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Impact of increased aid flows for HIV/AIDS in developing countries: working towards a sustainable response

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Summary

1. The objective of this work was to gain a better overview and understanding of the issues and possible policy responses around external aid for scaling up the AIDS response in developing countries.[2]

2. Despite as funding gap of about US$ 8.1 billion in 2007, there here has been a three-fold increase in development assistance for AIDS since 2002, reaching US$ 5.6 billion in 2005 (see section A), and an even larger increase since then. However, as aid for AIDS increases, concern has arisen about the sustainability of large aid inflows for AIDS and their impact on the macro economy of recipient countries. There are certain characteristics of the AIDS response that increase the risk of instability (e.g. proliferation of unaligned, vertical programmes, increased funding of recurrent expenditure, possible demand effects of drawing on scarce domestic goods and services, such as human resources).

3. Evidence of macroeconomic instability due to aid (e.g. 'Dutch Disease') is mixed. Where aid for AIDS is additional and significant, recipient governments should be able to manage its impact through careful planning and coordination of fiscal and monetary policy. Moreover, if aid is well managed and effectively spent, the returns to aid (e.g. improvements to productivity thanks to improved health status of a country) should be able to offset the short-term, negative effects, and enhance economic growth and development in the longer term. However, the way in which aid is delivered, especially the alignment with government processes and predictability of aid, is also a crucial but often uncertain factor determining the risk of macroeconomic destabilisation due to aid (see section B).

4. Country-specific cases offer some interesting illustrations of the way in which increased aid for AIDS can be tackled in country. The following points are worth emphasising (section C):

- Limited risk of macroeconomic instability due to increased aid for AIDS, though this depends to a large extent on the way in which aid is delivered;
- Importance for all donors to adhere to aid effectiveness ("Paris") principles in the field of AIDS;
- Increased aid for AIDS should not address HIV and AIDS in isolation but invest in strengthening the supporting health system and building capacity;
- HIV and AIDS should be addressed, directly and indirectly, through the overall national development agenda.

[1] With great thanks to technical advisers in DFID country offices and head quarters for their inputs and advice. The text (and any mistakes) is, however, the author's responsibility.
[2] The word "aid" refers to grants, bilateral, multilateral, global funds as well as private funding. Though a lot of the issues apply to conditional borrowing as well, this is not covered.

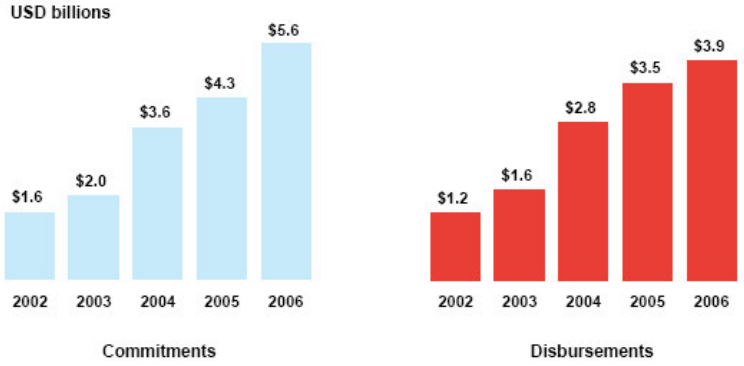
A. Aid + AIDS

A.1. Increased resources for AIDS

According to the latest analysis of funding for AIDS, 2006 saw the highest level of donor commitments ever, totalling US$ 5.6 billion, with disbursements of US$ 3.9 billion (seven in ten commitments). This is more than a three-fold increase since 2002 (see figure 1). In 2003, AIDS represented 1.8% of total ODA, and currently the share is over 2%.[3] Total resources for AIDS, including both donor and domestic funds, are expected to amount to US$ 10 billion by 2010.[4]

Most funding (76%) is provided bilaterally or earmarked through multilateral organizations, while the Global Fund for AIDS, TB, Malaria (GFATM) accounts for the rest. With 41%% of all disbursements, the US is the largest donor, though the fifth largest donor when measured in proportion to GDP.[5] Other major players are the World Bank's Multicountry HIV/AIDS Program (MAP) and the United States' President's Emergency Plan for Aids Relief (PEPFAR) initiative and US President Clinton's HIV/AIDS Initiative (CHAI).

Figure 1. Trends in donor government assistance for AIDS 2002-2006[6]



Some countries have certainly experienced a noticeable increase in aid earmarked for AIDS. Rwanda offers a striking illustration.

Box 1

Rwanda:
Increased external financing for AIDS

In 1998, National Health Accounts indicated a total per capita health expenditure of US$ 12 per year, with about 10% spent on prevention and treatment of HIV and AIDS. Of the total expenditure on AIDS, a disproportionate 93 percent came from household

[3] L. MacKellar, Priorities in Global Assistance for Health, AIDS and Population (HAP), OECD Development Centre Working Paper No. 244, 2005 and OECD DAC Statistics
[4] UNAIDS, Financial Resources required to achieve universal access to HIV prevention, treatment, care and support, 2007
[5] See UNAIDS, Financing the response to AIDS in low- and middle income countries: International assistance from the G8, European Commission and other donor Governments, 2006
[6] See UNAIDS, Financing the response to AIDS in low- and middle income countries: International assistance from the G8, European Commission and other donor Governments, 2006. Notes: Bilateral funding includes HIV-earmarked multilateral funding; GFATM contributions adjusted based on grant distribution by disease to date (58% for HIV). Data from 2002 and 2003 do not include Global Fund contributions.

out-of-pocket spending. Donors contributed 6%, and government the remaining 1% (2.5% of total government expenditure). Clearly this was not a sustainable situation, leading to catastrophic health expenditures for people living with HIV.[7]

By 2003, the last NHA exercise, the picture has changed drastically. Total per capita health expenditure was US$ 14 per year, with 15% of total health expenditure spent on AIDS. Donors now account for 74% of total expenditure on AIDS (1/3 of donor spending on health), government 9% (9% of total government expenditure) and households 16%.[8]

The share of household expenditure dropped thanks to donor involvement and price reductions for antiretroviral treatment. The increase in external funding is to a large extent because of the GFATM and PEPFAR. However, the subsequent dependence on external financing for health expenditure on AIDS and the relative neglect of other health problems, such as malaria, have also worried donors and government.

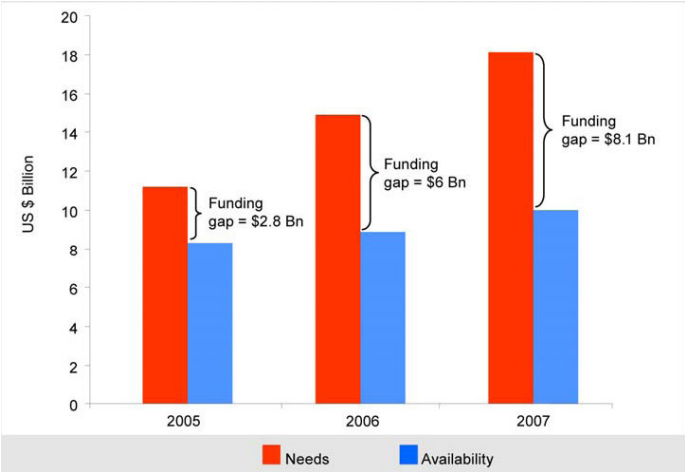
A.2. Financing gap for AIDS

This year UNAIDS estimated that if the scale up of HIV services continues at the same rate, funding needs will reach approximately US$ 15.4 billion in 2010 and US$ 22.5 billion by 2015. This includes costs of HIV prevention (including response to gender inequality and violence), treatment, care and support, also for orphans and vulnerable children, as well as costs of health system strengthening. However, in order to reach the targets of universal access US$ 42.2 billion is required by 2010 and US$ 54 billion by 2015, leading to coverage of antiretroviral therapy to 93% of those in need (assuming treatment starts with symptoms) in 2010. A phased scale-up towards universal access would require fewer resources (US$ 28.4 billion in 2010 rising to US$ 49.5 billion by 2015) and reach 90% coverage of those in need by 2015.[9]

Though the projections of available resources cannot be directly subtracted from the estimations of future resource needs, it is clear that the expected available resources do not match the requirements at a global level (see figure 3).[10] Moreover, the financing gap is expected to increase as, according to the latest Report on the Global AIDS Epidemic by UNAIDS, existing commitments and trends suggest the rate of increase in funding for AIDS may be declining, without declining needs.[11]

Figure 3. Resources available and needed for AIDS (US$ billion)[12]

[7] Schneider P. et al. Rwanda National Health Accounts 1998. 2000. Partnerships for Health Reform Technical Report 53; UNAIDS. 2002. Epidemiological Fact Sheet on HIV/AIDS Rwanda.
[8] Ministry of Health, Republic of Rwanda, National Health Accounts 2003, April 2006. See also, Ministry of Health, Republic of Rwanda, National Health Accounts 2002 with sub-analysis of HIV/AIDS, March 2005
[9] UNAIDS, Financial Resources required to achieve universal access to HIV prevention, treatment, care and support, 2007
[10] The package of services included in the estimations of resource requirements differs substantially from what available resources are being spend on, so that the two are not comparable. UNAIDS, Financial Resources required to achieve universal access to HIV prevention, treatment, care and support, 2007
[11] UNAIDS, 2006 Report on the global AIDS epidemic, May 2006 http://www.unaids.org/en/HIV_data/2006GlobalReport/default.asp
[12] See UNAIDS, Financing the response to AIDS in low- and middle income countries: International assistance from the G8, European Commission and other donor Governments, 2006.



A.3. Additional aid for AIDS?

The next question is whether there really is an increased inflow of total aid, so that the aid for AIDS is additional to other development assistance. Only rarely does an increase in aid flows earmarked to a particular area, such as AIDS, lead to an actual significant increase in the total flows of aid to AIDS-affected countries. More often, donors will re-allocate their aid budget around this priority, reducing aid allocations to other areas in favour of the aid for the earmarked area.

On a global level, in 2006, Official Development Assistance (ODA) actually fell by 5.1% to US$ 103.9 billion, the first fall since 1997. Nevertheless, apart from 2005, this is still the highest level recorded, in a decade long upward trend.[13] However, a lot of the recent increase in ODA has been due to debt relief, which mostly benefited Iraq and Nigeria (US$19 billion).[14] According to IMF and World Bank projections[15], net ODA disbursements are estimated to increase to US$128 billion in 2010, with half of it for Africa. As the debt relief programme finish, this increase in development assistance is expected to benefit core development programs.

It is important to note that aid flows are also notoriously volatile at a country level. Research has shown that aid is about seven times more volatile than other forms of revenue, especially in aid dependent countries and even more so for programme than project aid. Moreover, shortfalls in aid tend to coincide with shortfalls in domestic revenue so that aid is effectively exacerbating financing problems. The same research also shows that aid (project and programme) cannot be reliably predicted on the basis of donor commitments, with a tendency from all parties to overestimate disbursements.[16] Aid for AIDS is no different.

If the increased aid for AIDS is not additional at a country level, it inevitably leads to reduced aid flows for other areas, so that the recipient governments will be required to re-allocate resources around that earmarked commitment. Given that the aid is

[13]OECD press release www.oecd.org/document/17/0,3343,en_2649_33721_38341265_1_1_1_1,00.html

[14] World Bank IDA15, Aid architecture: An overview of the main trends in official development assistance flows, February 2007

[15] World Bank, Global Monitoring Report 2006: Strengthening Mutual Accountability - Aid, Trade and Governance, 2007

[16] See for example, D. Fielding and G. Mavrotas, The Volatility of Aid, WIDER Working Paper 2005/06, or A. Bulir and J. Hamann 'Aid Volatility: An Empirical Assessment', 2003, *IMF Staff Papers*, 50, N. Gemmell, N. and M. McGillivray 'Aid and Tax Instability in the Government Budget Constraints in Developing Countries', 1998, CREDIT Research Paper, 98/1, S. Pallage and M. Robe 'Foreign Aid and the Business Cycle', 2001, *Review of International Economics*, 9: 636-67.

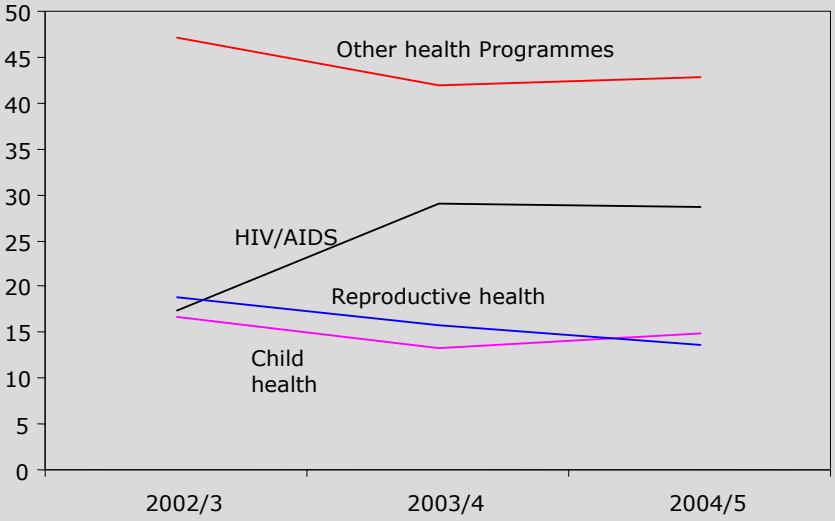
earmarked specifically for AIDS, recipient governments have to devote these resources to AIDS and make up for the shortfalls elsewhere, by cutting expenditure or re-allocating resources. In the best case, this happens as part of the national expenditure planning and budgeting process. However, because donor contributions often follow a different time frame or happen outside of government processes, the re-allocation is difficult to plan. In the worst case, this leads to crowding out of other development priorities. The latest Malawi National Health accounts illustrate this very well.

Box 2

MALAWI:
Increased expenditure for AIDS and allocation of resources

The Malawi National Health Accounts for 2002-2004[17], with sub-analysis on AIDS, is a striking illustration of the way in which increased resources for AIDS risk crowding out other health priorities. Figure 1 shows that while, as a share of total health expenditure AIDS expenditure is clearly increasing, expenditure on child health, reproductive health and other health programmes have been decreasing, even though in Malawi maternal mortality is exceptionally high and has worsened since 1990. In absolute terms, expenditure on all programmes has increased (given an increase in health expenditure from $15 in 2002/03 to $20 in 2003/04), however, this clearly indicates a change in expenditure mix.

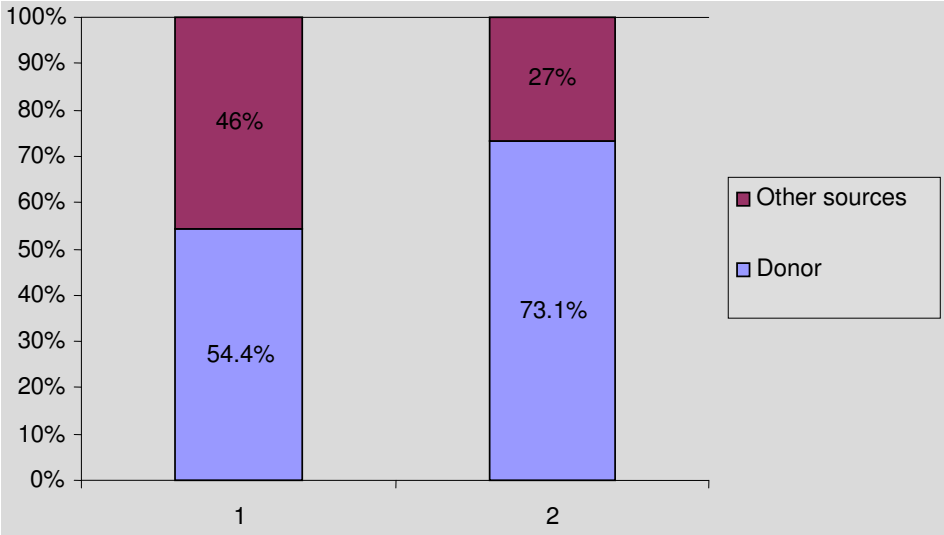
Figure 4: Programme specific health expenditure as % of total health expenditure, 2002/03-2004/05



A change in allocation of resources between programmes might not be an issue in itself, especially if absolute levels of funding do not decrease. However, it is important to note that this re-allocation of resources is based on a strong donor bias for AIDS, the driver of AIDS expenditure in Malawi (see figure 5), rather than government allocation processes. The large increase is mainly through the GFATM, but other bilateral and multilateral donors have also increased their expenditures between 2002 and 2006.

Figure 5: Donor Financing for General Health (excluding AIDS expenditures) and for AIDS Expenditures, 2004/05

[17] Ministry of Health, Government of Malawi. Bethesda, MD, PHRplus, Malawi National Health Accounts (NHA) 2002-2004 With Sub-accounts for HIV and AIDS, Reproductive and Child Health, March 2007, http://www.phrplus.org/Pubs/Malawi_NHA_Report2002-04.pdf



1= Total health financing excl. AIDS
2 = Total HIV/AIDS expenditures

Due to this dependency on donors, this reallocation of resources could be unsustainable. As the authors of the NHA report note: *"The small size of the Malawian economy, and the modest growth expected for the rest of the decade, means that the financing of HIV and AIDS services could severely limit provision of other health care services. A clear understanding of health sector financing must be maintained to ensure HIV and AIDS expenditures do not come at the expense of other health functions."*

Therefore, this process of re-allocating resources around an earmarked priority can only be beneficial to the overall development process if the aid allocations are fit with the wider health sector strategy and national development plan, and national expenditure planning process. Only in that case will the Ministry of Health be able to address other health problems with other sources of financing, and will the national government be able to safeguard other development priorities by allocating total government resources around the earmarked area according to the national development priorities (rather than donors'). This requires careful planning, for which it is necessary that external funding for a particular area is aligned with the national government's expenditure and budget process (even if the funding does not flow through government channels).

A.4. Proliferation of earmarked funding for AIDS

In the last decade, the number of bilateral donors grew from about 5 in the 1940s to more than 56 today. On top of those, there are currently over 230 international organizations, funds and programs. As a result, the average amount of donors per country nearly tripled, from about 12 in the 1960s to about 33 in by 2005.[18]

This trend is particularly pronounced in the health sector, where more than 100 major organizations are active. Moreover, many of these donors provide earmarked aid for AIDS through vertical programmes, which are often based on donor-specific programme development, implementation and/or performance monitoring. There are concerns in country that, despite the contributions of some of this aid, there is poor coordination and thus duplication of efforts, high transaction costs and risk of unsustainable programmes due to variable country ownership and alignment with

[18] World Bank IDA15, Aid architecture: An overview of the main trends in official development assistance flows, February 2007

country processes. For example, a UNAIDS report indicated that, despite the commitments to the "Three Ones", in 40% of countries the National AIDS Strategy is not used as a common framework for donors. Half of the countries reported only low or moderate sharing of monitoring results by international partners.[19] This would imply that the aid for AIDS has become more, but not necessarily better in terms of the lessons on aid effectiveness that donors have been taught during the last decade.

The proliferation of donors and their bias for AIDS programmes calls for a better division of labour between donors; and not only better division of labour within the framework of the National AIDS Strategy, but also within the wider development programme. If some donors address determinants of the AIDS epidemic and its impact indirectly through funding for other effective development programmes (e.g. education, reducing violence against women, small business development…), these donors should be able to claim some credit for the achievements of the national AIDS strategy as well, even if the earmarked funding for AIDS came from other donors.

Commitment to tackling AIDS does not necessarily require earmarked funding for AIDS by each donor individually. The response to AIDS also needs a multisectoral approach with attention to the underlying factors that affect susceptibility and vulnerability of people to HIV infection and the impact of AIDS. AIDS should be mainstreamed in other development programmes, not only to address the impact of the epidemic on the effectiveness of these programmes, but also to monitor the impact of these programmes on the course of the AIDS epidemic.

A.5. Aid effectiveness

Since 2002, a series of high level forums, in Monterrey, Rome, Marrakech and Paris, have led to a specific set of goals and objectives with regards to aid effectiveness. In short, the goal is to impact on transaction costs of development assistance and on the quality of governance (fiscal management and public expenditure choices). Therefore, donors and recipient governments work towards:

- Ownership: recipient-owned development strategies
- Alignment: increased use of national administration systems
- Harmonisation: co-ordinated and predictable donors

Without hesitation, these principles should also be applied to the AIDS response, increasingly so as the response is being scaled-up and moves from an emergency to a more long-term development approach. The proliferation of donors, often with vertical programmes that risk crowding out other development priorities, generating high transaction costs and undermining government structures and health systems (see section B) definitely requires more attention to aid effectiveness. The AIDS response (but other development priorities just as well) would furthermore benefit from international division of labour and aid allocations between countries and sectors; improved conditionality policies and longer term commitments for increased sustainability of the response.[20]

In 2004, UNAIDS launched the "Three Ones" principles, that are closely linked to general aid effectiveness principles. The Three Ones are: one agreed AIDS action framework that provides the basis for coordinating the work of all partners; one national AIDS coordinating authority, with a broad based multi-sector mandate; and

[19] UNAIDS, Effectiveness of multilateral action on AIDS: harmonized support to scaling up the national response. Report for 18th meeting of the UNAIDS Program Coordination board. 2006

[20] Some of this, though not focused on AIDS, is discussed in aid effectiveness literature such as A. Rogerson, Aid Harmonisation and Alignment: Bridging the Gaps between Reality and the Paris Reform Agenda, 2005, Development Policy Review, 23.5 and many others.

one agreed country-level monitoring and evaluation system. This also includes a tool to address harmonization and alignment challenges by assessing the strength and effectiveness of national partnerships in the AIDS response (CHAT), recently developed by UNAIDS and the World Bank.[21] According to a recent evaluation, these principles have been applied in country, though donor-specific operational systems and the fact that many donors do not participate does hinder further process.[22]

However, recipient governments and donors need to realise that in the short and medium term there will still be limitations to achieving the aid effectiveness goals, especially with regards to longer term, predictable funding. On the donor side, legislation, national budget and expenditure frameworks, shifting national priorities and so on will continue to limit the ability to pre-commit for the longer term.[23] For example, even though some donors increasingly engage in 10 year bilateral agreements (e.g. "Development Partnerships"), most often these do not include financial commitments. Therefore, recipient governments need to deal practically and realistically with certain level of unpredictable and volatile aid (for example by discounting donor commitments or protecting specific expenditure areas).[24,25] And donors will have to accept that this might not always lead to most effective use of aid (e.g. saving aid, short term planning as discussed below).

There has been some talk of an AIDS Fund to ensure that AIDS expenditure programmes would not fall below a certain pre-defined limit.[26] This mirrors the discussion on a broader Aid Guarantee Facility for official development assistance and will be confronted with the same political constraints.[27,28] An AIDS Fund can only be recommended if it does not crowd out other priorities. As said before, prioritising programmes and safeguarding expenditure in certain areas can only be sustainable if it is part of the overall government budget process, i.e. compared to other priority areas and handled according to aid effectiveness principles.

Multilateral funding is thought to be at least more predictable and longer term than bilateral funding. Global Funds, such as the GFATM, are often seen as potential candidates for delivering more predictable, longer term aid.[29] The Global Fund for Vaccines (GAVI), for example, is able to make financial commitments for 10 years. Because these funds base disbursements on performance-based indicators rather than political conditions, the pattern of disbursement volatility is at least different than that of bilateral and multilateral donors. On the other hand, there remain serious problems with regards to harmonization and alignment of Global Funds. However, the case of the GFATM in Mozambique is often used to illustrate the possibility of harmonizing and aligning with government structures.

Box 4

MOZAMBIQUE:

[21] http://data.unaids.org/pub/Report/2007/jc1321_chat_en.pdf?preview=true
[22] Attawell and Dickson, An independent assessment of progress on the implementation of the global task team recommendations in support of the national AIDS responses, 2007, HLSP
[23] A. Bulir and A. Hamann, 2005, Volatility of development aid: from the frying pan into the fire?" IMF
[24] See for example presentation by M. Foster, 2005 to the High level Forum on the Health MDGs, http://www.hlfhealthmdgs.org/HLFPresenationsIII/MickFoster.ppt
[25] See also IMF paper on flexible pre-commitment, which is revised only with substantial deviation of performance (measured by CPIA scores). B. Eifert and A. Gelb, Coping with aid volatility, Sept 2005, Finance & Development, 42-3
[26] E.g. Lewis, A War Chest for Fighting HIV/AIDS, 2005, Finance & Development 42-4
[27] M. Foster, 2005 to the High level Forum on the Health MDGs, http://www.hlfhealthmdgs.org/HLFPresenationsIII/MickFoster.ppt
[28] B. Eifert and A. Gelb, Coping with aid volatility, Sept 2005, Finance & Development, 42-3.
[29] Of course, debt relief is to date the most predictable way of increasing resources for development, once countries have reached HIPC completion point.

Sector-wide approaches and the GFATM

The GFATM has been criticized for creating parallel decision-making processes, which risk undermining the national response to AIDS and hindering a more integrated approach to health. However, there are also country examples of how the GFATM, though focused on AIDS, can be integrated with the wider health sector strategy and join other donors in their alignment efforts. Success varies, depending on country conditions.

In Mozambique, for example, the GFATM has been relatively successful at fitting in with country systems.[30] Here the GFATM agreed to use the health sector budget as the signal of government commitment to the three priority diseases, rather than using its own tracking system. Despite the fact that the Government's monitoring arrangements were still under development, the GFATM decided to use the national monitoring and reporting system in the hope of strengthening these by their support. This attitude influenced other development partners to join the pooled funding for the National AIDS Programme. Moreover, the GFATM's involvement in the SWAp also encouraged broader civil society engagement in health policy making and encouraged a stronger focus on rigorous monitoring of results. Nevertheless, challenges remain, for example for aligning the GFATM's funding rounds with government's expenditure planning process.

B. Sustainability of the AIDS response

The debate around fiscal sustainability of large aid inflows for AIDS covers quite a few different issues. One that has grabbed the attention of economists and non-economists alike has been the impact of increased aid on macroeconomic stability. Though evidence is mixed, governments have been cautious (B.1). As the AIDS response evolves away from importing drugs for treatment to more demand on domestic goods and services, the issue of external funding for recurrent expenditures (e.g. human resources for health) gains importance as well (B.2). Moreover, there is also some concern with regards to in country capacity to manage increased aid flows and implement the donor-funded AIDS programmes. Increased aid for AIDS should certainly not reduce the attention to the quality of spending (B.3). [31]

B.1. Large aid inflows and macroeconomic stability

Over the past few years several papers have discussed the macroeconomic impact of scaling-up aid. Generally, these studies conclude that *if* the aid is well spent and planned, macroeconomic instability (often referred to as 'Dutch Disease') can be avoided. The ultimate impact of aid will depend on how much the initial negative impact (inflation, exchange rate appreciation) can be mitigated in the short run by coordinated monetary and fiscal policy, and be compensated in the longer term by the positive impact of the investments made with the aid. The critical issue is that the increased spending should be focused on public investment, and complemented with

[30] C. Dickinson et al The Global Fund operating in a SWAp through a common fund : issues and lessons from Mozambique, 2007, HLSP Policy Brief

[31] It is important to beware of the fact that most of the increased aid for AIDS does not imply larger fiscal space (ability of government to raise spending without compromising longer term financial position), because a large share of the increased aid is not received by governments but rather by the private sector in both developing and developed countries. However, even if aid is not spent through government structures and in country, it can still have macroeconomic implications.

import of capital goods, both aimed at improving productivity and domestic supply of domestic goods and services.[32]

The macroeconomic consequences of increased aid have been studied in several countries. The IMF has studied Ethiopia, Ghana, Uganda, Mozambique, Tanzania, while the Overseas Development Institute (ODI) looked at Mauritania and Sierra Leone as well as Mozambique and Tanzania.[33]

The evidence of "Dutch Disease" as a result of increased aid flows is mixed, and where it is spotted, e.g. in Uganda, the studies seem to indicate that the phenomenon is probably short-lived and can be overcome in the long term.[34] This, however, requires more attention to improving productivity, and relieving supply-side and other constraints on (export) growth. Nevertheless, all studies recommend handling aid flows cautiously.

In practice, many recipient governments (e.g. Uganda, Ethiopia) have indeed been careful and limited their use of aid inflows out of fear for macroeconomic instability, unsustainable fiscal positions and limited capacity. Governments have responded by either saving aid (restricted budget deficit) or limiting the use of foreign exchange (increase foreign exchange reserves) [35], which is arguably a suboptimal use of aid, seen to hinder scaling-up of the AIDS response.

The role of the IMF in developing such apparently conservative macroeconomic frameworks has been the topic of fierce discussions in country (e.g. Uganda, Zambia) and globally.[36,37] Even though ultimately governments are responsible for the national expenditure planning and macroeconomic policy, the IMF has an important role to play in exploring ways of increasing the flexibility of the fiscal envelope, weighing the potential long term benefits of increased aid flows against the short term costs, and signalling about the risks of national policies.

In response to the critics, the IMF has stressed its flexibility, e.g. with regards to inflation targets or safeguarding expenditure in social sectors.[38] Nevertheless, country

[32] Following IMF publications, the terms "spending" and "absorbing" aid are currently being used. The former refers to the domestic government expenditure and the latter to the use of the foreign exchange by which the aid arrived in the country via the central bank.
[33] Country case studies by the Overseas Development Institute, UK, are summarized in Foster and Killick, What would doubling aid do for macroeconomic management in Africa?, 2006, ODI WP 264. The country case studies by the IMF described in S. Aiyar, A. Berg, M. Hussain, The Macroeconomic Challenge of More Aid, 2005, Finance & Development, 42-3 and S. Gupta, et al, Macroeconomic Challenges of Scaling Up Aid to Africa, 2005, IMF Working Paper.
[34] For example, on Dutch Disease in Uganda, see Heller and Gupta, (2002) "Challenges in Expanding Development Assistance", IMF Policy Discussion Paper, 02/5; Adam and Bevan, (2002) "Aid, Public Expenditure, and Dutch Disease" CSAE Working Paper 2003-02 and IMF (2004) Working Paper 04/49 March 2004 "Aid and Dutch Disease in low income countries", March 2004
[35] See footnote 30.
[36] See for example For IMF response see e.g. Dawson, T, "A Response to ActionAid International and Other Organizations", Sept 2004, http://www.imf.org/external/np/vc/2004/093004.htm
[37] UNDP has also entered the discussion on fiscal space for scaling-up towards the MDGs. See: conference on "Gearing Macroeconomic Policies to Reverse the HIV/AIDS Epidemic", 2006, with papers by Terry McKinley, Why is 'the Dutch Disease' always a disease? The Macroeconomic consequences of scaling up ODA", Nov 2005, Working Paper 10 and A. Chowdhury and T. McKinley, Gearing macroeconomic policies to manage large inflows of ODA: the implications for HIV/AIDS programmes, May 2006, Working Paper 17. See also UNDP e-discussion forum on Securing fiscal space for the MDGs www.undp.org/poverty/e-discussions/fiscalspace
[38] For example, the IMF's practitioners' checklist on macroeconomic challenges of scaling up aid to Africa suggests that inflation rates below 5% may not be appropriate because it leaves economies vulnerable to shocks. S. Gupta, R. Powell, and Y. Yan, Macroeconomic challenges of scaling up aid to Africa: a checklist for practitioners, 2006. See also an interesting paper on how inflation targets might not be a central issue by D. Goldsbrough, E. Adovor, and B. Elberger,

case studies on the impact of IMF-supported programmes on the health sector in Mozambique, Rwanda[39] and Zambia show wide variation in signals that IMF sends at country-level, not always being that transparent and pro-active in discussing its policy advice and the rational behind it.[40] However, these reports also recommend that other development partners facilitate macroeconomic policy-making by strengthening national priority-setting processes and budgetary planning; improving predictability of aid and making longer-term commitments, i.e. improve aid effectiveness (see above).

Nevertheless, a cautious approach might be particularly important in the face of increased aid flows for AIDS, as the response to AIDS is different to other, more traditional areas of aid expenditure. These differences might increase the risk of Dutch Disease-like macroeconomic instability:

a. With a reduction in prices for antiretroviral treatments, the import component of AIDS programmes has been reduced;
b. Moreover, there is a limit to what the domestic economy can absorb of imports without experience demand-effects (e.g. in transport industry, health care workers required to handle the imported goods);
c. As the response to AIDS is being scaled up, AIDS programmes increasingly draw on scarce domestic goods and services, in a health system with limited spare capacity, which has an effect on prices;
d. Though multisectoral, AIDS programmes are biased towards the social sectors as education and health rather than "productive" sectors such as infrastructure. Though it can certainly be argued that investments in education and health also impact on the productive capacity of an economy, this happens indirectly and in the longer run.[41]

It is therefore crucial that increased aid for AIDS also addresses supply-side issues and creates additional productive capacity. For example, if aid is directed at the efficiency of the health sector (e.g. training of health workers and improving management efficiency in the health sector), increased service delivery can be achieved with less inflationary impact (compared to for example, merely supplementing salaries). Moreover, if the improved service delivery raises the health status of the population, e.g. by expanding the coverage of antiretroviral treatment, the increased overall productivity of the population is expected to enhance economic development in the longer term, which would counteract initial negative impacts of the aid.

This requires placing the AIDS response within the wider national development plan. The aim is positive interaction between the AIDS response and the real economy. On the one hand, the economic stability of a country, affecting poverty and development, will impact on the course of the AIDS epidemic. On the other hand, the effectiveness of the aid for the AIDS response, improving the health status of the country, will support further social and economic development.

Box 8

Inflation Targets in IMF-Supported Programs, March 2007, CGDev Working Group on IMF Programs and Health Expenditures.

[39] D. Goldsbrough, T. Leeming, K. Christiansen IMF Programs and health spending: Case study of Rwanda, 2007, CGDev Working Group on IMF Programs and Health Expenditures.

[40] P. de Renzio, D. Goldsbrough, IMF Programs and health spending: Case study of Mozambique, 2007 / D. Goldsbrough, T. Leeming, K. Christiansen IMF Programs and health spending: Case study of Rwanda, 2007 / D. Goldsbrough, C. Cheelo, IMF Programs and health spending: Case study of Zambia, 2007, all part off CGDev Working Group on IMF Programs and Health Expenditures. http://www.cgdev.org/section/initiatives/_active/ghprn/workinggroups/imf

[41] There has been a general trend in official development assistance shifting from infrastructure and production to ODA for social sectors, particularly in Sub-Saharan Africa, where the social sector ODA now accounts for 60 percent of all sector allocable ODA. See World Bank IDA15, Aid architecture: An overview of the main trends in official development assistance flows, February 2007.

Rwanda
Macroeconomic framework and increased aid for AIDS

According to recent estimates, net aid disbursements in Rwanda amount to about 16% of GDP in 2007. Aid (on-budget) finances about half of public expenditures (32% of GDP) and also nearly half of all imports (33% of GDP in February 2007).[42] Though not exceptional when compared to some other African countries, these figures do imply a fair degree of aid dependency and the need to handle aid carefully.

As a result, the Government of Rwanda and donor positions on Rwanda's case for scaling up have not been fully aligned. While the Government is convinced of its ability to scale-up, donors have had concerns about capacity and aid absorption.[43] Therefore, the Rwandan Ministry of Finance and Economic Planning commissioned work on "Managing risks associated with aid increases in Rwanda" (financed by UK Department for International Development DFID).[44] The objective was to inform the Government of Rwanda, the Central Bank and other development partners about the macro-economic and other risks associated with increases in aid and to provide advice on how these risks can be mitigated.

According to the authors, the rapid increase in aid since 2003 (up to over 18% of GDP by 2005) did pose some challenges for macroeconomic policy, real exchange rate appreciation and risk of inflation or suppression of private sector credit growth due to higher government expenditure. The fact that only 54% of the increased aid was channeled through government surely did not help government manage the increased aid.

However, the paper also suggest that if the planned macroeconomic framework of the EDPRS (Rwandan national development plan) is realized, Rwanda should not face problems with spending and absorbing the projected aid between 2007 and 2012. Nevertheless, this remains a challenge and macroeconomic variables need to be monitored carefully. The consultants recommend that the Government of Rwanda facilitates the absorption of the aid (e.g. through financial deepening); carefully identifies financing needs and directs resources towards those (e.g. revived MTEF, priority funding areas); and that government is selective in accepting aid (e.g. assessing opportunity costs of aid with large local cost components). Government is recommended to lead donors to finance the priorities of the national development plan, which requires donors to align with the government programme and budget process, and allowing the government of Rwanda to offset the over-commitment to health (23% of total donor spending). Moreover, donors can contribute, for example through predictable timing of disbursements, alignment with government priorities and addressing operational bottlenecks.[45]

Aid for AIDS was not explicitly mentioned in this report or the terms of reference. As discussed, the risks of aid increases definitely apply to increases in aid for AIDS. However, though the aid for AIDS in Rwanda is certainly disproportional compared to other development priorities, on a macro-economic level, aid for AIDS by itself is not expected to increase risks beyond what can be managed by sound macroeconomic and fiscal policy.

[42] IMF data quoted in M. Foster and P. Heller, Managing the Risks Associated with Aid Increases in Rwanda: Initial Background Note, 2007.
[43] See also D. Goldsbrough, T. Leeming, K. Christiansen IMF Programs and health spending: Case study of Rwanda, 2007, CGDev Working Group on IMF Programs and Health Expenditures.
[44] M. Foster and P. Heller, Managing the risks associated with aid increases in Rwanda, 2007, Republic of Rwanda, Ministry of Finance and Economic Planning
[45] M. Foster and P. Heller, Managing the risks associated with aid increases in Rwanda, 2007, Republic of Rwanda, Ministry of Finance and Economic Planning

B.2. Recurrent expenditure: Human Resources for Health and AIDS treatment

As mentioned above, one particular aspect of increased aid for AIDS is the growing attention to human resources for health required to avoid diminishing returns to scaling-up the response to AIDS. External funding for human resources for health (HRH), will have an economic impact, given the scarcity of these resources in most developing countries, which can not be lifted easily or quickly, and the need for continuous funding.

Higher aggregated demand for domestic goods and services based on increased external financing for AIDS will inevitably also affect the goods and services in the health sector. If the health care labour market were market-led, the remuneration of health care workers (at least of a specific skills level) would certainly have increased significantly due to rapidly increasing demand for AIDS treatment and care and an inherently slower supply reaction (due to training needs over several years).

Even without such labour markets, it is clear that HRH need to be expanded in order to scale-up the response to AIDS without crowding out other health interventions. Both governments and donors are considering salary improvements as one of the options. This involves some risks with regards to economic stability:

- First, managing the overall government wage bill is an important component of governments' expenditure planning. It is very difficult to contain wage bill increases to one sector of the civil service only. However, in practice priority sectors such as health and education are often excluded from restrictions on the government's wage bill.
- Secondly, even if increased expenditure on HRH is a sound investment required for scaling up the response to AIDS, it does lead to significant recurrent costs. Recurrent expenditure financed by aid risks locking governments into spending commitments, that need to be fulfilled even if the aid inflow turns out to be temporary (whether or not the aid is in the form of earmarked funding for HRH or budget support).
- Therefore, governments will find it hard to commit to such long term commitments unless there is some degree of certainty that the external financing for these investments is permanent and predictable, so that in the long term the increase in recurrent costs remains affordable.

However, salary increases for health sector personnel is only one of many ways to improve the health sector response to AIDS and other options might be less inflationary. For example, improved working conditions, safety, better management and career opportunities, availability of treatment and in-kind salary supplements such as housing, are important factors for attracting and retaining health care personnel. Human resources for health can also be enhanced through improved geographical distribution, more cost-effective skills mix and better training and supervision. Upward pressure on the wages can also be counteracted by investments in expanding the capacity of the health sector, such as improvements in efficiency of current resources, training of new personnel and temporarily hiring (foreign) labour.

To ensure the investments in human resources for health are sustainable and will not crowd out other necessary expenditures, HRH plans need to be costed and prioritised carefully within the overall Health Sector strategy, with attention to country-specific needs and sector budgeting process. Moreover, the HRH plans need to be part of the wider government civil service reform programme, including pay policies and human resource planning, to ensure the investments are sustainable and affordable for the national government in the longer run (even without the same amounts of donor funding).

Malawi's Emergency Human Resource Programme offers an interesting case study on donor involvement with HRH in order to scale-up the response to AIDS.

Box 5

Malawi
Emergency Human Resource Plan

Currently the levels of staffing in Malawi are low even by African standards, with 2 physicians for 100,000 people, compared to 22 physicians for the same population in the AFRO region. There are 59 nurses and midwifes for 100,000 people in Malawi, while there are 117 for this population in the AFRO region as a whole.[46] The reasons for the lack of staff are insufficient training and staffing, AIDS-related attrition, and increasing numbers of staff moving out of the public sector (due to low pay, working conditions).[47]

Increased aid for AIDS through the GFATM and other pooled donors enabled the Government of Malawi to scale-up antiretroviral treatment. However, given the limited capacity of the health sector, this also risks diverting scarce resources, such as health care staff, from elsewhere in the health sector. Therefore, 2004, the government of Malawi launched a programme to deliver an Essential Health Package, which includes AIDS treatment and care, as part of a sector-wide approach. Donors provided a significant contribution to the Emergency Human Resources Plan, which underlies the implementation of this Essential Health Package.

The Emergency Human Resource Plan is a six-year programme, costed at US$ 272 million, funded to a large extent by the Government of Malawi, GFATM and DFID. This plan will be used to expand training capacity by 50% on average, address re-allocation with 'hardship incentives' and increase salaries of 11 key health cadres by 52% (taxed) in order to reduce the push factor into other jobs and overseas. While more health care workers are being trained, the programme also provides for temporary recruitment of volunteers. The Ministry of Health will address non-financial factors that determine retention and performance such as promotion policies, gender issues and quality of housing.[48]

Though the salary increases were actually a forwarding of planned pay reforms for the Malawi government as a whole, the Ministry of Finance (as well as other civil servants and the IMF) has now accepted the resulting salary differential for the health sector. Because the salary increases are currently only affordable with external funding, leaving the government of Malawi very vulnerable to aid shocks, DFID has committed itself to giving two years notice of plans to reduce its contribution to the salary support. [49] Nevertheless, even if support would be withdrawn with two years notice, it would still force the Government of Malawi to make some difficult expenditure choices as the commitment to increased salaries is difficult to exit from, thus inevitably crowding out other health priorities.

Antiretroviral treatment is another example of recurrent expenditure with high donor involvement. According to the WHO, by December 2006, between 1.8 to 2.2 million people living with HIV were receiving treatment in low- and middle-income countries, representing only 28% of the estimated 7.1 million people in need. Together, GFATM

[46] WHO Afro, African Health Workforce Observatory, HRH Fact Sheet Malawi, 2006
[47] Debbie Palmer, Tackling Malawi's Human Resource Crisis, Reproductive Health Matters, 2006, 14(27)
[48] For more information, see also Debbie Palmer, Tackling Malawi's Human Resource Crisis, Reproductive Health Matters, 2006, 14(27)
[49] Programme Memorandum DFID, Improving health in Malawi £100 million (2005/6 -2010/11) A Sector Wide Approach including Essential Health Package and Emergency Human Resource Programme" November 2004

and PEPFRAR, the two main international actors in the field of AIDS treatment provided support to programmes that covered 1,265,000 people in total.[50]

Increased resources, decreasing drug prices and simplified treatment regimes provided the opportunity to scale up national AIDS treatment and care responses.[51] The benefits of expanding treatment are believed to be large given the direct contributions to GDP of people who would otherwise have been ill and died prematurely, leaving behind both the young and the elderly, with subsequent loss of social capital. Treatment does not only benefit people living with HIV but also their families and the health staff working with these patients. Moreover, scaling up treatment and prevention together is expected to reinforce each other's effectiveness and success. A macroeconomic simulation for South Africa indicated that the negative effect of the AIDS epidemic on the economy can be reduced by the impact of a scaled-up ART programme on the health of the labour force.[52]

Nevertheless, the case for second and even third line treatment needs to be ascertained given that the infrastructure for providing treatment is still weak and inequitable and that these follow-up treatments are much more expensive and require more intense safety monitoring.[53,54] Given the generally weak capacity to scale-up treatment programmes, initiating such programmes with external funding risks extracting scarce financial and human resources from other parts of the health sector. With limited resources, moving to second line treatment could reduce the available resources for improving the efficacy and expanding coverage of first line treatment. Moreover, most governments are unable to finance these programmes from domestic revenues, so that as soon as external funding for AIDS declines, other expenditures in the field of AIDS and the broader health programme will be crowded out (see box 6). Or, even worse, expenditure for AIDS treatment will fall on patients. These risks need to be considered carefully (including financial sustainability[55]) and compared to the expected cost savings due to the availability of second-line treatment on a country-by-country basis.

Box 6

Malawi

[50] WHO, Towards universal access: scaling up priority HIV/AIDS interventions in the health sector : progress report, 2007. www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf

[51] The Global Price Reporting Mechanism for Antiretroviral Drugs at WHO shows that, depending on the regimen, the prices of most first-line antiretroviral drugs decreased by between 37% and 53% in low- and middle-income countries from 2003 to 2006.

[52] Bureau for Economic Research, The macroeconomic impact of HIV/AIDS under alternative intervention scenarios (with specific reference to ART) on the South African economy, 2006. www.ber.sun.ac.za/downloads/2006/aids/Final%20Aids%20Report_Jun06.pdf

[53] See for example the debate in India, where government was reluctant to introduce second-line treatment. DFID India supported the production of a discussion paper on this issue by the Indian Network for People Living with HIV/AIDS (INP+), India and second-line ART. Evaluating the way forward, 2007. This paper argues that it is possible for government to provide second-line treatment, but relies heavily on expected price reductions, production of generic drugs and donor funding, without addressing the sustainability of such funding.

[54] Médecins sans Frontières has recently initiated a "Second line crisis" campaign in which they stress the effectiveness of second line ART in resource-poor settings as well as the high costs, even for middle-income countries such as Thailand. See: http://www.msf.org/msfinternational/invoke.cfm?objectid=65D58C38-15C5-F00A-25DE21CB571D3E0E&component=toolkit.article&method=full_html. Also mentioned in the UNAIDS, 2006 Report on the Global AIDS Epidemic.

[55] This could be similar to the Financial Sustainability Plans (FSP) of the GAVI Alliance, however, such plans need to be made as part of the decision-making process rather than after the decision has been made to implement treatment programmes. Such plans need to be integrated with the broader health sector budget and national expenditure planning processes.

Resource requirements for antiretroviral treatment

The National Health Accounts 2002-2004 note with some concern the resource requirements for AIDS relative to the burden of disease. The authors quote a study, which estimated that by 2010 Malawi could be using 6.5% of GDP for AIDS-related health services up from 4.3% in 2000.[56]

This is based on a very modest coverage assumption of 10 % of people living with AIDS being given antiretroviral treatment (up from about 4% in 2005, or 18% of people living with AIDS in need), with a cost per patient per year of US$28.50 for palliative care, US$36 for the prevention of opportunistic infections, US$359 for the clinical treatment of opportunistic infections, US$1,400 for ART drugs, and US$600 for ART supporting inputs (e.g. monitoring).

The NHA therefore recommends maintaining a good understanding of health sector financing to ensure AIDS expenditures do not crowd out other health functions.[57]

B.3 Institutional capacity and health system strengthening

Literature on aid effectiveness has raised concerns about the existence of a threshold after which aid ceases to be effective, somewhere between 25% and 50% of GDP. Though on average low income countries received aid of only 2.9% of the total Gross National Income (GNI) in 2005 (Sub-Saharan Africa 5.5%), some countries have much higher aid to GNI ratios (e.g. Rwanda 27%, Malawi 28%, Burundi 47%).[58]

The above sections already discussed limits to increased aid flows for AIDS because of adverse macroeconomic ('Dutch Disease') or fiscal (unsustainable government programme) impact. However, there might also be limitations to the amount of increased aid flows that the public and private sector can manage and use effectively and efficiently. This could be called "institutional capacity", covering both management and implementation capacity and the impact of aid on public and private institutions in the recipient country. This capacity is very country-specific, depending on e.g. the national institutions, governance systems, public/private mix and the scale and kind of aid in a country.

The capacity of government to implement AIDS programmes will depend on the overall effectiveness of the public sector, which goes beyond human resources. The institutional capacity in countries that receive increased aid for AIDS will benefit from interventions that increase the overall effectiveness and efficiency of development programmes in general e.g. reform of public sector pay and employment structures, improved private-public mix, investments in public expenditure management, monitoring and evaluation. Again, even though investments in these areas are not earmarked for AIDS, they can be expected to have an important positive effect on the effectiveness of the AIDS response in country.

The private sector, both for profit and not-for profit, plays an important role in the national capacity to deliver AIDS-related services and to monitor the effectiveness of the AIDS response in country. In many countries, patients are already dependent on

[56] Ministry of Health, Government of Malawi. Bethesda, MD, PHRplus, Malawi National Health Accounts (NHA) 2002-2004 With Sub-accounts for HIV and AIDS, Reproductive and Child Health, March 2007, http://www.phrplus.org/Pubs/Malawi_NHA_Report2002-04.pdf

[57] International Monetary Fund. (2003) The Impact of HIV/AIDS on the Malawian Economy. Working Paper. Lilongwe, Malawi in Ministry of Health, Government of Malawi. Bethesda, MD, PHRplus, Malawi National Health Accounts (NHA) 2002-2004 With Sub-accounts for HIV and AIDS, Reproductive and Child Health, March 2007

[58] World Bank (2007) World Development Indicators 2007, Table 6.11 Aid Dependency

the private sector due to limited capacity of public health care, which has implications for the equity of the AIDS response. In the case of particularly fragile or failed states, there might even be a cause for working directly with the private sector as long as they work within the national AIDS and health sector plan. In the short term, implementation and management capacity is constrained in the private sector as well, especially in the context of AIDS, which depletes the available capacity, including knowledge and experience to deal with its adverse impact. It is important not to overwhelm the private sector but build its capacity over time.

In many developing countries, public administrative institutions that are expected to manage the increased aid flows are weak. In this context, large volumes of aid expose more opportunities for rent seeking and corruption. Though this concern is not particular about the field of AIDS, as governments increasingly depend on external aid flows, country ownership of the AIDS response might be reduced when programmes are determined by donor priorities and accountability systems become directed at donors rather than citizens. Moreover, increased external resources also risk reducing efforts to mobilise domestic resources for the AIDS response (e.g. public revenue and national savings).[59] The way in which aid is delivered is clearly an important determinant of country capacity to effectively use aid.

Reduced competition for financial resources for AIDS programmes could lower the incentives to prioritise interventions and generate best value for money from aid-funded programmes.[60] To date, national AIDS Strategies offer a wish-list of possible interventions with only limited background on the costs, effectiveness and resource requirements for the implementation of these strategies.[61] However, for the sustainability of the response, it is essential to understand financial implications (including opportunity costs) and anticipate demands on the budget given different possible financing options, including reductions in external aid. Moreover, when discussing the cost-effectiveness of AIDS-related interventions as an input for the prioritisation process, it is important to go beyond the health effects (e.g. disability-adjusted life years) to also include socio-economic and longer term impacts as well as the linkages between interventions.

The estimation of resource requirements should also cover the investments in infrastructure required to support the AIDS interventions. With regards to scaling-up the AIDS response, the capacity of the health sector and strength of the health system is fundamental. Initially, it was hoped that expanding the health sector response to AIDS, especially the provision of ART, would strengthen the overall health systems, by attracting financial resources, improving capacity of health care workers and investments in health infrastructure, such as laboratories.

However, increasingly concerns are being voiced about the way in which AIDS programmes risk undermining the health systems rather than strengthening them by creating parallel structures, placing a heavy burden on the scarce resources available in the health sector, without taking a longer term and sector wide approach to AIDS. There has even been talk about a health-system-tax on aid earmarked for AIDS. However, this has not been picked up for obvious reasons, such as administrative

[59] Terry McKinley, Why is 'the Dutch Disease' always a disease? The Macroeconomic consequences of scaling up ODA", Nov 2005, UNDP International Poverty Centre, Working Paper 10

[60] See also Foster and Killick, What would doubling aid do for macroeconomic management in Africa?, 2006, ODI WP 264.

[61] See Mullen, Review of National HIV/AIDS Strategies for Countries Participating in the World Bank's Africa Multi-Country AIDS Program (MAP), 2005, World Bank and also the very interesting article by Ainsworth and Teokul, Breaking the silence: setting realistic priorities for AIDS control in less-developed countries, 2002, Lancet 356

costs and the bias of certain donors towards funding for AIDS.[62] At least what is required is coordination or integration of the health sector component of the national AIDS Strategy with the Health Sector Strategy. Ideally this would also be reflected in the way in which donors channel aid for AIDS and support implementation of health sector AIDS programmes (see Box 7).

After being criticised for neglect of health system underlying the response to AIDS, TB and Malaria, the GFATM has increased its attention to health system strengthening. In Round 5 of the application process a health system strengthening (HSS) component was added (less than 1% of the total funding, for Malawi, Rwanda and Cambodia). For Round 6 it was decided that the health system strengthening should be integrated into the disease-specific components. The effect of this funding still needs to be seen. Box 7 provides some information on the impact of the GFATM on health system strengthening in Malawi.

Box 7

Malawi
Health system strengthening and the Global Fund

Since round 5 of the GFATM application process, Malawi has received support for health system strengthening. According to a recent evaluation of the system-wide effects of GFATM financing in Malawi, there have been different types of effects, both weakening and strengthening aspects of the health system. [63]

The Health Sector Strengthening component in Malawi is integrated with the human resource component of the Health Sector SWAp, the Emergency Human Resource Programme (see box 5), which is expected to improve the sustainability of the activities and relieve some pressure on the scarce human resources due to the implementation of programmes financed by the GFATM. However, the AIDS component of GFATM is channelled through the pool for the National AIDS Committee, which risks undermining the health sector response to AIDS due to lack of coordination and harmonisation. It might be more sustainable to integrate the funding for the health sector response to AIDS with the health sector-wide approach.

Moreover, in Malawi, as elsewhere, the way in which the GFATM's Country Coordination Mechanism involves the private sector and civil society is seen to have a positive effect on the health sector policy environment. However, GFATM resources are said to have lead to rapid growth of new non-governmental organisations, which are often not able to deliver sufficient quality of services.[64]

[62] E.g. Lewis, Addressing the Challenge of HIV/AIDS: Macroeconomic, Fiscal and Institutional Issues. 2005, CGDev Working Paper 58
[63] The System-wide effects of the Fund (SWEF) is a collaborative research network that studies the direct and indirect effects on the health system by the Global Fund in country http://www.phrplus.org/swef.php
[64] See Mtonya and Chizimbi, Systemwide effects of the Global Fund in Malawi: final report, 2006

C. Conclusions and recommendations

1. The increased aid for AIDS experienced in the past few years creates a unique opportunity to move from the emergency response towards a sustainable, longer term, developmental approach to AIDS. There has been a three-fold increase in development assistance for AIDS since 2002, reaching US$ 5.6 billion in 2005. Nevertheless, UNAIDS estimates that there is still a financing gap of about US$ 6 billion in 2006 (see section A).

2. However, as aid for AIDS increases, there is growing concern about the sustainability of large aid inflows for AIDS and their impact on the macroeconomy of recipient countries. Evidence of macroeconomic instability due to aid (e.g. 'Dutch Disease') is mixed. In a lot of countries the aid for AIDS does actually not amount to significant additional aid, but rather replaces aid in other sectors. Where aid for AIDS is additional and significant, recipient governments should be able to manage its impact through careful planning and coordination of fiscal and monetary policy. Moreover, if aid is well managed and effectively spent, the returns to aid (e.g. improvements to productivity thanks to improved health status of a country) should offset the short-term, negative effects, and enhance economic growth and development in the longer term. However, the way in which aid is delivered, especially the alignment with government processes and predictability of aid, is a crucial factor determining the risk of macroeconomic destabilisation due to aid.

3. Given the renowned volatility and unpredictability of external funding, some caution is warranted nevertheless, especially because there are some characteristics of the AIDS response that increase the risk of instability. For example:

- There has been a proliferation of actors in the field of AIDS, often funding disease-specific, vertical programmes that are not always aligned with government expenditure processes and thus difficult to acknowledge in macroeconomic an fiscal planning;
- AIDS programmes increasingly draw on scarce domestic goods and services, in a health system with limited spare capacity. There is also a limit to what the domestic economy can absorb of imports without experience demand-effects;
- Moreover, as the AIDS response evolves away from importing drugs for treatment to more demand on domestic goods and services, the sustainability of external funding for recurrent expenditures (e.g. human resources for health) needs to be considered carefully.

4. In this context, the following points are worth stressing:

- *The seems to be limited risk of macroeconomic instability due to increased aid for AIDS, though this depends to a large extent on the way in which aid is delivered:* The risk of macroeconomic instability due to increased aid for AIDS needs to be assessed on country-by-country basis. There are certain characteristics of the AIDS response and aid for AIDS that warrant some caution. Where aid for AIDS is additional and significant, recipient governments should be able to manage its impact through careful planning and coordination of fiscal and monetary policy. However, donor cooperation, in the form of transparency and predictability of aid, alignment to national development plans and budget processes and implementing effective programs, is a prerequisite for avoiding macroeconomic instability.
- *It is important that all donors adhere to aid effectiveness ("Paris") principles in the field of AIDS:* Lessons learned over the past decade with regards to development and aid effectiveness urgently need to be applied to the field of AIDS. This includes commitment to more predictable, longer-term aid, harmonization between donors, alignment with government processes and a

better division of labour between donors. Not only in order to avoid macroeconomic instability due to large increases in aid for AIDS but also to ensure a sustainable, longer term approach that is part of the wider development agenda of the recipient country.

- *Increased aid for AIDS should not address AIDS in isolation but invest in strengthening the supporting health system and building capacity:* In order to sustain the health response to AIDS in the longer run, health systems in affected countries need to be strengthened. Capacity limitations (not just in health sector) should not be a reason for not investing aid, but rather for investing differently. Careful assessment of existing administrative and implementation capacity of both the private and the public sector is necessary in order to ensure that increased aid builds rather than overwhelms what there is available.
- *AIDS should be addressed, directly and indirectly, through the overall national development agenda:* In order to avoid crowding out of other (health and) development priorities, ensure sustainability of the AIDS response and benefit from the interaction between the AIDS epidemic, AIDS response and economic development, AIDS needs to be placed within the wider development programme. On the one hand, the economic stability of a country, affecting poverty and development, will impact on the course of the AIDS epidemic. On the other hand, the effectiveness of the AIDS response, improving the health status of the country, will support further social and economic development. Efforts by donors and governments in these areas, even if not directly addressing AIDS, will nevertheless have a potentially large positive influence on the AIDS epidemic and its impact on individuals, households and socio-economic environment.

5. Malawi, Rwanda and Mozambique provide good illustrations of the way in which governments and donors can deal with increased aid for AIDS in country:

- In *Malawi* the AIDS response is facilitated by donor support for a sector-wide approach for health, e.g. through funding for an Emergency Human Resources Programme with longer term financial commitments.
- In *Rwanda*, the donor division of labour is addressed by complementing the strong bias towards the health sector response to AIDS with investments in other sectors, e.g. the education sector, and by building the capacity of the National AIDS Committee. The government of Rwanda and its partners also benefited from a study on managing the risks of increased aid, which concluded the risks are manageable.
- *Mozambique* illustrates work on aid effectiveness, alignment and harmonisation, in the field of AIDS with the integration of a disease-specific aid instrument like the Global Fund for AIDS, TB and Malaria in the wider health sector programme.