Health Paper
FUNDING THE FIGHT AGAINST HIV/AIDS

Sources and Methods of Funding the Health Sector Response to HIV/AIDS

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Executive Summary

This paper analyses the mechanisms by which the public health sector resources the fight against HIV/AIDS—drawing from interview-based case studies of the national health department and five provincial health departments.

In the public health sector resources tend to flow from centralised units located in health departments to a range of spending agents outside and inside the sector.

The national unit, the HIV/AIDS Chief Directorate in the national Department of Health, receives the bulk of its funding out of the general allocation made to the health department during the national budgeting process. The unit also houses a national programme aimed primarily at the provincial level and funded by a top slice of the national budget, the National Integrated Plan (NIP). At the national level, the national Chief Directorate for HIV/AIDS:

- directly runs a national social mobilisation and media campaign,
- provides grant funding to nationally based NGOs providing HIV/AIDS information, education and communication (IEC) services, and;
- outsources a variety of targeted projects to particular NGOs

At the provincial level, the Chief Directorate:

- manages the transfer of conditional grants for the NIP's three programmes—volunteer testing and counselling, Life Skills programmes in schools, and community and home-based care and support,
- provides grant funding to provincially-based NGOs providing IEC services,
- funds a number of particular provincial posts, and;
- directs certain in-kind resources at provincial units e.g. condoms

Provincial units can be health-based in their focus or can focus on building or co-ordinating an interdepartmental HIV/AIDS response in their province. In the first case, units receive resources from the national units and from the general allocation made to the health department in which they reside. In the second case, units receive additional resources from a top slice of the general provincial budget.[1]

Provincial HIV/AIDS units:

- Provide in-kind support to interdepartmental forums
- Directly implement a number of projects themselves. (These are often IEC-types projects in which granting funding is provided to NGOs to carry out projects.)
- Provide technical and policy support for established projects or services run by health delivery institutions, and monitor and evaluate these projects.

[1] Top-slicing is the practice of setting aside amount of money from the National Revenue Fund before the remaining funds are split up into the equitable shares of national, provincial and local governments (the vertical split).

- Manage and fund the implementation of new interventions in health delivery institutions i.e. health regions or districts, including providing grant funding to NGOs who are commonly seen as the key spending agents in new interventions.
- Decentralise funding to regions for the implementation of unit-identified projects.

We identified a number of key problems:

- Despite efforts of interdepartmental AIDS units in some provinces, departments outside the Department of Health are slow to mainstream HIV/AIDS into their budgeting and service delivery.

- In order for AIDS units to promote mainstreaming, they must be able to monitor and track expenditure in their projects accurately and with a fine level of detail. Financial information and management systems currently used make this very difficult.

- Many provincial units have received massive increases in funding over the past year or two despite a history of underspending in these units. This practice tends to encourage very crude costing and project resource assignment without careful planning.

- NGOs are seen as key spending agents in the units' programmes, yet many NGOs are new and often lack financial management, experience, and know-how, and thus may not be able to spend resources effectively and efficiently in the short term. Government must direct resources towards rapidly building the capacity of these NGOs.

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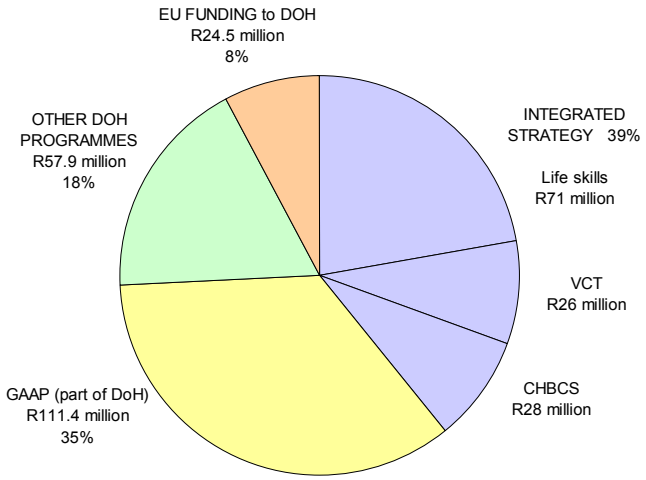
I. Introduction

The predominant enterprise in the health sector's response to HIV/AIDS is the National Integrated Plan, which was described in some detail in the preceding paper. Although theoretically the NIP is an interdepartmental strategy, spearheaded for now by the national level, the national Department of Health is playing a larger role than the other departments. The DoH houses many of the NIP staff and carries a large burden of co-ordination for all three programmes—VCT, CHBC, and Life Skills.

However the National Integrated Plan is not the only set of interventions run by the DoH to combat HIV/AIDS and mitigate its impact. The Chief Directorate for HIV/AIDS and STDs in the DoH conducted HIV/AIDS programmes prior to the launch of the NIP and continues to have units and projects aside from the NIP.

Figure 1 provides an overall idea of national level spending on HIV/AIDS. Besides the Integrated Strategy, the Government AIDS Action Plan is a key government HIV/AIDS programme. It is a national public awareness programme centred in the Chief Directorate. The graph shows how other DoH programmes and donor money from the European Union essentially make up the balance of the national money directed to HIV/AIDS.

Figure 1. 2001/02 National HIV/AIDS allocations
R318.9 million



The aim of this paper is to describe and analyse the allocation and spending processes for HIV/AIDS programmes run by the national Department of Health and provincial AIDS units. Since the National Integrated Plan programmes and spending mechanisms are covered carefully in the preceding paper, this paper focuses on the non-NIP health interventions.

Five provincial case studies, as well as research on the Chief Directorate, underpin this analysis. The provinces selected—largely on availability of data—were KwaZulu-Natal, Gauteng, Northern Province, Eastern Cape, and the Free State. Research was conducted via interviews with key programme and finance staff, both from DoH and Treasury, as well as study of internal policy documents and business plans. Unfortunately, difficulty with accessing staff and collecting data make the level of detail and understanding uneven across provinces and leave information gaps in the survey.

The first section of this paper covers the activities of the national Department of Health, besides the National Integrated Plan. (The NIP programmes and funding processes are covered in the preceding paper.) It first describes the structure and function of the Chief Directorate, and then lists the sources of national level funds. It concludes by summarising the funding mechanisms used in the Chief Directorate.

The second half of the paper focuses on the provincial level. Similarly, it first lays out the structures involved in HIV/AIDS co-ordination and service delivery at the provincial level. It then proceeds to describe the two primary sources of funding—nationally sourced resources, and provincially sourced funding streams.

Our final section covers the whole health sector—national and provincial—to draw out some of the key obstacles or challenges in the system right now which are obstructing the efficient and effective delivery of resources to spending agents when it comes to HIV/AIDS programmes.

Before proceeding, we briefly address the policy documents which guide the government response to the epidemic in the health sector. The relevant policy document for the national DoH is the NIP (although not all DoH programmes and units fall under the NIP), and the provinces are ostensibly being guided by the NIP, as well as strategies and business plans they develop for their specific province.

However, instead of possessing a comprehensive strategy, most of the provincial health departments studied have a set of plans for a collection of interventions. Except in the case of Gauteng, provinces appear to have used the SA HIV/AIDS strategy as a menu of intervention options.[2] In reality, provinces seem to be treating the current period as an experiment, with the immediate objectives of determining:

- costs of interventions;
- capacity implications for up-scaling;
- demand for the interventions, and;
- the extent to which the new interventions can replace the existing mainstream ones.

In this paper, we categorise the provincial 'strategies' as health centred, or interdepartmental.

- **Health-centred strategies** include activities which are not strictly health interventions, but are clustered around health because historically HIV/AIDS was considered a health issue.
- **Interdepartmental strategies** differ from health-type by giving more emphasis to the role of the health department in facilitating other government departments to develop HIV/AIDS responses. They usually include health-centred strategies. (Appendix A lists health-centred interventions and shows which provinces utilise them.)[3] Through interdepartmental strategies, support and resources are made available to departments for the purposes of policy development and planning and service delivery.

Provinces rarely have a discursive document explaining their AIDS 'strategy'. Therefore most information on activities in this study was gleaned from business plans. The following general observations can be made about the business plans and strategies guiding provincial AIDS units:

- **Little attention to internal co-ordination structures.** Except in Gauteng, 'strategies' largely ignore the building of internal institutions and structures required to achieve implementation of interventions (and broad based project development and rollout). Some mention is made of Interdepartmental Forums and Provincial and District AIDS Councils, but they are normally merely listed as activities of the unit. There appears to be little thought on how activities and spending can be mainstreamed.

[2] The Eastern Cape is planning to formulate a comprehensive strategy in the coming months.
[3] This table classifies interventions according to an objective-based typology developed by Gauteng and adapted by the author.

- **Strategies do not generally deal with demand-driven medical care**. The exception is Gauteng, whose strategy includes the research of practices and service impacts and the development of treatment protocols and their distribution.

- **Poor integration of interventions.** Most provinces have not given close thought to how to integrate the NIP interventions, although ostensibly this is an imperative of the programme and precondition for funding. Again the exception is Gauteng where attention is given to delivering services experienced as 'seamless' to patients, while delivery agents maintain their separateness.

- **Few performance indicators**. Most provinces do not appear to make use of key performance areas as a monitoring or management tool. Only the Free State and Gauteng have defined HIV/AIDS specific indicators.

II. National Level

A. Structure of Chief Directorate and Activities of its Units

The Chief Directorate for HIV and STDs in the national Department of Health is the key agent in HIV/AIDS policy and implementation at the national level. The Chief Directorate has the following basic structure:

Figure 2.
Chief Directorate organogram

This section provides an overview of the Directorate by outlining the structure and activities of each of its units. The purpose of the section is to provide the background for understanding the funding mechanisms for national HIV/AIDS interventions.

South African National AIDS Council

The Directorate acts as a secretariat for the South African National AIDS Council (SANAC); SANAC's funding comes from DoH. In 2000/01 this amounted to approximately R20 million (this allocation is still being drawn upon). The funds are taken out of the DoH budget and placed in a separate account to enable access. The signing power for the SANAC budget lies with the Chief Director and an official of the Office of the President.

Interdepartmental Committee on HIV/AIDS

Whereas the SANAC is comprised of lay people outside of government, the IDC is the body of national government department representatives. The Directorate also provides support to the IDC. Part of the brief of the IDC is to develop minimum HIV/AIDS programmes for government departments and to conduct HIV/AIDS impact studies. In terms of activities, the IDC has:

- conducted a mini survey last financial year on the amount spent by each national department on HIV/AIDS, and;
- identified eight departments who have been slower to move on the HIV/AIDS issue and focused on them. IDC appointed 8 people living with HIV to work in these departments.

National NGO Funding Unit

The National NGO Funding Unit provides grants to national, provincial and local NGOs working in the area of HIV/AIDS.

a. Structure

Each province has a person located in the Department of Health who acts as NGO co-ordinator, although this may not be their full-time task.[4] Each province collects applications from NGOs in its province, makes selections, and motivates for the funding of those organisations to the national NGO Funding Advisory Committee.[5]

The NGO Funding Advisory Committee is a national level body convened by the head of the NGO Funding Unit to consider all recommendations made to the Unit. Although the composition of the Committee varies from meeting to meeting, a minimum of four and usually 6-10 persons are present. Who participates in committee meetings depends upon the content of the applications being considered. Expertise and representatives from the relevant NGO sector or home province will be pulled in to review a grant application. The Committee has no statutory authority. It is intended to make grantee selection a collaborative process which draws upon the expertise available inside and outside the Chief Directorate.

[4] The salary of the provincial NGO co-ordinators are paid from the provincial budgets.
[5] The one exception is Gauteng, which has a fund of its own dedicated to NGOs in the field of HIV/AIDS.

b. Grant cycle

The Unit funds NGOs on an annual basis and follows a rolling programme. The majority of the grants are disbursed in April or March at the beginning of the fiscal year. (The National Funding Unit cannot disburse the funds until the money arrives in the Unit's budget, usually 4-5 April).[6] In consideration of the cash flow problems usually confronted by the smaller NGOs in particular, the national unit tries to speed the disbursal of those grants. The larger NGOs, for instance those at the national level, can wait longer for approval.

c. Source of government funds for NGOs

The bulk of funding for NGOs comes from national, although some provinces also have money set aside in their own budgets for NGOs. (Gauteng is an exception in that it has a significant fund set aside for grants to NGOs in the field of HIV/AIDS and thus does not receive money from the National NGO Funding Unit in the same manner.) In 2001/02 the National NGO Funding Unit has R28 million to distribute. The amount each province spends on NGOs varies considerably.[7]

Thus an NGO providing HIV/AIDS counselling services in the Eastern Cape might apply to the provincial Department of Health. The provincial NGO coordinator might decide to fund that NGO out of provincial funds available for NGOs—depending on the availability of those funds—or, if it feels the application is worthwhile, might pass it along to the national level and recommend that it receive national funds.

To limit the number of small grants sourced from national, the minimum award for a grant from national DoH is set at R75, 000.[8] Furthermore, The National NGO Funding Unit has stipulated that each province recommend up to 15 NGOs for a first reading or consideration by national, for a total of R1.7 million. The figure was intended to give the provinces a rough estimate of what resources they could expect from national, for planning purposes.
The R 1.7 million figure applied to all provinces, excluding Gauteng. In previous years, each province had received varying amounts based on per capita, in an effort to make the split equitable. However, it was soon realised that this failed to take into account the relative progress of the epidemic in each province, ability to spend, travelling time, etc.

After the first round of grants are made, funding was then allocated to fill the gaps according to the provincially assessed needs.The intention is for the R1.7 million to be used to establish a core set of services in the provinces, and then for additional funding to be allocated to credible NGOs. The amount going to the provinces in this second round varies since these grants are going to fill meet particular needs.

d. Provincial planning requirements for access to national NGO funds

The national NGO Funding Unit provides grants to approximately nine national NGOs. The rest of the funds are distributed to provincial NGOs. Since the National Funding Unit recognises that it is too removed from the provinces to make informed decisions on local

[6] For instance, until 31 May 2001 the Committee would consider proposals from NGOs whose funding expired 31 March 2001. The recommended applications are gives to the Deputy Director General for final approval by 15 June 2001.
[7] See provincial section on NGO funding below.
[8] However, in cases where there are no funds available for NGOs from the province, applications of less than R75, 000 may be submitted to national DoH.

organisations, it relies heavily upon the recommendations of its provincial NGO co-ordinators.

Recently the National NGO Funding Unit co-ordinator instituted a system whereby provincial NGO co-ordinators were required to submit an NGO programme plan to national before they were able to recommend NGOs for national funding. Writing this report requires the provincial co-ordinators to take stock of their human and financial resources for funding NGOs, and then to put together a plan for NGO funding which lays out programme priorities.[9]

In writing their Provincial NGO Programme Plan each NGO co-ordinator was asked to consider:

a. The number of districts in their province
b. How many NGOs and CBOs were currently funded from the provincial budget
c. How many provincial personnel were available to monitor NGOs
d. How many NGOs each provincial NGO co-ordinator was responsible for monitoring currently
e. Priority focus areas or target populations
f. Existing structures and projects which could be expanded
g. Neglected geographic areas and 'hot spots'

The aim is to encourage provinces to recommend NGOs for national funding in a manner which:

- is proactive and considers programme priorities as a whole instead of distributing grants in an ad hoc manner,
- is consistent with and complements the province's overall strategic plan for HIV/AIDS, if one exists; and,
- targets the current gaps (populations not reached, infection patterns which need to be targeted, particular types of services which are lacking in various geographic areas).

As mentioned above, once the original grants are distributed which make up the R1.7 allotment to each province, a reassessment is done in order to target additional grant money available the same financial year. The intention is for the provincial NGO planning process be iterative. Once the first group of NGOs is funded, provinces will want to reassess their NGO plan to determine which gaps have been filled and what needs remain. Provinces will need to undertake this reassessment in February in order to have it feed into and direct the next funding cycle commencing around April.

e. Coordination of NGO funding within the Directorate

Operationally, the NGO Funding Unit should co-ordinate its activities with the other units of the Directorate.

Policy coordination with Integrated Plan. The National Funding Unit tries to fund project content in line with priorities of the NIP, i.e. VCT and CHBC. The NGO operational plan is intended to complement and support the NIP. Most NGOs funded provide information, education and counselling. This is largely because these activities require the least expertise, have low start-up costs, and are thus relatively easy to monitor and to roll out.

[9] The provincial NGO plans were first introduced in a workshop with the provincial co-ordinators held by national in November 2000 and February 2001. In the first round of implementation, national received plans from all but two provinces.

Operational coordination within Directorate. Currently there is sometimes confusion with NGOs approaching more than one unit in the Directorate.

By including programme co-ordinators from other parts of the Directorate, the NGO Advisory Funding Committee serves to inform those units of NGO activities in their programme area which are taking place in the provinces. For example, the Home-based Care Co-ordinator has requested that all NGO funding requests he receives in his unit be channelled through the NGO National Funding Unit process, instead of being funded through his unit directly.

The TB Unit of the Directorate has its own NGO co-ordinator. The national NGO funding unit co-ordinator and the TB NGO co-ordinator are currently working to standardise the contracts and selection procedures used. The National NGO Funding Unit also tries to pull in the management of the TB directorate to inform and co-ordinate on NGO projects which include a TB component, or could cost-effectively be expanded to include a TB component.

f. Monitoring and Oversight by Provincial NGO Coordinators

All provinces have set up NGO Funding Committees to vet proposals and allocate funds.[10] The provincial NGO co-ordinator are the grantee organisations' point of contact with their funder. The responsibilities and tasks of the provincial NGO co-ordinator in monitoring grants and transferring funds to NGOs is discussed in detail in the provincial section of this paper.

g. Mentoring programme

The NGO Funding Unit co-ordinator recognised that some NGOs didn't have the skills or experience to submit an acceptable application. A mentoring programme—between established NGOs and smaller less developed CBOs—was established in May 2000. The idea is for the NGO Funding Unit to pay a large NGO in a province to take 3-4 CBO's under its wing, and work with them on programme and financial management. The NGO Funding Unit channels grants to the mentee CBO via the mentor NGO. The mentor NGO is given funds by the NGO Funding Unit to play this role—sufficient funds to finance a part-time co-ordinator and administrator.[11] The mentoring programme thus acts as an additional means to access national funds (indirectly). Small, less capacitated CBOs can submit a less polished application to a mentor NGO who adopts a few mentees through a selection process.

h. How NGOs access funds

To summarise, an NGO might receive money from two different sources: the budget controlled by the national NGO Funding Unit, or the money set aside in the provincial budget controlled by the provincial NGO co-ordinator.

Source 1: National funds. The money controlled by the National Funding Unit is ultimately delivered in grants to:

- national NGOs which generally provide central administrative services,

[10] The one exception is the Western Cape, where NGOs are selected by a committee for each metro region. As with the others, the province must give documentation and description of the committee's selection process to national to demonstrate that it is fair and transparent.

[11] For example, in the Eastern Cape, Youth For Christ is mentoring four newly-established CBO's. Youth For Christ will give R35, 000 to each CBO in the first year, upon their completion of a business plan. In the second year, Youth for Christ will continue supporting the CBOs and the CBOs will receive R50 thousand each.

- provincial NGOs—whose grant applications to their provincial NGO coordinator was passed along and recommended to the National Advisory Committee, and;
- small CBOs without sufficient capacity to receive the funds and administer the project without assistance. (See mentoring section for description of process.)

Source 2: Provincial funds. Any money available from the provincial budget for NGOs is allocated to provincial NGOs and CBOs according to decisions and criteria of the NGO co-ordinator and according to processes determined by the province.

In terms of technicalities and paperwork, NGOs are required to submit a number of documents and keep updated copies with national DoH. All NGOs and CBOs making an application for national funds must submit a number of documents. Appendix B lists these requirements.

Government AIDS Action Plan Directorate

The Government AIDS Action Plan (GAAP) office at the Directorate runs campaigns for national advocacy, action and dialogue and works with civil society and all sectors to increase public awareness and community mobilisation around HIV/AIDS issues. Its activities include:

- Mass media advertising
- Provision of communication resources to the public and private sector
- Media workers projects
- Living Openly project and exhibition
- Training celebrity AIDS ambassadors
- AIDS helpline
- AIDS memorial quilt

In addition, the national GAAP budget funds the salaries of 2 GAAP co-ordinators in each province. These posts (presently filled in 7 provinces) are supervised by the provinces and located in provincial offices, but funded by national and hired through a joint process between national and the province.[12]

HIV/AIDS Directorate

In summary, administratively the HIV/AIDS Directorate is organised by *programme* area and can be broken down into four main units. They are:

Partnership Support—tenders NGOs for national campaigns
STD's, TB and Barrier Methods—includes condom distribution and research
Youth Programmes—includes Life Skills programme
Care and Support—includes VCT, CHBCS and PWA[13]

The Youth Programme and Care and Support programmes contain the three NIP strategies—Life Skills, VCT and CHBC. For this reason, the structure, function, and activities of these two sections are discussed in the accompanying Education and Welfare papers.

[12] T. Skenjana, phone interview, 21 August 2001.
[13] Involved in income-generating activities for people with AIDS, also finalising a drug literacy campaign. (C. Serenata, email 27 July 2001).

a. Partnership Support

The Partnership Support office administers tenders to NGOs to provide services to specific population groups. Generally the office develops partnerships with a particular sector or industry. A tender is solicited to an NGO to provide services to the targeted population—primarily training workshops or public awareness campaigns. The population group or sector is the 'client'.

The national projects under its purview are widely varied. They include projects with the long distance trucking industry, public awareness campaigns targeting trains and buses, and programmes working with the tourism and hospitality industries, trade unions and the military. See Appendix C for a brief description of the nine primary programmes.

Partnership Support draws its resources from the HIV/AIDS Directorate budget, plus three sources of donor money: the European Union, USAID, and the Danish government. Some projects have a matching fund arrangement with the industry involved, some projects are entirely funded by international donors, and some use the resources of the HIV/AIDS Directorate. Appendix D lists the projects, their estimated budget for 2001/02, and the source of funds.[14]

b. Interdepartmental Support

The Interdepartmental Support office provides technical assistance to other national departments. The practices related to its programme development, relationship-building and multiple funding sources are similar to Partnership Support. Its projects include: capacity building, support, monitoring, co-ordination and multiple small projects linked to the Interdepartmental Committee on HIV/AIDS. Also:

- Integration and support of people with AIDS as HIV/AIDS co-ordinators in selected departments, and;
- Technical assistance to the Department of Public Service on the development of policies and capacity building programmes.

One of its large projects aims to build capacity to mitigate the impact of HIV/AIDS at the local government level. The IS co-ordinator has played a role of facilitating and developing co-ordination on this project between the three departments now involved: Health, Social Development and DPLG—by convening a steering committee to try to orient all the players towards the same goals. Other partners are: the South African Local Government Association (SALGA) and the Policy Project, an NGO funded through USAID which provides support to the DoH (mainly surrounding training.) The contributions of each partner are roughly as follows:

DoH:	Administration and funding; logistics for rollout.
Policy Project:	Development of training course and facilitation of master training; supply training materials; development and editing of training materials.
DPLG:	Served on steering committee.

[14] R. Schoeman, interview 17 July 2001. Also, Email correspondance20 July.

SALGA: Assisting with logistical arrangements in the provinces; Monitoring; assisting with rollout of workshops by making available their cadre of trainers.

Natl. Pop. Unit: Training of planners and policy-makers at government departments.

The budget for the project is drawn from a number of sources:

Table 1. Interdepartmental Support project budget

	Amount	Source of funds	
Master training	R 53, 444	European Union (funds from technical assistance programme)	
	R 8, 700 VAT	Directorate budget (taken from GAAP line-item)	
Roll out	R 689, 125	European Union	
	R 88, 675 VAT	Directorate	
TOTAL	R 839, 984		
Additional off-budget contribution:			
Master training (facilitation and training materials)		R 20, 000	Policy Project

In summary, the budget for all Interdepartmental Support projects derive from either departmental or EU funds. The aim is to utilise EU funding wherever the EU agreement permits, and to cover any other items/activities from the departmental budget. In-kind contributions are drawn from the Policy Project in the form of training support.

c. STDs TB and Barrier Methods

The STDs, TB and Barrier Methods unit (see Figure 2) contains five sub-units:

1. Condom Distribution—procures and distributes approximately 250 million male condoms annually. Also exploring distribution of female condoms.
2. Research and Surveillance—The Ante-Natal study is actually conducted by the regular research unit of the Health Department but is funded via the Research and Surveillance unit.
3. Traditional Healers
4. TB/HIV Integration: works towards integration of TB and HIV services at district level.[15]
5. STI (Syndromic) Management: STI health promotion materials; syndromic management.

Summary of Units and Activities

Table 2 shows the various units in the Chief Directorate for HIV/AIDS and STD's. It lays out the sub-units of each unit, and then describes work the unit does, and who it works with to accomplish it. (Those units involved with National Integrated Plan programmes are shaded.)

[15] To clarify, the TB/HIV subunit is a separate entity to the TB Directorate TB (on level with the HIV/AIDS and GAAP Directorates) mentioned above. The TB/HIV subunit works closely with the TB Directorate.

Table 2: Unit and functions of Chief Directorate for HIV/AIDS and STDs

Unit in the Chief Directorate	Sub-unit	Sub sub-unit	Function and role of national directorate
SANAC			Supports national advisory body
IDC			Supports and convenes IDC (national government body)
GAAP Directorate			Programmes run nationally from Directorate offices.
HIV/AIDS Directorate	Partnership Support		Administers tenders to national NGOs.
	Youth Programmes	YIS	Provides technical support to provinces which do implementation; networks with DoE; administers conditional grants to provinces for Life Skills programme
		YOS	
	STD's, TB and Barrier Methods	STI management	Works with provinces.
		Condom distribution	Co-ordinated, funded, procured, distributed by national office
		TB	Nationally run programmes; works closely with TB Directorate in Chief Directorate
	Research and Surveillance	Ante Natel Survey	Run nationally at Directorate.
	Clinical Care and Support	VCT	Provides technical support to provinces which do implementation; administers conditional grants to provinces for VCT
		CHBC	Provides technical support to provinces which do implementation; networks with DSD; administers conditional grants to provinces for CHBC
		PWA	
	Interdepartmental Support		Works with national departments
National NGO Funding Unit			Provides grants to national, provincial and community-based NGOs
TB			Responsible for DoH tuberculosis programmes; liases with TB unit in HIV/AIDS Directorate

B. Sources of Funds: Assigning Budget Allocations to Administrative Units

Referring again to figure 2, besides the office of the Chief Director herself, the Chief Directorate is essentially divided into 3 main branches: HIV/AIDS Directorate, GAAP, and the TB unit. In national Budget documents, the DoH funds allocated to the Chief Directorate for HIV/AIDS and STD's fall under Programme 2: Strategic Health Programmes of the DoH budget. Sub-programme 2 is the budget for the Chief Directorate for HIV/AIDS and tuberculosis. This sub-programme is further divided into three main line-items, as shown in

the Table 3. The *programme budget* under the auspices of the Chief Directorate for HIV/AIDS and STD's is the sum of these three line items, i.e. R 212.2 million for 2001/02.

Table 3. Allocation for Chief Directorate for HIV/AIDS and STD's from DOH

R'000	Budget 2000/01	Supplementary Adjusted Budget 2000/01	Total Budget 2000/01	Anticipated Expenditure 2000/01	Balance 2000/01 (rollover)	Budget 2001/02	MTEF 2002/03	MTEF 2003/04
HIV/AIDS & STD's	71,861	10,689	82,550	65,177	17,373	61,744	58,444	67,578
GAAP	93,556	15,450	109,006	96,546	12,460	111,430	116,379	119,008
Tuberculosis	1,676	-100	1,576	2,406	-830	4,953	5,179	5,410
Sub total	**167,093**	**26,039**	**193,132**	**164,129**	**29,003**	**178,127**	**180,002**	**191,996**
Conditional grants			16,819			34,100		
TOTAL			**209,951**			**212,227**		

Although these budget documents separate that money into three line-items, in practice the Chief Directorate works from a single budget. This programme budget is only the first of three sources of funds the Chief Directorate has to work with:

1. Allocation from DoH budget (programme budget)
2. Donor funds: European Union, USAID, and others
3. LoveLife Partnership

The next section gives details on the *programme budget* of the Chief Directorate and clarifies the relationship between the GAAP line item and the Chief Directorate as a whole. In addition to this programme budget, the Directorate has donor money available from the European Union, USAID and other funders. Section III identifies these donor revenue streams and the institutions and processes the Directorate uses to allocate these donor funds.

Thirdly, in addition to the programme budget and donor funds, the Directorate utilises the Lovelife partnership. Section 3 gives details on the anticipated amount of this allocation and how it will be administered.

Programme Budget of the Chief Directorate

Table 4 below displays the programme budget of the Chief Directorate for 2001/02, as described by the Deputy Director. (See also Appendix E).

Table 4: 2001/02 Programme Budget for Chief Directorate

Chief Directorate (CD's office herself)	**R 7.805 million** (This includes R 5 million to Medical Research Council and funds to SA Vaccine Initiative.)	
HIV/AIDS Directorate	**Partnership Support**	R 5.140 million
	Care & Support	R 9.306 million
	Youth	R 6.617 million
	STD's	R 24.124 million
GAAP	**R 111.380 million**	
TB unit	**R 4.953 million**	
Total	**R 169.325 million**	

In addition to GAAP communication and media activities, the GAAP line item of R111.4 million in 2001/02 also provides funds for other parts of the Directorate, including:

- GAAP media programmes run by GAAP personnel in the DoH Directorate.
- NGO Funding Unit (*R 28 million*[16])
- Condom distribution (R 20 million)
- Interdepartmental Committee (R 2 million)
- Prevention of Mother to Child Transmission (*R 25 million*[17])

Furthermore, GAAP money is used to fund provincial posts. The salaries of two people per province are financed through the Directorate---from the GAAP budget.

The use of funds from the GAAP line item to fund other areas of the Directorate demonstrates that the Chief Directorate operates in practice off one budget. The Chief Director allocates the GAAP, TB and HIV/AIDS sub-programme allocations amongst all the units of the Directorate.[18]

Condoms are the large cost drivers for the Chief Directorate budgeting. Condoms are procured with national funds and distributed centrally by the national DoH. The funds for buying the condoms is essentially patched together from different sources. For instance, in 2001/02 it is estimated that R90 million will be needed for condoms. R20 million of this will be taken from the GAAP sub-programme. This is combined with the R24.1254 million from the STD's sub-programme. This leaves roughly R40 million still needed. The Directorate is looking into requesting a special allocation from Treasury for this sum.

In Addition: Donor Funds

The international donor funds received by the Chief Directorate fall into three primary categories: European Union, USAID, and other funders. The first three sections discuss the amounts received and the funding arrangement for each. We then describe the Donor Co-ordination Forum, which is the primary means for connecting projects with donors, and thus is relevant to budgeting and financing mechanisms.

a. European Union funds

In 2001/02 the EU contributed R24.534 million to the Chief Directorate. This money sits on the Directorate budget and is controlled by the Chief Director. Procedurally speaking, the European Union enters into a contract with the DoH. When the Chief Directorate develops a business plan and budget for a project, it is signed by the President. The Directorate can then legally and administratively begin spending.

In terms of transfer of funds, the procedure is more complicated. European Union donor contracts run for three years. The European Union bureaucracy is slow to transfer the funds to the National Revenue Fund. Mechanisms are agreed upon to trigger payment—for example, submission of reports on project phases. The funds are then released in tranches from the RDP fund and conveyed to the DoH. The funds are gazetted in the Adjustments Budget, introduced in Parliament in October. The Adjustments Budget thus includes EU funding in addition to rollovers. In other words, because the funds arrive late in the financial

[16] The R28 million budget for the NGO funding unit is the sum of R18 220 from the GAAP line-item plus 10 000 of HIV and TB---SANAC.
[17] C. Serenata, email correspondence 27 June, 2001.
[18] GAAP budget is listed as a specific item because Cabinet wanted to keep it separate from the regular HIV/AIDS budget in anticipation of it being terminated at some point. (G. Muller 5.6)

year, programmes which include EU–funded activities will essentially 'overspend' on their budget until the EU funds arrive.

European Union funds are used by the Directorate to purchase male and female condoms. It is also frequently used to pay for travel of provincial officials to meetings etc.—this is because the procedures attached to accessing the money make it easy to draw upon for smaller, travel-related project costs.

b. USAID donor funds

In contrast to the European Union, USAID essentially retains control of funds donated and takes care of the acquisition of items. Although the Directorate makes agreements with USAID on funds anticipated and can use this in its programme planning, the Directorate does not have control of the budget but instead makes requests for funds as needed throughout the year.

USAID support is mainly technical assistance. In making decisions about when to approach USAID for funds for a particular programme, the Chief Director often turns to USAID to fund interventions DoH wants to undertake but realises that implementing those activities via government systems and procedures would be too cumbersome. By requesting funds from USAID, programmes can avoid lengthy tender procedures.

c. Other funders

Other international donors support the Chief Directorate with financial and technical assistance, but the amounts and procedures are not as clear-cut in the other instances. Often donors will pledge a particular amount over 2-3 years without specifying how much will be given in each year. Building close interactive relationships with donors, the Chief Director can be aware of a donor government's interest and factor this into programme planning without being guaranteed of a specific amount. Furthermore, some donors have written HIV/AIDS into their strategic priorities in policy documents or elsewhere, thus giving indication that the donor is amenable, but not specifying the financial resources the Directorate may rely upon.

d. Donor Co-ordination Forum

Soliciting, negotiating with, and communicating plans with the numerous donors is time-consuming. Particularly in those units of the Directorate where national is implementing programmes itself, programmes will require specific chunks of money for a particular purpose e.g. bringing provincial co-ordinators to a national meeting, supplying training manuals at a workshop. Or larger items, such as a large conference or publication costs. When faced with such a need, instead of approaching each donor one after another to explain the need and ask for the funds, the Deputy Director last year instituted a Donor Co-ordination Forum. Bilateral and multilateral donors are invited and simultaneously presented the same information on current proposals requiring full or partial funding. The project proposals are thus presented as a menu for donors to select from.

The Donor Co-ordination Forum meets periodically, when a sufficient number of proposals collect to warrant a meeting. Although the forum has been established and used primarily by DoH in its first months, the Department of Education and Social Development have also been invited to come and solicit funds for HIV/AIDS related proposals. Although

representative of DoE and DSD have attended, neither have yet utilised this forum to put proposals forward themselves, although this is the plan for the future.

Generally the Directorate uses donor funds not because are short in the programme budget but because donors can do what government cannot. Donor funds do not come attached with the same statutory regulations and tender procedures, or the same political or policy considerations attached to activities run by the government directly.

In Addition: Lovelife Partnership

In addition to the programme funds allocated in the DoH budget and international donor funds from USAID, the European Union and others, the Chief Directorate is also involved in the Lovelife Partnership with the Kaiser Family Foundation. Kaiser approached the South African government with an offer of a 3:1 match in funding. R25 million was designated as a direct allocation to the programme from Cabinet, to be matched by R75 million from Kaiser.[19]

The financial management of the Lovelife partnership will be done through Health Systems Trust, a national NGO; the Chief Directorate in DoH will not be responsible for implementation but is involved in content and design. Although arrangements have not concluded and the financing mechanism not yet finalised, all three Director Generals have signed off on the deal. The likely procedure is that National Treasury will now vote the R25 million into the Supplementary Budget, which, upon parliamentary approval, will allow transfer payments to be effected.

C. Funding Mechanisms Operating in the Chief Directorate

Section A outlined the subunits of the Directorate and their function. Section B then matched funding sources to each unit.

We found that each unit plays different roles and engages in different activities depending upon whether the spending agent for their programme is the Directorate, provinces, NGOs or other national departments. Each unit of the Directorate might be:

1. Implementing programmes or delivering services **themselves** (from the national DoH)
   For example: GAAP programmes are run from the offices in the Chief Directorate. Another example of services the Chief Directorate offices provide directly is their administrative support to two national policy-making/advising bodies: SANAC and IDC.

2. Supporting **provinces** in delivering services
   - by administratively and technically supporting IP programmes from national office
   - by distributing conditional grants to provinces

3. Funding **NGOs** to deliver services
   - via grants
   - through tenders and contracts

[19] The Partnership was intended to be intersectoral; Kaiser was looking for the involvement of the Departments of Sport and Recreation, Education and Health, however Education chose not to participate largely due to the provocative controversial approach used by Lovelife in their media campaigns.

4. Or, working with **other national departments** to implement programmes

Given the sources of funds flowing into Chief Directorate and funding mechanisms detailed above, the Chief Directorate did not manage to spend all of its budget in 2001/02. As a result, the balance (or funds unspent) in the three sub-programmes was rolled over into the 2001/02 budget. Table 5 gives the details.

Table 5.
Rollovers in Chief Directorate Budget

R 000 Sub-programmes of Programme 2: Strategic Health Programme	**2000/01 Budget**	**2000/01 Adjusted budget**	**Rollover (unspent in 2000/01)**	**2001/02 Budget**	**2001/02 Total to be spent**	**2002/03 MTEF**	**2003/04 MTEF**
HIV/AIDS and STDs	71,861	82,550	17,373	61,744	79,117	58,444	67,578
GAAP	93,556	109,006	12,460	111,430	123,890	116,379	119,008
Tuberculosis	1,676	1,576	-830	4,953	4,123	5,179	5,410
Total of subprogrammes		193,132	29,003	178,127	207,130	180,002	191,996
Conditional grants via DOH	*16,819*	*16,819*	*0*	*34,100*	*34,100*	-	-
Total of DOH money	16,819	209,951	29,003	212,227	241,230	180,002	191,996

This table shows three examples of difficulties described earlier in this paper.

- The Adjustments Budget for 2000/01 included another R10.689 million for the HIV/AIDS and STD's line item. This money is European Union grant funds: as described in section B, the EU take some time to be approved and transferred and are therefore gazetted in the Adjustments Budget. The EU funds therefore account for some of the additional funds added via the Adjustments budget.

- Second, difficulties in condom procurement were another contributing factor to the rollover from 2000/01. Hold-ups in the quality certification of the condoms procured delayed payment of the international suppliers.

- Additional money for buying condoms was needed in addition to the funds supplied via the HIV line-item (see discussion above.) Some of the R15.45 million requested in the Adjustments budget for GAAP was needed for the purchase of condoms.

III. Provincial Level

A. HIV/AIDS Structures

At the provincial level, there is typically an HIV/AIDS unit in the DoH--a body responsible for policy development, co-ordination and implementation. These units vary considerably from province to province--in terms of their staff size, resources, location in the Department, authority and funding mechanisms. This section first describes these HIV/AIDS units and the

other bodies at the provincial level involved in HIV/AIDS programmes. These include: regular health institutions; internal co-ordinating structures; provincial and district AIDS councils; NGO management structures; and local government agents.

HIV/AIDS Units

Appendix F gives an overview of the structures set up by provinces to run HIV/AIDS programmes. All structures are located within the health department, managed by them, with their budgets located within the broader Health Budget. Only Gauteng has a unit that has enjoyed its current status for a year of more i.e. 3 years. All the other provinces have upgraded the status of their units in the last six months or intend to upgrade them. This increase in stature reflects the increase in political priority given to the epidemic and the advent of the NIP programmes.

In the process new 'politically adept managers' have been appointed as directors, and in a number of cases, older managers at more a junior level have left. Throughout their histories all units have been characterised by rapid turnover of staff, draining 'institutional memory', although Gauteng and the Free State have retained some of their core management staff for some time.[20]

Broadly speaking, there are two types of AIDS units. Units either co-ordinate strategies:
- within health, or;
- both within health and between health and other departments.

AIDS units primarily focused on health strategies

The provinces with this type of HIV/AIDS unit vary greatly in where the unit is located in the department management structure. The Northern Province's unit is not located in any directorate and reports directly to the HOD, while the Free State's unit is located in the Health Support Chief Directorate. Both of these are thus separated from the line management responsible for routine service delivery. In the Eastern Cape, the unit falls under District Health Branch and is thus grouped with the line management responsibility for the bulk of routine delivery.

Units focused on an interdepartmental strategy / set of interventions

Of this type, Gauteng is the most developed. The Gauteng AIDS unit allocates portions of its budget to other provincial departments. The unit convenes an interdepartmental process to do budget planning. Out of this planning forum, a committee (the Interdepartmental Committee) is set up to monitor expenditure and adjust the budget. The HIV/AIDS unit then manages this interdepartmental strategy, helping departments to develop and implement programmes. The HIV/AIDS Unit itself is also involved in the direct delivery of certain services defined in the strategy and funded from its budget, however most of the budget is spent by the delivery department themselves. The unit reports directly to the HOD of the

[20] In the KZN, from early 2000 to the beginning of 2000, two bodies located in different parts on the Health Department's organisational structure handled the HIV/AIDS response in the Department. These bodies had differing status and roles; theoretically the one body was to be overseen by the other. Despite this relationship of oversight at the organisational level, the required level of co-operation did not emerge until 2001, when the manager of subordinate body resigned.

Health Department, who is seen as ultimately responsible for the implementation of the provincial HIV/AIDS strategy .[21]

KZN has a different set-up. The Provincial Aids Action Unit has been established as an interdepartmental unit although its budget is managed by the Health Department. The unit directly manages interventions previously housed in the DoH, but also plays a facilitating role to ensure that all provincial departments have HIV/AIDS strategies. The unit is divided into 'portfolios' and each portfolio is responsible for either a:

- particular health, education or welfare -type intervention;
- a set of activities carried out by another department, or;
- an activity carried out in partnership with a particular social sector or interest group.

Each portfolio has its own budget to directly fund the implementation of their projects. The unit portfolio managers collaborate with the AIDS co-ordinators in their relevant line departments in running AIDS unit programmes. (Primarily the line department AIDS co-ordinators are concerned with developing workplace programmes in their departments.)

Working with regular health institutions in delivering HIV programmes

In the past, the HIV/AIDS programmes were run somewhat independently of mainstream health institutions e.g. district offices would run awareness campaigns or AIDS counselling initiatives. However since the advent of the new interventions in care (HBC[22] and PMTCT) and the combination of counselling and testing (VCT), it has become more important to work with hospitals and mainstream delivery institutions in running these programmes. These new interventions are more complex, more dependent on participation of existing delivery structures, and more resource-intensive.

As a consequence of this change, line managers of districts and regions, such as district managers and CEOs of heath district complexes (districts and regional hospitals) are becoming more important to HIV/AIDS service delivery. Accordingly, there are to moves to decentralise budgets to them.

Also where HIV/AIDS units themselves are responsible for implementing services that entail the participation of health institutions, the unit director usually appoints a 'project manager' from amongst the unit staff who may have some degree of financial management authority. The project manager will interact with project teams appointed by the districts or regions in developing detailed operational plans and spending the funds.

The AIDS Training and Information Centres (ATICs) are central to IEC and for general counselling programme and condom distribution, although frequently are not mentioned in strategies. Some strategies allocate them a role in the training of lay counsellors in the VCT intervention. The ATICs, established in the mid 1990s by provinces, work particularly closely with the provincial AIDS units. Only the Eastern Cape transfers resources from the unit budget to all its ATICS to cover their core costs. Based on an historical arrangement, the

[21] Up until mid 2001, the interdepartmental unit was not formally separated from the health department. The interdepartmental unit continued to hold and manage the budgets of projects which had been made the DoH responsibility in the planning process. Formal separation is now underway, with some budgets being transferred to a) the Health Department's second AIDS unit, the Public Health AIDS unit, which pays a policy support role and is a subdirectorate under the Public Health Directorate, and b) DoH regions.

[22] When referring to HBC, we are speaking of the Health angle on the CHBC progrmme.

Free State unit pays for the staff costs of the Bloemfontein ATIC, but routes this through a district, which manages the funds and monitors the performance of the ATIC. All other ATICs seem to be funded from district budgets, sometimes via local government.[23]

Internal co-ordinating structures

The provinces have also typically set up some form of interdepartmental committee—meeting monthly—to co-ordinate government response to HIV/AIDS. The body is usually driven by health, and includes some combination of:

- the political heads of department (MECs);
- top management of departments, or;
- HIV/AIDS co-ordinators from each department, and; representatives from the HIV/AIDS Unit in health.

For example, in the Eastern Cape, co-ordination between departments on HIV/AIDS activities currently occurs through a Social Needs Cluster meeting, involving Heads of Departments and key programme managers from Health, Education and Welfare. HIV/AIDS is one of three standing issues discussed in its monthly meetings.

Gauteng has an Interdepartmental AIDS Committee which is a task team drawn from the broad annual planning meeting in which all departments and key civil society social sectors and interest groups are represented. The Committee meets monthly and is responsible for control of the unit interventions, which are mostly decentralised to departments. The committee reports to the Provincial Committee on AIDS, a provincial cabinet committee.

Provincial and district AIDS councils

All provinces studied have Provincial AIDS Councils. These are joint government-civil society bodies with membership drawn from provincial politicians and representatives of social sectors and interest groups, including business. They are aimed at co-ordinating broad strategies between the sectors, as well as drawing in funding and in-kind contributions. All provinces have set up or are setting up District AIDS Councils— the local counterpart to the provincial council, on the basis of local government district council boundaries. The HIV/AIDS units in the provincial DoH often provide support to district councils in their set-up and operation.

NGO management structures

All provinces have set up NGO Funding Committees to vet proposals and allocate funds. There is frequently a particular person assigned the responsibility of monitoring grants and running capacity-building programmes for NGOs. The salaries of these provincial NGO co-ordinators are paid from provincial budgets, not national, meaning that the interactions between the provinces and the national NGO Funding Unit must be handled via cooperation instead of organisational authority.

In KZN this person is the NGO Portfolio Manager. The KZN NGO business plan includes an NGO capacity-building programme (drawing on the national directorate for in-kind resources for training), and the development and testing of a monitoring tool. An NGO forum, facilitated by the unit, in which NGOs can share ideas and experience is also on the cards. In the Free

[23] Local government might make their contributions towards the running ATICs. Further study is required to ascertain this.

State and Northern Province, things seem to done on a more ad hoc basis. A single person, the NGO co-ordinator, undertakes the monitoring of NGOs, visiting sites, keeps in contact with NGOs and liases with district HIV/AIDS co-ordinators on the delivery progress of grantees. In the Free State the NGO co-ordinator is at present also responsible for capacity-building efforts for NGOs, although the unit is seeking donor funding for this. In Gauteng, NGO selection is decentralised to regions through multi-layered committee structure and regions are formally involved in monitoring.

Local government involvement

Unit projects (or projects that are historically somewhat separate from the unit) often require contributions from local government. For instance in the Free State, the Bloemfontein Municipality helps set up and run the District AIDS control with some assistance of the unit, and based on a historical agreement funds the Bloemfontein ATIC's non-personnel costs. Local government also runs STD and TB services as part of their primary health services. The funding of these services by provincial health departments varies across provinces.[24]

Locating administrative structures in provincial budget documents

In terms of the official provincial budget documents, the budgets for the HIV/AIDS units are found in the Department of Health's budget under Programme 2: District Health Service Budgets, except for Gauteng. Usually, the HIV/AIDS unit is located in the Community Health Subprogramme. In Gauteng, the AIDS unit budget is contained in Programme 1: Administration within the Departmental Management subprogramme.[25]

All provinces, with local variations, will structure their budgets as follows: Responsibility code (referring to the Programme / Structure e.g. District Health); Objective code (referring to a utilisation of funds within a Programme e.g. for HIV/AIDS Support); Standard Item; Line or Posting Items (as sub categories of Standard Items). The difficulty is that this system does not allow one to track funds used for discreet **activities** (e.g. HBC). The "lowest level" of aggregation (which could be used to show expenditure by activity) is the objective code, which also usually contains a range of expenditures (HBC, TB/HIV integration, IEC etc) without any dissagregation between projects.

Gauteng's objective code set-up allows for the most disaggregation between projects. VCT is given its own code (this project falls outside the interdepartmental unit strategy). There is a code for interdepartmental funding which exclude funds going to health department. Finally, there is "AIDS projects" code for all non-VCT, unit identified projects delivered by the health department. The financial management system also allocates batch numbers to payment advice slips which can be traced back to the person or projects that requested payment, and thus in turn to the activity or project.

For strategic and project planning, management and reporting, units generally use some kind of activity budget related to their business plans. These activity-type budgets are summarised in Appendix G. Because of the high level of activity aggregation inherent in the formal financial information system run by department, it is difficult to use the formal system to track activities and thus generate activity budget reports. Units often have to run parallel reporting systems.

[24] Further study is required to ascertain the significance of local government flows.
[25] The budget of Gauteng's Public Health AIDS unit is also contained within Programme 1, in a subdirectorate called Programmes.

B. Descriptions and Analysis of Funding Streams

In this section we describe the funding streams in detail. A funding stream is the flow of funds from their sources to the their ultimate spending agents via a number of spending controllers and budgeting authorities which split and direct the stream. This section considers:

- the process through which the streams are quantified
- the process through which the flow is controlled
- how the funds move through successive controllers
- who the ultimate recipient or spending agents are.

The content of the resources in the funding stream can be either money, or in-kind resources (i.e. goods and services).

Essentially, provinces rely upon two broad sources of funding: resources sourced from national, and provincially-sourced funding. Here we categorise the funding streams by their source.

The next section describes the six ways in which provinces receive resources from national. It is map of where and how national interfaces with the provinces. The following section describes the provincially-sourced funding streams—funds allocated from the province's own budget.

Resource streams sourced from the national health department

The national department of health provides resources to provinces in six ways.

1. NIP Conditional Grants

The National Integrated Plan co-ordinator's office is located in the Directorate. Currently the conditional grants are administered from the DoH office. The preceding paper covers the process for transferring the grants from national to provinces in detail, however here we describe how provinces absorb the grants into their budgets.

The NIP Health Conditional Grants, in most cases, are taken onto the unit budgets.[26] The standard item budget format has categories for professional services, transfer payments, and medicines etc. The entire sum of health conditional grants is listed as one item in the transfer payment category. This arrangement does not permit a distinction between VCT and HBC funds. Furthermore, putting all the conditional grants under one item has the advantage of permitting some tracking, but can create confusion when the funds are put in a inappropriate category. In the Eastern Cape, this has created a block in funds transfer when Treasury questions the logical connection between the requested payment and the standard item.

Because accessing conditional grant monies requires a business plan with a budget, NIP funded interventions are usually backed by some kind of an activity budget. Provinces may contribute their own resources to projects / interventions funded by conditional grants, but these contributions are not reflected on the business plans required to access the grant. If there is no business plan for the unit as a whole or the intervention area in which the project

[26] Gauteng has a different arrangement where an interdepartmental unit is functionally separated from the Health Department to a large extent, and conditional grants are taken onto the Health Department's budget and management by the Public Health AIDS unit.

covered by the grant falls, there is no official record of the contribution expected from the provincial budget.

2. National funding of provincial posts

The National Directorate also funds salaries for a wide array of posts located in provincial units. Part of the national GAAP budget goes to fund two coordinators in every province (two Assistant Director posts, for external (NGOs, CBOs and business) and internal liaison.) In addition there are a number of Assistant Director and Administrative Assistant posts associated with the NIP interventions (VCT, HBC, PMTCT). Most provinces have appointed the PMTCT Assistant Director, while a number of provinces are still in the process of appointing assistant directors for VCT and HBC.[27]

The national department pays staff in these posts directly. The appointment process is run by the province and the selection decision must be verified by national. The national directorate provides job descriptions for the posts which can be negotiated by the units, although the national directorate has the final say. The appointees have short-term contracts (1-2) years with the national department; it is envisaged that in the future the staff will simply to taken over the by the provinces.

3. Condoms and the national procurement and distribution of in-kind resources

Some units of the Directorate support provinces by providing in-kind assistance.
One example is training provided by nationally funded trainers e.g. training of trainers for HBC in the Eastern Cape; training NGOs in project management, and training condom distribution site co-ordinators in the KZN.

The major example of national procuring resources is the condom programme. Condoms are procured with national funds and distributed centrally by the national DoH. (In addition, provinces may have their own smaller budgets for condoms.) The Chief Directorate: HIV/AIDS & STDs is responsible for delivering male condoms to 190 primary sites in the provinces.

The Chief Directorate estimated that the provinces required a total of 392 million condoms in 2001.[28] They reached this estimate by first conducting a survey of provincial condom coordinators. The estimate is derived from:

- Assessments by coordinators of what the off-take rate will be in their province
- Assessment of the provincial health system's capacity to distribute condoms from primary sites
- The demand for condoms.

In 2001/02 the Chief Directorate introduced a Logistics Management Information System (LMIS) to make condom distribution to the primary delivery sites more efficient. Prior to the LMIS, sites were provided with an arbitrary monthly stock

[27] The Northern Province reports a number of other nationally funded posts: High Transmission Area Officer, Surveillance Officer, Data Capture Officer and two general HIV/AIDS (PWAs).
[28] This figure of 392 million seems to be a conservative estimate considering that researchers believe it takes about 750 condoms in a public sector programme to avert an HIV infection. On this basis, a total of 460 million condoms would be needed to address the current estimate of 1,700 new infections per day.

allocation which did not take into account actual needs. This resulted in some sites building up over twelve months' supply whereas others suffered from frequent and often prolonged stock outs. The LMIS is based on a simple inventory control record or "bin card" which tracks what quantities have been received, what has been issued and where, and keeps a running balance on product on hand. One result of this method is that condoms are now much better accounted for at the primary delivery site level.

At the end of the month this card is used to complete a Monthly Stock Return which is faxed to the Chief Directorate. Information from the Monthly Return is entered into the computerized Distribution Planning module of the LMIS which generates delivery quantities and dates based on the documented consumption and stock levels of the primary sites. The intention is to ensure that sites receive new supplies in time to prevent them falling below a three month "minimum" stock level.

The new system is starting to have a measurable impact this year in reducing stock-outs at the primary sites in the provinces. However some provincial plans for increasing condom availability and accessibility were not realised, and thus the provinces' estimates of condoms needed turned out to be overly optimistic. Given this scenario, the estimated requirement for 2002 has been reduced to 358 million.

As mentioned above, some provinces procure additional condoms using their own resources. This then creates the need for coordination between the national and provincial efforts. Gauteng aims to supply 7 million pieces per month, 2.5 million of which are supplied from its own budget. The 2.5 million supplies five of the province's 42 sites, the balance being supplied by the Chief Directorate. According to the Chief Directorate this because the province lacks confidence in the ability of the national department to deliver sufficient condoms. With the introduction of the LMIS, the Chief Directorate believes it has sorted out these problems and is encouraging Gauteng to allow it to service all the province's primary sites. Gauteng confirms that it is not completely confident in national's ability to supply the required condoms, and the political stakes of condom shortages are very high. The province also points out the demand for condoms is growing in the province and there is some uncertainty of the extent of this growth. By doing some of its own procurement of condoms, Gauteng can build up a contingency supply. Gauteng uses the same suppliers as national; the national tender is simply extended to accommodate Gauteng.

4. NGO grants

As previously described, the National NGO Funding Unit provides grants from its own budget to provincial NGOs and CBOs. In Gauteng NGO funding is devolved to line departments. The section above covers this process in detail.

5. Commissioned work that (partially) benefits the provinces

Another instance where national interfaces with provinces is by commissioning the provincial departments of health to conduct research on behalf of the national department. This is how

the Annual Antenatal Survey was conducted.[29] The Free State reported that national commissioned provincial antenatal studies from the Data Collection and IT Section in their Health Department. The Northern Province reports the funding arrangement as a three-way partnership involving health institutions, the Unit and the national department, with the national department paying for the lab work.

6. Prevention of Mother to Child Transmission Programmes

As mentioned earlier, the PMTCT co-ordinator operates from the national Directorate offices. At the time of writing there was no information on the amount of funding national planned to make available to provinces to fund PMTCT programmes, or of the form that transfer would take. Thus far there was been no fund transfers for this purpose. Provinces have been asked to develop and submit business plans for MTCT programmes with budgets (but were not given a budget ceiling to guide them).

In the Free State, the unit has begun spending against its business plan in the expectation that it will receive the requested funds from national. They have not budgeted any funds from the provincial budget for this purpose in the event that national funding does not come through.

The Eastern Cape and KZN have allocated their own funds towards PMTCT. Ironically, of all the new, nationally initiated interventions, these projects tend to be the most advanced in implementation, clearly indicating the political prioritisation can push implementation despite the lack of secure funding.

Provincially sourced funding streams

Apart from resources provided by the national government, provinces rely upon four primary funding streams for them to support their HIV/AIDS programmes:

1. Provincial AIDS unit programme budget: Direct funding of HIV/AIDS unit programme through the unit budget.
2. Other contributions to provincial AIDS unit programmes: Contributions to HIV/AIDS programmes by other areas of the provincial health department or other provincial departments.
3. HIV/AIDS-specific spending outside the provincial AIDS unit: Funds which are specifically spent on HIV/AIDS but are not part of the unit programmes.
4. Indirect spending in regular budget caused by HIV/AIDS: Service delivery budgets impacted on by HIV/AIDS, usually outside of provincial AIDS unit programmes.

Provincial sources for HIV/AIDS are either the general provincial budget, from which funds are top sliced, or the provincial health department budget.

[29] The survey is the only instance where the Directorate conducts research itself. All other research needed by the Directorate is conducted by the national Health department's unit tasked with research for all of DoH.

1. AIDS unit's programme budget (excluding conditional grants)

Determining global amount of AIDS unit's programme budget

The provinces studied fund their HIV/AIDS unit's programme budget:

- As a line-item in Health's regular department budget, or;
- as a combination of a top slice of the general provincial budget (i.e. the provincial budget before it is allocated to the departments) and as a line-item in the regular health department budget.

How is the global amount of the HIV/AIDS unit's programme budget determined? The process for deciding the global budget for the AIDS unit depends on the source of the funds. Appendix H summarises the processes of quantification in each province.

AIDS unit funded as line item in health department budget.

In those provinces where the AIDS unit is funded as a line-item in the health department's budget, four different methods are used to determine the global amount.

- **Unit budget quantified through the normal budget process in which the allocations compete on an equal footing with other priorities (Free State).** For example in the Free State, the global health budget is split into Budget Programme Allocations in a meeting between Programme Directors. They negotiate the programme split on the basis of "historical costs, crude assessments of need and cost, and lot of political lobbying beforehand". The Budget Programme Director views it as a highly competitive process in which any budget allocation which underspends will be penalised in the future.

- **Top-down allocation by Health Department budgeting authorities – ability to spend seen as key criteria (Northern Province).** There is great uncertainty amongst some of the key people involved in the HIV/AIDs strategy in the province at present about the how the 2001 allocation was made to the unit and whether it was based upon a unit business plan.[30] Factors behind this uncertainty include:

  - the great number of different business plans for 2001 of unclear origin and status
  - since 1999, the shuffling of the responsible for AIDS between different managers
  - the recent upgrading of the unit to a directorate and the appointment of a new director from outside of the organisation.

  The 2001 unit allocation was deciding during the normal budget planning cycle held in 2000. According to the director previously responsible for the AIDS unit, one of the main concerns in determining the allocation was that the amount could be spent in the space of a year – this was judged on the basis of the unit spending record. However, the province only received notice of the amounts of 2001 NIP conditional grants they would receive too late in their planning cycle (February 2001) to be able to take them into consideration during the original drafting process. As a result the health finance section

[30] We know is that there are a range of business plans which give intervention allocations and whose totals approximate the global amount given to the unit, but whether and how the business plans were used in the process of deciding the allocation is unclear. We also know that historically directors have not been involved in budgeting.

later reduced the AIDS unit budget by the amount of the conditional grants to maintain the amount they judged the unit could spend in a year.

- **The Executive Committee or top political executive prescribes the level of funding that should dedicated to HIV/AIDS (Eastern Cape).** The Health Department was asked to spend R33 million each year for three years, starting in 2000. However this resulted in serious confusion and misunderstanding between Treasury and Health over whether Health was expected to take this money from its regular budget, or whether Health would be receiving a special top-slice of this amount. In 2000, the R33 million was not set aside at all, while in 2001 it was taken from the regular Health Department budget.

- **Baseline budgeting used to decide the global AIDS unit budget.** The Northern Province is moving towards a process whereby the allocations for existing services will be projected forward on the basis of unit cost increases and increases in demand for services. If positive, the difference between health departments' actual global allocations and the baseline is then available for new priority projects. Similarly the Free State stated it is beginning to introduce zero-based activity budgeting, which may signal a move toward baseline budgeting.

AIDS unit funded from combination of top slice and health department allocation

In Gauteng, the 2001 AIDS unit budget totalling R70 million, was a drawn from two sources: the top-slice, and the health department allocation. Prior to 2001, the department received its entire budget from the top-slice. As far as the unit director is aware, the portion of the unit budget sourced from a top slice of the provincial budget was determined by a cabinet decision based on the following information:

- The MTEF with its projected outputs;
- Costings around new interventions and the demand for those interventions;
- Regular progress reports on the progression of the epidemic and the outputs of spending and new trends in intervention policy, and;
- The size and purpose of allocation from the Health department to interdepartmental unit.

The allocation from the DoH is the sum of HIV/AIDS designated amounts that are determined through the department's normal budget process. The allocation to the unit was apparently not "scientifically" determined, although the department has have extensive experience in budgeting for HIV/AIDS service outputs and so the output implications of the allocations were presumably know and deemed acceptable. They are transferred to the interdepartmental unit because of the role the unit has historically played in developing HIV/AIDS projects. In 2001, the department transferred approximately R20 million to the interdepartmental unit for HBC and hospice beds projects.

The KZN AIDS unit budget consists of three provincially sourced amounts, in addition to the national conditional grants (see Appendix H for more detail):

- Firstly, an allocation based on a decision of the provincial cabinet;
- Secondly, an allocation by the health department from the health department's allocation, and;
- Thirdly, an allocation by the health department that matches the national conditional HIV/AIDS grants in some manner.

Crowding out regular health department spending?

When all or some of the AIDS unit budget is decided through the health department's regular budget process, it suggests two key issues:

- To what extent does the AIDS unit budget affect the total amount going to the provincial health department?
- To what extent does the AIDS unit budget displace regular spending in other areas of the health department?

The provinces have different experiences with this issue. In the Free State, the allocation to the health department is done on a historical incremental basis and not adjusted for the extra burden of HIV/AIDS. However there are plans to introduce activity-based budgeting into the interdepartmental allocation process in the future.

Also in the Free State, the DHS Programme Manager also makes the allocation to the HIV/AIDS subprogramme and, in securing the programme budget in a negotiation process between other programme managers, attempts to accommodate both the DHS services and HIV/AIDS intervention within the programme allocation. This arrangement may limit the impact of the HIV/AIDS intervention on the DHS. This is not the case in the Eastern Cape where the AIDS unit budget is ring-fenced and no compensatory adjustments are made to the DHS Budget. If expenditure in the AIDS unit budget is tardy, ring-fencing could have the effect locking resources away from areas of more successful spending.

How AIDS unit budget is broken down

General approaches to allocating AIDS unit budget

The way that unit budgets are broken down depends to large extent on how the global amount of AIDS budget was determined. Appendix I contains a table detailing the general approaches used by the provinces in drawing up their AIDS unit budget. The table suggests the following typology:

- **Joint business planning process within a given global budget envelope, using activity-based costing (Gauteng).** Once the annual global allocation is determined, the interdepartmental AIDS unit in health facilitates an annual planning meeting in which all departments and key civil society sectors are represented. In preparation for this meeting, the AIDS unit adjusts the MTEF figures on the basis of new costings and the new global allocation for the upcoming year, and then makes this information available to departments.

  The departments are already underway with their own annual planning, of which AIDS is a component. In theory the annual meeting is a joint planning discussion for the purpose of co-ordinating activities and working out which aspects of the plan should be funded off the AIDS unit budget. The portion of the AIDS unit which was sourced from DoH is earmarked for particular health projects, but these are not the only resources that flow to health programmes from the unit budget i.e. in 2001 HIV programmes run in health outside the AIDS unit received an additional R10 million from the AIDS unit.

  Following the annual meeting the departments go back and do detailed planning based on the spending envelopes they were assigned and the standards and targets agreed upon at the meeting.

The plans the departments come up with are submitted to the unit which compiles them into an AIDS unit annual plan and budget. The unit in turn submits the plan and budget to the Health HOD for approval. In making approval, the head of the health department considers:

- equity between department allocations (health should not be receiving excessive amount, and the unit should be seen to be non-partisan), and;
- the delivery record of departments.

➢ **Combination of historical increments for pre-existing activities and crude costings for new activities within a budget envelope (Free State and Eastern Cape).** Both Free State and Eastern Cape provinces seem to use a mixture of approaches when formulating their unit budgets. Posts are costed at approximately their real costs, while some pre-existing projects may be incrementally increased from a base that has evolved over time (through control adjustments etc).

Frequently the amounts linked to new or newly prioritised projects are based on a judgement of the relative importance or likely spending demands of the new project in relation to the other project allocations and the global unit budget. The R1 million given to NGO funding in the Free State is a good example of this.[31]

➢ **Top down business planning (Northern Province).** What we know about the process through which the global budget is determined is outlined above. The allocations made to individual AIDS interventions are taken from the budget attached to the unit's business plan. Because the provincial health allocation to the unit budget has been reduced by the NIP conditional grant amount (following the receipt of the information about the conditional grant amounts), the unit budget has to be redesigned to accommodate the grants (with their conditions), while remaining compatible with the original business plan.[32] The director will undertake these adjustments in conjunction with the health finance section.

➢ **Portfolio business planning in the absence of envelopes (making adjustments necessary) (KZN).** The director asked the portfolio manager to develop and submit business plans in the absence of any guidelines on their budget ceilings. The director now has to fit these business plans into the global KZN unit allocation, while roughly remaining within the standard item distribution associated with the unit budget. This scenario is likely to be an even trickier process than the process above, and result in even more arbitrary cuts or increases.

[31] The Free State stresses that the real costs of interventions are not known to them at present and a number of the allocations are based on what seems to be right and will be fine-tuned in the budget monitoring and control process.

[32] The unit's standard item budget was untouched during adjustment for the conditional grants and so probably also requires change.

Provincial own funds spent on NIP programmes

All provinces allocate amounts to VCT and/or HBC programmes in addition to the NIP conditional grants received by the AIDS unit from national.[33] This raises issues of which funds flow to which parts of these programmes.

In KZN, the HBC conditional grant is managed separately from the amount the province allocated to HBC, each being spent on different projects. The provincial health allocation appears to be based on some kind of activity budgeting and cover mainly established activities, with a few new ones added. The provincial money allocated to VCT in addition to the conditional grant is used for specific activities intended to complement the conditional grant-funded VCT activities. Similarly in the Eastern Cape, the additional VCT funds from the AIDS unit budget are linked to particular purposes separate from the conditional grant.

In the Free State, the provincial amount allocated to HBC is supposed to serve as a buffer to absorb any over-expenditure on activities covered by the grant. The amount appears arbitrary.

Use of buffers or contingency funds in AIDS unit budgets

In the Eastern Cape the PMTCT line-item has deliberately been inflated to act as a kind of contingency reserve for other HIV/AIDS interventions. The intention is to use the budget for unplanned spending on medicines that might arise from VCT. The province feels that people need to be given an incentive to use the VCT services in the form of some kind of a prophalaxis drug (co-trimaxazole (Bactin)). A certain level of funding has been set aside from health department funding on the VCT budget for this, but the feeling is that the demand will too high for that budget to cope.

NGO funding and transfer mechanisms[34]

Apart from the provinces' access to money from the National NGO funding unit, all provincial AIDS units have their own separate funds to provide NGO grants, with the exception of Gauteng.[35] The Free State has two funds—one for IEC and the other for HBC. While the Free State restricts the IEC fund to IEC activities only, the Northern Province explicitly makes the NGO fund available to support a wide variety of activities.

Thus as described in the section above, NGOs in the provinces can receive funds from the National NGO Funding Unit (via a recommendation to national from the provincial NGO co-ordinator) or an NGO might receive a grant from the provincial budget directly. The National NGO Funding Unit assumes that NGOs receiving money form national and from provincial budgets undergo the same selection procedures and requirements with the provincial NGO Funding Committee.

The existence of funds for NGOs from the provincial budget and from the National NGO Funding Unit requires co-ordination between these two levels. NGO co-ordinators must have criteria for assessing whether a) an application merits funding, and b) whether that funding

[33] This precludes the Northern Province, where there is confusion about the unit business and detailed budget.
[34] The structures set up to manage and support these funds and their functions are discussed in A2.1.5.
[35] In Gauteng, the fund is located on individual intervention allocations (as a line item), which are mostly transferred to line departments, as mentioned previously.

can be provided with provincial funds, and c) if not, ought the application be forwarded and recommended to the national NGO funding unit. Information on how provinces decide whether a qualified NGO will be recommended to national for funding or funded from the provincial money available is somewhat unclear. In the Free State, generally more established or previously-funded NGOs are recommended to national, while the province itself gives grants to smaller, younger NGOs.

With some of the larger funds such as KZN, Eastern Cape and Northern Province, it's unclear whether all NGOs supported by the AIDS unit and the districts will be funded exclusively from these funds. In the Free State, the AIDS unit director responsible stated that individual interventions, which will eventually be decentralised, will contract and monitor the NGOs used in their activities. Similarly in the other provinces, it seems that NGOs may also be funded from individual intervention or project budgets.

In the cases of decentralisation to projects it is unclear whether the NGO will be monitored by the NGO co-ordinator, and whether NGOs will be screened by the provincial NGO Funding Committees set up in most provinces. As it is a departmental procedural requirement[36] that all NGOs funded by the department are vetted, all NGOs seeking funding will probably continue to pass through the Committees. In the Free State, a separate committee has been set up to vet HBC NGOs applying for funding, although the province intends to establish one committee for all NGOs. In most provinces, regions and NGO monitors are represented on Committee—allowing a flow of information between the vetting authority and the level of service delivery.

Size and number of grants. In some provinces individual allocations to NGOs might be quite small e.g. KZN and FS where the annual payments are R5000-R25000. The Free State has spread its funding over numerous NGOs (approximately eighty in 2001). These payments are to new NGOs, which the province is trying to test for future funding. In their assessment, a large number of NGOs will be required in the future and the core of known and reliable NGOs ('established NGOs') has to be broadened.

Transfer of funds and monitoring. In most provinces, the provincial NGO co-ordinator handles NGOs funded by the National NGO Funding Unit *and* NGOs funded by the province. With respect to the nationally-sourced grants, the ultimate authority rests with the national DoH in the National NGO Funding Unit and the provincial NGO co-ordinator acts as a monitor and point of contact between national and NGO (for example: submitting activity reports to national, making site visits, updating provincial recommendations on NGO applications each year). Gauteng has more decentralised system of monitoring which involves regions, the intergovernmental unit, and the regular health unit.

Provinces also have requirements and procedures pertaining to those NGOs they support directly from provincial funds. The PMFA obliges departments to ensure that the NGOs they fund have proper financial management and control systems.[37] In the absence of a written assurance from NGOs about these systems, the departments have to take measures to ensure that the money transferred is properly spent. These requirements upon NGOs can include: regular reporting procedures, audit requirements and submission of audited statements, regular monitoring procedures, scheduled and unscheduled inspection visits or

[36] This procedure may also be given in provincial treasury directives.
[37] PFMA section 38 (j).

performance reviews.[38] The regulations also specify the reasons for which the department is permitted to withhold payment e.g. agreed objectives are not attained.[39]

Transfers to NGOs usually occur in form of annual grants which are often paid in instalments subject to adequate performance, financial control and reporting which is all specified in an agreement or contract between the NGO and the unit. (NGO monitors are meant to validate the NGO reports, however some provinces have only one monitor and NGO oversight capacity is thus thinly stretched.) In the Free State, because the funds to NGOs are so small, grants are released in a lump sum. The only sanction available to the AIDS unit is to blacklist the NGO for future years.

KZN, in contrast, has a highly bureaucratic system for releasing funds to NGOs. Each NGO submits receipts on work undertaken which is processed by the unit. Receipts go via the NGO Funding Portfolio Manager to the Chief Administration Clerk in the DoH. This long process often results in mistakes or delays. At the least, NGOs are paid 3 weeks to a month after submitting.

2. Contributions to AIDS unit programmes from outside unit – designated and non-designated

Especially in the case of new interventions, other institutions besides the AIDS unit end up contributing resources to run programmes. The resource contributions might be

- incidental expenses e.g. time to attend training courses, transportation to courses, management time in attending courses, or;
- expenditure required for a particular activity e.g. setting up step-down facilities, rendering STD control services, distributing condoms.

ATICS play an important role in a number of unit strategies. The provincial AIDS unit might also require technical or support sections of the health department for their contributions.[40] These contributions can either be reflected explicitly on the budgets of these other institutions as HIV/AIDS expenditure (designated) or not (non-designated).

Non-designated

Most frequently, other institutions contributing to AIDS unit programmes do not specifically designate spending in their budgets for this purpose.

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

The Free State has suggested that the monitoring and control function can be used to ensure that regions have adequate resources to make their required contributions. However this is possible in the Free State because control of the unit budget and the district budgets is held by one person, the programme budget director.

[38] These are given in section 8.3 of the Treasury Regulations issued in terms of the PFMA..
[39] The Provincial Treasury can issue further directives on NGO funding.
[40] For example: corporate communication designing and managing the media campaign, IT or Epidemiology Section conducting antenatal study, the nutrition of mothers and children for mothers on PMTCT programme by the Integrated Primary Health Care Directorate.

As mentioned, budgeting in delivery sections is frequently not project based and therefore it is difficult for the review authority to understand what is included within them. Monitoring and control would thus have to be extremely proactive, focussed and detailed to achieve the necessary adjustments.

Designated

In KZN, the health department (as opposed to the unit) allocates funds to regions specifically designated for HIV/AIDS at the beginning of the financial year. It is unclear whether these funds are housed in a designated fund by regions and whether they are required to report on them to the AIDS unit or another authority. None of the respondents could provide a clear view on what these funds are used for. Some of the Portfolio Managers in the AIDS unit, when drawing up their business plans, seemed to think that regions could draw on these budgets (and their own budgets) to make significant contributions toward meeting portfolio plans. Others were unaware of the funds the region already had, and therefore planned to transfer large amounts of their portfolio budgets to the regions.

3. Dedicated HIV/AIDS expenditure outside the AIDS unit activities

The previous section looked at contributions by institutions outside the AIDS unit to the implementation of AIDS unit programmes. A third funding stream is contributions by non-AIDS unit institutions which are designated for HIV/AIDS but are not part of the AIDS unit's programmes.

This category is small and problematic to identify. Generally, these expenditures are for:

a) long-established health services that have a special bearing on HIV/AIDS and need to be reoriented to maximise their impact on the epidemic e.g. TB Services;[41]
b) long-established HIV/AIDS specific interventions, now funded by the districts / regions;
c) policy-making and research processes that fall outside of the unit strategy. [42]

As regards the third group, the Premier's Office in KZN has allocated a portion of its 'Provincial Policy and Co-ordination Programme' to policy development under the headings of the 'Integrated Response Framework to Poverty and HIV/AIDS' and the 'Provincial Gender Equity Programme', which includes a component on gender and HIV/AIDS. Gauteng is the only other province to allocate funding for policy development and research; it does so within its AIDS unit, but draws on donor funding.

4. Routine service delivery budgets impacted by AIDS

Generally speaking, there is between little and no clear research on the impact of HIV/AIDS on regular health services which is available to provinces for budgeting purposes. Provinces must generate approaches based on modelling estimates and anecdotal evidence:

- The Free State only has anecdotal evidence of the impact of HIV/AIDS on mainstream health services. The AIDS unit's approach is to observe the take-up of the new

[41] In the Free State, TB services do not appear to fall within the ambit of the strategy, where in most provinces they are mainstreamed contributions to the strategy. TB Management is usually subject to a unit intervention.
[42] We have not considered this category closely in our study and merely include a brief discussion for completeness.

interventions; observe the effect they have on the mainstream burden; get some idea of the relative cost differences between mainstream and new services; and then plan new services on the basis of this understanding

- The Gauteng unit has done modelling on the impact on mainstream health services and the cost implications. They have modelled and monitored the costs of new interventions in quite some detail e.g. they have detailed costings for HBC model, that seem to question the costing figures arrived at by the national department.

- KZN has no systematic process to determine future budgetary implications, and relies on anecdotal and 'common sense' reading on the basis of the consumption of services to make projections.

- The Finance Section in Health & Welfare Department of the Northern Province is in the process of developing systems and mechanisms to assess the future budget impact. At present they are looking at pharmaceutical spending and incidence of returning patients.

Additional funding streams

a. Donor funds

Although this is not a primary focus of this research project, provinces also receive donor contributions. These non-governmental sources include contributions and partnerships with civil society and the private sector.

Civil society resources are often in-kind or in the form of sponsorships. AIDS councils frequently solicit contributions from non-government sources, although the provincial AIDS units might approach other groups e.g. pharmaceutical companies training of medical practitioners in STD protocol. In the Northern Province, Spoornet and National Roads Agency (parastatals) have donated money to the High Transmission Area project. Appendix J gives further examples of how provinces use these donor funds.

The Free State is in the process of establishing a HIV/AIDS provincial fund to which cash contributions from the public at large, including civil society group e.g. business, can be made. The fund would be under the control of the Provincial AIDS council and will be initially used to fund their co-ordination activities. Once large enough it could be used to fund a wider array of projects.

Some of these arrangements with NGOs and universities might be better described as partnerships. For example, the Free State makes extensive use of the 'STI Initiative' and the Health Systems Trust to provide staff training on STI services.[43] Appendix J contains further examples of some of the cooperative efforts underway between provinces and universities.

b. Contributions from local government

Provinces also seem to draw on local government resources in an ad hoc fashion. Both examples come from the Free State. Through an historical arrangement, the Bloemfontein Municipality funds the operational costs of the Bloemfontein ATIC. Staff costs are covered by the unit and routed through the district. The provincial AIDS unit also expects District

[43] The Free State sends its STD Co-ordinator to the STD Initiative headquarters for training, while the HST funds workshops run by the STD Initiative for line staff STD service providers.

Councils to make a contribution towards the costs of setting and running District AIDS councils. In the future, Gauteng hopes to leverage local government resources in a systematic and strategic fashion through the 'local integrated strategies' it is facilitating.

Expenditure monitoring and control

The previous section looked carefully at the nationally-sourced and provincially-sourced funding streams. This section looks at how these funding streams are monitored and what expenditure control systems are in place at the provincial level.

There are three basic instruments for budget monitoring and control mentioned in this paper: activity budgets, business plans, and performance indicators. Its important to note that the processes described below are used by provinces to track AIDS unit budgets *and* NIP conditional grant monies.

a. Monitoring

Activity budgets and financial monitoring

Each of the provinces submitted business plans in order to access the conditional grants from national. However few of the provinces have detailed useful business plans and activity budgets for the rest of their AIDS unit budget. For example, KZN is still in the process of compiling its overall business plan, and individual intervention business plans have not been authorised. In the Northern Province, the entire unit business plan is under question, while in the Eastern Cape only global interventions amounts are given.

Where activity budgets exist with the provinces, they are informal and do not form the basis of the financial management systems. There are two systems in use by provinces: the widely-used FMS system, and Basic Accounting System (BAS) which is an 'on-line' system being introduced in some provinces e.g. Gauteng and the Northern Province. Both systems use objective codes and divide the budget into standard items and then posting level items. **However these categories cannot provide the level of detail needed to track how much has been spent for each project or activity**. Some AIDS unit directors and project managers say that they attempt to reconcile expenditure to the activity budget informally by keeping their own records. Furthermore, it is extremely unclear how, without a routine system of activity-based reporting, provinces will be able to report to national on the progress made on their NIP business plans.

Performance monitoring

Some of the provincial unit business plans are better than others at including indicators for monitoring performance. Gauteng and the Eastern Cape seem to be the best covered, although the Eastern Cape plan is not a full-scale business plan with milestones and associated time frames. Gauteng's business plan does include a complex set of indicators relating to intervention coverage targets. As noted above, KZN, Northern Province, and the Free State do not have finalised business plans. However, the Free State has defined some broad indicators based on achieving a certain level of coverage of the VCT and HBC interventions e.g. 25% of towns have implemented VCT.

The Gauteng AIDS unit director has suggested that prevalence and behaviour surveys as well as external intervention evaluations be conducted in order to better monitor programmes.

b. Expenditure control

The ultimate budget controller for the health department budget is the Chief Accounting Officer, which in practice is the HOD. The role played by the HOD seems to vary in practice from province to province. For example, in KZN once business plans are approved, each activity expenditure requires a detailed budget motivation, and this is carefully scrutinised by the HOD who 'often asks for cheaper options to be explored'. The portfolio managers seem to be responsible for forwarding activity expenditure plans to the HOD (although formally this may be through the Unit Director).

The finance sections in health departments also play a monitoring role. For instance, in the Eastern Cape the finance section watches expenditure flows and advises the unit director if the pace is too slow. In the Northern Province, which is keen to encourage meaningful decentralisation of budget responsibility, the chief financial officer tracks expenditure closely without resorting to "micro-controls."

Day-to-day budget management and control is usually taken care of by the AIDS unit director.[44] Below the unit director, there is another level of budget control - that associated with project / intervention implementation, a large amount of which occurs in the regions or districts.

In the short term, it is impossible to simply move spending authority for a project from one individual to another. The reason for this is that spending authority is attached to staff ranking, meaning that an individual's spending authority can only be increased if they are promoted. [45]

With spending authority fixed, two possible methods remain for decentralising programmes:

- Moving project responsibility: a manager or co-ordinator is given responsibility for a new project.
- Transferring budgets: budgets are moved from a central level to less central.

Below we describe three scenarios, with different types/degrees of decentralisation.

1. **Delegation within the unit and funds remain on unit budget.** Control responsibility for particular conditional grant-funded items may be delegated to staff under the "control" of the unit director in accordance with the rank of the staff member. For instance, in KZN the NIP health conditional grants are allocated to AIDS unit portfolio managers. These managers, whom are ranked at Assistant Director level, are given a certain level of control over the budgets allocated to their portfolios. Delegated budget items remain on the unit budget, and barring any lower level of delegation, the portfolio manager would spend the money directly.

[44] In the Free State, for instance each of the budget programmes are managed by a specific director (drawn from the line-management structure). As mentioned above, unit budgets reside in District Health Services Programme. The budget programme director is the same person as the director in charge of the unit (although this is set to change with the conversion of the subdirectorate to a directorate). As District Health Services also includes Health Districts (clinics and district hospitals), the unit director is uniquely positioned to control the expenditure of the unit and expenditures of districts, where a significant amount of unit budget spending actually occurs and whose resource contribution are vital to unit-funded interventions.

[45] Authority is defined by the limits to which an individual can authorise expenditure for, without having to seeking authorisation herself and laid out in department rules.

2. **Delegation outside of unit, but funds remain on unit budget.** Similar to the first scenario, budget items may remain on the unit budget, however they may be spent by delivery institutions *outside* the AIDS unit. Here a project manager with the appropriate level of authority is designated by the AIDS unit or the district etc. This project manager then authorises the spending of unit funds during project implementation.

   In other cases, spending co-ordination responsibility may be delegated to staff without spending / control authority. Such co-ordinators would need to obtain authorisation from another person in authority.

3. **Decentralisation of programme responsibility *and* transfer of budget from the unit to the district or regions.** A budget item can be moved from the AIDS unit budget onto the budget of a line manager outside of the AIDS unit. This requires a budget 'correction'.[46] However there are statutory limits to the amount of funds that can be moved via a budget correction. For instance, the Free State is contemplating decentralisation of the portion of its VCT budget for the construction of counselling facilities. Another example is found in the Eastern Cape where the unit is planning to decentralise R400 000 to each of the 5 regions for condom distribution in 2001.[47]

   In interdepartmental units, funds move between the unit and departments. In Gauteng, most of the unit's budget is decentralised to departments in a formalised manner towards the beginning of the year through an adjustment budget. The accounting officer of the receiving department is responsible for allocating these funds to relevant department sections and ensuring that systems are in place to direct spending in line with the annual interdepartmental plan. Departments themselves may choose to centralise funding to AIDS units within their administrative structure; decentralise to regions; or have some arrangement which is a combination of the two. For example, Gauteng's regular Health Department runs a combined system. Department-based units may use similar processes to those described above to transfer and control spending.

c. Transfer mechanisms to spending agents from the budget in which the fund resides

Funds are normally transferred to spending agents, whether within or outside the unit, through the internal accounting system. In theory, spending controllers with an adequate level of authorisation only need the responsibility code, objective code and standard item to get a transfer of funds to the spending agents they are managing. Where the project manager or co-ordinator does not have the required level of authority, she must seek authorisation. In the case of the Free State, this only takes a number of days.

After expenditure is authorised, payment has to be issued. The respondent in the Eastern Cape reports that this follows a convoluted process. The AIDS unit sends a payment requisition to Health's Financial Management Branch which then submits it to the Provincial

[46] There are statutory limits to a budget correction that can take place without the need for legislation. According to the PFMA (section 43), budget programmes (i.e. main divisions of a vote) can be changed by below 8% of their totals without legislation having to passed. Decentralisation of HIV/AIDS budgets is unlikely to be effected by this limitation as the amounts to be transferred are relatively small and funds are most likely to move between the unit and regions, whose budgets occur in the ***same*** the budget programme.

[47] Regional directors have to submit business plan to access these funds. The process is made more complicated by the re-alignment of regional boundaries to those of districts.

Treasury which in turn will pay on an order issued by the Health Department given 'certain criteria are met'. Such a lengthy procedure has high transaction costs. However most provinces seem to follow a similar procedure. This appears unavoidable unless health departments are given the authority and capacity to pay accounts directly.

IV. Challenges with current funding mechanisms

A. General difficulties at national level

As addressed in the preceding paper, in NIP programmes where offices in the Chief Directorate are supporting the provincial implementation of programmes, the relationship with the provinces can be a source of problems.

Looking at the Chief Directorate as a whole, including non-NIP activities, there are two other primary sources of difficulty. First, in units where the Directorate is responsible for implementing programmes at a national level, the tender process requirements and efforts to around it, can create large transaction costs. Second, the Chief Directorate, in working with other national departments, generally struggles to convince other national departments to view HIV/AIDS as part of their core business.

Effects of tender process requirements

By law, the DoH must undertake advertisement, solicitation of tenders, assessment, and panel decisions involved in the required tender process for any supplier which is to be paid over R 30, 000. The Partnership Support unit does operate through tenders, but many units of the Chief Directorate try to avoid the complicated and time-consuming procedure. When national departments are primarily tasked with supervision and policy setting, this ceiling is not frequently reached. However, because the NIP was only established in 2001, it is still developing and decentralising to the provinces. For now, the national office is shouldering much of the program co-ordination and implementation itself. Furthermore, the national HIV/AIDS programmes—such as GAAP's public awareness campaigns—are implemented by the Chief Directorate. [48]

Thus, these sections of the Chief Directorate which are trying to actually implement programmes themselves are feeling especially constrained by the tender requirements for suppliers past R30, 000. One option is to fractionalise a project budget and patch together funding from different sources—so that each does not contribute over R30, 000 in sum. Although this avoids the hold-up in the project timeline required by a months-long tender process, it creates huge transaction costs. Dealing with lots of small contributors, suppliers, and partners takes significant co-ordination, administrative time, and extra financial management. The Chief Directorate contains more than one examples of complicated budgeting resulting from these incentives and constraints.

[48] The problem is alleviated at the provincial level where departments set thresholds independently (subject to Provincial Treasury regulations if there are any). For example, in the Free State and Gauteng the threshold is R100,000.

Incorporating HIV as core business in other departments

A basic theme underlying the DoH's relationship with the other national departments has been the need to demonstrate that HIV/AIDS is not simply a health issue, but must be taken on and understood as part of the core business of multiple departments. [49] Centralising the national response to HIV/AIDS in the Chief Directorate presents a trade-off—it has the advantage of improving communication, budgeting and efficiency, but the disadvantage of reinforcing the notion that HIV/AIDS can and ought to be dealt with in DoH alone.

By the Chief Directorate's perception, interdepartmental meetings were not successful because of a pervasive attitude that HIV/AIDS was essentially DoH's responsibility, and the role of other departments remained to advise. This has improved noticeably in the last year as other departments better recognise the effect HIV/AIDS has and will have on other sectors. By DoH's perception, it is not that other departments are unwilling to integrate HIV/AIDS into their work, but that they are unclear on how to make the connection to their core funding and how practically to incorporate the impact of HIV/AIDS in their budgets.

As long as HIV/AIDS is viewed as an added priority, it is susceptible to being sidelined in budgeting and management. By the DoH's perception, AIDS must be built into the core business of departments instead of competing with other priorities.[50] Ideally, government response to HIV/AIDS would be incorporated into existing spending and HIV-specific line-items would only be used for start-up costs. [51]

B. Issues in provincial health department strategies

Mainstreaming HIV/AIDS in regular health service delivery

In our research, unit staff frequently identified their strategic responsibilities as being to assist the Health Department to budget for HIV/AIDS epidemic. One of their key strategies to achieve this seems to be[52] to run a series of projects from a central unit in the hope that this experience will give clinics and districts the knowledge of how to budget for the projects and the motivation to do so. This strategy has yet to prove effective. Rather, the unit budgets grow. A key criterion for success in HBC, for example, would be whether it can be decentralised to districts and local government, rather than become a growing responsibility for the provincial unit.

Two of the reasons for the lack of progress in mainstreaming could be that:

- The incentives do not exist for districts and clinic to mainstream an HIV/AIDS angle into regular service delivery.
- The continuity and quality of staff in the units to drive the process over time has been absent. (Gauteng is an exception to this, although the unit can experience rapid turnover in its lower level posts, with a number of them unfilled at present). (The provinces report success in mainstreaming STD control).

Integration of NIP programmes

[49] C. Serenata, interview 28 May 2001.
[50] Dr. Liz Floyd, Idasa briefing, 31 May 2001.
[51] Dr. Liz Floyd, Idasa briefing, 31 May 2001.
[52] It is not clearly stated in documentation, but can be inferred by their responses to questions

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

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

C. Problems with funding streams

National funding of provincial posts

When national funds provincial posts, it increases provincial capacity but can also create new difficulties:

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

From the perspective of the provinces, the content of nationally funded posts in provincial offices seem to be decided on without reference to the provincial AIDS unit. In KZN, Assistant Director posts for VCT and HBC already existed before national informed the province would pay for these portfolios. The provincial AIDS unit was then unable to convince national to spend the available funds on other staff posts instead.

NGO grants

Audit and application requirements. Selected NGOs must meet certain requirements to receive funding, as listed above. These necessary requirements allow the provincial co-ordinator and national NGO Funding unit to monitor projects and be aware of potential problems, but they also slow the process down considerably from the perspective of the grantees. Where NGOs have difficulty fulfilling requirements, NGO capacity building projects (mentioned as a priority by all provinces) and the mentoring programme organised by the National Funding Unit are intended to address this.

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

Limited grant oversight capacity at provincial level. The National NGO Funding Unit has stipulated that each province recommend no more than 15 NGOs for a first reading or

consideration by national, for a total of R1.7 million. The figure was intended to give the provinces a rough estimate of what resources they could expect from national, for planning purposes. Further grants—beyond this ceiling—were distributed to the provinces later in the financial year. However one limitation is in finding credible NGOs who meet the necessary structural and financial requirements (contained in the PFMA) for receiving public funds. Another limitation might be the capacity at the provincial level to sufficiently and responsibly manage a large number of grantees. For example, the Free State and Northern Province each have a single person to monitor and support NGOs.

One solution to this problem would be for the National Funding Unit to fund salaries of additional provincial NGO co-ordinators. However this is not possible because the National NGO funding unit is not permitted to use its budget for provincial salaries—it can only go towards NGO grants.

NGO payments. Some provinces' NGO payment systems are very cumbersome and costly to run e.g. receipt-based payment in KZN. Furthermore, at present, the national system can put provinces in a troublesome position. One province has reported that the approval of business plans submitted by NGOs previously funded by national department has been slow this year (due to the increase in NGO application assessment staff in the department). When the lengthy approval process at the national level delays payment of grants, provincial co-ordinators can become the middle-man in conveying NGO frustrations to the national level. (Furthermore, the lengthy approval process can have the effect of interrupting services.)

Conditional Grants

The issue of conditional grants is covered in greater detail in our first paper.

Funding of Prevention of Mother to Child Transmission Programmes

The status of PMTCT funding was unclear at the time of writing. Some provinces are using bridging funding from elsewhere in their budgets (Northern Province and Free State) in anticipation that a national grant will cover what they have submitted in their business plan. There is no clarity on what will be ultimately available to offset spending to date.

Some provinces have allocated their own funds to PMTCT, but are operating within two site guidelines set by national. There may be an oversupply of money if a national 'grant' eventually comes through.

In-kind 'payments' by national

National procurement of in-kind contributions is sometimes at odds with the implementation plan of provinces and may impact on their budgets in negative ways. For example, national selection of blood tests for initial HIV testing requires that a nurse do the test, whereas the province planned otherwise. This suggests there is limited co-ordination in setting medical standards / guidelines within projects, and that national standards are being imposed on provincial projects. While this might be the right decision, further negotiation between provinces and national prior to budgeting would allow better provincial planning and resource control.

Budgeting process

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

More specifically, other problems are evident with the budgeting process:

- Units and the Health Finance Sections may have different approaches to mainstreaming HIV/AIDS expenditure. The sudden allocation of large amounts to a unit may mean that established projects that are already meant to be mainstreamed are kept on the unit budget, along with new ones, in a bid to minimise underspending. This may set up precedents in spending that disrupt the functioning of the unit budget and gives negative incentives to clinics and other health institutions to shift spending to units and not budget properly e.g. the Eastern Cape.

- Districts are usually expected to contribute to provincial AIDS unit interventions, although the expected contributions are not usually made explicit timeously in the budget process. The budget process is not providing for enough coordination and communication between the provincial AIDS units and the regions. Given the limitation of the financial management system (discussed below) units can often not detect whether the districts has budgeted enough.

- Conditional grant business plans and provincial budgets and plans for the same activities (VCT and HBC) are drawn up separately and without reference to each other. Provincial unit plans may be drawn up without anticipation of conditional grants. One of the contributing factors behind this is that there as yet no MTEF projections on conditional grants, and provinces are informed of their allocation very late in their budgeting processes. This can result in:

  (a) 'double funding' of activities
  (b) doubling of effort if both sources used
  (c) no real sense of how slightly different sets of activities within same basket, funded by different sources, align.

- In some provinces difficulties arise when the managers of individual interventions are required to develop their intervention budgets from the bottom-up while concurrently the global allocation is essentially handed to the unit in a top-down fashion. In the case of KZN in 2001, although the top-down process preceded the bottom-up, intervention managers were given no budget envelopes to guide them. As a result, when the individual intervention budgets are summed together they do not equal the global allocation. The bottom-up and top-down versions of the budget must then be reconciled—a slow process with high transaction costs and which likely leads to arbitrary cuts.

Financial management system and budget control

Expenditure reports generated by the financial management occur in terms of 'objectives' which are often very large groups of activities, and are structured by standard line items (e.g. personnel, administrative) and then further broken down into posting-level items. Broadly speaking, this has two key negative effects. First, the system does not allow for tracking of

expenditure on particular projects and thus makes monitoring and control, vital when trying to pilot new services and mainstream them, very difficult. Second, this system also makes reporting on conditional grants difficult.

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

- The misallocation of conditional grants / project budgets to incorrect line items disrupts the flow of funds because the provincial AIDS unit cannot justify the expenditure authorisation if its presented in an incorrect form.

- In general, provinces have no capacity within the province to track what expenditure is attributable to HIV/AIDS, e.g. there is no database ability to analyse pharmaceutical purchase trends. There appears to no way to 'tag' HIV-related expenditure in the FMS systems.

V. Conclusion

Within government, the public health sector has historically taken up the responsibility for HIV/AIDS and until two years ago, interventions and projects have overwhelmingly been run from health departments. The advent of the government's new National Integrated Plan in 2000 marked a shift towards a government response to HIV/AIDS which includes all departments and all social sectors.

The Health Sector still takes the lead, but is also promoting and developing responses in other government departments and leverage resources from outside government to complement public responses. At the national and provincial level, funding resources and expertise are centralised in specialised, high profile HIV/AIDS units which utilise a number of strategies:

- Supporting interdepartmental forums which aim at getting departments to commit their own resources to fighting HIV/AIDS in efficient and effective ways;
- Funding joint government-civil society forums which are aimed at leveraging resources from civil society;
- Directly implementing certain projects that are quite broad, but have historically become associated with health e.g. social mobilisation and information, education and communication;
- Directly implementing certain projects that are more strictly health related;
- Providing funding and in-kind support to activities implemented by agencies outside of the unit, and;
- Accessing and packaging donor funds for particular activities run from inside or outside of the unit.

The Chief Directorate for HIV/AIDS at the national Department of Health, except for its support for interdepartmental and civil society forums, has tended to direct its activity at supporting and resourcing health-type interventions.

Some provincial AIDS units have taken a different interdepartmental approach—by providing funding for interventions carried out in other departments, and directly supporting those departments at a technical level to develop these interventions. The first, limited strategy appears to have had little success in getting departments to mainstream HIV/AIDS interventions, although as HIV/AIDS becomes prioritised at the political level, mainstreaming is beginning to occur. The weak response of other departments outside health is largely due to their uncertainty about a) the precise size and nature of the impact of the epidemic on their budgets and; b) how this should be incorporated onto their budgets e.g. which expenditures should be displaced.

The interdepartmental approach used by other provincial AIDS units may hold more potential, in that if gives departments some project experience and knowledge about the costs involved. However without incentives and other institutions that force departments to start mainstreaming interventions, the response could be too slow.

Units are also involved in promoting and supporting responses within the public health sector. To this end, the Chief Directorate provides resources and support to provincial health departments. Funds flow in the form of conditional grants (National Integrated Plan).[53] The national unit also directs a large variety of in-kind resources to provinces from national. The main issues here are whether these resources fit with provincial circumstances and priorities, how a better fit can be achieved, and whether the resources are sustainable.

Provincial units provide funding for interventions carried out in the regions because a) they require the use of health facilities and professional staff, b) they should, if successful, become part of the core-business of regions. Funding is transferred to region is various forms. Decentralisation of funding to regional budgets represents a total transfer of responsibility to regions and probably holds the most potential for building project capacity and spending experience in the regions. This form of transfer seems to be the least used by provincial units.

The lack of progress in mainstreaming suggests serious shortcomings in the interdepartmental and intradepartmental budget planning processes. These are largely not explored in our research and require in depth further investigation.

[53] This is discussed in detail in the Introductory paper.

Appendix A.

Provincial strategy documents and business plans on HIV/AIDS

Possess department wide business plan, AIDS strategy only a minor component	***Free State –*** Also possesses discussion documents and a 'strategy' summary.
Developed AIDS unit business plan	***Northern Province*** - has a number of different ones, uncertainty about which apply, if any[54] ***KZN*** - Over-all annual strategy for the new unit is pending.[55] ***Gauteng***- annual plan. Gauteng also has a 5-year strategic plan for the AIDS unit. ***Eastern Cape*** - set of operational plans for unit activities
Possess project/intervention/portfolio plans	***KZN*** - Each project has own detailed plan, which have preceded KZN unit global business which is still being compiled
Have plans for NIP conditional grants: VCT, HBC and MTCT[56]	***All provinces -*** VCT and HBC all covered in unit business plans giving a broader set of activities for VCT and HBC than the NIP conditional grant business plans

[54] Director of HIV/AIDS unit recently appointed and unhappy with all business plans
[55] KZN also has a strategy document from precursors to the present HIV/AIDS unit.
[56] Form of transfer and source of national funding uncertain at time of research.

Components of health-type provincial strategies

Social mobilisation and communication	Prevention & Education	Prevention	Care	Local intersectoral	Organisation and co-ordination	NGO funding
Health promotion: *Gauteng*	Youth strategy: *Gauteng, Eastern Cape*	STD management: *all*	Counselling: *Gauteng, KZN*	Local strategies: *Gauteng*	AIDS councils: *Gauteng, FS*	NGO funding: *Free State, KZN, Eastern Cape, Northern Province*
IEC: *Free State*	Peer Education: *Gauteng*	VCT: *all*	TB / AIDS: *Eastern Cape, KZN, Northern Province*		Leadership: *Gauteng*	Monitoring and capacity building: *all*
Promote Human Rights: *Eastern Cape*	Workplace programmes: *Gauteng*	Condom supply and distribution: *all*	Step down facilities: *Free State*		Capacity Building: *Gauteng*	
Grass roots mobilisation: *KZN*	IEC: *Free State*	PMTCT: *all*	Diflucan: *Free State*		Private Sector Partnerships: *Eastern Cape*	
	High transmission areas: *Northern Province, Eastern Cape*		General medical (including TB and other opportunistic diseases): *Gauteng*		Interdepartmental: *Gauteng, Eastern Cape, Free State, KZN*	
	ATICs: *Eastern Cape*		HBC: *All*		Surveillance and research: *Free State, Northern Province, Gauteng*	
	GAAP: *Northern Province*		General palliative: *Gauteng*		Association of PWA: *Northern Province*	
					Extension of Contract posts: *Northern Province*	

Appendix B.

Required documents for NGO funding

- **Current certificate of registration** under the Non-profit Organisation Act, no. 71. Of 1997. (with a certified copy on file with the NGO Funding Unit).

- **Agreement form**—legally binding contract between the DoH and the organisation—must be signed off by Deputy Director General, national DoH.

- **Business plan**

- **Detailed budget**

- **NGO quarterly reports**, including internal financial statements, which are to be received and assessed by the provincial co-ordinators and then copied to the National Funding Unit.

- **Director's report or Annual Report** (in addition to quarterly reports)

- **Audited financial statement**—must be conducted within six month of end of NGO's financial year. Must be done by chartered accountant.

- **Updated organisational information**—e.g. NGO personnel—to be kept on file with National NGO Funding Unit which will is kept on a new database of funded organisations.

- **Certified copy of NGO's constitution**—most recent version; signed by chair of board.

- **Certified copies of the financial policy and procedural guidelines** must have "effective, efficient and transparent financial management and control systems in place."

Appendix C.

Partnership Support Activities

1. **Road Freight Association AIDS Programme**—This project targets the long-distance trucking industry. An NGO, the Learning Clinic, received the one-year tender to conduct the national programme which includes peer education with sex workers and mobile clinics. The second phase is now proceeding with a 2 year tender for R 3 million. The project is operated under a matching fund arrangement between the Directorate and the industry, or client.

2. **Project with Transport and Education Departments**—the target group for this public awareness programme is commuters, via trains and buses. Partnership Support is leading this project in cooperation with the Care and Support section of the Directorate. A two-year tender for the project is currently closing.

3. **Organisations operating in High Risk Environments**—This project is aimed at assisting the creation of policies and practices for dealing with HIV/AIDS in places of work such as shebeens and taverns.

4. **Capacity-building programme**—In its third year now, this programme works with development NGOs, faith-based organisations, traditional healers, the disabled community, and corporate sector to build capacity. A rapid response team of trainers conducts workshops on skills-building, provision of proper treatment, medical issues, etc.

5. **South African AIDS Directory**—A directory of government and NGOs involved in the response to HIV/AIDS, in electronic and hard copies.

6. **SA Civil Military Alliance**—This project includes the cooperation of SAPS, Defence, DSD, Civil Service etc. and provides an interface between the military and civil society on HIV/AIDS issues. A member of the SADF is seconded to the project (salary paid by DoH) with an office in the Directorate.

7. **Women In Partnership Against AIDS**—Through a series of workshops across the country and a national summit, this programme has identified needs, held capacity building workshops, and is currently developing project proposals.

8. **Trade Unions**—The Partnership Support office also supports labour federations, including COSATU, FEDSU and NACTU with training for the head offices on HIV/AIDS issues.

9. **Hospitality and Tourism Industry**—In the beginning phases, this project is targeting businesses which interact and rely upon tourists.

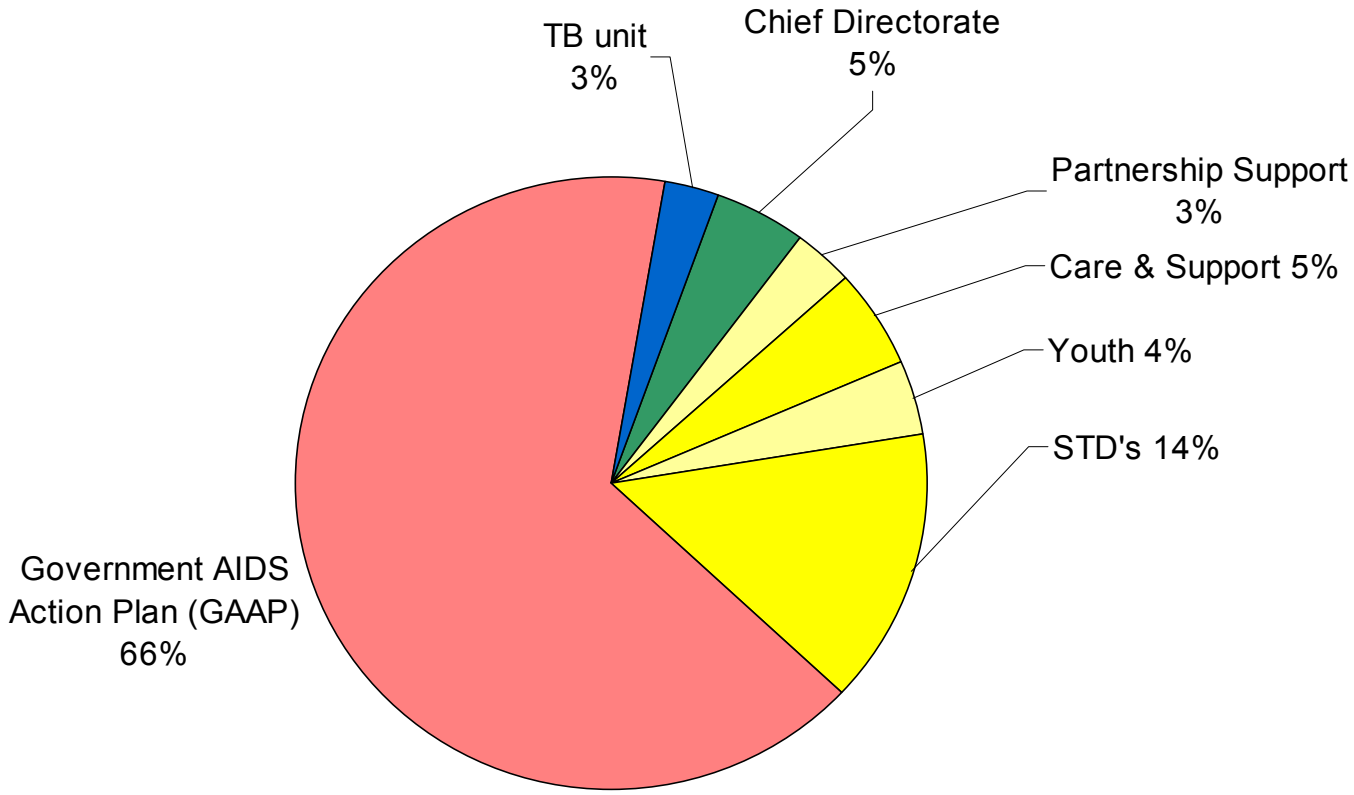
Appendix D.

Partnership Support projects with estimated budgets

Project	Estimated budget	Source of funds
Trucking against AIDS	R 500,000 R 600, 700	national HIV/AIDS Directorate budget Trucking industry
Project with Depts. Of Transport and Education targeting trains, buses and taxis	R 3.5 million	European Union
Project targeting taverns and shebeens	R 1 million	national HIV/AIDS Directorate budget
Capacity-building programme	R 2 million (plus consultants)	Half from USAID; half from national HIV/AIDS Directorate budget
South African AIDS directory	R 150, 000	national HIV/AIDS Directorate budget
SA Civil Military Alliance	R 1 million	R150,000 from EU for travel, and rest from Natl HIV/AIDS budget
Women in Partnership Against AIDS	R 600,000 R 30 million over 3 years	European Union Danish government
Trade Unions	R 1.8 million (including one million to mineworkers and to prisons) R 4 million	national HIV/AIDS Directorate budget USAID
Hospitality and tourism	R 1.4 million	national HIV/AIDS Directorate budget

Appendix E.

Chief Directorate: HIV/AIDS and STDs Programme Budget, 2001



Appendix F.

Overview of Provincial HIV/AIDS units—strategic focus and brief history

Province	Name of unit	Strategic focus of unit	Brief history (where available)
Gauteng	Interdepartmental AIDS Unit	Interdepartmental	Established in 1998
KZN	AIDS Action Unit	Interdepartmental	• Since 1993 managed through an HIV/AIDS sub-directorate under Health Programmes Directorate • In 1999 a separate structure, Provincial AIDS action unit set to run a media and social marketing and mobilisation campaign, under Health Department, but outside line structure • In 2001 two structures merged under the Director of the AIDS Action Unit
Northern Province	HIV/AIDS Directorate	Health type	• Previously managed through the Sub-Directorate for Communicable Diseases Control which a broad directorate that included occupational and environmental health and epidemiology • Established May 2001
Eastern Cape	HIV/AIDS Division[57]	Health type, with some interdepartmental role	• Previously one of number of programmes in Communicable Diseases, Chronic Diseases & Geriatrics Sub-directorate in the Primary Health Care Directorate • In early 2001, a HIV/AIDS Division established
Free State	HIV/AIDS Subdirectorate, with some responsibility for HIV/AIDS interventions delegated to the Chronic Diseases Directorate and to the Nutrition, Mother and Child Health Subdirectorate	Mainly health-type, although somewhat broader secretariat role to the interdepartmental committee	At present HIV/AID subdirectorate under Primary Health Care Chief Directorate; specific directorate in the process of being established

[57] An Eastern Cape designation for directorate.

Appendix G.

Provincial budget formats and FMS accounting systems

Province	Coverage by activity-type budget
GT	Formal budget in MTEF format broken down by intervention
KZN	Portfolio managers have own budget by activities but not yet authorised, may change No overall business plan with budget
FS	No formal activity budget, approximate figures given in discussion document to interventions and some activities
EC	Each intervention given global allocation in operational plan
NP	Activity budget given in business plan with unclear status

Appendix H.

Processes for determining global AIDS unit budgets

Province	Source	How is global amount of AIDS unit's budget decided?	How is global amount of provincial health department budget decided?
Free State	Line item in health department budget	Through department budgeting process, involving significant historical incremental budgeting	Historical incremental - but moving towards zero-based activity budgeting
Northern Province	Line item in health department budget	Top down decision within the health department; ability to spend seen as important criteria	Not collected
Eastern Cape	Line item in health department budget	Unit budget prescribed by provincial cabinet	Not collected
Northern Province (proposed)	Line item in health department budget	Baseline budgeting based on activity budgeting	Not collected
Gauteng	Combination: Top slice from provincial budget and allocation from health department	Top slice: Provincial cabinet decision based on MTEF, new costings and political judgement Health allocation: health department internal budgeting process	Not collected
KwaZulu Natal	Combination: Top slice from provincial budget Allocation from health department in two parts	• Top slice – historical incremental based on the first top slice (2000) • health allocation - historical incremental on series of previous years' allocations • health allocation based on matching national grants	Not collected

Appendix I.

Provincial approaches for breaking down AIDS unit budget

	Source of AIDS unit budget	**How is global amount of AIDS unit budget decided?**	**How is the AIDS unit budget split between interventions and activities?**
Gauteng	Top slice	Provincial cabinet decision based on MTEF, new costings and political judgement	• Follows the global unit budget determination • joint planning process between departments sets the parameters for detailed business planning and budgeting by department • department submissions are compiled into annual plan and budget (MTEF) by unit director and given to HOD of Health for approval taken into account the distribution of resources between departments • MTEF budget broken down by project / intervention for presentation in budget statement two • Reporting system budget in standard and posting level item format, without interventions or projects
Free State	Health Allocation	Through department budgeting process, involving significant historical incremental budgeting	• Historical incremental on previously existing items • 'crude estimates' for new items • formally budget only available in standard item form • budget control emphasised as method for achieving appropriate allocations
Northern Province		Top down departmental budgeting process	• In theory unit business plan with budget submitted to budget authority during the budgeting process • business plan forms the basis of detailed budget • formal budget only available in standard item form - presumably business plan converted into standard item budget
Eastern Cape		Unit budget prescribed by provincial cabinet	• Detailed standard item budget for admin • gross amounts for each intervention • standard item budget • all budgets appear to be handed down in a top-down fashion by the Health Finance section
Proposed in Northern Province		Baseline budgeting based on activity budgeting	• Zero-based activity budgeting
KZN	Combination	Top slice, health allocation based on historical incremental and matching national grants; unit budget includes a standard line item lay out	• Each portfolio (project / intervention) managers formulate and submit business plan for his/her portfolio without envelope for each project being set • Directorate will attempt to fit submitted amounts into the global envelope for the unit, satisfying standard item prescription - this is still in the process of being done

Appendix J.

Provincial uses of donor funds

	Project	**Donor**
Gauteng	Research, project monitoring, policy development	Information not collected.
Free State	NGO capacity building	Ireland Aid (pending)
Eastern Cape	IEC through theatre Workshop on VCT PTMTCT Managing STIs Design and procurement of HBC kits High transmission areas	Equity Project/SFH[58] (Equity Project is funded via USAID) World Health Organisation Project Support Assoc. (based in Zimbabwe)
KZN	Integrated AIDS/TB programme	Belgian Co-op

Partnerships with universities

	Project	**University**
Eastern Cape	Counselling course for nurses (PMTCT) MTCT nurse training Clinical trials (Neviropine)	Rhodes UWC University Transkei (motivation for involvement by university, decision pending)
Free State	Possible training on use of Diflucan (contracted)	Bloemfontein Univ/Academic Hosp
KZN	Research support on the effective management of STIs VCT: developing guidelines and systems for referring PWA requiring care at non-medical sites; establishing a mentorship system for lay counsellors; standardisation of counselling records (contracted)	University of Natal Durban
Northern Province	Nothing reported.	
Gauteng	Information not collected.	

[58] Society for Family Health (SFH) is a local NGO acting as a non-profit service provider.

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Ms Pauline Moetlo, Director of the Communicable Diseases, Occupational and Environmental Health and Epidemiology Directorate, Health Services Branch.

Mr Mpho Mofokeng, Chief Financial Officer, Finance Branch.

Dr JA Kotze, Director: Financial Planning, Budget & Revenue, Finance Branch.

Mr M. Moshwana, Deputy Director: Budget Planning, Finance Branch.

KwaZulu Natal

Dr S.S.S. Buthelezi, Director: Provincial Aids Action Unit, 2 July 2001.

Ms Jabu Hlazu, Assistant Director and Portfolio Manager: STD and Barrier Methods, 2 July 2001.

Ms Gay Koti, Assistant Director and Portfolio Manager: Care Counselling and Support and Home Based Care, 3 July 2001.

Ms Thuli Buthelezi, Community Liaison Officer and Portfolio Manager: NGOs, 3 July 2001.

Ms Sue McDonald, Acting Assistant Director: Voluntary Counselling and Testing, 3 July 2001.

Mr Johan Brits, Director: Finance, Department of Health, 3 July 2001.

Eastern Cape

Ms Nomalanga Makwedini, Director: HIV/AIDS Division, Department of Health, 28 June 2001.

Ms Nonzwakazi Madonsele, Deputy Director: HIV/AIDS Division, Department of Health, 28 June 2001.

Mr Pakisa Peppetta, Director: Finance, Department of Health, 29 June 2001.

Mr Jos TeBraake, General Manager: Accounting Services (Chief Director equivalent), Provincial Treasury, 29 June 2001.