

# CONSOLIDATED SPENDING ON HIV AND TB IN SOUTH AFRICA (2011/12 – 2013/14)

Undertaken for the South African Investment Case 2015, with  
support from the Global Fund for AIDS, TB, and Malaria

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Prepared by Teresa Guthrie, Tess Ryckman, Shan Soe-Lin, and Robert Hecht

On behalf of the South African Investment Case Steering Committee, SANAC, NDOH, Global Fund and UNAIDS

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## Abbreviations and Acronyms

AFR	Annual Financial Reports (GF PRs)
ART	Anti-retroviral treatment
CHBC	Community and home based care
DCS	Department of Correctional Services
DOD	Department of Defence
DOE	Department of Basic Education
DOH	Department of Health
DSD	Department of Social Development
EA	Expenditure Analysis (PEPFAR's reports)
EPWP	Expanded Public Works Programme
EFR	Enhanced Financial Report
ES	Equitable share
E&S	Earmarked and specific
ETB	Extrapulmonary tuberculosis
FY	Financial year
GF	Global Fund to Fight AIDS, TB and Malaria
Govt	Government
HCT	HIV counselling and testing
HSRC	Human Sciences Research Council
IC	Investment Case
IP	Implementing Partner (PEPFAR)
MMC	Medical male circumcision
MDR-TB	Multidrug-resistant Tuberculosis
MTEF	Medium Term Expenditure Framework
NASA	National AIDS Spending Assessment
n.d.	not disaggregated
NDOH	National Department of Health
NFM	New Funding Model (Global Fund)
NHA	National Health Accounts
NHI	National Health Insurance
NIMART	Nurse initiated and managed ART
NSP	National Strategic Plan
OI	Opportunistic infection
OOPE	Out-of-pocket expenditure
OVC	Orphans and vulnerable children
PEP	Post-exposure prophylaxis
PEPFAR	President's Emergency Plan for AIDS Relief (United States Government)
PFIP	Partnership Framework Implementation Plan (PEPFAR)
PMTCT	Prevention of mother-to-child transmission
PR	Principal Recipient (GF)
PrEP	Pre-exposure prophylaxis
PTB	Pulmonary tuberculosis
SA	South Africa
SANAC	South African National AIDS Council
SAPS	South African Police Service
SBCC	Social and behaviour change communication
SDA	Service Delivery Area (for GF PRs)

SDC	Step down care
TB	Tuberculosis
USG	United States Government
XDR-TB	Extensively drug-resistant Tuberculosis

## Executive Summary

The South African (SA) government has played the key role in designing, financing, implementing and monitoring the response to HIV and TB in the country, which has included the world's largest public anti-retroviral therapy (ART) programme, provided free to persons living with HIV. Development partners have also played important roles in supporting and financing aspects of the response, as well as the private sector to a lesser degree. Given the increasing demand for treatment but with the need to contain the epidemic through effective prevention interventions, yet within a limited budget ceiling, the government has led the development of its Investment Case (IC) to assess if current spending is achieving its maximum impact, and if adjustments or realignments for greater impact are required. The research for the IC included the designing of the most cost-effective package of interventions based on available evidence, the modelling of the potential impact and cost of various scenarios, as well as an examination of past spending on HIV and TB, the latter being the focus of this report.

This review of past expenditure attempts to measure the trends in spending from 2011/12 to 2013/14 and the contributions of the three key sources in South Africa - namely the SA government, the United States President's Emergency Program for AIDS Relief (PEPFAR) and the Global Fund (GF) - to identify which interventions have been prioritised, how much has been spent in aggregate from all three major sources, how the financial burden has been shared across these funders, and what the future commitments might cover in terms of the resources required for the optimal package. In addition, the process examines the financial information systems of the three key sources and made recommendations for their harmonisation and improvement for routine resource tracking. This importantly feeds into the GF's longer-term efforts to improve recipient countries' public financial management systems, and hence the usefulness of this report in identifying areas needing strengthening.

This expenditure review builds on previous efforts such as the National AIDS Spending Assessment (NASA) covering 2007 to 2009, and the Annual Planning Tool that covered 2010. However, it is unique in that it includes TB spending and that it has consolidated all the data from the three sources into one database (compatible with the public finance system) for easier and more timely, analysis, so as to explore the feasibility and functionality of such a consolidated system for future routine tracking. This mapping will also feed into the System of Health Accounts (SHA) being planned in SA for 2015-2016, and will provide the detailed disaggregation of the HIV spending required for the SHA HIV component. Such consolidation yields a rich set of findings in a timely manner that can be used to guide policy, improve programmes, feed into other reporting systems and strengthen performance monitoring and accountability.

The total spending on HIV and TB in South Africa increased from R17.4 billion in 2011/12, to R19.2 billion in 2012/13 and again to R22.1 billion in 2013/14, representing an average annual increase of 16% over the three years. Of these amounts, the largest and growing contribution came from the SA government. These public contributions formed 80% of the total HIV and TB spending in 2013/14 and steadily increased from R13.3 billion (2011/12) to R17.8 billion (2013/14). This occurred at a time when the South African economy was declining, and public expenditures were being reduced. PEPFAR provided the next largest but decreasing share, at R3.7 billion (17%) in 2013/14, down from R3.9 billion (22%) in 2011/12, in line with PEPFAR's stated intention to phase down its financial contributions to South Africa. The GF contributions increased from R214 million (1%) in 2011/12 to R662 million (3%) in 2013/14, after an initially slow uptake of the new Single Stream Fund (SSF) grant. Of the total spending, HIV-related activities accounted for 82% and TB for the remaining 18%.

Of the HIV spending (excluding the TB), the largest (and growing) share at 40% went to care and treatment activities, mostly for ART, reaching R8.9 billion in 2013/14. HIV counselling and testing (HCT), Programme Enablers (mostly M&E and management) and Social Enablers (mostly support for orphans and vulnerable children, OVC) were the next largest areas of expenditure, while the remaining IC programmes received relatively small proportions. Spending on other programmes not included in the IC list of priority interventions amounted to 14% of the total. The bulk of this went towards community and home based care (CHBC) activities, with smaller amounts for step-down care, palliative care, workplace programmes, training, and some other prevention activities. While these items are outside of what IC modeling found to be the most effective core spending areas, due to a lack of evidence, it does not necessarily imply these interventions should not be funded as they may form important programmatic enablers. Nevertheless, it may be necessary to explore the spending on these activities in greater detail to ascertain their value for money or potential efficiency gains.



The majority of SA public funds (57%) were channelled through the HIV conditional grant (CG) to the Department of Health (DOH), followed by the DOH's voted (Equitable Share) funds (34%). The majority (69%) of the DOH CG went to ART, while the majority (60%) of the voted funds went towards TB treatment, although a growing proportion (4%) of the voted funds also went towards ART. The other departments' spending was relatively small but provided important interventions, such as the Department of Social Development's support (5%) for OVC and the Department of Basic Education's (1.3%) prevention interventions for youth in school (through the Lifeskills conditional grant).

The largest portion of PEPFAR's spending was allocated to care and treatment for HIV (25% of PEPFAR funds in 2013/14), though this was a smaller share as compared to the allocation of the Government's spending for ART. The remaining PEPFAR funds were evenly spread across the other IC categories, with contributions to HCT (9%), medical male circumcision (MMC) (10%), prevention of mother-to-child transmission (PMTCT) (8%), TB interventions (8%), social and behavioural change communications (SBCC) (6%), Programme (11%) and Social (9%) Enablers, with smaller amounts spent on key populations (2%) and other biomedical interventions (5%), for which PEPFAR was the primary funder. The GF contributions were small in absolute terms, but also primarily went to care and treatment (58% of GF spending in 2013/14) and HCT (12%).

For future joint planning between the three players, it is important for the SA government to note that, in addition to PEPFAR's contribution to care and treatment spending, they were also the largest proportional contributor to SBCC, MMC, other biomedical interventions (eg. Pre-Exposure Prophylaxis) and PMTCT programmes. The GF has played an important supportive role in the national response, especially with regards to key population interventions and HCT, as well as Programme and Social Enablers.

Regarding allocative efficiencies, this expenditure analysis showed that the past spending on HIV and TB has indeed tended to focus on those interventions identified as having the greatest impact by the IC modelling, and it appears that the financial effort has been aligned with priorities specified in the National Strategic Plan (NSP) and has contributed towards the achievement of the NSP targets to increase the number of persons accessing treatment and to reduce the number of new infections.

The spending on treatment will continue to increase, but should be complemented by supportive efforts to improve adherence, patient tracking and viral load monitoring, so that the quality of care and outcomes are high for the money invested in ART. It is imperative that the government remain the key funder for the ART programme, to ensure long-term sustainability, which may require the ring-fencing of the ARV funds to ensure that the current and future patients will continue to receive their ARVs, irrespective of development partners' funding priorities and trends.

Concurrently, there is need to strengthen the prevention interventions as well as the Programme and Social Enablers to ensure that the treatment and prevention interventions achieve the greatest impact possible. Geo-spatial targeting of efforts towards the areas of highest HIV transmission will be important to generate high impact, and joint planning between the SA government, PEPFAR agencies and the GF will be crucial to maximize coverage, while not neglecting the other, lower priority, areas.

This study did not include a review of the technical efficiency of current spending. While there may be some scope for savings within these programmes, these potential efficiency gains should not be over-estimated, as generally the public health programmes operate on less than optimal resources, both financial and human. Therefore the greatest potential savings may only be through the reduction of the anti-retroviral (ARV) tender prices or by applying different modes of delivery.

Looking ahead, the SA government's contribution over the medium term expenditure framework (MTEF) period is expected to continue to increase, while PEPFAR's contributions may decrease as per the Partnership Framework Implementation Plan (PFIP) till 2018/19. The GF indicative allocation for the next grant (2016/17-2018/19) may also result in less funding than has been received under the current grant, though this will also depend on the overall size of the next replenishment and on any changes that may occur to the GF's allocation formula. Although the increase in SA government funding is expected to make up for the gap left by the decreasing PEPFAR and GF allocations, the resources needed to achieve the 90-90-90 targets could require an additional 36% above the currently expected funding for HIV and TB between 2016/17 and 2018/19, if the scale-up rates are achieved as modelled.

All partners will need to strategically plan together to meet the funding requirements if the investment required for maximum impact is to be achieved, and to ensure the absorption of available funds is optimal.

This report makes many detailed suggestions for possible improvements to the SA government financial system, the PEPFAR expenditure tracking and the GF's reporting system, so as to facilitate a consolidated, routine expenditure tracking system in the future. These are noted below, and are based on the belief that any such efforts must be undertaken within the public finance system, which will require strengthening for optimal performance.

#### **Improvements to the government of South Africa's public financial reporting:**

- Ensure standardised use of the variables and naming/ classifications – provide hard-coded drop down menus
- Improve the coding of the TB expenditure
- Train and support finance and programme officers responsible for the requisitioning and capturing of expenses, at provincial and district levels
- Add variables identifying the System of Health Accounts (SHA) classification for the health function and the Medium Term Strategic Framework (MTSF) goals (for the Annual Planning Tool, APT), to allow for routine SHA and APT, and other, reports
- Improve linkages between budgets and expenditure in BAS
- Improve the classification of the level of provision and facility type
- Link expenditure to output data for improved monitoring and analysis of performance

#### **Improvements to the PEPFAR Expenditure Analysis (EA) reporting:**

- Disaggregate the Facility Based Care and Treatment Support (FBCTS) and Community Based Care and Treatment Support (CBCTS), and redefine 'infection control'
- Improve the coding of TB expenditure
- Indicate the type of service provider
- Agree with the SA government on where the overheads, supervision and other costs should be captured
- Consider quarterly or half-yearly reports, so as to improve the matching to the SA Government's financial year
- Match the USG COP budget codes with the EA classifications

#### **Improvements to the GF reporting** (these may be addressed in the new AFRs):

- Use more specific categories of interventions, that are clearly defined and can only include one intervention at a time (mutually exclusive)
- Ensure standardised use of the classifications (drop down menus and clear definitions)
- Improve the classification and coding of TB expenditure
- Add geographical indicators: provincial and district levels
- Link the GF interventions (new modules) to the cost components
- Consolidate the quarterly reports into annual reports, which should be available online
- Match the annual reports to the SA Government's financial year (if possible)
- Provide training and support to Principal Recipients (PRs) to apply the new Annual Financial Reports (AFRs) correctly

#### **Moving towards routinised expenditure monitoring:**

- A common structure and crosswalking of categories should be agreed upon, that must be compatible with, or built within, the public finance system
- The matching (crosswalking) of PEPFAR EA programmes and GF new modules should be standardised for all countries
- Add variables to indicate the national priorities and SHA functions to which all health expenditures are contributing
- Improve public finance systems to provide detailed expenditure data that is transparent and publicly available

Given the importance of obtaining accurate, timely HIV expenditure information for South Africa, where more than 7 million persons are infected with HIV and TB combined spending exceeds R22 billion (US\$2 billion) annually, it is vitally important that this system of annual expenditure mapping and analysis be institutionalized and annually repeated so as to feed into major spending and programming decisions. To do so, the Government needs to take the lead in deciding on the detailed annual process and on what inputs are expected from the two large external funders and from its own national departments. It must also determine which Government unit will coordinate, synthesize, and publish the annual spending results. The National Department of Health, the South African National AIDS Council and the National Treasury all have the potential to play this role. The selected unit may require additional capacity building to enable it to perform these expenditure mapping and analysis functions. Certainly both the Global Fund and PEPFAR could also play constructive parts, by advocating for a sustained expenditure mapping effort, assisting the Government to improve its public finance system, and providing timely and easily aligned expenditure data on a regular basis.

## 1. Introduction and methodology

South Africa has the largest HIV and tuberculosis (TB) epidemics in the world. In 2013/14 there were 6.4 million people living with HIV in the country as well as almost 400,000 new cases of TB (SANAC, 2014).<sup>i</sup> According to the 2012/13 Human Sciences Research Council (HSRC) survey, the national HIV prevalence among all ages was 12.2% (95% CI: 11.4-13.1). The South African (SA) government has played a pivotal role in developing, financing and driving the national response to HIV and TB, and South Africa now has the largest number of people receiving anti-retroviral treatment (ART) on the public health system, over 2.5 million people by the end of 2014.<sup>ii</sup>

At the 2011 UN General Assembly High Level Meeting on HIV, countries including South Africa adopted the Political Declaration pledging to strive to reduce new HIV infections, deaths due to HIV, and HIV-related stigma and discrimination by 50% by 2015. An important component of Political Declaration was the introduction of the 'investment approach' to achieve substantial and sustainable impacts in the global HIV response by 2015 and beyond (Schwartlander 2011<sup>iii</sup>, UNAIDS, 2011<sup>iv</sup>). The SA government, led by the South African National AIDS Council (SANAC) and the National Department of Health (NDOH), and with the support of UNAIDS and other development partners, developed an Investment Case (IC) for both HIV and TB in 2014 and 2015. The South African HIV and TB IC borrows elements of the investment framework, such as the consideration of biomedical and behavioural programmes, alongside of strategic enablers of the HIV response and development synergies whose implementation often falls into the remit of government department other than Health<sup>1</sup>. For HIV, the SA IC adds the category of the technical efficiency<sup>2</sup> (TE) factor, which works to improve the efficiency of only one programme (whereas enablers and synergies often aim at improving the efficiency or uptake across a number of programmes). The aims of the SA IC were to:

- Review all relevant programmes, programmes, and social and programme enablers that could contribute to an efficient HIV and TB response;
- Calculate the most cost effective mix of such programmes and enablers; and
- Inform relevant domestic and donor budgets.

While Phase 1 targeted the national-level domestic and donor budgets (including GFATM and PEPFAR), Phase 2 (with results due in September 2015) will produce provincial-level results, and Phase 3 (starting in September 2015) will aim at the district level. The SA IC therefore proposes a package of programmes and the associated resources required to achieve the 90-90-90 targets<sup>3</sup> promoted by the Department of Health (DOH).

One component of the SA IC involved a review of previous spending trends on HIV and TB in South Africa, from three funding sources: the SA government; the United States Government (USG) funding via the President's Emergency Plan for AIDS Relief (PEPFAR); and the Global Fund to Fight AIDS, TB and Malaria (GF). The findings of this expenditure tracking are thus presented in this report, and are compared with the package of the most cost-effective programmes, as modelled by the IC team. This report also includes recommendations on the utilisation and allocation of funds, as well as possible improvements to expenditure tracking systems.

This expenditure tracking effort sought to answer the following questions:

- i. What are the trends in the past expenditures on HIV and TB in South Africa, and what were the contributions of the SA government, the USG, and the GF?
- ii. What have been the trends in contributions and has the SA government replaced any reductions from external sources?
- iii. Which programmes have been prioritised and are these the most cost-effective options as per the IC categories (allocative efficiencies)?
- iv. How do the future commitments compare with the resources needed for the optimal mix to reach the 90-90-90 targets?
- v. What would be required to achieve a routine system of consolidating all players' expenditure data for harmonised reporting and tracking of expenditure against outcome indicators?

More detail on the expenditure tracking methods are provided below, after a brief overview of the current funding for HIV in SA.

<sup>1</sup> Refer to the full Investment Case report for further details and findings (pending).

<sup>2</sup> Technical efficiency in the context of the SA IC analysis refers to the maximisation of output (for example, HIV tests done) given a set level of inputs (for example, healthcare staff).

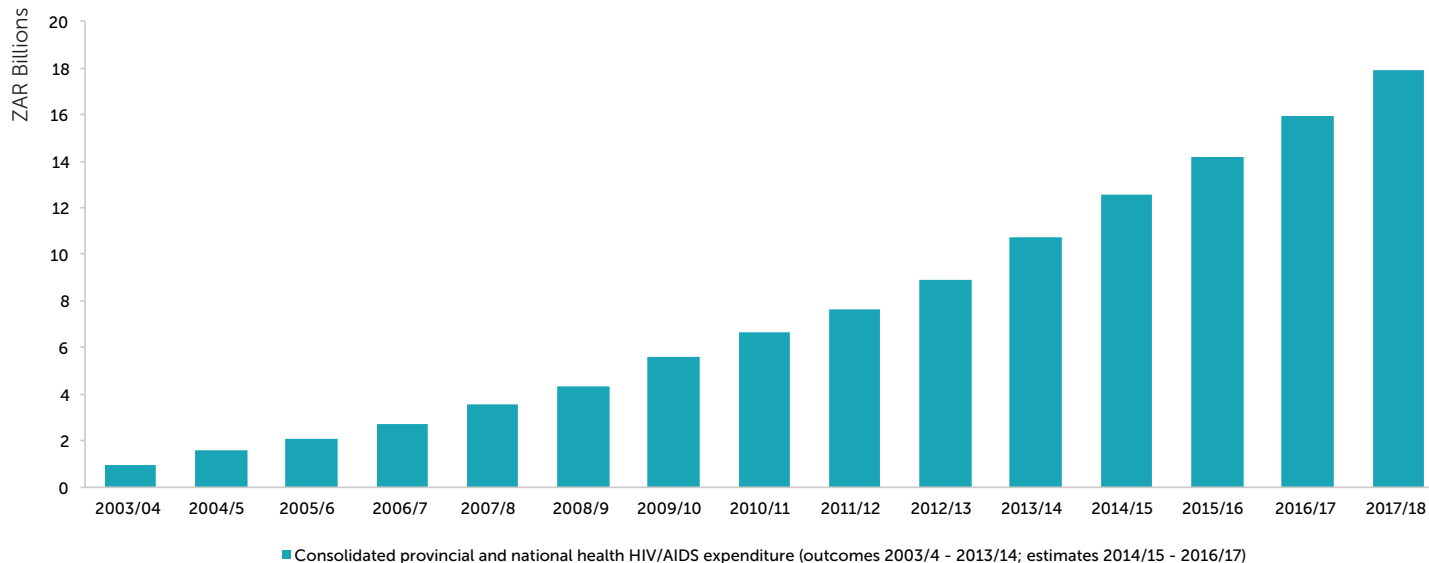
<sup>3</sup> UNAIDS Paris Declaration, Dec 2014. 90% of people know their HIV status, 90% of people who know their HIV-positive status are on treatment, 90% of people on treatment with suppressed viral loads.

## 1.1 General trends in financing for HIV in South Africa

HIV and TB services in South Africa are funded through public revenue, external development partners (donors), and the private sector—which includes company contributions and some individuals' out-of-pocket expenses (OOPE)—although the latter are low because the government provides HIV and TB treatment free to the patient. The last comprehensive expenditure tracking effort from the NASA (SANAC, 2012<sup>v</sup>), found that in 2009/10, 75% of total spending came from public sources, 16% from external sources and 8% from the private sector. The public HIV allocations in the health budget have grown from R966 million in 2004/5 to R13.6 billion in 2014/15, representing a 1400% growth in public allocations over the decade. The HIV budget allocations grew by 15% between 2013/14 and 2015/16 on an annual average nominal basis (Ndlovu et al, 2013:2<sup>vi</sup>), as shown in Figure 1 below.

Looking forwards over the Medium Term Expenditure Framework (MTEF) period (2014/15 - 2017/18), Ndlovu & Meyer-Rath (2014<sup>vii</sup>) found that R44 billion is budgeted for HIV programmes over the next three years as part of the public HIV allocations in the health budget which include the Conditional Grant (CG) and the Equitable Share (ES) (also known as 'voted funds') by the national and provincial departments of health, up from a budget of R41 billion over the past five years (2009/10 - 2013/14). The total national health HIV allocation has grown by 9.6% from 2013/14 to 2014/15, with an expected real growth of 7.6% over the next three years. The HIV budget has also been increasing as a share of consolidated (provincial and national) health spending, represented by a share of 7% in 2012/13, 9% in 2014/15, and 10% in 2016/17.

**Figure 1: Historical and Projected Health HIV Funding in South Africa (nominal ZAR million, 2003/4 to 2016/17)**



Sources: (Ndlovu et al, 2015); National Treasury (2004/5 - 2015/16 documents): Estimates of Provincial Expenditure; Estimates of National Expenditure; Medium Term Budget Policy Statements; Budget Reviews; Division of Revenue Bills/Acts.

## 1.2 Expenditure tracking scope and methodology

### 1.2.1 Scope

This expenditure review covers SA government financial years (FY) 2011/12 to 2013/14, and includes all SA government funding for HIV and TB (for all departments, conditional and voted funds), as well as GF and PEPFAR contributions. Expenditures are shown by year, funder, and programme area. The SA government and PEPFAR data have been split by province, but the GF spending was not available by province, since their Principal Recipients (PRs) did not split their expenditure by location at the time of the study.

### 1.2.2 Sources of data and estimations

Data on expenditures for HIV and TB came from the expenditures records of the implementing departments, National Treasury, and donors.

For all public spending, the Basic Accounting System (BAS) provides expenditure details for every transaction, and those that are labelled as HIV/AIDS or TB can be easily traced. This labelling of expenditure is routine for the HIV conditional grants (CG) for the Department of Health (DOH) and the Department of Education (DOE), but is done less systematically for the voted (equitable share) spending of the DOH, the Department of Social Development (DSD), and other departments. For the DSD, all their home-based care programme spending was labeled as support for OVCs since it could not be ascertained which proportion went to other community based support services. For some of the DOH voted funds, only the HIV/AIDS label was provided and hence these had to be labelled as HIV not disaggregated.

The DOH's TB expenditure in the BAS records is only labelled as such for Multi-Drug Resistant TB (MDR-TB), Extensively Drug Resistant TB (XDR-TB), and for the TB hospitals. Thus the bulk of the spending on TB prevention and out-patient treatment for Pulmonary TB (PTB) and Extrapulmonary TB (ETB) could not be easily identified in the BAS records. The NDOH therefore requested these costs be estimated by applying a unit cost per patient to the patient numbers per year. The details of these estimates are provided in the Appendices.

The data for PEPFAR's spending came from PEPFAR's Expenditure Analysis tool (EA), which contains spending reported by PEPFAR's implementing partners for 2012/13 and 2013/14, with 2014/15 data expected to be available in early 2015. However, there was no EA undertaken for 2011/12, and therefore PEPFAR spending for this year had to be estimated using the NASA figures for 2010 and interpolating to the 2012 data, assuming a straight-line increase and similar proportional split between programmes as for 2012.

The GF expenditure data came from their Principal Recipients' (PRs) Enhanced Financial Reports (EFRs), which captured actual expenditure for each of their Service Delivery Areas (SDAs) or programme areas.

### 1.2.3 Exclusions

Missing from this first phase of the IC are other external sources which only accounted for 3% of the total HIV spending in 2009/10, and private sources which formed around 8%, according to the most recent National AIDS Spending Assessment (NASA). The additional external sources may be added in the second phase of the SA IC. Any other (non USG and GF) external donor funding that went to the DOH (and was captured in the BAS records) was not included in this initial phase, but will be incorporated in the next version.

Similarly, other in- and out-patient costs related to the treatment of opportunistic infections (OIs) could not be identified since they are embedded in the general health care spending of the DOH, and it was beyond the scope of this project to attempt to estimate these costs.

For USG spending, only funding which went through PEPFAR was included. USAID spent additional money on TB in South Africa, but these funds did not go through the PEPFAR mechanism and therefore were not captured in the EA reports and are missing from this analysis.<sup>4</sup> These were relatively small amounts, approximately 3% of the other PEPFAR spending reported here.

### 1.2.4 Financial years

The expenditure data in this report is presented according to the SA government's financial year (FY), which runs from April 1 to March 31. The USG's FY runs from October 1 to September 31. The GF did not have a fixed financial year during the period under review, but rather the reporting periods were based on the dates on which the grants commenced, which varied per grant. Therefore, matching

<sup>4</sup> USAID additional contributions to TB (not reported in the EA data): USG FY11 - \$13,972,000, USG FY12 - \$12,000,000, USG FY13 - \$12,008,901.

the reporting periods for all three sources according to the SA government FY proved challenging, especially as the PEPFAR EA tracks annual amounts only according to the USG FY. Therefore, the SA government FY 2012/13 (commencing in April 2012) was labeled as 2012 and matched with the PEPFAR EA data for their FY 2011/12 (commencing in Oct 2011). The following Table 1 shows the best possible overlap match. For the GF data, the EFRs per quarter reports were used to match data to the SA government FY, as far as possible.

**Table 1: Matching the SA Government and USG Financial Years for the Expenditure Analysis**

Labeled as:	SAG		USG	
Common Year	Start	End	Start	End
2011/12	Apr-11	Mar-12	Oct-10*	Sep-11*
2012/13	Apr-12	Mar-13	Oct-11	Sep-12
2013/14	Apr-13	Mar-14	Oct-12	Sep-13

\* No EA data (2010/2011/12) to match with SA Govt 2011/12 - estimated

Throughout this report, the reported years related to the SA government's FY. Therefore 2011 refers to 2011/12 (SAG FY), which was matched to USG's FY 2010/11.

### 1.2.5 Exchange rates

The following annual average exchange rates were applied in converting US dollars to ZAR:

2011/12	2012/13	2013/14
7,4234	8,4924	10,1052

Source: OANDA (<http://www.oanda.com>).

### 1.2.6 Crosswalking categories

The SA government, PEPFAR and the GF use different categorisations for their activities and programmes. This required a crosswalking (matching as closely as possible) between the three datasets, as well as matching these to the agreed-upon IC programmes. The development of a crosswalk required in-depth understanding of each sources' programmes, their definitions and coding, and involved discussions with programme managers to find the best match.

Before the GF and PEPFAR data could be matched to the BAS categories, the latter had to be consolidated into a core common list. This was necessary because the BAS categories (names of the programmes) were not standardised across programmes, across provinces, and even within provinces. There was also variation in the naming of the core set of programmes for the DOH HIV conditional grant, sometimes with different spellings (or errors) of the same interventions. In addition, the required detail of the activity was not always classified under the same variable (BAS Objective levels 6 and 7). Therefore all possible variables had to be searched for potential information on the activities, and then a standardised sub-set of 'common BAS codes' was developed to first categorize all public spending according to a reduced list of activities. Over 300 different codes were found for all the public HIV and TB activities, and these were collapsed into 38 common BAS codes (see Appendix B). These formed the basis against which all the PEPFAR and GF activities were matched (see Appendix C and D). Once they had been matched to the BAS categories, they were more easily matched to the IC programmes. In addition, these were matched to the NASA categories for global comparisons (refer to the Appendix) and, at a later stage, will be matched to the National Health Accounts (NHA<sup>5</sup>) and the new GF New Funding Model (NFM) Modular Template categories<sup>6</sup>.

The PEPFAR EA data uses a few aggregate categories that could not be disaggregated to the level available in the BAS data, and hence some estimations based on PEPFAR's suggestions had to be computed. For example, their category 'Facility-Based Care, Treatment

<sup>5</sup>The NHA in SA is being planned for 2015/16-2016/17.

<sup>6</sup> The GF will be piloting its new categories in 2015/16.

and Support' included ART and TB/HIV activities and these were split 75% and 25% respectively (as per a previous analysis undertaken by Results for Development, 2014<sup>viii</sup>). The other PEPFAR categories were logically matched. Appendix B shows the PEPFAR-BAS crosswalk in more detail.

The GF Service Delivery Areas (SDAs) were sometimes broad and could contain more than one programme or activity. Unfortunately, the spending on these programmes could not be disaggregated from the EFRs. In such cases, the entire spending was attributed to the one activity that was assumed to be the most common. For example, 'HIV and TB case finding' had to all be matched to HIV HCT, since the TB testing could not be extracted. Sometimes the Objective provided more insight into the SDA label. For example, 'care for the chronically ill' was matched to community and home based care, since its Objective was to increase access to support for rural communities. Refer to Appendix C for the GF SDA crosswalk to the matching BAS category.

The following sections present the key findings of the analysis of the consolidated past HIV and TB spending in South Africa.

## 2. Findings

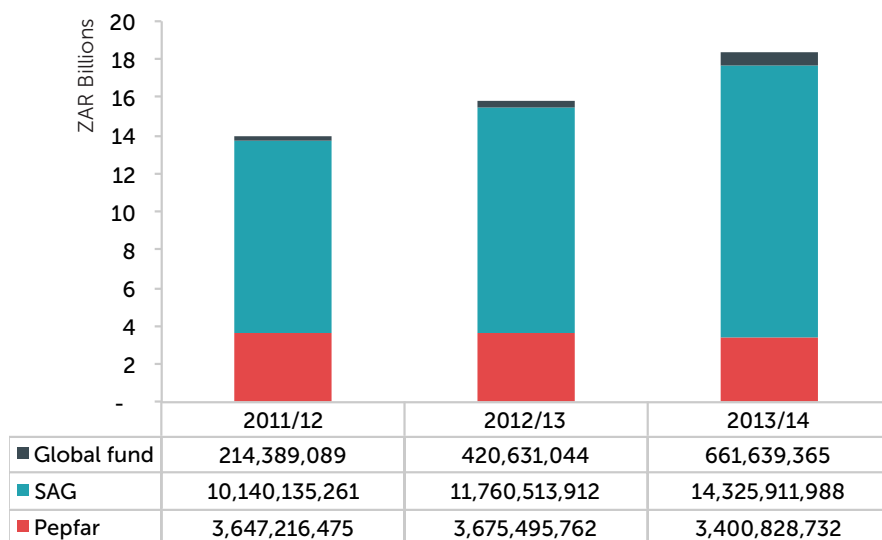
### 2.1 Total spending on HIV and TB by funding source and programme

The total spending by the SA government, PEPFAR, and the GF on HIV and TB came to R17.4 billion in 2011/12, R19.2 billion in 2012/13, and R22.1 billion in 2013/14. The SA government was the largest contributor over the three years, with its share of spending increasing from 76% of the total in 2011/12 to 80% in 2013/14; followed by the PEPFAR contributions which decreased from 22% in 2011/12 to 17% in 2013/14; and the GF contributions which increased from 1% in 2011/12 to 3% in 2013/14. Details of all HIV and TB spending are provided in Table 3, while Figure 2 shows only the HIV contributions.

**Table 2: Total Spending on HIV and TB in South Africa by Source (ZAR, %, 2011/12-2013/14)**

Spending (ZAR)	2011/12	2012/13	2013/14	% change (2011/12- 2012/13)	% change (2012/13- 2013/14)
SA Govt.	13 293 518 754 (76%)	14 882 754 276 (77%)	17 773 204 828 (80%)	12%	19%
PEPFAR	3 870 712 658 (22%)	3 900 724 859 (20%)	3 694 922 752 (17%)	1%	-5%
Global fund	214 389 089 (1%)	420 631 044 (2%)	661 639 365 (3%)	96%	57%
<b>Total (ZAR)</b>	<b>17 378 620 502</b>	<b>19 204 110 179</b>	<b>22 129 766 946</b>		
<b>Total (US\$)</b>	<b>2 341 059 420</b>	<b>2 261 328 974</b>	<b>2 189 938 541</b>		

**Figure 2: Total Spending on HIV (excluding TB) in South Africa by Source (ZAR, 2011/12-2013/14)**



\* SAG = South African government. NB. This graph excludes TB spending.



The SA government's public funding showed large increases over the three years: 12% from 2011 to 2012 and 19% from 2012 to 2013, largely driven by the increasing demand for antiretroviral treatment (ART). The GF spending also increased significantly over the three-year period, albeit from a small base due to initial delays<sup>7</sup> in the start-up of the Single Stream Funding grant (2011). PEPFAR spending decreased by 5% between 2012/13 and 2013/14, as per their USG-SA government bilateral Partnership Framework Implementation Plan (PFIP<sup>ix</sup>).

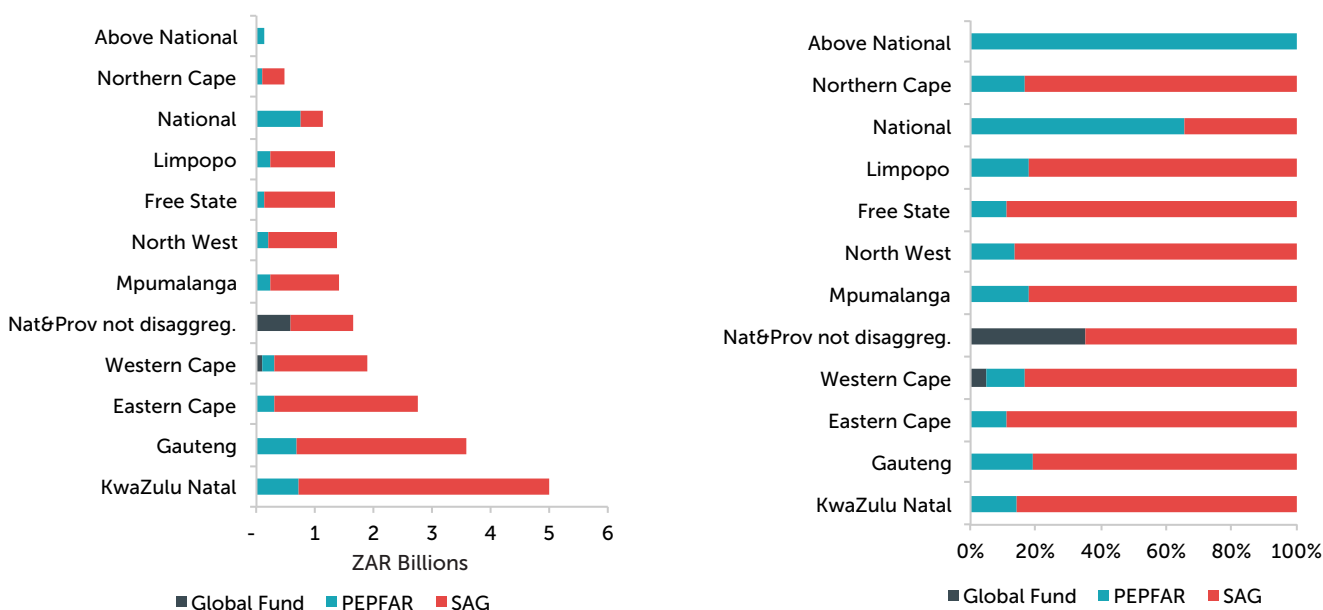
Table 4 (below) shows the breakdown of these totals by HIV, TB and HIV/TB integrated spending, the latter accounted for only a small portion of spending (1%) in 2013/14, while 81% of the total went to HIV and the remaining 18% to TB.

**Table 3: Total Spending by HIV, TB, and HIV/TB (ZAR, 2011/12-2013/14)**

Spending (ZAR)	2011/12	2012/13	2013/14	Grand Total	% Share (over 3 years)
HIV	13 774 978 081	15 686 235 058	17 999 562 790	47 460 775 929	81%
HIV/TB	226 762 744	170 405 661	388 817 295	785 985 700	1%
TB	3 376 879 676	3 347 469 461	3 741 386 861	10 465 735 998	18%
<b>Grand Total</b>	<b>17 378 620 502</b>	<b>19 204 110 179</b>	<b>22 129 766 946</b>	<b>58 712 497 627</b>	<b>100%</b>

Figure 3 shows the provincial split of HIV and TB spending. The bulk of the funding went to KwaZulu-Natal (23%), Gauteng (16%), and Eastern Cape (12%). The smallest amounts went to Limpopo, Free State, North West (all with 6%), and Northern Cape (2%). The GF spending could not be split by province and hence was captured in the 'national & provincial not disaggregated' category. The public spending that went via the Department of Social Development (DSD), the Department of Correctional Services (DCS), the South African Police Service (SAPS) and the Department of Basic Education's (DOE) Lifeskills programme could not be disaggregated by province and is therefore included in the 'national & provincial not disaggregated' category. PEPFAR had a small amount of spending that occurred outside the country, but was considered as benefitting South Africa (e.g. on non-South African-based consultants doing work on South Africa), and this was labelled as 'above national' in the figure below. The largest shares of total funding supported activities in KwaZulu-Natal (23%), Gauteng (16%) and Eastern Cape (12%). The smallest share went to Limpopo, Free State, North West (all with 6%) and Northern Cape with 2%.

**Figure 3: Spending on HIV and TB of Sources by Province (ZAR billions, %, 2013/14)**



<sup>7</sup> Delays in the GF implementation included the enrollment of some new PRs, and initial slow ART spending due to conformity to the WHO quality assurance requirements taking some time, but improved once the DOH had established the Central Procurement Unit (CPU).

## 2.2 HIV and TB spending activities by the SA Investment Case categories

The programmatic spending is presented below according to the agreed-upon SA IC programmatic areas. These were deemed to be the most cost-effective mix of programmes after reviewing all the evidence and modelling the package to achieve the 90-90-90 targets, namely:

- Care and treatment (including pre-ART, ART, nurse initiated and managed ART: NIMART, and some palliative care))
- Medical male circumcision (MMC)
- Comprehensive condom programming
- HIV Counseling and Testing (HCT)
- Prevention of Mother-to-Child Transmission (PMTCT)
- Other biomedical prevention (post-exposure prophylaxis: PEP, pre-exposure prophylaxis: PrEP, sexually transmitted illnesses: STI treatment, microbicides)
- Prevention for key populations
- Social behaviour change communication
- TB prevention, diagnosis, and treatment
- Programme and Social Enablers

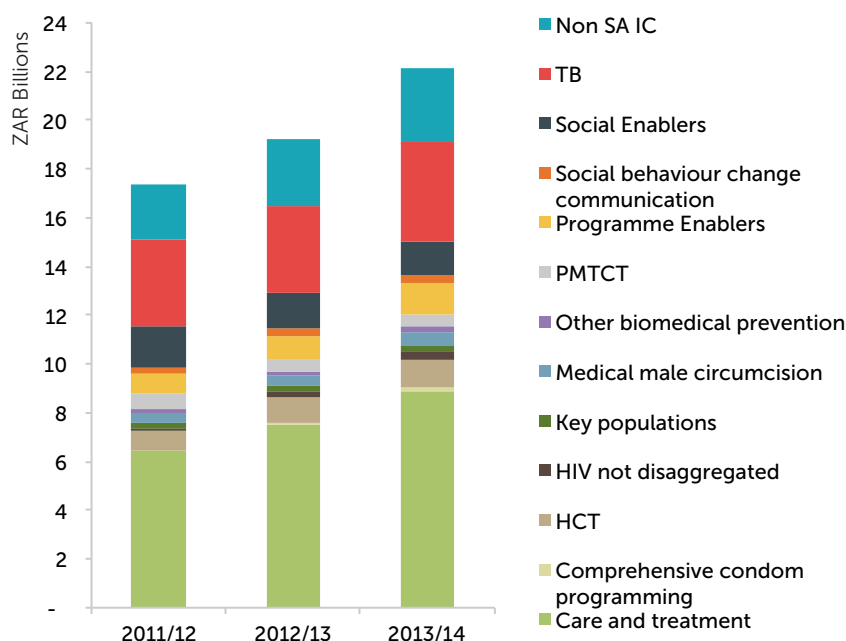
There was other spending—mostly public, such as for home-based care and step-down care—that could not be classified within these categories and was listed as ‘non-SA IC.’ The full SA Investment Case report includes definitions of the programmes included under each of these categories (refer to Appendix A), while the other appendices provide the crosswalk of the BAS programmes, the GF SDAs, and the PEPFAR EA programmes into these IC codes as well as a list of specific programmes included under Programme and Social Enablers. In addition, there was some spending that could not be disaggregated<sup>8</sup> into specific programmes and these were labeled as ‘n.d.’ (not disaggregated).

The largest proportion of spending across the three years (39%) went to care and treatment activities (including ART, pre-ART, adherence, and NIMART), increasing from R6.4 billion in 2011/12 (37% of the total) to R8.9 billion in 2013/14 (40%). TB activities (including diagnosis and treatment of PTB, ETB, MDR TB, and XDR TB) also increased from R3.6 billion in 2011/12 to R4.1 billion in 2013/14, but decreased proportionally from 21% to 18% of the total spending. The spending on HCT also increased from R835 million in 2011/12 to R1.1 billion in 2013/14 (while remaining 5% of the total in all three years), and spending on MMC increased from 2% to 3% from R408 million to R557 million. Meanwhile the PMTCT spending declined from R590 million (3%) to R483 million (2%), noting that the cost of the ARVs for infected mothers were included under the treatment and care spending. Another 13% over the three years went towards activities that were not included in the SA IC programme list. All of the remaining programmes (SBCC, key populations and other biomedical prevention activities, condom distribution) received only 1% or less of the total spending. Figure 4 below shows that over the three years, the proportional spending on social enablers decreased from 10% to 6%, while spending on programme enablers increased slightly from 5% to 6% in 2013 (refer to section below for details on these expenditures). Appendix I contains the detailed table of spending by IC category.

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<sup>8</sup> The ‘not disaggregated’ spending was mainly for public sources, where the BAS records did not give any detail, but only labeled the spending as ‘HIV/AIDS’.

Figure 4: Total HIV and TB Spending according to the South African Investment Case Categories (ZAR billions, 2011/12-2013/14)



Refer to the appendix for the detailed figures included here.

For joint planning purposes, it is important to know how much funding for each programme is coming from each funder. Although the SA government provides the majority of total funds for HIV and TB in South Africa, there are some programme areas for which PEPFAR was the key funder, such as PMTCT, SBCC, MMC and other biomedical prevention programmes.

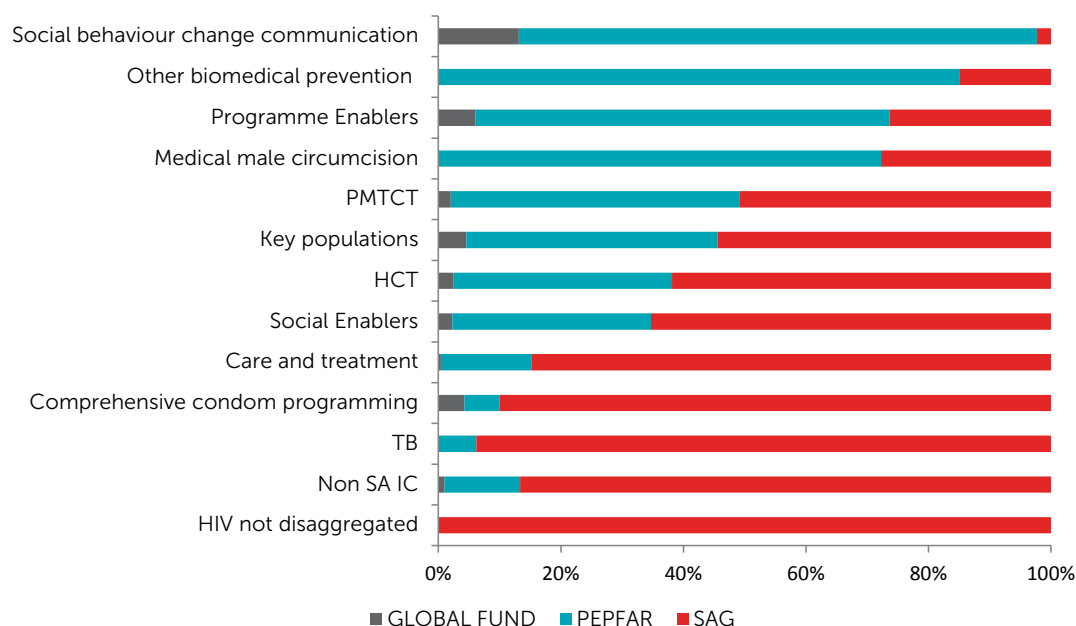
The following Table 5 and Figure 4 display total and proportional spending on SA IC programme areas by funding source in 2013/14.

Table 4: Spending on HIV and TB by Funding Source in 2013/14 (ZAR)

Spending on the IC Programme Areas (2013/14)	Global Fund	PEPFAR	SA Govt	GF %	PEPFAR%	SAG %
Care and treatment	381 701 2685	907 045 919	7 617 633 697	4%	10%	86%
Comprehensive condom programming	-	8 930 315	381 701 268	0%	5%	95%
HCT	81 553 812	343 111 261	716 380 961	7%	30%	63%
HIV not disaggregated			286 337 033	0%	0%	100%
Key populations	15 515 202	91 578 710	141 760 039	6%	37%	57%
Medical male circumcision	36 062 662	359 239 587	171 384 222	6%	63%	30%
Other biomedical prevention		188 144 473	56 249 390	0%	77%	23%
PMTCT	10 935 695	290 225 318	181 925 373	2%	60%	38%
Programme Enablers	40 611 362	390 542 143	884 131 363	3%	30%	67%
Social behaviour change communication	5 205 935	221 036 231	93 250 000	2%	69%	29%
Social Enablers	50 535 385	334 078 423	1 010 518 000	4%	24%	72%
TB		294 094 020	3 788 403 572	0%	7%	93%
Non SA IC	39 241 720	266 896 352	2 658 755 146	1%	9%	90%
<b>Grand Total in 2013/14</b>	<b>661 639 365</b>	<b>3 694 922 752</b>	<b>17 773 204 828</b>	<b>3%</b>	<b>17%</b>	<b>80%</b>

NB. Although some of the GF funding might have gone towards TB activities, these were not easily disaggregated from the Service Delivery Area and are therefore included in the HIV spending.

**Figure 5: Proportional Spending by Sources according to the SA IC Categories (% , 2013)**



For purposes of understanding the activities that are being funded under the social and programme enablers, which are aggregated categories and together formed 12% of the total HIV spending in 2013, Table 6 provides their breakdown into specific activities. The largest portion went towards Orphans and Vulnerable Children (OVC), followed by programme management, and Monitoring and Evaluation (M&E) activities.

**Table 5: Spending on Programme and Social Enablers (ZAR, 2011/12-2013/14)**

	2011/12	2012/13	2013/14	Grand Total
<b>Programme Enablers</b>	<b>818 448 373</b>	<b>997 903 407</b>	<b>1 315 284 868</b>	<b>3 131 636 648</b>
M&E	508 424 408	514 134 986	316 253 924	1 338 813 319
Building comm. Capacity/ Inst. strengthening (non-BAS)	24 765 941	18 555 429	19 674 787	62 996 157
Laboratories	34 856 104	35 126 367	76 071 967	146 054 438
Pharmacovigilance		938 575	8 230 642	9 169 217
Programme management	250 401 920	429 148 050	895 053 547	1 574 603 517
<b>Social Enablers</b>	<b>1 693 432 074</b>	<b>1 522 875 270</b>	<b>1 395 408 130</b>	<b>4 611 715 475</b>
Political commitment strengthening		1 660 917	8 737 434	10 398 351
Stigma reduction	6 547	17 647	-	24 195
GBV/Gender equality	2 089 702	1 879 224	3 482 388	7 451 313
OVC support	1 326 497 404	1 143 733 432	1 097 109 328	3 567 340 164
Policy and systems development	175 463 329	172 550 244	82 078 980	430 092 553
Youth in school	189 375 092	203 033 806	204 000 000	596 408 898
<b>Grand Total</b>	<b>2 511 880 448</b>	<b>2 520 778 677</b>	<b>2 710 692 998</b>	<b>7 743 352 123</b>

## 2.3 HIV and TB spending activities by the SA Government BAS categories

In order to match all the spending according to the categories used by the SA government's basic accounting system (BAS), which is most useful for the SA government's planning purposes, expenditures were also classified using the BAS categories. These are more detailed than the SA IC categories, and provide detail of the other 'non-SA IC' spending. The bulk of the spending from all three sources went to ART (40%), followed by community- and home-based care (CHBC) (11%), OVC (5%), TB in-patient treatment (5%) and diagnosis (4.6%), HCT (5%), programme management (4%), TB out-patient treatment (3.8%), and MMC (3%). The remaining activities received small proportions of the funding. Spending on activities by PEPFAR or GF that could not be matched to a BAS category are indicated as 'non-BAS.'

**Table 6: Total Spending according to the SA BAS Categories, by Source (ZAR, 2013/14)**

BAS category by Thematic Area	SAG	PEPFAR	Global Fund	Grand Total	% Share
<b>HIV Treatment &amp; Care</b>					
<i>(sub-total)</i>	<b>10 007 910 137</b>	<b>1 173 942 271</b>	<b>404 805 892</b>	<b>11 586 658 299</b>	<b>52.4%</b>
ART Treatment	7 600 429 142	907 045 919	380 583 120	8 888 058 180	40.0%
CHBC	2 248 355 868	133 448 176	23 104 624	2 404 908 668	10.9%
HIV Treatment not disagg	17 204 556		1 118 148	18 322 704	0.1%
Palliative / hospice care	21 456 953			21 456 953	0.1%
SDC	120 463 619	133 448 176		253 911 795	1.1%
<b>Prevention (sub-total)</b>	<b>1 877 050 695</b>	<b>1 502 265 895</b>	<b>144 905 403</b>	<b>3 470 442 503</b>	<b>15.9%</b>
Blood bank		11 119 205		11 119 205	0.1%
Condoms	166 476 032	8 930 315	-	175 406 347	0.8%
DCS Inmates HIV/TB programmes	24 731 618		3 659 290	28 390 907	0.1%
HCT (or VCT)	716 380 961	343 111 261	81 553 812	1 141 046 035	5.2%
HTA (CSW & clients)	103 442 948	23 656 657	3 607 056	130 706 660	0.6%
Key Pop IDU (non-BAS)		5 495		5 495	0.0%
Key Pop MSM (non-BAS)		49 767 965	1 214 618	50 982 583	0.2%
Key Pop Other (non-BAS)			2 666 334	2 666 334	0.0%
Key pop prevention other nec.	13 585 474	18 148 594		31 734 068	0.1%
Mass media/ soc.mob	93 250 000	221 036 231	5 205 935	319 492 166	1.4%
MMC	171 384 222	359 239 587	36 062 662	566 686 471	2.6%
Other Prevention (non-BAS)		143 958 336		143 958 336	0.7%
PEP/ OPEP/ NOPEP	55 649 570	33 066 932		88 716 503	0.4%
PMTCT	181 925 373	290 225 318	10 935 695	483 086 386	2.2%
Prevention not disagg	116 667 611			116 667 611	0.5%
STI	599 819			599 819	0.0%
Uniformed HIV services (DOD/SAPS)	27 253 819			27 253 819	0.1%
Workplace prevention	1 703 248			1 703 248	0.0%
Youth in school	204 000 000		-	204 000 000	0.9%
<b>Programme Enablers (sub-total)</b>	<b>1 006 985 392</b>	<b>469 530 286</b>	<b>59 839 296</b>	<b>1 536 354 974</b>	<b>6.9%</b>
M&E	102 127	314 470 175	1 681 622	316 253 924	1.4%
PE: Building comm. Capacity/ Inst. strengthening (non-BAS)			19 674 787	19 674 787	0.1%
PE: Lab (non-BAS)		76 071 967		76 071 967	0.3%
PE: Workforce (non-BAS)			16 137 096	16 137 096	0.1%
PE. Pharmacovigilance (non-BAS)			8 230 642	8 230 642	0.0%

<b>BAS category by Thematic Area</b>	<b>SAG</b>	<b>PEPFAR</b>	<b>Global Fund</b>	<b>Grand Total</b>	<b>% Share</b>
Programme Management	884 029 236	-	11 024 311	895 053 547	4.0%
Policy and systems development		78 988 143	3 090 838	82 078 980	0.4%
Training	122 854 030			122 854 030	0.6%
<b>Social Enablers (sub-total)</b>	<b>806 518 000</b>	<b>255 090 280</b>	<b>47 720 870</b>	<b>1 109 329 150</b>	<b>5.0%</b>
CE Political commitment (non-BAS)			8 737 434	8 737 434	0.0%
CE Stigma reduction (non-BAS)			-	-	0.0%
GBV/gender equality (non-BAS)			3 482 388	3 482 388	0.0%
OVC (DSD HIV support)	806 518 000	255 090 280	35 501 048	1 097 109 328	5.0%
<b>Development Synergies (sub-total)</b>			<b>4 367 905</b>	<b>4 367 905</b>	<b>0.0%</b>
Youth services (not disagg)			4 367 905	4 367 905	0.0%
HIV not disagg	286 337 033			286 337 033	1.3%
<b>TB prevention/diagnosis/ treatment (sub-total)</b>	<b>3 788 403 572</b>	<b>294 094 020</b>		<b>4 082 497 592</b>	<b>18.4%</b>
TB control/management/surveys	70 224 101			70 224 101	0.3%
TB treatment (clinics or outpatient)	832 439 237			832 439 237	3.8%
TB treatment (hospitals)	1 076 390 840			1 076 390 840	4.9%
TB treatment not disaggregated		294 094 020		294 094 020	1.3%
TB XDR/MDR treatment	447 238 662			447 238 662	2.0%
TB/HIV (Integration)	341 110 731			341 110 731	1.5%
TB Diagnostics	1 021 000 000			1 021 000 000	4.6%
<b>Grand Total in 2013/14</b>	<b>17 773 204 828</b>	<b>3 694 922 752</b>	<b>661 639 365</b>	<b>22 129 766 946</b>	<b>100%</b>

\* PE: Programme Enabler, CE: Critical Enabler.

The following section provides greater disaggregation of the South African government's public spending on HIV and TB.

## 2.4 South African government's spending on HIV and TB

Total public spending on HIV and TB in South Africa is presented in Table 8 below, including the conditional grants (CG) and all equitable share (voted) funds, but excluding any donor funding going through the Department of Health (DOH) or other departments. Although the BAS records provide some detail of the different levels of responsibility in terms of the directorates, programmes and facilities that spent the funds, these are not analyzed here. In addition, the departments sub-contract NGOs and other service providers for certain programmes and services. These costs are included in the totals of the relevant department, but are not separated out.

The CG for HIV that flows through the DOH is the greatest public funding mechanism (57.2%), amounting to R10.5 billion in 2013/14, followed by voted funds from the DOH's equitable share (33.8%), reaching R5.7 billion in 2013/14 (this includes the estimated TB in-patient costs). There were other funds used for HIV and TB, such as : the Expanded Public Works Programme (EPWP), the Health Infrastructure Grant, the Hospital Revitalisation Grant, the National Health Insurance (NHI) Grant, the National Tertiary Services Grant, and other national and provincial 'earmarked and specific' (E&S) funds. These have been lumped together in the table below and made up 2.4% of the total. It is not clear why these grants may have been used for HIV and TB, or if it was incorrect labelling of the source (Fund\_Level in BAS). This means that 93.4% of all public funding for HIV and TB was channelled through the DOH (not counting donor funds flowing through the DOH). Overall, the public funding for HIV and TB has been steadily increasing over the three year period.

**Table 7: Public Sources for HIV and TB – Department and Funding Mechanisms (ZAR, 2011/12-2013/14)**

Sources of Public Funding	2011/12	2012/13	2013/14	Grand Total	% Share ('11-13)
DOH HIV Conditional Grant	7 246 240 201	8 515 582 501	10 515 916 337	26 277 739 039	57.2%
DOH Voted (equitable share) (mostly for TB)	4 717 797 529	5 090 185 003	5 737 885 479	15 545 868 011	33.8%
Other DOH public funds	340 351 936	288 490 907	456 899 576	1 085 742 419	2.4%
DOE CG (Lifeskills)	189 000 000	203 000 000	204 000 000	596 000 000	1.3%
DSD Voted	744 565 666	734 917 000	806 518 000	2 286 000 666	5.0%
DOD Voted	34 269 915	16 521 279	23 109 487	73 900 681	0.2%
SAPS Voted	4 895 651	4 943 893	4 144 332	13 983 876	0.0%
DCS Voted	16 397 855	29 113 693	24 731 618	70 243 166	0.2%
<b>Grand Total</b>	<b>13 293 518 754</b>	<b>14 882 754 276</b>	<b>17 773 204 828</b>	<b>45 949 477 858</b>	<b>100%</b>

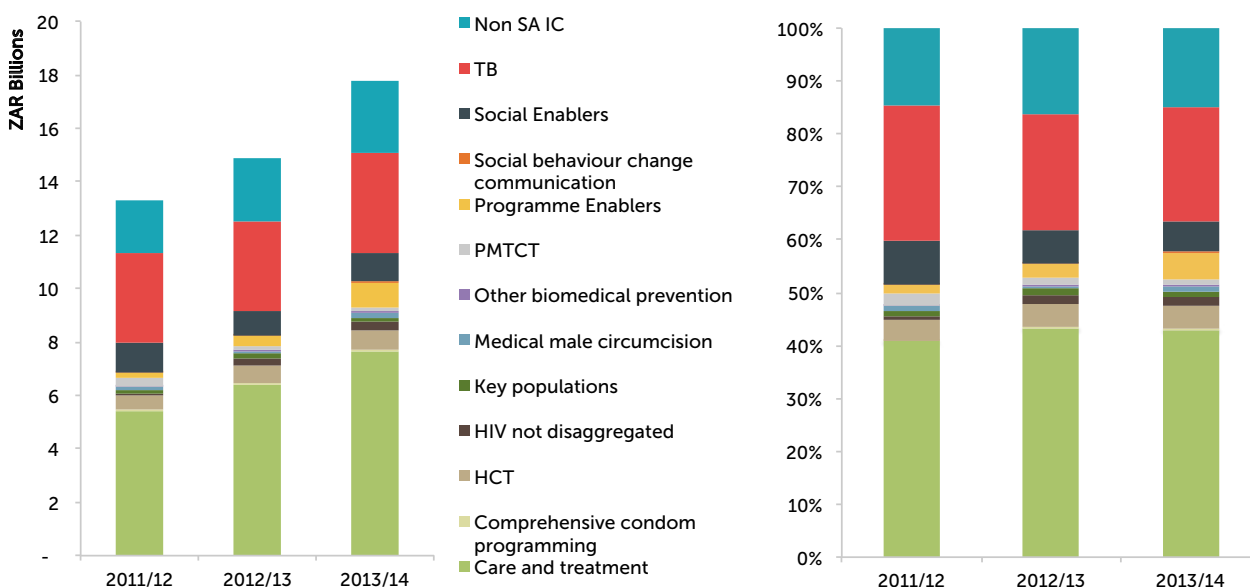
Source: BAS records: 2011/12 – 2013/14. National Treasury Records.

\* DOH; Department of Health, DOE: Department of Basic Education, DSD: Department of Social Development, DOD: Department of Defence, SAPS: South African Police Service, DCS: Department of Correctional Services.

The other departments' HIV activities made smaller but important contributions to the overall response. The Department of Social Development (DSD) spent 5% of the total public funds, primarily on CHBC, while the Department of Basic Education [T62] (DOE) Lifeskills conditional grant (1.3%) benefitted youth-in-school. The Department of Defence (DOD), South African Police Services (SAPS) and the Department of Correctional Services (DCS) also financed HIV services for the army, police and prison inmates, respectively.

Figure 6 matches all of the public spending to the SA Investment Case programme categories.

**Figure 6: Public Expenditure on HIV and TB according to the SA IC Categories (ZAR billions, %, 2011/12-2013/14)**



The spending on the care and treatment activities has increased in both nominal terms (by 40% over the three years) and proportionally, from 41% of the total in 2011/12 to 43% in 2013/14. The TB spending, including XDR/MDR TB and the estimated PTB costs, accounted for 22% of total spending over the three years, increasing in nominal amounts (by 12% over the period), but decreasing as a share of the total public spending (from 25% to 21%). The spending on the programme enablers more than doubled between 2012/13 and 2013/14. A significant portion (15%) was spent on activities not in the IC list of programmes—namely CHBC, step down care (SDC), and

palliative care<sup>9</sup>. The figures are broken down in more detail under the CG and voted analysis of the DOH spending below.

The DOH spending is examined in more detail below, due to the magnitude of these funds, and their influence on the strategic direction of the overall response.

#### 2.4.1 DOH spending on HIV and TB (conditional grants and voted funds)

As mentioned, 93.4% of all public revenue for HIV and TB flows through the DOH in South Africa. The largest portion of all the DOH HIV funds (61%) came through the conditional grant (CG) for HIV, which has been steadily increasing in recent years. However, the voted portion (from the equitable share) also made up a significant contribution (36%) and represents the provincial departments' commitment to the HIV and TB response. In addition to the CG and voted funds, a number of other grants and voted sources were identified from the BAS records, although their contributions were relatively small. These included the Expanded Public Works Programme (EPWP), the Health Infrastructure Grant, the Hospital Revitalisation Grant, the NHI Grant, the National Tertiary Services Grant, and other national and provincial 'earmarked and specific' (E&S) funds.

**Table 8: Sources of DOH Public Funds for HIV and TB (ZAR, 2011/12-2013/14)**

Source of DOH Public Funds	2011/12	2012/13	2013/14	Grand Total	% Share ('11-13)
CG Comprehensive HIV	7 246 240 201	8 515 582 501	10 515 916 337	26 277 739 039	61%
Voted funds (Equitable Share)	4 717 797 529	5 090 185 003	5 737 885 479	15 545 868 011	36%
Other grants/voted	340 351 936	288 490 907	456 899 576	1 085 742 419	3%
<b>Grand Total</b>	<b>12 304 389 667</b>	<b>13 894 258 411</b>	<b>16 710 701 392</b>	<b>42 909 349 470</b>	<b>100%</b>

Source: DOH (national and provincial) BAS records: 2011/12 – 2013/14.

<sup>9</sup> Some palliative (in-patient) care is included in the IC cost estimates for the final stage of care of people failing treatment.



Splitting these amounts by the activities labelled in the BAS records, Table 10 shows the CG, the voted funds and the total DOH spending, in 2013/14. For the previous years, refer to the Appendix.

**Table 9: Total DOH Public Spending on HIV and TB by Funding Channel and the BAS Categories (ZAR, 2013/14)**

DOH HIV & TB Interventions	DOH HIV CG	DOH Voted (Equitable Share)	Other DOH public funds	Grand Total	% Share (2013/14)
ART Treatment	7 237 529 245	362 537 000	362 896	7 600 429 142	43.5%
CHBC	521 322 513	1 692 853 564	34 179 791	2 248 355 868	13.5%
Condoms	112 696 543		53 779 490	166 476 032	1%
HCT (or VCT)	694 225 887	22 139 176	15 898	716 380 961	4.3%
HIV not disagg	19 440 030	43 533 907	223 363 096	286 337 033	1.7%
HIV Treatment not disagg	16 554 928	649 628		17 204 556	0.1%
HTA (CSW & clients)	101 866 748	-	1 576 200	103 442 948	0.6%
Key pop prevention other nec.		13 585 474		13 585 474	0.1%
M&E		102 127		102 127	0%
Mass media/soc.mob		-	93 250 000	93 250 000	0.6%
MMC	171 327 688	52 733	3 800	171 384 222	1.0%
Palliative/hospice care		21 456 953		21 456 953	0.1%
PEP/OPEP/NOPEP	55 221 781	427 789		55 649 570	0.3%
PM	722 130 908	137 133 328	24 765 000	884 029 236	5.3%
PMTCT	181 597 872	327 501		181 925 373	1.1%
Prevention not disagg	99 030 164	17 637 447		116 667 611	0.7%
SDC	120 288 313	175 306		120 463 619	0.7%
STI	229 419	370 400		599 819	0%
TB control/management/surveys	14 485 421	47 712 869	8 025 811	70 224 101	0.4%
TB treatment (clinics or outpatient)		832 439 237		832 439 237	5.0%
TB treatment (hospitals)	(15 711)	1 058 829 158	17 577 392	1 076 390 840	6.4%
TB XDR/MDR treatment		447 238 461	201	447 238 662	2.7%
TB/HIV (Integration)	340 892 100	218 632		341 110 731	2.0%
Training	107 092 488	15 761 541		122 854 030	0.7%
Workplace prevention		1 703 248		1 703 248	0%
TB Diagnostics		1 021 000 000		1 021 000 000	6.1%
<b>Grand Total</b>	<b>10 515 916 337</b>	<b>5 737 885 479</b>	<b>456 899 576</b>	<b>16 710 701 392</b>	<b>100%</b>

Source: DOH (national and provincial) BAS records: 2011/12 – 2013/14.

\* HTA: High transmission areas – programmes for commercial sex workers & truck drivers/ other clients.

\* nec: not elsewhere class

Overall, 76% of DOH spending for HIV and TB went towards HIV interventions, 24% went to TB services, and 2% went to HIV/TB integration activities. The DOH spending on ART reached R7.6 billion in 2013/14 (46% of the total DOH spending on HIV and TB, and 69% of the DOH CG). This was a dramatic increase from previous years, reflecting the massive scale up of the ART programme. Community and home based care services (CHBC) reached R2.2 billion in 2013/14 (13.5%), and included all the DOH community services (mostly from voted funds), as these could not be disaggregated into HIV and non-HIV related (hence will have overestimated the CHBC spending for HIV). CHBC represents an important service provided by the DOH and its rollout should assist in reducing the burden on facility-based care. Nevertheless, further exploration into the impact and value for money for the CBHC could be undertaken to ascertain if any potential efficiency gains could be made. Spending on condoms was only 1%, while the step down care (SDC) spending was less than 1%. A small amount of spending (1%) could not be disaggregated, and this was because the BAS label did not include an activity, but simply indicated 'HIV/AIDS.' These were labelled 'HIV treatment or prevention not disaggregated.'

Of the DOH spending on HIV and TB, around 3% of TB spending went to MDR/XDR; 6% for in-patient treatment (specifically for MDR-TB); and 5% went for PTB treatment through clinics, community health centres, and mobile clinics, and 6.1% for TB diagnostics. Section 2.8 provides further breakdown of the TB spending.

#### 2.4.2 DOH Conditional Grant spending on HIV and TB

Turning to the DOH HIV CG specifically, the following Table 11 shows the total CG increased from R7.2 billion to R10.2 billion between 2011/12 and 2013/14, with nearly 70% going to ART over the three-year period, increasing from R5 billion to R7.2 billion. Spending on condoms increased more than tripled over the three years from R44 million to R112 million, but forming less than 1% of the CG total, while programme management quadrupled over the period, forming 4.4%. Spending on HIV counselling and testing (HCT) formed 7% of the total CG over the three years, and increased from R516 million in 2011/12 to R694 million in 2013/14. Spending on CHBC increased slightly to R521 million in 2013/14, taking 5.4% of the total CG. Although small proportions (1.4%) of the CG went to MMC, there was a 50% increase in spending between 2011/12 and 2013/14, from R113 million to R171 million. Only 2.5% of the CG went towards PMTCT and 2.1% to TB treatment, and shares to the other HIV activities were relatively small.

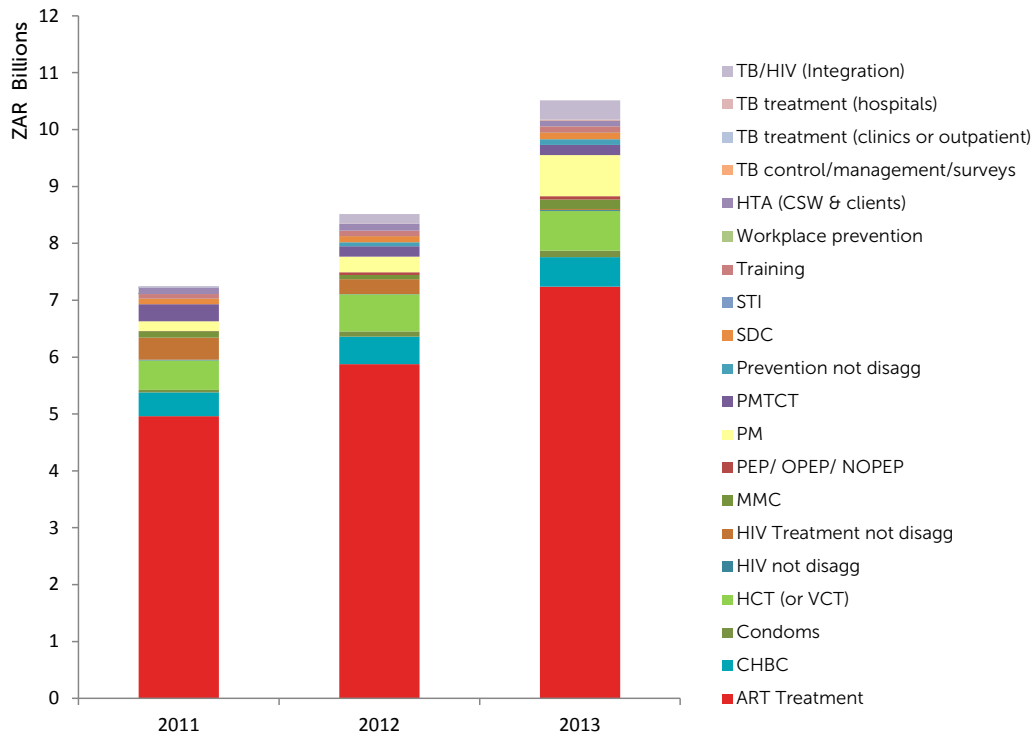
**Table 10: DOH Conditional Grant Spending on HIV and TB (ZAR, 2011/12-2013/14)**

Spending by Activity	2011/12	2012/13	2013/14	Grand Total	% Share ('11-13)
<b>HIV Sub-Total</b>	<b>7 222 684 966</b>	<b>8 343 035 208</b>	<b>10 160 554 527</b>	<b>25 726 274 700</b>	<b>97.9%</b>
ART Treatment	4 959 619 397	5 875 133 174	7 237 529 245	18 072 281 816	68.8%
CHBC	420 652 317	485 447 541	521 322 513	1 427 422 371	5.4%
Condoms	44 542 610	89 448 736	112 696 543	246 687 888	0.9%
HCT (or VCT)	514 530 638	653 677 152	694 225 887	1 862 433 677	7.1%
HIV not disagg	15 110 854	5 132 964	19 440 030	39 683 847	0.2%
HIV Treatment not disagg	386 066 083	261 544 412	16 554 928	664 165 423	2.5%
MMC	113 292 235	75 215 258	171 327 688	359 835 182	1.4%
PEP/OPEP/NOPEP	3 823 488	47 711 965	55 221 781	106 757 234	0.4%
Programme Management	173 590 671	272 623 481	722 130 908	1 168 345 060	4.4%
PMTCT	299 865 689	181 007 442	181 597 872	662 471 002	2.5%
Prevention not disagg	207 307	72 002 015	99 030 164	171 239 486	0.7%
SDC	96 822 071	106 769 764	120 288 313	323 880 148	1.2%
STI	81 829	535 169	229 419	846 417	0.0%
Training	81 698 724	97 983 578	107 092 488	286 774 791	1.1%
HTA (CSW & clients)	112 781 052	118 802 558	101 866 748	333 450 357	1.3%
<b>TB Sub-Total</b>	<b>23 474 590</b>	<b>172 544 381</b>	<b>355 377 521</b>	<b>551 396 493</b>	<b>2,1%</b>
TB control/management/ surveys	26 194	2 753 540	14 485 421	17 265 155	0.1%
TB/HIV (Integration)	23 448 396	169 790 842	340 892 100	534 131 338	2.0%
<b>Grand Total</b>	<b>7 246 159 556</b>	<b>8 515 579 589</b>	<b>10 515 932 047</b>	<b>26 277 671 193</b>	<b>100%</b>

Source: DOH (national and provincial) BAS records: 2011/12 – 2013/14.

The above data are displayed graphically in Figure 7 below, and show the bulk of the CG going towards ART.

Figure 7: DOH Conditional Grant Spending on HIV and TB (ZAR billions, 2011/12-2013/14)

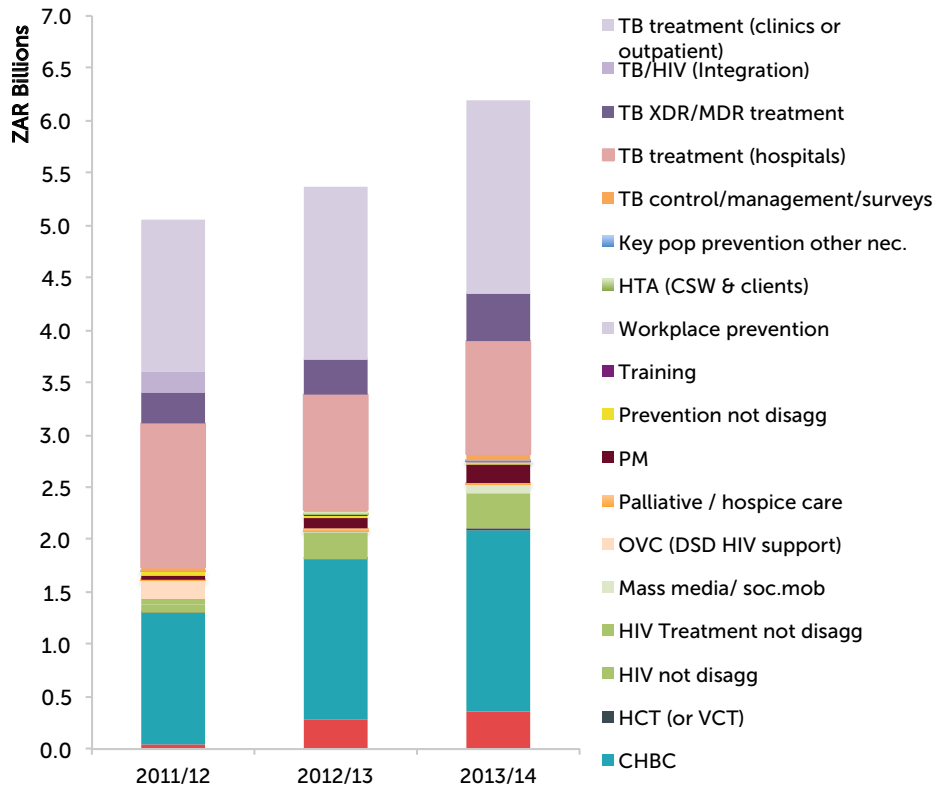


Source: DOH (national and provincial) BAS records: 2011/12 – 2013/14.

### 2.4.3 DOH Voted Funds spending on HIV and TB

Figure 8 shows the split of DOH voted funds for HIV and TB activities. The activity split is different from the CG, with larger proportions of funding going to TB and CHBC. Over the three year period, 60% of voted funds went to TB interventions. Of the TB spending, half went to out-patient treatment of PTB (including diagnostics), and the other half went to MDR/XDR-TB treatment and TB hospital costs. CHBC received 27% of voted funds (but this could not be disaggregated between HIV-related care and non-HIV, and therefore is possibly an overestimation of HIV CHBC spending, but could warrant further examination to ascertain which services are being provided for these funds and their impact on households), while only 4% went towards ART. However, voted spending for ART increased during this period, from R37 million in 2011/12 to R363 million in 2013/14. This may indicate that the CG allocations for ART have become insufficient and provinces are having to top-up with their equitable share (voted funds). The relevant figures may be found in Appendix N of this report.

Figure 8: DOH Voted Funds (ES) Spending on HIV and TB (ZAR billions, 2011/12-2013/14)

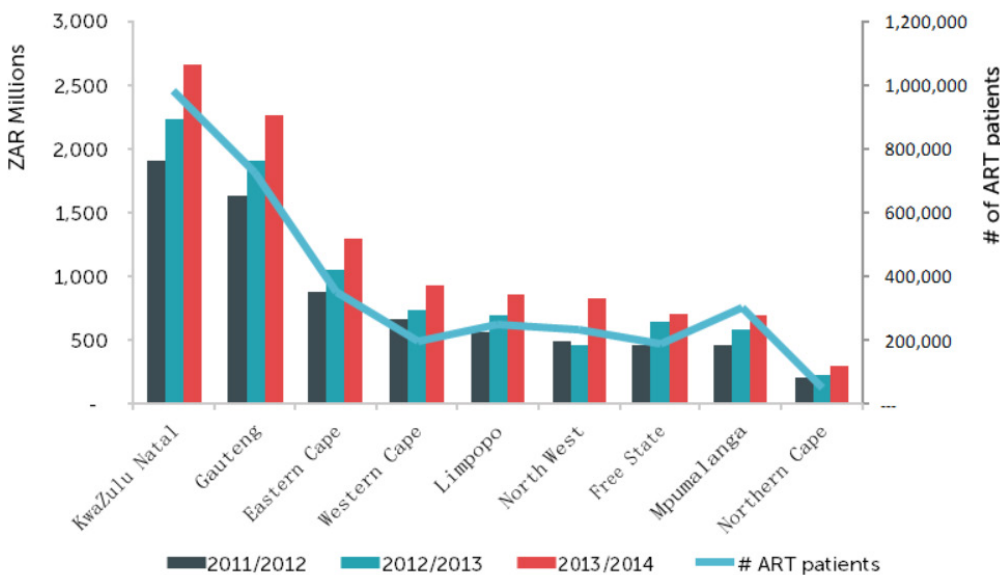


Source: DOH (national and provincial) BAS records: 2011/12 – 2013/14.

#### 2.4.4 DOH spending on HIV and TB by province

The DOH CG is split between provinces based on an assessment of their need and numbers of HIV-positive people, shown in the following Figure 9. These data are important to inform both equitable and geo-spatial high-impact allocation of funding, and to ensure that efforts are targeting the districts with the highest burden of disease.

Figure 9: DOH CG for HIV per Province (ZAR millions, 2011/12-2013/14)



Source: Provincial DOH BAS records: 2011/12 – 2013/14.

Figure 9 above shows that DOH CG spending has been steadily increasing in each province over the three years shown, with KZN and Gauteng having the largest shares (26% and 22% respectively), followed by Eastern Cape (12%). The remaining provinces received smaller shares of 9% or less, with Northern Cape receiving just 3% of DOH CG. More detailed figures are provided in Appendix M.

The spending by external development partners is now examined in more detail, beginning with PEPFAR and followed by the GF.

## 2.5 PEPFAR spending on HIV and TB

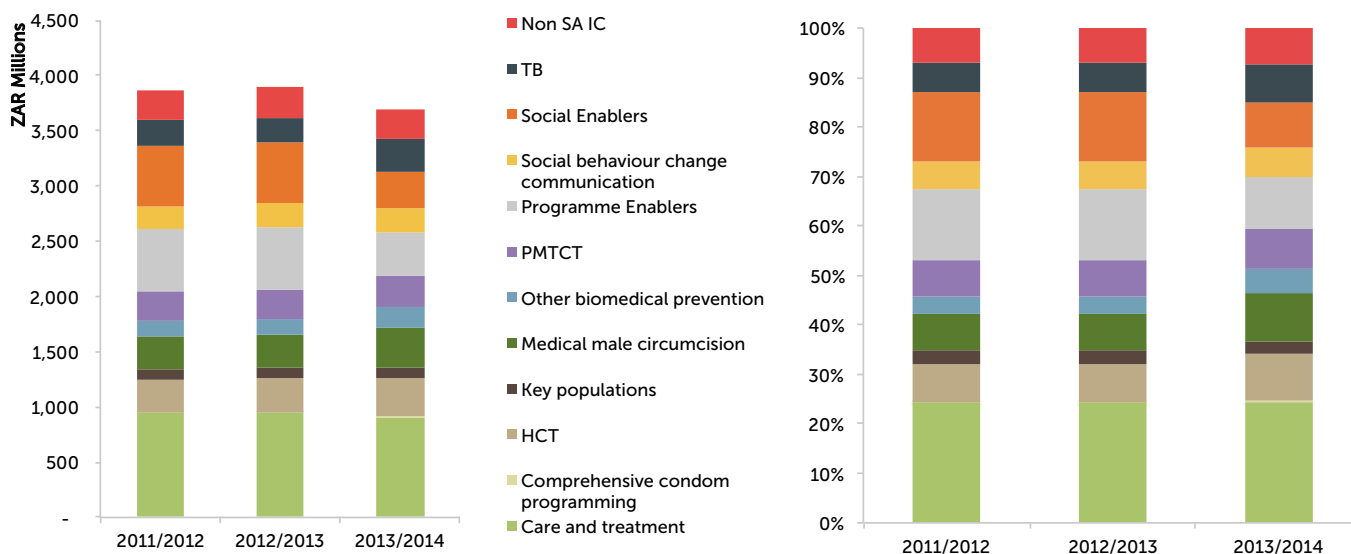
The following data was obtained from the PEPFAR Expenditure Analysis (EA) reports and was analysed in more depth by Results for Development (2013). These data were then crosswalked to the SA government BAS and IC codes for comparability. As explained previously, there were no EA data available for 2011/12, and hence the 2011/12 figures below were estimated based on the NASA 2010 data and the EA 2012 data, by interpolating between the years, and assuming a straight-line change between the three years.

The EA data are first presented first according to the SA IC programme areas and then according to the PEPFAR EA categories.

### 2.5.1 PEPFAR HIV and TB spending according to the SA Investment Case categories

As shown earlier, the PEPFAR contributions decreased by 5% between 2012/13 and 2013/14, as was anticipated with their transition planning and as outlined in their Partnership Framework Implementation Plan (PFIP). Figure 10 shows the annual breakdown of PEPFAR EA data crosswalked to the SA IC Categories. Similar to the SA government spending, the largest portion of PEPFAR spending went to care and treatment (25% in 2013/14). The remaining funds were fairly evenly distributed between the other IC categories, and remained more or less proportionally constant over the three years. PEPFAR also made important contributions to TB, HCT, MMC, PMTCT, SBCC, Programme and Social Enablers, and smaller contributions to key populations and other biomedical programmes (where they were the primary funder). Overall, there was a slight decrease in the care and treatment spending, with larger cuts for Programme and Social Enablers. The full data table can be found in Appendix P.

**Figure 10: PEPFAR Spending according to the SA IC Categories (ZAR millions, %, 2012/13-2013/14)**



Source: PEPFAR EA data. Refer to the Appendix for the data. The USAID additional contributions to TB (not reported in the EA data): USG FY11 - \$13,972,000, USG FY12 - \$12,000,000, USG FY13 - \$12,008,901.

### 2.5.2 PEPFAR HIV and TB spending according to the EA categories

Table 12 below provides the breakdown of spending according to the EA category and year. Despite the overall decrease, spending on certain programmes, such as HIV counselling and testing (HCT), strategic information, and MMC increased significantly. Spending on facility-based care, treatment, and support (which includes both HIV and TB treatment) experienced a slight increase. Programs with the largest cuts were OVC (down 32%) and health systems strengthening (down 19%). The spending on surveillance fluctuated because of funding large surveys that were not constant annual amounts. Programme management spending was not zero in 2013/14 but was included with the EA categories with which the spending is associated. The programme management spending in 2011/12

and 2012/13 was only that not associated with any other programme area.

**Table 11: PEPFAR Spending according to the EA Categories (ZAR, 2011-13)**

Spending by EA Category	2011/12	2012/13	2013/14	Grand Total	% (2011/12)	% (2012/13)	% (2013/14)
Blood Safety	3 255 914 (0.1%)	3 281 159	11 119 205	17 656 278	0.1%	0.1%	0.3%
Community Based Care, Treatment, & Support	277 343 752	296 759 448	272 259 932	846 363 133	7.2%	7.6%	7.4%
Facility Based Care, Treatment, & Support	1 170 989 382	1 156 125 686	1 191 435 258	3 518 550 326	30.3%	29.6%	32.2%
Health Systems Strengthening	168 393 762	90 317 878	73 458 911	332 170 551	4.4%	2.3%	2.0%
HIV Counseling & Testing	297 471 427	299 777 920	349 370 512	946 619 858	7.7%	7.7%	9.5%
Infection Control		57 692 316	97 101 412	154 793 728	0.0%	1.5%	2.6%
Laboratory Strengthening		35 126 367	76 071 967	111 198 334	0.0%	0.9%	2.1%
Orphans and Vulnerable Children	380 472 180	383 422 233	260 453 860	1 024 348 273	9.8%	9.8%	7.0%
PEP	12 871 456	13 010 821	33 196 017	59 078 293	0.3%	0.3%	0.9%
Prevention of Mother to Child Transmission	277 903 277	283 078 376	290 225 318	851 206 972	7.2%	7.3%	7.9%
Program Management	17 892 838	18 031 573	-	35 924 410	0.5%	0.5%	0.0%
SORP - General Populations	210 159 316	273 909 423*	267 979 335	752 048 075	5.4%	7.0%	7.3%
SORP – Not disaggregated*	217 356 526	98 714 609		316 071 135	5.6%	2.5%	0.0%
SORP - Key Pops (CSWs)			41 947 258	41 947 258	0.0%	0.0%	1.1%
SORP -Key Pops (IDUs)			5 495	5 495	0.0%	0.0%	0.0%
SORP -Key Pops (MSM)			50 942 914	50 942 914	0.0%	0.0%	1.4%
Strategic Information	506 637 855	272 421 495	297 882 479	1 076 941 829	13.1%	7.0%	8.1%
Surveillance	34 856 104	317 526 211	22 116 929	374 499 244	0.9%	8.1%	0.6%
Voluntary Medical Male Circumcision	295 108 869	301 529 342	359 355 951	955 994 163	7.6%	7.7%	9.7%
<b>Grand Total</b>	<b>3 870 712 658</b>	<b>3 900 724 859</b>	<b>3 694 922 752</b>	<b>11 466 360 269</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: PEPFAR EA data (2012 & 2013). The data for 2011 was estimated based on NASA 2010 and EA 2012. Refer to the Appendix for the US\$ equivalent of the above data.

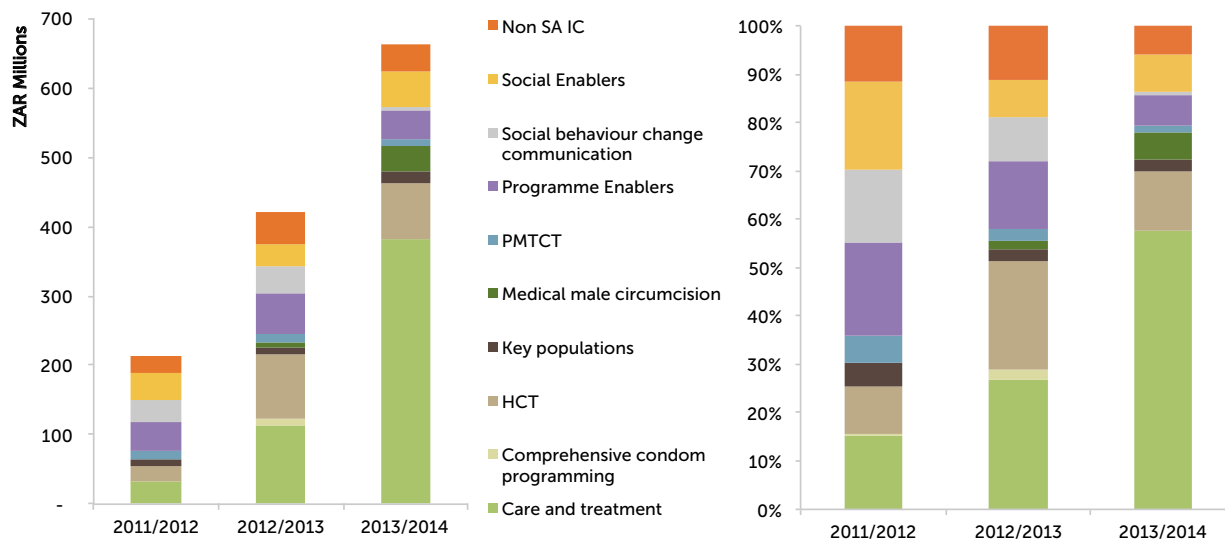
\* SORP: Sexual and Other Risk Prevention. The EA SORP key population data for 2011/12 and 2012/13 could not be split between specific population groups, as in 2013/14, so shown in the not disaggregated row.

## 2.6 Global Fund spending on HIV

### 2.6.1 Global Fund spending by the SA Investment Case categories

Applying the SA IC categories to the GF data from Principal Recipients (PRs) in their Expanded Financial Reports (EFRs), the following Figure 11 and Table 12 show that the GF's expenditure more than tripled from just over R200 million in 2011/12 to R650 million in 2013/14, mainly as a result of the increase in care and treatment spending. It should be noted that the EFRs report on the spending according to the GF's Service Delivery Areas (SDAs) and these tend to be broad, such as 'care for the chronically ill' and therefore lack the detail and disaggregation of the activities included therein. It was beyond the scope of this study to request more expenditure details from the PRs, and therefore some nuances may have been lost when matching the SDA to the closest IC category. For example, spending on TB programmes was not clearly labelled in the SDAs and may have therefore been absorbed under the 'care and treatment' category below, or under the 'HIV and TB case finding' SDA

**Figure 11: Global Funding Spending according to the SA Investment Case Categories (ZAR millions, %, 2011/12-2013/14)**



Source: GF PRs' EFRs.

Moving to a new Single Stream Funding (SSF) grant caused some of the low spending levels in 2011/12, since it required new processes as well as bringing on a new PR. Spending increased primarily due to the Care and Treatment spending on ART, which occurred only after the WHO Quality Control requirements were met in 2013 and the DOH had established the Central Procurement Unit (CPU) to manage the procurement and disbursement of ARVs paid for by the GF. The care and treatment spending rose from R32 million in 2011/12 to R382 million in 2013, increasing from 15% to 58% of the total grant spending. There was also a major increase in spending on condoms between 2011/12 and 2012/13, but no spending on these in 2013/14. This may have been due to a large supply purchased in 2012/13 that was still being distributed in 2013/14. Spending on MMC and social enablers increased in 2013/14, while spending on SBCC and programme enablers decreased. Spending on key populations increased over 50% in 2013/14, but decreased as a share of total spending.

**Table 12: Global Funding Spending according to the SA Investment Case Categories (ZAR, 2011/12-2013/14)**

Spending according to the IC Categories	2011/12	2012/13	2013/14	Grand Total	% (2011/12)	% (2012/13)	% (2013/14)
Care and treatment	32 622 727	113 195 644	381 701 268	527 519 638	15%	27%	58%
Comprehensive condom programming	805 862	8 993 154	-	9 799 016	0.4%	2%	0%
HCT	20 876 932	93 989 087	81 553 812	196 419 831	10%	22%	12%
Key populations	10 823 250	10 552 079	15 515 202	36 890 531	5%	3%	2%
Medical male circumcision	-	6 829 619	36 062 662	42 892 281	0%	2%	5%
PMTCT	11 972 931	11 070 091	10 935 695	33 978 717	6%	3%	2%
Programme Enablers	41 381 899	58 747 721	40 611 362	140 740 982	19%	14%	6%
Social behaviour change communication	32 412 213	38 124 107	5 205 935	75 742 255	15%	9%	1%
Social Enablers	39 077 408	31 836 606	50 811 708	121 725 722	18%	8%	8%
Non SA IC	24 415 868	47 292 938	39 241 720	110 950 526	11%	11%	6%
<b>Grand Total</b>	<b>214 389 089</b>	<b>420 631 044</b>	<b>661 639 365</b>	<b>1 296 659 499</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: GF PRs' EFRs. Refer to the Appendix for the US\$ equivalent data.

### 2.6.2 Global Fund spending by GF Service Delivery Areas

As explained above, the GF PRs report according to their contractual SDAs. The following Table 14 provides the GF split by their SDAs, showing greater disaggregation than the previous IC categorisation. The largest share of spending went to ART, reaching 58% in 2013/14. In some cases, the names of the SDAs changed between the years or different grants. For example, much of the 'testing and counselling' activities were labelled under 'HIV and TB case finding' in 2013/14, which explains the decrease in the 'testing and counselling' category in 2013/14. In the table above showing the IC categories, both these SDAs were captured as HCT. The spending on people living with disabilities, which was relatively small in 2011/12 and 2012/13, decreased further in 2013/14 which may have been due to it no longer included in the new grant.

**Table 13: Global Funding Spending according to the GF SDA Categories (ZAR, 2011/12-2013/14)**

Spending by GF SDA Categories	2011/12	2012/13	2013/14	Grand Total	% ('11)	% ('12)	% ('13)
Antiretroviral treatment (ARV) and monitoring	32 622 727	113 195 644	380 583 120	526 401 490	15.2%	26.9%	57.5%
Care and support for the chronically ill	22 973 312	14 779 232	17 827 482	55 580 026	10.7%	3.5%	2.7%
Combination Prevention-Prisoners			3 659 290	3 659 290	0.0%	0.0%	0.6%
Combination prevention-Low Socio Economic population			1 876 509	1 876 509	0.0%	0.0%	0.3%
Combination Prevention-MSM and LGBTI			298 828	298 828	0.0%	0.0%	0.0%
Commercial Sex Workers	2 106 241	1 882 646	3 607 056	7 595 944	1.0%	0.4%	0.5%
Community-based response to the HIV and TB epidemics	567 723	101 555	4 385 142	5 054 420	0.3%	0.0%	0.7%
CSS: Human resources: skills building for service delivery, advocacy and leadership		1 660 917	6 643 708	8 304 626		0.0%	0.4%



Spending by GF SDA Categories	2011/12	2012/13	2013/14	Grand Total	% ('11)	% ('12)	% ('13)
CSS: Management, accountability and leadership		289 855	1 303 215	1 593 070	0.0%	0.1%	0.2%
Enabling Environment			2 093 726	2 093 726	0.0%	0.0%	0.3%
HIV & TB case finding		12 128 814	77 155 906	89 284 720	0.0%	2.9%	11.7%
HIV Care & Support			1 118 148	1 118 148	0.0%	0.0%	0.2%
HIV Drug resistance monitoring and prevention		938 575	8 230 642	9 169 217	0.0%	0.2%	1.2%
HSS: Community Systems Strengthening	2 774 310	2 604 279	3 330 295	8 708 885	1.3%	0.6%	0.5%
HSS: Health Workforce		32 385 009	16 137 096	48 522 105	0.0%	7.7%	2.4%
HSS: Monitoring and Evaluation	1 786 553	3 659 629	1 681 622	7 127 805	0.8%	0.9%	0.3%
HSS: Other	438 107	-	276 322	714 429	0.2%	0.0%	0.0%
Institutional support and programme management for SRs and PR	2 545 172	2 275 539	3 373 570	8 194 281	1.2%	0.5%	0.5%
Medical male circumcision		6 829 619	36 062 662	42 892 281	0.0%	1.6%	5.5%
Men Who Have Sex with Men	1 172 882	637 847	915 790	2 726 520	0.5%	0.2%	0.1%
Out of School Youth	553 504	1 899 189	1 506 403	3 959 095	0.3%	0.5%	0.2%
Palliative and step-down care in-patient services	874 833	27 142	892 000	1 793 975	0.4%	0.0%	0.1%
Peer education programme amongst youth in secondary schools	375 092	33 806	-	408 898	0.2%	0.0%	0.0%
People with Disabilities (PWD)	2 843 326	2 513 360	789 825	6 146 510	1.3%	0.6%	0.1%
PMTCT	11 972 931	11 070 091	10 935 695	33 978 717	5.6%	2.6%	1.7%
Prevention: Behavioral Change Communication - community outreach	31 655 880	23 848 948	8 067 437	63 572 265	14.8%	5.7%	1.2%
Prevention: Behavioral Change Communication - Mass media	4 903 631	17 894 195	-	22 797 825	2.3%	4.3%	0.0%
Prevention: Condom distribution	805 862	8 993 154	-	9 799 016	0.4%	2.1%	0.0%
Program management and administration	14 829 404	35 594 088	11 024 311	61 447 803	6.9%	8.5%	1.7%
Support for orphans and vulnerable children	29 536 500	25 394 199	35 501 048	90 431 747	13.8%	6.0%	5.4%
Supportive environment: Policy development including workplace policy	6 631 459	2 850 813	2 814 515	12 296 788	3.1%	0.7%	0.4%

Spending by GF SDA Categories	2011/12	2012/13	2013/14	Grand Total	% ('11)	% ('12)	% ('13)
Supportive environment: Stigma reduction in all settings	6 547	17 647	-	24 195	0.0%	0.0%	0.0%
Supportive environment: Strengthening of civil society and institutional capacity building	19 446 459	13 385 756	11 667 707	44 499 922	9.1%	3.2%	1.8%
Testing and Counseling	20 876 932	81 860 273	4 397 906	107 135 111	9.7%	19.5%	0.7%
Women at Risk, Including those affected by GBV and risk through occupation	2 089 702	1 879 224	3 482 388	7 451 313	1.0%	0.4%	0.5%
<b>Grand Total</b>	<b>214 389 089</b>	<b>420 631 044</b>	<b>661 639 365</b>	<b>1 296 659 499</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Source: GF PRs' EFRs. Refer to the Appendix for the US\$ equivalent data.

### 2.6.3 GF spending by their Principal Recipients

The following Table 14 shows the GF spending by their PRs. These are then compared with the annual budgets of the PRs, to give some indication of their absorption rates. The NDOH spent the largest share of the GF money in the years shown (54%), followed by the NGOs: National AIDS Coalition of South Africa (NACOSA) with 15%, and the National Religious Association for Social Development (NRASD) with 12.7%. The Western Cape DOH spent 9.6% and Right to Care (RTC) 9.1%, the latter only commencing their activities in 2012/13.

**Table 14: Global Fund HIV, AIDS and TB spending by Service Provider (Principal Recipients) (ZAR, %, 2011/12-2013/14)**

GF Principal Recipients	2011/12	2012/13	2013/14	Grand Total	% Share ('11-13)
NACOSA	65 495 552	61 960 423	66 664 648	194 120 623	15.0%
NDOH	43 230 170	288 182 793	363 775 092	695 188 055	53.6%
NRASD	71 604 497	45 518 760	46 983 701	164 106 958	12.7%
Right to Care		22 813 983	95 517 884	118 331 867	9.1%
WC DOH	34 058 871	2 155 085	88 698 041	124 911 996	9.6%
<b>Grand Total</b>	<b>214 389 089</b>	<b>420 631 044</b>	<b>661 639 365</b>	<b>1 296 659 499</b>	<b>100%</b>

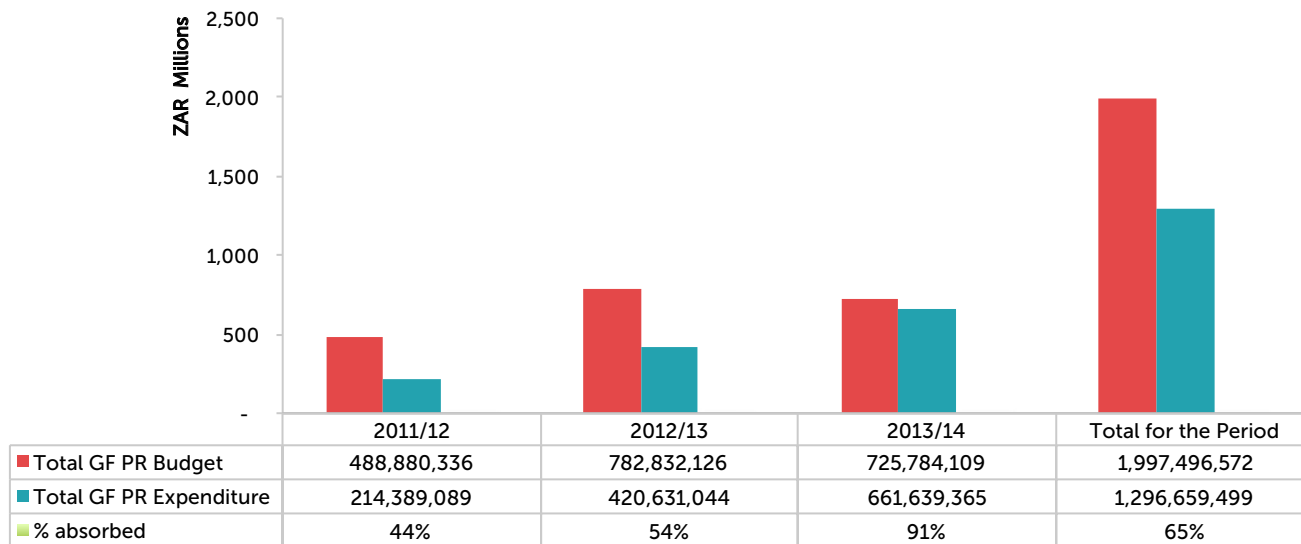
Source: GF PRs EFRs. NB. The full WCDOH spending for 2012/13 was not available.

NACOSA: National AIDS Coalition South Africa. NRASD: National Religious Association for Social Development. RTC: Right to Care.

The following figures show the expenditure against the annual budgets for each PR. It should be noted that there may have been adjustments (realignments or reallocations) to the budgets that are not shown here. The following data were taken from the PRs' annual workplans and summary budgets, mostly for the previous grant (SSF 1 and some Round 10) in 2011, 2012, and six months of 2013. The last six months of 2013/14 were the beginning of the new SSF 2 grant.

Figure 12 shows the total GF annual budget and expenditure, highlighting the initial slow uptake of the GF grant, which was later addressed through the increasing spending by the NDOH on care and treatment. The absorption rate increased from 44% in 2011/12 to 54% in 2012/13 and 91% in 2013/14, with an overall absorption rate of 65% over the three-year period.

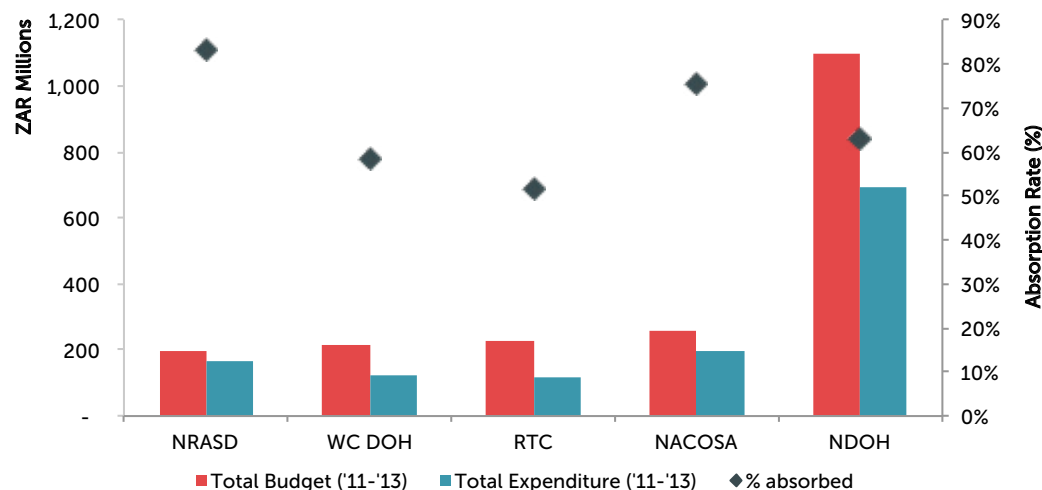
Figure 12: Total GF Annual Budget and Expenditure in SA (ZAR millions, 2011/12-2013/14)



Source: GF PRs EFRs and Annual Summary Budgets.

Figure 13 shows the performance of each PR, with their total expenditure over the three-year period compared to their budgets for the period. NRASD achieved 83% absorption of their budget for the three year period, followed by NACOSA at 76% the NDOH at 63%, the WC DOH at 58%, and RTC at 52%. Because the NDOH had the largest share (55%) of the total GF approved grant, their underspending primarily affects the overall burn rate of the grant.

Figure 13: GF PRs Total Budgets and Expenditure for the period 2011/12-2013/14 (ZAR millions)



Source: GF PRs EFRs and Annual Summary Budgets. Note that the WC DOH expenditure shown above is lower than actual since one of their EFRs was not available at the time of analysis.

## 2.7 Spending on TB in South Africa

South Africa has a high burden of TB, with the World Health Organisation (WHO) statistics giving an estimated incidence of 500,000 cases of active TB in 2011/12 (about 1% of the population). This is the third highest incidence worldwide after India and China, and the incidence has increased by 400% over the past 15 years (TB Facts, 2015\*).

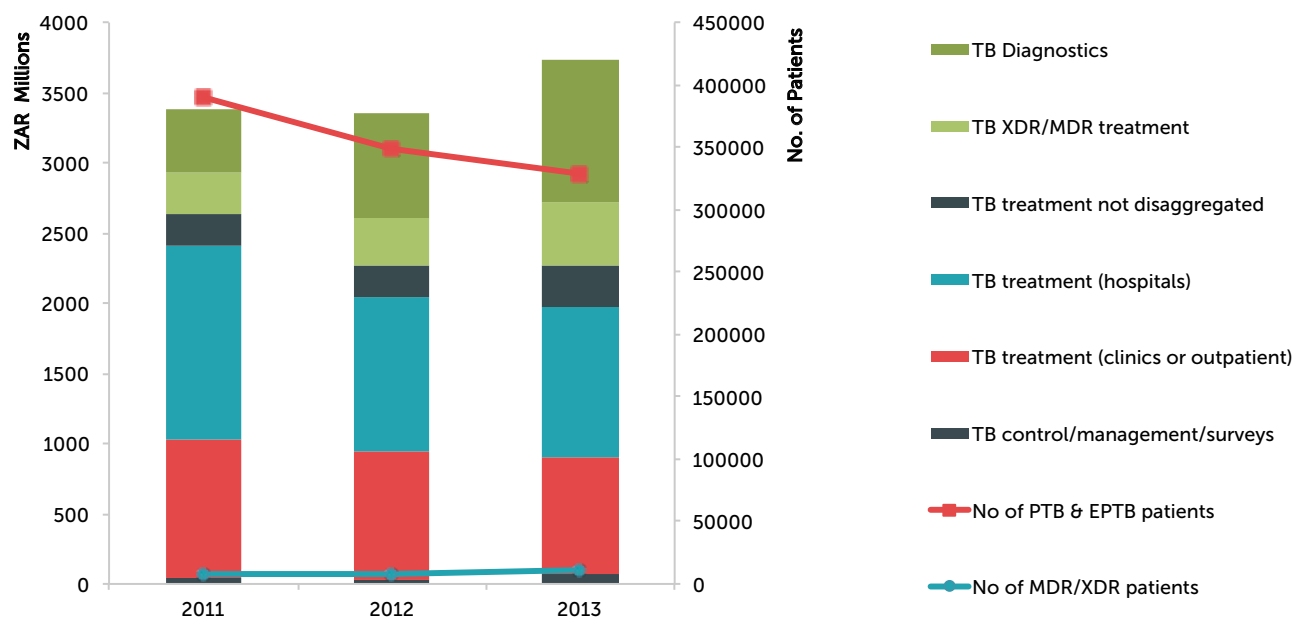
Unfortunately, there have been no efforts prior to the IC to track the spending on TB in SA, and therefore this section looks at the findings regarding TB spending in more detail. As explained in the methods section, the BAS records only indicate the spending that

was labelled as MDR/XDR-TB or as TB hospitals. The NDOH therefore requested that the other spending on PTB and ETB be estimated based on patient numbers and unit costs. The detailed estimation methods are presented in Appendix C. The total actual spending on MDR/XDR-TB and the TB hospitals, with the estimated spending on PTB & ETB are presented below in Figure 15 and Table 16. The unit costs applied were as follows:

TB Treatment Costs per Patient		
PTB & EPTB	Retreatment TB	MDR & XDR TB
R2 361	R4 059	R127 847

Sources: Drug sensitive costs: Sinanovic E, Foster N, Cunnama L, Vassall A. 2015. *Personal communication*. Drug resistant costs: Schnippel K. 2015. *Personal communication*. Lab costs: TB Diagnostic Market Analysis Consortium,

**Figure 14: TB Spending in SA (all sources) by programme (ZAR millions, %, 2011/12-2013/14)**



Sources: BAS records for TB hospital and XDR/MDR-TB spending. Estimates for PTB, ETB and diagnostic spending. Drug sensitive costs: Sinanovic E, Foster N, Cunnama L, Vassall A. 2015. *Personal communication*. Drug resistant costs: Schnippel K. 2015. *Personal communication*. Lab costs: TB Diagnostic Market Analysis Consortium, 2015.

Excludes USAID additional contributions to TB (not reported in the EA data): USG FY11: \$13,972,000, USG FY12: \$12,000,000, USG FY13: \$12,008,901.

The total spending on TB (excluding the HIV/TB integration spending presented earlier) decreased slightly from R3.38 billion in 2011/12 to R3.35 billion in 2012/13, but increased again to R3.74 billion in 2013/14. The largest share over the three years (34%) went to TB hospitals, which was mainly for MDR/XDR-TB treatment, but this decreased slightly over the period from R1.4 billion in 2011 to R1.1 billion in 2013, probably because of large capital investments in 2011 for the building of the MDR hospitals. Another 10% was specifically spent on XDR/MDR-TB, and this spending increased from R292 million in 2011/12 to R447 million in 2013. The estimated spending on PTB and ETB (in clinics and outpatient units) accounted for 21% of the three year total, while TB diagnostics took another 21% and steadily rose over the period shown (in fact, driving the overall increase in TB spending). TB 'treatment activities' accounted for 7% of the total, and could not be further disaggregated since these were mainly from PEPFAR's facility based treatment and care spending. It is unclear on what they were specifically spent. Note that the diagnostic spending (forming 20% of the total TB spending) were estimates provided by the Diagnostic Market Consortium. Due to the lack of detailed expenditure data on TB tests, it is difficult to ascertain if these were reasonable amounts to be spending on diagnosis, and would require further exploration.

**Table 15: TB Spending in SA (all sources) by programme (ZAR millions, 2011/12-2013/14)**

<b>TB Spending by Intervention (ZAR)</b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>	<b>Grand Total</b>	<b>% share ('11-13)</b>
TB control/ management/ surveys	35 915 782	31 430 556	70 224 101	137 570 439	1.3%
TB treatment (clinics/ outpatient)	998 834 860	914 707 589	832 439 237	2 745 981 687	26.2%
TB treatment (hospitals)	1 379 395 601	1 095 419 239	1 076 390 840	3 551 205 679	33.9%
TB treatment not disaggregated	223 496 183	225 229 097	294 094 020	742 819 300	7.1%
TB XDR/MDR treatment	292 237 250	346 682 980	447 238 662	1 086 158 893	10.4%
TB Diagnostics	447 000 000	734 000 000	1 021 000 000	2 202 000 000	21.0%
<b>Grand Total</b>	<b>3 376 879 676</b>	<b>3 347 469 461</b>	<b>3 741 386 861</b>	<b>10 465 735 998</b>	<b>100%</b>
<b>No of PTB &amp; EPTB patients</b>	<b>389 974</b>	<b>349 582</b>	<b>328 896</b>		
<b>No of MDR/XDR patients</b>	<b>7 868</b>	<b>8 591</b>	<b>11 759</b>		

Sources: BAS records for TB hospital and XDR/MDR-TB spending. Estimates for PTB, ETB and diagnostic spending. Drug sensitive costs: Sinanovic E, Foster N, Cunnamo L, Vassall A. 2015. *Personal communication*. Drug resistant costs: Schnippel K. 2015. *Personal communication*. Lab costs: TB Diagnostic Market Analysis Consortium, 2015.

Excludes USAID additional contributions to TB (not reported in the EA data): USG FY11: \$13,972,000, USG FY12: \$12,000,000, USG FY13: \$12,008,901.

The estimated spending on PTB and ETB using the patient numbers supplied by the NDOH are shown in Table 16 below. Note that the estimated diagnostic costs were split between the provinces based on their total number of PTB and XDR/MDR-TB patients, therefore these are not attributable only to PTB. Improved tracking of the provincial expenditure on TB diagnostics would assist in highlighting which provinces may not be adequately prioritizing the identification of TB patients and their close contacts. In addition, the unique patient identification system would reduce the numbers of patients being lost to follow-up in the health care system, and may reduce cases of multiple tests on the same patient, due to their mobility.

**Table 16: Estimated spending on PTB and ETB by province (# of patients, ZAR, 2011/12-2013/14)**

<b>Province</b>	<b>2011/12</b>				
	<b># PTB+ETB patients</b>	<b>PTB+ETB Costs</b>	<b># Retreatment patients</b>	<b>Retreatment Costs</b>	<b>Diagnostic Costs</b>
Eastern Cape	52 976	R125 086 502	7 070	R28 696 047	R69 056 344
Free State	20 091	R47 438 128	2 681	R10 882 763	R25 844 164
Gauteng	48 930	R115 533 048	6 530	R26 504 392	R64 381 204
KwaZulu Natal	104 911	R247 712 771	14 000	R56 827 692	R135 861 070
Limpopo	19 549	R46 159 057	2 609	R10 589 332	R25 045 312
Mpumalanga	21 572	R50 935 784	2 879	R11 685 159	R27 829 498
North West	24 803	R58 564 381	3 310	R13 435 232	R31 804 659
Northern Cape	8 861	R20 923 439	1 183	R4 800 038	R11 935 595
Western Cape	42 365	R100 032 121	5 654	R22 948 331	R55 242 154
Total # pts/ Spent per annum	344 059	R812 385 230	45 915	R186 368 985	R447 000 000
<b>Total PTB Cost 2011/12 (inc all labs)</b>					<b>R1 445 754 215</b>

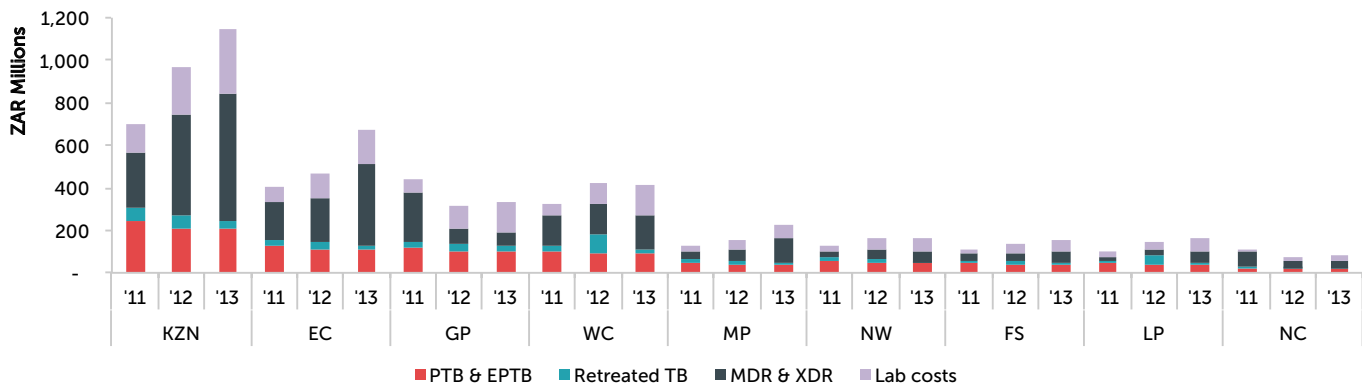
2012/13					
Province	# PTB+ETB patients	PTB+ETB Costs	# Retreatment patients	Retreatment Costs	Diagnostic Costs
Eastern Cape	47 145	R111 316 876	8 347	R33 882 114	R117 052 543
Free State	17 705	R41 805 012	3 135	R12 724 415	R43 277 401
Gauteng	43 215	R102 039 133	7 652	R31 058 198	R105 439 191
KwaZulu Natal	88 302	R208 497 480	15 635	R63 461 496	R220 601 876
Limpopo	17 157	R40 511 142	3 038	R12 330 594	R41 762 134
Mpumalanga	17 296	R40 840 126	3 063	R12 430 728	R42 621 806
North West	20 726	R48 938 343	3 670	R14 895 626	R50 758 843
Northern Cape	7 103	R16 772 155	1 258	R5 105 031	R17 684 258
Western Cape	38 346	R90 540 748	6 789	R27 558 373	R94 801 948
Total # pts/ Spent per annum	296 996	R701 261 015	52 586	R213 446 574	R734 000 000
<b>Total PTB Cost 2012/13 (inc all labs)</b>					<b>R1 648 707 589</b>

2013/14					
Province	# PTB+ETB patients	PTB+ETB Costs	# Retreatment patients	Retreatment Costs	Diagnostic Costs
Eastern Cape	46 603	R110 038 591	5 180	R21 024 727	R164 097 903
Free State	17 943	R42 366 016	1 994	R8 094 741	R60 842 495
Gauteng	44 473	R105 008 729	4 943	R20 063 687	R149 558 644
KwaZulu Natal	86 769	R204 877 096	9 644	R39 145 221	R302 926 688
Limpopo	17 561	R41 465 018	1 952	R7 922 590	R59 754 523
Mpumalanga	17 336	R40 933 769	1 927	R7 821 086	R60 497 820
North West	18 180	R42 927 014	2 021	R8 201 929	R61 660 721
Northern Cape	7 615	R17 979 579	846	R3 435 301	R26 240 199
Western Cape	39 517	R93 306 384	4 392	R17 827 757	R135 421 007
Total # pts/ Spent per annum	295 997	R698 902 196	32 899	R133 537 041	R1 021 000 000
<b>Total PTB Cost 2013/14 (inc all labs)</b>					<b>R1 853 439 237</b>

Sources: BAS records for TB hospital and XDR/MDR-TB spending. Estimates for PTB, ETB and diagnostic spending. Drug sensitive costs: Sinanovic E, Foster N, Cunnamo L, Vassall A. 2015. *Personal communication*. Drug resistant costs: Schnippel K. 2015. *Personal communication*. Lab costs: TB Diagnostic Market Analysis Consortium, 2015. TB patients numbers from ND

Adding the XDR/MDR costs, the provincial total spending on TB is shown in Figure 15 below, with KZN carrying the greatest (and rapidly increasing) burden of the disease, followed by Gauteng and Western Cape.

Figure 15: Provincial Total Spending on TB (ZAR millions, 2011/12-2013/14)



Source: BAS records for TB hospital and XDR/MDR-TB spending. Estimates for PTB, ETB and diagnostic spending

This concludes the presentation of past spending on HIV and TB in South Africa. The next section examines future commitments and resources needed.

## 2.8 Future allocations/ commitments for HIV and TB

In anticipating the future available funds for HIV and TB in South Africa, the SA government's medium term expenditure framework (MTEF) budget allocations for 2015/16 to 2017/18, are provided in Table 19 below. While there may be some small adjustments to these amounts, they usually convert into actual available public funds.

Confirmed grant amounts from the GF for 2014/15 and 2015/16 are also included in the table below, but these are the total remaining contract amounts for the current grant, which may not be fully disbursed by the GF (dependent upon the absorption of available funds by the PRs). For 2016/17 to 2018/19, the GF indicative amounts for the new grant (as provided in the GF allocation letter) will be applied for in the new South African GF Concept Note (currently being developed), and again, these full amounts may not be realised. These amounts are split equally over the three year funding period, and show potentially less funding that is currently being spent per annum from GF.

PEPFAR commitments outlined in the PFIP are included below. Again, it is uncertain if these will fully convert into available funding. It has been assumed that their contribution may plateau at around US\$250 million per year by 2017/18, but this may not be correct and total amounts could continue to decrease further.

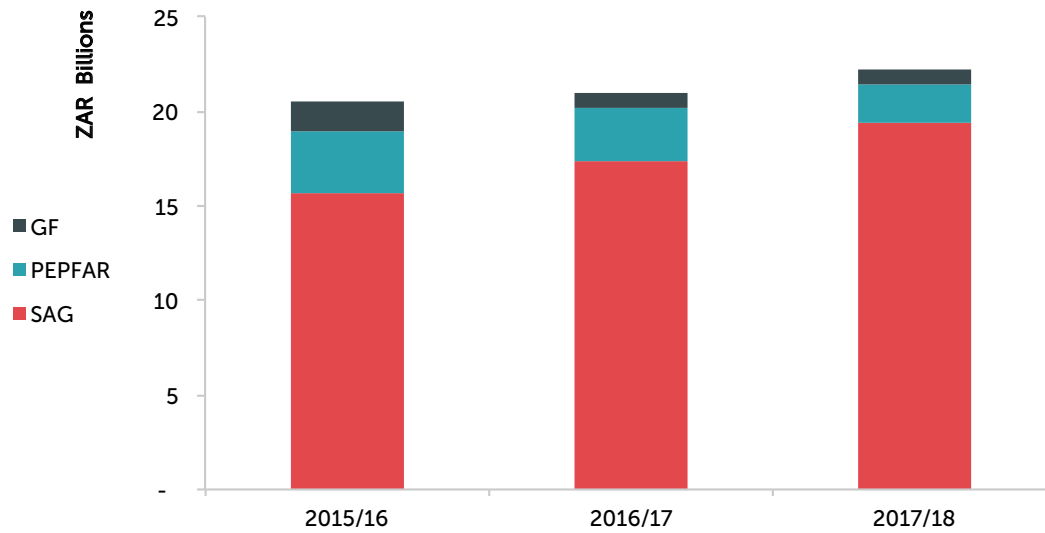
A breakdown of the future funding commitments by programme area was not available.

Table 17: Estimated Future Funding Commitments for SA Government, GF and PEPFAR (ZAR, 2014/15-2017/18)

Sources	2014/15	2015/16	2016/17	2017/18	2018/19	% in 2018/19
SA Govt	13 988 743 275	15 626 238 702	17 397 425 125	19 384 769 225	21 617 943 345	87%
PEPFAR	4 819 500 000	4 336 500 000	3 675 000 000	2 625 000 000	2 625 000 000	11%
GF	1 462 771 506	1 564 863 896	735 000 000	735 000 000	735 000 000	3%
<b>Total</b>	<b>19 191 170 567</b>	<b>20 565 619 926</b>	<b>20 967 425 125</b>	<b>22 154 769 225</b>	<b>21 617 943 345</b>	<b>100%</b>

\* SA Govt. sources: Estimates of National Expenditure and Provincial Budgets (2015/16). Excludes provincial discretionary (voted) budgets. Historical spending by DCS, DOD, and SAPS from NT reports, and future year estimates were adjusted for inflation. PEPFAR: PFIP agreement. GF: remaining budget for current grant (2013/14-2015/16) and indicative funding ceiling for new ceiling for new Concept Note (2016/17-2018/19), as per GF allocation letter.

Figure 16: Estimated Future Funding Commitments for SA Government, GF and PEPFAR (ZAR billions, 2014/15-2018/19)

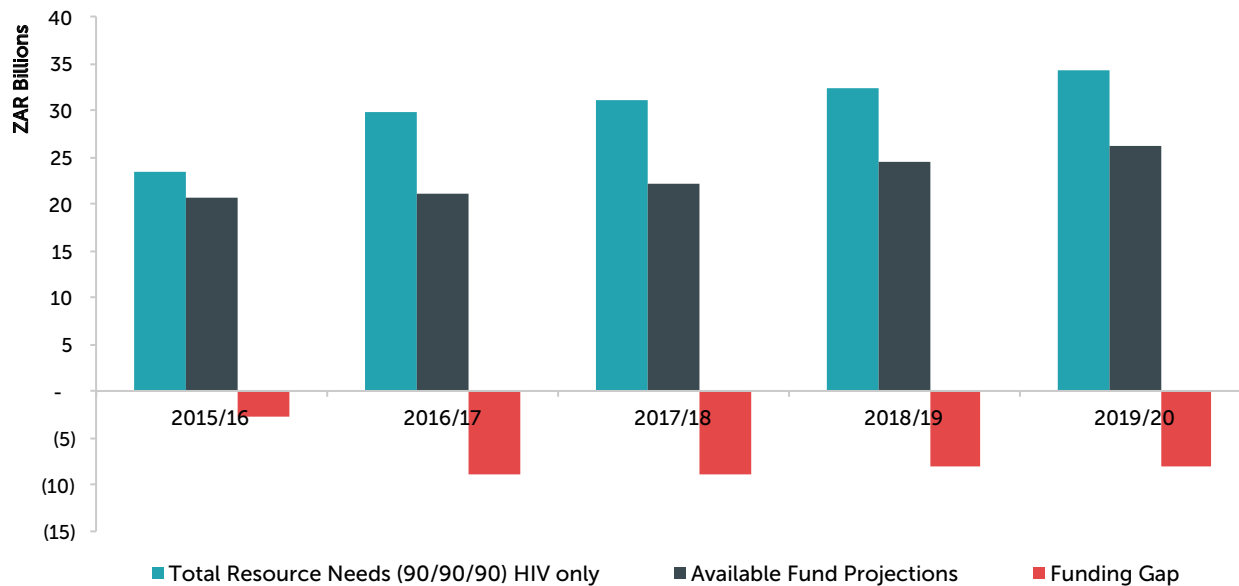


\* SA Govt. sources: Estimates of National Expenditure and Provincial Budgets (2015/16). Excludes provincial discretionary (voted) budgets. Historical spending by DCS, DOD, and SAPS from NT reports, and future year estimates were adjusted for inflation. PEPFAR: PFIP agreement. GF: remaining budget for current grant (2013/14-2015/16) and indicative funding ceiling for new Concept Note (2016/17-2018/19), as per GF allocation letter. Note the GF amounts have recently been increased (Dec 2015).

Figure 18 compares the funding commitments displayed above with the total estimated investment case resource needs for HIV (excluding TB at this point) to generate the potential total funding gap that might be experienced in future years. The financing gap could increase to almost R10 billion by 2016/17, assuming that the rapid scale-up to achieve the 90-90-90 targets are to be achieved by 2019/20. This equates to about 36% in total additional required on top of the projected available funding, and would therefore require significant and rapid resource mobilisation which could consider innovative funding options, such as Social Impact Bonds, additional earmarked levies (on sugar, airtime, cigarettes), currency conversion taxes, and private sector contributions. In addition, further exploration into current programmatic spending to ascertain if any additional technical or allocative efficiencies could be gained, to ensure maximum impact of current spending..



Figure 17: Potential Funding Gap for HIV in South Africa (ZAR billions, 2015/16-2018/19)



\* Future HIV funding needs – Investment Case estimations (2015). Future funding commitments: SA Govt. sources: Estimates of National Expenditure and Provincial Budgets (2015/16). Excludes provincial discretionary (voted) budgets. Historical spending by DCS, DOD, and SAPS from NT reports, and future year estimates were adjusted for inflation. PEPFAR: PFIP agreement. GF: remaining budget for current grant (2013/14-2015/16) and indicative funding ceiling for new Concept Note (2016/17-2018/19).

### 3. Summary and Recommendations

#### 3.1 Summary of key findings

The South African government has played the key role in designing, financing, implementing and monitoring the response to HIV and TB in the country, with the development partners also playing an important role in supporting and financing aspects of the response. Given the increasing demand for treatment and the limited budget ceiling, the government has led the development of the IC to assess if current spending is achieving its maximum impact, and if adjustments or realignments for greater impact would be required. Hence, this review of past expenditure attempted to measure the trends in spending from 2011 to 2013 and the contributions of the three key sources in South Africa - namely the SA government, PEPFAR and the GF - to identify which interventions had been prioritised, and what the future commitments might cover in terms of the resources that would be required for the optimal package. In addition, the process examined the financial information systems of the three key sources included in the review and makes recommendations for their harmonisation and improvement for routine resource tracking.

This expenditure review builds on previous efforts such as the NASA covering 2007 to 2009, and the Annual Planning Tool that covered 2010. However, it is unique in that it consolidated all the data from the three sources into one database for easier analysis, so as to explore the feasibility and functionality of such a consolidated system for future routine tracking. The consolidated database was structured as per the BAS records, also to improve its chances of being used by the SAG on an on-going basis.

The total spending on HIV and TB in South Africa has been steadily increasing over the years, from R17.4 billion in 2011/12, to R19.2 billion in 2012/13 and again to R22.1 billion in 2013/14, representing a 15% increase from 2012/13. Of these amounts, the largest and growing contribution came from the SA government. These public contributions formed 80% (R17.8 billion) of the total HIV and TB spending in 2013/14. PEPFAR provided the next largest but decreasing share, at R3.7 billion (17%) in 2013/14, down from R3.9 billion (22%) in 2011. The GF contributions increased from R214 million (1%) in 2011 to R662 million (3%) in 2013, after an initially slow uptake of the new Single Stream Fund (SSF) grant. Of the total spending, HIV-related activities accounted for 82%, while TB accounted for the other 18%.

Of the HIV spending (excluding the TB), the largest (and growing) share went to care and treatment activities, mostly for ART, reaching R8.9 billion in 2013/14 (40%). HCT, Programme Enablers (mostly M&E and management) and Social Enablers (mostly support for OVC)

were the next largest expenditures, while the remaining IC programmes received relatively small proportions. Spending on other programmes not included in the IC list of interventions amounted to 14% of the total. The bulk of this went towards community and home based care activities, with smaller amounts for step-down care, palliative care, workplace programmes, training, and other prevention activities.

Of all of the SA public funds, a large portion (57%) were channelled through the HIV conditional grant (CG) to the DOH, followed by the DOH's voted (equitable share) funds (34%). The majority (69%) of the DOH CG went to ART, while the majority (60%) of the voted funds went towards TB treatment, although an increasing proportion of the voted funds also went towards ART (4% in 2013/14). The other departments' spending was relatively small but provided important interventions to complement DOH activities, such as the DSD's support (5%) for OVC and DOE's (1.3%) prevention interventions for youth in school (through the Lifeskills conditional grant).

Examining PEPFAR's spending found that the largest portion was allocated to care and treatment for HIV (25% in 2013/14). The remaining PEPFAR funds were evenly spread across the other IC categories, with significant contributions to HCT (9%), MMC (10%), PMTCT (8%), TB interventions (8%), SBCC (6%), Programme (11%) and Social (9%) Enablers, with smaller amounts spent on key populations (2%) and other biomedical interventions (5%), and for which PEPFAR was the primary funder. The GF contributions were small in comparative terms, but also primarily went to care and treatment (58% of GF spending in 2013/14) and HCT (12%).

Importantly, regarding allocative efficiencies, this expenditure analysis showed that the past spending on HIV and TB has indeed tended to focus on those interventions identified as having the greatest impact by the Investment Case modelling, and it appears that the financial effort has been aligned with priorities specified in the NSP and has contributed towards the achievement of its targets.

For future joint planning between the three players, it is important for the SA government to note that, in addition to PEPFAR's contribution to care and treatment spending, the USG is also the largest proportional contributor to SBCC, MMC, other biomedical interventions (eg. PrEP) and PMTCT programmes. The GF has played an important supportive role in the national response, especially with regards to key population interventions and HCT, as well as other Programme and Social Enablers.

Looking ahead, the SA government's contribution over the medium term expenditure framework (MTEF) period is expected to continue to increase, while PEPFAR's contributions may decrease as per the Partnership Framework Implementation Plan (PFIP) till 2018/19, and may then plateau. The GF indicative allocation for the next grant (2016/17-2018/19) may also result in less funding than has been received under the current grant, although recently (Dec' 2015) the GF indicated that additional 'above allocation' amounts were being granted to South Africa. Although the increase in SA government funding is expected to make up for the gap left by the decreasing PEPFAR and GF allocations, the resources needed to achieve the 90-90-90 targets could require almost an additional 36% above anticipated available funding for HIV and TB, if the scale-up rates are achieved as modelled. All partners will need to strategically plan together to meet the funding requirements if the investment required for maximum impact is to be achieved.

## 3.2 Recommendations

The recommendations made in this section relate to the allocative funding choices of the three funders and their expenditure reporting systems.

### 3.2.1 Allocative (programmatic) choices for the greatest impact – utilisation of available funding

The IC package of programmes have been determined, through modelling based on available evidence, to be the most cost-effective to achieve the 90-90-90 targets. Therefore the past expenditure data was classified according to those IC programmes, and the findings showed that the spending on HIV and TB between 2011/12 and 2013/14 has indeed tended to focus on those programmes identified as having the greatest impact by IC modelling. Although a wide range of programmes were identified from the three funders, these could mostly be aggregated into the IC core list of programmes, with only 14% being spent on other (non IC) activities, which have also been deemed important (such as home and community based care, palliative and step-down care). It appears that the past financial effort has been aligned with priorities specified in the National Strategic Plan (NSP) and has contributed toward progress in meeting the associated NSP targets.

More specifically, given that South Africa has the largest public ART programme in the world and has recently committed to the 90-90-90 targets, the prioritisation of funding by the SA government, PEPFAR, and GF for care and treatment activities—specifically, expanding ART coverage—is appropriate. According to modelling from the IC, the spending on treatment will have the greatest

impact on reducing mortality, morbidity, and the transmission of HIV in the country. Only with a massive effort in the next few years to increase the number of people on ART will the number of new infections, and hence the number of people needing treatment, start to reduce. This will require all partners to contribute increased funds towards treatment or related supportive programmes (e.g., adherence support, patient tracking, viral load monitoring). However, it is imperative that the government remain the key funder for this critical ART programme, to ensure long-term sustainability. This may require the ring-fencing of the anti-retroviral (ARV) funds to ensure that the current and future patients will continue to receive their ARVs, irrespective of the development partners' funding priorities and trends.

Along with the focus on treatment, there is also a need to strengthen the prevention programmes as well as the Programme and Social Enablers to ensure that the prevention and treatment interventions can achieve their targets. Spending on MMC, condoms, SBCC, HCT and other biomedical programmes has increased between 2011 and 2013, but may not yet have enabled the scale-up necessary for the greatest impact. The HCT efforts must be linked to treatment and with greater efforts to reduce the number of patients not returning for treatment. The PEPFAR and GF support for these prevention programmes has been crucial and will continue to be, as the public funds are increasingly committed to treatment. Geo-spatial targeting of efforts towards the areas of highest HIV transmission will be important to ensure the greatest impact of limited resources, and therefore joint planning between the SA government, PEPFAR agencies, and the GF will be necessary to ensure adequate coverage of these areas while not neglecting the other, lower priority, areas.

The public departments, particularly the DOH, are the key service providers in the South African response. It is important to ensure these services will be continued, even if external funding continues to decline. However, the NGOs funded by PEPFAR and GF also play critical roles in supporting and expanding the reach of programmes and providing services not prioritised by the government, such as SBCC, key populations, care and support (adherence, OVC, CHBC, etc), research and other programme and social enablers. It will be important for PEPFAR and GF to continue to support NGOs to deliver and expand these important services, and for the SA government to consider increasing funding to them, especially if external funds for NGOs continue to decrease.

This study did not include a review of the technical efficiency of current spending. While there may be some scope for savings within these programmes, these potential efficiency gains should not be over-estimated, as the public health programmes generally operate on less than optimal resources, both financial and human. Therefore the greatest potential savings may only be through the reduction of the ARV tender prices, or by applying different modes of delivery.

### **3.2.2 Improving expenditure reporting systems - moving towards routine systems**

The process of analysing the public BAS records, the PEPFAR EA data, and the GF's PRs' EFRs highlighted a number of challenges and limitations which could be addressed to improve the routine tracking of spending on HIV and TB in a harmonised manner. These are noted below.

#### **Suggested improvements to the BAS records:**

- i. Ensure that all provinces are using the BAS variables consistently and correctly. For example, the programme details should only be in the sub-programme and objective levels, and not in the responsibility variables, as one or two provinces were doing. The responsibility levels should show the directorate, programme, and the facility/ service provider with as much detail as possible.
- ii. Agree and fix the options (in drop-down menus) for coding the HIV and TB programmes in the sub-programme and objective levels. As indicated, over 300 variations were found of only 35 programmes. These could easily be hard-coded with some additional options for unusual, or special, programmes. While these would apply mainly to the DOH, they should also apply to the other departments, since their HIV expenditure was generally poorly coded.
- iii. Improve the coding and capturing of TB programmes, with as much disaggregation as possible: TB prevention (specific: IPT, other), TB screening, TB diagnostics (specify if capital investments in equipment), TB treatment (specify: in- or out-patient), and TB patient management (tracking systems, pharmacovigilance), etc.
- iv. Training of the district and provincial financial officers who are responsible for capturing the expenditures is necessary to ensure the standardised use of variables and classifications. In addition, programme managers need similar training to ensure

that the requisitioning of expenditures includes all the relevant detail to enable the correct coding by financial officers.

- v. It would be useful for the SHA purposes, as well as overall health monitoring, to apply disease-specific codes to all expenditure as far as possible, and not only for HIV and TB. Obviously, some expenditure would have to be labelled as 'general health care' or 'provincial/district management,' but where known, the illness identifier would be valuable.
- vi. Although the BAS variable indicating the responsibility level should indicate the level of service (provincial, district, facility), there are large sums of money paid for medicines, supplies, laboratories, etc. that are coded as single transactions attributed to the provincial level. While this is correct in terms of accounting cost centres and transfers, it would be useful to split these expenditures (if possible) according to the district in which the medicines, supplies, or tests were consumed.
- vii. Ultimately, each expenditure should also be linked to the programme output data, such as the numbers of patients on ART, HIV and TB tests, OVCs support, etc.

#### **Suggested improvements to the PEPFAR EA categories:**

- i. The EA category 'facility-based care, treatment, and support' should be disaggregated into more specific programmes: ART, TB (out- or in-patient) treatment, palliative care (if in hospices) etc.
- ii. The EA category 'community-based care, treatment, and support' should be disaggregated into more specific programmes: home-based care, adherence support, palliative care (if in homes) etc.
- iii. Redefine and further disaggregate the EA category of 'infection control' for greater clarity on programmes included therein.
- iv. Given the increasing need for TB programmes, PEPFAR should allow for more nuanced reporting, such as: TB prevention (specific: IPT, other), TB screening, TB diagnostics (specify if capital investments in equipment), TB treatment (specify: in- or out-patient), TB patient management (tracking systems, pharmacovigilance), etc.
- v. It would be useful for the EA data that is made publicly available to indicate the type of service provider, (e.g. public or NGO). PEPFAR need not share the names of implementing partners but expenditures could be coded by a variable of 'type of implementer.'
- vi. Since PEPFAR is improving their geo-spatial targeting at the district level, it will be useful, if not imperative—for their own monitoring purposes as well as for joint planning purposes with the South African government—to label all expenditure by the district that benefits from the expenditure.
- vii. The EA reporting period should be matched, as far as possible, to the public financial year. This could be accomplished by conducting the EA twice each year, since the financial years are off by exactly six months.
- viii. PEPFAR uses different budget codes from the expenditure classifications in the EA. This makes it difficult to compare budget allocations with actual spending. This obstacle could be alleviated if PEPFAR budgeted using the same EA programme areas, or crosswalk them for automated comparisons.

#### **Suggested improvements to the GF reporting by Principal Recipients:**

Since the GF is moving away from the EFRs and towards the Annual Financial Reports (AFRs), the following suggestions are based on the experience with the EFRs, and may have already been addressed through the AFRs:

- i. The SDAs in the EFRs were somewhat broad, and sometimes included various interventions for which the specific expenditure (per programme) could not be extracted. For example, 'HIV and TB case finding' could not distinguish the spending on HIV testing from the TB screening and diagnosis costs. Also the SDA's were not always applied in a standardised manner by the PRs, resulting in many SDAs with slight variations and small amounts of spending. The new modular template should have more specific, pre-defined programmes, which can be selected by the PRs from drop-down menus (with some flexibility for adding unusual or special projects). These hard-coded categories should ideally be comprehensive (or exhaustive) and

mutually exclusive, meaning that almost any expenditure could be captured, and within only one programme, as far as possible. It is easier to aggregate detailed data after it has been collected, but it is impossible to disaggregate data once it has been collected in an aggregated category.

- ii. The GF TB expenditure needs to be more disaggregated, for example into TB prevention (specific: IPT, other), TB screening, TB diagnostics (specify if capital investments in equipment), TB treatment (specify: in- or out-patient), and TB patient management (tracking systems, pharmacovigilance).
- iii. Since the GF is also moving towards geo-spatial targeting of high impact areas, it will be essential to label all expenditure at least by the provincial level, and if possible, by the district that benefits from the expenditure. As seen above, this study could not disaggregate the GF spending by province. The new AFRs should include the geographic indicator, by the two levels: province and district.
- iv. The current EFRs report the expenditure first by cost category and then again by SDA. However, the cost category is not linked to the SDA, so it is not possible to ascertain the cost components of a specific SDA. While some of these may be obvious—for example, the purchase of ARVs can be easily attributed to the HIV treatment SDA—it is not easy to attribute the spending on human resources to the SDAs for which they are employed. It would be relatively simple for the PRs to report their cost category spending by specific programme, and would allow for deeper analysis of programmatic cost categories.
- v. The quarterly EFRs were useful to be able to match the PRs' expenditures to the government's financial year. However this took careful manipulation of the EFR data. It is suggested that the PRs expenditure be reported by quarters, irrespective of the date of commencement of the grant, and then be aggregated to match the public financial year. The final versions of these aggregated annual reports should be easily available online to the public.
- vi. All PRs will need training and support in the use of the new AFRs to ensure their standardised and correct application.

#### **Suggestions for consolidated, routine expenditure monitoring:**

To ensure that South Africa can coordinate and harmonise the efforts of all the major HIV and TB funders on an ongoing basis, the development of routine, mandatory on-line reporting for all public departments and external donors would be essential. A minimum core set of variables could be automatically extracted from the BAS records (if the above suggestions with regards to the standardised use of the variables and classifications are implemented), and this could provide the common structure of the database. The development partners' records would have to match this structure for ease of consolidation and automated analysis. The NHA or CHAI's Annual Planning Tool (APT) may provide the platform for this effort—if it is built upon the public BAS structure (to allow for automated extraction from the BAS files), and if all development partners can structure their datasets accordingly and with sufficient disaggregation of the programme category. The crosswalking undertaken for this report will assist in matching the PEPFAR and GF categories to the BAS categories. In order for this to be a routine and simplified process, all parties need to agree on the structure and minimum package of data and variables to be included.

A few additional variables could be added to the BAS entries, to the EA reports, and to the GF EFRs/AFRs which indicate the NSP objective, the DOH MTSF strategic goal, and the SHA category and illness to which the expenditure contributes. This would greatly enhance the aggregation of the data to show overall progress towards the national targets, as well as allowing for easier alignment to the NHA reports (especially if the NHA will be routinized, and should be applied to all the health spending, not only HIV and TB). In turn, this would allow for improved planning and allocative decisions which avoid duplication and gaps. However, it must be noted that the capturing of the correct NSP priority area or the MTEF strategic goal must be done by the programme managers when requisitioning the expenditure. The finance officers who capture the expenditures into the BAS system would not be able to identify the correct priority area without the programme manager's selection.

In order to replicate this South African experience of consolidating various expenditure data sets in other countries, similar processes will be required. The standardisation of the PEPFAR and GF datasets (especially the GF's new funding model's modules) will probably be the easiest aspects to undertake globally, if similar steps could be taken as suggested above. In countries with strong public financial information systems, the steps taken in South Africa could be more easily applied, and which would lead to more effective

management and efficient allocation of the public HIV funding. In other countries, weak public financial data may pose greater challenges depending on the quality, accuracy, and degree of disaggregation currently applied to each expenditure. These public systems may require more extensive preparatory efforts to improve and standardise their financial procedures, but these longer-term improvements to the public finance system will be necessary for countries to effectively manage their HIV and TB expenditures and ultimately improve their health outcomes.

In conclusion, we thank and commend the three partners – the South African government, PEPFAR and the GF – for their willingness to share their expenditure data, their assistance in correctly coding their expenses, and their commitment to using the findings to inform their future allocative decision-making, joint planning and hopefully to improve their financial information systems.

Results for Development, on behalf of the South African Investment Case Steering Committee, November 2015.

## Appendices

### A. The SA Investment Case Programmes

Program area	Intervention/ Technical efficiency factor/ Enabler	Description
<b>HIV</b>		
<b>1. Programmes</b>		
ART	Cotrimoxazole ART at current guidelines Universal test and treat	Eligibility at CD4<500 and PMTCT B+
Male medical circumcision	General population MMC Early infant male circumcision MMC age group targeting (10-14) MMC age group targeting (15-19) MMC age group targeting (20-24) MMC age group targeting (25-49)	Note that only men who are highly sexually active are eligible for circumcision in the model.
Comprehensive condom programming	Condom availability	This refers to distributing sufficient condoms to ensure that a specified level of protected sex acts can be achieved
Key populations	Male and female condom education	
PMTCT	PrEP for sex workers PMTCT Infant testing at birth Infant testing at 6 weeks	Triple ART initiation in pregnant women
HCT	General population HCT Testing of pregnant women Testing of adolescents	
Social and behaviour change communication	SBCC campaign 1 SBCC campaign 2 SBCC campaign 3	This campaign has a message of reducing multiple sexual partners and increasing testing in adolescents This campaign has a message of increase condom usage and self-efficacy This campaign has a message of increasing HIV testing, condom usage, condom self-efficacy, and MMC
Prevention	PrEP for discordant couples PrEP for adolescents Microbicides	
<b>2. TE factors</b>		
ART	Indirectly supervised pharmacy assistants GP down-referral Home-based ART Community-based adherence supporters Adherence clubs	
HCT	Point-of-care CD4 testing Provider-initiated HCT Mobile HCT Home-based HCT	

Program area	Intervention/ Technical efficiency factor/ Enabler	Description
	Workplace HCT HCT invitations to pregnancy partners	
<b>3. Critical enablers</b>		
Critical enabler	SASA! community-based gender-based-violence programme Life skills and vocational training for out-of-school adolescent girls Risk reduction for alcohol and substance users Risk reduction for substance users School-based HIV/STI risk reduction Teacher support Parental monitoring School feeding Positive parenting Supporting adolescent orphan girls to stay in school State-provided child-focused cash transfers	
<b>TB</b>		
<b>1. Programmes</b>		
Reach high risk groups	1. Screen for vulnerable populations TB	Proportion of high risk groups symptom screened for TB  If no active TB and eligible for IPT, initiate on IPT
Diagnose and link to care	2. Diagnose and treat TB	Proportion of estimated TB cases diagnosed and treated  If HIV co-infection, appropriate treatment includes ART
Treat and retain in care	3. Successfully treat TB	Proportion of all TB cases treated successfully  RIF resistant TB, successful outcome



## B. The Common BAS Categories Applied to all Public HIV and TB Spending

### BAS Common Categories for HIV and TB Spending

ART Treatment

Blood bank

CE Political commitment (non-BAS)

CE Stigma reduction (non-BAS)

CHBC

Condoms

DCS Inmates HIV/TB programmes

HCT (or VCT)

HIV not disagg

HIV Treatment not disagg

HTA

Key pop prevention

Key pop prevention n.d.

Key pop prevention other nec.

M&E

Mass media/ soc.mob

MMC

OVC (DSD HIV support)

Palliative / hospice care

PEP/ OPEP/ NOPEP (occupational or non-occupational)

PM

PMTCT

Policy and systems development

Prevention not disagg

SDC

STI

TB control

TB not disagg

TB treatment (clinics or outpatient)

TB treatment (hospitals)

TB treatment not disaggregated

TB XDR/MDR treatment

TB/HIV (Integration)

Training

Uniformed HIV services (DOD/SAPS)

Workplace prevention

Youth services (not disagg)

### C. Crosswalking the PEPFAR EA Categories to the SA government (BAS) Categories

PEPFAR EA Category	Matching BAS Category
25% of Facility-Based Care, Treatment, & Support	TB/HIV
Sexual & Other Risk Prevention-General Population (certain sub-categories only)	Communications (BCC)
Condoms (in the EA cost category and not by programme)	Condoms
HCT	HCT
Sexual & Other Risk Prevention-Key Populations	High Transmission Areas (HTA)
VMMC	MMC
PEP	PEP
PMTCT	PMTCT
75% of Facility Based Care, Treatment, & Support	ART Treatment
ARVs (cost category)	
75% of Surveillance (as per PEPFAR suggestion)	Monitoring & Evaluation
Strategic Information	
25% of Surveillance (as per PEPFAR suggestion)	Policy & Systems Development
Non-Activity Level Health Systems Strengthening	
Blood Safety	Blood Banks
OVC	OVC
Sexual & Other Risk Prevention-General Population (certain sub- categories only) Infection Control	Other Prevention
Lab Strengthening	Lab Strengthening

#### D. Crosswalking the Global Fund SDA Categories to the SA government (BAS) Categories

SDA	Corresponding BAS category
Antiretroviral treatment (ARV) and monitoring including expansion of electronic registers	ART Treatment
ARV Drug Resistance Monitoring	PE. Pharmacovigilance (non-BAS)
Care and support for the chronically ill	CHBC
Care and support: Care and support for the chronically ill	CHBC
Care and support: Support for orphans and vulnerable children	OVC (DSD HIV support)
Combination Prevention- Prisoners	DCS Inmates HIV/TB programmes
Combination prevention-Low Socio Economic population	Key Pop Other (non-BAS)
Combination Prevention-MSM and LGBTI	Key Pop MSM (non-BAS)
Commercial Sex Workers	HTA (CSW & clients)
CSS: Financial resources	PE: Building comm. Capacity/Inst. strengthening (non-BAS)
CSS: Human resources: skills building for service delivery, advocacy and leadership	CE Political commitment (non-BAS)
CSS: Management, accountability and leadership	PE: Building comm. Capacity/ Inst. strengthening (non-BAS)
Enabling Environment	CE Political commitment (non-BAS)
HIV & Care Support	HIV Treatment not disagg
HIV & TB case finding	HCT (or VCT)
HIV Drug resistance monitoring and prevention	PE. Pharmacovigilance (non-BAS)
HSS: Community Systems Strengthening	PE: Building comm. Capacity/Inst. strengthening (non-BAS)
HSS: Health Workforce	PE: Workforce (non-BAS)
HSS: Monitoring and Evaluation	M&E
HSS: other - M&E	M&E
HSS: Other, specify	Policy and systems development
Institutional support and programme management for SRs and PR	PE: Building comm. Capacity/ Inst. strengthening (non-BAS)
Medical male circumcision	MMC
Men Who Have Sex with Men	Key Pop MSM (non-BAS)
Monitoring & Evaluation Systems	M&E
Out of School Youth	Youth services (not disagg)
People with Disabilities (PWD)	Key Pop Other (non-BAS)
Pharmacovigilance	PE. Pharmacovigilance (non-BAS)
Please Select...	HIV not disagg
PMTCT	PMTCT
Prevention: BCC - community outreach	Mass media/ soc.mob
Prevention: Behavioral Change Communication - community outreach	Mass media/ soc.mob
Prevention: Behavioral Change Communication - community outreach	Youth services (not disagg)
Prevention: Behavioral Change Communication - Mass media	Mass media/soc.mob

SDA	Corresponding BAS category
Prevention: Condom distribution	Condoms
Prevention: Counseling and Testing	HCT (or VCT)
Prevention: PMTCT	PMTCT
Programme management and Administration cost	PM
Support for orphans and vulnerable children	OVC (DSD HIV support)
Supportive environment: Policy development including workplace policy	Policy and systems development
Supportive environment: Program management and administration	PM
Supportive environment: Program management and administration	ART Treatment
Supportive environment: Program management and administration	Youth in school
Supportive environment: Program management and administration	CHBC
Supportive environment: Stigma reduction in all settings	CE Stigma reduction (non-BAS)
Supportive environment: Strengthening of civil society and institutional capacity building	PE: Building comm. Capacity/ Inst. strengthening (non-BAS)
TB/HIV	TB/HIV (Integration)
TB/HIV collaborative activities: HIV care and support for HIV-positive TB patients	TB/HIV (Integration)
Testing and Counseling	HCT (or VCT)
Treatment: Antiretroviral treatment (ARV) and monitoring	ART Treatment
Women at Risk, Including those affected by GBV and risk through occupation	GBV/gender equality (non-BAS)

## E. The Crosswalk for the Five Classification Systems

SA IC categories	BAS Common Codes	EA Program Areas	NASA Categories	SHA Code
1.1-3. ART (incl. pre-ART, HB treatment, NIMART)	ART Treatment	Facility Based Care, Treatment, & Support (75%)	ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment	HC.1.3.1. Curative outpatient care: ART
1.4. Treatment Adherence	Adherence (non-BAS)	Adherence (non EA category)	ASC.02.01.07 Psychological treatment and support services	HC.1.3.1. Curative outpatient care: ART
1.nec. SDC (non SA IC)	SDC	Community Based Care, Treatment, & Support (50%)	ASC.02.01.09 Home-based care	HC.3.4. Home-based long-term care (health)
1.nec. CHBC (non SA IC)	CHBC	Community Based Care, Treatment, & Support (50%)	ASC.02.01.09 Home-based care	HC.3.4. Home-based long-term care (health)
1.nec. Palliative Care (non SA IC)	Palliative/hospice care	Palliative care (Non EA category)	ASC.02.02.02 Inpatient palliative care & ASC.02.01.08 Outpatient palliative care	HC.3.1. In-patient long-term care (health)
1.nd. C&T not disaggreg	HIV Treatment not disagg	C&T not disaggreg (non-EA)	ASC.02.98 Care and treatment services not disaggregated by programme	HC.1.nec. Unspecified curative care
2. MMC	MMC	Voluntary Medical Male Circumcision	ASC.01.18 Male circumcision	HC.6.5.4.1. Disease control programmes: MMC
3. Comprehensive Condom Programming	Condoms	Condoms	ASC.01.13 Public and commercial sector male condom provision	HC.5.1.3 Pharmaceuticals and other medical non-durable good: condoms
4.1. Key pops: CSWs	HTA (CSW & clients)	Sexual and Other Risk Prevention - Key Populations (CSWs)	ASC.01.08.01-.98 Programmatic programmes for sex workers and their clients not disaggregated by type	HC.6.3. Early disease detection programmes
4.2. Key pops: MSM	Key Pop MSM (non-BAS)	Sexual and Other Risk Prevention - Key Populations (MSM)	ASC.01.09.01-.98 Programmatic programmes for MSM not disaggregated by type	HC.6.3. Early disease detection programmes
4.3. Key pops: Inmates	DCS Inmates HIV/TB programmes	Key Pops Inmates (non EA category)	ASC.01.04.99 Other programmatic programmes for vulnerable and accessible populations not elsewhere classified (n.e.c.)	HC.6.3. Early disease detection programmes
4.nec. Other Key Pops.	Key Pop Other (non-BAS)	Sexual and Other Risk Prevention - Key Populations (Other)	ASC.01.04.99 Other Programmatic programmes for vulnerable and accessible population not elsewhere classified	HC.6.3. Early disease detection programmes
4.nd. Key Pop not disaggreg.	Key pop prevention n.d.	Sexual and Other Risk Prevention - Key Populations	ASC.01.04.98 Programmatic programmes for vulnerable and accessible population not disaggregated by type	HC.6.3. Early disease detection programmes

SA IC categories	BAS Common Codes	EA Program Areas	NASA Categories	SHA Code
4.nec. Other Key Pops: IDUs	Key Pop IDU (non-BAS)	Sexual and Other Risk Prevention - Key Populations (IDUs)	ASC.01.10.01-.98 Programmatic programmes for IDUs not disaggregated by type	HC.6.3. Early disease detection programmes
4.nec. Other Key Pops.	Key pop prevention other nec.	Sexual and Other Risk Prevention - Key Populations (Other)	ASC.01.04.98 Programmatic programmes for vulnerable and accessible population not disaggregated by type	HC.6.3. Early disease detection programmes
4.nec. Other Key Pops: Youth	Youth services (not disagg)	DS: Youth (non EA)	ASC.01.05 Prevention – youth in school & ASC.01.06 Prevention – youth out-of-school	Non NHA category
5. PMTCT	PMTCT	Prevention of Mother to Child Transmission	ASC.01.17.98 PMTCT not disaggregated by programme	HC.6.3. Early disease detection programmes
6. HCT	HCT (or VCT)	HIV Counseling & Testing	ASC.01.03 Voluntary counselling and testing (VCT) & ASC.02.01.01 Provider- initiated testing and counselling (PITC)	HC.6.3. Early disease detection programmes
7. SBCC	Mass media/ soc.mob	Sexual and Other Risk Prevention - General Populations (certain sub-areas)	ASC.01.01.98 Communication for Social and behavioural change not disaggregated by type	HC.6.1. Information, education & counseling (IEC) programmes
8.1. Prevention: PEP	PEP/OPEP/ NOPEP	PEP	ASC.01.22.01-.99 Post-exposure prophylaxis	HC.6.3. Early disease detection programmes
8.2. Prevention: PrEP	PrEP (Non-BAS)	Other prevention: PrEP (non EA category)	PrEP: Non NASA	HC.6.3. Early disease detection programmes
8.3. STI syndromic management	STI	Other prevention: STI (non EA category)	ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)	HC.6.3. Early disease detection programmes
8.4. Prevention: Microbicides	Other Prevention (non-BAS)	Other prevention (non EA category)	ASC.01.15 Microbicides	HC.5.1.3 Pharmaceuticals and other medical non-durable goods
8.nec. Other Prevention (Non SA IC)	Other Prevention (non-BAS)	Infection Control	ASC.01.99 Prevention activities n.e.c.	Non SHA category
8.nd. Prevention not disaggreg (Non SA IC)	Prevention not disagg	Other prevention (non EA category)	ASC.01.98 Prevention activities not disaggregated by programme	HC.6.nec. Unspecified preventive care
9.1. TB treatment services	TB treatment (clinics or outpatient)	TB (non EA)	ASC.02.01.02.02 OI outpatient treatment	HC.1.3. Curative outpatient care
9.1. TB treatment services	TB treatment (hospitals)	TB (non EA)	ASC.02.01.02.02 OI outpatient treatment	HC.1.1. Curative inpatient care
9.1. TB treatment services	TB treatment not disaggregated	FBCT (25%)	ASC.02.01.02.02 OI outpatient treatment	HC.1.nec. Unspecified curative care
9.2. TB post treatment, MDR treatment	TB XDR/MDR treatment	TB (non EA)	ASC.02.01.02.02 OI outpatient treatment	HC.1.3. Curative outpatient care

SA IC categories	BAS Common Codes	EA Program Areas	NASA Categories	SHA Code
9.3-4. TB diagnosis, TB case finding	TB Diagnosis (non-BAS)	TB (non EA)	TB diagnosis (non NASA)	HC.6.3. Early disease detection programmes
9.5-6. TB Preventive therapy, IPT	TB prevention (IPT, etc) (Non-BAS)	TB (non EA)	ASC.02.01.02.01 OI outpatient prophylaxis	HC.6.3. Early disease detection programmes
9.7. TB Control	TB control/ management/ surveys	TB (non EA)	TB control (non NASA)	HC.7.1.1. Planning & Management
9.nec. TB/HIV Integration (non SA IC)	TB/HIV (Integration)	TB (non EA)	TB/HIV Integration (non NASA)	HC.7.1.1. Planning & Management
9.nd. TB not disagg	TB not disagg	TB (non EA)	ASC.02.01.02.98 OI outpatient prophylaxis and treatment not disaggregated by type	HC.1.nec. Unspecified curative care
<b>Social Enablers</b>				
SE.1. Political commitment and advocacy	CE Political commitment (non-BAS)	CE Other (non EA)	ASC.07.01-.99 Enabling environment	Non SHA category
SE.2. Laws, policies and practices	Policy and systems development	Health Systems Strengthening	ASC.04.01 Planning, coordination and programme management	Non SHA category
SE.3. Stigma reduction	CE Stigma reduction (non-BAS)	CE Other (non EA)	ASC.07.01-.99 Enabling environment	Non SHA category
SE.4. Social protection	DSD: Social Grants	DS: Poverty alleviation (non EA)	ASC.06.01-.99 Social protection services and social services	Non SHA category
SE.5. Education	Youth in school	DS: Youth (non EA)	ASC.01.05 Prevention – youth in school & ASC.01.06 Prevention – youth out-of-school	Non SHA category
SE.6. Alcohol reduction programmes	Alcohol reduction (non-BAS)	CE Other (non EA)	ASC.07.01-.99 Enabling environment	Non SHA category
SE.9. Gender equality/GBV	GBV/gender equality (non-BAS)	CE Other (non EA)	ASC.07.05 Programmes to reduce Gender Based Violence	Non SHA category
SE.10. Poverty reduction	DS: Poverty alleviation (non-BAS)	DS: Poverty alleviation (non EA)	ASC.06.01-.99 Social protection services and social services	Non SHA category
SE.11. OVC	OVC (DSD HIV support)	Orphans and Vulnerable Children	ASC.03.01-.99 OVC services	Non SHA category
<b>Programme Enablers</b>				
PE.1. Network connectivity and information systems	M&E	Strategic Information	ASC.04.03 Monitoring and evaluation	HC.7.1.2. Monitoring & Evaluation (M&E)

SA IC categories	BAS Common Codes	EA Program Areas	NASA Categories	SHA Code
PE.1. Network connectivity and information systems	M&E	Surveillance	ASC.04.03 Monitoring and evaluation	HC.7.1.2. Monitoring & Evaluation (M&E)
PE.1. Network connectivity and information systems	PE. Pharmacovigilance (non-BAS)	Pharmacovigilance	ASC.04.05 Serological-surveillance (serosurveillance)	HC.6.5. Epidemiological surveillance & risk & disease control programmes
PE.1. Network connectivity and information systems	PE: Lab (non-BAS)	M&E	ASC.04.05 Serological-surveillance (serosurveillance)	HC.7.1.2. Monitoring & Evaluation (M&E)
PE.1. Network connectivity and information systems	PE: Other (non-BAS)	PE other (non EA)	ASC.04.99 Programme management and administration n.e.c.	HC.7.1.1. Planning & Management
PE.2. Community-Centered design & delivery	PE: Building comm. Capacity/ Inst. strengthening (non-BAS)	PE other (non EA)	ASC.07.03 AIDS-specific institutional development	Non SHA category
PE.3. Management and incentives	PM	Program Management	ASC.04.01 Planning, coordination and programme management	HC.7.1.1. Planning & Management
PE.4. Research & innovation	PE. Research (non-BAS)	Research (non EA)	ASC.08.01-.99 HIV and AIDS-related research activities	HKR.4. Research and development
PE.5. Blood safety	Blood bank	Blood Safety	ASC.01.19 Blood safety	Non SHA category
PE.6. Integration	PE: Other (non-BAS)	PE other (non EA)	ASC.04.99 Programme management and administration n.e.c.	HC.7.1.1. Planning & Management n.e.c.
PE.10. Employer practices	Workplace prevention	Other prevention (non EA category)	ASC.01.11.01-.99 Programmatic programmes in the workplace	Non SHA category
PE.nec. Workforce (non SA IC)	PE: Workforce (non-BAS)	PE other (non EA)	ASC.05.99 Human resources n.e.c.	Non SHA category
PE.nec. Training (non SA IC)	Training	Training (non EA)	ASC.05.03 Training	HKR.5. Education and training of HR
<b>Development Synergies (non SA IC)</b>				
DS: Uniformed/ Armed HIV services (non SA IC)	Uniformed HIV services (DOD/ SAPS)	DS: Uniformed/ Armed HIV services (non EA)	ASC.01.04.98 Programmatic programmes for vulnerable and accessible population not disaggregated by type	Non SHA category
All other HIV not disaggregated	HIV not disagg	All other EA categories not above	ASC.98 HIV not disaggreg	HC.1.nec. Unspecified curative care



## F. The Estimations of the PTB and ETB Past Costs in South Africa

### Background

The spending on pulmonary and extrapulmonary TB may not have been identified as such in the BAS records due to being part of the general health spending. The spending on MDR and XDR TB was more clearly labelled as the 'TB hospital spending,' but may also have omitted the diagnostic costs.

The IC Steering Committee advised that the TB past spending could be estimated using costing techniques – by applying the unit costs of all ingredients to the numbers of patients, and captured as actual expenditure.

### Method

The following unit costs were applied, as were applicable in these past years (source K.Schnipple):

<b>TB Treatment Unit Costs:</b>	
<b>Non-MDR (PTB/ETB/RR):</b>	
First-line drugs Cat I&II	R326
Patient Management	R2 035
<b>Total per PTB/ETB/RR patient:</b>	<b>R2 361</b>
<b>Retreatment drug sensitive cases</b>	<b>R4 059</b>

<b>MDR/XDR:</b>	
MDR drugs	R18 740
Patient Management	R109 108
<b>Total per MDR/XDR patient (two years treatment)</b>	<b>R127 847</b>

<b>TB Diagnostic costs (2012/13 &amp; 2013/14 estimated by the TB Diagnostics Market Analysis Consortium)</b>	
2011/12	R447 000 000
2012/13	R734 000 000
2013/14	R1 021 000 000

The patient numbers for 2011/12 to 2013/14 were obtained from the NDOH. These included PTB, ETB, RR, MDR, and XDR cases. Refer to the section on TB above for the patient numbers and resultant costs.

The re-treatment cases were estimated as 12% of all the PTB cases, and their costs applied to those numbers. Note that the RR cases in the 2012/13 records appeared too low, so these were estimated as 23% of the total MDR/XDR cases (for 2012/13 only, as 2013/14 figures appeared correct)<sup>10</sup>. The same unit cost for MDR/XDR treatment was applied to the RR cases.

The costs of TB screening have not been estimated or included since no unit cost was available nor numbers undertaken in these past years. The diagnostic spending was taken from the TB Diagnostic Market Analysis Consortium's estimations (2015<sup>xi</sup>). These national estimates were split between the provinces based on their proportion of TB patients.

<sup>10</sup> The percentages that formed the retreatment cases and the RR cases were provided by K.Schnipple – personal communiqué.

G. Spending on HIV and TB in SA by source (US\$, 2011/12-2013/14)

Sources in USD	2011/12	2012/13	2013/14	Total US\$	% Share ('11)	% Share ('12)	% Share ('13)
PEPFAR	521 420 462	386 011 643	379 952 364	1 287 384 469	22%	20%	17%
SAG	1 790 758 784	1 752 479 190	1 827 635 282	5 370 873 256	76%	77%	80%
Global fund	28 880 175	49 530 291	68 036 995	146 447 461	1%	2%	3%
<b>Grand Total</b>	<b>2 341 059 420</b>	<b>2 188 021 125</b>	<b>2 275 624 641</b>	<b>6 804 705 186</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

H. Spending on HIV (excluding TB) by source (ZAR, 2011/12-2013/14)

Source of HIV funding	2011/12	2012/13	2013/14	Grand Total	% Share ('11)	% Share ('12)	% Share ('13)
PEPFAR	3 647 216 475	3 675 495 762	3 400 828 732	10 723 540 969	26%	23%	18%
SAG	10 140 135 261	11 760 513 912	14 325 911 988	36 226 561 160	72%	74%	78%
Global fund	214 389 089	420 631 044	661 639 365	1 296 659 499	2%	3%	4%
<b>Grand Total</b>	<b>14 001 740 825</b>	<b>15 856 640 718</b>	<b>18 388 380 085</b>	<b>48 246 761 629</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

I. Spending on TB (excluding HIV) by source (ZAR, 2011/12-2013/14)

Source of TB funding	2011/12	2012/13	2013/14	Grand Total	% Share ('11)	% Share ('12)	% Share ('13)
PEPFAR	223 496 183	225 229 097	294 094 020	742 819 300	7%	7%	8%
SAG	3 153 383 493	3 122 240 364	3 447 292 840	9 722 916 698	93%	93%	92%
<b>Grand Total</b>	<b>3 376 879 676</b>	<b>3 347 469 461</b>	<b>3 741 386 861</b>	<b>10 465 735 998</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

The USAID additional contributions to TB (not reported in the EA data): USG FY11 - \$13,972,000, USG FY12 - \$12,000,000, USG FY13 - \$12,008,901.

J. Total Spending according to the South African Investment Case Programme Areas (ZAR, %, 2011/12-2013/14)

Spending (ZAR)	2011/12	2012/13	2013/14	Grand Total	% Share ('11-13)
Care and treatment	6 409 216 707	7 485 878 382	8 892 967 961	22 788 063 051	39%
Comprehensive condom programming	46 533 198	211 891 054	175 406 347	433 830 599	1%
HCT	833 546 557	1 048 788 656	1 141 046 035	3 024 381 245	5%
HIV not disaggregated	96 005 160	137 979 411	287 337 033	520 321 604	1%
Key populations	237 471 479	274 924 351	248 853 952	761 249 782	1%
Medical male circumcision	408 514 701	379 441 921	556 686 471	1 354 643 092	2%
Other biomedical prevention	143 932 376	188 690 835	244 393 863	577 017 074	1%
PMTCT	590 055 927	472 239 901	483 086 386	1 545 382 215	3%
Programme Enablers	818 448 373	997 903 407	1 315 284 868	3 131 636 648	5%
Social behaviour change communication	247 211 514	262 726 025	319 492 166	829 429 706	1%
Social Enablers	1 693 432 074	1 522 875 270	1 395 408 130	4 611 715 475	8%
TB	3 603 642 421	3 517 875 121	4 082 497 592	11 204 015 134	19%
Non SA IC	2 244 001 565	2 702 445 194	2 964 893 219	7 911 339 978	13%
<b>Grand Total</b>	<b>17 378 620 501</b>	<b>19 204 110 177</b>	<b>22 129 766 945</b>	<b>58 712 497 623</b>	<b>100%</b>

\* 'non SA IC' refers to specific programmes that were not included in the SA IC list of programme areas but for which spending occurred.

K. Spending on the 'non-IC categories' (ZAR, 2011/12-2013/14)

Non-IC Activities	2011/12	2012/13	2013/14	Grand Total
CHBC	1 845 062 050	2 177 962 854	2 404 908 667	6 427 933 571
Palliative/hospice care	7 764 098	24 770 907	21 456 953	53 991 957
PE: Workforce (non-BAS)		32 385 009	16 137 096	48 522 105
Prevention not disagg	27 653 302	90 648 083	116 667 611	234 969 995
SDC	239 075 921	246 985 535	253 911 795	739 973 251
Training	82 003 891	106 927 551	122 854 030	311 785 472
Uniformed HIV services (DOD/SAPS)	39 165 566	21 465 172	27 253 819	87 884 557
Workplace prevention	3 275 737	1 300 084	1 703 248	6 279 070
<b>Grand Total</b>	<b>2 244 001 565</b>	<b>2 702 445 194</b>	<b>2 964 893 219</b>	<b>7 911 339 978</b>
<b>% of total HIV/TB spending</b>	<b>13%</b>	<b>14%</b>	<b>13%</b>	<b>13%</b>

L. All Public Expenditure on HIV and TB according to the SA IC Categories (ZAR, %, 2011/12-2013/14)

Public Spending According the to SA IC Categories (ZAR)	2011/12	2012/13	2013/14	Grand Total	% Share ('11-13)
Care and treatment	5 435 709 230	6 418 293 647	7 617 633 697	19 471 636 574	42.4%
Comprehensive condom programming	44 639 344	201 801 472	166 476 032	412 916 849	0.9%
HCT	515 198 199	655 021 646	716 380 961	1 886 600 806	4.1%
HIV not disaggregated	96 005 160	137 979 411	286 337 033	520 321 604	1.1%
Key populations	129 270 772	166 239 784	141 760 039	437 270 596	1.0%
Medical male circumcision	113 405 832	75 215 258	171 384 222	360 005 311	0.8%
Other biomedical prevention	7 825 938	51 529 073	56 249 390	115 604 400	0.3%
PMTCT	300 179 719	181 111 765	181 925 373	663 216 856	1.4%
Programme Enablers	217 679 678	375 431 593	884 131 363	1 477 242 634	3.2%
Social behaviour change communication	5 727 977	13 909 525	93 250 000	112 887 502	0.2%
Social Enablers	1 105 488 724	937 917 000	1 010 518 000	3 053 923 724	6.6%
TB	3 380 146 238	3 292 646 025	3 788 403 572	10 461 195 834	22.8%
Non SA IC	1 942 241 945	2 375 658 074	2 658 755 146	6 976 655 165	15.2%
<b>Grand Total</b>	<b>13 293 518 754</b>	<b>14 882 754 273</b>	<b>17 773 204 828</b>	<b>45 949 855 858</b>	<b>100%</b>

Source: BAS records (all departments): 2011/12 – 2013/14.

M. DOH Total Spending (CG and voted) on HIV, AIDS and TB (ZAR, %, 2011/12-2013/14)

Spending by Activity (ZAR)	2011/12	2012/13	2013/14	Grand Total	% Share ('11-13)
<b>HIV Sub-Total</b>	<b>8 924 243 429</b>	<b>10 601 612 387</b>	<b>12 922 297 819</b>	<b>32 448 153 632</b>	<b>75.6%</b>
ART Treatment	4 996 890 238	6 157 032 658	7 600 429 142	18 754 352 038	43.7%
CHBC	1 681 974 306	2 023 307 834	2 248 355 867	5 953 638 007	13.9%
Condoms	44 639 344	201 801 472	166 476 032	412 916 849	1.0%
HCT (or VCT)	515 198 199	655 021 646	716 380 961	1 886 600 806	4.4%
HIV not disagg	96 005 160	137 979 411	286 337 033	520 321 604	1.6%
HIV Treatment not disagg	438 818 992	261 260 989	17 204 556	717 284 537	1.7%
M&E		(90 797)*	102 127	11 330	0.0%
Mass media/soc.mob	5 727 977	13 909 525	93 250 000	112 887 502	0.3%
MMC	113 405 832	75 215 258	171 384 222	360 005 311	0.8%
OVC (DSD HIV support)	171 923 058**			171 923 058	0.4%
Palliative/hospice care	7 764 098	24 770 907	21 456 953	53 991 957	0.1%
PEP/ OPEP/ NOPEP	5 861 057	50 406 999	55 649 570	111 917 627	0.3%
Programme Mgmt	217 679 678	375 522 390	884 029 236	1 477 231 304	3.4%
PMTCT	300 179 719	181 111 765	181 925 373	663 216 856	1.5%
Prevention not disagg	27 654 302	90 648 083	116 667 611	234 969 995	0.5%
SDC	100 404 046	107 238 443	120 463 619	328 106 107	0.8%
STI	1 964 880	1 122 074	599 819	3 686 773	0.0%
Training	82 003 891	106 927 551	122 854 030	311 785 472	0.7%
Workplace prevention	3 275 737	1 300 084	1 703 248	6 279 070	0.0%
HTA*** (CSW & clients)	112 872 917	137 126 092	103 442 948	353 441 956	0.8%
Key pop prevention other nec.			13 585 474	13 585 474	0.0%
<b>TB Sub-Total</b>	<b>3 380 146 238</b>	<b>3 292 646 025</b>	<b>3 788 403 572</b>	<b>10 461 195 834</b>	<b>24.4%</b>
TB control/management/ surveys	35 915 782	31 430 556	70 224 101	137 570 439	0.3%
TB not disagg	80 645			80 645	0.0%
TB treatment (hospitals)	1 379 395 601	1 095 419 239	1 076 390 840	3 551 205 679	8.3%
TB XDR/MDR treatment	292 237 250	346 682 980	447 238 662	1 086 158 893	2.5%
TB/HIV (Integration)	226 762 744	170 405 661	341 110 731	738 279 136	1.7%
TB treatment (clinics or Outpatient -estimated)	998 754 215	914 707 589	853 439 237	2 745 901 041	6.4%
TB diagnostics (estimated)	447 000 000	734 000 000	1 021 000 000	2 202 000 000	5.1%
<b>Grand Total</b>	<b>12 304 389 667</b>	<b>13 894 258 411</b>	<b>16 710 701 392</b>	<b>42 909 349 470</b>	<b>100%</b>

Source: DOH (national and provincial) BAS records: 2011/12 – 2013/14.

\* M&E spending appears to have been mis-coded in the BAS records, as the NDOH reports that their M&E activities incurred greater expenditure than indicated here.

\*\* DOH contributed support (voted funds) to OVCs, linked to the DSD programme of OVC support.

\*\*\* HTA: High transmission areas – programmes for commercial sex workers & truck drivers/ other clients. OVC support – the DOH and DSD collaborate to provide these services

N. DOH CG for HIV per Province (ZAR, %, 2011/12-2013/14)

DOH CG Spending by Province (ZAR)	2011/12	2012/13	2013/14	Grand Total	% Share ('11-13)
KwaZulu Natal	1 907 366 212	2 226 707 196	2 652 217 482	6 786 290 890	26%
Gauteng	1 621 862 828	1 901 293 000	2 258 483 000	5 781 638 828	22%
Eastern Cape	877 556 346	1 040 502 202	1 299 291 850	3 217 350 399	12%
Western Cape	660 578 448	738 079 021	927 546 996	2 326 204 465	9%
Limpopo	570 739 506	690 396 332	860 670 717	2 121 806 555	8%
North West	488 987 851	463 040 801	825 302 000	1 777 330 652	7%
Free State	456 531 824	639 782 971	699 554 415	1 795 869 210	7%
Mpumalanga	448 558 509	586 097 000	690 591 000	1 725 246 509	7%
Northern Cape	214 058 678	229 683 977	302 258 876	746 001 532	3%
<b>Grand Total</b>	<b>7 246 240 201</b>	<b>8 515 582 501</b>	<b>10 515 916 337</b>	<b>26 277 739 039</b>	<b>100%</b>

Source: Provincial DOH BAS records: 2011/12 – 2013/14.

O. DOH Voted (ES) funds for HIV and TB (ZAR, 2011/12-2013/14)

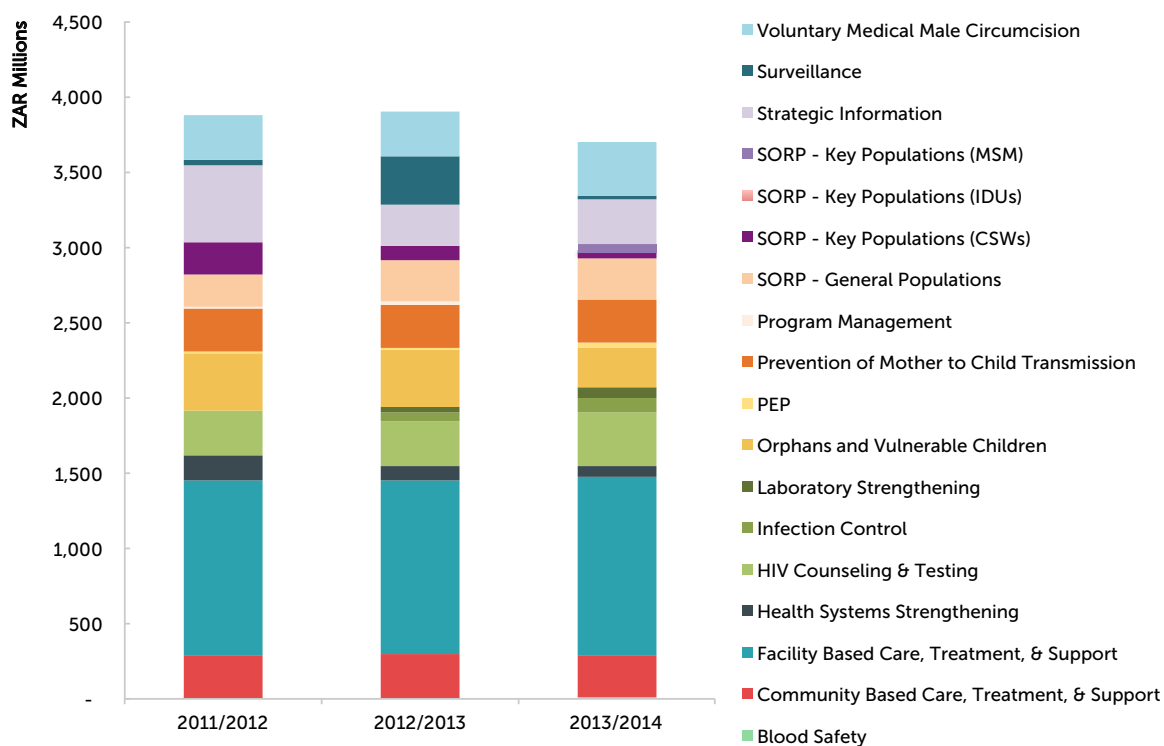
DOH Voted HIV and TB Activities	2011 /12	2012/13	2013/14	Grand Total	% Share ('11-13)
<b>HIV</b>	<b>1 701 558 463</b>	<b>2 258 577 176</b>	<b>2 761 743 293</b>	<b>6 721 878 932</b>	<b>40.4%</b>
ART Treatment	37 270 841	281 899 484	362 899 897	682 070 222	4.1%
CHBC (Community based services)	1 261 321 989	1 537 860 293	1 727 033 355	4 526 215 637	27.2%
Condoms	96 734	112 352 737	53 779 490	166 228 961	1.0%
HCT (or VCT)	667 561	1 344 493	22 155 074	24 167 128	0.1%
HIV not disagg	80 894 306	132 846 447	266 897 003	480 637 756	2.9%
HIV Treatment not disagg	52 752 909	(283 423)	649 628	53 119 114	0.3%
M&E		(90 797)	102 127	11 330	0.0%
Mass media/ soc.mob	5 727 977	13 909 525	93 250 000	112 887 502	0.7%
MMC	113 596	-	56 533	170 129	0.0%
OVC (DSD HIV support)*	171 923 058			171 923 058	1.0%
Palliative/hospice care	7 764 098	24 770 907	21 456 953	53 991 957	0.3%
PEP/OPEP/NOPEP	2 037 570	2 695 034	427 789	5 160 393	0.0%
PM	44 089 007	102 898 909	161 898 328	308 886 244	1.9%
PMTCT	314 030	104 323	327 501	745 854	0.0%
Prevention not disagg	27 654 302	18 646 068	17 637 447	63 837 816	0.4%
SDC	3 581 974	468 680	175 306	4 225 959	0.0%
STI	1 883 051	586 905	370 400	2 840 356	0.0%
Training	305 167	8 943 973	15 761 541	25 010 681	0.2%
Workplace prevention	3 068 430	1 300 084	1 703 248	6 071 762	0.0%
HTA (CSW & clients)	91 865	18 323 534	1 576 200	19 991 599	0.1%
Key pop prevention other nec.			13 585 474	13 585 474	0.1%
<b>TB</b>	<b>3 356 591 002</b>	<b>3 120 098 735</b>	<b>3 443 041 761</b>	<b>9 909 731 498</b>	<b>28.6%</b>
TB control/management/surveys	35 889 588	28 677 016	55 738 680	120 305 284	0.7%
TB treatment (hospitals)	1 379 395 601	1 095 416 331	1 076 406 550	3 551 218 482	21.4%
TB XDR/MDR treatment	292 237 250	346 682 980	447 238 662	1 086 158 893	6.5%
TB/HIV (Integration)	203 314 348	614 819	218 632	204 147 799	1.2%
TB treatment (clinics or Outpatient - estimated)	998 754 215	914 707 589	853 439 237	2 745 901 041	16.5%
TB diagnostics (estimated)	447 000 000	734 000 000	1 021 000 000	2 202 000 000	13.2%
<b>Grand Total</b>	<b>5 058 149 465</b>	<b>5 378 675 911</b>	<b>6 194 785 054</b>	<b>16 631 610 430</b>	<b>100.0%</b>

\* DOH contributed support (voted funds) to OVCs, linked to the DSD programme of OVC support.

P. PEPFAR Spending by the EA Thematic Areas (US\$, 2011/12-2013/14)

PEPFAR Spending (US\$)	2011/12	2012/13	2013/14	Grand Total	% in 2011/12	% in 2012/13	% in 2013/14
Care & Treatment	195 103 744	171 080 629	144 845 742	511 030 115	37%	37%	40%
OVC	51 253 089	45 148 866	25 774 241	122 176 196	10%	10%	7%
Prevention	177 024 919	156 727 659	148 561 475	482 314 053	34%	34%	41%
Systems Strengthening	98 038 710	86 362 339	46 464 225	230 865 273	19%	19%	13%
<b>Grand Total</b>	<b>521 420 462</b>	<b>459 319 493</b>	<b>365 645 683</b>	<b>1 346 385 637</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>

Q. PEPFAR Spending according to the EA Categories (ZAR millions, 2012/13-2013/14)



Source: PEPFAR EA data (2012/13 & 2013/14). The data for 2011/12 was estimated based on NASA 2010/11 and EA 2012/13.

R. PEPFAR Spending according to the EA Categories (US\$, 2012/13-2013/14)

PEPFAR EA Spending Categories (US\$)	2011/12	2012/13	2013/14	Grand Total	% in 2011/12	% in 2012/13	% in 2013/14
Blood Safety	438 601	386 364	1 100 345	1 925 310	0.1%	0.1%	0.3%
Community Based Care, Treatment, & Support	37 360 745	34 944 120	26 942 558	99 247 423	7.2%	7.6%	7.4%
Facility Based Care, Treatment, & Support	157 742 999	136 136 509	117 903 184	411 782 692	30.3%	29.6%	32.2%
Health Systems Strengthening	22 684 183	10 635 142	7 269 417	40 588 741	4.4%	2.3%	2.0%
HIV Counseling & Testing	40 072 127	35 299 553	34 573 340	109 945 019	7.7%	7.7%	9.5%
Infection Control	-	6 793 405	9 609 054	16 402 459	0.0%	1.5%	2.6%
Laboratory Strengthening	-	4 136 212	7 528 002	11 664 214	0.0%	0.9%	2.1%
Orphans and Vulnerable Children	51 253 089	45 148 866	25 774 241	122 176 196	9.8%	9.8%	7.0%
PEP	1 733 903	1 532 055	3 285 043	6 551 001	0.3%	0.3%	0.9%
Prevention of Mother to Child Transmission	37 436 118	33 333 142	28 720 393	99 489 653	7.2%	7.3%	7.9%
Program Management	2 410 329	2 123 260	-	4 533 589	0.5%	0.5%	0.0%
Sexual and Other Risk Prevention - General Populations	28 310 386	32 253 476	26 518 954	87 082 816	5.4%	7.0%	7.3%
Sexual and Other Risk Prevention - Key Populations (CSWs)	29 279 916	11 623 877	4 151 057	45 054 849	5.6%	2.5%	1.1%
Sexual and Other Risk Prevention - Key Populations (IDUs)	-	-	544	544	0.0%	0.0%	0.0%
Sexual and Other Risk Prevention - Key Populations (MSM)	-	-	5 041 257	5 041 257	0.0%	0.0%	1.4%
Strategic Information	68 248 761	32 078 269	29 478 138	129 805 169	13.1%	7.0%	8.1%
Surveillance	4 695 437	37 389 455	2 188 668	44 273 560	0.9%	8.1%	0.6%
Voluntary Medical Male Circumcision	39 753 869	35 505 787	35 561 488	110 821 144	7.6%	7.7%	9.7%
<b>Grand Total (US\$)</b>	<b>521 420 462</b>	<b>459 319 493</b>	<b>365 645 683</b>	<b>346 385 637</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>



S. Global Fund Spending according to their SDAs (US\$, 2012/13-2013/14)

GF Expenditure on SDA (US\$)	2011/12	2012/13	2013/14	Grand Total	% share ('11-13)
Antiretroviral treatment (ARV) and monitoring	4 394 580	13 329 052	37 662 107	55 385 739	38.5%
Care and support for the chronically ill	3 094 716	1 740 289	1 764 189	6 599 194	4.6%
Combination Prevention-Prisoners	-	-	362 119	362 119	0.3%
Combination prevention-Low Socio Economic population	-	-	185 697	185 697	0.1%
Combination Prevention-MSM and LGBTI	-	-	29 572	29 572	0.0%
Commercial Sex Workers	283 730	221 686	356 950	862 366	0.6%
Community-based response to the HIV and TB epidemics	76 477	11 958	433 949	522 385	0.4%
CSS: Human resources: skills building for service delivery, advocacy and leadership	-	195 577	657 454	853 031	0.6%
CSS: Management, accountability and leadership	-	34 131	128 965	163 096	0.1%
Enabling Environment	-	-	207 193	207 193	0.1%
HIV & TB case finding	-	1 428 196	7 635 268	9 063 464	6.3%
HIV Care & Support	-	-	110 651	110 651	0.1%
HIV Drug resistance monitoring and prevention	-	110 519	814 496	925 015	0.6%
HSS: Community Systems Strengthening	373 725	306 660	329 563	1 009 948	0.7%
HSS: Health Workforce	-	3 813 411	1 596 910	5 410 321	3.8%
HSS: Monitoring and Evaluation	240 665	430 930	166 412	838 007	0.6%
HSS: Other	59 017	-	27 345	86 362	0.1%
Institutional support and programme management for SRs and PR	342 858	267 950	333 845	944 653	0.7%
Medical male circumcision	-	804 204	3 568 723	4 372 927	3.0%
Men Who Have Sex with Men	157 998	75 108	90 626	323 732	0.2%
Out of School Youth	74 562	223 634	149 072	447 268	0.3%
Palliative and step-down care in-patient services	117 848	3 196	88 271	209 315	0.1%
Peer education programme amongst youth in secondary schools	50 528	3 981	-	54 509	0.0%
People with Disabilities (PWD)	383 022	295 954	78 160	757 136	0.5%

<b>GF Expenditure on SDA (US\$)</b>	<b>2011/12</b>	<b>2012/13</b>	<b>2013/14</b>	<b>Grand Total</b>	<b>% share (‘11-13)</b>
PMTCT	1 612 864	1 303 529	1 082 185	3 998 578	2.8%
Prevention: Behavioral Change Communication - community outreach	4 264 337	2 808 270	798 345	7 870 952	5.5%
Prevention: Behavioral Change Communication - Mass media	660 564	2 107 083	-	2 767 647	1.9%
Prevention: Condom distribution	108 557	1 058 965	-	1 167 522	0.8%
Program management and administration	1 997 657	4 191 287	1 090 954	7 279 898	5.1%
Support for orphans and vulnerable children	3 978 837	2 990 226	3 513 147	10 482 210	7.3%
Supportive environment: Policy development including workplace policy	893 318	335 690	278 521	1 507 530	1.0%
Supportive environment: Stigma reduction in all settings	882	2 078	-	2 960	0.0%
Supportive environment: Strengthening of civil society and institutional capacity building	2 619 616	1 576 204	1 154 624	5 350 444	3.7%
Testing and Counseling	2 812 314	9 639 239	435 212	12 886 765	9.0%
Women at Risk, Including those affected by GBV and risk through occupation	281 502	221 283	344 613	847 398	0.6%
<b>Grand Total</b>	<b>28 880 175</b>	<b>49 530 291</b>	<b>65 475 138</b>	<b>143 885 604</b>	<b>100%</b>

T. SA HIV and TB spending by NASA Categories (for GARPR reporting), ZAR in 2013/14

NASA Categories	Global fund	PEPFAR	SAG	Grand Total
ASC.01.01.98 Communication for Social and behavioural change not disaggregated by type	5 205 935	221 036 231	93 250 000	319 492 166
ASC.01.03 Voluntary counselling and testing (VCT) & ASC.02.01.01 Provider-initiated testing and counselling (PITC)	81 553 812	343 111 261	716 380 961	1 141 046 035
ASC.01.04.98 Programmatic programmes for vulnerable and accessible population not disaggregated by type		18 148 594	13 585 474	31 734 068
ASC.01.04.98 Programmatic programmes for vulnerable and accessible population not disaggregated by type			27 253 819	27 253 819
ASC.01.04.99 Other Programmatic programmes for vulnerable and accessible population not elsewhere classified	2 666 334			2 666 334
ASC.01.04.99 Other programmatic programmes for vulnerable and accessible populations not elsewhere classified (n.e.c.)	3 659 290		24 731 618	28 390 907
ASC.01.05 Prevention – youth in school & ASC.01.06 Prevention – youth out-of-school	4 367 905		204 000 000	208 367 905
ASC.01.08.01-.98 Programmatic programmes for sex workers and their clients not disaggregated by type	3 607 056	23 656 657	103 442 948	130 706 660
ASC.01.09.01-.98 Programmatic programmes for MSM not disaggregated by type	1 214 618	49 767 965		50 982 583
ASC.01.10.01-.98 Programmatic programmes for IDUs not disaggregated by type		5 495		5 495
ASC.01.11.01-.99 Programmatic programmes in the workplace			1 703 248	1 703 248
ASC.01.13 Public and commercial sector male condom provision	-	8 930 315	166 476 032	175 406 347
ASC.01.15 Microbicides		143 958 336		143 958 336
ASC.01.16 Prevention, diagnosis and treatment of sexually transmitted infections (STI)			599 819	599 819
ASC.01.17.98 PMTCT not disaggregated by programme	10 935 695	290 225 318	181 925 373	483 086 386
ASC.01.18 Male circumcision	36 062 662	359 239 587	171 384 222	566 686 471
ASC.01.19 Blood safety		11 119 205		11 119 205

NASA Categories	Global fund	PEPFAR	SAG	Grand Total
ASC.01.22.01-.99 Post-exposure prophylaxis		33 066 932	55 649 570	88 716 503
ASC.01.98 Prevention activities not disaggregated by programme			116 667 611	116 667 611
ASC.02.01.02.02 OI outpatient Treatment (TB is presented below)		234 508 114		234 508 114
ASC.02.01.03.98 Antiretroviral therapy not disaggregated neither by age nor by line of treatment	380 583 120	907 045 919	7 600 429 142	8 888 058 180
ASC.02.01.09 Home-based care	23 104 624	266 896 352	2 368 819 487	2 658 820 463
ASC.02.02.02 Inpatient palliative care & ASC.02.01.08 Outpatient palliative care			21 456 953	21 456 953
ASC.02.98 Care and treatment services not disaggregated by programme	1 118 148		17 204 556	18 322 704
ASC.03.01-.99 OVC services	35 501 048	255 090 280	806 518 000	1 097 109 328
ASC.04.01 Planning, coordination and programme management	14 115 148	78 988 143	884 029 236	977 132 527
ASC.04.03 Monitoring and evaluation	1 681 622	314 470 175	102 127	316 253 924
ASC.04.05 Serological-surveillance (serosurveillance)	8 230 642	76 071 967		76 071 967
ASC.05.03 Training			122 854 030	122 854 030
ASC.05.99 Human resources n.e.c.	16 137 096			16 137 096
ASC.07.01-.99 Enabling environment	8 737 434			8 737 434
ASC.07.03 AIDS-specific institutional development	19 674 787			19 674 787
ASC.07.05 Programmes to reduce Gender Based Violence	3 482 388			3 482 388
ASC.98 HIV not disaggreg			286 337 033	286 337 033
TB control (non NASA)			70 224 101	70 224 101
TB diagnosis (non NASA)			1 021 000 000	1 021 000 000
TB Treatment (ASC.02.01.02.02)		294 094 020	2 121 560 625	2 415 654 645
TB/HIV Integration (non NASA)			341 110 731	341 110 731
<b>Grand Total</b>	<b>661 639 365</b>	<b>3 694 922 752</b>	<b>17 773 204 828</b>	<b>22 129 766 946</b>

## U. SA HIV and TB spending by System of Health Accounts (SHA) Categories

The expenditure mapping applied the following SHA dimensions:

- ✓ Sub-national level (SNL);
- ✓ Institutional units providing revenues to financing schemes (FS.RI);
- ✓ Revenues of health care financing schemes (FS);
- ✓ Financing agents (FA);
- ✓ Financing schemes (HF);
- ✓ Health care function (HC);
- ✓ Classification of disease (DIS);
- ✓ Beneficiaries (BEN).

The mapping did not analyze the expenditure by service/ health provider (HP), nor by production factor (FP).

Importantly, the disaggregation of the HIV and TB interventions (health care functions) was first undertaken according to the South African categories used in their public finance system (BAS), and according to the Investment Case (IC) list of priority interventions. The GF spending by intervention was obtained from their principle recipients (PRs) Expanded Financial Reports (EFRs), while the PEPFAR spending was obtained from their Expenditure Analysis (EA) data, and these were matched to the BAS and IC categories. Thereafter the data were cross-walked to the National AIDS Spending Assessment (NASA) AIDS Spending Categories (ASC) and to the NHA health care functions (HC).

Equally important, the consolidated database of the three sources was created within the public finance (BAS) structure, applying the BAS dimensions and creating full financial transactions (as per the NASA and SHA methodology) to avoid double counting and to allow for the creation of the SHA bivariate matrices. Applying the BAS structure will hopefully make it easier for the SAG to continue to undertake this consolidation on a routine basis, rather than adopting another software, which often does not get sustained by public officials.

### Cross-walking the BAS categories to SHA dimensions

The crosswalk was guided by the System of Health Accounts (SHA) 2011 Manual WHO and the WHO excel file providing the NASA-SHA cross-walk, as well as with discussion with the WHO-SA, to ensure compatibility with their agreed dimensions.

The majority of the interventions / health care functions were mapped to the HC codes as per the SHA-NASA crosswalk (which was being finalized with UNAIDS at the time of the analysis, hence changes might have been required). All the HIV interventions were also labeled with DIS.1.1.1.

HIV/AIDS and other STIs, while all the TB interventions were labeled as DIS.1.2.nec Unspecified TB.

The following activities were labelled as **Non-NHA activities**: advocacy, legal/ policy reform, OVC, youth interventions, poverty alleviation, gender based violence reduction, social protection, stigma reduction, community/institutional development, workplace interventions, and blood safety. Since there were only three sources of funding included in this mapping, the following were applied for the FS.RI, FS, FA and HF codes:

#### BAS Matching Variable (for public revenue only):

FS.RI = Fund_Level 3-6 (included only public revenue)	FS = Fund_ Level 3-6	FA = Department	HF = all Central government schemes (since only applied BAS for public funds)	HC = Sub- Programme_ Level_6 and Objective_ Level_7	SNL = National_Provincial
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#### SAG funds to NDOH:

FS.RI.1.1. Government	FS.1. Transfers from government domestic revenue	FA.1.1.1. Ministry of Health	HF.1.1.1. Central government schemes
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#### SAG funds to provincial DOH (voted/ equitable share):

### BAS Matching Variable (for public revenue only):

FS.RI.1.1. Government	FS.1. Transfers from government domestic revenue	FA.1.2.1. Provincial Ministry of Health	HF.1.1.2.1. Provincial government (for the ES/voted)
<b>SAG conditional grants to provincial DOH:</b>			
FS.RI.1.1. Government	FS.1. Transfers from government domestic revenue	FA.1.2.1. Provincial Ministry of Health	<b>HF.1.1.1. Central government schemes (for the CG)</b>
<b>SAG funds to other Departments:</b>			
FS.RI.1.1. Government	FS.1. Transfers from government domestic revenue	FA.1.1.2 = Correctional services; FA.1.1.3= DBE; FA.1.1.4 = DSD; FA.1.1.5= Defense; FA.1.1.6= SAPS ; FA.1.1.7 not yet assigned	HF.1.1.1. Central government schemes for the CG to DOE, the other departments were HF.1.1.2.1. Provincial government (for the ES/voted)

BEN codes applied:

Code	Name
BEN.1	Sex Workers
BEN.2	Men who have sex with men
BEN.3	Transgender people
BEN.4	Injecting drug users (IDUs)
BEN.5	Serodiscordant couples
BEN.6	Mothers and Children
BEN.7	Clients of STD Clinics
BEN.8	Mobile and displaced populations
BEN.9	Uniformed and institutionalized pop
BEN.10	Orphans and Vulnerable Children (O
BEN.11	Other key populations

NB. TB patients were labelled as BEN.11. Other key populations, with the DIS.1.2.nec Unspecified TB. Where the spending on key populations could not be disaggregated by SW/MSM/IDU, these were also labelled as BEN.11. BEN.9. Uniformed and institutionalized populations was applied to the programmes for correctional facility inmates (prisoners). BEN.nec. Other and unspecified beneficiaries (n.e.c.) was applied to programmes which are non-targetted, such as M&E, surveillance, etc.

### SA NHA findings for HIV and TB from 3 sources: SAG, GF & PEPFAR, ZAR (2011-2013)

SNL. (ZAR)	2011	2012	2013	Grand Total
SNL.1. National	928 623 398	914 228 116	1 135 481 055	2 978 332 569
SNL.2.1 ec Eastern Cape Province	2 268 034 377	2 492 927 007	2 765 828 505	7 526 789 890
SNL.2.2 fs Free State Province	1 058 076 751	1 252 079 178	1 349 588 468	3 659 744 396
SNL.2.3 gp Gauteng Province	3 238 616 721	3 357 668 395	3 592 724 511	10 189 009 627
SNL.2.4 kz KwaZulu-Natal Province	3 826 947 503	4 407 819 486	4 983 819 036	13 218 586 026
SNL.2.5 lp Limpopo Province	1 017 401 634	1 156 168 103	1 344 134 948	3 517 704 684
SNL.2.6 mp Mpumalanga Province	1 015 078 861	1 203 823 462	1 426 440 097	3 645 342 420
SNL.2.7 nc North West Province	843 497 806	766 520 793	1 382 204 732	2 992 223 331
SNL.2.8 nc Northern Cape Province	355 286 436	342 086 631	494 006 002	1 191 379 068
SNL.2.9 wc Western Cape Province	1 362 919 296	1 606 853 931	1 900 202 129	4 869 975 356
SNL.2.nec Other Province (not disaggregated)	1 169 459 306	1 406 971 824	1 635 444 761	4 211 875 891
SNL.9 Other (above national)	294 678 413	296 963 250	119 892 701	711 534 364
<b>Grand Total</b>	<b>17 378 620 501</b>	<b>19 204 110 177</b>	<b>22 129 766 945</b>	<b>58 712 497 623</b>

DIS. (ZAR)	2011	2012	2013	Grand Total
DIS.1.1.1. HIV/AIDS and other STIs	14 001 740 825	15 856 640 716	18 388 380 084	48 246 761 625
DIS.1.2.nec. Unspecified TB	3 376 879 676	3 347 469 461	3 741 386 861	10 465 735 998
<b>Grand Total</b>	<b>17 378 620 501</b>	<b>19 204 110 177</b>	<b>22 129 766 945</b>	<b>58 712 497 623</b>

FS.RI. (ZAR)	2011	2012	2013	Grand Total
FS.RI.1.1. Government	13 293 518 754	14 882 754 273	17 773 204 828	45 949 477 855
FS.RI.1.5.2.8. Multilateral donors: GF	214 389 089	420 631 044	661 639 365	1 296 659 499
FS.RI.1.5.1.25. Bilateral donors: USG	3 870 712 658	3 900 724 859	3 694 922 752	11 466 360 269
<b>Grand Total</b>	<b>17 378 620 501</b>	<b>19 204 110 177</b>	<b>22 129 766 945</b>	<b>58 712 497 623</b>

FS. (ZAR)	2011	2012	2013	Grand Total
FS.1. Transfers from government domestic revenue	13 293 518 754	14 882 754 273	17 773 204 828	45 949 477 855
FS.7. Direct foreign transfers	4 085 101 748	4 321 355 903	4 356 562 117	12 763 019 768
<b>Grand Total</b>	<b>17 378 620 501</b>	<b>19 204 110 177</b>	<b>22 129 766 945</b>	<b>58 712 497 623</b>

FA. (ZAR)	2011	2012	2013	Grand Total
FA.1.1.1. Ministry of Health	219 897 555	200 007 051	394 191 888	814 096 494
FA.1.1.2. Other ministries and public units	989 129 087	988 495 865	1 062 503 437	3 040 128 389
FA.1.2.1. Provincial Department of Health	12 084 492 111	13 694 251 357	16 316 509 503	42 095 252 972
FA.1.9.nec. All other government units (CCM)	214 389 089	420 631 044	661 639 365	1 296 659 499
FA.6.2.Foreign governments	3 870 712 658	3 900 724 859	3 694 922 752	11 466 360 269
<b>Grand Total</b>	<b>17 378 620 501</b>	<b>19 204 110 177</b>	<b>22 129 766 945</b>	<b>58 712 497 623</b>

HF. (ZAR)	2011	2012	2013	Grand Total
HF.1.1.1. Central government schemes (for the CG)	7 435 240 201	8 718 582 497	10 719 916 337	26 873 739 035
HF.1.1.2.1. Provincial government (for the ES/voted)	5 858 278 552	6 164 171 776	7 053 288 491	19 075 738 819
HF.4.2.2.2. Foreign development agency schemes	4 085 101 748	4 321 355 903	4 356 562 117	12 763 019 768
<b>Grand Total</b>	<b>17 378 620 501</b>	<b>19 204 110 177</b>	<b>22 129 766 945</b>	<b>58 712 497 623</b>

HC. (ZAR)	2011	2012	2013	Grand Total
HC.1.1. Curative inpatient care	1 379 395 601	1 095 419 239	1 076 390 840	3 551 205 679
HC.1.3. Curative outpatient care	1 291 072 110	1 261 390 569	1 279 677 900	3 832 140 580
HC.1.3.1. Curative outpatient care: ART	5 977 006 164	7 225 068 044	8 888 058 180	22 090 132 388
HC.1.nec. Unspecified curative care	758 320 334	624 469 497	598 753 757	1 981 543 588
HC.3.1. In-patient long-term care (health)	7 764 098	24 770 907	21 456 953	53 991 957
HC.3.4. Home-based long-term care (health)	2 084 137 971	2 424 948 388	2 658 820 463	7 167 906 822
HC.5.1.3 Pharmaceuticals and other medical non-durable good: condoms	46 533 198	211 891 054	175 406 347	433 830 599
HC.5.1.3 Pharmaceuticals and other medical non-durable goods (including microbicides)	119 979 069	120 909 346	143 958 336	384 846 751
HC.6.1. Information, education & counseling (IEC) programmes	247 211 514	262 726 025	319 492 166	829 429 706
HC.6.3. Early disease detection programmes (Including: HCT/VCT, all Key Pop interventions, TB prevention (IPT) and diagnosis.	2 124 070 555	2 588 935 009	2 978 934 791	7 691 940 355

HC. (ZAR)	2011	2012	2013	Grand Total
HC.6.5. Epidemiological surveillance & risk & disease control programmes	34 856 104	36 064 942	84 302 610	155 223 655
HC.6.5.4.1. Disease control programmes: MMC	408 514 701	379 441 921	566 686 471	1 354 643 092
HC.6.nec. Unspecified preventive care	27 654 302	90 648 083	116 667 611	234 969 995
HC.7.1.1. Planning & Management	513 080 447	630 984 266	1 306 388 379	2 450 453 092
HC.7.1.2. Monitoring & Evaluation (M&E)	508 424 408	514 134 986	316 253 924	1 338 813 319
HKR.5. Education and training of HR	82 003 891	106 927 551	122 854 030	311 785 472
Non NHA category	1 768 596 033	1 605 380 349	1 475 664 190	4 849 640 572
<b>Grand Total</b>	<b>17 378 620 501</b>	<b>19 204 110 177</b>	<b>22 129 766 945</b>	<b>58 712 497 623</b>

(NB. The HKR.5 category is not normally included in this HC list, but since we did not do FP, it is included here so can be seen by SAG.

BEN. (ZAR)	2011	2012	2013	Grand Total
BEN.1. Sex Workers	114 979 158	139 008 738	130 706 660	384 694 556
BEN.2. Men who have sex with men	1 172 882	637 847	50 982 583	52 793 312
BEN.4. Injecting drug users (IDUs)			5 495	5 495
BEN.6. Mothers and Children	590 055 927	472 239 901	483 086 386	1 545 382 215
BEN.7. Clients of STD Clinics	1 964 880	1 122 074	599 819	3 686 773
BEN.9. Uniformed and institutionalized populations (correctional facilities inmates)	16 397 855	29 113 693	28 390 907	73 902 455
BEN.10. Orphans and Vulnerable Children (OVC)	1 326 497 404	1 143 733 432	1 097 109 328	3 567 340 164
BEN.11. Other key populations	3 537 189 835	3 554 664 164	3 991 900 195	11 083 754 195
BEN.12. People living with HIV	8 507 727 225	9 936 048 328	11 586 658 299	30 030 433 852
BEN.13. General population	2 075 638 175	2 561 506 419	2 863 094 723	7 500 239 317
BEN.nec. Other and unspecified beneficiaries (n.e.c.)	1 206 997 158	1 366 035 580	1 897 232 549	4 470 265 288
<b>Grand Total</b>	<b>17 378 620 501</b>	<b>19 204 110 177</b>	<b>22 129 766 945</b>	<b>58 712 497 623</b>

HC x FS. 2013. (ZAR)	FS.1. Transfers from government domestic revenue	FS.7. Direct foreign transfers	Grand Total	Public %	Foreign %
	HC.1.1. Curative inpatient care	1 076 390 840		1 076 390 840	6%
HC.1.3. Curative outpatient care	1 279 677 900		1 279 677 900	7%	0%
HC.1.3.1. Curative outpatient care: ART	7 600 429 142	1 287 629 038	8 888 058 180	43%	30%
HC.1.nec. Unspecified curative care	303 541 589	295 212 168	598 753 757	2%	7%
HC.3.1. In-patient long-term care (health)	21 456 953		21 456 953	0%	0%
HC.3.4. Home-based long-term care (health)	2 368 819 486	290 000 976	2 658 820 463	13%	7%
HC.5.1.3 Pharmaceuticals and other medical non-durable good: condoms	166 476 032	8 930 315	175 406 347	1%	0%
HC.5.1.3 Pharmaceuticals and other medical non-durable goods		143 958 336	143 958 336	0%	3%
HC.6.1. Information, education & counseling (IEC) programmes	93 250 000	226 242 166	319 492 166	1%	5%
HC.6.3. Early disease detection programmes	2 117 315 763	861 619 028	2 978 934 791	12%	20%
HC.6.5. Epidemiological surveillance & risk & disease control programmes		84 302 610	84 302 610	0%	2%



HC x FS. 2013. (ZAR)	FS.1. Transfers from government domestic revenue	FS.7. Direct foreign transfers	Grand Total	Public %	Foreign %
HC.6.5.4.1. Disease control programmes: MMC	171 384 222	395 302 249	566 686 471	1%	9%
HC.6.nec. Unspecified preventive care	116 667 611		116 667 611	1%	0%
HC.7.1.1. Planning & Management	1 295 364 068	11 024 311	1 306 388 379	7%	0%
HC.7.1.2. Monitoring & Evaluation (M&E)	102 127	316 151 797	316 253 924	0%	7%
HKR.5. Education and training of HR	122 854 030		122 854 030	1%	0%
Non NHA category	1 039 475 067	436 189 123	1 475 664 190	6%	10%
<b>Grand Total</b>	<b>17 773 204 828</b>	<b>4 356 562 117</b>	<b>22 129 766 945</b>	<b>100%</b>	<b>100%</b>

HCxDIS. 2013. (ZAR)	DIS.1.1.1. HIV/AIDS and other STIs	DIS.1.2.nec. Unspecified TB	Grand Total	HIV %	TB %
HC.1.1. Curative inpatient care		1 076 390 840	1 076 390 840	0%	29%
HC.1.3. Curative outpatient care		1 279 677 900	1 279 677 900	0%	34%
HC.1.3.1. Curative outpatient care: ART	8 888 058 180		8 888 058 180	48%	0%
HC.1.nec. Unspecified curative care	304 659 737	294 094 020	598 753 757	2%	8%
HC.3.1. In-patient long-term care (health)	21 456 953		21 456 953	0%	0%
HC.3.4. Home-based long-term care (health)	2 658 820 463		2 658 820 463	14%	0%
HC.5.1.3 Pharmaceuticals and other medical non-durable good: condoms	175 406 347		175 406 347	1%	0%
HC.5.1.3 Pharmaceuticals and other medical non-durable goods	143 958 336		143 958 336	1%	0%
HC.6.1. Information, education & counseling (IEC) programmes	319 492 166		319 492 166	2%	0%
HC.6.3. Early disease detection programmes	1 957 934 791	1 021 000 000	2 978 934 791	11%	27%
HC.6.5. Epidemiological surveillance & risk & disease control programmes	84 302 610		84 302 610	0%	0%
HC.6.5.4.1. Disease control programmes: MMC	566 686 471		566 686 471	3%	0%
HC.6.nec. Unspecified preventive care	116 667 611		116 667 611	1%	0%
HC.7.1.1. Planning & Management	1 236 164 278	70 224 101	1 306 388 379	7%	2%
HC.7.1.2. Monitoring & Evaluation (M&E)	316 253 924		316 253 924	2%	0%
HKR.5. Education and training of HR	122 854 030		122 854 030	1%	0%
Non NHA category	1 475 664 190		1 475 664 190	8%	0%
<b>Grand Total</b>	<b>18 388 380 084</b>	<b>3 741 386 861</b>	<b>22 129 766 945</b>	<b>100%</b>	<b>100%</b>

All other bivariate matrices are available if required.

## References

- i. SANAC, 2014. Progress Report On The National Strategic Plan For HIV, TB, And STIs (2012-2016). Pretoria: SANAC. [www.sanac.org.za](http://www.sanac.org.za)
- ii. *ibid.*
- iii. Schwartländer, B, et al. 2011. Towards An Improved Investment Approach For An Effective Response To HIV/AIDS. *Lancet* 377:2031-41.
- iv. UNAIDS, 2011. A New Investment Framework For HIV. <http://www.unaids.org/sites>
- v. SANAC. 2012. The National AIDS Spending Assessment (2007/08 to 2010/11). [www.sanac.org.za](http://www.sanac.org.za)
- vi. Ndlovu N, Vilakazi M, Majozi M, Sithole F, Mbatha K, Guthrie T. 2013. Trends In National And Provincial Health And HIV/AIDS Budgeting And Spending In South Africa. CEGAA Occasional Paper 2013-1. [www.cegaa.org](http://www.cegaa.org)
- vii. Ndlovu, N., Meyer-Rath, G. 2014. Reflecting On Health, HIV/AIDS And TB Budgets And Services In South Africa: Review of the 2014 South African National Budget. Budget Policy Brief 6. CEGAA & HERO.
- viii. Results for Development. 2014. PEPFAR-South African government Joint AIDS Expenditure & Budget Report.
- ix. South African government And United States Government. Partnership Framework Implementation Plan (PFIP). 2012
- x. TB Facts. 2015. TB in South Africa | National & Provincial Statistics. <http://www.tbfacts.org/tb-statistics-south-africa.html>
- xi. TB Diagnostic Market Analysis Consortium, 2015. [www.tbevidence.org/resource-center/market-analyses/](http://www.tbevidence.org/resource-center/market-analyses/)





1111 19th Street NW, Suite 700

Washington, DC 20036

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