.<sup>14</sup> Young people bear a disproportionate burden: among 15 - 34-year-olds, the unemployment rate reached 38.9% by the end of 2018. The budget deficit and debt-to-gross domestic product (GDP) ratio also continued to grow (Table 2).

In 2018, National Treasury attempted to reduce the budget deficit and debt by raising revenue through a value-added tax (VAT) increase from 14% to 15%,<sup>19</sup> while boosting service delivery with additional allocations for the education sector following the announcement of fee-free higher education. Despite these fiscal pressures and broader macro-economic challenges, the analysis below shows how the SAG continues to intensify public spending on HIV and TB.

### Analysis of total and health budget allocations (2013/14 - 2020/21)

Figure 1 shows trends for total budgets and health budgets across national and provincial spheres of government. Total allocations increased from R1.1 trillion in 2013/14 to R1.7 trillion in 2018/19, and are expected to reach R1.9 trillion in 2020/21, reflecting 2% real annual growth. Meanwhile, consolidated general health allocations increased by on average 3% annually in real terms, from R133 billion in 2013/14 to R192 billion in 2017/18, and are expected to exceed R240 billion in 2020/21. The medium-term expenditure framework (MTEF) for 2018/19 - 2020/21 allocates 12.3% of the total budget to health, short of the 2001 Abuja Declaration target of 15%, which African governments committed to.<sup>23</sup>

Allocations to the NDoH for HIV and TB have grown by 7% annually, from R11.0 billion in 2013/14 to R18.3 billion in 2017/18, and are set to surpass R25 billion in 2020/21. As a share of the consolidated health budget, this corresponds to an increase from 8.3% in 2013/14 to 10.5% in 2020/21 (Figure 2). This growth is largely driven by continued

Table 1: Consumer price index information, South Africa, 2013 - 2020

Financial year	2013	2014	2015	2016	2017 Base year	2018	2019	2020
CPI fiscal year index	84.1333	89.2655	93.3717	99.2541	104.5146	110.0538	115.9967	122.3766
% CPI	0.058	0.061	0.046	0.063	0.053	0.053	0.054	0.055
Base year 2017	0.80499	0.85410	0.89338	0.9497	1	1.053	1.10986	1.17090

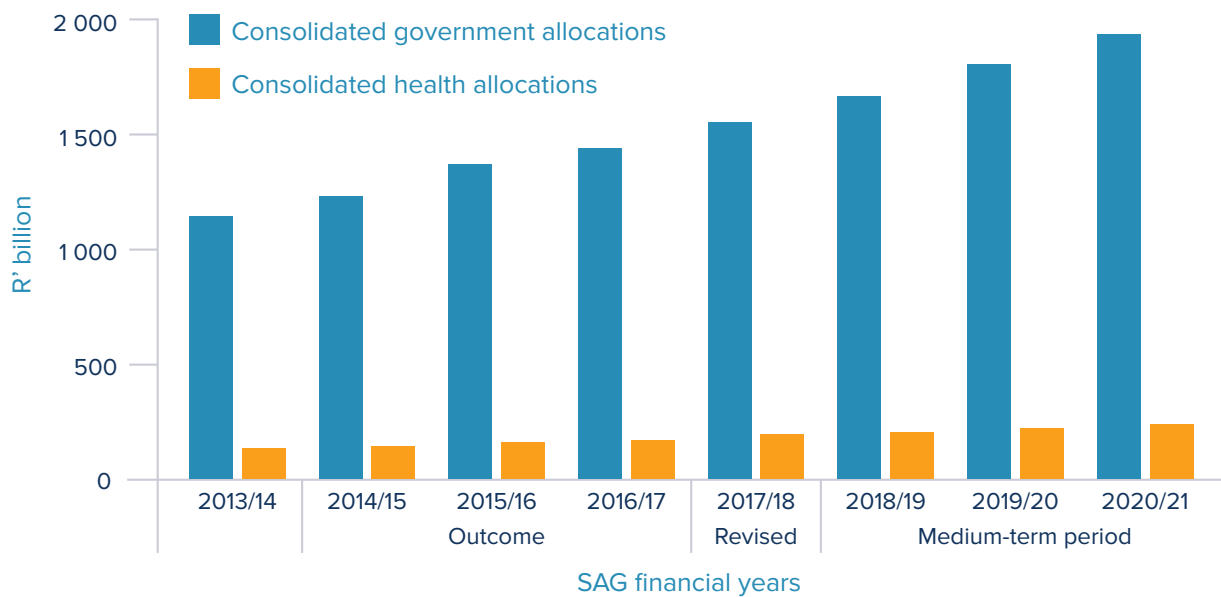
Source: National Treasury, 2018.<sup>22</sup> (Authors' calculations.)  
CPI = consumer price index.

Table 2: Budget deficit and debt-to-GDP ratio as a percentage of the consolidated fiscal framework, South Africa, 2014/15 - 2021/22

Year	Outcomes				Revised estimate	Medium-term forecast		
	2014/15	2015/16	2016/17	2017/18		2018/19	2019/20	2020/21
Budget deficit	3.6%	3.7%	3.6%	4.0%	4.2%	4.5%	4.3%	4.0%
Debt-to-GDP	46.5%	49.0%	50.7%	53.3%	55.6%	56.2%	57.8%	58.9%

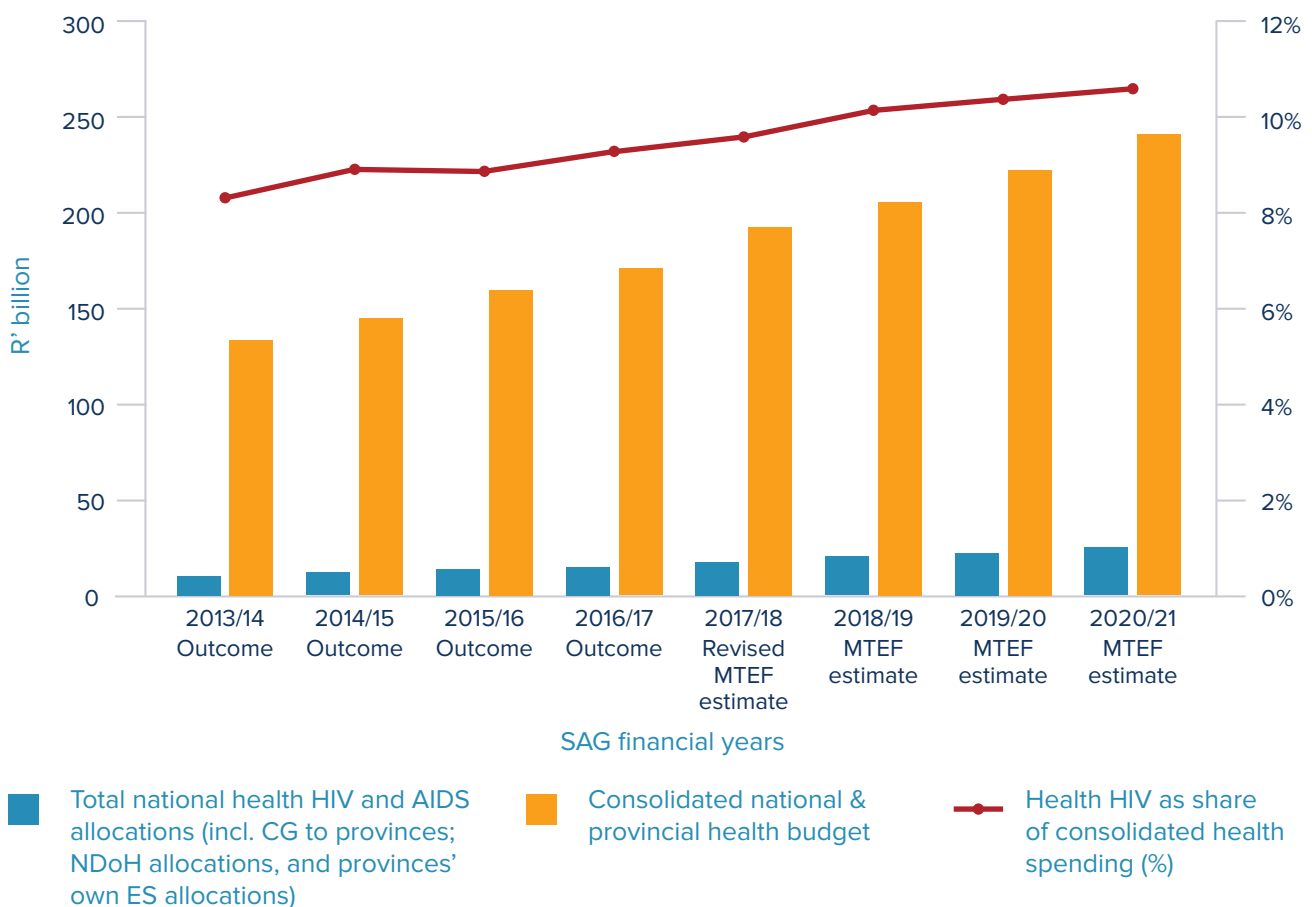
Source: National Treasury, 2019.<sup>21</sup> (Authors' calculations.)  
GDP = gross domestic product.

Figure 1: Consolidated government and health expenditure for 2013/14 - 2017/18 and budget estimates for 2018/19 - 2020/21, South Africa (R' billion, nominal)



Source: National Treasury, 2019.<sup>21</sup>(Authors' calculations.)  
SAG = South African Government.

Figure 2: Consolidated health and HIV budget allocations for 2013/14 - 2020/21, South Africa (R' billion, nominal)



Sources: National Treasury, 2018;<sup>16</sup> National Treasury, 2018.<sup>19</sup> (Authors' calculations.)

CG = Conditional Grant; ES = equitable share; MTEF = medium-term expenditure framework; NDoH = National Department of Health; SAG = South African Government.

expansion of the ART sub-programme to meet the UNAIDS (Joint United Nations Programme on HIV/AIDS) 90-90-90 targets by 2020/21.<sup>24</sup> Notably, a portion of health-sector spending on HIV is embedded in general primary healthcare (PHC) spending, such as salaries of nurses providing HIV alongside other PHC services, which cannot be easily quantified and attributed to HIV. Moreover, only NDoH spending is shown in Figure 2, although other departments also make important contributions to the HIV response.

The Comprehensive HIV and AIDS Conditional Grant has always accounted for more than 90% of the health-HIV budget allocations, with the remainder coming from the NDoH budget and provinces' own voted funds, which have tended to fluctuate (Table 3). Since 2017/18, the grant incorporated additional funds for TB, and subsequently R4.4 billion was added for a new community health services component,<sup>c</sup> which aims "to help provinces standardise the work of primary healthcare outreach teams and integrate them into the national health system."<sup>22</sup>

Among the provinces, KwaZulu-Natal has always received the highest proportion of health HIV and TB funding (26.9% in 2018/19), followed by Gauteng (22% in 2018/19), and the

Eastern Cape (11.3% in 2018/19), while the Northern Cape continues to receive the smallest share (2.3% in 2018/19) (Figure 3). Proportional allocations of the HIV and TB conditional grants across provinces have remained mostly constant over time, determined by the NDoH's allocation formula.<sup>d</sup>

### Multi-sectoral and programmatic analysis of HIV and TB expenditure for 2014/15 - 2016/17

A multi-sectoral HIV and TB expenditure review was conducted of the BAS records together with US Government and Global Fund sources for 2014/15 through 2016/17,<sup>e</sup> including the first-ever district-level analysis<sup>f</sup> of HIV and TB spending.<sup>11</sup> Public TB spending in this section includes both the conditional grant and voted funds labelled as TB-related.<sup>9</sup> In addition, this section includes the public spending on HIV by the Department of Social Development (DSD) and the Department of Basic Education (DBE), while the budget section did not include this.

Combined spending on HIV and TB increased from R22.5 billion in 2014/15 to R28.8 billion in 2016/17 (Figure 4, left panel), reflecting an average annual growth of 13% over the three years. By 2016/17, the SAG accounted for 76%

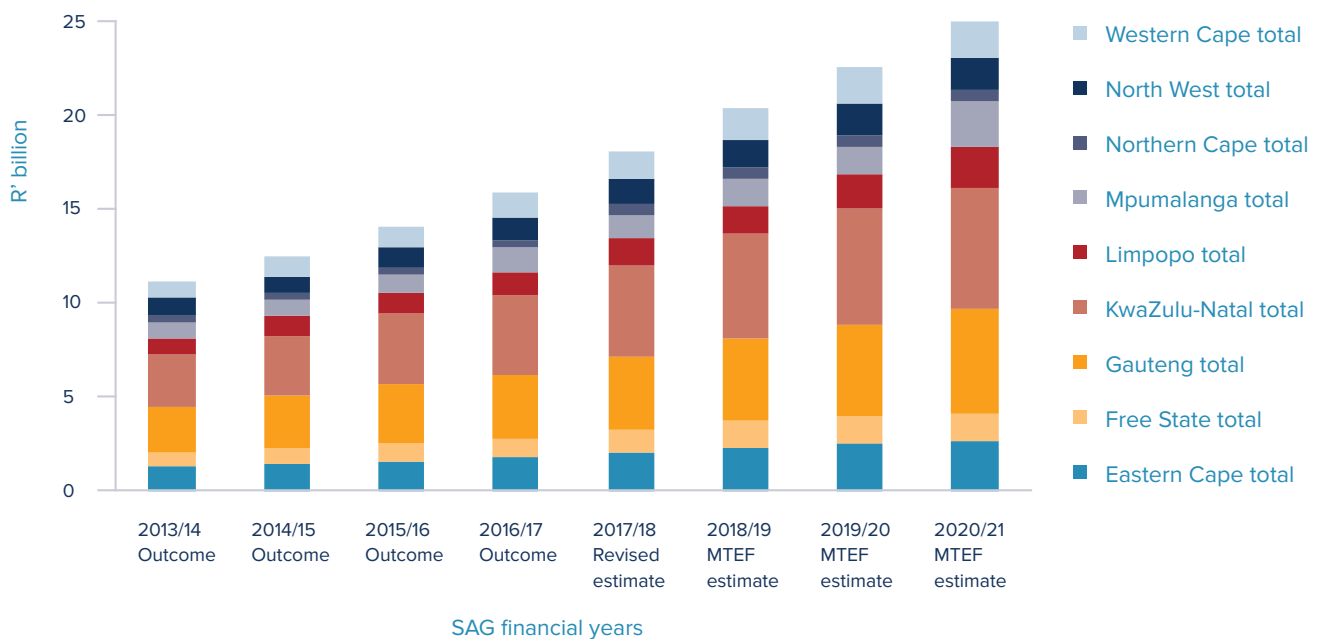
Table 3: Consolidated national and provincial health-HIV and TB allocations by government funding channel, 2013/14 - 2020/21, South Africa (R'000, nominal)

R'000	SAG financial years							
	2013/14 Outcome	2014/15 Outcome	2015/16 Outcome	2016/17 Outcome	2017/18 Outcome	2018/19 MTEF estimate	2019/20 MTEF estimate	2020/21 MTEF estimate
National CG to provinces	10 488 542	11 993 257	13 608 145	15 330 383	17 557 903	19 921 697	22 038 995	24 438 000
Total provincial ES	675 315	518 158	489 643	555 069	528 803	432 371	419 142	511 972
Total direct national ES (excl. CGs)	370 392	470 711	354 355	415 517	446 597	542 103	572 505	530 300
<b>Grand total</b>	<b>11 534 249</b>	<b>12 982 126</b>	<b>14 452 143</b>	<b>16 300 969</b>	<b>18 533 303</b>	<b>20 896 171</b>	<b>23 030 642</b>	<b>25 480 272</b>

Source: National Treasury, 2017;<sup>15</sup> National Treasury, 2017;<sup>18</sup> National Treasury, 2019.<sup>17</sup> CG = Conditional Grant; ES = equitable share; MTEF = medium-term expenditure framework.

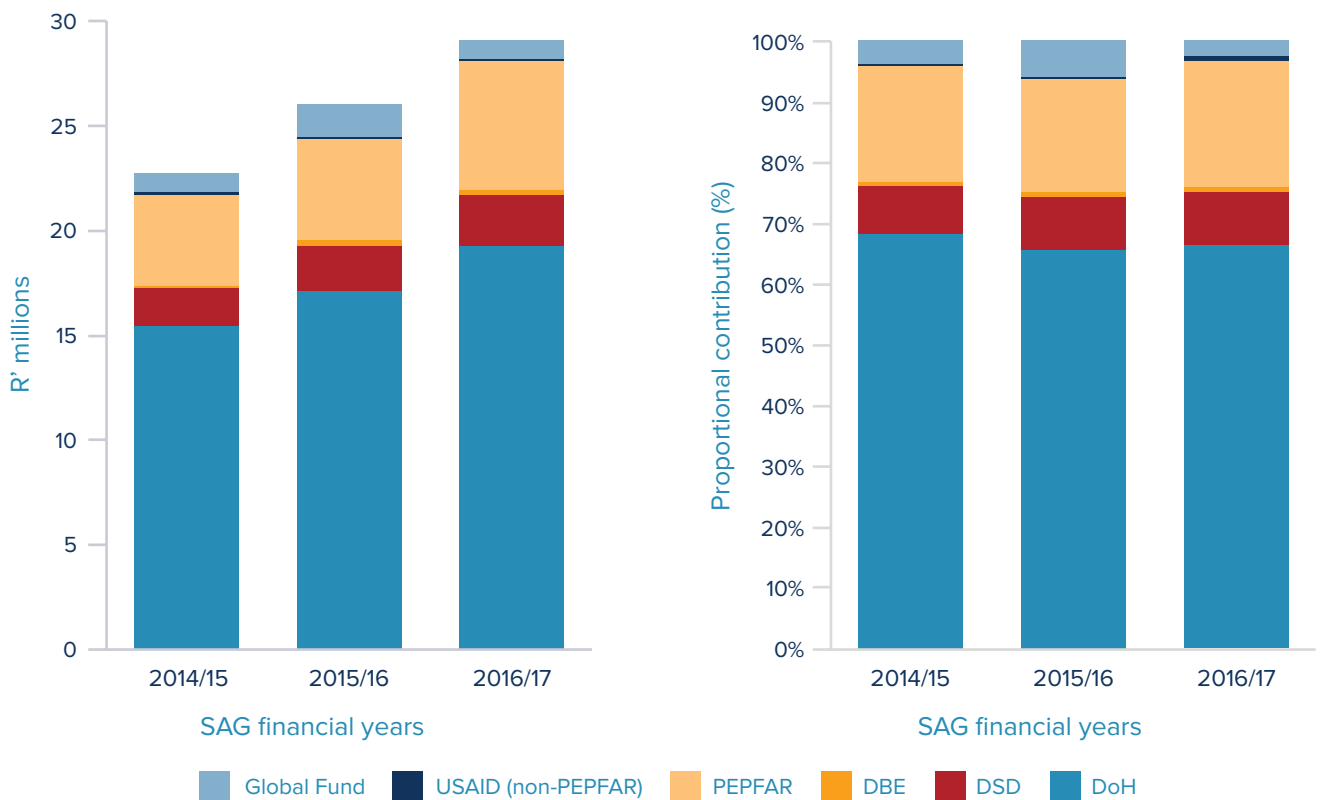
- c The MTEF for 2019/20 - 2021/22, published after this study was completed, further expands the grant's scope and divides it into separate components for HIV and AIDS, TB, malaria, and community outreach.
- d The allocation formula is reported in the Division of Revenue Act<sup>20</sup> every year.
- e Previous studies have covered earlier years.
- f The district-level analysis in this study only included SAG and US Government spending because Global Fund data were not geographically disaggregated.
- g The TB expenditure figures presented in this section are therefore much higher than the budgeted figures presented above, which could only identify the conditional grant ring-fenced amounts for TB, and that also excluded the donor contributions to TB.

Figure 3: Combined health-HIV and TB conditional grant and equitable share funding by province. 2013/14 - 2020/21, South Africa (R' billion, nominal)



Sources: National Treasury, 2017;<sup>18</sup> National Treasury, 2019.<sup>17</sup> (Authors' calculations.)  
MTEF = medium-term expenditure framework; SAG = South African Government.

Figure 4: Total HIV and TB spending by source and year (R' millions) (left) and funder share (%) (right), South Africa, 2014/15 - 2016/17



Source: Guthrie et al., 2018.<sup>11</sup>

DBE = Department of Basic Education; DSD = Department of Social Development; NDoH = National Department of Health; PEPFAR = President's Emergency Plan for AIDS Relief; USAID = United States Agency for International Development.

of total spending (66% by the NDoH, 9% by the DSD and 1% by the DBE), followed by the US Government (21%) and the Global Fund (3%) (Figure 4, right panel). An analysis of the previous three-year period (2011/12 - 2013/14) found that in 2013/14 the SAG contributed 80% (R17.8 billion), the US Government 17% (R3.7 billion), and the Global Fund 3% (R662 million) of the total R18.4 billion<sup>h</sup> for HIV and TB.<sup>9</sup>

Donor commitments to HIV and TB in South Africa remained strong despite long-term expectations of declining external support. Support from the US Government, mainly through PEPFAR, grew over the three years, from R4.2 billion in 2014/15 to R6.0 billion in 2016/17.<sup>i</sup> The US Government contribution increased steadily from 19% to 21% over the same period. This trend may reverse in the coming years given that PEPFAR's spending in South Africa is expected to decline to R5.8 billion in 2019/20.<sup>25</sup> Meanwhile, after Global Fund spending increased from R865 million in 2014/15 to R1.5 billion in 2015/16, its contribution dropped to R806 million (3%) in 2016/17. This mainly reflected sluggish spending in the first year of a new three-year grant cycle. Importantly, the new Global Fund grant amounted to R4.3 billion<sup>j</sup> for 2016 - 2018, compared with roughly R3 billion spent from the 2013 - 2015 grant.

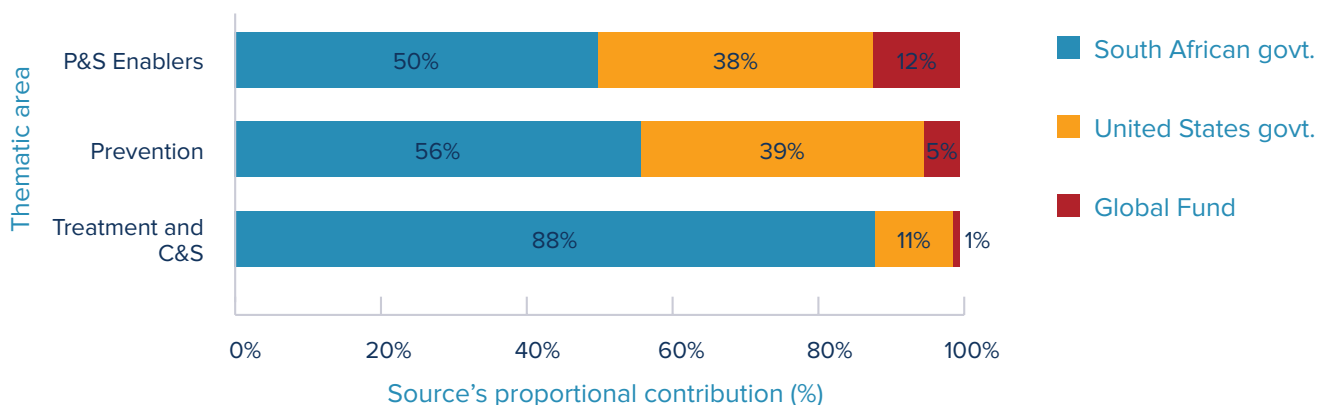
The extent of South Africa's reliance on external funding varies across HIV programme areas (Figure 5). In 2016/17, the SAG financed 88% of HIV treatment costs (including care and support). In contrast, only slightly more than half (56%) of spending on prevention – including youth and workplace interventions, condom distribution, and an independent human papilloma virus vaccination programme – was

financed domestically. Likewise, the SAG contributed 50% of investments in programme enablers such as communication, social mobilisation, and advocacy activities, as well as the DSD's substance-abuse prevention and training efforts. Interventions for which donors provided more than half the financing in 2016/17 included HIV testing services, prevention of mother-to-child transmission (PMTCT), medical male circumcision (MMC), and outreach to key populations.

The South African Government's spending on ART increased from R9.8 billion in 2014/15 to R12.8 billion in 2016/17, reflecting the steady expansion of treatment – by the end of 2016/17, nearly 4 million people living with HIV (PLHIV) remained in care. The next biggest areas of spending were home-based care (9%), HIV testing services (7%), care for orphans and vulnerable children (7%) and MMC (4%).

Spending on TB also continued to rise due to growing domestic and donor financing, increasing from R2.5 billion in 2014/15 to R2.9 billion in 2016/17, an annual average 8% increase over the three years. In 2016/17, the SAG (via the NDoH) accounted for 77% of total TB spending, with the US Government contributing 22% (nearly 16% through PEPFAR and 6% through separate USAID funding). The Global Fund contributed R30 million in 2016/17, 1% of total TB spending, and also funded integrated TB/HIV interventions for key populations, such as for inmates of correctional services and peri-mining populations, which were coded in the study as HIV spending. The Global Fund's continuing commitment to TB is reflected in the new Global Fund grant covering 2019 - 2021.

Figure 5: Funder relative contributions to HIV programme areas, South Africa, 2016/17 (%)



Source: Guthrie et al., 2018.<sup>11</sup>

C&S = care and support; P&S = programme and social.

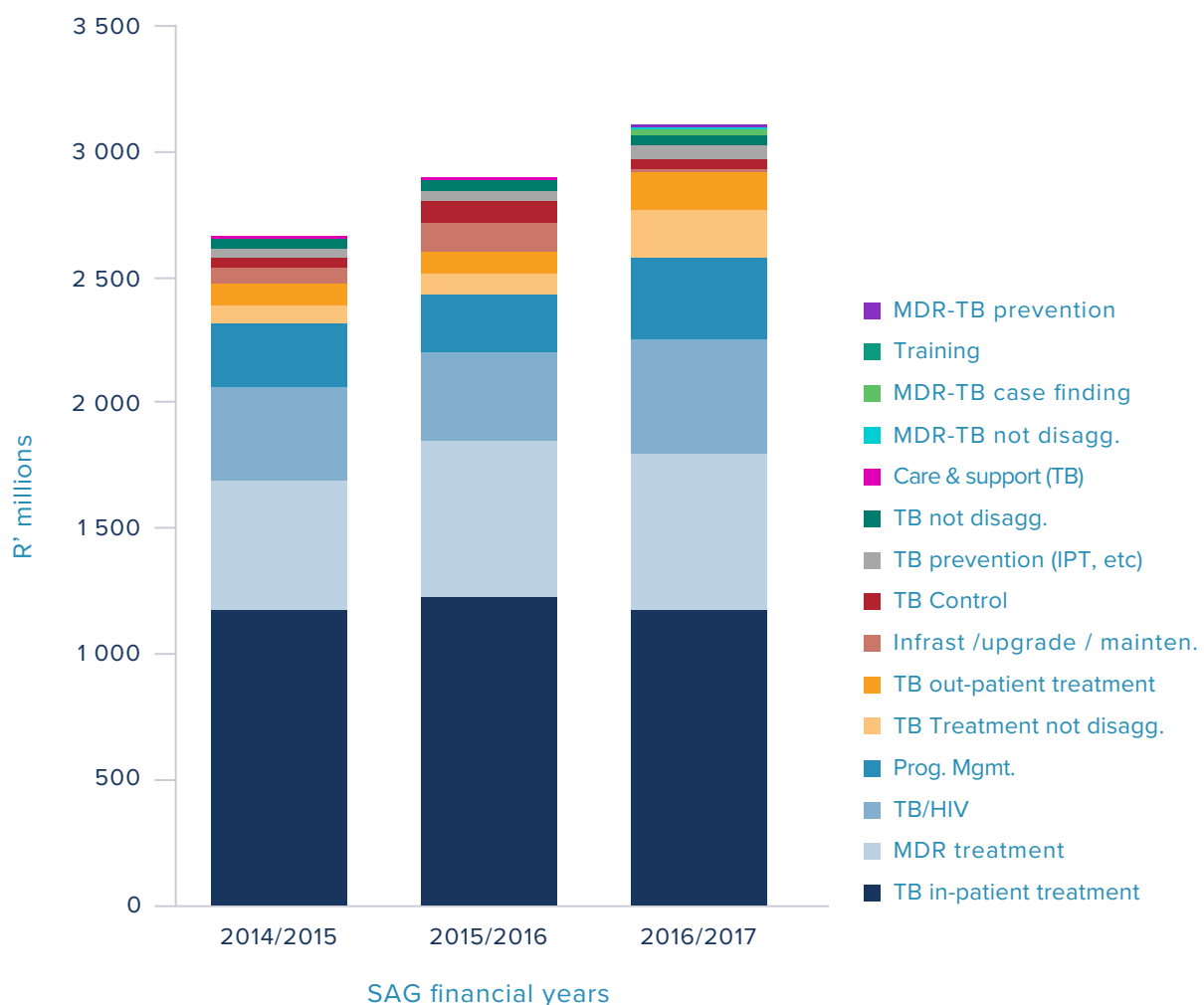
- h Note that the previous analysis (2011/12 - 2013/14) included some estimates of TB spending in the public sector, due to weaker coding than in the current period of study.
- i The US dollar amount of PEPFAR's contribution decreased from 2014/15 to 2015/16, but the Rand value increased due to the weakening Rand.
- j This amount is equivalent to the US\$324 million committed by the Global Fund, based on an exchange rate of R13.25 per US dollar used by the Global Fund in the approved budget for the 2016 - 2018 grants, provided by the South African National AIDS Council.

The NDoH's TB spending focused mostly on treatment of drug-sensitive and drug-resistant cases (Figure 6), while prevention efforts were funded mostly by the US Government, and multidrug-resistant (MDR)-TB case finding and care and support were funded mostly by the Global Fund. The largest portion of NDoH spending was captured under 'hospitals' in the BAS records, and therefore labeled as 'TB inpatient treatment'. However, this included medicines for outpatients visiting clinics in hospital catchment areas and hence included some outpatient TB treatment as well. Additionally, estimates of NDoH spending on TB prevention, case finding, screening and diagnosis are likely too low because salary costs of public sector health

workers who provided TB services were not labeled as TB-specific in the BAS. The analysis was also generally hampered by poor coding of TB spending by certain provinces,<sup>k</sup> limiting comparison and full understanding. Promisingly, there were signs of improvement in the coding of TB spending from voted funds since the previous study for the period 2012/13 - 2014/15.<sup>9</sup>

The district-level analysis of combined SAG and US Government spending on HIV (undertaken for the first time in a recent HIV and TB expenditure review),<sup>11</sup> found that spending was roughly distributed according to HIV burden, proxied by numbers of PLHIV in each district.<sup>l</sup> KwaZulu-Natal

Figure 6: Total TB spending by intervention, South Africa, 2014/15 - 2016/17 (R' millions)



Source: Guthrie et al., 2018.<sup>11</sup>

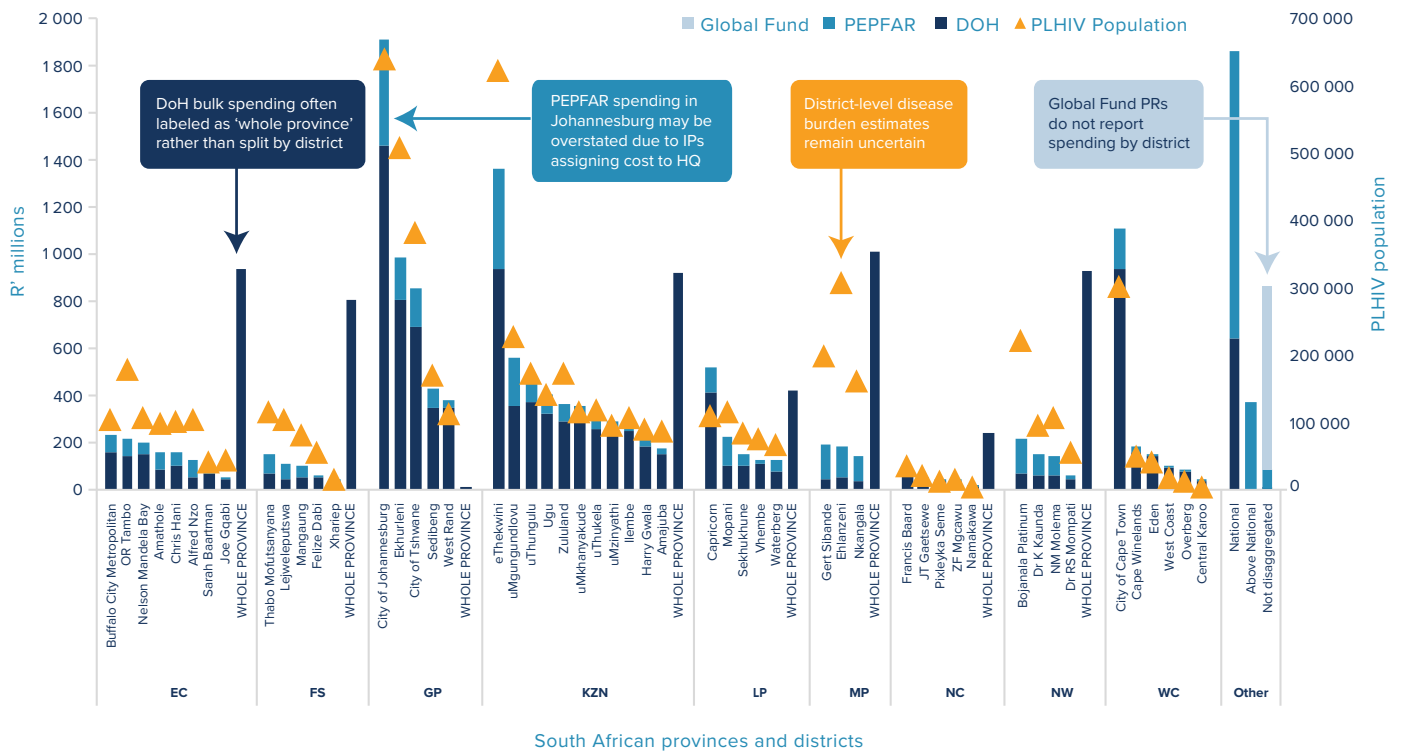
Note: The NDoH's HIV/TB integration efforts, including HIV/TB testing, were coded as HIV spending in this study. Some values are too small to appear in Figure 6.

disagg. = disaggregated; Infrast/upgrade/mainten. = infrastructure upgrade and maintenance; IPT = isoniazid preventive therapy; MDR-TB = multi-drug resistant tuberculosis; Prog. Mgmt = programme management; SAG = South African Government.

- k For example, North West provincial DoH did not label any TB in their BAS records, yet they treated 16 762 TB patients in 2016/17. KwaZulu-Natal coded their TB spending more consistently, and thus displayed the greatest TB spend, also reflecting their greater burden of disease.
- l For this analysis, the district PLHIV estimates were provided by PEPFAR. These estimates were based on three sources: The Antenatal Care Survey, the Human Sciences Research Council HIV Behavioural Survey, and the NDoH's 'total remaining on ART' indicator, and they are generally accepted until the Thembisa model generates more reliable district estimates. Unfortunately, Global Fund spending could not be disaggregated by district.



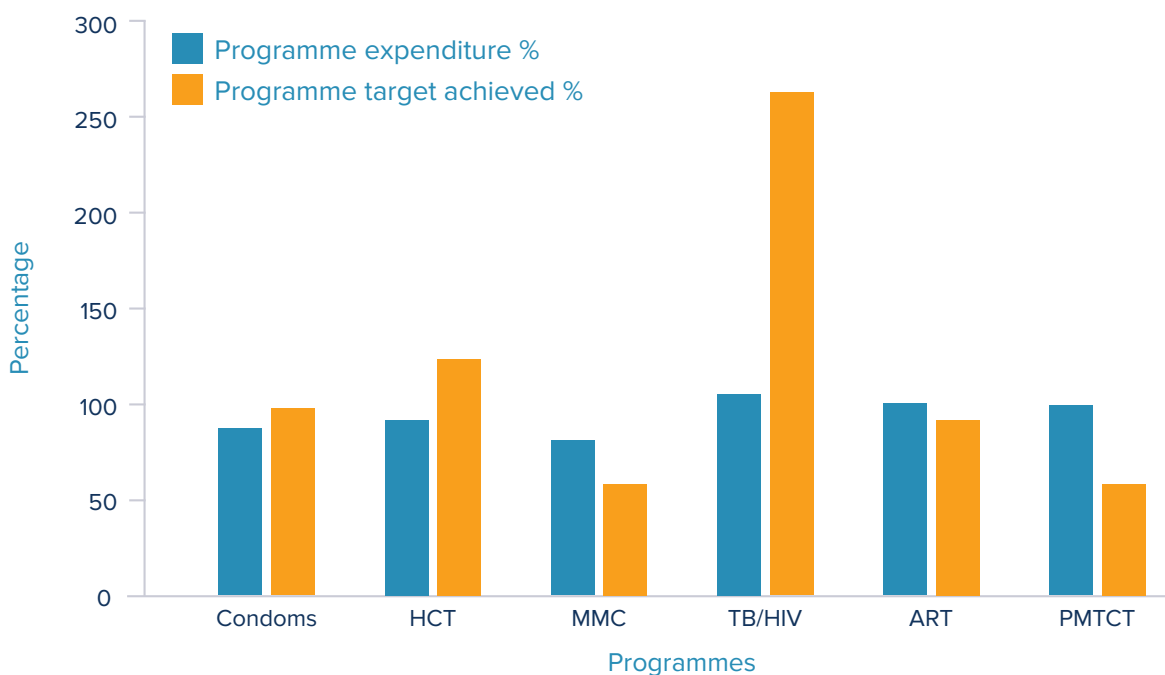
Figure 7: HIV spending by district and funder (R' millions, left axis) and number of people living with HIV (right axis), South Africa, 2016/17



Source: Guthrie et al., 2018.<sup>11</sup>

EC = Eastern Cape; FS = Free State; GP = Gauteng; HQ = headquarter; IP = implementing partner; KZN = KwaZulu-Natal; LP = Limpopo; MP = Mpumalanga; NC = Northern Cape; NW = North West; PR = principal recipient; WC = Western Cape.

Figure 8: Comprehensive HIV, AIDS and TB conditional grant sub-programme spending against selected performance targets, South Africa, 2016/17 (%)



Source: Simelane et al., 2018.<sup>10</sup>

ART = antiretroviral therapy; HCT = HIV counselling and testing; MMC = medical male circumcision; PMTCT = prevention of mother- to- child transmission.

and Gauteng, the most HIV-burdened provinces, spent the most on HIV. Eight metropolitan areas accounted for over a quarter of HIV spending (26%), reflecting the concentration of PLHIV in major cities like Johannesburg, Durban (eThekweni), Tshwane and Cape Town (Figure 7). Deeper analysis of district-level HIV spending was hampered by large shares of SAG expenditure being coded in the BAS as ‘whole province’ rather than individual districts. Additionally, neither the Global Fund nor its principal recipients report spending by district.

### NDoH HIV and TB sub-programme analysis

The detailed planning and reporting of the conditional grant enabled further analysis of provincial expenditure and programmatic performance. In addition to absorbing budgets, it is important that provinces spend on the correct programme areas and achieve programmatic performance

targets for which finances were allocated. Table 4 and Figure 8 show the difference between provincial DoH total sub-programme absorption rates,<sup>m</sup> and the percentage of sub-programme targets achieved.

Given that the conditional grant sub-programmatic budgets are based on business plans costed in line with provincial targets, ideally sub-programme spending should be closely aligned with target achievement, unless some efficiency gains (where performance outpaces expenditure, such as for HIV testing services) or dramatic cost hikes (where expenditure eclipses performance, such as for MMC and PMTCT) happened during the year. Figure 8 shows variances between expenditure and performance in 2016/17.

Absorption of the ART sub-programme budget was 101% in 2016/17, while the number of clients remaining on treatment

Table 4: Provincial DoH core national performance targets and actual performance (2016/17), financial and non-financial data (HIV, AIDS and TB conditional grant), South Africa, 2015/16 - 2016/17

Sub-programme	Indicator	Baseline (2015/16)	2016/17 Targets	2016/17 Performance	2016/17 Budget R'000	2016/17 Expenditure R'000	2016/17 Expenditure %	Target achieved %
Condoms	Number of male condoms distributed	833 397 571	924 615 352	912 786 845	429 283	374 366	87.2	98.7
HIV testing services	Number of clients tested for HIV (including antenatal)	12 417 523	11 760 312	14 488 440	875 931	811 271	92.6	123.2
Medical male circumcision	Number of medical male circumcisions performed	464 629	700 000	415 114	350 318	286 436	81.8	59
HIV/TB	Number of HIV-positive clients screened for TB	1 103 975	1 173 450	3 077 692				262.3
	Number of HIV-positive clients started on IPT	390 701	575 746	393 400	610 903	648 260	106.1	68
ART	Number of patients on ART remaining in care	3 403 605	4 164 131	3 806 194	10 714 297	10 885 298	101.6	91.4
PMTCT	Number of babies PCR-tested at 10 weeks	97 688	257 571	151 084	275 866	273 761	99.2	58.7

Source: Adapted from NDoH, 2017.<sup>2</sup>

ART = antiretroviral therapy; IPT = isoniazid preventive therapy; PCR = polymerase chain reaction; PMTCT = prevention of mother-to-child transmission.

m Absorption rate is the percentage of the budget spent.

was 3 806 194, only 91.4% of the target of 4 164 131.<sup>4</sup> Provinces failing to meet their targets reported challenges with capturing data on the District Health Information Software, and data-verification problems with districts.

The condom sub-programme achieved 98.7% of its 2016/17 target, while on average spending only 87.2% of the allocation, with some provinces over- or under-achieving. Provincial HIV managers attributed under-performance to lack of dedicated transport from storage sites to facilities, inadequate condom storage capacity, and late deliveries of condoms by suppliers. Corrective measures taken included implementation of standard operating procedures, regular correspondence between suppliers and provincial programme managers, and assistance from the NDoH with registration of suppliers in provinces where they provide services.

The MMC sub-programme was the second-lowest-performing sub-programme in 2016/17, achieving only 59% of its target. Moreover, despite a 43% increase in MMC spending from 2015/16 to 2016/17, the number of circumcisions performed declined by 21%, from 524 401 to 415 114. Further analysis is required to identify cost drivers and understand the increased spending despite declining performance. Suggested actions included deployment of dedicated MMC social mobilisers and provision of transport to MMC sites.

The TB/HIV sub-programme had mixed performance in 2016/17 as it over-achieved (262.3%) against its target with regard to the number of HIV-positive clients screened for TB, but under-performed (68% achieved) on the number of HIV-positive clients started on isoniazid preventive therapy. The NDoH has worked to strengthen TB screening for all HIV-positive clients but records only newly HIV-diagnosed clients to avoid double-counting.<sup>2</sup> Nevertheless, the TB/HIV sub-programme recorded the largest budget absorption rate in 2016/17 at 106%.

## Conclusions

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The results reported in this chapter show the magnitude of HIV and TB spending, and trends for this spending by the SAG, the US Government and the Global Fund. The study results have also informed the management and planning processes of all three funders.<sup>n</sup> Members of the study team have provided capacity building and technical support to provincial DoHs to address many of the challenges expressed by their programme and financial managers in budget planning and execution. Tools and processes are being enhanced through the Financial Capacity and Technical Support Project for Provinces, a USAID-funded partnership programme between the NDoH, the Health

Economics and Epidemiology Research Office, and the Centre for Economic Governance and Accountability in Africa. Ongoing analyses are needed to generate fresh data for annual and future planning purposes.

HIV and TB budget allocations are expected to grow in the future, despite the fiscal constraints in the country. However, the challenge remains to reduce new HIV infections, which continue to put pressure on the government's overall response and financing of HIV and TB. Although ART contributes to reduced HIV infection rates, major prevention efforts are still required, and these are among the HIV interventions currently most dependent on donor funding.

## Recommendations

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Timely and accurate data on spending trends are critical for policy, planning and programme management. More effort needs to be made to integrate output analysis and routine expenditure analysis in order to measure value-for-money and impact. Routine expenditure analysis can facilitate dialogue between national and sub-national actors, especially the NDoH, National Treasury and provincial DoHs to improve technical efficiency given the scarcity of public resources. Such analysis could also help the government and partners to compare their past and current budgets with spending and outputs, and better understand issues of efficiency and equity. This information could also be combined with findings from the South African HIV and TB Investment Case<sup>26</sup> to allow government officials to make and defend sometimes controversial decisions to reallocate funds across interventions or geographies.

Harmonised analysis of domestic and donor spending enables better joint planning, including full ownership of financing responsibility by government and eventual transition away from donor support. The breakdown in this review of SAG, US Government and Global Fund contributions to specific HIV and TB interventions should inform government with regard to future domestic resource allocation and sustainability, particularly donor-dependent interventions.

Lessons learnt in financing the HIV and TB responses through the Conditional Grant Framework<sup>20</sup> should inform resourcing and management of other public policy priorities. This analysis shows the value of ring-fenced funding, which allows for detailed and accurate expenditure tracking directly linked to outputs. The incorporation of community outreach services into the grant could extend these benefits to an increasingly integrated pool of funds for PHC services. The impact of these efforts should be monitored and reflected upon to see how best provincial HIV and TB sub-programme performance can be further enhanced.

<sup>n</sup> Within the SAG, the findings gained most traction within the NDoH. The national DSD also found the expenditure tracking findings useful but noted that measurement against the provincial performance was challenging because the funds are voted and therefore provincial DSDs are not obliged to report to national officials on their use.

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