Policy Brief

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The Macroeconomic Framework & the Fight Against HIV/AIDS in Africa

The Cases of Ghana and Malawi

AFRODAD

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HIV/AIDS HAS BECOME A LEADING CAUSE OF DEATH IN THE AFRICAN CONTINENT. It not only constitutes a serious constraint to growth and stability of most African economies and societies, but has actually begun to destroy the hard-won development. Even countries with a relatively low national HIV prevalence rate have pockets of crises that are concealed by national statistics- clusters of people or specific locations where the prevalence rate is as high as 20 per cent or more. Over three quarters of total deaths from AIDS occurred in Sub Saharan Africa. More than 10 million children in the region had been orphaned by AIDS by 2005 (UN 2005). While the global prevalence rate is estimated at 1 per cent, the average for sub-Saharan Africa is over 9 per cent thus making the continent the highest incidence of the disease. HIV/AIDS thus constitutes a serious developmental challenge to not only policy makers but also policy implementers in Africa.

Addressing this state of emergency requires that governments operate outside the traditional restrictive macroeconomic policies and budget ceilings that have constricted some recipient governments from giving HIV/AIDS the attention it deserves. In this regard, governments need to assess their macroeconomic policy goals and impact on the pandemic. The region therefore needs stronger domestically led policy formulation and strong public institutions to develop a flexible macroeconomic framework to address the challenges posed by the disease. Sub Saharan countries must strive to move out of the tight macro-economic frameworks that are based on conditionalities imposed by the lending instruments of the International Monetary Fund. The implication is that fighting HIV/AIDS requires a broad socio-economic and political framework, requiring the input of all stakeholders.

In recent years, there have been increasing concerns about macroeconomic policy constraints interfering with the ability of many African governments to increase health sector spending and getting access to urgently needed funds for HIV/AIDS human resource development. The International Financial Institutions (IFIs) and, in particular, the IMF have been accused of undermining health care systems in many developing countries through conditionalities that favour budgetary ceilings as a panacea for macroeconomic stability. The economic policies sometimes affect overall spending, resulting in caps on the health sector, salary and recruitment of health workers and the acceptance of large amounts of financial assistance. IMF policies often require that countries forgo significant grants for health care in order to ensure macroeconomic stability[1].

AFRODAD has conducted a two country study aimed at looking at the linkages between macroeconomic frameworks provided by the International Financial Institutions (IFIs) and the social spending, and in particular, the fight against HIV/AIDS in Ghana and Malawi. This study reviewed the major channels through which fiscal and monetary policies impact on public expenditure frameworks and how this, in turn, affects the ability of the countries under study to design and implement public programmes concerning those living with and affected by HIV/AIDS and assessing the debt positions of the case studies to see how the HIV/AIDS has impacted on their financial portfolios and planning abilities or vice-versa.

PRGF FEATURES AND THE MACROECONOMIC FRAMEWORK - COUNTRY EXPERIENCES

The IMF established the Poverty Reduction and Growth Facility (PRGF) in 1999 to make the objectives of poverty reduction and growth more central to lending operations[2] to its poorest member countries.

This marked a further step in the IMF response to public criticism following the introduction of the HIPC initiative. Reviews of the PRGF IMF staff in 2002 and by the Independent Evaluation Office (IEO) of the IMF in 2004 confirmed that the design of the programmes supported by PRGF lending had become more accommodating to higher public expenditure, in particular social spending on pro-poor services. Field data from all the countries in the study supported this development in health and education.

PRGF-supported programs are essentially the macroeconomic framework for achieving growth and poverty reduction. In order to ensure that PRGF programs do not lose focus on poverty reduction, they are supposed to be framed around a country's Poverty Reduction Strategy Paper (PRSP). Targets and policy conditions in a PRGF-supported program are supposed to be drawn from a country's PRSP.

[1]A large coalition of NGOs representing people living with HIV/AIDS in 38 countries wrote a petition to the IMF and World bank managing directors in August 2004, demanding assurances that there will be no imposition of strict adherences to budget ceilings and inflation target and that there will not be blockade of funds available for the fight against HIV/AIDS. The petition signified major concerns of civil society organizations about the impact of the activities of IFIs on policy constraints in developing countries.

[2]http://www.imf.org/external/np/exr/facts/howlend.htm

[3]http://www.imf.org/external/np/sec/pn/2002/pn0230.htm

HIV/AIDS has been given eminence in national strategies for economic growth and poverty reduction and the achievement of the Millennium Development Goals. National institutions and frameworks have been created to facilitate the design, implementation and monitoring of HIV/AIDS related strategies. In Ghana HIV/AIDS is addressed along with other health issues (e.g. malaria), education and gender under the broader category of Human Resources Development. National Aids Framework (NAF) has been developed to manage the pandemic under the Ghana Aids Commission (GAC). In Malawi, coordination of the multi-sectoral response to HIV/AIDS is vested in the National AIDS Commission (NAC), a semi-autonomous organ under the Office of the President and Cabinet (OPC).

PRGF has been instrumental in shaping the fiscal space as well as the macroeconomic stability in Ghana and Malawi. Ghana received a Poverty Reduction Growth Facility (PRGF), amounting to SR 184.5 million, which was fifty percent of its quota with the IMF in 2003. Malawi qualified for a PRGF programme beginning 2005. The programme has undergone three consecutive successful reviews and is due for a fourth review in September 2007. When the lending instrument is analysed against its impact, the studies note the following:

THERE IS EVIDENCE OF STABLE MACROECONOMIC INDICATORS. Both countries have registered higher economic growth rates compared to the late 90s, falling rates of inflation and stable exchange rate under the IMF programs. Ghana's growth rate hit 6.2 per cent in 2006 as compared to 3.2 per cent in 2000. The country also witnessed a fall in inflation rate to 10.5% in 2006 up from 40% in 2000. Similar trends have been registered in the exchange rates. In Malawi economic growth increased to 4½ percent in 2003, up from 2 percent in 2002, but regrettably below that needed for significant poverty reduction. The average rate of inflation continued to decline in 2003, reinforcing a key element of macroeconomic stability.

MAJOR CHALLENGES REMAIN IN FIGHTING HIV/AIDS. There are currently major handicaps in the governments' planned interventions on HIV/AIDS in the country studies. Funding in the HIV/AIDS sector remains inadequate. The reports indicate that less than half the funding required to implement the activities to achieve the target for universal access has been secured in both countries. There are also infrastructural constraints as most intervention areas, particularly in the rural parts of the country are not easily accessible by road. In addition, storage facilities for antiretroviral drugs are often lacking. The poor infrastructural conditions in rural areas have also proven to be impediments for the posting of qualified health personnel to rural areas. As a result, there is also the problem of inadequacy of personnel to cover all the intervention areas.

THE FISCAL FRAMEWORK HAS INCREASED TAX BURDENS TO THE ORDINARY CITIZENS. Following HIV/AIDS funding shortfalls during the last decade, the government of Ghana has embarked upon extensive consultations with stakeholders including civil society and the private sector to finding alternative strategies to ensuring macroeconomic stability without impediments to social spending. Ghana's fiscal policies in recent years have therefore been more focused on ensuring effective control of public expenditure and the reduction of domestic debt.

Emphasis in recent times has also been on increasing the revenue base. Thus, broad based taxation was widened to cover incomes and property. As can be expected, taxes from domestic goods and services have exceeded those of the previous year by 3.2%. Value added tax is also an area government fiscal policy has given a lot of attention in view of its contribution towards revenue generation. In the 2007/2008 budget, the government introduced a beverage tax to ensure that there is adequate revenue to tackle extra budgetary requirements of the health sub-sector and in particular the treatment, care and management of HIV/AIDS in the country.

This is also with a view to finding sustainable alternatives of footing the social spending bill even where donor support is less than satisfactory. Sources from the Ghana Ministry of Health indicate that other strategies that are being considered include integrating the traditional medical care to orthodox medicine in order to reduce cost of treatment and additional health budgets. This inward looking strategy reduces the danger of extra budgetary inflows distorting macroeconomic stability.

[4]The adjusted target floor on net foreign assets of monetary authorities was 58.1 million Kwacha. Malawi successfully applied for a waiver of this target, as its net foreign assets amounted to 44.2 million Kwacha

THE FISCAL POLICY FRAMEWORK HAS ENSURED BUDGET CEILINGS FOR SOCIAL SPENDING. There are currently major handicaps in the government's planned interventions on HIV/AIDS in Ghana. Indeed, funding in this sector has been woefully inadequate. The Annual Programme of Work (APOW) for HIV/AIDS 2007 indicates that "one of the major challenges for operationalizing the NSF II has been mobilizing enough funds". The report admits that less than half the funding required to implement the activities to achieve the target for universal access has been secured for 2007. Consequently, the Ghana AIDS Commission considers the year 2007 as the year of fund raising (APOW, 2007, p24).

The use of budget ceiling payment module under the PRGF program made the Ministry of Finance in Malawi introduce Central Payment System (CPS) whereby all payments by Ministries and Departments would be made centrally by the AG. In addition the Ministries and Departments were asked to close all bank accounts maintained in the commercial banks and operate from the MG Pooled Account Number 1 based at the Reserve Bank of Malawi. However, this contravened the National Aids Commission (NAC) grants facility procedure that requires all grants to be managed through dedicated bank accounts. As a result the majority of grants disbursements to the public sector were suspended for a period of over nine months until the AG agreed to let the NAC funds to continue operating outside the CPS until a later date. Therefore vital HIV/AIDS financing failed to flow to the people that were in need of it.

Furthermore the ceiling required the government to spend not more than 7% of the total budget for wages and salaries. This has resulted in the Government not being able to recruit and retain personnel that would manage the HIV and AIDS interventions. This has resulted in a serious human resource problem in the health sector that is struggling to utilize and absorb the huge financial resources that are earmarked for HIV and AIDS.

For example the adjusted ceiling target on central government wages and salaries is 26.030 million Kwacha. Based on the budget for the Malawi Growth and Development Strategy (MGDS) and based on the planned activities for the health sector alone, Malawi intends to provide incentives to health workers in order to raise retention rates (19.305 million Kwacha), maintain qualified workers (41.236 million Kwacha), and strengthen training capacity of health institutions (858 million Kwacha). Thus, the ceiling is far below what is specified in the MGDS as being necessary to fight the pandemic.

THE FISCAL POLICY FRAMEWORK IS WEAK IN ADDRESSING THE FINANCING GAPS IN HIV/AIDS RELATED PROGRAMS. Even though spending in the health sector shows an increase in fiscal spending in HIV/AIDS related programs in nominal terms in both countries, there still exists a large funding gap.

The funding shortfall has been identified as one of the major handicaps of planned intervention. In 2006 the estimated budget for HIV/AIDS programme in Ghana stood at US $77,419,253 as against US $54,000,000 total amount received in form of grants from multilateral and bilateral agencies. Not surprising the Ghana AIDS Commission has pegged funding ceiling for NGO and Faith Based Organizations (FBOs) at ¢30,000, 000 (US $ 3,333) and ¢12,000,000 (US$1,333), respectively. Indeed, the funds allocated for HIV/AIDS intervention programmes per year for most NGOs and CBOs can hardly cover a weekly activity. Based on the level of funding already committed by the national government and its donors, the World Health Organization (WHO) estimates a funding gap of over US $12.8 million for HIV/AIDS activities in Ghana. Currently all aspects of HIV programmes in Ghana including prevention, treatment, care and support, behavioural change, coordination, monitoring, evaluation and surveillance are under-funded. The GPRS II estimates that a resource envelope of US$8.6 billion is required to do so; indicating an overall funding gap of $1.79 billion.

The resource requirements for implementing the NAF (2005-09) in Malawi are estimated at US$ 619.6 million. To date, only a total of US$342.0 million has been committed by domestic and external funding sources. This leaves a funding shortfall of about US$ 277.6 million, approximately 27%, which the Government of Malawi (GoM) financed via borrowing. The funding gap becomes wider in the context of the Universal Access (UA) (2006-2011) estimated at US$1.67 billion considering that only 30% of total required funding has so far been committed. This enormous funding gap poses serious challenges to the country in the quest for attainment of the targets for the NAF and the Universal Access (UA).

With a restrictive fiscal space under the PRGF, it is proving difficult for these countries to lure additional resources to address the pandemic for fear of their destabilising factor in the macroeconomic fundamentals.

Weak fiscal space has compromised ownership in the design and implementation of HIV/AIDS related programs. In Malawi, the requirement to achieve the benchmark for the floor on net foreign assets of the monetary authorities even though later waived[4] led the government to direct the National Aids Commission to transfer its Foreign Currency Denominated Accounts (FCDAs) from the commercial banks to the Reserve Bank of Malawi on 1st July 2005. This was in contravention of the Memorandum of Understanding (MOU) that the Government of Malawi and the Funding Partners signed in June 2003 which stipulated that the FCDAs would be maintained in the commercial banks. As a result of this, the donors withheld funding to NAC for a period of six months until the GoM accepted that NAC could temporarily re-open the FCDAs in commercial banks.

During this period the NAC grants facility was greatly under-resourced and this affected the target communities that these resources were meant to service.

Consequently in Ghana, there have been myriads of external interference in macroeconomic planning in general and HIV/AIDS spending in particular. Loose cohesion between formulated budgets and budget execution, and diverging views on setting priorities and reflecting those in budget formulation has been in the forefront in undermining the government's efforts to address the pandemic. Behind the access to treatment, are restrictive macroeconomic policies and budget ceilings that have constricted health sectors from giving HIV/AIDS the attention it deserves.

THE FISCAL FRAMEWORK HAS BEEN INEFFECTIVE IN ADDRESSING THE DEBT PROBLEM. Ghana has received significant debt relief in recent years after reaching the HIPC status in July 2004. Approximately US$2.186 billion in HIPC assistance was committed by all its creditors (IMF, 2006). Under the G8 multilateral debt relief, Ghana is to be relieved by an additional US$ 4.2 billion by the middle of 2009. However, despite the tremendous debt relief the country still has considerable public debt. From an external debt of $5.9 billion in 2001, Ghana's current debt in 2007 is estimated around US$3.546 billion. Payments going to external debt service (approximately 3 trillion cedis) are greater than pension, social security, gratuities and the national health fund combined. Furthermore, despite graduation from the HIPC programme, the volume of Ghana's debt stock has increased.

Malawi's level of indebtedness has been increasing steadily in recent years. The 2005/06 financial year also saw net foreign borrowing peak at 15.817 million Kwacha. At the end of 2005, Malawi's outstanding debt stock amounted to about US$3.0 billion, representing an increase of 15.4 percent from US$ 2.6 billion recorded in 1999. Net domestic debt, which was 17.4% of GDP in 2002, rose to 22.6% in 2004, and is currently hovering at just under 20%; despite an average increase in growth of real GDP of 4.4% during the same period (IMF, 2007). In addition, interest payments on net foreign borrowing have absorbed crucial funds. In the 2003/04 financial year, payments on foreign debt were 2.114 million Kwacha; in 2004/05, 2.962; and in 2005/06, 3.459 million Kwacha.

The higher opportunity costs of external and domestic debt service payments constrain the fiscal space available for social development planning, which is all the more reason for front-loading of HIPC and MDRI payments.

RECOMMENDATIONS

Macroeconomic stabilization and growth policies do not take place in a vacuum, they affect real lives and real people. National governments as well as the lending institutions should be cognisant of this fact at all times. Fiscal policies and the space they provide have the potential for dealing decisively with HIV/AIDS in the countries understudy. Even though current trends show elements of marked improvements there is, however, a need for a fundamental shift on how we design and execute the macroeconomic framework. It is with this in mind that we propose the following:

THE IMF AND WORLD BANK MUST RECOGNIZE HIV/AIDS AS MORE THAN A DISEASE. Just as the Malawi and Ghana governments adopted a more holistic framework with respect to containing the pandemic, so too should the IMF take the view that HIV/AIDS is not just a health crisis but cuts through all sectors and ministries. The inability to curb the virus is a direct result of the underdevelopment of infrastructure, specifically the inability of these countries to supply basic social services.

When viewed in this light, mainstreaming increased public infrastructure expenditure with social expenditure is key. National governments should thus be allowed to determine their own levels of flexibility as regards the fiscal space necessary to address the pandemic as well as the problem of underdevelopment.

IT IS NECESSARY TO OFFER ALTERNATIVE AND SUSTAINABLE FINANCING SOLUTIONS TO GOVERNMENTS. The resource gaps, after taking into consideration the Universal Access Targets, are considerable. Domestic taxes and VAT are insufficient to meet the programmed activities. As countries have turned towards undertaking loans from the private sector, the IMF has included criteria with a view to curbing domestic debt.

The institutions should work in a more integrative fashion. The World Bank typically takes the lead in infrastructural projects while the IMF concern themselves with macroeconomic stability. However, what is required is acknowledgement that that stability is based on macroeconomic foundations and can not be attended to separately. Increased consultations between these financial institutions and sharing of expertise would go far in creating a coherent development financing strategy, taking into consideration the countries' priorities.

Further, the attention to domestic debt levels is without context, as it does not address the reasons why significant levels have accrued. The constricted fiscal space, specifically the floor on net foreign assets and the ceiling on central government expenditures, combined to create the situation in which the Malawi and Ghana governments found that private sector borrowing was necessary to fund the activities, which had been identified as necessary to combating HIV/AIDS.

THE IMF SHOULD APPLY THE FRONT-LOADING OF DEBT RELIEF. The spreading of HIPC and MDRI debt relief has higher opportunity costs, when taking into consideration the amount of external debt service payments vis a vis the cost of health programmes and activities targeting vulnerable groups. Mechanisms should thus be put in place to motivate front loading as the need for resources to address the HIV/AIDS are immediate.

THE IMF NEEDS TO BECOME PARIS-DECLARATION COMPLIANT. Just as other donor countries have restructured the manner in which their aid is delivered and managed, so to must the IMF, as it is a signatory to the agreement. Compliance to the PD entails dropping from its lending instrument conditionalities (benchmarks and targets) which have no bearing on the development plans for which partner countries seek funding, coordination and harmonisation with other donors to reduce the transaction costs of developing countries, and an acknowledgement of the priorities and activities that have been identified by recipient countries.

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