This groundbreaking study attempts to comprehensively map out structures, organisations and processes dealing with the HIV/Aids pandemic in South Africa. For the first time this is done through a corruption and accountability lens.

It comes at a time when the country has seen massive increases in funding capacity, yet the realisation of positive results remains slow and uneven. The study's main premise is that if the increase in funding has not translated into positive results, then we need to consider other factors that may be impinging on delivery, including absent or inadequate accountability mechanisms and instances of corruption.

The study shows that corruption and poor oversight are a potentially lethal cocktail when combined with the rapaciousness of HIV/Aids. In doing so, it brings into sharp focus the impact of corruption on the poor and marginalised in our society.

Every misused cent takes medicines and prevention commodities away from people. HIV corruption steals HIV tests, condoms, TB medicines, food and ARV's. Corruption literally steals life. The anti corruption report on HIV/Aids is inestimable as a resource for civil society and government to prevent corruption.

Zackie Achmat, National Chairperson, Treatment Action Campaign (TAC)

'Where is the money going?' – a recurrent question plaguing researchers and reporters working on health and HIV/Aids in South Africa. Time constraints and the inherently difficult nature of the HIV/Aids money-matrix have made this task almost impossible. This report is the first comprehensive attempt to shed light on the money trail.

Khopotso Bodibe, Journalist, Health-e News Service

A lethal cocktail • Collette Schulz-Herzenberg • TI Z • ISS

Transparency International Zimbabwe

INSTITUTE FOR SECURITY STUDIES

A lethal cocktail

Exploring the impact of corruption on HIV/Aids prevention and treatment efforts in South Africa

Collette Schulz-Herzenberg

Edited by Trusha Reddy

A lethal cocktail

Exploring the impact of corruption on
HIV/Aids prevention and treatment efforts in South Africa

Collette Schulz-Herzenberg
Edited by Trusha Reddy

2007
Institute for Security Studies
Transparency International (Zimbabwe)

Transparency International Zimbabwe

Transparency International Zimbabwe (TI-Z) is the local autonomous and independent National Chapter of Transparency International (TI). TI-Z was formed in 1996 by a group of dedicated and concerned Zimbabweans to fight against corruption and its effects on society. TI-Z is part of the growing network of TI National Chapters fighting corruption through networks of integrity within civil society, business, academia and government to curb corruption both nationally and internationally.

The vision of the Institute for Security Studies is one of a stable and peaceful Africa characterised by human rights, the rule of law, democracy and collaborative security. As an applied policy research institute with a mission to conceptualise, inform and enhance the security debate in Africa, the Institute supports this vision statement by undertaking independent applied research and analysis; facilitating and supporting policy formulation; raising the awareness of decision makers and the public; monitoring trends and policy implementation; collecting, interpreting and disseminating information; networking on national, regional and international levels; and capacity-building.

ISBN-13: 978-1-920114-23-7

Institute for Security Studies
P O Box 1787, Brooklyn Square 0075
Tshwane (Pretoria), South Africa
Tel: +27 12 346 9500/2 Fax: +27 12 460 0998
email: pubs@issafrica.org
www.issafrica.org

Transparency International Zimbabwe
96 Central Avenue
Harare, Zimbabwe
Tel: +263 4 793 246 Fax: +263 4 793 247
email: tizdir@mweb.co.zw
www.kubatana.net/tiz

Language editing and layout: Page Arts +27-21-686-0171
Photos: www.africanpictures.net
Printing: C J Litho, Cape Town

Table of contents

List of tables and graphs iv
List of abbreviations and acronyms v
Acknowledgements viii
Executive summary ix

Chapter 1: Introduction *Trusha Reddy* *1*

1.1 Outline of the study 2
1.2 Aims and objectives 5
1.3 Conceptual definitions 5
1.4 AIDS funding diagram 6
1.5 Significance 7
1.6 Limitations 7
1.7 Structure of the report 8
1.8 Methodology 9

Chapter 2: South Africa *Collette Schulz-Herzenberg* *13*

2.1 Background 14
2.2 Accountability in the HIV/AIDS sector 32
2.3 The prevention of HIV/AIDS 49
2.4 The treatment of HIV/AIDS 54
2.5 Conclusion 73

Chapter 3: Conclusion *Trusha Reddy & Collette Schulz-Herzenberg* *75*

3.1 Summary analysis 76
3.2 Recommendations 81

Postscript 85
Bibliography 91
Websites 101
Appendix: List of interviewees 102

List of tables and graphs

Table 1:	Key HIV/AIDS policy documents adopted since 2000	16
Table 2:	Comparison of state spending (R000) versus HIV prevalence rates	20
Table 3:	HIV/AIDS conditional grants to provinces 2005/06 (R000)	24
Table 4:	Breakdown of spending by government on HIV/AIDS from 1999 to 2009 (R000)	24
Table 5:	The donor matrix for HIV and AIDS financial commitments to South Africa	27
Table 6:	Donor amounts received by South Africa in US dollars	28
Table 7:	Performance-based funding requirements: the Global Fund	36
Table 8:	Pharmaceutical companies supplying ARVs	71
Table 9:	Southern Africa: increase in prevalence of HIV from 1990 to 2006	76
Table 10:	Increase in South African budget allocation from 1999 to 2006	77
Table 11:	Vulnerabilities to corruption in the prevention of HIV/AIDS	78
Table 12:	Vulnerabilities to corruption in the treatment of HIV/AIDS	79
Graph 1:	Proportional increase in HIV/AIDS state expenditure and HIV prevalence rates from 1999/00 to 2005/06	21

List of abbreviations and acronyms

AAHA	Alliance Against HIV/AIDS
AG	Auditor-General
AIDS	acquired immune deficiency syndrome
ALP	AIDS Law Project
ANC	African National Congress
ARV	antiretroviral
ART	antiretroviral therapy
AusAID	Australian Agency for International Development
AZT	azidothymidine
BIS	Budget Information Service (IDASA)
CBO	community-based organisation
CCM	Country Coordinating Mechanism (of the Global Fund)
CDC	Centers for Disease Control (US)
CIDA	Canadian International Development Agency
CSO	civil society organisation
DA	Democratic Alliance
DANIDA	Danish International Development Assistance
DCI	Development Cooperation Ireland
DG	director-general
DFID	Department for International Development (UK)
DoRA	Division of Revenue Act
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GRIP	Greater Nelspruit Rape Intervention Project
GTZ	Deutsche Gesellschaft für Technische Zusammenarbeit (Germany)
HAART	highly active antiretroviral therapy
HIV	human immunodeficiency virus
HSRC	Human Sciences Research Council
HST	Health Systems Trust
IDASA	Institute for Democracy in South Africa
ILO	International Labour Organisation
IOM	International Organisation for Migration
ISS	Institute for Security Studies
JCSMF	Joint Civil Society Monitoring Forum
JICA	Japan International Cooperation Agency

KfW	Kreditanstalt für Wiederaufbau (KfW Bankengruppe)
LSP	Latex Surgical Products (Pty) Limited
MCC	Medicines Control Council
MEC	member of the (provincial) executive committee
MRC	Medical Research Council
MSF	Médecins Sans Frontières (Doctors without Borders)
NAPWA	National Association of People Living with AIDS
NCOP	National Council of Provinces
NDoH	national Department of Health
NGO	non-governmental organisation
NPO	non-profit organisation
ODAC	Open Democracy Advice Centre
OECD	Organisation for Economic Cooperation and Development
PAF	Programme Acceleration Funds (UNAIDS)
PEPFAR	US President's Emergency Plan for AIDS Relief
PFMA	Public Finance Management Act
PCWHA	people living with HIV/AIDS
PMTCT	prevention of mother-to-child transmission
PRF	provincial revenue fund
PSAM	Public Service Accountability Monitor
PSC	Public Service Commission
RDP	Reconstruction and Development Programme
SAMA	South African Medical Association
SANAC	South African National AIDS Council
SIDA	Swedish International Development Cooperation Agency
SIU	Special Investigating Unit
STD	sexually transmitted disease
STI	sexually transmitted infection
TAC	Treatment Action Campaign
TB	tuberculosis
TI	Transparency International
TI-Z	Transparency International Zimbabwe
UCT	University of Cape Town
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNODC	United Nations Office on Drugs and Crime
UNTG	United Nations Theme Group on HIV and AIDS

UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	voluntary counselling and testing
WHO	World Health Organisation

Acknowledgements

We acknowledge with thanks a grant received by Transparency Zimbabwe (TI-Z) from Action Aid International (AAI), without which this project would not have been possible. The funding represents a significant investment in opening up research into an urgent new area of work and concern amongst the infected and affected people of Africa.

Thanks are also due to Danish International Development Assistance (DANIDA) for their financial contribution towards field travel for the commissioned researcher. Special thanks also to the Norwegian Agency for Development Co-operation (NORAD) for their financial contribution towards the printing of the report.

I would like to express my appreciation to TI-Z for engaging the Institute for Security Studies (ISS) Corruption and Governance Programme in managing the research project. The programme views this approach as fundamental in promoting collaboration among civil society organisations in the region on common issues of our time.

Many thanks are given for the contribution of all those involved in the process of putting this report together, including, most significantly, the following people:

- *Mary-Jane Ncube*, TI-Z, for her engagement with donors, as well as her support and input in developing the methodology and implementing the project
- *Hennie van Vuuren*, head of the ISS Corruption and Governance Programme, for his supportive engagement with TI-Z, the editor and the commissioned researcher throughout the process
- *Collette Schulz-Herzenberg*, South African commissioned researcher, for assisting in developing the methodology and for contributing a thoroughly researched chapter while working to a tight deadline
- All interviewees who participated in the research and who helped shape our report findings and ultimately the recommendations drafted
- *Page Arts cc* for their efforts and patience in copy-editing the report

Finally, we are indebted to all those not mentioned by name here who supported and assisted the project with advice and encouragement.

Trusha Reddy
Editor

Executive summary

In comparison with other countries across the Southern African region, South Africa is perhaps in a unique position in its struggle to combat the HIV/AIDS pandemic. There has been a gradual increase in prevalence rates from the first recorded rate of 20 per cent in 1999/00 to 30 per cent in 2005/06, which is often attributed to the fragmented response to prevention and treatment efforts. At the same time, there have been massive increases in funding capacity, yet, despite this, the realisation of positive results remains slow and uneven.

Based on this complex interplay of variables, in mid-2006 Transparency International-Zimbabwe and the Institute for Security Studies Corruption and Governance Programme decided to embark on a groundbreaking study into corruption and accountability in HIV/AIDS prevention and treatment efforts in South Africa. The basic premise was that if the increase in funding did not translate into positive results, then we would need to consider other factors, including a lack of or inadequate accountability mechanisms and instances of corruption, that may be impinging on delivery. The findings remain the first real attempt worldwide to comprehensively map out (primarily government) structures, bodies and processes dealing with the pandemic through a corruption and accountability lens.

The report shows that corruption and poor oversight are a potentially lethal cocktail when combined with the rapacious AIDS disease. In doing so, it brings the impact of corruption on the poor and marginalised in our society into sharp focus: our ability to control corruption in the prevention of HIV/AIDS is as dramatic and clear-cut as a choice of life over death. Ultimately, it challenges state and non-state actors to improve on efforts so that those infected and affected by the scourge are assisted.

The main findings of the report from the case study are listed below.

Accountability mechanisms

Regarding the state bodies dealing with delivery, AIDS efforts and funds are coordinated both nationally and provincially. However, there are significant challenges to contend with, as listed below, which suggests that the proverbial 'devil is in the detail'.

1. Budgetary management and execution – in essence, *budget-tracking mechanisms* – appear to be lacking, especially in relation to disaggregated expenditure data on donor funding.

2. In addition, the *lack of tracking of donor funding* poses the risk of duplication of resources and efforts between the government and civil society.

3. The *lack of accountability* for financial mismanagement is also cited as a source of concern. Furthermore, the *lack of transparency* (including openness to engage with civil society and the media) has been a key feature impacting on delivery.

4. *Underspending in provinces* due to lack of capacity and internal management problems is a compounding impediment to delivery. In this regard, the Auditor-General (AG) is reported to have submitted qualified audit reports on health for several provinces over the past few years.

5. Key concerns relate to the *lack of institutionalisation of processes for the spending of HIV/AIDS funding*. The more loose and unregulated the system for the provision of funds and services, the greater the chance of corruption. Where services are rolled out for the first time, resource distribution is often characterised by ad hoc solutions and improvisation. Few associated institutional structures and oversight mechanisms are in place. Where they exist, they are poorly conceptualised and undeveloped.

Corruption

In the South African context, corruption in the HIV/AIDS sector does not only pertain to abuses in funding and other conventionally corrupt activities. Other factors play a role. First, high levels of poverty appear to encourage the abuse of resources by HIV-infected people in particular. Secondly, the politicisation of the disease has created numerous channels for abuse and consequently undermined HIV/AIDS policy and its active implementation, patient care and certain health regulatory bodies. Finally, as mentioned above, where systems are weak, it becomes difficult to disentangle corruption from mismanagement and system failure as the root causes of poor HIV/AIDS responses.

While the report recognises the above, it also documents those instances of corruption that pertain to the abuse of funds and power, as listed below. The

researcher has collated many such cases that have been reported in the media over the past few years and uncovered others through interviews with health officials, non-governmental organisations (NGOs) and academics working in the field. In some cases, these are recorded here as allegations, as they have yet to be proved or tested in court.

1. *National Association of People Living with AIDS (NAPWA)* – NAPWA is argued to have poor oversight over and accountability for public funds and a lack of transparency in investigations.

2. *National Food Parcel Emergency Programme* – The programme's records for delivering food parcels to those infected and affected were found to be unsatisfactory and incomplete. Inadequate control of the approval of beneficiaries meant that the validity of the beneficiaries could not be verified in all instances.

3. *South African National AIDS Council (SANAC)* – The Congress of South African Trade Unions and the Treatment Action Campaign (TAC) have charged SANAC with being a dysfunctional body that lacks accountability. They raised concerns about significant underspending by SANAC in 2002. Moreover, they claim that a large amount was squandered on unoccupied offices for the SANAC secretariat, a criticism also raised by the AG. The SANAC Trust also received a qualified audit in 2004/05 due to the unsatisfactory processing of NGOs' financial statements of donor funding.

4. *Sibongile Manana, member of the Mpumalanga provincial executive committee for health* – The TAC accused Manana of failing to provide AIDS drugs in hospitals. She was also responsible for dismissing a doctor for allowing an HIV treatment charity to operate on hospital premises.

5. *National Department of Health (NDoH) and Matthias Rath* – The Director-General of Health, Thami Mseleku, intervened to order the release of a shipment of tablets imported by the controversial Matthias Rath which had been impounded by port health officials.

6. *UBhejane* – Many in government continue to promote the herbal remedy uBhejane as an alternative to antiretrovirals (ARVs). The Democratic Alliance, an opposition political party, claims uBhejane violates the Medicines and Related Substances Act.

7. *Dr Costa Gazi, Cecilia Makiwane Hospital in Mdantsane, Eastern Cape* – Dr Gazi, former head of public health, was suspended from the hospital after voicing frustration at the government's ARV policy in 1999.

8. *Patients selling antiretroviral drugs* – Doctors quote anonymous, anecdotal evidence suggesting that many people who believe or know themselves to be HIV-positive, but are unable to access ARVs through the public health system for various reasons, are purchasing and using ARVs.

9. *Disability grant* – There is alarming anecdotal evidence from a cross-section of health practitioners that the current disability policy encourages HIV-positive patients to suppress their CD4 count deliberately in order to become or remain ill and thus qualify for a disability grant.

10. *Stolen or missing ARVs* – A reputedly well-known phenomenon in the public health sector is the theft or disappearance of drugs, particularly from large facilities like hospitals. It is assumed that these drugs are sold to the private sector.

11. *Tendering and procurement* – The AG reported that the NDoH had spent R1,9 million on a pamphlet on AIDS without following any tendering processes.

Note: The postscript highlights additional areas of corruption noted after the research period.

Recommendations

The report discusses the following list of recommendations to various stakeholders:

1. Government

1.1. Emphasis is placed on recording both donor commitments and actual disbursements in departmental budgets. Departments are also advised to provide public information on how donor funds are spent. Finally, they should improve coordination and increase utilisation of the donor matrix to facilitate the tracking of monies and disbursements.

1.2. With respect to the National Revenue Fund, government departments should be encouraged to express HIV/AIDS expenditure in disaggregated form and introduce uniform standards for provinces to account for HIV/AIDS funds. The quality of reporting in departmental annual reports should be improved so that they can serve as better oversight and monitoring tools.

2. Donors

2.1. More comprehensive analysis and a deconstruction of donor funding to South Africa need to be done. Currently, it is almost impossible to assess the overall amounts spent on HIV/AIDS because direct donor funding is not accounted for. Information could also ensure better synchronisation between donor spending and national expenditure to avoid duplication and improve financial accountability.

2.2. Donors are also advised to make information on their allocations publicly available – on their websites, for instance.

3. Civil society

3.1. Comprehensive monitoring and evaluation mechanisms for the activities of and use of funds by NGOs and community-based organisations are still generally weak and must be beefed up.

3.2. Service providers should be encouraged to develop internal checks and balances for their finances and to practise sound accounting. They ought also to make information available for public scrutiny.

4. Further research

More research is required on the sources of HIV/AIDS funding and accountability mechanisms, especially relating to international donors. In addition, research on the possible variations in corruption between provinces needs to be undertaken.

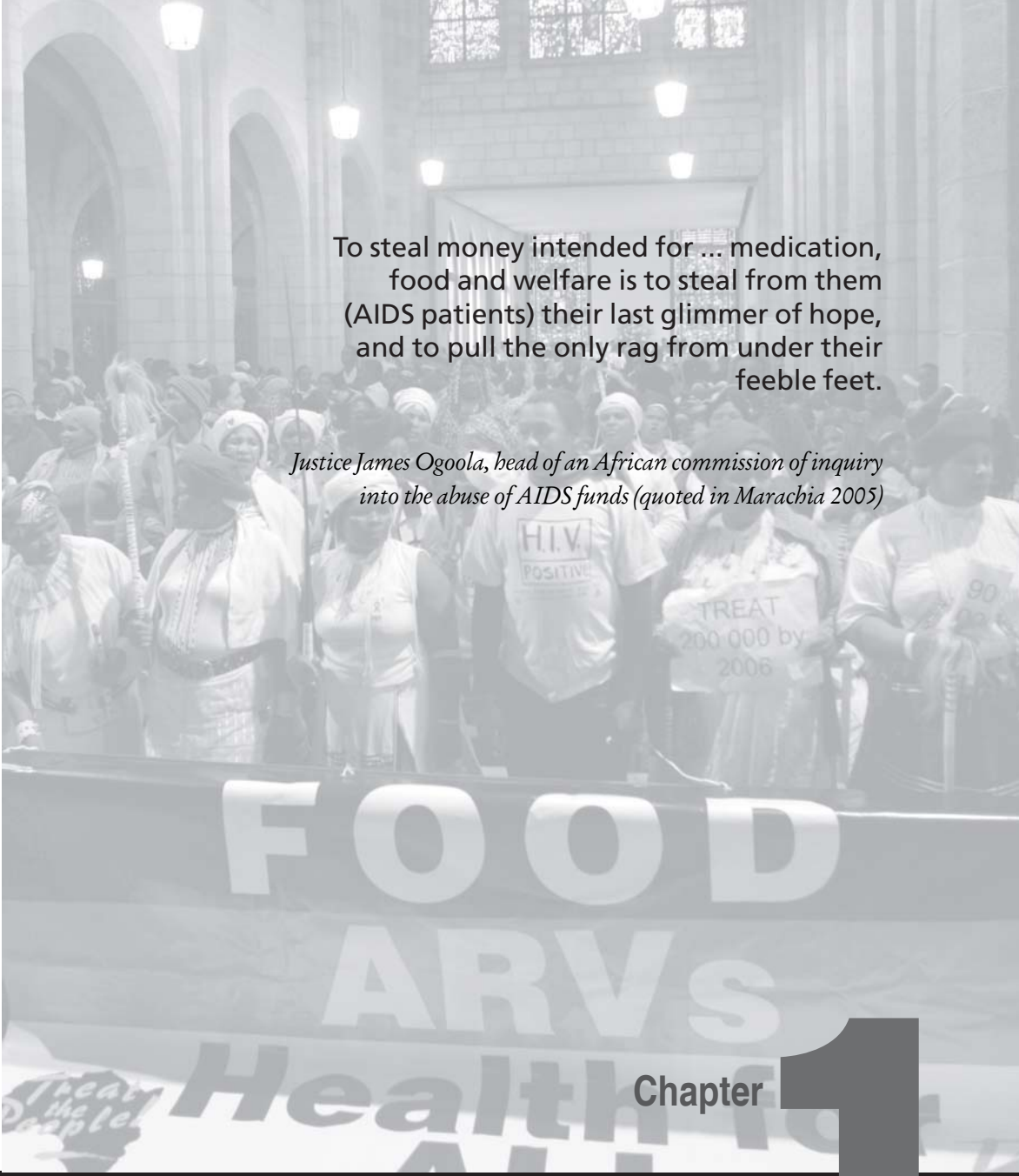
5. General

5.1. *Accountability and information* – Monitoring by all stakeholders can be an important check on arbitrary exercises of power and the squandering

of funds. However, monitoring HIV/AIDS resources requires attention to be focused on multiple players, including government departments, external donors and funded organisations such as NGOs.

5.2. *Protection of whistle-blowers* – A whistle-blowing culture should be promoted. Citizens, government officials and NGOs must to made thoroughly aware that a convenient means of lodging complaints of poor service or corrupt activities exists and that they will be duly protected against reprisals.

5.3. *Developing a culture of openness* – The researcher faced significant obstacles to sharing information from the national and provincial departments of health. These limitations prevent many definitive conclusions being drawn with regard to the efficacy of existing oversight mechanisms and the level of uniformity of enforcement across provinces. An open attitude would enable a fair account of the many sound accounting and anti-corruption mechanisms already introduced and even give the government an opportunity to rebut allegations of corruption.



To steal money intended for ... medication, food and welfare is to steal from them (AIDS patients) their last glimmer of hope, and to pull the only rag from under their feeble feet.

Justice James Ogoola, head of an African commission of inquiry into the abuse of AIDS funds (quoted in Marachia 2005)

Chapter 1

Introduction

1.1 Outline of the study

The nature and scale of the HIV/AIDS pandemic have finally captured the attention and purse strings of world funders and local state actors alike. Although contributions are still widely argued to be below the amounts necessary to combat the disease effectively,[2] the increase in funding is significant. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), more than US$6,1 billion was available to be spent in low- and middle-income countries in 2004 to combat the disease, which is more than six times the US$1 billion spent in 2000 (TI-Z 2006). African countries also made a commitment to combating the disease in 2001, when they signed the Abuja Declaration, pledging to allocate 15 per cent of their countries' national resources to such expenditure. With 60 per cent of all people living with the HI virus resident in sub-Saharan Africa and 2,3 million people recorded to have died of AIDS in the region in 2004, the funding spotlight on this region is fully warranted. Southern Africa remains most afflicted by the disease in the region.

The influx of funds as well as the hike in state HIV/AIDS prioritising and budgeting in the most affected countries is a double-edged sword, however, especially so in the corruption-ridden countries of Southern Africa, Transparency International Zimbabwe (TI-Z) notes.[3] On one hand, it offers an enormous opportunity for countries to implement prevention and treatment initiatives that are essential to an effective combating strategy. On the other hand, it presents great temptation for corruption in the appropriation of funds allocated to these initiatives; nepotism, influence buying and bribery in the procurement of medication and supplies; and informal payments to medical officials by members of the public to secure treatment.

At a methodology workshop conducted at the outset of this research project,[4] the thinking around this understanding of corruption informed the formulation of three basic guiding questions:

- Where is the money coming from?
- Where is the money going to?
- Where are the weak links?

The findings of the research indicate that there are no conclusive answers to these questions. Ironically, this revelation speaks volumes in itself. The ability

to definitively and comprehensively map out the structures, players and vulnerabilities in a sector speaks to fundamental issues of transparency, accountability, fairness and democracy. Moreover, it testifies to the institutionalisation of these values as the cultural norm in a state.

Let us briefly examine the issues raised in these questions. In South Africa, the case study chosen, there is some knowledge of the dominant sources of funding directed to government coffers. This is largely because the funds can be traced back to external donors that make their contributions public knowledge. South Africa is considered relatively transparent as compared to other countries in the region because of the relative openness of that government to scrutiny. However, there is something of a paradox in the Ministry of Health. Last year the director-general (DG), Thami Mseleku, imposed a blanket ban on health officials speaking to the media.[5] This has ramifications for researchers as well, stymying the process of obtaining information.

If there is to be any change in the status quo, HIV/AIDS funding needs be used in a way that maximises the benefit to intended recipients. Recent corruption scandals in Africa – in Kenya and Uganda, for instance – show that this does not always happen. Actual instances of abuse of funds and, more generally, of office noted in the course of the research buttress these findings. Otieno Amisi argues, however, that the money fails to reach the infected and affected because of problems including inflated administration costs (Amisi 2005) rather than corruption per se. Furthermore, the inappropriate spending of money may also be as inimical to the combating of the disease. 'Too little of this money is currently reaching community initiatives' (Amisi 2005) says Geoff Foster, a child health expert in Zimbabwe, in a report for the charity Save the Children. As important as these findings are, they impose a manufactured dichotomy, which this research eschews. Rather, the net is cast wide in order to explore a broad range of issues that have a bearing on the misdirection of funds, to present a more holistic picture of the challenges and to detect the weak links in state systems dealing with AIDS funds.

This study is largely exploratory. It discusses a range of challenges faced by both countries in the effective delivery of AIDS prevention and treatment, but focuses on potential areas of abuse. The dearth of research on the issue is explained thus: apart from a few publicised cases and growing allegations of misuse of these funds by the state and civil society institutions administering

them, corruption has largely been ignored. This is in part because organisations involved in the sector and responsible ministries generally do not want to reveal the problems for fear of scaring off donors who have only recently exhibited some generosity. Some organisations may also see the corruption issue as detracting from their main agenda of lobbying government for increased spending and roll-out. There is also the paradox that although donor funds continue to pour into the region to fight the virus, the prevalence rate of the pandemic is increasing in some countries while not significantly changing in others.

The evident lack of transparency and accountability in the administration of institutional systems and procedures justifies a stocktaking exercise to ensure that targets are being met. The dearth of research and investigation into these issues similarly warrants correction. The collaboration of the Transparency International chapter in Zimbabwe with the Institute for Security Studies (ISS) Corruption and Governance unit in Cape Town is thus timeous and necessary.

For the reasons highlighted, South Africa is well positioned as a case study in this project. It is believed that rich, peculiar data have emerged from the findings. As this study has been limited by resource constraints, including a six-month schedule and a restrictive budget, the second phase of the project aims to use the methodology designed here to review other countries in the region and to deepen and refine the interrogation of the case studies chosen for this project. TI-Z also aims, in the second phase, to focus on donor agencies, taking a look at their appropriateness, responsiveness and accountability to the infected and affected. As an exploratory exercise, this study only highlights the salient issues and provides some insight into the case studies.

The focus of the research is on applied policy, so the country reports include recommendations that could help policymakers in the country under review and the region generally minimise the impact of corruption on HIV/AIDS work. Recommendations to other stakeholders are included in the conclusion. Some examples of good practice are highlighted, as they may prove valuable to policymakers in other countries as well.

It is also important to note that while this research is policy-oriented and not intended as an exposé of unreported corruption cases, it is useful to mention examples of reported or alleged corruption in order to contextualise the problem. Where allegations have not been tested in court, researchers have documented the sources of such allegations.

1.2 Aims and objectives

The broad aims of the research project are:

- To strengthen understanding of the nature and forms of corruption in the region
- To play a central role, through advocacy and lobbying, in the formulation of policies discouraging and penalising unethical and corrupt conduct in the private and public sectors
- To support the demand for transparency and accountability in public affairs and in international business transactions

The specific objectives are:

- To ascertain the prevalence of corruption in institutions administering HIV/AIDS funds in the region
- To establish the nature and extent of corruption in these institutions
- To identify causes of the various forms of corruption
- To establish best practices and monitoring mechanisms and recommend these to policymakers
- To advocate for an information campaign through the media

1.3 Conceptual definitions

The research was underpinned by two pivotal concepts that together provide a consistent focus to the report.

Corruption in HIV/AIDS delivery is the abuse of public trust, public funds and/or public office for personal, private and/or illegitimate gain. This includes:

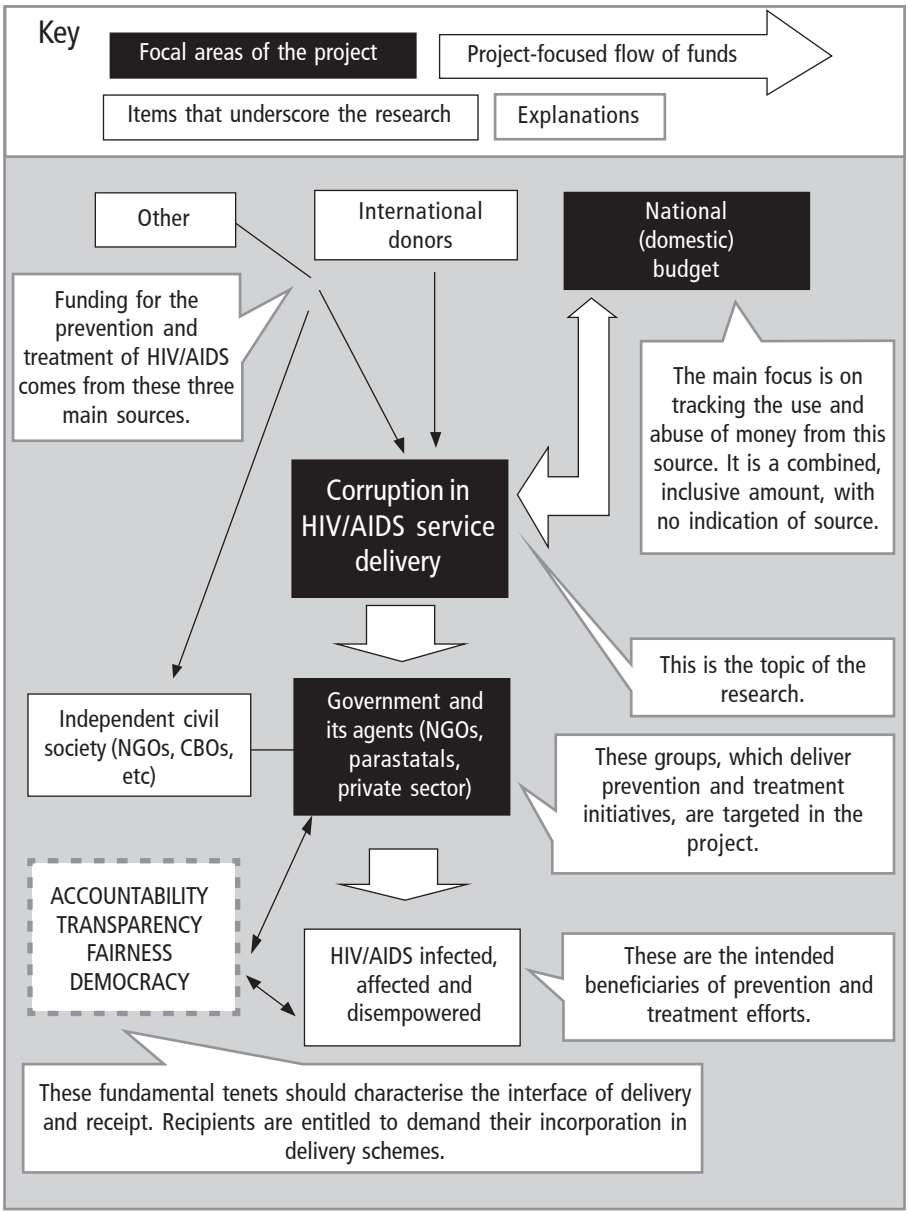
- *Primarily*, fraud, bribery, nepotism, cronyism and political corruption (including party interests)
- *Secondarily*, deliberate mismanagement and negligence

Effective public service delivery on HIV/AIDS in Southern Africa is the use of state resources – through government and its agents – transparently and accountably to promote prevention and treatment activities that are to the benefit of the infected, affected and disempowered.

1.4 AIDS funding diagram

This diagram depicts the flow of funds for HIV/AIDS prevention and treatment efforts from source to delivery vehicles and finally to the intended targeted recipients.

Figure 1: AIDS funding diagram



1.5 Significance

Although AIDS corruption cases and related issues have been reported in the media and some international publications, including the Global Corruption Report published by Transparency International (TI) and reports of the World Health Organisation (WHO), there is a dearth of in-depth research into the abuse of HIV/AIDS funding from a country perspective. This exploratory research might therefore be the first of its kind in the world. An assessment of and reflection on the state and nature of the use of funds is implicit throughout the report.

The research also attempts to open up the broader HIV/AIDS debate to include the marginalised issue of corruption. Efforts to gather funds for AIDS treatment and prevention are obviously crucial to combating the epidemic, but unless the use (including the misuse, abuse and non-use) of such funds is scrutinised, these efforts will remain insufficient. Equally important is the scrutiny of those in power, their agendas and their influence on disbursement processes. This report highlights both issues. It also attempts to provide a vehicle for the expression of contentions around AIDS issues that were previously difficult to articulate in any traditional framework of discussion.

1.6 Limitations

This research was subject to four main limitations:

1.6.1 Lack of existing research

Because this research is largely exploratory, it can only identify emerging issues and trends. The specific cases examined are not intended to be generalised in the wider context of South Africa.

1.6.2 Access to information

The researcher was severely restricted in some instances. She was denied access to documents and individuals crucial to understanding key issues. The nature of the relationship between state and civil society, in particular on a topic of such sensitivity, was also debilitating, though not disabling.

1.6.3 Sensitivity of topic

Corruption and HIV/AIDS are sensitive issues in South Africa,. The South African government's stance on prevention and treatment is notoriously controversial. This centres on the AIDS denialism of the president, the controversial views and funds management of the Minister of Health and her DG and the antagonistic relationship between the government and civil society actors, most prominently the Treatment Action Campaign (TAC).

1.6.4 Resource constraints

Time was crucial factor in this research. The entire project was just six months in duration and the country studies were conducted in a two-month period. The limited funding also prevented researchers from conducting field research over a wide area.

1.7 Structure of the report

The research focuses on the rich findings of the country case study. This chapter outlines the methodology, which includes the design parameters and the structure and themes of the country study. Data collection and analysis are also detailed, highlighting the various sources of information.

Chapters 2 explores the findings from South Africa. As these hinge on an underlying methodology, the case study discusses issues under headings including, most significantly: background, accountability mechanisms and corruption in the prevention and treatment of HIV/AIDS. There is a balance between description and investigation in the research.

The last chapter, Chapter 3, presents a succinct summary analysis. Recommendations that have emerged from the research are targeted at various actors including governments, civil society organisations (CSOs), external donors and researchers. There are also some general, more issue-based recommendations.

1.8 Methodology

1.8.1 Design parameters

1.8.1.1 Type of study

The research incorporates elements of analytical description and investigation. The background includes descriptive analysis, as does part of the work on prevention and treatment. Case studies of corruption in prevention and treatment are primarily investigative.

1.8.1.2 Time period of study

The study is largely contemporary in nature. However, the rationale guiding the retrospective descriptive analysis is based on two distinct factors: firstly, the record of first infections and their rapid increase and, secondly, the genesis of the mobilisation of state resources in response to the pandemic.

1.8.1.3 Area and level of analysis

Area: This is largely process-oriented (i.e. the researcher tracked the story to various locations) whilst mindful that the overall findings need to present a national picture. The area covered was determined by the availability of resources, including, most saliently, the cost of travel.

Level: This was determined by the location of institutions dispersing funds or resources. In most cases, these are in the major city in which the researcher is based. Whilst it is important to conduct grass-roots level analysis for the sake of a holistic understanding, this should only be attempted with due consideration to the resources available, including time and money, and in keeping with the overall project aim.

1.8.1.4 Unit of analysis

The main units of analysis are the government and its agents, including non-governmental organisations (NGOs), parastatals and the private sector, that are tasked with the delivery of HIV/AIDS prevention and treatment initiatives.

1.8.1.5 Indicators of corruption

These are based on a working definition of corruption.

1.8.1.6 Base values and understandings

The project is guided by universal principles of human rights and democratic governance, including fairness, openness, transparency and accountability.

1.8.2 Case study: structure and themes

1.8.2.1 Background

This section describes the context in which the prevention and treatment of HIV/AIDS are delivered. The context is both qualitative and qualitative. 'Qualitative' includes the following:

- The politico-socio-economic environment
- The spatial setting
- The perceptual and experiential tendencies of citizens of the countries concerned

'Quantitative' includes the following:

- The amount of spending
- The donors contributing funds to the AIDS effort
- The agencies responsible for dispersing funds

1.8.2.2 Accountability in the HIV/AIDS sector

This section outlines most pertinently the government structures that are assigned to administer HIV/AIDS funding through prevention and treatment efforts and activities. It also highlights the channels of funding from the government to external agencies responsible for these efforts, including NGOs and community-based organisations (CBOs), and in the outsourcing of specific activities including the marketing of awareness campaigns.

1.8.2.3 The prevention and treatment of HIV/AIDS

This section serves three associated purposes:

- To detail the institutional framework that guides prevention efforts
- To inform an understanding of the vulnerabilities to abuse and misuse in prevention initiatives
- To highlight actual and potential areas for abuse or misuse in these initiatives

1.8.3 Data collection and analysis

Data on the case study was intensively collected, analysed and written up by the researcher over two months. The shortness of the period very narrowly circumscribed what could realistically be achieved. In spite of this, the rich, layered and complex findings are testimony to what may be achieved by a critically minded researcher with a well-directed approach to the subject matter (in turn informed by a solid methodological understanding).

The process included desktop research for background material. Secondary sources of information were identified, including government structures, CSOs and academic units involved in AIDS work. Interviews were mostly conducted in the field, in city hubs where the disbursing agents and major AIDS activities were located. These included Cape Town, Durban and Bloemfontein. Ancillary interviews took place over the telephone with external donors, among others.

Interviews were requested using a proforma 'letter of intent' that stipulated the nature of the research and information requested. Because the letter officially represented the organisations involved, the researcher found it most useful as a way of gaining access to sources of information. However, the researcher also noted that once access was granted, the eliciting of information from interviewees was more challenging, for two mutually reinforcing reasons: firstly, the sensitivity of the topics of corruption and HIV/AIDS and, secondly, the lack of information on corruption in HIV/AIDS efforts. Regarding the former, the deliberate suppression of information and the coercion faced by respondents within their countries and offices militated against full and open cooperation with the project.

The experience of the researcher was generally that the vast amount of information on HIV/AIDS was not matched by information and knowledge about corruption in the sector. There were, however, variations within this model. Certain experiences in the CSO sector substantively supported assertions of abuse. The researcher also identified points of vulnerability to corruption, where concrete information was not forthcoming.

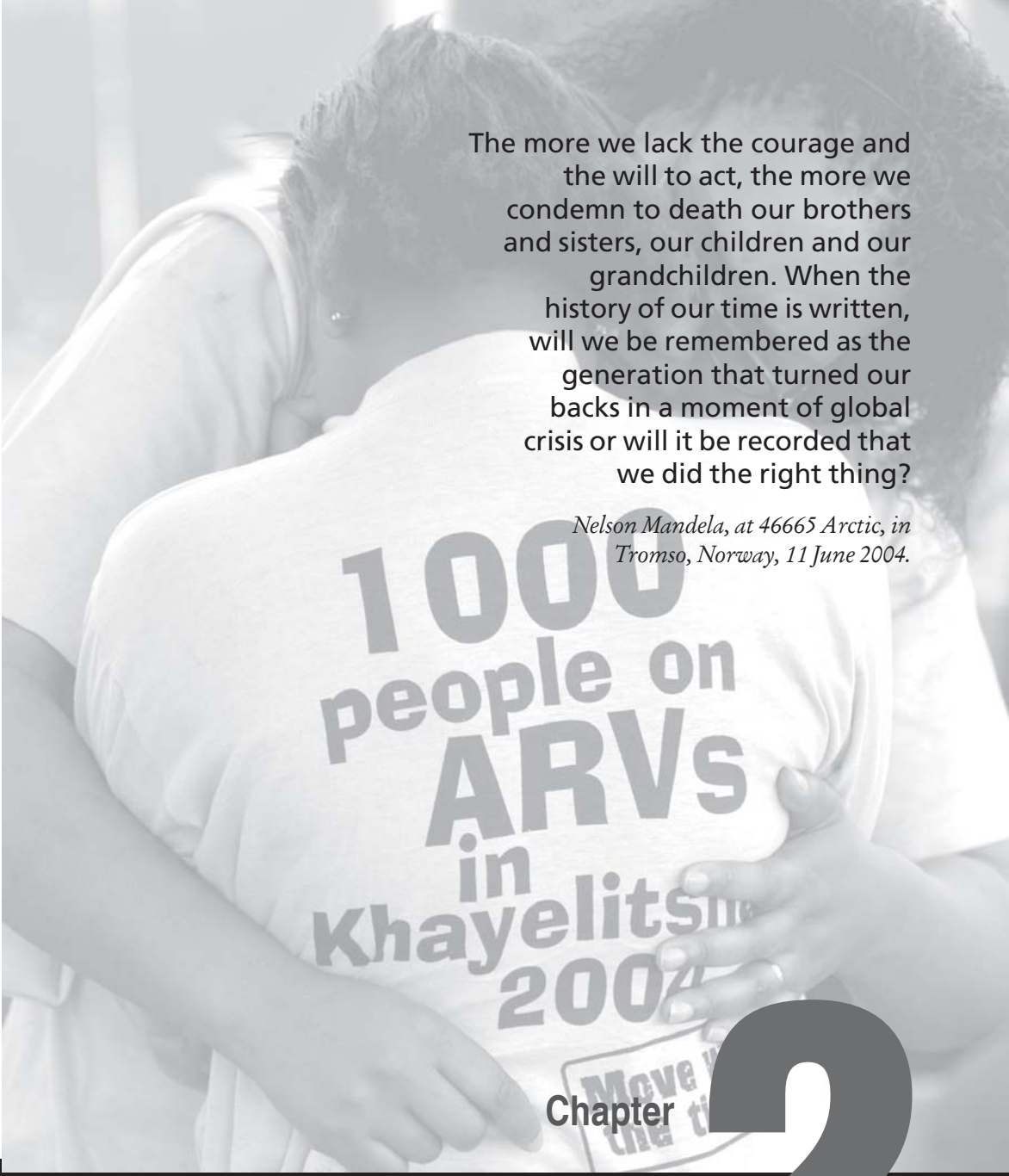
The following groups were most helpful in providing information:

- *CSOs, including NGOs and CBOs*, were conversant with the flow of funding. They could identify loopholes and cases of corruption in government funding and provide an opinion on the state of prevention and treatment efforts.

- *Academics involved in AIDS research* could provide opinions on the government's management of funds and accountability structures, and on corruption hot spots and vulnerabilities.

- *External donors* provided information on the amounts of funds dispersed and the nature of agreements on the use of monies.

- *Drug companies* provided information on the use of funds to manufacture antiretrovirals (ARVs).



The more we lack the courage and the will to act, the more we condemn to death our brothers and sisters, our children and our grandchildren. When the history of our time is written, will we be remembered as the generation that turned our backs in a moment of global crisis or will it be recorded that we did the right thing?

Nelson Mandela, at 46665 Arctic, in Tromso, Norway, 11 June 2004.

Chapter 2

South Africa

2.1 Background

2.1.1 The HIV/AIDS pandemic in South Africa

Southern Africa is the subregion most affected by the HIV/AIDS pandemic. South Africa now competes with India as the country with the largest number of people living with HIV (Barnett & Whiteside 2006:335). The 2005 National HIV and Syphilis Antenatal Sero-prevalence Survey, released in 2006, found that HIV infection rates had risen slightly to 30,2 per cent from 29,5 per cent in 2004. The total population living with the HIV infection is estimated at 5,54 million (NDoH 2006c).[6]

HIV/AIDS started to spread across the Southern African region during the late 1980s. In 1990, HIV prevalence was 0,7 per cent, rising to 14,2 per cent in 1996 and 19,94 per cent in 1999. By 2002 it had increased to 26,5 per cent (Barnett & Whiteside 2006:10).

Barnett and Whiteside believe that the spread of the disease was assisted by South Africa's peculiar history, which provided perversely ideal conditions for the pandemic (2006:159). The AIDS epidemic starkly reflects the history of the region. Migration and mobility, disorder and conflict, a philosophy of fatalism, deprivation (reinforced by apartheid policy), inequality (institutionalised and legalised under apartheid) and poverty are all characteristics of a risk environment where susceptibility is high. Sadly, they are also the features of South Africa's history and society.

Significant provincial variations, or sub-epidemics, exist within the national epidemic. While some provinces appear to be stabilising with high levels of infection, other provinces display differing patterns overall. In 2004 the Western Cape had a rate of 15 per cent, while the Eastern Cape, Free State and KwaZulu-Natal were at 28 per cent, 30 per cent and 41 per cent respectively with the highest HIV prevalence rates (Barnett & Whiteside 2006:132). Even in the Western Cape, where the lowest rates exist, a recent survey among women showed no sign of a decline in HIV prevalence, which rose from 15 per cent in 2005 to 16 per cent in 2006 (Hartley 2006). The national prevalence rate for women stood at 30 per cent in 2004 and was reconfirmed at 30,2 per cent in 2006 (HSRC 2005). Significant variations in HIV prevalence rates call for different responses. It may be reasonably argued, for instance, that where

infections are lowest, prevention should remain a priority, whereas areas with high infection require more focus on treatment and care.

HIV/AIDS infections vary across age groups, with the highest infection rates in the 20 to early 30s age group (HSRC 2005). HIV/AIDS is also found in every race group, although prevalence amongst blacks is substantially greater.

The socio-economic impact of HIV/AIDS is profound and manifests primarily among individuals and households. The time span of the infection is now sufficiently long to have a visible impact on the health of the individual. The increased burden of illness and death attributable to HIV/AIDS, especially in rural and lower-income households, has weakened households and communities, also creating a growing phenomenon of child-headed households and almost a million orphans (Booysen et al 2002). The TAC states that 900 people die every day in South Africa from AIDS-related illnesses.

HIV/AIDS has economic consequences. The impact on the health sector is increased public health expenditure, with HIV/AIDS utilisation requirements increasing more than threefold between 2000 and 2010 (Martin 2003:27). The cost to the government of AIDS-related care was R1,493 billion in 2000, rising to R4,077 billion in 2009. Because of HIV/AIDS, South Africa will require a real annual increase in government health expenditure of 6,9 per cent per annum from 1997 to 2010 (Barnett & Whiteside 2006:320).

A study of South Africa by ING Barings found that in 2000 government revenue was 0,7 per cent lower than it would have been in the absence of AIDS and projected that by 2011 it would be 4,1 per cent lower (Barnett & Whiteside 2006:322). A second study suggests that by 2010 the economy will be 17 per cent smaller than it would have been without AIDS and per capita income will be eight per cent lower (Barnett & Whiteside 2006:309). Either way the macroeconomic impact is inescapable. AIDS will cause the economy to grow more slowly, which, in turn, will jeopardise development and growth prospects.

The political impact of HIV/AIDS is also apparent. AIDS is likely to affect the government's ability to deliver goods and services efficiently (Barnett & Whiteside 2006:316). The disease also affects elections and electoral systems, with the high number of by-elections in the region possibly due to the loss of politicians to the virus (Chirambo 2006). Generally, the loss of skilled and experienced politicians undermines the capacity of democratic structures and institutions, which traditionally act as oversight institutions in a democracy.

2.1.2 Government's response to HIV/AIDS

The Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa (Comprehensive Plan), adopted by the cabinet in November 2003, embodies the government's main response to HIV/AIDS. The Comprehensive Plan is based on developing a continuum of care, combining prevention to ensure that those who are not infected remain so. There is also provision for treatment with care and support for those infected or affected. It is based on a five-year strategic plan adopted in 2000 (NDoH 2000) and has developed into what is probably the largest programme in the world, sustained by a budget which has expanded and is set to grow still further. Essential to the success of this programme is the strengthening of the national health system.

Table 1: Key HIV/AIDS policy documents adopted since 2000	
2006	NDoH Strategic Plan 2006/07–2008/09
2006	Republic of South Africa: Progress Report on Declaration of Commitment on HIV and AIDS, prepared for the UN General Assembly
2004	Monitoring and Evaluation Framework for the Comprehensive HIV and AIDS Care, Management and Treatment Plan for South Africa
2003	Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa
2000	HIV/AIDS/STD Strategic Plan for South Africa, 2000–2005

State bodies directly involved in HIV/AIDS programmes include the national and provincial ministries and departments responsible for health and social development. Public health care institutions such as hospitals and clinics are responsible for much of the treatment and care of HIV-infected patients. The government has set up and continues to fund a number of large-scale public-awareness prevention programmes such as Khomanani, Soul City and loveLife. In addition, the South African National AIDS Council (SANAC) was launched in January 2000, comprising representatives of 16 government ministries, 17 civil society sectors, 18 government departments and the parliamentary committees on health (NDoH 2005:133). SANAC's main role, from the government's point of view, is threefold: to act as adviser to government, develop national partnerships and mobilise resources.

The government maintains that HIV/AIDS, as a health problem, must be understood in the broader context of social problems such as poverty and inequality. Any response should therefore be integrated into a wider holistic approach. General responses to the disease should address obstacles such as weak health systems, the human resource crisis, access to affordable commodities, and stigma and discrimination. The Comprehensive Plan acknowledges these contextual factors when it highlights universal care, equitable implementation and strengthening the national health system as guiding principles (NDoH 2003:16–24).

In 2006 the government reviewed the HIV/AIDS strategic plan, with its targets, partnerships and coordinating mechanisms. The latest Strategic Plan 2006/07–2008/09 lists as a priority the acceleration of the implementation of the Comprehensive Plan for HIV/AIDS (NDoH 2006a:11).

2.1.3 Civil society responses to HIV/AIDS

The response of civil society to the pandemic has been both dramatic and varied as organisations adopt roles as activists lobbying government, as monitors of government policy and in facilitating and effecting delivery. Thousands of NGOs and CBOs play critical roles by providing a range of services in voluntary counselling and testing (VCT), nutrition, community-based and home-based care and support for people living with HIV/AIDS (PLWHA) and ensuring successful implementation of the Comprehensive Plan. NGOs and CBOs are able to extend services that government is unable to provide directly, filling gaps in the health and welfare systems. A 2002 study found that the highest percentage of NGOs, numbering over 22 755, were located in the social services sector, while those in health and education totalled 6 517 and 5 730 respectively (Swilling & Russell 2002:28–9). HIV/AIDS-related work is done in all these sectors.

In addition, several rights-based campaigns in the HIV/AIDS sector have successfully challenged the state over policy choices on issues of treatment, thus highlighting how the Constitution and Bill of Rights can act as advocacy tools to realise social justice ends. The best-known case concerns the TAC's legal challenge to the state to provide treatment for PLWHA. The Joint Civil Society Monitoring Forum (JCSMF), launched in 2004, also monitors and evaluates the government's ARV treatment programme.[7] A number of

organisations are involved in realising legal, treatment and other rights for HIV-infected people such as the AIDS Law Project (ALP) and and Médecins Sans Frontières (MSF).

2.1.4 The politicisation of HIV/AIDS

Given the magnitude and character of the HIV/AIDS pandemic in South Africa, a massive, committed and coherent response by the government and its political leaders is required to meet the challenges of HIV/AIDS effectively. Yet, despite comprehensive policy initiatives, numerous health practitioners, experts, academics and activists criticise the South African government's response to HIV/AIDS on a range of fronts:

- The state mobilises its initiatives slowly. Treatment programmes only started to gain momentum across provinces in mid-2004, despite increases in prevalence rates and allocated budgets (Nattrass 2006a:1)

- Implementation and operationalisation of care and treatment in public facilities are uneven across provinces (JCSMF 2004:6–9)

- Performance targets set by the government in key policy documents are problematic in that they vary, do not include incremental targets and are often accompanied by little explanation, making it difficult to hold the government to account for delivery[8]

- HIV/AIDS data is contentious, with official HIV statistics receiving criticism (Barnett & Whiteside 2006:64–5)

- Finally, the problem of political will with respect to AIDS among South Africa's political leaders is cited as a major constraint to the successful implementation of prevention and treatment activities (Nattrass 2006a:12; Barnett & Whiteside 2006:605)

Political inertia is regarded as the major constraint in the fight against HIV/AIDS in South Africa and is said to stem directly from debates about the nature and cause of the disease (Barnett & Whiteside 2006:317; Nattrass 2006a:12). The politicisation of the disease goes back to President Thabo Mbeki's controversial comments in 1999 and 2000 that questioned the causal

link between HIV and AIDS and the efficacy of ARVs such as azidothymidine (AZT). Since then various health ministers have been criticised for their lack of active support for the roll-out of highly active ARV therapy (HAART), stances on alternative treatments and nutrition, and delaying tactics in the tendering processes for ARVs. As Nicoli Nattrass, an HIV/AIDS economist, states, 'The Health Minister appears to be undermining, rather than energising the rollout' (Nattrass 2006a:19). Reasons for the persistent apathy and political interference in AIDS-related matters remain largely a mystery, although they may be driven by ideological beliefs about science (Nattrass 2006b:12).

The nature, cause and combating of HIV/AIDS remain a contested terrain, and activism over the right to treatment continues. In August 2006 the TAC took the Department of Correctional Services to court for failing to provide ARVs to prisoners in Westville Prison, and called for the resignation of the current Minister of Health, Dr Manto Tshabalala-Msimang, citing most notably her lack of performance and political will to tackle the crisis. The court instructed the department to produce a roll-out plan for prisoners by 8 September 2006 (Sapa 2006e). In the same month the South African Council of Churches commented publicly about its concern over ongoing tensions between NGOs and the government, while the South African Democratic Teachers Union criticised the government for its lack of leadership over HIV/AIDS and the health minister's promotion of beetroot as a traditional cure for the disease (*News at Ten* 2006). International pressure and criticism continue to mount. At the Sixteenth International AIDS Conference in Toronto in 2006, the South African government came under fire for failing to contain the country's HIV epidemic and for the health minister's controversial stance on nutrition and ARVs. Criticisms were also levelled at the South African government by Stephen Lewis, UN Special Envoy for AIDS in Africa, regarding the South African government's response to the pandemic. A group of HIV scientists recently sent a letter to President Mbeki expressing their concern over policy (Abdool Karim et al 2006).

The politicisation of HIV/AIDS has ramifications with regard to corruption and accountability. It appears to relate indirectly to instances of abuse and corruption on the part of public officials and other individuals by affording a degree of protection, as discussed in later sections. The politicisation of the disease also hinders research into issues of corruption and accountability,

especially because it restricts access to information and contributes to a culture of secrecy. Although section 32(1) of the Constitution states that 'everyone has the right of access to any information held by the state', and this right is protected by the Promotion of Access to Information Act, the reality is that provincial and national health officials, although supportive of this research in principle, were wary of sharing even basic descriptive information relating to oversight mechanisms already in place until approval was granted by certain senior figures in the departments of health. In most instances, requests for approval were not granted within the research time frame.

Senior public officials have also become increasingly defensive as a result of ongoing criticisms of the national Department of Health (NDoH). During the course of this research, Thami Mseleku, the DG, issued a statement ordering provincial health officials not to comment to the media on HIV/AIDS (IRIN PlusNews 2006).

2.1.5 Funding HIV/AIDS activities in South Africa

While donor funding has increased dramatically over the years, the most significant source of HIV/AIDS funding in South Africa remains government revenue (Ndlovu 2006:3).[9] Budget analysts have found that as the impact of HIV/AIDS intensifies, so government increases its share of financial allocations (Ndlovu 2006:7). The WHO's progress report on the expansion of AIDS treatment, released in June 2005, noted that 'South Africa has committed US$1 billion over the next three years to scaling up antiretroviral treatment, by far the largest budget allocation of any low- or middle-income country' (UNAIDS & WHO 2005:16). Table 2 depicts simultaneous increases in state spending and HIV prevalence rates.

Table 2: Comparison of state spending (R000) versus HIV prevalence rates

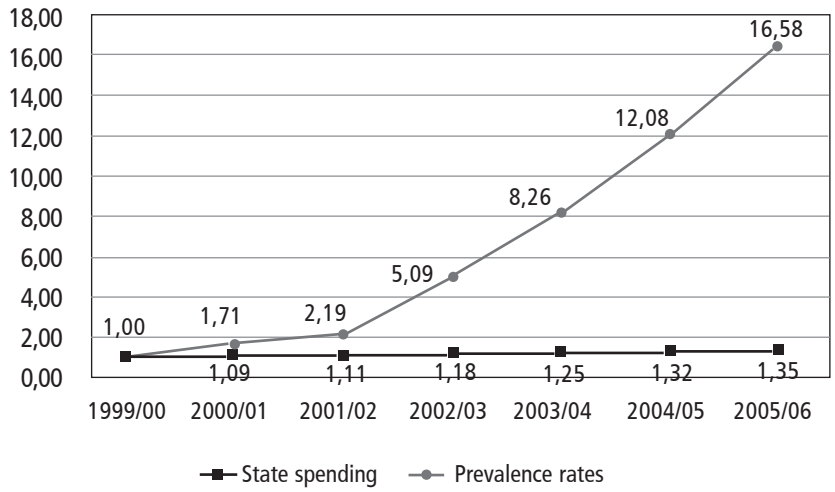
Year	99/00	00/01	01/02	02/03	03/04	04/05	05/06
State spending	137 000	234 000	300 000	697 000	1 132 000	1 655 000	2 271 000
Prevalence rates	22,4%	24,5%	24,8%	26,5%	27,9%	29,5%	30,2%

Sources: National Treasury; Barnett & Whiteside 2006:133

The proportional increase in state expenditure has been dramatic compared with the proportional increase in HIV prevalence rates over the seven-year period. Expenditure was approximately 16,5 times higher in 2005/06 than in 1999/00, while prevalence rates were only 1,35 times higher.

Proportional state expenditure increased by 1 558 per cent between 1999/00 and 2005/06, while prevalence rates increased by 35 per cent in the same period. Graph 1 illustrates this increase.

Graph 1: Proportional increase in HIV/AIDS state expenditure and HIV prevalence rates from 1999/00 to 2005/06



In 1998 donor support accounted for less than one per cent of revenue in the public health sector (Martin 2003:28). The Budget Information Service (BIS) at the Institute for Democracy in South Africa (IDASA) reports that public sector funds earmarked for HIV increased by 99 per cent in nominal terms from 2001 to 2002, while donor funds simultaneously increased by 101 per cent – only very slightly faster than government funds. However, donor funding as a share of the total amount earmarked for HIV/AIDS spending dropped from 44 per cent in 2000 to 40 per cent in 2002 as national expenditure increased (Ndlovu 2006:7).

With HIV/AIDS interventions being funded mainly from public revenue, the financial impact on the health budget has been dramatic. According to

South Africa's National Treasury, in 2006/07 approximately R5 billion is being spent on HIV/AIDS programmes.[10] Of that amount R3,5 billion is from national revenue while it is estimated that roughly R1,5 billion comes from donor funding. A broader estimate by the Treasury of the indirect cost of HIV/AIDS stands at around R10 billion per year.

Identifying what proportions of overall HIV/AIDS spending derive from the national budget versus foreign donor funding is almost impossible. Unknown amounts of donor funding flow directly into NGOs, and because they are not channelled via a public institution, these funds are extremely difficult to track. Donor funding allocations are also spread over differing funding periods, making it awkward to disaggregate amounts into each financial year. Finally, provincial treasuries do not require provincial departments to include donor income in their budgets. In relation to funding for HIV/AIDS treatment, Nattrass (2006a:9) argues that:

> *Disentangling the relative contributions of donors and the South African government for the public sector rollout is a complex business! Unfortunately, neither the donors nor the South African public sector provide sufficient data for the relative impacts to be unpacked at national level.*

Experts at the University of Cape Town's Health Economics Unit argue that attempts to gain a clearer understanding of the relative contributions by the state and foreign donors using patient costing may prove ineffective because there are too many unknown variables.[11] AIDS budget experts suggest that one could guesstimate the percentage of money spent by government agencies that comes from donors by looking at provincial and national budget books, but since many donor allocations are not recorded this exercise would be plagued by inaccuracies.[12]

Nevertheless, budget experts agree that government spending makes up the greatest proportion of the overall amount of funding available for HIV/AIDS activities.[13] Government funds in their various forms therefore offer the greatest potential for abuse, corruption and misappropriation.

2.1.5.1 State financing mechanisms

External donor funding is considered in this section, but with most of the funding for HIV/AIDS prevention and treatment coming from the national budget, the report focuses on that.

There are three main mechanisms by which HIV/AIDS interventions are financed (Martin 2003:29):

- The budgetary allocations to HIV/AIDS through the NDoH and other sectoral departments
- The HIV/AIDS allocation as part of the equitable share grant to provincial governments
- The conditional grant for the National Integrated Programme

2.1.5.1.1 Departmental budgets

These include vertical allocations from the NDoH budget to provincial and local government HIV/AIDS units. The bulk of the NDoH expenditure has been for condoms, for NGO support, for information, education and communication, for capacity-building and for care and treatment protocols (Martin 2003:29).

2.1.5.1.2 Equitable share grants to provinces

The majority of government HIV/AIDS expenditure is channelled through a block grant directly from the National Treasury to provincial governments in the form of an equitable share grant, which allows for ring-fenced HIV-related spending at provincial level.

2.1.5.1.3 Conditional grants

In 2001 the South African government introduced conditional grants, which are special budgetary allocations to provincial departments from the National Treasury to fund specific programme activities (Martin 2003:30). Two conditional grants relate to HIV/AIDS: the social development grant for community and home-based care services and the health grant for the Comprehensive Plan, which covers the prevention of mother-to-child transmission (PMTCT), VCT and antiretroviral therapy (ART).[14] Each grant has certain objectives. Provinces are expected to increase their own allocations for HIV/AIDS from their equitable share. However, conditional grants are important supplementary funds and ensure prioritisation and protection of HIV/AIDS spending.

Table 3 sets out the comprehensive HIV/AIDS conditional grants transferred to the provinces in the most recent financial year.

Table 4 reflects government spending on HIV/AIDS since 1999. The table indicates additional amounts allocated by provinces from their equitable share

Table 3: HIV/AIDS conditional grants to provinces 2005/06 (R000)

Province	Amount transferred	Actual spending	Variance: (over-)/under-expenditure	% difference: (over-)/under-expenditure
Eastern Cape	159 005	161 489	(2 484)	(1,6%)
Free State	115 874	96 398	19 476	16,8%
Gauteng	185 048	207 328	(22 280)	(12,0%)
KwaZulu-Natal	251 468	239 550	11 918	4,7%
Limpopo	125 899	94 110	31 789	25,2%
Mpumalanga	81 392	90 019	(8 627)	(10,6%)
Northern Cape	48 050	57 652	(9 602)	(20,0%)
North West	100 921	104 941	(4 020)	(4,0%)
Western Cape	82 451	92 649	(10 198)	(12,4%)
Total	1 150 108	1 144 136	5 972	0,5%

Source: Interview with Mark Blecher.

Table 4: Breakdown of spending by government on HIV/AIDS from 1999 to 2009 (R000)

Year	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09
Provincial HIV subprogramme	62	60	80	308	669	1 201	1 703	2 526	2 831	3 063
Conditional grant	0	17	54	210	334	782	1 135	1 567	1 646	1 735
Provincial own	62	43	25	98	335	419	568	958	1 185	1 327
National DoH	74	164	211	455	676	1 107	1 566	1 977	2 083	2 188
National own	74	148	157	245	343	326	431	410	437	453
Subtotal (CG; prov. & nat. own)	137	207	237	553	1 011	1 527	2 135	2 935	3 268	3 516
Education conditional grant	0	27	64	144	120	129	136	144	152	162
Subtotal	137	234	300	697	1 132	1 655	2 271	3 080	3 420	3 677

Source: Interview with Mark Blecher.

to supplement the HIV/AIDS conditional grant. Subtracting the conditional grant amounts (shown in the second row) from provincial spending on HIV subprogrammes (first row) reveals what provinces have added from their equitable share (third row).

2.1.5.2 Donor funding

HIV/AIDS funds from international donors and aid agencies are vital additional resources to national government revenue. The Organisation for Economic Cooperation and Development (OECD) conducted a detailed analysis of foreign aid commitments for HIV/AIDS to developing countries in the period from 2000 to 2002 and found that South Africa was amongst the five countries that received the largest shares, with eight per cent of all HIV/AIDS commitments. In 2000, according to OECD data, 99 per cent of this eight per cent was spent on HIV/AIDS control programmes, including prevention, education, care for orphans and vulnerable children, treatment of sexually transmitted diseases (STDs) and PMTCT (Ndlovu 2006:6).

HIV/AIDS donor funds enter South Africa through various channels:

- Directly to NGOs
- To the National Revenue Fund at the National Treasury
- To the NDoH (which usually requires separate accounts for specific activities)
- Directly to provincial treasuries
- Directly to provincial departments, such as the departments of health or social development

2.1.5.2.1 Types of donors

- *United States government*

Through various agencies including the US Agency for International Development (USAID) and the President's Emergency Plan for AIDS Relief (PEPFAR), the US government provides the largest amount of donor funds for HIV/AIDS programmes in South Africa, amounting to US$126,4 million (R886 million) over a six-year period (2001–2006) (Ndlovu 2006:2).

In January 2003, President George W Bush announced the establishment of PEPFAR, a US$15 billion initiative to fight the HIV/AIDS pandemic over

five years, with a special focus on 15 of the hardest-hit countries. It targets four specific areas:

- Prevention of HIV transmission
- Treatment of AIDS and associated conditions
- Care, including palliative care for HIV-infected individuals
- Care for orphans and vulnerable children

PEPFAR is South Africa's biggest donor, at US$221 million for the 2006/07 financial year, which is close to R1,5 billion. PEPFAR grant recipients in South Africa are somewhat disparate, including Catholic Church programmes and NGOs such as Right To Care.

- *Bill & Melinda Gates Foundation*

South Africa receives money from the Global Health Programme, which is part of the foundation. In particular, the foundation invests large amounts of money in research institutions such as the National Institutes of Health and the Medical Research Council (MRC) for research on vaccines, microbiocides and clinical and basic science aspects of HIV. For example, in 2006 the MRC received US$400 000 to support an international conference on vaginal microbicides for the prevention of HIV and sexually transmitted infections (STIs).

- *Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)*

The Global Fund was established in July 2001 (Barnett & Whiteside 2006:367). It has become a major actor in responding to the global AIDS problem and is a key vehicle for resource mobilisation. The fund encourages partnerships between the public sector, civil society and the private sector. According to its website, South Africa received US$69 477 276 over two years and US$233 941 575 over five years (GFATM 2005a). Funds have been allocated to KwaZulu-Natal (US$26 741 529 for Round 1) through the Enhancing Care Initiative Grant, the Western Cape government (US$15 521 456 for Round 3) and the NDoH (US$8 414 000 for Round 2). Funds for the 2006/07 financial year total US$29,2 million.

- *Smaller donors*

South Africa receives funds from a host of smaller donors. Table 5 shows the NDoH donor matrix for HIV/AIDS financial commitments.

Table 5: The donor matrix for HIV and AIDS financial commitments to South Africa

Donor (see List of abbreviations and acronyms)	Approved funding amounts in foreign currencies	Approved funding amounts in rands	Funding period
ILO	US$170 964	R1 196 748	2002–2007
New Zealand Aid	NZ$450 000	R1 800 000	2003–2005
IOM	US$320 000	R2 240 000	2003 in pipeline
JICA (Japan)	$495 000	R3 465 000	2001–2006
Norway	kr4 000 000	R4 000 000	2000–2003
Finland	653 742	R5 229 936	2002–2005
UNDP - UNTG (CDC, UNAIDS PAF)	US$755 000	R5 285 000	1997–2004
UNFPA	$1 103 658	R7 725 606	1998–2003
SIDA (Sweden)		R15 000 000	2004–2005
UNICEF, UNFPA, UNDP	$2 300 000	R16 100 000	2003–2004
UNODC	$2 388 900	R16 722 300	1997–2004
UNICEF	$4 500 000	R31 500 000	2002–2006
DCI (Ireland)	4 241 698	R33 933 584	2001–2005
GTZ (Germany)	5 500 000	R44 000 000	2001–2008
UNDP	$10 228 900	R71 602 300	1997–2006
KfW (Germany)	9 000 000	R72 000 000	2003–2005
Belgium	10 157 305	R81 258 440	2002–2008
DANIDA (Denmark)	$17 100 000	R119 700 000	2001–2006
CIDA (Canada)	$24 200 000	R121 000 000	2003–2008
AusAID (Australia)	AU$52 770 000	R263 850 000	2000–2008
European Union	142 500 000	R344 000 000	2000–2007
GFATM*	$65 030 986*	R455 216 902	2004–2005
DFID (UK)	£41 087 322	R493 047 864	2001–2007
US government	$126 435 932	R885 996 524	2001–2006
TOTAL DONOR AID		**R2 341 401 117**	**1997–2008**

* The Global Fund amount indicated here is sourced from progress reports on the Global Fund website as of the end of April 2005.

These figures are adapted from the NDoH's Donor Matrix as revised on 15 July 2004. Conversions are approximations by the NDoH of exchange rates on 10 June 2004. EUR = R8 (R8,05); USD = R7 (R6,67); AUD = R5 (R4,62); GBP = R12 (R12,19); DKK = R1 (R1,08); NZD = R4 (R4,18); CAD = R5 (R4,91)

Source: Ndlovu 2006:9.

The NDoH annual report for 2004/05 states that funds were being received from the European Union for the Public Health Sector Support Programme,

from Belgium for HIV prevention, from the Global Fund for TB and AIDS and malaria prevention, and from the CDC (Centers for Disease Control) for HIV/AIDS activities (NDoH 2005:76). The report also states that foreign aid donations received in that year amounted to R111 772 000 and were deposited into the Reconstruction and Development Programme (RDP) fund. Expenditure amounted to R102 922 000.

Table 6 provides a detailed breakdown of amounts received from South Africa's two largest donors, the Global Fund and PEPFAR.

Table 6: Donor amounts received by South Africa in US dollars*

Years	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	Total
Global Fund	25 161 280	17 102 066	29 229 912	29 929 380	26 683 628	9 185 261	137 392 525
KZN	18 995 159	7 746 730	11 911 669	11 911 669	11 911 669	-	62 476 898
NDoH	-	-	4 407 000	4 007 000	-	-	8 414 000
W. Cape	6 186 121	9 355 336	12 911 243	14 010 711	14 871 957	9 186 261	88 501 629
PEPFAR	89 272 988	148 187 427	221 000 000	-	-	-	458 460 415
Total	114 434 268	165 289 493	250 229 912	29 929 380	26 783 626	9 186 261	595 852 940

* Last updated in 2004.

Source: Interview with Mark Blecher.

Obtaining accurate data on donor funding is challenging. Although figures (and details of intended recipients) are probably best obtained from the donors themselves, it is difficult to compile a comprehensive list of donors. First, the NDoH's 2004 donor matrix is outdated. Second, government departments are not very forthcoming with donor information or simply do not have complete information. Third, when funds travel directly to NGOs, it is harder to identify the donors. The OECD 2004 report is also limited because it only reports on commitments made by donor countries, not on actual disbursements, and it only uses information from OECD Development Assistance Committee countries (Ndlovu 2006:5).

2.1.5.3 Prevention vs treatment

Just as it is hard to distinguish between government and donor funding, it is equally difficult to establish which proportions of overall HIV/AIDS expenditure

go to prevention and which to treatment. Budget experts interviewed suggest that one could attempt to track money designated for HIV/AIDS programmes within the HIV/AIDS directorates at both national and provincial levels, as well as with foreign donors, and then categorise prevention and treatment activities.[15] However, this would entail four major exercises:

- Tracking all government HIV-related programmes using the national and provincial treasuries' budget books
- Requesting all national and provincial departments concerned to compile a breakdown of all donor monies received and related activities
- Tracking all foreign donations by requesting a breakdown of funds from donors and related activities
- Requesting greater detail from government about how conditional grants are divided

Besides the fact that specific information is lacking, much of the spending on HIV/AIDS in the public health system is indirect, owing to the nature and impact of the disease. Large amounts are spent across the entire health system on HIV-positive patients without being recorded as 'HIV expenditure'. This includes all medicines and general nursing care in medical, maternity and paediatric units or wards treating illnesses that are attributable to HIV, but are not known to be or recorded as such. In other words, the indirect burden on the health system means that government is spending on HIV/AIDS throughout the health budget, albeit indirectly. These additional demands ultimately show up across other programmes, for instance in the need for increased human resources.[16]

These data limitations make evaluations of HIV/AIDS allocations and expenditure extremely challenging, especially if a breakdown is desired of functional classifications such as prevention, care and support, and treatment.

2.1.6 Corruption in South Africa

South Africa is described as a country with 'occasional corruption', where, on the whole, political, corporate and bureaucratic corruption is limited (Pedley nd). However, many South Africans (41%) perceive a lot of corruption and see it is one of the most important problems which should be addressed, while

slightly fewer (39%) contend that there is a lot of corruption, but it is not the most pressing issue (UNODC nd). According to the 2003 ISS National Victims of Crime Survey, petty corruption was the second most prevalent crime in the country after housebreaking (Van Vuuren 2004:11). Of most concern was that many citizens do not know how to report corruption and, although South Africa has good whistle-blower provisions, are afraid of the consequences if they do. Moreover, a comparison between the 1998 and 2003 National Victims of Crime Surveys suggests that the rate of corruption has almost tripled from 2 per cent to 5,6 per cent.

TI's 2002 Global Corruption Barometer found that 83 per cent of South Africans felt that corruption affected their personal and family lives significantly – 57 per cent very significantly, and 26 per cent somewhat significantly – while only 17 per cent felt it had little impact (TI 2003:20). The same report shows a relatively high number of respondents in South Africa choosing medical services as their first choice for eliminating corruption from an institution. Of 12 institutions, medical services appear as the fourth choice (11%), after the police service (24%), political parties (21%) and the education system (14%) (TI 2003:31). The Global Corruption Barometer also found that over 50 per cent of South Africans expected corruption in general to increase over the next three years. Two years later, the 2004 TI Global Corruption Barometer Report showed that 23 per cent of South African citizens expected corruption to increase a lot over the next three years, 14 per cent expected it to increase a little, and 16 per cent expected it to stay the same, while 40 per cent expected a decrease (TI 2004:21).

The 2006 Afrobarometer survey shows that 56 per cent of the South African electorate believed that government was handling the combating of HIV/AIDS fairly or very well, an increase of 10 per cent over 2004, with 40 per cent feeling that it was doing fairly or very badly. However, when asked how many health workers were involved in corruption, only 19 per cent of respondents believed that none were involved in corruption, while 44 per cent stated that some were, 20 per cent that most were, and 7 per cent that all were. Approximately 12 per cent did not know. This suggests that 71 per cent of the public think that health workers take part in corrupt activities (Afrobarometer 2007).[17] Explanations from respondents on why corruption is so evident in the health sector emphasise the lack of accountability and transparency in health care operations.

Generally, there is a lack of reliable data on corruption in the HIV/AIDS sector in South Africa and globally from perception surveys and statistics. While not empirically definitive, perceptions highlight where abuses are widely assumed to take place and have thus become reliable indicators of corruption. Yet only a few countries have sector-specific data on perceptions (Lewis 2006:16). Maureen Lewis, an expert on governance and corruption in health systems, explains why data on perceptions is useful:

> *Greater efforts to track such information can guide both policymakers and donors providing a benchmark for individual countries. (Lewis 2006:16)*

According to Transparency International multiple opportunities exist for corruption in the prevention and treatment of HIV/AIDS (TI 2006a:103). Corruption affecting HIV/AIDS programmes is magnified by the scale of the pandemic, the stigma attached to the disease, the multiplicity of new agencies and the high cost of drugs. Moreover, the rapid inflow of donor funds and increases in the national budget to fight the disease in South Africa, amounting to a massive R5 billion annually, provide further opportunity for corruption. Corruption also acts as an obstacle to the successful implementation of HIV-related programmes, thus exacerbating the pandemic. A Human Sciences Research Council report on the financing of HIV/AIDS programmes in the region states that with increased budgetary and donor allocations, there is an increased need for efficiency in budget management and budget execution (Martin 2003:51).

It is important to note that the deterioration of health generally and the increasing extent of corruption at all levels of the health system result from a myriad of interrelated problems experienced in many low-income and transitional countries. These include: a shortage of drugs and medical supplies, inadequate payment (or non-payment) of health workers' salaries, poor-quality care, the HIV/AIDS pandemic and inequitable health care services (Vian nd).

It is important to make it clear at the outset that most interviewees in the HIV/AIDS and health sectors could not point to many proven cases of corruption. Furthermore, none of the cases they did cite amounted to grand corruption. However, the concerns raised were supported by anecdotal evidence of many incidents of petty corruption and mismanagement of resources. Through frank appraisal by interviewees and desktop analysis, the research also identifies numerous locations where abuses can occur. Findings suggest

that a successful response to HIV/AIDS requires strict adherence to anti-corruption mechanisms, so as to ensure the proper utilisation of all resources.

2.2 Accountability in the HIV/AIDS sector

This section gives an overview of the quality and effectiveness of accountability and oversight mechanisms that relate to HIV/AIDS funds. With most of the financing of HIV/AIDS interventions coming from the state, opportunities exist for corruption in the budget funding process. Particular attention is therefore given to levels of accountability and oversight in the public sector, the degree of transparency and ease of access to information.

2.2.1 State initiatives to combat corruption

Efforts by the government to combat corruption and promote an open, accountable democracy are numerous and include legislation such as the Prevention and Combating of Corrupt Activities Act, No. 12 of 2004, the Promotion of Access to Information Act, No. 2 of 2000, the Protected Disclosures Act, No. 26 of 2000, the Public Finance Management Act (PFMA), No. 1 of 1999, and the Local Government: Municipal Finance Management Act, No. 56 of 2003. South Africa also has a number of specialised anti-corruption institutions, which are mandated to support constitutional democracy and vested with a range of powers. These constitutional and oversight bodies include the Public Protector, the Public Service Commission (PSC) and the Independent Complaints Directorate. Criminal justice agencies include the South African Police Service, the National Prosecuting Authority, the Directorate of Special Operations, the Asset Forfeiture Unit and the Special Investigating Unit (SIU). Other state bodies that have a mandate to combat corruption include the Auditor-General (AG) and the national and provincial legislatures, which have a key oversight role. Civil society and the private sector are equal members with government of the National Anti-Corruption Forum, which promotes a cross-sectoral approach to tackling corruption.

2.2.1.1 The Public Service Anti-Corruption Strategy

The Public Service Anti-Corruption Strategy was introduced in 2002 and spearheaded by the Department of Public Service and Administration. It requires

all public service departments and other entities to have a certain 'minimum level anti-corruption capacity' to address fraud, abuses of power, embezzlement, conflicts of interest, bribery, favouritism and nepotism, extortion and insider trading, and the abuse of privileged information. The strategy extends to all government departments, including the NDoH.

The strategy requires anti-corruption hotlines to be established to promote openness and encourage whistle-blowing. The national anti-corruption hotline for the public sector (0800-701-701), which is managed by the PSC, is displayed on the website of the NDoH. The hotline receives complaints on all departments and is claimed to have improved access for the reporting of misconduct.

2.2.2 National Treasury and HIV/AIDS funds[18]

In view of the importance of combating HIV/AIDS, the National Treasury recently standardised the provincial budget structure, creating a dedicated HIV/AIDS subprogramme for government revenue to encourage consistency in spending on HIV/AIDS and to assist the monitoring of that spending. This also allows the Treasury to measure additional provincial spending on HIV/AIDS activities over and above the conditional grant, as shown in Table 4 above.

As part of its monitoring and evaluation strategy, the National Treasury receives monthly expenditure reports and quarterly performance reports on conditional grant expenditure from the NDoH and the provinces. Initially dissatisfied with the execution of HIV/AIDS activities in the provinces, the Treasury has begun to place greater emphasis on the quarterly performance reports, which stress outcomes-based results.

The National Treasury is currently endeavouring to regulate donor activities in the country in order to achieve greater integration with government efforts and has developed official development assistance guidelines under the auspices of its International Development Cooperation directorate (Ndlovu 2006:4). The Treasury is also requesting all departments to indicate donor funds received. However, most departments fail to update their records of donor funds.

2.2.3 National Department of Health

The NDoH monitors provincial performance on HIV/AIDS through financial reports, business plans and site visits. As discussed below, however, the

department has demonstrated poor budget management systems and inadequate monitoring of provincial HIV/AIDS resources, expenditure and performance.

First, the NDoH tendency to underspend affects HIV/AIDS conditional grants and related areas such as condoms.[19] In 2005/06 the NDoH underspent by R102 million, of which R80 million related to the core department. In 2004/05 the NDoH underspent by R114 million in the core department and R430 million in total.

Also of concern are the AG's qualified audit opinions of the department's financial statements for four consecutive years.[20] Points raised refer directly to HIV/AIDS and non-compliance with the Division of Revenue Act (DoRA), No. 7 of 2003. DoRA lists all conditional grants to be received by the provinces, of which a couple are HIV/AIDS-related, and outlines the purpose and stipulations of each grant.[21] The 2004/05 annual report stated:

> *The DoRA framework with reference to the HIV/AIDS grant requires that all [provincial] business plans be approved by 1 April 2004. Two of the nine business plans were not received by the national department by the due dates stipulated in the DoRA.*
>
> *Although transfers had been withheld during the year, it is evident that in-year monitoring of grant expenditure is not effective and consistently performed to enable the department to identify non-compliance with the DoRA and the DoRA Framework. This was evident in the late submission of monthly reports and incomplete information on the reports.*
>
> *The Department did not provide guidelines on reporting [to provinces] to ensure effective financial and operational monitoring as required by DoRA. (NDoH 2005:79)*

As highlighted here, a number of elements pertaining to HIV/AIDS management and expenditure are qualified – and the more elements that are qualified, the more problematic a department's administration. It appears that there is a lack of accountability for the management of public money in the NDoH. Opportunities for corrupt activities increase where oversight and accountability are poor. At the time of writing, the office of the DG, Thami Mseleku, had not responded to a request for an interview to obtain the department's comments on these serious indictments.

2.2.4 State coordination and monitoring of donor funding

With donor aid forming a considerable part of the response to the epidemic, it is important to monitor funding flows between donors, government agencies

and NGOs. The NDoH is responsible for coordinating, dispersing and monitoring the spending of significant amounts of donor funds.

To assist with the monitoring of donor financial commitments for HIV/AIDS, the NDoH developed a database referred to as a 'donor matrix', which lists various relevant items that assist in tracking projects. These include: the amounts committed by donors and the objectives and activities of bodies responsible for implementation, such as government departments, research institutes and NGOs. It names the accounting officers and departmental and donor contact persons. Since donors provide monies for various programmes and varying funding periods, the matrix also indicates the duration of each funding flow.

The BIS describes the matrix as 'an important development to help correct the earlier situation where there was no record or database of donor funds for HIV and AIDS in South Africa' (Ndlovu 2006:8). This valuable information facilitates and encourages monitoring and should be developed further. However, the database is limited in several respects: it only provides information on financial 'commitments', not actual allocations; data is reported over multiple years; and it is somewhat outdated, having last been updated in July 2005 (Ndlovu 2006:1).

Monitoring donor funding is further hampered by a lack of disaggregated expenditure information. Departments are not required to record donor expenditure as a regular item in the budget book. So although data on HIV/AIDS expenditure is available in budget books, it is organised in such a way that it is impossible to account for donor money. To obtain an expenditure report on donor monies, one would have to address a request directly to the NDoH or to the donors themselves.[22]

It also takes years for donor funding information to be synchronised and become publicly available. This challenges national and provincial governments and the NGO sector to look more broadly at their budgetary processes for reporting on donor funds received. Since money from aid agencies ends up in the national coffers, it ought to be treated like public revenue funds and subject to the same scrutiny. In particular, Ndlovu argues that:

> *From a financial management perspective, it would make good business practice to have donor aid monies reported in the national budget. One of the reasons for this is that donor aid forms a large part of national resources to be utilised on HIV and AIDS, so they need to be recognised and reported*

> *accordingly. This would ensure that transparency and accountability are extended to donor as well as government money. (Ndlovu 2006:5)*

The spending of bilateral donor funds for HIV/AIDS is slow compared with the spending of government funds for two main reasons (Ndlovu 2006:2). First, some donor funding is ring-fenced for very specific purposes. Ring-fenced or earmarked funds typically come with strict spending conditions. Although this helps ensure that new and critical projects are funded, donor and government priorities can clash, limiting flexibility for implementers who need money to spend on vital local priorities. Secondly, the spending of donor funds is slowed by a weak health system and insufficient capacity on the part of the government to use the money.

2.2.5 Donor initiatives

Most donors set stringent guidelines. For example, the Global Fund enters into 'grant agreements' with principal recipients, such as the NDoH or a provincial government nominated through the Country Coordinating Mechanism (CCM) responsible for grant proposals.[23]

Table 7: Performance-based funding requirements: the Global Fund

Requirement	Content	Timing/frequency
Disbursement requests and progress updates	Programmatic and financial progress updates: actual results achieved vs plans and actual expenditures vs budget Statement of sources and uses of funds	Quarterly reports and quarterly grant tranche
Fiscal year progress reports	Consolidated programmatic and financial information for programme	End of fiscal year
Audit reports	Report by qualified auditor covering all PR programme expenditures during the fiscal year Copies of audit reports covering subrecipients' programme expenditures during the fiscal year	End of fiscal year

Source: GFATM nd.

The grant agreement specifies the programme budget and intended programme results to be measured by key indicators, such as performance. Principal recipients (generally governments) should also have appropriate systems in place to assess and monitor the subrecipient's implementation and use of grant proceeds, including reporting and audit requirements. Guidelines for performance-based funding can be found at the Global Fund's website and are displayed in Table 7 (GFATM nd).

The Global Fund has demontrated its readiness to act if it detects financial mismanagement by either a principal recipient or subrecipient. The government-funded campaign initiative loveLife, South Africa's largest prevention programme for youth, had its funding stopped in December 2005 when the Global Fund's board voted not to continue funding for the existing grant (GFATM 2005b; Chibba 2005).[24] Concerns related to performance, financial and accounting procedures, and the need for an effective governance structure.

2.2.6 Direct donor funding

Where donors channel resources directly to service providers such as NGOs, CBOs and research institutes, accountability mechanisms and enforcement depend largely on guidelines set up by donors themselves. Standards vary. For example, PEPFAR and USAID have strict accounting mechanisms, while donors like the Swedish International Development Cooperation Agency (SIDA) are more relaxed. Although less accountability provides space for dubious accounting by recipients, experts warn that stringent stipulations can hamper effective and innovative grass-roots activities, which may flourish when requirements are more relaxed. PEPFAR has been highlighted as being too strict, to the detriment of many NGOs. A careful balance is required, so that spending is adequately controlled but the funding apparatus is not so complicated that local organisations cannot meet the requirements (Itano nd).

Direct funding is particularly difficult to track because there is no centralised reporting mechanism for all international aid to the NGO sector.[25] It is not regulated by the state and no public information exists about expenditure or performance-based outcomes. The Minister of Health, Dr Manto Tshabalala-Msimang, has called on recipients to 'play their part by utilising resources in an effective, efficient and responsible manner whilst maintaining accountability' in order to 'generate credibility and donor confidence' (Tshabalala-Msimang 2006b).

The lack of information also challenges government's ability to plan, budget and coordinate effective responses to HIV/AIDS and to avoid duplication or 'double dipping'. The Minister of Health has called for the improved coordination and alignment of domestic and donor funds in order to have access to information to ensure better planning and improve effectiveness (SAFM 2006; Tshabalala-Msimang 2006a). However, some NGOs have rejected her call, perceiving it as the NDoH trying to monopolise all aspects of funding (SAFM 2006). Some NGOs reject the idea of centralised funding via government because of the delays and bureaucratisation it can bring. This development highlights how the politicisation of HIV funding can depress calls for accountability and transparency.

Because of the lack of readily available and up-to-date information, direct donor funding remains a key challenge in monitoring and accounting for HIV/AIDS resources.

2.2.7 The provinces

The implementation of HIV/AIDS policies and the expenditure of funds for that purpose are largely the responsibility of provincial governments. The vast majority of HIV/AIDS funds go directly to provinces, where the bulk of HIV/AIDS services are delivered. Monitoring and oversight of funds should therefore be focused primarily at that level.

Analysis for this report indicates four channels of liaison with regard to provincial accounting for and oversight of HIV/AIDS funds:

- Horizontal liaison between provincial treasuries and the provincial departments of health and social development that spend and allocate HIV funds
- Vertical liaison between national and provincial treasuries
- Vertical liaison between national and provincial departments to account for the execution of funds and related performance outcomes
- Horizontal liaison between provincial departments and the organisations they fund

Two directorates are responsible for the bulk of HIV/AIDS funds and the roll-out of prevention, care and treatment at provincial level, namely the primary

health care HIV and AIDS, STI and TB Unit, and the Comprehensive Care, Management and Treatment Unit.

As mentioned earlier, DoRA sets out stipulations for HIV conditional grants. DoRA states that provincial health departments must provide the NDoH with business plans, report on their actual and projected spending every month, and publish quarterly reports setting out expenditure against each conditional grant. Using the National Treasury website one can track expenditure on the HIV/AIDS Comprehensive Plan per province.[26]

In contrast, there are no requirements for the public reporting of HIV-related equitable share expenditure. Neither is equitable share expenditure data pertaining to the funding of the HIV/AIDS programme disaggregated. This means that accountability and transparency are far greater for HIV/AIDS conditional grant expenditure than for equitable share funds.[27]

The government has recently removed the HIV/AIDS conditional grant for community and home-based care (under the Department of Social Development) and asked provinces to use their equitable shares to keep the programme financed.[28] This could have negative ramifications for the programme. First, whilst several provinces, such as the Western Cape, have complied, not all provincial treasuries have done so. Now HIV/AIDS community and home-based care financing has to compete with multiple other priorities to be funded by provinces from the equitable share.

Overall, using equitable shares instead of conditional grants to fund HIV-related programmes means expenditure reporting is less transparent, which undermines public transparency. HIV/AIDS programmes also run the risk of not being funded since they compete with numerous other provincial and national priorities instead of being ring-fenced.

All funds spent by provinces are audited by provincial auditors, as outlined in provincial department annual reports, and this presents an additional monitoring tool. However, auditing fails to take into account the performance and impact of funded HIV/AIDS activities. An additional problem is that it is unclear whether the provincial premiers' offices and the NDoH are performing follow-up checks to ensure that problems reported in the audits are rectified.

Another discrepancy relating to HIV/AIDS funding is the underspending of budgetary allocations by provincial health departments. Many struggled to absorb the large amounts set aside by the government in earlier years. In 2000

only 36 per cent of the overall amount allocated in provincial budgets was spent. This improved to 61 per cent in 2001 and 85 per cent in 2002.[29] The massive increase in expenditure was accompanied by a massive increase in the actual amount of money being provided. The improvement in provinces' ability to spend increasing proportions of an ever-increasing budget is due to greater flexibility in grants and an increased capacity to spend funds ring-fenced for HIV as health institutions become more experienced and capacitated to deliver HIV/AIDS services. Mark Blecher at the National Treasury commented on the much improved HIV/AIDS-related spending by provinces compared with the first years of the conditional grant, when spending was very slow. In the 2005/06 financial year R1,150 billion was given to provinces and R1,144 billion spent by them. However, there is also a pronounced variation in underspending between provinces, as indicated in Table 3 above.

Case study
Underspending: the cases of Mpumalanga and the Eastern Cape

In 2002 it was reported that Mpumalanga had spent no funds on PMTCT services or home-based care in the previous financial year (Thom 2002). Although spending in the Mpumalanga Department of Health increased by 19 per cent in 2003/04, the health committee noted with concern the large amounts of money, euphemistically referred to by the provincial department as 'savings', which were still not being spent. In 2003/04, the department failed to spend R143 million of the R2,152 billion it was allocated (Ndaki 2004).The Public Service Accountability Monitor (PSAM) reports that in the 2003/04 financial year the Eastern Cape provincial health department underspent its HIV/AIDS conditional grant by 46,9 per cent (PSAM 2005a:7). The AG also found that the conditional grants were not being monitored adequately in terms of their measurable outputs (PSAM 2005a:12). In the 2004/05 financial year, the department recorded a small improvement in spending, underspending by R8,43 million, or 8,5 per cent of its health grant (PSAM 2005b:12). However, in terms of the provincial HIV/AIDS subprogramme, under District Health Services, the province failed to spend R16,80 million, or 12,73 per cent of its budget, despite the department's claim that it had prioritised HIV/AIDS management in the province (PSAM 2005b:7). The AG also noted that insufficient control had been exercised over medical supplies purchased in terms of the HIV/AIDS conditional grant (PSAM 2005b:15).

2.2.8 Donor funds to provinces

According to the PFMA all donor funds sent directly to provincial departments should be recorded and the provincial treasury notified. However, many departments do not record all donor funds, which means that the fiscal policy offices of provincial treasuries often do not have complete information. Due to the large amounts of donor funding being received in the Western Cape, primarily from the Global Fund in recent years, that province's health budget has introduced, in its District Health Services programme, a subprogramme listing donor funds received. However, this is not standard practice for provincial budgets, so it remains difficult to track or monitor provincial donor funds.

The PFMA also stipulates that any expenditure from donor funds that have been deposited into provincial revenue funds (PRFs) should be gazetted. Yet if the funds come directly from the donor, and the donor stipulates that they need to be put into a separate account (as USAID does), these funds do not flow through PRF and therefore do not require gazetting. This represents a loophole in the reporting process and further undermines accountability and transparency.

The fiscal policy office in the Western Cape treasury is currently in the process of improving its oversight and coordinating capabilities for donor funds across departments.[30] This effort suggests that the provincial government is aware of the lack of accountability and coordination of donor funds. It may be argued that all provincial treasuries should be encouraged to do the same.

The spending by provinces of donor funds for HIV/AIDS is often slower than their spending of government funds for the two main reasons stated above in relation to absorption problems (Ndlovu 2006:2). Increases in government and donor allocations for HIV/AIDS without improvements in the capacity to spend challenge the overall strength of the health system. Given that the provision of HIV/AIDS services in the public sector depends on the overall ability of the health sector to provide all health services, absorption capacity is increasingly becoming the issue for HIV/AIDS spending in South Africa, rather than the availability of resources. For this reason, Ndlovu argues that the donor community should be able to invest in capacity-building in the government system to ensure that the resources they inject into the government are utilised effectively and efficiently (Ndlovu 2006:2).

The European Union 'Partnerships for Health' programme is a six-year programme developed in collaboration with the South African government and other international partners. The aim of the programme is to strengthen and support cooperation between non-profit health providers (NGOs and CBOs) and government services to create formalised partnerships for the delivery of primary health care, specifically those services addressing HIV/AIDS. It is currently being conducted in five provinces and is based at the NDoH (NDoH nd).[31]

2.2.9 Parliamentary oversight

The National Council of Provinces (NCOP) has shown excellent and dynamic oversight skills in its treatment of provincial spending over the past few years.[32] The chair of the NCOP's Select Committee on Finance meets the members of the provincial executive committees (MECs) responsible for health and the treasury and their heads of department and interrogates them about expenditure reports at the highest level. This increased level of scrutiny is said to have contributed to improvements in provincial spending.[33] However, the committee is also aware that it needs to increase its non-financial or performance-related oversight capabilities. While departmental expenditure reports may show that funds have been spent efficiently, they give little detail about how expenditure translates into actual performance and achievements. Measuring the impact of HIV/AIDS-related spending is significantly more challenging because non-monetary output is more difficult to measure.

2.2.10 Civil society organisations

As countries respond to the pandemic, an array of new institutions has emerged, including national AIDS commissions to coordinate responses and NGOs as providers of services. Whilst these organisations attract funding, they are still in the process of developing and testing the efficacy of their oversight and monitoring mechanisms.

With hundreds of organisations receiving funding via both national and provincial departments to operate as delivery institutions for HIV/AIDS-related activities, it is essential that they be subject to stringent and transparent accountability mechanisms. In the early years, pressure on the state to roll out

services meant that less formal relationships existed between the state and NGOs and CBOs, which were not governed by strict controls and contracts. Over time, however, the government has moved to improve and tighten controls, introducing contractual relationships or service agreements which reduce the possibility of fraud and corruption.

However, minimum standards are still being developed, with some provincial departments currently reassessing their relationships with the NGOs they fund. This is demonstrated by the new draft policy on 'The Financial Awards to Service Providers' by the Department of Social Development in KwaZulu-Natal, which calls for greater accountability and transparency (Social Development nd). It describes financing options, types of financing, eligibility criteria and requirements for funding. Requirements include a business plan, which should reflect audited financial statements, registration as a non-profit organisation (NPO), activity-based budgets, objectives, outputs and outcomes. Contracts spell out the service provider's obligations in respect of deliverables (outputs), reporting and accounting, and stipulate monitoring and evaluation procedures to ensure accountability for public funds received. This move reflects a shift in the focus of government from funding based on input to outcome-based funding, as well as a shift from lack of accountability to accountability for public funds. It will be interesting to monitor the passage of this important policy document and its replication across provinces and departments.

There is some anecdotal evidence of funds being channelled to fictitious NGOs set up by officials in provincial district government departments and district offices. The TAC cited one case at Lusikisiki in the OR Tambo district in the Eastern Cape, where an NGO worker was fired for whistle-blowing, having stated that the NGO was claiming funding falsely. In another case, the TAC found that municipal health workers were strongly recommending organisations linked to their friends or relations for funding. The TAC points out, however, that such cases based on anecdotal evidence are difficult to prove without a government-led investigation.

2.2.10.1 NDoH oversight

NGOs are funded by the NDoH through the National NGO Funding and Coordination Unit in the HIV/AIDS and TB cluster if they provide a service in three or more provinces. NGOs are identified by provincial offices and then

their names are submitted to the national office for funding. An applicant must be registered as an NPO and have a constitution and a functioning governing board. It is also required to submit a copy of a financial policy signed by its board. Around R56 million is made available each financial year by the NDoH for NGOs doing HIV/AIDS- and TB-related work (NDoH 2005:117, 2006b).

2.2.10.2 Provincial oversight

Provincial HIV/AIDS coordinators are responsible for the monitoring and evaluation of funded NGOs.[34] Selected NGOs are required to sign a contract with the government for a period of one year. NGOs have to repeat this process and reapply for funding annually, and they are not guaranteed renewed funding every year. NGOs must also submit several reports relating to oversight and accountability each year, including financial quarterly reports, which are audited independently prior to submission, and an annual work plan.

The NDoH also organises regular training programmes on internal financial management for NGOs.

NGO respondents highlighted a number of problems with respect to government funding:

- Funds are withdrawn, with the result that programmes cannot be implemented
- The late release of funds and gaps in the funding cycle have the same effect
- Funding applications are denied for arbitrary and unfounded reasons
- Certain government officials treat NGOs with a lack of respect
- Certain provincial government officials abuse their power
- There is poor communication

These problems are highlighted below.

Gauteng

A study of six HIV/AIDS NGOs in the province of Gauteng showed that contractual partnerships with the government were working well and all NGOs were meeting the necessary governance, financial and reporting requirements.

Five of the six were heavily dependent on the government for funding and all relied on the government for training support. Slow and interrupted disbursements following delays in annual reapplications for funding hampered delivery of services in some NGOs. Contact between regional HIV/AIDS coordinators and NGOs was regular – all NGOs received a visit from a government official in each quarter. The quality of relationships with HIV coordinators varied. A highly successful NGO-government relationship was evident in at least one district, which could provide a role model for other districts (CHP 2004:iv, 37–9).

Free State

The Free State provincial health department has introduced a capacity-building training course using an external service provider, PricewaterhouseCoopers, to equip and capacitate NGOs to manage their resources better. Training areas include human resources, project management, financial management and management skills. Although the course is not compulsory, it is regarded as an incentive to attract funding from government. Accountability mechanisms help to identify financial mismanagement. In one instance, the department withdrew funding from a group of NGOs working on HIV/AIDS activities when it was discovered that they were unable to fully account for their expenditure.[35] The following case study suggests that the course does improve delivery to communities.

Case study
The Alliance Against HIV/AIDS (AAHA)

AAHA is a consortium of six local organisations in the Free State that work in communities in Bloemfontein and surrounding districts, specialising in HIV/AIDS awareness campaigns and children's health education and nutrition. AAHA also provides a support group for PLWHA. Despite a number of challenges, AAHA manages to reach many communities, even in remote rural districts.

Registered as an NPO in 2004, AAHA has been operational and attracting government funding for the past five years. The provincial Department of Health provided the consortium with R50 000 in its first year and then insisted that it successfully complete the capacity-building training course before being granted R80 000 for the second year. AAHA consistently met the reporting requirements. As

its work expanded to include a greater geographical area, an increase in funding was required and the alliance was referred to the NDoH for funding of its third, fourth and fifth financial years. By 2005, AAHA was in receipt of approximately R195 000. In order to receive national funds, AHAA still relies on a provincial department recommendation.

A new set of criteria has been imposed on the consortium which increases departmental oversight of expenditure. The NDoH requires AAHA to operate in more than three districts of the province; spending has to be according to strict proportions for programmes and activities (60%), management (30%) and administration (10%); and within the first year of national funding AAHA has to submit monthly financial and statistical reports.

Case study
KwaZulu-Natal

The yearly procedure for reapplication for funding and the time required to complete the selection process have resulted in funding gaps and become one of the major issues in the partnership between NGOs and the government. A large NGO based in a semi-rural area of the province, which was established in 1992 and provides diverse HIV/AIDS services such as counselling, home-based care, income-generating schemes and a hospice to a large patient base, has experienced significant delays with government funding.[36] They have lost up to six months of funding and are currently a year behind schedule in receiving funds. They also report that huge inefficiencies at provincial level have obliged the NDoH to step in to help NGOs receive their funding. The NGO does not receive regular notification of renewals of funding proposals.

Many of the problems experienced by NGOs relate directly to the provincial health department official responsible for overseeing their funding. On a visit to the NGO four years ago, it was agreed that this official could purchase items to the value of R500 from the Bead Shop, one of the income-generating schemes, and pay later. The official still owes the organisation that R500, and has not returned since then for follow-up or oversight visits. The director of the NGO is deeply frustrated and complains that this individual – who is their official contact or liaison at the provincial department – is highly elusive, never returns phone calls or replies to correspondence and actually makes an effort to avoid any contact, despite endless funding challenges that require departmental assistance. To make it worse, the precariousness of the funding environment means that the NGO might never lodge a complaint for fear of funding being withdrawn.

Regarding the reports, such as quarterly reports, required in terms of its service agreement, the NGO also tells an exasperating tale of documentation submitted

repeatedly (via fax, courier and e-mail) to both the NDoH and its provincial office, which is subsequently lost.

The NGO has developed a transparent and accountable financial system which is open to public scrutiny and has been commended by the NDoH. It practises the division of duties regarding funds management, with only two points of authorisation for spending as a built-in system of checks and balances, and could readily produce detailed documents showing the history of funds received since 1996.

Other NGOs in KwaZulu-Natal report that funds are cut arbitrarily or denied for reasons that are unfounded. The Open Door Crisis Centre provides services to survivors of abuse and rape, VCT and assistance with related trauma issues. In operation since 1997, the organisation currently receives no funding from either the health or social development department. Reasons cited by the government include the fact that the NGO is based in Pinetown and therefore caters for a relatively advantaged community, and that it owns a building and can raise its own funds independently of government. The director believes that funding decisions based on criteria such as area are highly misleading. A breakdown of monthly figures for 2005 shows clearly that most of the people visiting the centre, far from belonging to an advantaged group, come from very disadvantaged areas. Over 55 per cent are black and 65 per cent are women. The number of people receiving services in 2005 amounted to 4 007.

The new draft policy on 'The Financial Awards to Service Providers' recently formulated by the provincial Department of Social Development in KwaZulu-Natal argues that NGOs based in previously working and middle-class areas still tend to serve white communities (Social Development nd:9). It is vital to ensure that transformation and equity take place in the NPO sector, and especially that resources are redirected to NPOs in previously disadvantaged areas. However, taking into account the demographical statistics and types of HIV/AIDS services relevant to NGOs such as the Open Door Crisis Centre, it seems that old funding criteria such as location and surrounding infrastructure are outdated and do not take account of dramatic socio-economic and demographic shifts in specific areas. It also appears that previously disadvantaged people, including blacks, women and children, are further disadvantaged if their closest point of contact for critical HIV-related assistance is underfunded.

Eastern Cape

The 2003/04 and 2004/05 AG reports on the Eastern Cape department of social development found that the records for transfer payments to NGOs were unsatisfactory, as the information was not complete or updated (Eastern Cape 2004:76, 2005:65). The validity of the beneficiaries could not be verified in all instances. The following shortcomings were revealed:

- Business plans, registration certificates and annual evaluations of NGOs were not always available on file.
- There were discrepancies between payments made to NGOs and the amounts confirmed as received by them.
- Claim forms were not always reconciled to payments made.
- The NGO database and NGO files posed a serious challenge.

PSAM found that there were no mechanisms to monitor funds that had been transferred to district municipalities for HIV/AIDS-related activities and called for closer monitoring of district municipalities and for the enforcement of service agreements with HIV/AIDS NGOs (PSAM 2005a:7).

Case study
South African National AIDS Council (SANAC)

The Congress of South African Trade Unions (COSATU) and the TAC have raised concerns about significant underspending by SANAC in 2002. Of the R30 million used to establish the government's South African National AIDS Trust (SANAC Trust), only R520 000 was utilised. Moreover, they claim that a large part of that amount was squandered on unoccupied offices for the SANAC secretariat, a criticism also raised by the AG. They argue that the failure to spend the money and the wastage of expenditure are indicative of a dysfunctional body and a lack of accountability (COSATU & TAC 2005).

The SANAC Trust received a qualified audit in 2004/05 due to the unsatisfactory processing of NGOs' financial statements of donor funding.[37] The NDoH strategic plan for 2006/07 and 2008/09 lists among its objectives improved governance and management of SANAC and the strengthening of SANAC's oversight over public entities and other bodies (NDoH 2006a:31).

The TAC submission to the African Peer Review Mechanism had this to say about SANAC's dysfunctional state:

> SANAC was established in 2000 to be the highest national advisory body on HIV/AIDS, a role it is not seen to fulfil. Its conduct has been characterised by few meetings, missed meetings, a lack of accountability and poor leadership. When meetings have happened the agendas have been drafted late and without consultation. SANAC has received two qualified audits from the Auditor-General.
>
> Furthermore, SANAC is the official South African co-ordinating mechanism for grant proposals to the Global Fund to Fight AIDS, TB and Malaria (Global Fund). Its lack of co-ordination and tardiness have resulted in a number of grant opportunities being lost or grants of poor quality being sent to the Global Fund.

> The Minister of Health and previous SANAC chairperson, former Deputy President Jacob Zuma, failed to ensure that most of the R30 million used to establish SANAC in 2002 was spent. As of February 2005 only R520 000 of this money had been used. A large portion of this has been wasted on unoccupied offices for the SANAC secretariat, something that has drawn criticism from the Auditor-General. (TAC 2006)

2.3 The prevention of HIV/AIDS

2.3.1 South Africa's prevention strategies

A government's first goal in the struggle against HIV/AIDS should be a clear and effective prevention strategy. Ideally, when prevention strategies work, the result is fewer HIV/AIDS cases for the government to deal with. According to Barnett and Whiteside, governments are only required to deal with the impact of the disease when prevention fails (Barnett & Whiteside 2006:319).

The Comprehensive Plan states that prevention efforts are central to government's response to HIV/AIDS (NDoH 2003, 2005). The current range of prevention strategies in South Africa includes VCT, PMTCT, post-exposure prophylaxis, syndromic management of STIs, TB management, the provision of barrier methods including increased condom use, the provision of nutrition supplements, life skills programmes, and information, education and communication campaigns. Emphasis is placed in encouraging healthy lifestyles through nutrition and sexual abstinence.

These services should be available at all public health facilities. By December 2005, 77 per cent of public health facilities were offering PMTCT services, almost double the 41 per cent of 2003/04, and 88 per cent were providing VCT services, up from 64 per cent. The NDoH plans to expand both services to 100 per cent of public health facilities in the 2006/07 cycle and to develop a system to assess the impact of the PMTCT programme NDoH 2006a:6). The distribution of condoms increased to 386 million male and 1,3 million female condoms in 2005/06 from 347 million and 1,1 million in 2004/05 respectively (NDoH 2006a:6).

Prevention activities were strengthened through the Khomanani (Xitsonga for 'caring together') campaign and loveLife, mass communication campaigns

driving the message for sexual behavioural change. The government has spent more than R300 million on the Khomanani campaign over the past five years (Njamela 2006).

Despite efforts to implement prevention strategies, infection rates remain high, suggesting that the impact of large allocations and spending is limited. So where do the problems lie? Experts believe one of the major problems is allocative efficiency. The NDoH spends its funding on reducing infections and alleviating the effects of HIV disease as more and more people are being infected and affected, whilst largely overlooking crucial preventative measures. In fact, until recently the TAC has focused almost exclusively on the provision of ARVs to the infected.

Where large-scale public-awareness prevention programmes do exist, such as Khomanani, Soul City and loveLife, they have been criticised for not being wide-ranging. Generally, health departments assume that people are sufficiently aware of the dangers of unprotected sex, especially among children, and thus fail to engage the general public sufficiently.[38] Health workers commented on limited literacy being a decisive factor in undermining safe sexual behaviour or treatment among patients who struggle to understand complex concepts about the HIV infection and related medical terms such as 'viral load' and 'immune system'. It appears that the country requires many more community-based programmes that focus on preventative measures.

Nationally 2006 was declared the Year for Accelerated Prevention Strategies and all nine provinces were required to produce action plans (Eastern Cape 2006). Yet the government's major communication programme, Khomanani, was allowed to terminate in 2006 without a new tender process being launched. The NDoH DG, Thami Mseleku, defended the decision not to renew the tender, stating that the government wanted to see the results of an independent evaluation of Khomanani before issuing a new tender (Njamela 2006). Considering the importance of prevention as a tool in tackling the spread of HIV/AIDS, some argue that government should have pre-empted its evaluation and the ending of the contract so as to avoid a delay and gap in communication programme activities. The department has said the project will continue, but to date the future of Khomanani remains uncertain (Njamela 2006).

Recently, the NDoH introduced its new strategic plan for 2006/07 to 2008/09, which outlines the department's priorities, activities and measurable

objectives for this period in both prevention and treatment (NDoH 2006a:28–31). But a necessary requirement for preventing the spread of HIV/AIDS or turning the epidemic around, even though insufficient on its own, is political leadership, which must begin at the highest level if there is to be national success. Barnett and Whiteside argue that the case of South Africa demonstrates how the absence of clear and decisive leadership damages prevention activity. Prevention activities, which should have the largest impact on the spread of the disease, are often lowest on the political agenda (Barnett & Whiteside 2006:361).

The 2006 TI Global Corruption Report highlights how prevention activities for HIV/AIDS are prone to corruption. This includes the submission of false claims for awareness and educational activities or materials and for programmes aimed at alleviating the effects of the disease, such as feeding programmes, and health workers extorting illicit payments from patients at VCT sites (TI 2006a:104).

Case study
The National Association of People Living with AIDS (NAPWA)[39]

In 2004, using the Promotion of Access to Information Act, the TAC applied for access to all government correspondence and documentation pertaining to NAPWA. This was based on rumours of corrupt management and the misallocation of funds by NAPWA. After receiving the relevant documentation, TAC identified clear instances of the PFMA not having been adhered to.

The ALP, acting on behalf of the TAC, lodged a complaint with the AG and the Public Protector, officially requesting the AG to investigate how NAPWA spent its public funding.

Concerns over financial abuse related to the following:

- The *Sowetan* newspaper had published allegations that NAPWA had not paid staff and had been forced to close several offices even though these were agreed allocations for which sufficient funds had been released. Between 1999 and 2003 NAPWA received close to R10 million from the national and provincial departments of health.
- NAPWA's financial auditing was poor and the association was unable to provide complete audits of expenditure.

- Thandoxolo Doro, the national organiser of NAPWA, also admitted to continuing to use a car that had been meant to be raffled by NAPWA in December 2003.

As a consequence the AG submitted a qualified report to the NDoH stating that the department had failed to account correctly for NGO funding, singling out NAPWA as an example. The NDoH stopped funding NAPWA, but shortly thereafter the TAC and ALP discovered that NAPWA's funding allocations had resumed. In response to their request for an explanation from the NDoH, they received a letter stating that NAPWA had reregistered as an NPO, had completed their auditing process and was therefore eligible for a resumption in funding. Despite continued allegations of corruption, NAPWA continues to receive funding, according to Nathan Geffen of the TAC.

In 2005 the AG's office was expected to report to Parliament on the findings of its investigation into NAPWA. Yet the AG report was never made public, nor was it mentioned in the NDoH annual report. To date the ALP has found no confirmation that the details of the investigation were in fact reported and continues to request public documentation and findings from the AG's office concerning these allegations of corruption and mismanagement.

The NAPWA case is cited as an example of poor oversight over and accountability for public funds and a lack of transparency in investigations. Concerns still exist about NAPWA's ability to spend funds efficiently, accountably and transparently. The organisation's lack of performance also raises doubts about its ability to meet its mandate. Critics such as the TAC say that NAPWA, as the national organising force for people living with AIDS, should focus on setting high ethical standards and holding other organisations to account for their activities and performance (DA 2006; Business Anti-Corruption Portal nd; TAC 2006; Mthembu 2006; Deane 2004; Itano nd; TAC 2004; ISS 2003).

Another case of misappropriation regarding prevention strategies occurred in 1996, when then health minister Nkosazana Dlamini-Zuma was reprimanded by the AG for not coherently accounting for the expenditure of R14 million for an HIV/AIDS educational play known as *Sarafina II* (Itano nd). In August 1995 the NDoH awarded a R14,27 million contract to internationally acclaimed playwright Mbongeni Ngema to produce a sequel to the musical *Sarafina* that would be about AIDS and would reach young people. *Sarafina II* also presents an example of the NDoH failing to follow tender procedures, as discussed below. Ngema allegedly spent more than R600 000 on equipment at his private residence which was not provided for in the contract. In addition, contrary to

the contract and without authorisation, he allegedly lent close to R246 000 to individuals; leased two cars and and paid R78 768 rental plus petrol, insurance, maintenance and repair; bought an Opel Astra for R27 203; and paid chartered accountants Ernst and Young R15 300 (Dickson 1998).

At the time the reluctance of some members of Parliament, particularly in the health portfolio committee, to ask difficult questions of the Ministry of Health during its investigations raised serious questions about the role of Parliament in ensuring transparency and accountability in the government (PHILA 1996). In addition, the Public Protector questioned the action of the NDoH and asked whether it had been necessary for the department to spend R14,2 million to attain its goal of putting across the HIV/AIDS message or whether that could have been done at a lower price. In short, the Public Protector found the *Sarafina II* AIDS play a worthy exercise, but decided that the mismanagement following the initiative could not be justified (PHILA 1996).

2.3.2 Feeding programmes

Through the Department of Social Development, the Comprehensive Plan makes nutrition resources available for those infected and affected by HIV/AIDS, particularly to HIV-positive children and pregnant women. In 2005/06, the department was allocated R74 million for its HIV/AIDS programme. In 2004/05, the programme reached 109 267 families with 73 048 food parcels. The home- and community-based care programme in the provinces is being expanded mainly through NGOs and CBOs. According to the NDoH, nutrition supplements worth R7 million were given to PLWHA and TB sufferers in 2004/05. By December 2005, according to the government, 329 278 people eligible for nutritional supplementation were being assisted (NDoH 2006a:6).

Despite these undertakings, in assessing the nutrition assistance programme, the fourth JCSMF report noted anecdotal evidence indicating fragmentation and unevenness, with the programme being beset by problems (JCSMF 2005). The report also indicates serious problems with the implementation of the nutrition programme in Mpumalanga. In particular, it states that:

- Food parcels and supplements are not available at all clinics in the area
- Food parcels sometimes go rotten at hospitals or are stolen

Dr Harry Moultrie, a paediatrician at the Harriet Shezi Children's Clinic in Soweto, the largest paediatric treatment site in South Africa, reported that only six per cent of children on ARV treatment at Harriet Shezi have access to nutritional support, fortified maize meal and milk formula through the resident dietician. They have no access to food parcels (JCSMF 2005). Often social workers are not available to advise patients on where and how to access food parcels and supplements or are unaware of the criteria that have to be met by patients to qualify for food parcels. As at April 2005, none of the infected adult and paediatric patients at Harriet Shezi were accessing food parcels. It appears that the funds allocated for food parcels are not being accessed and utilised. If they are being budgeted and spent appropriately, then what is actually happening to the food resources is a mystery.

There is anecdotal evidence of doctors in KwaZulu-Natal paying for food for HIV patients out of their own pockets.

The nutrition portion of the HIV/AIDS conditional grant cannot be assessed, given that expenditure reporting on the budget is not disaggregated, so it is unclear how these amounts are being spent.

Recently, the Eastern Cape provincial auditor, Singa Ngqwala, referred to missing food parcels as a serious problem in the province. The AG's 2003/04 report on the Eastern Cape's Department of Social Development found that the National Food Parcel Emergency Programme records were unsatisfactory and incomplete. Inadequate control of the approval of beneficiaries meant that the validity of the beneficiaries could not be verified in all instances. As Ngqwala stated in the AG's report, 'In the absence of proper internal control measures the possibility of monetary loss cannot be excluded, but the monetary implications cannot be quantified without the performance of a forensic investigation' (Eastern Cape 2004:76; Dispatch 2004).

2.4 The treatment of HIV/AIDS

2.4.1 South Africa's treatment strategies

The range of treatment strategies at public health facilities includes counselling, nutrition, treatment of opportunistic infections and ARVs. ARVs are available to people whose CD4 count drops to 200 or less,[40] who are said to have AIDS. A CD4 count of 500 to 1 600 is generally considered healthy (Barnett &

Whiteside 2006:34). ARVs are provided in accredited facilities free of charge. There is at least one service point in each of the 53 health districts, with 192 sites nationwide (NDoH 2006a:6). By June 2006 more than 175 000 people were on ART in all 53 districts. State bodies responsible for treatment include public health facilities such as tertiary and district hospitals and clinics. Certain NGOs such as MSF also provide comprehensive treatment programmes. However, successful treatment is still undermined by long queues in some areas, low male access, inadequate access for children, and too few pregnant women on HAART (Gray 2006). State support for PLWHA is expanding through increased registration for government social grants and higher grants, as well as growing home- and community-based care programmes.

TI's 2006 Global Corruption Report states that while prevention programmes are vulnerable to corruption, it is treatment programmes that are most affected (TI 2006a:104–5). This includes money for expensive and high-level drugs embezzled at some point in the procurement and distribution chain, theft by ministries and national AIDS councils of funds allocated for treatment and the sale of medicines by patients or doctors. Patients' access to ARV drugs also presents opportunities for abuse or corruption, often exacerbated by poverty and inequality. Those who do not meet requirements for ARVs (such as the CD4 count cut-off point) may try to use financial, political or other inducements to get onto treatment programmes.

Even where ARVs are provided free by the state, health workers may ask for 'top-up payments' or bribes. Free ARVs are a valuable and saleable commodity, especially for poorer patients and pharmaceutical, hospital and depot workers. Where ARVs leak out of the health system, informal markets have emerged which cater for ineligible people who may not have reached the CD4 count of 200 but still want ARVs. However, buying treatment informally, without being required to adhere to a treatment protocol, is risky and ineffective. In addition, national procurement processes for the supply of ARVs also present opportunities for corruption.

Corruption in the pharmaceutical supply chain can take many forms: products can be diverted or stolen at various points in the distribution system; officials may demand 'fees' for approving products or facilities, for clearing customs procedures or for setting prices; violations of industry marketing code practices may distort medical professionals' prescribing practices; demand for

favours may be made of suppliers as a condition for prescribing medicines; and counterfeit or other forms of substandard medicines may be allowed to circulate. The pharmaceutical system is technically complex, so each of the five core decision points of the chain – registration, selection, procurement, distribution and service delivery – needs to have solid institutional checks and balances in place (TI 2006b).

Many of the doctors and nurses who were approached about their experiences regarding treatment and the national roll-out programme commented that their ability to spot corruption was very limited because they worked at the end of the service line or because the staff at their health institutions were largely accountable to senior staff members. However, a number of disparate areas emerged as real or potential sites for corruption or as cases that required improved accountability and reporting mechanisms. Some relate to monetary or resource-based forms of corruption, while others can be described as non-monetary forms of corruption. The latter are discussed in the next section.

2.4.2 The lack of political commitment

The South African government's attitude to treatment has been characterised by suspicion and mistrust towards ART (Nattrass 2006a:1). The Minister of Health, Manto Tshabalala-Msimang, defied calls to introduce ARVs for PMTCT until a Constitutional Court ruling forced her hand. Similarly, the Ministry of Health resisted the introduction of HAART in the public sector until, on 8 August 2003, the cabinet undertook to provide free ARV treatment in the public health sector. On 19 November 2003, little more than three months later, government published the Comprehensive Plan. Below are set out instances where the state failed to act with appropriate haste.

2.4.2.1 HAART targets

First, given South Africa's resources and epidemiological characteristics, a recent econometric analysis argues that performance in terms of HAART coverage is poor, both in comparison with other countries and in relation to the targets set by the government's own Comprehensive Plan (Nattrass 2006a:3). The government's treatment plan envisaged placing 54 004 people on treatment by March 2004, 197 624 by March 2005 and 453 650 by March 2006 (NDoH 2003). However, by March 2005 the number of patients had risen to only 43 000, though it then increased to 112 000 at the end of 2005 (Nattrass

2006a:6; Barnett & Whiteside 2006:366). However, this strong growth of 16 per cent over 18 months was not nearly sufficient to catch up with the original targets. The number of people on HAART was still less than 30 per cent of the original planned total (Nattrass 2006a:7).

2.4.2.2 Tendering delays

National government plays a vital role in securing access to ARVs for infected people by setting up tenders for the procurement of drugs. Yet much criticism has been levelled at the government for the delays that have plagued the tendering process, due in part to the health minister's procrastination with regard to drug procurement (JCSMF 2004:13; Nattrass 2006a:6).

In March 2004 the drug procurement timetable was presented to the National Assembly's Portfolio Committee on Health, and it stated that drugs would be available for a public sector roll-out in July 2004. However, the award of the drug tender was only finalised and announced on 2 March 2005, some 13 months after the drug procurement process had commenced and more than 16 months after the Comprehensive Plan had been adopted. The completion of negotiations with drug companies to supply ARV drugs to state hospitals came 15 months after the cabinet had approved ARV treatment (Smart 2005). It is important to insert a caveat here. Delays in tendering were due partly to the Clinton Foundation's concerns about using PEPFAR money to buy generic ARVs, which apparently delayed the original purchasing plans (Smart 2005). This meant the government had to forgo Clinton Foundation assistance in the tendering process and implementation and procure the supply of drugs by itself.

Nevertheless, many doctors and activists argued that the government had a constitutional obligation to push forward 'to prevent avoidable death, particularly where there is a pandemic'.

2.4.2.3 Increasing budgets vs underutilisation of public resources

Nattrass argues that despite substantial donor and government funding specifically designated for treatment roll-out, the health ministry has not mobilised these resources accordingly (Nattrass 2006a:1). Contextual insight also suggests that AIDS denialism and deliberate mismanagement, rather than incapacity to manage resources, by the NDoH is the cause of slow budgetary spending. The National Treasury is making roughly R1 billion available for

treatment for 2006/07, and it is highly likely to increase available funds to the Conditional Grant over the next few years as the treatment programme continues to expand.[41] Nattrass argues that there is a danger that the contribution of donors has taken the pressure off the NDoH to utilise public resources fully and appropriately (Nattrass 2006a:10). The slow pace of spending also shows a lack of accountability to both Parliament and the Treasury in terms of meeting targets and deadlines.

2.4.3 The abuse of power and privilege

The research undertaken for this report has revealed that conflict and confusion stemming from the politicisation of HIV/AIDS create space for abuses of power by political actors in support of controversial views. These arguments are illustrated in the case studies below.

Case study
Health MEC Manana, Mpumalanga

In 2002, the TAC accused the former MEC for health in Mpumalanga, Sibongile Manana, of failing to comply with the Constitutional Court order to provide nevirapine to HIV-positive pregnant women although nevirapine was central to government policy. The TAC subsequently filed papers at the Pretoria High Court which stated: 'Far from facilitating the provision of Nevirapine, [Manana] and her officials have attempted to prevent and obstruct its provision and to pressure doctors who do provide it.'

In the same year Manana was also responsible for dismissing a doctor for allowing an HIV treatment charity to operate on hospital premises. Dr Thys von Mollendorff, superintendent of the Rob Ferreira public hospital in Nelspruit, gave permission for a charity organisation, the Greater Nelspruit Rape Intervention Project (GRIP), to operate from an unused office in the hospital to provide free counselling and treatment to rape victims. This occurred at a time when government had not yet endorsed the use of ARVs to prevent rape victims' contracting AIDS. Manana further accused GRIP of illegally squatting in two state hospitals and subsequently attempted to evict the organisation, but failed. Von Mollendorff was dismissed for insubordination because he had defied the provincial authorities by allowing doctors to prescribe ARV treatments.

Manana opposed the provision of HIV/AIDS drugs in state hospitals and insisted the drugs were part of a plot to undermine President Thabo Mbeki and the African National Congress (ANC) government. She also claimed that the drugs endangered black lives and threatened to turn the country into a 'banana republic'.

The need for party loyalty and threats from the executive of the consequences of failing to comply with personal views of the Minister of Health may partly explain the behaviour of some health officials: they fear that dissidence may lead to dismissal. (Altenroxel 2002a; 2002b; 2003a; Davids 2003)

Case study
Department of Health intervenes to free seized drugs

The *Mail & Guardian* reported in July 2006 that NDoH DG Thami Mseleku had ordered the release of a shipment of tablets imported by the controversial Matthias Rath and impounded by Port Health officials. Rath, a wealthy German entrepreneur, sells vitamins through the Rath Foundation and claims that his micronutrients treat, or cure, a range of illnesses including AIDS. His misleading and aggressive advertising style has earned him international condemnation and he has been the subject of a number of warnings and rulings by regulatory authorities in various countries (Nattrass 2006b:21). It appears that controversial individuals are afforded improper protection by the department in a regulated environment and therefore benefit directly by being able to operate without restraint.

Mseleku's intervention raised concerns about the close relationship between Rath and the Department of Health and whether port officials had broken the law by irregularly releasing the shipment. Officials of Port Health, which is a subdirectorate of the NDoH, impounded the tablets because they contained N-acetylcysteine, a substance listed in Schedule 2 of the Medicines and Related Substances Act. The Act requires that all medicines containing Schedule 2 substances be registered with the Medicines Control Council (MCC). Such medicines need a special import permit and can only be dispensed by a doctor or a pharmacist. Rath's tablets were not registered with the MCC, nor did he have the correct import permit.

According to Jonathan Berger, a lawyer with the ALP, this release was irregular since only the MCC can authorise an exemption. The chairperson of the MCC, Professor Peter Eagles, confirmed the DG's personal involvement in granting permission for the tablets to be released. The TAC's Nathan Geffen stated that the incident confirmed the organisation's suspicions of collusion between the NDoH and Matthias Rath, and called for the DG to be suspended immediately for exceeding his authority. At the time of writing, the South African Medical Association (SAMA) had recently called for an investigation into the release of the consignment and stated that the public's trust in the system that ensured medicine safety had been compromised. (Joubert 2006; Sapa 2006d)

2.4.4 The abuse of funds

Following an expose by *The Star* newspaper, several reports showed massive corruption in Mpumalanga's health department under the province's then health MEC, Sibongile Manana. The accusations included fraud, nepotism, misspending and irregular tender procedures. One of the forensic reports, audited by PricewaterhouseCoopers, confirmed gross mismanagement of the province's HIV/AIDS budget and stated: 'There is evidence to suggest that officials in the department have contravened the PFMA and its regulations thereto, in particular the provisions relating to fruitless and wasteful expenditure, irregular expenditure and unauthorised expenditure' (Altenroxel 2003b). Around one third of the AIDS budget had been spent on soccer days, plays and prayers, with a local unregistered charity receiving over R1 million in funding. After these accusations, the premier of the province, Ndaweni Mahlangu, and the head of the Mpumalanga health department, Riena Charles, were quietly shifted to new positions. This case highlights how weak internal oversight processes can succumb to political interests.

Several interviewees could point to cases of NGOs and CBOs being suspected of abusing both donor and government funds.[42] One NGO providing home-based care services for those infected with HIV/AIDS in the OR Tambo district of the Eastern Cape employs a number of women carers who should receive a significant allowance from the funding. However, the director of the organisation is accused of pocketing most of the organisation's funds instead of paying the carers, who only receive sporadic allowances and are abused and used for corrupt purposes. In an environment where oversight regulations are underdeveloped, it is possible that such anecdotes are indicative of a widespread phenomenon.

2.4.5 Misrepresentation of medicines and support for alternative remedies

Across South Africa the market for untested and unregulated alternative therapies is expanding even as ART becomes more widely available. The championing of nutritional alternatives and traditional medicines over ARVs and calls by senior health officials for patients to exercise 'choice' in treatments have unwittingly created confusion among patients as they attempt to separate fact from fiction regarding ARV treatments and other products (Nattrass

2006b:17). The most publicised cases include the Rath Foundation's vitamin supplement and the herbal remedy uBhejane. Neither is registered with the MRC and their clinical benefits are at best unproven, yet both claim successful treatments or 'curing' of AIDS.

2.4.5.1 Matthias Rath

Rath's claim that his vitamin supplement, VitaCell, can 'reverse AIDS' and his urging of HIV-positive people to abandon their 'toxic' ARV drugs has earned him international condemnation (Nattrass 2006b:21; Joubert 2006). The product is distributed mainly in townships in the Western and Eastern Cape and KwaZulu-Natal.[43] The multivitamins cost more than ARVs and are aggressively advertised using scaremongering claims about ARVs (Nattrass 2006b:21). Misleading advertising has led to a number of warnings and rulings against Rath by regulatory authorities in several countries (Nattrass 2006b:21).

No action has yet been taken against him, not even by the MCC, although complaints have been lodged with the Department of Health and the MCC (Nattrass 2006b:22). Many activists and medical professionals believe that he is state-endorsed through the tactical support of the health ministry (Nattrass 2006b:21–2). The Rath Foundation seems to have had the implicit if not explicit support of the health minister for an unofficial trial or experiment, conducted outside of South Africa's regulatory structures, in Khayelitsha in 2004 and 2005 (Nattrass 2006b:22). As late as March 2006, AIDS activist Zachie Achmat remained certain that the government was continuing to support Rath (Sapa 2006b). Some interviewees, who choose to remain anonymous, wonder whether certain individuals in state-led institutions such as NAPWA, the South African National Civic Organisation and the NDoH and certain health care workers are paid to endorse and sell Rath's products. As Nattrass explains:

> *In this context of desperation and fear, those who claim to have provided a 'cure' for AIDS stand to do well. (Nattrass 2006b:21)*

In July 2001, the *Sunday Times* reported that the Minister of Public Works, Stella Sigcau, had cooked up an anti-AIDS remedy based on ground, sun-dried peach leaves and other 'secret' ingredients, saying that her work was in early stages, but she would be applying for a patent (Nattrass 2006b:21).

2.4.5.2 UBhejane

The herbal remedy uBhejane is being promoted as an alternative to ARVa. An opposition political party, the Democratic Alliance (DA), claims uBhejane violates the Medicines and Related Substances Act. Zeblon Gwala, who makes uBhejane and whose supporters include the mayor of eThekweni (Durban), has defended his product (Calvert 2006).

The health minister, KwaZulu-Natal health MEC Peggy Nkonyeni and eThekwini's mayor have all encouraged people to take the product, while its main promoter is Professor Herbert Vilakazi, special adviser to the KwaZulu-Natal premier, Sbu Ndebele (Sapa 2006c). The health minister and the MEC apparently told a home-based care project run by Deputy President Phumzile Mlambo-Ngcuka's mother to administer uBhejane to HIV-positive patients (Nattrass 2006b:24). But scientists and AIDS experts caution that it is far too early to tell whether uBhejane is effective in fighting HIV (Sapa 2006c). In May 2005 the Medical University of South Africa reported that the product had failed scientific testing as a cure for HIV/AIDS. It did, however, help improve patients' appetites and their physical well-being (Sapa 2005; National Review 2005). The product is currently being researched at the Nelson Mandela School of Medicine at the University of KwaZulu-Natal. The university has stated that so far that preliminary findings have not found any proven benefits for people with HIV/AIDS (Sapa 2006c).

The DA has complained about the manufacture of 'fake cures' and has laid charges of fraud and of contravening the Medicines and Related Substances Act against Zeblon Gwala for producing and selling uBhejane as an AIDS cure (Nattrass 2006b:25).

Activists point out that traditional medicines designed for the public health sector are increasingly regarded as a potentially lucrative industry. This could lead to legitimate institutions like traditional healers and traditional medicines being corrupted for financial gain – as perverse a scenario as drug company profiteering.[44]

In a cross-sectional study, 233 traditional healers were interviewed in three selected communities in KwaZulu-Natal. Results indicate that the most common conditions seen were STIs, a variety of chronic conditions, HIV/AIDS (20%) and tuberculosis (29%). Although most healers had a correct knowledge of the major HIV transmission routes, prevention methods and ARV treatment, their

knowledge was poorer on other HIV transmission routes, and 21 per cent believed that there was a cure for AIDS (Peltzer et al 2006:1).

Of concern is the damage being done to the reputation of indigenous knowledge systems, particularly traditional medicines and practitioners. Sipho Mthathi, secretary-general of the TAC, argues that there is a need to establish the effects of these medicines on the human body using the correct testing methods and procedures.[45] By doing so, the state can isolate and promote those that are safe and effective against HIV/AIDS. In South Africa the opportunity exists to open centres of excellence where potentially useful traditional substances can be progressively developed in line with good practice to make a contribution in the fight against HIV/AIDS. Although legislation places all alleged remedies and cures under the ambit of medicines, the health minister appears to be acting according to an alternative set of rules for 'traditional' or alternative' remedies – even to the point of supporting their distribution through the public health system without their ever having been scientifically tested (Nattrass 2006b:24).

Critics, including doctors, are of the opinion that herbal products and 'cures' for HIV/AIDS have undermined the ARV treatment programme and the well-being of patients in numerous ways (Nattrass 2006b).[46] They undermine patient management by confusing patients about treatment issues. Since most of these products are expensive, patients are being financially exploited. Furthermore, their marketing is deliberately misleading and uses key words that are designed to appeal to people living with HIV/AIDS by referring to 'immune compromising illnesses' and 'immune system boosters'. Currently traditional medicines remain unregulated and the MCC seems unable to control the flow of these products into the mass market. There is anecdotal evidence from doctors in HIV/AIDS clinics of many people coming to clinics wanting either to test substances on patients or to approach patients to sell them various nutritional supplements. A number of NGOs operating in semi-rural and rural areas also report that people market the products directly outside ARV clinics.[47]

In 2005 the JCSMF pointed to a need to protect people from unsubstantiated claims about nutrition and food (JCSMF 2005:9). In particular the forum noted the vulnerability of PLWHA to exaggerated or unfounded claims about food and vitamin preparations and made several appeals for improvements in the situation regarding untested products. In particular, they called on:

- The MRC to carry out independent investigations into the nutritional or medicinal value of certain products
- Leaders in the nutrition industry to ensure that its advertising of nutrition and micronutrient supplements was accurate and ethical
- The NDoH and MCC to create an adequate regulatory framework for untested health products

2.4.5.3 Political interference and support for alternative therapies

Nattrass argues that the health minister has not only displayed direct resistance to implementing programmes using ART in South Africa, but has also portrayed ARVs as a 'poison' and supported and protected purveyors of scientifically untested alternatives. In so doing, she has challenged and eroded the authority of science and scientific regulation in the health sector, represented by the MCC and the MRC (Nattrass 2006b:1). Both have experienced political interference as a consequence of their conventional scientific approach to AIDS. Nattrass maintains that:

> *By supporting and facilitating the running of unofficial, unscientific 'trials' of products punted as alternatives to antiretrovirals, the Health Minister has sharply curtailed the ambit of the scientific regulation of medicine. (Nattrass 2006b:1)*

According to a statement from the NDoH, the minister is preparing legislation to free alternative and traditional remedies from the requirements of scientific testing. The minister noted her intentions in a press release:

> *In finalising the regulation of these medicines, we are avoiding the pitfalls of putting such products in the same regulatory environment as pharmaceutical drugs whose testing is very different. (Nattrass 2006b:25)*

2.4.6 Whistle-blowers and protection

For those wanting to blow the whistle on instances of abuse or corruption, this research found that the ramifications may be highly detrimental to their careers and personal lives. One doctor working at a treatment centre in a Western Cape hospital was sidelined after he blew the whistle on corruption.[48] The doctor alleged that a senior official had spent funds from an external donor meant for HIV/AIDS programmes on luxury equipment. In addition, funds

had been siphoned off through the appointment of a new staff member. The doctor was subsequently dismissed and has recently appeared in court to contest the case on the grounds of unfair dismissal. Another case is highlighted in the box below.

Case study
Costa Gazi, Eastern Cape

Dr Costa Gazi, former head of public health at Cecilia Makiwane Hospital in Mdantsane, Eastern Cape, was suspended after voicing frustration at the government's ARV policy in 1999. In particular, he publicly criticised the previous health minister, Dr Nkosazana Dlamini-Zuma, for her failure to provide ARVs in the public sector and accused her of manslaughter. Dr Gazi faced 13 charges of misconduct at a disciplinary hearing, but was only convicted on one charge in terms of the Public Service Act for prejudicing the administration of the department.

The Public Service Act prohibits slander of any kind that may bring a government department into disrepute, and on that basis a court in the Eastern Cape found that the suspension was in order. This disciplinary action preceded the promulgation in 2000 of the Protected Disclosures Act, which protects whistle-blowers from occupational reprisals.

In February 2006 Gazi appealed the ruling before a full bench of three judges, arguing that the department had not shown that his criticism had adversely affected the administration of the department, especially in light of the raging debate about the health department's policy. In addition, he argued that the limitation in the Public Service Act on a public servant's right to exercise freedom of expression was not justifiable.

This appeal was successful. Referring positively to the right to freedom of expression, the judgment of the appeal court also found that the NDoH had contributed to the intense public debate on HIV/AIDS treatment roll-out. (Sapa 2006a)

If there are serious negative ramifications for whistle-blowers, it is unlikely that many cases of corruption will ever come to light. The Protected Disclosures Act, No. 26 of 2000, needs to be enforced to afford whistle-blowers the necessary protection.

2.4.7 A form of political corruption?

The state has produced the necessary tools to ensure a comprehensive treatment strategy, but the problem of inadequate political will and ineffective leadership

is widely cited as the major constraint on implementation (Nattrass 2006a:12).[49] The success of the state's treatment efforts should therefore be framed in two contexts: firstly, that of official policy, legislation, and available funds; and secondly, the political environment. If the factors discussed above amount to a *conscious* reluctance or lack of political commitment on the part of the health ministry and NDoH to implement treatment policy actively and aggressively, this raises the question of whether the government's inaction, negligence or attempts to stymie the provision of ARVs and implementation of HIV/AIDS policies equates with political corruption.

'Political corruption' is conventionally understood as the misuse of public office for private gain. Degrees of corruption vary greatly, from minor uses of influence and patronage to do and return favours to institutionalised bribery and worse (Wikipedia nd). Political corruption takes place at the highest levels of political authority among politicians and decision-makers who use their power to sustain that power and the accompanying status and wealth.

Cases of conventional corruption have been referred to in this section. However, significant cases of non-delivery and political interference have also been mentioned. They raise the question of whether the narrow legal definition of 'political corruption' ignores certain aspects such as the lack of political will to curb a health problem or implement a life-saving policy (Amundsen 2000). Political corruption is also said to exist when laws and regulations are more or less systematically abused by the rulers – side-stepped, ignored, or even tailored to fit their interests (Amundsen 1999). In the light of the government's constitutional mandate to protect everyone's 'right to life' and 'right to have access to health care services ... [and] emergency medical treatment' and to 'take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of ... these rights' (Constitution 1996: ss 11 and 27), acknowledging both the existing policy and the sufficient budget, a failure to implement HIV/AIDS activities amounts to a failure to obey constitutional imperatives.

This report poses the question: should political interference that undermines established policy and regulations and the slow delivery or non-delivery of policy be regarded as forms of political corruption? If personal views subvert public policy and regulations, through the abuse of political power, does this equate with political corruption? Corruption is traditionally understood as a

means to illicit gain or benefits. One might then ask how political decision-makers stand to benefit from inaction or failure to enforce policy. It is difficult to set out here specific benefits that politicians might gain from political interference and inaction, precisely because the motives for these actions are still unclear. If the lack of political will and increasing interference by health officials are driven by ideological beliefs about the cause and nature of the disease, it may be that certain powerful individuals, by asserting their ideological beliefs, stand to benefit intellectually at the expense of other (scientific or conventional) beliefs (and the well-being of those infected).

Contestation and inaction over HIV/AIDS may also be driven by reasons that are not merely ideological. Inaction on the HIV roll-out may arise out of concern for the ongoing financial implications for the national budget. This seems unlikely however, since the National Treasury has provided ample financial resources for aggressive roll-out. Yet, without knowing the rationale behind the denialism and inactivity around HIV/AIDS demonstrated by numerous political actors in South Africa, one is unlikely to be able to identify associated benefits.

2.4.8 Poverty and the abuse of resources

2.4.8.1 Patients selling ARVs

The alleged sale of ARVs by some patients in Kenya has raised fears that the same might be happening in South Africa (Mulama 2006). There are several reasons for the existence of such an illegal market, even though access to ARVs from the public health system is essentially free. Doctors quote anecdotal evidence suggesting that many people who believe or know themselves to be HIV-positive, but are unable to access ARVs through the public health system for various reasons, are purchasing and using ARVs.[50] As stated earlier, ARVs are only freely available from a clinic when a infected person's CD4 count has dropped below 200. Doctors might withhold ARVs if a patient is a drug addict, an alcoholic or suffering from certain other illnesses. However, misunderstandings about treatment due to a lack of information, poor education or illiteracy lead people to administer ARV drugs by themselves without medical supervision. Doctors fear that this exacerbates the disease.

The increasing demand for ARVs makes the drugs a valuable commodity to those who receive them free from the public health sector. There are patients who register in more than one treatment centre and sell the extra ARV drugs. Some who only have one source of drugs sell their ARVs and go without. The need for food because of poverty has been cited as a reason for selling ARVs. The supply of ARVs into an informal market is thus linked to high levels of poverty and unemployment.[51]

2.4.8.2 The disability grant

There is alarming anecdotal evidence from a cross-section of health practitioners that the current disability policy encourages HIV-positive patients to suppress their CD4 count deliberately in order to become or remain ill and thus qualify for a disability grant (Jooste 2003). Social grants are provided for the disabled. However, there are currently no specific criteria for determining whether an AIDS patient qualifies for such a grant. Instead, the decision is left to doctors, who generally sign off on a grant if the patient's blood test shows a CD4 cell count of 200 or below. Two AIDS counsellors at one of Durban's biggest hospitals report that an estimated 30 per cent of their clients say they do not follow their ARV regimens because they hope to become sick enough to qualify for a disability grant (Phillips 2006). In a desperate bid to supplement their income, patients are gambling with their lives. This underscores the levels of deprivation. Sometimes a patient whose CD4 count has risen will pay a person with a dangerously low CD4 count to take the blood test for them, using the sicker patient's ID card in order to be certified for a disability grant (Phillips 2006).

Doctors and health workers point to a degree of misinformation and confusion about the disability grant.[52] Many patients are under the impression that an HIV/AIDS grant is available and that, once tested positive, they will automatically qualify. Patients are unhappy to hear that they stand to lose the disability grant as they begin to feel better and their CD4 count increases. Since many ARV patients and grant recipients are unemployed and poor, doctors fear that some patients may find the idea of improving their CD4 count financially unattractive. This can undermine the strict application of ARV treatment as patients attempt to control the rise of their CD4 count.

In addition, the SIU briefed the National Assembly Portfolio Committee

on Social Development that one of its main concerns with regard to disability grant fraud cases and organised crime was doctors certifying people as disabled even though they were not, and receiving payment in return. People with HIV and AIDS were a problem as classification depended on their CD4 count and these counts could fluctuate.[53] The government has prosecuted a number of doctors for issuing false disability certificates. Typically, a corrupt doctor charges R200 for this illicit service (Phillips 2006).

The South African government is struggling to balance AIDS-related social services like disability and orphan care grants with the need to guard against fraud. The number of disability grants issued in South Africa increased by 30 per cent in 2002/03 and by 32 per cent in 2003/04. The increased number of claims due to HIV/AIDS is one reason, but the national Department of Social Development believes fraud (and maladministration) may be another (Itano nd).

The abuse of the disability grant and ARVs generally is a manifestation of chronic poverty more than of corruption or greed. Sadly, in some cases, instead of providing a safety net, the design of the grant system may be perpetuating serious illnesses and poverty. The Department of Social Development is currently looking at the possibility of introducing a chronic diseases grant to cover HIV/AIDS and TB, which may alleviate this issue.[54] Such a grant could also include strict ARV programme adherence as a precondition for recipients.

2.4.9 Stolen or missing ARVs

A well-known phenomenon in the public health sector is the theft or disappearance of drugs, particularly from large facilities like hospitals.[55] It is assumed that these drugs are sold to the private sector. The TAC has highlighted two anecdotal reports: one from the Umtata and Port Elizabeth depots in the Eastern Cape, where it is suspected that medicines disappear into doctors' private practices, and another of a traditional healer receiving ARVs from a health worker employed at a clinic. Patients were receiving the healer's herbal treatments, which contained the ARVs.

2.4.10 Funding shortages

Despite increases in donor funding and national revenue allocations, several doctors and nurses raised concerns that funding of the national roll-out appeared to be drying up. A doctor stationed at an ARV clinic in the Western Cape

assumed that the roll-out budget was shrinking when the clinic cut down on HIV-related tests and drugs.[56]

Staff at the Uitenhage ARV clinic in the Eastern Cape were also puzzled at the evident contradiction between the increases in the provincial conditional grant and the apparent unwillingness of the provincial Department of Health to furnish the clinic with the transport that was vital for outreach and community-based care and home visits to HIV patients. In a province characterised by high levels of poverty and unemployment, transport is a serious problem for most patients requiring a weekly visit to the clinic, especially those from rural outlying areas. Despite requests by the ARV clinic, the provincial department was yet to respond to this need at the time of writing. As a result the ARV clinic was struggling to reach all infected patients and had resorted to giving patients a month's supply of ARVs to administer themselves. This is not conducive to ensuring that patients follow the regimen prescribed by policy.

2.4.11 Tendering and procurement in the health sector

Health projects involve a number of procurement-related activities such as the construction of infrastructure, the management and operation of service providers, the contracting of services, and the purchase and delivery of goods. Experts often quote drug selection, procurement and use as problem areas (TI 2006b), but careful attention should be given to all types of contracting processes to prevent corruption. Sound information systems, monitoring systems and management tools are all useful in this regard (U4 nd).

In 1997, a scandal erupted over the health department's decision to award the contract for *Sarafina II* without following tendering procedures. The Heath Special Investigation Unit pointed out in 1998 that the tendering process was flawed because the tender had never been submitted to the Tender Board and the normal procedure inviting tenders had not been adopted; the procedural departmental tender committee and the State Tender Board had never awarded a tender; and the company receiving the contract, the Committed Artists Theatre Company, had no legal status and could not become a party to a contract (Dickson 1998).

Since then, the department has avoided making anyone accountable for this debacle, and the AG has over several years pointed out inadequacies in the

department's response. In 2000/01 the AG highlighted the lack of progress in the investigation into *Sarafina II*. He also pointed out that R1,9 million had been spent on a pamphlet on AIDS without following any tendering processes (DA 2006).

The comprehensive plan recognises that a 'central component of expanded HIV/AIDS care and treatment is the production, procurement and supply of medicines, in particular antiretrovirals' (NDoH 2003:143). It also emphasises that for proper implementation, the drug procurement system must ensure secure and sustainable volumes of medicines to meet the demand envisaged, and 'the supply of ARVs must be uninterrupted to meet the treatment needs of patients' (NDoH 2003:146).

In March 2005 the tender for the supply of ARV medicines to public health facilities was announced. The tender, worth over R3,7 billion and expiring in 2007, was awarded to the seven pharmaceutical companies listed in the table below, with Aspen Pharmacare as the largest local generic producer.

Table 8: Pharmaceutical companies supplying ARVs

Company	Nature of company	Share of tender
Aspen Pharmacare	Local generic manufacturer	32%
Abbot Laboratories	Multinational importer	31,5%
MSD	Multinational importer	25,5%
Ingelheim Pharmaceuticals	Multinational importer	6%
GlaxoSmithKline	Multinational importer	2%
Bristol-Myers Squibb	Multinational importer	1,66%
CIPLA Medpro	Local generic importer	1,33%

Source: JCSMF 2004:13.

The general impression among experts is that there was strict application of tendering requirements.[57] Towards the end of 2003, the NDoH established a drug procurement team headed by Dr Humphrey Zokufa (JCSMF 2004:18). The national negotiating task team for ARV drug procurement that completed negotiations with pharmaceutical companies was composed of government officials, with a number of academic and other independent stakeholders. Those

interviewed suggest that scrutiny by a range of players is implicitly a form of oversight.

There have been several criticisms, however. One raised earlier in this report concerns unacceptable delays in the national tendering and procurement processes for ARV medicines. The JSCMF received a number of reports in 2005 regarding problems with drug availability in various parts of the country, due largely, in their view, to the inability of one company (MSD) to meet demand (JCSMF 2004:14).

Andy Gray, a senior lecturer with the department of therapeutics and medicines management at the Nelson R Mandela School of Medicine, also criticised the rigidity of the tendering system for HIV/AIDS drugs. Firstly, the three-year award cannot accommodate new entrants who may offer cheaper generics or new products or dosage forms. Secondly, there is no electronic stock management or patient record system yet in place to manage and secure the distribution of drug stocks (Gray 2006).

Aspen Pharmacare is South Africa's largest generics company and Africa's largest pharmaceutical manufacturer. It is also the world's first generics producer to receive approval by the US Food and Drug Administration for the manufacture and export of selected generic ARVs to PEPFAR-recipient countries in sub-Saharan Africa. Where companies are dominant, Gray warns that a potential exists for abuse:

> *One single firm may dominate the sales in an area such as cardiovascular drugs or in the management of a particular disease such as ulcers or HIV/AIDS. Such firms may, within that particular area, wield considerable influence. (Gray & Matsebula 2000:5)*

Aspen recently saw its operating profit rise as it boosted manufacturing volumes of ARV pills. However, the company wants the freeze on medicine prices lifted and has lodged a 'formal application' with the NDoH for an increase in medicine prices to take into account cost increases in the raw materials that go into these drugs (AllAfrica 2006).

Dr Marta Darder, coordinator of MSF's campaign for access to essential medicines in South Africa, is wary of the government's dependence on the private sector to supply its treatment programme, with the possibility of excessive margins of profit. She has stated that she would prefer a situation like that in Thailand and Brazil, where government-owned facilities are successfully

supplying those countries' treatment programmes with affordable ARVs. Although the companies supply the public sector with ARV drugs on a 'cost-recovery' basis, private-sector prices are still high, at more than three times the subsidised rate (IRIN 2005).

Increasing the number of local manufacturers and levels of competition may be the key to ensuring cheaper ARVs. Gray points to a number of good-quality pharmaceutical production plants in South Africa that could move into ARV production with the right technology. Gray also says that if the goal is to keep prices down by encouraging competition, more can be done by the government to provide such companies with financial incentives (IRIN 2005).

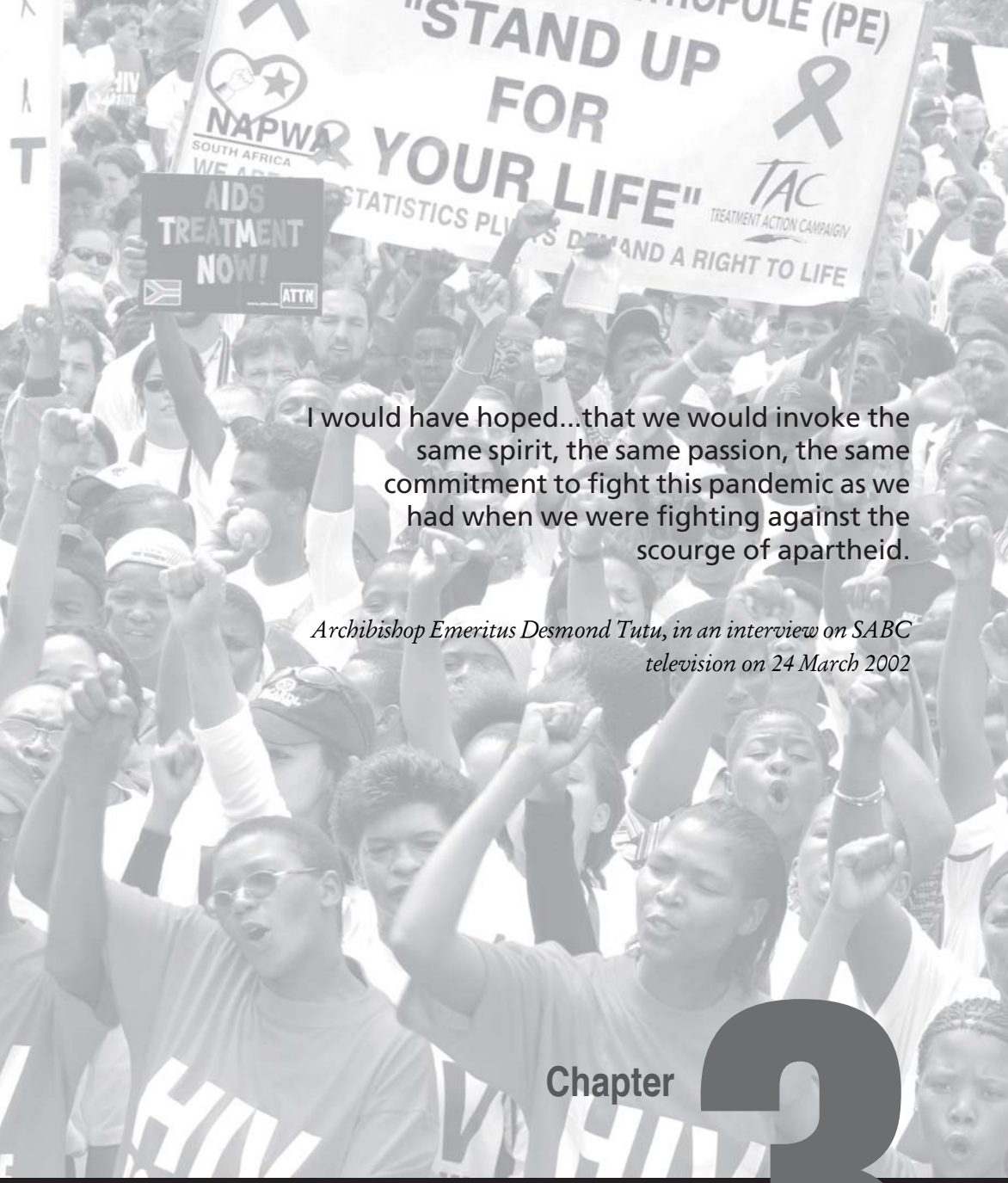
Prompted by the need to monitor general health trends, the ARV programme and general patient records in public hospitals and clinics, the government is currently upgrading its IT infrastructure. A national tender worth hundreds of millions of rands for the procurement of a new electronic information system is currently under adjudication (Kahn 2006). Leading IT and health care firms are gearing up to bid for the government contract. The initiative bodes should bolster accountability and transparency in monitoring efforts – as long as the procurement processes are above board.

2.5 Conclusion

Corruption in the HIV/AIDS sector is largely unreported. Where corruption exists, it appears to be a result of several factors, such as weak institutions and a lack of enforcement of policy and regulations. Abuses of political power occur where the relevant political institutions are either too weak or unwilling to curb them. Corrupt activities, particularly among HIV-infected people, appear to be a direct result of high levels of poverty and inequality.

In spite of these overall findings, some laudable attempts at accountability by the NDoH and other bodies are worth mentioning. It is commendable that the NDoH has introduced mechanisms and initiatives to monitor and oversee the expenditure of government funds, such as service agreements between the state and NGOs. In addition, the donor matrix ensures that donor information is available. Most external donors have also enhanced accountability by setting stringent expenditure guidelines for their recipients.

As development assistance from the largest donors like the Global Fund dissipates and 'exit strategies' commence, South Africa will face the dual challenge of providing committed political leadership and increased government revenue for the fight against HIV/AIDS. For these reasons, stringent monitoring and assessment are vital at every level to ensure that state resources are used in an accountable, transparent, efficient and fair manner. Furthermore, greater emphasis should be placed on monitoring outputs of activities as well as expenditure to ensure that programmes meet their objective of mitigating the effects of AIDS.



I would have hoped...that we would invoke the same spirit, the same passion, the same commitment to fight this pandemic as we had when we were fighting against the scourge of apartheid.

Archibishop Emeritus Desmond Tutu, in an interview on SABC television on 24 March 2002

Chapter 3

Conclusion

This section comprises a summary analysis and recommendations.

3.1 Summary analysis

In order to provide an integrated understanding of the information presented in this report, the flow of this summary largely correlates with the structure of the country study. Thus there are comments on the background, state accountability and the prevention and treatment of HIV/AIDS, addressing salient issues. There are also final general comments presenting fundamental contentions that have emerged and are likely to frame future discussions on the subject.

3.1.1 Background

3.1.1.1 Prevalence of HIV/AIDS

The general picture of prevalence in Southern Africa shows that the disease is not abating. The major hike appeared from 1990 to 1996, when the increase in number of those infected shot up from 0,7 per cent to 14,2 per cent (Barnett & Whiteside 2006:10). Thereafter an incremental increase of approximately 8,31 per cent was recorded from 1996 to 2004. From 2004 to 2006 the increase is only 0,7 per cent, which can be attributed to the intersecting impact of increases in country funds, capacity, public awareness and political will to deal with the problem. However, as explained by the country case study, the damage caused by AIDS in the short to medium and long term is profound. Amongst the repercussions most broadly is a long list under the triadic rubric: psycho-social, socio-economic and politico-economic. Table 9 displays the increase in prevalence in the region from 1990 to 2006.

Table 9: Southern Africa: increase in prevalence of HIV from 1990 to 2006

Year	Percentage increase in prevalence
1990	0,7%
1996	14,2%
1999	19,94%
2002	25,5%
2004	29,5%
2006	30,2%

Source: Barnett & Whiteside 2006:10.

The situation in South Africa presents a microcosm of the broader regional picture.

South Africa's first recorded rate is over 20 per cent in 1999/00. Thereafter there is a gradual increase in prevalence to about

30 per cent in 2005/06. It is important to stress that the politics and politicisation around AIDS in the country have had a major impact on prevention and treatment efforts, compared with other, more vigorous and proactive, Southern African countries.

3.1.1.2 Budget

South Africa has enjoyed a tremendous, relatively consistent increase in budgetary allocations, as displayed in Table 10, despite the government's controversial posturing on the enveloping issues. International donor funding is also received from various sources including PEPFAR, the Bill & Melinda Gates Foundation and the Global Fund. Despite the massive increase in funding capacity, the realisation of positive results is slow and uneven.

Table 10: Increase in South African budget allocation from 1999 to 2006

Year	99/00	00/01	01/02	02/03	03/04	04/05	05/06
State spending	137 000	234 000	300 000	697 000	1 132 000	1 655 000	2 271 000

3.1.2 State AIDS bodies, agencies and accountability mechanisms

It is generally agreed that combating corruption requires more than just the appropriate infrastructure. Indeed, South Africa appears to have most of the requisite structures and legislation in place to tackle corruption, and the government has publicly acknowledged the existence of corruption, but the study has noted a general lack of political will and transparency in dealing with corruption.

Regarding state bodies to deal with AIDS prevention and treatment delivery, the proverbial devil is in the detail. Although AIDS efforts and funds are coordinated both nationally and provincially, budgetary management and execution – in essence, budget-tracking mechanisms – appear to be lacking, especially in relation to disaggregated expenditure data on donor funding. The lack of accountability for financial mismanagement is also cited as a source of concern. Underspending in provinces due to lack of capacity and internal management problems is a compounding impediment to delivery. In this regard,

the AG is reported to have submitted qualified audit reports on health for various provinces over the past few years. Finally, the lack of tracking of donor funding poses the risk of duplication of resources and efforts between the government and civil society sources.

3.1.3 Prevention of HIV/AIDS

Table 11 indicates state vulnerability to corruption in prevention activities as listed by TI.

Table 11: Vulnerabilities to corruption in the prevention of HIV/AIDS

Scope of the corruption	
Weak inter-agency coordination	Yes, there appears to be a lack of coordination between national and provincial structures, as evidenced by AG audit reports and expert interviewee responses. The latest prevention plan has not yet been produced since the contract for the last delivery company came to an end.
Poor accountability, cash flows and procurement, stockholding and distribution of supplies	Accountability in prevention activities is generally an issue of concern. Highlighted 'hot spots' of concern are around the somewhat dismal efforts of loveLife and Khomanani to achieve targets set.
Weak administrative capacity within and between government and NGO agencies	Lack of national and provincial capacity is generally noted to be an impediment to efforts to combat the disease.
Fictitious NGOs	Yes, there are alleged reports of these operating in the country.

Source: Adapted from TI 2006c.

3.1.4 Treatment of HIV/AIDS

Table 12 similarly highlights potential and actual areas of concern in the treatment of HIV/AIDS in the country.

Table 12: Vulnerabilities to corruption in the treatment of HIV/AIDS	
Scope of corruption	
Poor accountability; procurement chains; border, importing and registration procedures; drug, medicine and equipment theft	All items listed are reported to be areas of concern. The controversial relationship between the NDoH and Matthias Rath in the importing of AIDS drugs is a case in point. The belligerent attitude towards civil society groups and the media also affects accountability detrimentally.
Staff payments (real and fictional)	There are no reports of these in this research.
Staff needing own medicines	The research recorded no reports of this.

Source: Adapted from TI 2006c.

3.1.5 General comments

3.1.5.1 Grand versus petty corruption

South Africa is is no stranger to grand corruption scandals. In recent years the country has been beset with a series of scandals that have involved or been linked to the international realm. Yet to date no grand corruption in the traditional sense has been reported in relation to AIDS. Mostly due to resource constraints, the country study was not able to uncover any grand corruption.

3.1.5.2 Politics and political corruption

The AIDS issue has opened up broader and often neglected discussions on corruption. These include issues of political corruption that deal with the consequences of power and influence in framing debates and decisions over the use of funds. The abuse of power may not be so easy to detect in in the president's AIDS 'denialism', for instance, as it is in the giving or accepting of bribes in the arms scandal.

One may ponder whether it is the nature of the government, the scale of the response needed to combat the disease, the complexity of the issues or the elusiveness of a cure that stirs up such passion and confusion about appropriate

responses to AIDS. Corruption potentially embeds itself within that precarious tangle of relationships, providing yet a further dimension of evasiveness militating against the pressing demands for prevention and treatment.

3.1.5.3 Institutionalisation

Key concerns relate to the lack of institutionalisation, access to information and oversight mechanisms for HIV/AIDS funding. The less the institutionalisation of accountability mechanisms for the provision of funds and services, the greater the chance of corruption. Where services are rolled out for the first time, resource distribution is often characterised by ad hoc solutions and improvisation. It is not surprising that few associated institutional structures and oversight mechanisms are in place. Where systems exist, they are poorly conceptualised and undeveloped. Under such conditions, rapidly expanding budgets and donor funds offer opportunities to siphon off funds unnoticed (TI 2006a). Fraud and corruption are inevitable, especially where massive amounts of money move between multiple actors in a loosely regulated environment.

3.1.5.4 Weak systems

Where systems are weak, it is difficult to disentangle corruption from mismanagement and system failure as the root cause of poor HIV/AIDS responses (TI 2006a). Although significant additional government resources have been mobilised for HIV/AIDS, outputs have not necessarily increased commensurately (Martin 2003:51). A number of sectoral experts have noted concerns relating to the overall performance of some HIV/AIDS programmes. Many believe that the problems affecting the overall performance of prevention and treatment programmes may be partly due to the abuse of resources, fraud or corruption, but also relate to management problems and issues of politicisation and political will.

3.1.5.5 Impact on donor funding

Many respondents supported the view that part of the reason for the mismanagement of or corruption in AIDS funding currently receiving so little attention is that scandals might cause vital donor funds to be diverted from countries in need, such as South Africa. Risking international funding would

be counterproductive to the greater cause of fighting HIV/AIDS. Donors and the government must make efforts to limit corruption, but it is vital to strike a balance in regulation between clamping down overzealously and being excessively relaxed. Neither will serve the ultimate objective of effectively providing support and resources for combating HIV/AIDS.

3.2 Recommendations

These recommendations are targeted at governments, external donors, CSOs and other researchers. They include general comments aimed at a fostering a more productive engagement with the issues.

3.2.1 Government

With respect to donor funds, government departments are encouraged to record both donor commitments and actual disbursements in their budgets. They are also advised to provide public information on how donors' funds are spent. Finally, they should improve coordination and increase utilisation of the donor matrix to facilitate the tracking of monies and disbursements.

With respect to the National Revenue Fund, government departments should be encouraged to express HIV/AIDS expenditure in disaggregated form and introduce uniform standards for provinces to account for HIV/AIDS funds. They ought also to provide detailed information on decision-making procedures for service providers and NGO funding. Information with respect to each department's own funding mechanisms should be made more accessible to public scrutiny. Detailed information on expenditure by government-funded service providers and NGOs – institutions that are insulated from popular oversight – should be forthcoming. Improved oversight of service provider and NGO performance and expenditure, in order to curb corruption, is encouraged, whilst it must be borne in mind that excessively rigid rules can hamper the work of such organisations.

The quality of reporting in departmental annual reports should be improved so that they can serve as better oversight and monitoring tools. AG reports provided in national and provincial annual reports furnish important information, indicating areas for further investigation. However, more emphasis should be placed on impact assessment and outcomes-based results of HIV/

AIDS activities. The power of oversight bodies to 'crack the whip' over offending departments and organisations should be enhanced.

3.2.2 Donors

This research has highlighted the need for a more comprehensive analysis and deconstruction of donor funding to South Africa. Currently, it is almost impossible to assess the overall amounts spent on HIV/AIDS because direct donor funding is not accounted for. Further studies may choose to track donor funds by recipient (government, CSOs and universities) or source (listing all donors) or both.

External donors should be encouraged to provide detailed and timely public information via websites and annual reports about whom they give how much money to and for what, so as to encourage transparency and accountability and independent monitoring. Information can also ensure better synchronisation between donor spending and national expenditure to avoid duplication and improve financial accountability. Considering the lack of overall strategy and the large number of unregulated channels for funding to South Africa, there is tremendous potential for duplication.

3.2.3 Civil society

Where sound accountability mechanisms exist between government departments and organisations, delivery to communities is improved and corruption and financial mismanagement are minimised. However, comprehensive monitoring and evaluation mechanisms for NGO and CBO activities are still generally weak. The lack of transparency in this regard suggests that creative accounting and the abuse of public resources by NGOs might well be occurring.

Service providers should be encouraged to develop internal checks and balances for their finances and to practise sound accounting. They ought also to make information available for public scrutiny.

3.2.4 Further research

Finally, this research merely serves as an attempt to highlight potential sites and causes of corruption in the HIV/AIDS sector in South Africa. To do justice to this area, further in-depth research is required. This might include

additional research on the link between poverty, policies and HIV/AIDS corruption, on sources of HIV/AIDS funding and accountability mechanisms, especially international donors, and on possible variations in corruption between provinces.

3.2.5 General

3.2.5.1 Accountability and information

Monitoring by government, donors, citizens, civil society and the media can be an important check on arbitrary exercises of power and the squandering of funds. However, monitoring HIV/AIDS resources requires attention to be focused on multiple players including government departments, external donors and funded organisations such as NGOs. A precondition for monitoring and accountability is comprehensive information, and this requires multiple actors to make their information publicly available so as to strengthen oversight and accountability.

3.2.5.2 Protection of whistle-blowers

Existing whistle-blower legislation should be promoted and enforced to a greater extent, particularly in the HIV/AIDS sector, where the politicisation of the disease appears to undermine confidence in whistle-blowing. Citizens, government officials and NGOs must be made thoroughly aware that a convenient means of lodging complaints of poor service or corrupt activities exists and that they will be duly protected against reprisals. Without whistle-blowers, the facts about corruption will remain elusive.

3.2.5.3 Developing a culture of openness

Despite the South African government's commitment to the right of access to information, it was particularly difficult to obtain details from the national or provincial departments of health with respect to general information on the flow of funds for HIV/AIDS and on oversight and accountability mechanisms applicable to government-funded NPOs. Exceptions included the provincial and national treasuries. Although many departments welcomed this research in principle, all departmental officials approached insisted on obtaining permission from senior officials before sharing basic information pertaining to

the study. Most departments had not responded by the end of the research period. These limitations prevent many definitive conclusions being drawn with regard to the efficacy of existing oversight mechanisms and the level of uniformity of enforcement across provinces. Ironically, the government's wariness of sharing information also made it difficult to obtain a fair account of the many sound accounting and anti-corruption mechanisms already introduced and even to give the government an opportunity to rebut allegations of corruption.

Postscript: Recent developments in the HIV/AIDS sector November 2006 to September 2007

HIV and AIDS and STI Strategic Plan for South Africa, 2007–2011

Cabinet endorsed the plan on 3 May 2007 shortly after it had been approved by SANAC. The document is being lauded as a progressive, unambiguous plan to combat the disease, and its adoption 'can ensure the end of a period of confusion, conflict and recrimination regarding HIV/AIDS policy', the SANAC Law and Human Rights Working Group has stated (SANAC 2007). It is being hailed as progressive because it sees HIV/AIDS as a human rights issue. The leadership provided during the process by Deputy President Phumzile Mlambo-Ngcuka, former Deputy Minister of Health Nozizwe Madlala-Routledge[58] and Dr Nomonde Xundu, chief director of HIV and AIDS, TB and STIs in the NDoH, was particularly welcomed, the press statement indicated. Since then, however, and led by the TAC on 29 August 2007, over 1 500 people gathered in Cape Town to demand that the South African government implement the plan (TAC 2007).

The condom scandal

On the 23 August 2007 the Department of Health recalled 20 million potentially defective government condoms. This is after media reports alleged that Sphiwe Fikizolo, a testing manager at the South African Bureau of Standards, which is responsible for ensuring that all condoms produced in the country conform to WHO standards, had accepted bribes from the manufacturer in return for certifying defective condoms. The condoms did not meet several standard tests for strength, pressure and lubrication. Following these allegations of corruption, Jeffery Hurwitz, executive director of Latex Surgical Products (Pty) Limited (LSP), which had manufactured the condoms, Sajeev Joseph, an employee, and Fikizolo face charges of fraud and corruption (IRIN 2007; Reuters 2007).

It is estimated that the lives of millions of South Africans could be at risk as a result of defective condoms. However the NDoH maintains that of the 20 million LSP condoms recalled, only an estimated seven million would have been directly compromised by the alleged corruption. The mass recall is also said to have severely undermined the government's HIV/AIDS prevention strategy through the condomisation campaign due to a loss of public confidence. A total of 439 male and three million female condoms were distributed by the state in 2006. The cost in 2005/06 was R187 million (Naidoo 2007).

NAPWA corruption crisis?

The director of NAPWA, Nkululeko Nxesi, faces allegations of financial mismanagement, fraud and unfair labour practices by senior staff members in the organisation. The *Financial Mail* reported in March 2007 that a letter written by NAPWA's human resources manager, Thabisa Dyala, to the organisation's board alleged that the director had borrowed R46 000 from NAPWA, none of which was repaid. Despite these accusations, he was cleared by the NAPWA board of any financial mismanagement. Further media reports in March 2007 suggested that the director of NAPWA had resigned after a probe into the organisation's financial affairs, but Nxesi remains head of the organisation. NAPWA also denied that any investigations into financial irregularities were taking place. Then, on 3 May 2007, Dyala addressed a letter to Deputy President Phumzile Mlambo-Ngcuka and Acting Minister of Health Jeff Radebe listing numerous accusations against Nxesi, including mismanagement of NAPWA funds, unfair labour practices, non-payment of creditors and deducting PAYE (pay-as-you-earn) and Unemployment Insurance Fund contributions from staff salaries without forwarding them to the appropriate departments (the South African Revenue Service and the Department of Labour respectively).

Matthias Rath

The TAC and SAMA have asked the Cape High Court for an interdict to ban Matthias Rath from selling or distributing unregistered medicines, conducting unauthorised clinical trials, publishing misleading advertisements and making false claims about multivitamins. The two bodies have also asked the court to order the state to take reasonable measures to rein Rath in. Their application was lodged in November 2005. In April 2007 the court ruled that it would accept the late filing of an affidavit by Matthias Rath in opposition to the application. The outcome was still pending in September 2007.

In July 2007 the DA laid a criminal charge against Matthias Rath for contravening section 36 of the Health Professions Act, No. 56 of 1974, by depicting himself as a registered medical doctor and creating the misleading impression that he was able to offer medical advice about treating HIV/AIDS. The DA lodged a similar complaint with the Health Professions Council of South Africa (HPCSA) in July, requesting it to act against the German national for contravening the law by depicting himself as a medical doctor in literature available at his new Cape Town office. The party alleged that Matthias Rath was in contravention of the law, since he was not registered as a doctor in South Africa. The HPCSA stated in response that it could not take action against

Matthias Rath since it only dealt with registered health professionals and had no jurisdiction over people not registered as doctors (Sapa 2007a, 2007b, 2007c, 2007d, 2007e, 2007f).

The Advertising Standards Authority recently ruled that any future advertising from Rath's foundation and its allied organisations would have to be vetted by the Association for Communication and Advertising (Van Noort 2007).

HIV rapid test tender contract in court

One of the main suppliers of rapid HIV tests for the past three years, Callcom, took government to court in August 2007 over its latest tender to supply kits to provincial health departments, prisons and the military (*Business Day* 2007). The contract is estimated to be worth R21.5 million a year.

Callcom, which was awarded the highest points in the bid, accuses government of unfairly awarding parts of the contract to firms that scored lower than it did on points and price. Reporter Tamar Kahn of *Business Day* argues that "while the legal challenge is not expected to disrupt the supply of tests unless the courts find in favour of Callcom and scraps the tender, it casts the spotlight on the extent to which businesses and the public can access information about the process of awarding of state tenders". Callcom turned to the courts after failing to get the tender reviewed by health department officials and the treasury.

Notes

1 This commission investigated the abuse of Global Fund money that went missing in Uganda.
2 According to online AIDS journal *JournAIDS* the amount of $6.1billion available in 2004 is 'considerably lower than the UNAIDS-estimated $15-billion needed to effectively respond to the HIV/AIDS epidemic in low- and middle-income countries in 2006. This figure is expected to rise to $22-billion in 2008' (JournAIDS nd).
3 Ibid.
4 The methodology workshop held on 18 August 2006 included TI-Z (the initiator of the project), the Institute for Security Studies, Cape Town (managers of the project) and the commissioned researcher who conducted the case study work in South Africa and another researcher from Zimbabwe who was originally supposed to be featured in this report.
5 This was a finding of the present country study.
6 The prevalence rate is the absolute number of infected people in the population.
7 The co-founders include a number of civil society organisations such as the AIDS Law Project (ALP), the Health Systems Trust (HST), the Centre for Health Policy, the Institute for Democracy in South Africa (IDASA), the Open Democracy Advice Centre (ODAC), the TAC, the School of Public Health and Family Medicine at the University of Cape Town, the Public Service Accountability Monitor (PSAM) and Médecins Sans Frontières (MSF). The HST and ALP websites (www.hst.org.za and www.alp.org.za) are used to disseminate information for the forum.
8 Interview with Nathan Geffen
9 Interviews with Nhlanhla Ndlovu and Susan Cleary
10 Interview with Mark Blecher
11 Interview with Susan Cleary
12 Interviews with Nhlanhla Ndlovu and Alison Hickey
13 Interviews with Nhlanhla Ndlovu, Alison Hickey, Mark Blecher and Peter Barron
14 Initially there was also an education conditional grant for a life skills: HIV and AIDS programme.
15 Interviews with Nhlanhla Ndlovu and Alison Hickey
16 Interviews with Mark Blecher and Alison Hickey
17 The Afrobarometer survey series of South Africa is designed to assess attitudes about democracy, markets and civil society in South Africa and to track the evolution of such attitudes over time. The samples are drawn using multi-stage, stratified, area cluster probability samples. Each survey carries out at least 2 200 personal interviews.
18 Interview with Mark Blecher
19 Interview with Mark Blecher
20 There are five opinions that the AG can give: first, a clean report, with no problems; second, 'emphasis of matter', or quantifiable problems that should be made public; third, a qualified opinion, which means that the AG cannot completely approve a department's finances; fourth, disclaimers; and fifth, adverse opinions, which mean that department's finances are in a state of disarray.

21 Schedule 5 of DoRA outlines allocations per province for each of the conditional grants. The Act gives additional information about the two HIV grants.
22 Interview with Alison Hickey
23 The Country Coordinating Mechanism coordinates all funding proposals between the Global Fund and funding applicants, such as NGOs.
24 Interview with Peter Barron
25 Interview with Nhlanhla Ndlovu
26 www.treasury.gov.za
27 Interview with Alison Hickey
28 Interview with Alison Hickey
29 Interview with Nhlanhla Ndlovu
30 Interview with Alison Hickey
31 Interview with Helen Schneider
32 South Africa's national Parliament is made up of two chambers. The National Assembly is elected directly through a national vote and the NCOP comprises delegates from the provinces. The NCOP has a special responsibility for provincial oversight.
33 Interview with Mark Blecher.
34 Interviews with NGOs in the Free State and KwaZulu-Natal
35 Interview with Oompie Lehote
36 Due to the sensitive nature of the subject, the NGO requested that its identity remain confidential.
37 Interview with Mark Blecher
38 Interview with Nhlanhla Ndlovu
39 Interviews with Nathan Geffen and Sipho Mthathi at TAC and with Fatima Hassan at ALP
40 The CD4 count measures the number of CD4 cells in the body. These cells organise the overall immune response to foreign bodies and infections and are the prime targets of HIV.
41 Interview with Mark Blecher
42 The interviewees shared this information on condition of anonymity.
43 *In South Africa, the term township applies to many types of urban areas, however, under Apartheid, the term township commonly came to mean a single-race residential development which confined non-whites (Africans, 'coloureds' and Indians) who lived near or worked in white-only communities. Soweto and Alexandra are two of the most well known of these. Townships for non-whites were also called locations.* (Dictionary nd)
44 'Drug company profiteering' is defined as demanding an 'unconscionable price' for a drug or demanding prices or terms that lead to any unjust or unreasonable profit (Stryker 2005).
45 Interview with Sipho Mthathi
46 Interviews with Nathan Geffen and Sipho Mthathi at the TAC; with doctors and nursing staff at various ARV clinics; and with NGOs such as Hillcrest AIDS centre
47 Interview with Hillcrest AIDS Centre

48 Interview with Open Democracy Advice Centre
49 This view was also expressed in several interviews.
50 Those interviewed requested anonymity.
51 Official unemployment in 2003 was 28,2 per cent, but the expanded definition gives 41,8 per cent. The Gini coefficient for gross income inequality is approximately 0,7 (Seekings & Nattrass 2006:318, 303).
52 Interviews with Dr Ingrid Wilson and with nursing staff at ARV clinic in Uitenhage
53 Briefing on social grants anti-fraud campaign to the Portfolio Committee on Social Development by the Special Investigating Unit, 30 August 2006.
54 Interview with Sipho Mthathi
55 Interviews with Andy Gray and Helen Schneider
56 The doctor spoke on condition of anonymity.
57 Interviews with Helen Schneider, Susan Cleary and Andy Gray
58 Madlala-Routledge was recently sacked by President Thabo Mbeki for allegedly taking an unauthorised trip to Madrid to attend an HIV/AIDS conference. There has been widespread condemnation of this move from trade unions and civil society as she was seen by many as a hands-on, progressive force within the department.

Bibliography

Abdool Karim, Q et al, 2006. *Expression of concern by HIV scientists: letter to South Africa's President Thabo Mbeki*. 4 September. Available from: http://www.aidstruth.org/letter-to-mbeki.php [accessed 14 February 2007].

Africa Recovery, 2002. *Global health fund releases $616 million to fight AIDS, TB and malaria*. Africa Recovery, United Nations, 25 April. Available from: http://www.un.org/ecosocdev/geninfo/afrec/newrels/globalf.htm [accessed 22 February 2007].

Africa Recovery, 2005. *1 in 3 African countries ineligible for AIDS loans.* Available from: http://www.un.org/ecosocdev/geninfo/afrec/vol14no4/htm/loans_box.htm [accessed 18 September 2007].

Afrobarometer, 2007. *Afrobarometer Survey 2006 Series of South Africa Survey data*. Information to be released later this year. Permission is required from the SA Director of Afrobarometer to use information included here. See contact at: http://www.afrobarometer.org.

AllAfrica, 2006. *South Africa: Aspen calls for end to state price freeze*. AllAfrica, 22 August. Available from: http://allafrica.com/stories/200608220184.html [accessed 22 February 2007].

ALP and TAC, 2004. *'Our people are suffering, we need treatment'*. Updated report on the implementation of the operational plan for comprehensive HIV/AIDS care, management and treatment for South Africa. AIDS Law Project and Treatment Action Campaign.

ALP and TAC, 2005. *'Let them eat cake': a short assessment of provision of treatment and care 18 months after the adoption of the Operational Plan*. Updated second joint report on the implementation of the Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa. AIDS Law Project and Treatment Action Campaign.

Altenroxel, L, 2002a. 'Insubordinate' doctor fights to keep working. *IOL HIV/AIDS*, 1 28 February. Available from: http://www.iolhivaids.co.za/index.php?fSectionId=1593&fArticleId=2911074 [accessed 21 February 2007].

Altenroxel, L, 2002b. TAC takes MP to court in Aids drug battle. *The Star*, 18 December. Available from: http://www.int.iol.co.za/index.php?sf=628&set_id=1&click_id=13&art_id=vn20021218061150665C337675 [accessed 21 February 2007].

Altenroxel, L, 2003a. Health MEC 'lied to Constitutional Court'. *The Star*, 6 February. Available from: http://www.thestar.co.za/index.php?fArticleId=45643 [accessed 21 February 2007].

Altenroxel, L, 2003b. 'Why do they still have jobs?' *The Star*, 2 September. Available from: http://www.fraudinvestigator.co.za/fraud_news_september_2003.htm [accessed 21 February 2007].

Amisi, O, 2005. Is Aids money spent well? *Kenya Times*, 20 November. Available from: Online url: http://www.timesnews.co.ke/20nov05/insight/ins4.html [accessed 22 February 2007].

Amundsen, I, 1999. *Political corruption: an introduction to the issues*. Bergen: Chr. Michelsen Institute.

Amundsen, I, 2000. *Corruption: definitions and concepts*. Brighton: Eldis. Available from: http://www.eldis.org/static/DOC10575.htm [accessed 21 February 2007].

Barnett, T and Whiteside, A, 2006. *AIDS in the twenty-first century: disease and globalisation*. 2nd ed. Hampshire: Palgrave Macmillan.

Bate, R and Schwab, B, 2005. *Accountability or action?* 17 May. Washington DC: American Enterprise Institute for Public Policy Research. Available from: http://www.aei.org/about/filter.,contentID.20038142214500071/default.asp [accessed 20 February 2007].

Booysen, F et al, 2002. The socio-economic impact of HIV/AIDS on households in South Africa: results of a study in Welkom and QwaQwa. Bloemfontein: Centre for Health Systems Research and Development, University of the Free State. Published in the *AIDS Bulletin*, 11(1), March. Medical Research Council.

Burton, P et al, 2004. *National victims of crime survey: South Africa 2003*, Mono No. 101, Pretoria: Institute for Security Studies.

Business Anti-Corruption Portal, nd. *South Africa Country Profile*. Copenhagen: Global Advice Network. Available from: http://www.business-anti-corruption.com/normal.asp?pageid=98 [accessed 20 February 2007].

Calvert, S, 2006. HIV patients get sicker on herbal 'cures': Western pills shunned by Africans. *The Baltimore Sun*, 21 August. Available from: http://www.aidstruth.org/patients-get-sicker-on-herbal-cures.pdf [accessed 21 March 2007].

Chibba, R, 2005. *Major Love Life funder pulls the plug*. *Mail & Guardian online,* 21 December. Available from: http://www.mg.co.za/articlePage.aspx?articleid=259695&area=/breaking_news/breaking_news__national/ [accessed 17 February 2007].

Chirambo, K, 2006. *Democratisation in the age of HIV/AIDS: tracking the impact of a pandemic on the electoral processes in Africa*. Governance and AIDS Programme, Institute for Democracy in South Africa.

CHP, 2004. *Non-governmental organisations providing support groups for people living with HIV/AIDS in Gauteng Province*. An evaluation commissioned by the HIV Prevention and Care Unit, Gauteng Department of Health. Johannesburg: Centre for Health Policy, School of Public Health, University of Witwatersrand.

COSATU and TAC, 2005. *Joint COSATU and TAC statement on failure of government to spend SA National AIDS Trust money*. Available from: http://www.tac.org.za/Statements/COSATU_TAC_SANAC.htm [accessed 20 February 2007].

DA, 2006. *How not to manage other people's money: an overview of the ongoing financial mismanagement at the Department of Health*. Available from: http://www.da.org.za/da/Site/Eng/News/Health-Document-OverviewOfFinancialMismangementIntheDOH.doc [accessed 20 February 2007].

Davids, N, 2003. Now rest your case, Miss Manana. *Sunday Times*, 2 February. Available from: http://www.aegis.org/news/suntimes/2003/ST030201.html [accessed 21 February 2007].

Deane, N, 2004. Auditor general drawn into Aids fund chaos. *Mail & Guardian*, 2 April. Available from: http://www.aegis.com/news/DMG/2004/MG040401.html [accessed 20 February 2007].

Dickson, P, 1998. Heath unit sets out Sarafina II charges. *Dispatch Online*, 17 November. Available from: http://www.dispatch.co.za/1998/11/17/easterncape/SARAFINA.HTM [accessed 20 February 2007].

Dictionary, nd. Township (South Africa). *Dictionary by LaborLawTalk*. Available from: http://dictionary.laborlawtalk.com/Township_(South_Africa) [accessed 21 February 2007].

Dispatch, 2004. AG questions R94m food project records. *Dispatch Online*, 17 November. Available from: http://www.dispatch.co.za/2004/11/17/Easterncape/dfood.html [accessed 20 February 2007].

Eastern Cape, 2004. *Department of Social Development Annual Report 2003/2004*. Bisho: Department of Social Development.

Eastern Cape, 2005. *Department of Social Development Annual Report 2004/2005*. Bisho: Department of Social Development.

Eastern Cape, 2006. Eastern Cape Department of Health advertisement. *The Herald*, 22 September, p 15.

Forster, G and Williamson, J, 2000. A review of current literature on the impact of HIV/AIDS on children in sub-Saharan Africa. *AIDS*, **14** (Supplement 3) S275-S284.

Getzen, T, 1997. *Health economics: fundamentals and flow of funds*. New York: Wiley.

GFATM, 2005a. *Grants to countries in Africa, rounds 1-5 funding*. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria. 30 September. Available from: http://www.theglobalfund.org/en/files/publications/factsheets/Funding%20for%20Countries%20in%20Africa%20Rds%201-5.pdf [accessed 14 February 2007].

GFATM, 2005b. *Global fund closes funding gap*. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria. 16 December. Available from: http://www.theglobalfund.org/en/media_center/press/pr_051216.asp [accessed 17 February 2007].

GFATM, nd. *Guidelines for performance-based funding*. Geneva: Global Fund to Fight AIDS, Tuberculosis and Malaria. Available from: http://www.theglobalfund.org/pdf/7_pp_guidelines_performancebasedfunding_4_en.pdf [accessed 18 September 2007].

Government Gazette, 2003. *Division of Revenue Act. No 7 of 2003*. 454 (29). Available from: http://www.info.gov.za/gazette/acts/2003/a7-03.pdf [accessed 18 September 2007].

Gray, A and Matsebula, T, 2000. Drug pricing briefing summary. *South African Health Review*. Health Systems Trust.

Gray, A, 2006. *CCMT – the drug management issues*. Presentation for JCSMF. Durban: Department of Therapeutics and Medicines Management, Nelson R Mandela School of Medicine.

Guthrie, T and Hickey, A, 2004. *Funding the fight: budgeting for HIV/AIDS in developing countries*. Cape Town: Institute for Democracy in South Africa.

Hartley, A, 2006. Rate of HIV pregnancies continues its upwards trend. *Cape Times*, 13 September, p 6.

HSRC, 2005. *Factsheet two: national HIV prevalence in South Africa - the graphics.* Media release, 30 November. Available from: http://www.hsrc.ac.za/Factsheet-40.phtml [accessed 18 September 2007].

IDASA, 2006. *South Africa: budgeting for HIV and AIDS workshop manual. Strengthening civil society capacity to monitor government resource allocation and utilisation for HIV and AIDS*. AIDS Budget Unit, Institute for Democracy in South Africa.

IRIN PlusNews, 2006. SA government Aids gag unconstitutional – watchdog. *IOL HIV/AIDS*, 6 Sep. Available at: http://www.iolhivaids.co.za/index.php?fSectionId=1591&fArticleId=3427805 [accessed 14 February 2007].

IRIN, 2005. *'Lazarus Drug': ARVs in the treatment era*. Integrated Regional Information Networks, September. Available from: http://www.irinnews.org/IndepthMain.aspx?IndepthId=12&ReportId=56081 [accessed 22 February 2007].

IRIN, 2007. South Africa: *Condom recall hurts prevention drive.* UN Integrated Regional Information Networks. 30 August. Available from: http://allafrica.com/stories/200708300593.html [accessed 18 September 2007].

ISS, 2003. *Activist fears for his life after voicing suspicions about Aids Trust Fund*. 25 November. Cape Town: Institute for Security Studies. Available from: http://www.iss.co.za/dynamic/administration/file_manager/file_links/ISSUE1003.HTML?link_id=3&slink_id=2117&link_type=12&slink_type=13&tmpl_id=3 [accessed 20 February 2007].

Itano, N, nd. *Graft follows AIDS money*. Johannesburg: South African Institute of International Affairs. Available from: http://www.saiia.org.za/modules.php?op=modload&name=News&file=article&sid=454 [accessed 20 February 2007].

JCSMF, 2004. *Resolutions of the 2nd meeting of the JCSMF*. Polokwane, Limpopo: Joint Civil Society Monitoring Forum.

JCSMF, 2005. *Resolutions of the 4th meeting of the JCSMF.* Nelspruit: Joint Civil Society Monitoring Forum.

Jooste, I, 2003. Desperate people rely on HIV to get money. *Independent Online*, 14 December. Available from: http://www.iol.co.za/index.php?click_id=125&art_id=ct20031214121134737V640626&set_id=1 [accessed 21 February 2007].

Joubert, P, 2006. Health department DG frees seized Rath drugs. *Mail & Guardian online*, 7 July. Available from: http://www.mg.co.za/articlePage.aspx?area=/insight/insight__national/&articleId=276515 [accessed 21 February 2007].

JournAIDS, nd. *HIV/AIDS funding*. HIV/AIDS and Media Project, Journalism Programme, University of the Witwatersrand. Available from: http://www.journaids.org/funding.php [accessed 26 March 2007].

Kahn, T, 2006. IT firms queue for patients' data system tender. *Business Day*, 28 June. Available from: http://www.mybroadband.co.za/nephp/?m=show&id=3335 [accessed 22 February 2007].

Kahn, T, 2007. AIDS-test supplier challenges contract. *Business Day*, 30 August.

Lewis, M, 2006. *Governance and corruption in public health care systems*. Working Paper No. 78. Centre for Global Development.

Macharia, J, 2005. The elusive trail of Aids funds in Africa. *Independent Online*, 14 October. Available from: http://www.iol.co.za/index.php?set_id=1&click_id=68&art_id=qw1129262761708B216 [accessed 23 March 2007].

Martin, HG, 2003. *A comparative analysis of the financing of HIV/AIDS programmes in Botswana, Lesotho, Mozambique, South Africa, Swaziland, Lesotho and Zimbabwe*. Cape Town: Human Sciences Research Council Press.

Mthembu, GT, 2006. South African health system requires a state of emergency. Letter published in *City Press*, 3 September. Available from: http://www.tac.org.za/nl20060905.html [accessed 20 February 2007].

Mulama, J, 2006. Using ARVs to fill empty stomachs. *Mail & Guardian online*, 14 June. Available from http://www.mg.co.za/articlePage.aspx?articleid=274450&area=/insight/monitor/ [accessed 21 February 2007].

Naidoo, P, 2007. Condoms in numbers. *Financial Mail*, 31 August, p 31.

National Review, 2005. Homespun remedy fails to cure AIDS. *National Review of Medicine*, 2(10), 30 May. Available from: http://www.nationalreviewofmedicine.com/news_in_brief/2005/nb2_issue10_may30_pg2.html [accessed 21 February 2007].

Nattrass, N, 2004. *The moral economy of AIDS in South Africa*. Cambridge University Press.

Nattrass, N, 2006a. *South Africa's 'rollout' of highly active antiretroviral therapy: a critical assessment*. Working Paper No. 158. Centre for Social Science Research, University of Cape Town.

Nattrass, N, 2006b. *AIDS, science and governance: the battle over antiretroviral therapy in post-apartheid South Africa*. AIDS and Society Research Unit Paper, University of Cape Town.

Ndaki, K, 2004. *Mpumalanga shaping up*. 22 June. Pretoria: Centre for the Study of AIDS. Available from: http://www.csa.za.org/article/articleview/297/1/1/ [accessed 19 February 2007].

Ndlovu, N and Daswa, R, 2006. *Monitoring AIDS treatment rollout in South Africa: lessons from the Joint Civil Society Monitoring Forum (JCSMF)*. Budget Brief No. 161, Budget Information Service, Institute for Democracy in South Africa.

Ndlovu, N, 2006. *An exploratory analysis of HIV and AIDS donor funding in South Africa*. Budget Brief No. 155. Budget Information Service, Institute for Democracy in South Africa.

NDoH, 2000. *HIV/AIDS/STD Strategic Plan for South Africa, 2000–2005*. Pretoria: Department of Health.

NDoH, 2003. *Operational Plan for Comprehensive HIV and AIDS Care, Management and Treatment for South Africa*. Available from: http://www.info.gov.za/otherdocs/2003/aidsplan.pdf [accessed 22 February 2007].

NDoH, 2005. *Department of Health Annual Report 2004/05*. Pretoria: Department of Health.

NDoH, 2006a. *Strategic Plan 2006/07–2008/09*. Pretoria: Department of Health. Available from: http://www.doh.gov.za/docs/misc/stratplan/2006-2009/index.html [accessed 27 March 2007].

NDoH, 2006b. *More funding for AIDS and TB NGOs*. Press release, 25 January. Pretoria: Department of Health. Available from: http://www.doh.gov.za/docs/pr/2006/pr0125.html [accessed 19 February 2007].

NDoH, 2006c. *HIV infection rate remains at same level*. 21 July. Press release. Pretoria: Department of Health, 21 Jul. Available from: http://www.doh.gov.za/docs/pr/2006/pr0721.html [accessed 8 February 2007].

NDoH, nd. *Partnerships for Health*. Pretoria: Department of Health. Available from: http://www.doh.gov.za/eu/ [accessed 19 February 2007].

News at Ten, 2006. SABC3 TV, 28 and 31 August.

Njamela, Y, 2006. Confusion reigns over Khomanani? *Health-e*, 24 August. Available from: http://www.health-e.org.za/news/article_audio.php?uid=20031488 [accessed 20 February 2007].

Pedly, D, nd. *South Africa: Corruption and the role of donors*. Bergen: U4 Anti-Corruption Resource Centre. Available from: http://www.u4.no/themes/coordination/role_of_donors_south_africa.cfm [accessed 15 February 2007]

Peltzer, K, Mngqundaniso, N and Petros, G, 2006. HIV/AIDS/STI/TB knowledge, beliefs and practices of traditional healers in KwaZulu-Natal, South Africa. *AIDS Care*, **18**(6): August 2006; 608–613.

People's Daily Online, 2006. NAC Under Fire. 10 September 10.

PHILA, 1996. *The Sarafina II controversy*. Public Health Intervention through Legislative Advocacy Work (PHILA) Legislative Update No.3, June. Cape Town: National Progressive Primary Health Care Network. Available from: http://www.healthlink.org.za/pphc/Phila/sarafina.htm [accessed 20 February 2007].

Phillips, MM, 2006. Dangerous decision – in South Africa, poor AIDS patients adopt risky ploy to get disability payments, some skip medications, putting lives in peril aiming to be 'very, very sick'. *The Wall Street Journal*, 7 April. Available from: http://www.aegis.com/news/wsj/2006/WJ060402.html [accessed 21 February 2007].

PHNI (Population, Health and Nutrition Information Project), 2004. *Children on the brink 2004*. New York: UNAIDS, UNICEF and USAID.

PSAM, 2005a. *Eastern Cape Department Health – Monitoring Brief for the 2003/04 financial year*. Grahamstown: Public Service Accountability Monitor.

PSAM 2005b. *Eastern Cape Department Health – Monitoring Brief for the 2004/05 financial year*. Grahamstown: Public Service Accountability Monitor.

Reuters, 2007. South Africa recalls 20M condoms. *CNN*, 28 August. Available from: http://www.cnn.com/2007/WORLD/africa/08/28/safrica.condoms.reut/ [accessed 18 September 2007].

Rose-Ackerman, S, 1999. *Corruption and government: causes, consequences, and reform*. Cambridge: Cambridge University Press.

RSA, 1996. Constitution of the Republic of South Africa, Act 108 of 1996.

SAFM, 2006. *Donor funding: NGOs and national Department of Health*. After Eight Debate (radio broadcast), 15 June.

SANAC, 2007. *National Strategic Plan on HIV and AIDS (2007–2011): a new opportunity for a fairer South Africa.* Press statement from SANAC Law and Human Rights Sector Working Group. 2 May. Available from: http://www.tac.org.za/nl20070504.html [accessed 18 September 2007].

Sapa, 2005. SA Aids 'cure' fails test. *News24*, 11 May. Available from: http://www.news24.com/News24/South_Africa/Aids_Focus/0,,2-7-659_1703479,00.html [accessed 21 February 2007].

Sapa, 2006a. Court reserves judgment in Costa Gazi case. *Dispatch Online*, 21 February. Available from: http://www.dispatch.co.za/2006/02/21/SouthAfrica/agazi.html [accessed 21 February 2007].

Sapa, 2006b. Achmat: govt behind Rath. *Mail & Guardian online*, 3 March. Available from: http://www.mg.co.za/articlePage.aspx?articleid=265863&area=/breaking_news/breaking_news__national/ [accessed 21 February 2007].

Sapa, 2006c. No benefit from 'Aids cure'. *News24*, 18 March. Available from: http://www.news24.com/News24/South_Africa/Aids_Focus/0,,2-7-659_1900611,00.html [accessed 21 February 2007].

Sapa, 2006d. MRC head dismisses Rath 'link'. *Mail & Guardian online*, 8 June. Available from: http://www.mg.co.za/articlePage.aspx?articleid=273955&area=/breaking_news/breaking_news__national/ [accessed 21 February 2007].

Sapa, 2006e. Judge's critical ARV ruling finds SA government in contempt. *IOL HIV/AIDS*, 29 August. Available at: http://www.iolhivaids.co.za/index.php?fSectionId=1591&fArticleId=3416207 [accessed 13 February 2007].

Sapa, 2007a. State silent on Rath settlement, says TAC. *Mail & Guardian online*, 25 April. Available from: http://www.mg.co.za/articlePage.aspx?articleid=305849&area=/breaking_news/breaking_news__national/ [accessed on 18 September 2007].

Sapa, 2007b. Court 'reluctantly' accepts Rath affidavit. *Mail & Guardian online,* 26 April. Available from: http://www.mg.co.za/articlePage.aspx?articleid=305997&area=/breaking_news/breaking_news__national/ [accessed on 18 September 2007].

Sapa, 2007c. Health Council says it cannot stop Matthias Rath. *Mail & Guardian online,* 12 July. Available from: http://www.mg.co.za/articlePage.aspx?articleid=313790&area=/breaking_news/breaking_news__national/ [accessed 18 September 2007].

Sapa, 2007d. Rath matter out of HPSCA's jurisdiction. *Independent Online,* 12 July. Available from: http://www.iol.co.za/index.php?set_id=1&click_id=2624&art_id=nw20070712161330761C155246 [accessed on 18 September 2007].

Sapa, 2007e. Rath lawyers hit back at DA. *Mail & Guardian online,* 13 July. Available from: http://www.mg.co.za/articlePage.aspx?articleid=313924&area=/breaking_news/breaking_news__national/ [accessed 18 September 2007].

Sapa, 2007f. DA to lay criminal charges against Rath. *Mail & Guardian online,* 27 July. Available from: http://www.mg.co.za/articlePage.aspx?articleid=315097&area=/breaking_news/breaking_news__national/ [accessed 18 September 2007].

Seekings, J and Nattrass, N, 2006. *Class, race and inequality in South Africa*. Pietermaritzburg: University of KwaZulu-Natal Press.

Shisana, O et al, 2005. *South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2005*. Fact Sheet 2. Cape Town: HSRC Press.

Sithole, M et al, 2003. *Opinion poll on Zimbabwean perceptions on corruption in Zimbabwe*. Harare: Transparency International Zimbabwe.

Smart, T, 2005. South Africa completes negotiations for large-scale antiretroviral procurement. *Aidsmap News*, 22 February. Available from: http://www.aidsmap.com/en/news/5C4983F9-7A77-491C-8FB1-D56D64590D02.asp [accessed 21 February 2007].

Social Development, nd. *Policy on the Financial Awards to Service Providers* (third draft). KwaZulu-Natal Department of Social Development.

Strand, P and Mattes, R, nd. *Public opinion on AIDS in Africa*. Centre for Social Science Research, University of Cape Town.

Stryker, J, 2005. HealthVote2005: Proposition 78 and Proposition 79. *California Healthline*, 6 September. Available from: http://www.californiahealthline.org/index.cfm?Action=dspItem&itemID =116185&ClassCD=CL126 [accessed 21 February 2007].

Sunday Times, 2004. Doctors say Manto is stalling. *Sunday Times*, 22 February. Available from: http://196.44.3.66/2004/02/22/news/news08.asp [accessed 21 February 2007].

Swilling, M and Russell, B, 2002. *The size and scope of non-profit sector in South Africa*. Johannesburg: Witwatersrand University.

TAC, 2004. *TAC statement on Auditor-General's qualified audit opinion of the Department of Health*. 18 October. Muizenberg: Treatment Action Campaign. Available from: http://www.tac.org.za/newsletter/TACStatement onAuditor.htm [accessed 20 February 2007].

TAC, 2006. *The HIV epidemic: a discussion of the response of the South African government*. Submission to African Peer Review Mechanism. Muizenberg: Treatment Action Campaign. Available from: http://www.polity.org.za/pdf/TACAfricanPeerReview.pdf [accessed 20 February 2007].

TAC, 2007. *Implement the AIDS plan*. Available from: http://www.tac.org.za/ [accessed 18 September 2007].

Tayler, L and Dickinson, C, 2006. The link between corruption and HIV/Aids. *IAPAC Monthly*, 12(2), February.

Tella, R et al, 2001. *Diagnosis of corruption*. Washington, DC: Inter-American Development Bank.

Thom, A, 2002. Underspending threatens provinces' health care. *Health-e*, 15 May. Available from: http://www.health-e.org.za/news/article.php?uid=20020512 [accessed 17 February 2007].

TI, 2003. *Global Corruption Report 2002*. London: Transparency International.

TI, 2004. *Global Corruption Report 2004*. London: Transparency International.

TI, 2005. *The causes of corruption in the health sector: a focus on health care systems*, Transparency International.

TI, 2006a. *Global Corruption Report 2006: Corruption and health*. London: Transparency International.

TI, 2006b. *Global Corruption Report 2006 Summary Sheet: Corruption in the pharmaceutical sector*. London: Transparency International.

TI, 2006c. *Working Paper: Corruption & HIV/AIDS*. London: Transparency International.

TI-Z, 2006. *Study on corruption in public service delivery with special focus on HIV/AIDS funds in Southern Africa*. Research proposal presented to Action Aid International. Transparency International Zimbabwe.

Tshabalala-Msimang, M, 2006a. *Minister of Health calls for sustainable financing of HIV and Aids programmes*. 11 January. Pretoria: Department of Health. Available from: http://www.doh.gov.za/docs/pr/2006/pr0111.html [accessed 17 February 2007].

Tshabalala-Msimang, M, 2006b. *Address by the Minister of Health of South Africa, Dr M.E. Tshabalala-Msimang during the Mid-Term Review of the Global Fund Replenishment*. 4 July. Pretoria: Department of Health. Available from: http://www.doh.gov.za/docs/sp/2006/sp0704.html [accessed 17 February 2007].

U4, nd. *Corruption in public procurement: health sector*. Bergen: U4 Anti-Corruption Resource Centre. Available from: http://www.u4.no/themes/procurement/procurementinhealth.cfm [accessed 22 February 2007].

UNAIDS and WHO, 2003. Sub-Saharan Africa. AIDS epidemic update.

UNAIDS and WHO, 2005. *Progress on Global Access to HIV Antiretroviral Therapy*. Geneva: World Health Organization.

UNAIDS, 2002. *A global overview of the epidemic*. Report on the global HIV/AIDS epidemic.

UNDP, 2003. *Human Development Report 2003*. Geneva: United Nations Development Programme.

UNODC, nd. *Country corruption assessment report*. United Nations Office on Drugs and Crime. Available from: http://www.unodc.org/southafrica_reports/index1.htm [accessed 27 March 2007].

Van Noort, E, 2007. Matthias Rath ads reckless in the extreme. *Mail & Guardian online*, 30 August. Available from: http://www.mg.co.za/articlePage.aspx?articleid=249514&area=/breaking_news/breaking_news__national/ [accessed on 18 September 2007].

Van Vuuren, H, 2004. Small bribes, big challenges: extent and nature of corruption in South Africa. *South African Crime Quarterly*, 9 September. Cape Town: Institute for Security Studies. Available from: http://www.issafrica.org/index.php?link_id=3&slink_id=1093&link_type=12&slink_type=12&tmpl_id=3 [accessed 15 February 2007].

Van Vuuren, H, 2005. *National Integrity Systems Report, Transparency International, Country Study Report: South Africa 2005*. Cape Town: Institute for Security Studies.

Vian, T, nd. *Corruption in the health sector*. Bergen: U4 Anti-Corruption Resource Centre. Available from: http://www.u4.no/themes/health/causesandconsequences.cfm [accessed 15 February 2007].

Wikipedia, nd. *Political corruption*. Available from http://en.wikipedia.org/wiki/Political_corruption [accessed 21 February 2007].

World Bank, 2004. *World Development Report 2004: making services work for poor people*. Washington DC: World Bank.

Websites

AIDS Education Global Information System	www.aegis.com
AIDS Law Project	www.alp.org.za
AIDS Media Center	www.aidsmedia.org
Aidsmap	www.aidsmap.com
AIDSTruth.org	www.aidstruth.org
allAfrica.com	www.allafrica.com
American Enterprise Institute for Public Policy Research	www.aei.org
AVERT	www.avert.org
Bill & Melinda Gates Foundation	www.gatesfoundation.org
The Body	www.thebody.com
Business Anti-Corruption Portal	www.business-anti-corruption.com
Centre for the Study of AIDS	www.csa.za.org
Chr. Michelsen Institute	www.cmi.no
Democratic Alliance	www.da.org.za
Department of Health (South Africa)	www.doh.gov.za
Department of State: Office of the US Global AIDS Coordinator	www.state.gov/s/gac/
GFATM	www.theglobalfund.org
Health, Economics and HIV/AIDS Research Division (University of KwaZulu-Natal)	www.heard.org.za
health-e	www.health-e.org.za
Health Systems Trust	www.hst.org.za

Appendix 1: Interviews

In-depth interviews

1. Nhlanhla Ndlovu: AIDS Budget Unit at IDASA. 22 August 2006
2. Per Strand: researcher on HIV/AIDS and governance, Democracyin Africa Research Unit, University of Cape Town (UCT). 24 August 2006
3. Professor Nicoli Nattrass: economist, UCT. 24 August 2006
4. Susan Cleary: Health Sciences Unit at Medical Campus, UCT. 24 August 2006
5. Dr Ingrid Wilson: Tygerberg Hospital, HIV/AIDS Clinic. 28 August 2006
6. Nathan Geffen: TAC. 5 September 2006
7. Peter Barron: HST . 8 September 2006
8. Helen Schneider: Centre for Health Policy, School of Public Health, University of Witwatersrand, Johannesburg. 11 September 2006
9. Sipho Mthathi: general secretary, TAC, 12 September 2006
10. Mrs Shai-Mahtu: senior manager, HIV unit, Free State Department of Health. 14 September 2006
11. Oompie Lehote: AAHA, Bloemfontein, Free State. 14 September 2006
12. Alison Hickey: acting senior manager, Budget Office, Provincial Treasury, Western Cape. 19 September 2006
13. Dr Mark Blecher: director of social services, National Treasury. 19 September 2006
14. Mrs Klassens: nursing manager; Sister Rabbie: acting head; ARV clinic, Uitenhage Provincial Hospital. 22 September 2006
15. Alan Whiteside and Maanda David Nelufule: Health Economics and HIV/AIDS Research Division (HEARD), University of KwaZulu-Natal. 28 September 2006
16. NGO: Open Door Crisis Centre, Durban. 28 September 2006
17. NGO: Hillcrest AIDS Centre, Durban. 28 September 2006
18. Ida Jooste: specialist current affairs producer and journalist on social development issues, SABC. 4 October 2006

Additional interviews via e-mail and telephone

1. Fatima Hassan: attorney, ALP.
2. Andy Gray: senior lecturer, Department of Therapeutics and Medicines Management, Centre for the AIDS Programme of Research in South Africa (CAPRISA), Nelson R Mandela School of Medicine, University of KwaZulu-Natal
3. Christina Schrade: adviser to the executive director, GFATM, Switzerland
4. Andrew Boulle: School of Public Health and Family Medicine, UCT
5. Teresa Guthrie: independent budget analyst, Cape Town
6. Stacey-Leigh Joseph: project head, Monitoring and Research, PSAM, Rhodes University
7. Marianne Camerer: anti-corruption expert, Department of Philosophy, University of Stellenbosch, and Institute of Global Integrity, Washington
8. Kondwani Chirambo: IDASA, Pretoria
9. Dr Vlasiu: attorney, Johannesburg
10. Mia Malan: international correspondent, Internews
11. ODAC
12. Desmond Tutu Foundation
13. Professor Sheila Meintjies: Political Studies, School of Social Sciences, University of the Witwatersrand
14. Pieter Fourie: Johannesburg University
15. HSRC: Social Aspects of HIV/AIDS and Health (SAHA)
16. Herman Reuter: project coordinator for MSF in Lusikisiki, Eastern Cape
17. Jonathan Walton: Black Sash, Grahamstown
18. MRC

Government officials approached for permission to research

1. Thami Mseleku: director-general, NDoH
2. Dr Ron Chapman: acting head of health, Free State Provincial Government
3. Pierre Uys: MEC for health, Western Cape