Macroeconomic Policy Impacts on the Fight Against HIV/AIDS in Malawi

AFRODAD

Preface

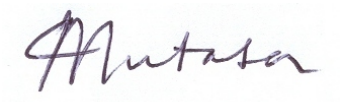
AIDS was declared an economic development crisis by the World Bank in 2000. It is been estimated that per capita growth in some of the countries in sub-Saharan Africa has fallen by 0.5%-1.2% each year as a direct result of AIDS. By 2010, per capita GDP in some of the hardest-hit countries may drop by 8%. Health care systems in many countries have also been overwhelmed by growing numbers of HIV/AIDS patients.

The Millennium Development Goal (MDG) 6 calls for the halting and reversing of the spread of HIV/AIDS by 2015, while Goal 8 on global partnership, especially the need for financing development are the basis upon which Goal 6 can become a reality. More often than not the costs and value addition of combating the HIV pandemic are underestimated, although the great question of what to prioritize between reducing human misery and enhancing economic growth has been on the table for some time. Ironically developing countries (which have more than 90% of the World population who are HIV positive) are the most affected by the pandemic yet they have fewer resources to combat the disease.

It is now an open secret that IMF policies regulating macroeconomic and monetary policies undermine developing nations' ability to social services delivery and spending. Despite many promises for reform each year, the relevant policy documents from the IMF continue to prioritize overly conservative stability conditionalities over pro-poor and development policies, including investments in health and education sectors critical to the creation and preservation of human capital. This has thus hindered universal access to HIV treatment, care and prevention in most developing countries especially in Sub-Saharan Africa.

The IMF role as gatekeeper and its signalling role to other donors when countries miss certain targets of the macroeconomic conditionalities have not only exacerbated poverty and suffering but has in a way denied many people access to health- HIV treatment and care. There is basically no logic in funding the access to HIV treatment especially availing anti-retroviral (ARVs) and other related drugs in situations where proper and future counselling due to inadequate health personnel is not available to ensure proper guides in the use of the drugs. Thus, there is need for the Bretton woods institutions to revisit their macroeconomic policies in developing countries if sustainable development is to be achieved. This is mandatory especially with issues such as the wage ceilings put on recipient governments, restrictive foreign exchange reserves, mounting domestic debt among many others.

Studies conducted by AFRODAD, including this one demonstrate that safeguarding macroeconomic growth and stability at the expense of halting HIV/AIDS has been disastrous for poor countries as this further exacerbates macroeconomic instability. The pandemic is a huge threat to human well-being and debating economic growth is of secondary importance in this regard. The HIV/AID pandemic is an urgent human tragedy that demands immediate and concerted response from all stakeholders in all societies. The Bretton Woods institutions need to move with caution, exercise flexibility and not restrict the policy space for policy makers in developing countries. Abandoning the usual insatiable hunger for macroeconomic stability 'at all cost' and removing conditionalities will mean that the Bank and Fund will not stand in the way of developing countries' efforts to combat the disease. Concentrating investments in capacity development-increase personnel and better remuneration should be a priority for any HIV/AIDS strategy in developing countries especially in Sub-Saharan Africa.



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List of Acronyms/Abbreviations

AIDS	Acquired Immune-Deficiency Syndrome
ART	Anti-Retroviral Therapy
CIDA	Canadian International Development Agency
DFID	Department for International Development Agency
GOM	Government of Malawi
GBS	General Budget Support
GFTAM	The Global Fund to Fight Tuberculosis, AIDS and Malaria
HIPC	Highly Indebted Poor Countries
HIV	Human Immune-Virus
IDA	International Development Association
IFI	International Financing Institution
IMF	International Monetary Fund
MDG	Millennium Development Goals
MGDS	Malawi Growth and Development Strategy
MEGS	Malawi Economic Growth Strategy
MOH	Ministry of Health
NAC	National AIDS Commission
NAF	National HIV and AIDS Action Framework
NSF	National Strategic Framework
ODA	Official Development Assistance
OPC	Office of the President and Cabinet
OVC	Orphans and Other Vulnerable Children
PLWHA	People Living with HIV and AIDS
SWAp	Sector Wide Approaches
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
WHO	World Health Organisation

Executive Summary

Since Independence in 1964, external assistance has financed most of the Government of Malawi's (GoM) development strategy. The proportion of net aid as a percentage of GDP has historically hovered between 20 and 30%. Despite the dependency on foreign assistance, fears of experiencing Dutch Disease symptoms, which include the appreciation of the local currency as a result of fiscal deficit spending, are unsubstantiated. Malawi has experienced commendable results in as far as those macroeconomic indicators are concerned. The economy has stabilised with falling rates of inflation and a stable exchange rate.

The appealing macroeconomic indicators notwithstanding, rates of HIV/AIDS prevalence remain at an alarming level. Malawi has the sixth highest HIV prevalence rate in the world. In 2005, 14.1 percent of adults aged between 15 and 49 were infected with the virus that causes AIDS, with, on average, 78,000 deaths per year from HIV-relates illnesses.

The broad objective of the study is to provide evidence of the interaction between macroeconomic fundamentals, social spending and the fight against HIV/AIDS and examining the shared policy space is shared between International Financial Institutions, the GoM and its citizens by 1) reviewing the major channels through which fiscal and monetary policies impact on public expenditure frameworks and how this, in turn, affect the ability of the GoM to design public programmes concerning those living with and affected by HIV/AIDS and 2) performing an assessment of the debt positions and aid management of the case studies to see how the HIV/AIDS has impacted on their financial portfolios and planning abilities or vice-versa.

Key Observations

Malawi has recognized in its MGDS that HIV/AIDS is a multi-faceted problem, which requires a multi-sectoral approach. As a result, it has included projects such as rehabilitation of roads, water, health facilities, and communications as part of the strategy to curb the spread the pandemic.

The Government of Malawi has budgeted for the fight against HIV/AIDS in its National Action Framework (2005 2009) and again for the higher Universal Access targets (2006 2011). The NAF has a funding shortfall of US$277.6 million, which was financed via borrowing. The UA budget has only received commitments for 30% of total resources required; leaving a gap of $US633 million.

Existing aid modalities in Malawi include the Global Fund, debt relief, pool funding, grants, and debt-financing. There appears to be no empirical link between ODA, fiscal spending and inflation in Malawi.

Malawi is currently under a PRGF arrangement, which has a number of benchmarks and targets that must be met. The following have been determined to have adverse affects on the country's fight against HIV/AIDS:

- The floor on net foreign assets promoted borrowing on Malawi's part in order to meet it, as evidenced by the increase in domestic debt. It also resulted in a delay of disbursement of funds from the Pool Fund, as other development partners preferred to have the funds in commercial banks rather than at the Reserve Bank.
- The ceiling on government wages/salaries is far below what is specified in the MGDS as being necessary to combating HIV/AIDS.
- The ceiling on domestic debt is not in alignment with the ceiling on central government expenditures. It essentially reduces the options of the GoM to address the finance gap of the NAF and UA.
  There is pressure from the IMF to re-organise its utility companies on a for-profit structure contrary to the observations made in the MGDS, which is that the lack of these basic amenities has contributed to the pandemic. Further, in order to carry out the improved provision of these essential services, Malawi has taken IDA and IBRD loans.
- Though the IMF expressed concern over Malawi's absorptive capacity, its loans to Malawi have increase 16%.

1 Introduction and Background

Since Independence in 1964, external assistance has financed most of the Government of Malawi's (GoM) development strategy. The proportion of net aid as a percentage of GDP has historically hovered between 20 and 30%(1). In the 2006/07 budget, official development assistance (ODA) accounted for 80% of planned expenditures and 45% of total resources available to the government. The main donors of Malawi are DFID, EU, World Bank and Norway; in order of the level of support. DFID accounts for 28% of total ODA, with 16.7% in the form of grants. The EU accounted for 20% of total ODA to Malawi, though 53.6% of it was in the form of project support (AFRODAD, 2007). The predictability of aid from the main partners is discussed in a later section.

Despite the dependency on foreign assistance, fears of contracting the famous Dutch Disease, which is the appreciation of the local currency as a result of fiscal deficit spending, are unsubstantiated. Malawi has experienced commendable results in as far as those macroeconomic indicators are concerned. The economy has stabilised with falling rates of inflation and a stable exchange rate. Economic growth has picked up amidst famine and hunger, though it has intermittently compromised the good performance. All this is happening in the context of increasing official development assistance (ODA), particularly directed towards health services and the HIV/AIDS pandemic.

1.1 Extent and Depth of HIV/AIDS Pandemic in Malawi

The appealing macroeconomic indicators notwithstanding, rates of HIV/AIDS prevalence remain at an alarming level. The first AIDS-related case in Malawi was diagnosed in 1985. Since then HIV and AIDS has continued to have a devastating impact on individuals, families, communities and the nation. Malawi has the sixth highest HIV prevalence rate in the world. In 2005, 14.1 percent of adults aged between 15 and 49 were infected with the virus that causes AIDS. The number of HIV-infected adults in Malawi is 940,000 (2005); increased from 900,000 in 2003 (Walters, 2007). The number of people on free ARVs is said to have increased from 4,500 in 2003 to 100,000 in June 2007, but this is only 20% of those infected, according to UNAIDS. Considering that the number of people on ARVs worldwide is estimated at 700,000, Malawi ranks high on the number of infected people on treatment. There are on average 78,000 deaths per year from HIV-relates illnesses (UNAIDS). By the end of 2010, about 233,675 persons would be in need of ART. In 2005, about 87,000 people died of HIV and AIDS related illnesses. AIDS deaths have directly resulted into orphan-hood, which in 2005 was estimated to be at 501,963 maternal/paternal and dual orphans. Overall, the country is estimated to have slightly over a million orphans (National AIDS Commission, 2007). HIV/AIDS was declared a national disaster in Malawi, as it has had very devastating consequences on the social fabric and the economy.

The compromised productive potential of the country notwithstanding, AIDS has also resulted in key public sector institutions including health, education and home affairs facing a huge human resource crisis. For example, there has been a high teacher attrition rate in the education sector between 1999 and 2005. Over 6,000 teachers are estimated to have died of HIV and AIDS related conditions in the specified period (National AIDS Commission, 2007).

The Ministry of Health is the main supplier of health services in Malawi, and accounts for 64% of all formal and allopathic health facilities (World Bank, 2004a). The other main supplier of health services is the Christian Health Association of Malawi (CHAM), which manages approximately 26% of the facilities, operates on a not-for profit basis and receives a subsidy from the government. There is a relatively small formal private sector offering a limited range of health services primarily in urban areas, and the use of traditional healers and traditional birth attendants continues. The government provides core health services, defined as the Essential Health Package (EHP), to all citizens free of charge, though the use of CHAM facilities incurs a small fee. Access to health facilities is good, with 84% of people being within 5 kilometres radius of a health facility. The constraint is with geographical coverage but the provision of services. A survey in 2003 of Malawi health facilities revealed that while the structures exist, only 10% were able to provide the Essential health Package (Mangham, 2007).

1.2 Research Objectives and Methodology

The broad objective of the study is to provide evidence of the interaction between macroeconomic fundamentals, social spending and the fight against HIV/AIDS and examining the shared policy space is shared between International Financial Institutions, the GoM and its citizens. The specific objectives are:

- To review the major channels through which fiscal and monetary policies impact on public expenditure frameworks and how this, in turn, affect the ability of the GoM to design public programmes concerning

(1) African Development Indicators, World Bank

those living with and affected by HIV/AIDS.

- To perform an assessment of the debt position and aid management of Malawi to see how the HIV/AIDS has impacted on their financial portfolios and planning abilities or vice-versa.
- To assess the linkages between IFIs economic policy conditionalities vis-à-vis the fight against HIV/AIDS in Malawi and to recommend changes to those conditionalities and ways of doing business that would enable the GoM to implement its programmes.

In conducting this study, a review of literature was carried out on the subject of study and other related topics. Sources of the material used include official documents by government, donors, academia and civil society. Documentation on Malawi's PRGF programme as well as Staff Working Papers of the IMF was reviewed to understand the arrangement between the IMF and Malawi. In addition, key officials in the key ministries and Persons Living with HIV and AIDS (PLWHA) have been interviewed in order to establish the impact of macro-economic policies on the state of public services, especially health services.

This report looks at the experience of Malawi in the fight against HIV/AIDS in the context of its relationship with external partners. What follows is a description of the national strategy and institutions involved in the fight against HIV/AIDS, and the financial resources required for Malawi to achieve targets. There is some analysis of donor arrangements and programmes that are targeted. There is a discussion on the link between increased aid and macroeconomic stability and the evidence available for Malawi. There is a review of Malawi's current Poverty Growth and Reduction Facility arrangement, Malawi's growing debt stock and consequences of such on fiscal space.

2 National Strategy to Fight Hiv/aids

In its first Poverty Reduction Strategy Paper (PRSP), the GoM presented HIV and AIDS as a crosscutting issue, discussing the effects of HIV/AIDS on growth, poverty and productivity. UNAIDS was also in agreement stating that national policies for reducing poverty and spurring development will also limit the spread and impact of HIV, such as better access to health care and treatment for AIDS, and to education (including out-of-school children); increased rural and urban productivity; and improved legal rights and participation for women. In 1999/2000 Malawi developed a National Strategic Framework (NSF) for HIV/AIDS covering the period to 2004. The NSF was succeeded by the National Action Framework (NAF) which is essentially a comprehensive, multi-sectoral national response to HIV/AIDS for the period 2005 2009.

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). The NAC was established in 2001, replacing the National AIDS Control Programme that was under the Ministry of Health (MOH), NAC was established in 2001 as a public trust to provide leadership and coordination of the National Response to HIV/AIDS in Malawi. From 2003, Government introduced a Department of Nutrition and HIV/AIDS within the Office of the President and NAC falls under that department.

Malawi has a second generation PRSP called the Malawi Growth and Development Strategy (MGDS) that guides the economic policies and strategies. The MGDS recognizes that the most vulnerable and most likely to suffer from the impact of AIDS are the poor.

It is a social problem because of its negative consequences on the communities and social structures. It is a cultural issue because some cultural practices and beliefs fuel the spread of the disease and mask positive traits of the system while encouraging stigma, discrimination and denial. It is a political problem because a sick person will not contribute to the political development of the country. It is a health issue because it affects directly a large number of people and the health-care system itself or fabrics of society. HIV and AIDS is an economic issue as it leads to reduction in economic growth by reducing the productivity of the labour force and drains investment resources in all sectors. HIV and AIDS is a development issue because it affects negatively all sectors of the economy (MGDS, 2006).

Hence, the MGDS includes as part of its fight against HIV/AIDS projects such as improving infrastructure (roads, water, health buildings, water, communications and medical equipment).

There is a strong linkage between the MGDS and the NAF. The key HIV and AIDS activities and outputs in the MGDS are based on the NAF. This implies that through financing of the NAF, the MGDS HIV and AIDS outputs are automatically achieved.

2.1 HIV/AIDS within the Context of MGDS

The MGDS recognizes that human development is important if the country is to achieve its economic growth and development agenda. In addition, Malawi seeks to achieve and sustain MDGs which are also long-term targets and aspirations for the people of this country. As such, building a healthy, educated and gender sensitive population is a priority for Malawi (MGDS, 2006). Indeed the documents cites challenges to containing the spread of HIV/AIDS, which include hunger and poverty and causes individuals to become more vulnerable to infection; inadequate supply of Anti-retrovirals (ARVs) and access to nutritious diets; low levels of education; limited institutional capacity; deep-rooted harmful socio-cultural values and practices, beliefs and traditions and poor coordination amongst the service providers.

The strategy outlined in the MGDS cuts across a number of sectors and requires the participation and expertise from various ministries like Gender, Education, and Health. etc.). The proposed activities include reducing absenteeism, increasing net enrolment and reducing drop-out rates to equip students with basic knowledge and skills to enable them to function as competent and productive citizens. It also aims to reduce gender inequalities.

Malawi has recognised that poverty and HIV and AIDS are reciprocally influenced. Despite coordinated efforts the country still faces a number of challenges in containing the spread and impact of HIV and AIDS on development. The HIV and AIDS pandemic has compounded the dual burden of malnutrition and disease. It therefore does not see tackling HIV and AIDS problems alone as a lasting solution. As such, Government advocates the need for addressing

issues of HIV and AIDS and nutrition as a package, which it hopes will translate into increased knowledge of the interaction between nutrition and HIV and AIDS; improved and diversified dietary practices for people living with HIV and AIDS; and increased provision of HIV and AIDS-related nutrition interventions.

Among the strategies outlined in the MGDS to specifically contain and eventually eradicate the HIV/AIDS pandemic are activities directed both towards treatment and prevention. They include:

- Improving knowledge and capacity of young people, orphans, the elderly and physically challenged and other vulnerable groups to practice safer sexual intercourse and increase their access to HIV testing and counselling; and behaviour change
- Initiating and strengthening joint planning, monitoring and evaluation processes among national authorities, stakeholders and development partners
- Implementing and increasing equitable access to ARVs and treatment of opportunistic infections
- Building and strengthening the capacity of public and private organizations to mainstream HIV and AIDS into their core businesses and Building capacity at all levels in the national response to HIV and AIDS with special focus for local service delivery.
- Promoting high quality community home-based care services, adequate nutrition, including provision of nutrition therapy for people living with HIV and AIDS (PLHA) and drafting, enacting and enforcing HIV and AIDS legislation
- Expanding services for prevention of mother to child transmission, testing and counselling, access to condoms, STI management, and access to behaviour change communication
- Integrating the elderly, orphans and the physically challenged affected by HIV and AIDS into the mainstream development
- Promoting adequate nutrition, including provision of nutrition therapy that cover assessment, counselling, education and demonstration, supplementary feeding, therapeutic feeding, referral to health facility and production of high nutritive value foods for a nutritious diet to HIV and AIDS individuals
- Improving the provision of support and protection of the infected and affected groups

Table 2.1 MGDS Key Priority Areas, by percent of total

Year	2006/07	2007/08	2008/09	2009/10	2010/11	Total
Agriculture and Food Security	18.48	16.3	9.5	9.3	10.4	12.82
Irrigation and Water Development	1.9	6.5	14.0	15.0	5.5	8.7
Transport/Infrastructure Development	53.7	51.5	52.4	52.4	59.8	53.7
Energy Generation and Supply	5.9	4.9	2.2	1.9	3.0	3.6
Integrated Rural Development	8.5	9.2	11.5	11.2	9.9	10.1
Nutrition/HIV/AIDS	**12.0**	**11.6**	**10.4**	**10.3**	**11.4**	**11.1**
Total	100.0	100.0	100.0	100.0	100.0	100.0

Assumption: Govt will contribute 10% of HIV and AIDS resources prevention and management costs. Source: MGDS, 2006.

Table 2.2 Annual Budget Allocations to Nutrition/HIV/AIDS

Year	Allocations (Malawi Kwacha)	Human Resource Requirements (presently at 16,647)
2006/07	2,006,982,544	6,500
2007/08	2,053,817,559	23,922
2008/09	1,852,383,499	48,393
2009/10	1,824,925,059	97,900
2010/11	1,750,136,161	198,051
Total	**9,488,244,820**	400,657

Source: MGDS, 2006

Among the medium term goals listed, as a multi-faceted approach to fighting AIDS, are intentions to work with ministries like that of Water Development to enhance water supplies and sanitation technologies; Roads to target areas where access to medical facilities is difficult, and Energy to extend electricity services. Lastly, the MGDS identifies the incremental human resource requirements necessary for carrying out all of these activities.

2.2 UNAIDS Universal Access Initiative

In accordance with what was discussed in Gleneagles in 2005, UNAIDS has set guidelines for countries to assist them in determining national targets for moving towards universal access. The idea behind it being that the provision of HIV/AIDS services should be made available to all those in need. The targets should not be aimed at achieving universal coverage, nor should they be done in isolation of the other Millennium Development Goals.

Malawi began setting targets within this context immediately after the consultative processes of the National Action Framework for 2005 2009. According to the Government of Malawi (2006), the universal access targets were more ambitious. The targets for the NAF were to be elevated via a steering committee and sub-groups working on the areas of prevention, treatment and impact mitigation.

The process of doing so revealed challenges in achieving certain targets, which included:

- The lack of the legal and regulatory frameworks essential to ensure non-discrimination and protection of the rights of people living with HIV and AIDS and special groups

Although the national policy on HIV and AIDS explicitly addresses the promotion and protection of the rights of PLHA and other vulnerable groups, enforcement of the existing laws has been a major problem. Malawi, therefore, still lacks the legal and regulatory frameworks essential to ensure non-discrimination and to protect the rights of people living with HIV and AIDS and special groups, such as MSM, CSW and OVCs.

To address this situation, a comprehensive legislative review was undertaken and a number of statues are currently being reviewed. In the meantime, NAC will continue to collaborate with legal and human rights institutions to develop the appropriate operational frameworks and to build capacity in the institutions responsible for enforcement and public education. Specifically, it was found that the Public Health Act being too old and hence the need for revision to incorporate new developments in area of HIV and AIDS. Key funding partners such as Global Fund, UN Agencies and US Government having not yet joined the Pool Funding.

There has been remarkable degree of harmonization among stakeholders and donors in the HIV and AIDS sector in Malawi. However, there remains the following harmonization agenda to be addressed within the balance of 2006: a) expansion of the existing MOU of poolfunding donors to include other key players such as Global Fund, UN agencies, the USG and others; b) the Global Fund to begin subscribing to the pool-funding mechanism as a pool-donor; c) an evaluation of the value-added to having a standalone Country Coordinating Committee for Global Fund; d) utilization of the NAC-led joint annual reviews as donors' primary evaluation hence, basis for their fund releases for the interventions being financed; and e) utilization of the newly launched Malawi Partnership Forum as a mechanism for 360-degrees accountability among all stakeholders in the HIV and AIDS sector, including international development partners and NGOs (National AIDS Commission, 2007). These challenges are significant, as one-third of net ODA to

The modalities of disbursing aid are evolving. More aid is now delivered off-budget in Malawi. This has its own advantages and disadvantages. Civil society organisations are applauding such developments as they have always been advocating for an all inclusive approach. However, the inclusiveness is only partial because the CSOs are rarely involved at the policy formulation stage. The result is that some donors are disbursing directly to the CSOs without sharing the information to the authorities. This causes some problems in the implementation of fiscal and monetary policies.

The national response to HIV and AIDS in Malawi is financed from both domestic and external sources. The bulk of the financing for HIV/AIDS activities is obtained from grants from external donors such as the Global Fund, UNDP, CDC and AfDB, the Kingdom of Norway, CIDA, DfID and the World Bank. Domestically the Malawi Government and out-of-pocket expenditures also provides the resources for HIV/AIDS expenditures. The detailed sources of current financing sources are provided below.

Some development partners in Malawi have committed to aligning their development assistance to the country planning cycles. For instance, under the United Nations Development Assistance Framework (UNDAF), UN institutions in Malawi are committed to coordinating and aligning their development assistance to the National Planning processes. Furthermore, by containing the spread of the HIV epidemic in the country, this will contribute to reduced morbidity and mortality in the long term.

According to the National AIDS Commission, of the total resources committed, the Global Fund has 37%; GoM has 29%, UN agencies with 22% and bilateral donors, 14%.

3.1 Global Fund

The Malawi Proposal for the Round 1 HIV/AIDS Grant amounting to US$196.0 million was approved in July 2002 for a 5 year period to 2008. The GF had initially committed US$41.8 million to Malawi for Phase 1 of the grant for a period of two years ending 2005. The Phase 1 grant was fully disbursed by December 2005 and Phase 2 of the HIV/AIDS grant amounting to US$136.9 million was signed in August 2006 for a period of two years to September 2008. The overall grant was reduced by almost US$17.0 million due to the re-costing of the budget and delay in signing Phase 2 grant which meant that unabsorbed funds from Phase 1 amounting to US$5.19 million were carried over to the next grant but counted against the overall grant. As at June 2007, a total of US$38.0 million has been disbursed under Phase 2.

In addition, Malawi was also awarded a Round 5 HIV/AIDS and OVC grant of US$19.0 million in September 2006 for the 5 years ending 2011. The Phase 1 of this grant amounting to US$7.7 million ends in 2008 and to date only US$1.98 million has been disbursed under this grant.

A total of US$41.2 million has been transferred directly from Global Fund to UNICEF Supply Division in Copenhagen, Denmark, for the procurement of ARVs and other health products. These transfers have been made between April 2004 and February 2007. Under the HIV/AIDS grant a total of US$90.6 million is expected to be spent offshore for drug supplies and out of this amount a total of US$41.2 million has already been spent. The remaining difference of US$49.4 million will be utilized between June 2007 and September 2008 which is the terminal date for the grant. It is therefore worthwhile to note that a substantial amount of HIV/AIDS related foreign funding will be used to buy health products abroad and these products will just be transferred to Malawi. The money spent off-shore do not This is unlikely to have a significant inflationary pressure or excessive real exchange rate appreciation from such spending.

Currently the Malawi has submitted a Round 7 proposal with a budget cap of US$35.0 million over the next 5 years. In addition, Malawi has recently qualified for the Rolling Continuation Channel (RCC) whereby the Global Fund has committed to support the Round 1 HIV/AIDS Grant for a further 5-year period from 2008 without considering a fresh proposal.

Traditionally in Malawi, external financing was through funds ear-marked from both bilateral and multilateral donors, and it was channelled through a range of implementers, including the GoM. In 2003, a grant agreement with the Global Fund was signed for an allocation of $196 million over 5 years. It was ear-marked for specific activities, though 65% was allocated specifically towards ARV Therapy. The NAC was the principal recipient. In 2006, another agreement was reached for a grant of $85 million, with an emphasis on strengthening the health system and orphans. PriceWaterhouse Coopers facilitates the disbursement on behalf of the fund. The Global Fund is a discrete donor; it is not harmonized with other donors under the Health SWAP and HIV pool-funding.

Malawi currently passes to NGOs (IMF, 2007).

- Critical shortage of human resources
- Untimely disbursement of funds to local level implementers
- The existence of separate reporting and accounting mechanisms for major funding initiatives.

The additional consultations for Universal Access therefore offered an opportunity for the country to revisit the national targets contained in NAF to ensure maximum coverage and positive forward looking ambition regarding targets. In March 2006 the three sub-groups mentioned earlier came up with Universal Access indicators and targets (Government of Malawi, 2006). The NAF has thus been re-costed to ascertain the resource requirements in the context of universal access targets of UNAIDS and MGDS. The current budget of the NAF therefore goes beyond 2009 to 2011 to accommodate both universal access and MGDS targets.

3 Financing the Fight Against HIV/AIDS

The GoM constructed a budget corresponding to the main themes, targets, and specified activities of the MGDS. Table 3.1 outlines the expectations of Malawi with respect to income and expenditures for the relevant years.

Table 3.1 National Budget Framework (as % of GDP)

Year	2004/05	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11
Total Revenue and Grants	38.8	43.5	39.7	38.5	37.3	38.5	38.5
Revenue	24.8	24.6	24.4	25.6	24.0	25.0	25.0
Tax Revenue	21.8	21.5	21.4	21.3	21.2	21.3	21.3
Grants	14.0	18.9	15.3	14.3	13.3	13.5	13.5
Total Expenditures	42.9	44.7	40.6	39.2	38.4	39.5	39.5
Current Expenditures	32.2	31.9	28.6	27.3	26.4	27.5	27.5
Capital Expenditures	10.4	12.8	12.0	11.9	12.0	12.0	12.0
Overall Balance	-4.1	-1.3	-0.9	-0.7	-1.1	-1.0	-1.0
Nominal GDP	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Source: Ministry of Economic Planning and Development

The budget process follows the Medium Term Expenditure Framework (MTEF), and all activities budgeted by the sectors are aligned to the ones that are in the MGDS. For HIV and AIDS activities, the policy is that each ministry allocates 2 percent of its recurrent PRSP budget allocation. NAC provides the ministries with the resources for supporting mainstreaming of HIV and AIDS.

Malawi needs an estimated amount of US$619.6 million to finance HIV and AIDS interventions between 2005 and 2009 in order to meet national targets in the NAF. Because Malawi embraced the UNAIDS initiative of Universal Access, which runs until 2011, the total cost estimate is US$1.16 billion. The cost implications for each of the priority areas, prevention, care and treatment is detailed in Table 3.2.

Table 3.2 Cost Summary of National HIV and AIDS Action Framework (NAF) and Universal Access

PRIORITY AREA	NAF (2005-2009)		UNIVERSAL ACCESS (2006-2011)	
	Total Cost US$	%	Total Cost US$	%
Prevention and Behaviour Change	245,317,196	39.6	397,972,383	34.1
Treatment Care and Support	205,285,840	33.1	534,001,410	45.8
Impact Mitigation (Socio-economic and Psychosocial)	102,574,830	16.6	165,483,100	14.2
Mainstreaming, Partnerships and Capacity Building	8,957,740	1.4	7,332,070	0.6
Research and Development	21,740,620	3.5	30,280,240	2.6
Monitoring and Evaluation	17,764,090	2.9	14,960,600	1.3
Resource Mobilization and Utilization	1,669,750	0.3	1,029,300	0.1
National Policy Coordination and Programme Planning	16,338,600	2.6	15,071,855	1.3
GRAND TOTAL	**619,648,666**	**100.0**	**1,166,130,958**	**100**

A further break-down of the annual cost implications of each priority area may be found in Appendix 1.

3.2 Pool-Funding

There is a parallel scheme of four donors CIDA, DFID, Norway and World Bank formed in 2003. It sought to harmonize financial procedures to support implementation of multi-sectoral programme, managed by NAC. Seventy-two ($72) million was allocated between the years 2003 and 2008. Eighty (80%) percent of the funds were to be channelled to implementing partners in the public sector, private sector, civil service and community groups.

3.3 Debt Relief

Malawi qualified for HIPC Debt Relief (August 2006) as well as the MDRI with a top-up. There are two possible ways of delivering debt relief. The first is one where the savings realised from the debt relief are pumped into the budget and made available for expenditure (above the line) immediately. The second methodology releases no savings in the immediate but the debt relief is calculated by lessening the amortisation (below the line) which reduces the amount of principal and interest that would otherwise have been due in the future.

Where most of the debt relief due in the current year is used for retiring domestic debt, as was the case in Malawi, the consequences on fiscal and monetary policy are different.

Table 3.3 Debt Relief, millions Malawi Kwacha

Year	2002/03	2003/04	2004/05	2005/06	2006/07
HIPC Debt relief	3588	5261	5078	7041	5078
MDRI (IMF)	0	0	0	0	3685

Source: IMF, 2007

IMF MDRI debt relief commenced in that year with $13.2 million; with 20.7 in 2007, and projected 8.3 and 6.4 in 2008 and 2009 (IMF, 2007).

3.4 International Financing Institution (IFI) Grants

The World Bank has approved a grant of US$35.0 million for a Multi-sectoral AIDS Program (MAP) for a period from 2003 - 2008. These funds are disbursed directly to NAC and, as at June 2007, the sum of US$26.7 million had been disbursed by the Bank.

3.5 Bilateral Grants

3.5.1 Kingdom of Norway

Norway committed a total of US$10.0 million over a 5 year period from 2003- 2008. As at June 2007, the total committed funds had been disbursed to NAC. Meanwhile, negotiations are underway to secure continued follow on funding from Norway that is expected to remain at the level of US$2.1 million annually for the next five years.

3.5.2 Department for International Development (DfID)

Out of the committed sum of US$7.2 million for the period from 2003 2008, DfID had disbursed the whole amount by May 2007. Meanwhile, negotiations are underway to secure continued follow on funding from DfID estimated at US$8.8 million annually for the period from 2006 2011 to align the funding to the MGDS. In addition, DFID also provides a substantial financial support to the Health Sector through SWAp and a significant proportion of these funds are earmarked for general Health Sector Strengthening activities that directly benefits HIV and AIDS interventions.
In a parallel programme, the GoM has planned to increase the salary of health workers under the Emergency human Resource Programme, between 2004 2010 to recruit, retain and train staff. DFID has offered to support the programme by donating US$100 million (IRIN, 2007).

3.5.3 The Canadian International Development Agency (CIDA)

CIDA had committed the sum of US$10.0 million for the period from 2003 2008 which has almost been disbursed to NAC as at June 2007. Again, a new financing agreement is being negotiated to cover the period to 2011.

3.5.4 Centers for Disease Control (CDC) and Prevention of the US Government

An estimated amount of US$2.0 million was committed under this Cooperative Agreement for the period from 2002

2006. Under this agreement, a total of US$1.7 million has been disbursed to Malawi. A new agreement effective October 2006 will make available to Malawi annual grants of US$300, 000 for the next 5 years. However, to date no funds have yet been drawn down due to low absorptive capacity of the carry-over funding from the previous grant. Although Malawi is not among the fifteen beneficiary countries of the United States President's Emergency Plan for AIDS Relief (PEPFAR), the US Government through USAID and CDC is providing substantial funding to the national response. The USAID is providing support for PMTCT, programmes supporting

abstinence and being faithful, condom promotion and blood safety. In 2006, the total expenditure on these programmes was about US$ 6 million and projections for 2007 are expected to be of about the same magnitude of funding. In addition, USAID is funding some international and local Non-Governmental Organizations including some organizations working with young people such as Population Services International (PSI), and Save the Children (USA).

3.6 Deficit Financing

The Government of Malawi (GoM) has committed a total of US$10.0 million to be disbursed in yearly instalments of US$2.0 million from 2003 - 2008. As at June 2007, GoM had disbursed the Malawi Kwacha equivalent of US$6.7 million. It is expected that GOM will continue funding the National Response to HIV/AIDS beyond 2008 as part of its continued commitment to the Pooled Funding mechanism. In addition, HIV and AIDS activities for each ministry are allocated 2 percent of the ORT budget allocation.

3.7 The Finance Gap

The existing and projected financing gap of the national HIV/AIDS response is difficult to estimate precisely because most development partners commit funding on an annual basis depending on appropriation from their governments. In addition, some external development assistance is channelled directly to the implementing partners especially NGOs and is not captured by the national resource tracking systems.

The resource requirements for implementing the NAF (2005-09) 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 GoM financed via borrowing. A discussion of the loans, foreign and domestic, incurred follows in Chapter 6.

The funding gap becomes wider in the context of the 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 UA.

Table 3.4 Donor Commitments to the NAF/UA, millions USD

Source	2005	2006	2007	2008	2009	Totals
Bilaterals						
USAID	10.04	12.05	12.05	12.05	12.05	58.24
CDC	3.59	3.96	3.96	3.96	3.96	19.43
Norway	2.1	2.1	2.1	2.1	2.1	10.50
CIDA	1.6	1.6	1.6	1.6	N/A	6.40
DFID	1.8	1.8	1.8	1.8	N/A	7.20
JICA	0.16	0.31	0.26	N/A	N/A	0.73
EU	N/A	N/A	N/A	N/A	N/A	--
Rep. China (T)	N/A	N/A	N/A	N/A	N/A	--
Sub-total	*19.29*	*21.82*	*21.77*	*21.51*	*18.11*	*102.50*
UNITED Nations						
WB*	12.70	12.70	12.70	9.22	2.220	49.54
WFP**	14.73	14.73	14.73	0.00	0.000	44.19
UNICEF	7.71	7.10	7.53	7.30	7.000	36.64
UNFPA	2.01	2.20	3.30	3.30	3.300	14.11
WHO	0.42	0.89	0.89	0.89	0.890	3.98
UNDP	1.11	1.00	0.75	0.725	0.725	4.31
UNAIDS	0.69	0.69	0.85	0.85	0.850	3.93
FAO/UNHCR/ILO	0.40	0.40	0.40	0.50	0.500	2.20
Sub-total	*39.77*	*39.71*	*41.15*	*22.79*	*15.48*	*158.90*
Global Fund, R-1	29.65	44.35	56.29	53.73	0	184.02
Global Fund, R-2	12.75	17.56	20.77	17.93	15.41	84.42
Sub-total	*42.40*	*61.91*	*77.06*	*71.66*	*15.41*	*268.44*
African Dev. Bank	N/A	N/A	N/A	N/A	N/A	N/A
Government						
NAC	2.00	2.00	2.00	2.00	2.000	10.000
Ministries	1.08	1.27	1.45	1.64	1.64	7.080
MOH+	27.05	31.94	36.37	41.2	41.2	177.760
Sub-total	*30.13*	*35.21*	*39.82*	*44.84*	*++44.84*	*194.84*
Grand Total	**131.59**	**158.65**	**179.80**	**160.80**	**93.84**	**724.68**
Bilateral						*14%*
United Nations						*22%*
GF						*37%*
Government						*27%*

Source: National Aids Commission, June 2006

**Includes allocations to MASAF: $28.5m per year for 2005-7 and $33.3m for 2008-10. 20% of the allocation is assumed for HIV.*

*** Bulk of funding is for food relief impact mitigation measures among households burdened by HIV and AIDS (chronically-ill, orphans, orphan care-takers. +Estimated at 65% of MOH recurrent budget minus salaries.*

++Simple extrapolation of 2008 estimates.

Table 3.5 Donor Disbursements

SOURCE(S)	AMOUNT COMMITTED (2003 – 2008) (USD)	AMOUNT DISBURSED (USD)	% DISBURSED
The Global Fund	186,322,595.00	81,784,804.00	44
World Bank	35,000,000.00	26,700,000.00	76
CIDA	10,000,000.00	10,000,000.00	100
Kingdom of Norway	10,000,000.00	10,000,000.00	100
DfID	7,200,000.00	7,200,000.00	100
GoM	10,000,000.00	6,677,000.00	67
UNDP	3,800,000.00	1,900,000.00	50
CDC	2,000,000.00	1,711,000.00	86
ADB	600,000.00	450,000.00	75
TOTALS	**264,922,600.00**	**146,422,804.00**	**55.2**

Source: National Aids Commission, June 2007

When the universal access targets and their cost implications are incorporated, the finance gap widens.

Table 3.6 Universal Access Finance Gap, millions USD

Priority Area	Finance Gap
Prevention and Behaviour Change	375,904,648.50
Treatment, Care, and Support	514,352,574.00
Impact Mitigation	-28,483,689.00
Mainstreaming Partnerships and Capacity Building	-3,581,792.00
Research and Development	15,378,600.00
Monitoring a nd Evaluation	10,283,334.00
Resource Mobilisation and Utilisation	1,029,300.00
National Policy Coordination and Programme Planning	13,321,855.00
Total	**898,204,830.50**

Source: Government of Malawi

When current programme expectations are raised to the level of universal access to services, this level of financial commitment quickly becomes inadequate from two perspectives. At near universal access to treatment, a country like Malawi is looking at about 200,000 people on treatment. Even if 100% of funds committed for the NAF are disbursed, the gap for the years 2008 2011 is estimated to be approximately US$633 million.

4 IMPACTS ON PUBLIC EXPENDITURE FRAMEWORKS, THE MACROECONOMY, AND SOCIAL SERVICES DELIVERY

Since aid will be spent by the public sector, there are implications for fiscal policy. The nature and composition of aid will determine its effects on the national economy.

What are the potential macroeconomic impacts of increased fiscal spending? ODA is received in foreign currency. It is delivered in kind or in cash. In cash, it is either spent on imports or local goods and services. If it is spent on imports (assuming there are no substitutes locally available), economic theory states that the current account deficit widens, but there is no change in relative prices within the sector targeted and certainly no economy-wide inflationary effects experienced. On the other hand, there is the possibility of experiencing long-term productivity gains as a result of the imports (e.g. the purchase of ARV's resulting in longer working lives and thus increased tax revenues to the GoM).

If the aid is spent on locally procured goods and services, the initial effect is an increase in the money supply and then an increase in demand of the goods/services. In this case, as we are discussing the procurement of such related to the HIV/AIDS pandemic, the increase in demand in the health sector will result in an increase in prices in the health sector (e.g. demand for hospital beds, nurses, etc.). The GoM being the main provider of health services in Malawi, this is most likely the outcome as supply constraints are endemic in the structure of the sector. Of course, if the increased consumption of goods/services has the longer-term effect of increasing supply capacity, allowing the main service provider to meet the increase demand, then the price increases are only temporary.

Thus, the effect of aid will depend on the composition of the expenditure associated with the aid flow, as well as the size of the inflow; this is a significant result from the perspective of fiscal policy (Walters, 2007). Included in this, as a determining factor, is the destination of the aid. In this case, since the health sector is primarily private, there are real economy effects that must be anticipated within sector, but no evidence that that the increases in prices will be reflected across all sectors. That is, a change in the fiscal deficit and a subsequent change in relative prices are not in themselves inflationary. In fact, it is submitted that a larger fiscal deficit does not raise aggregate demand as long as the aid is absorbed.

Charts 4.1 and 4.2 display the trend in total grants received and annual inflation rates, respectively. From the year 1998/99, the former has increased steadily whereas the latter has declined. The downward trend was disturbed in 2004. The average annual rate of inflation increased from 11.5 percent recorded in 2004 to 15.4 percent in 2005. This was on account of food shortages, which pushed up the general price level. High maize production, the implementation of Input Subsidy Programme and increased winter cropping, have worked to counteract it. From May 2006 to May 2007, Malawi's inflation rate has dropped from 15.8 to 7.9%.

Chart 4.1 Total Grants (billion Kwacha)

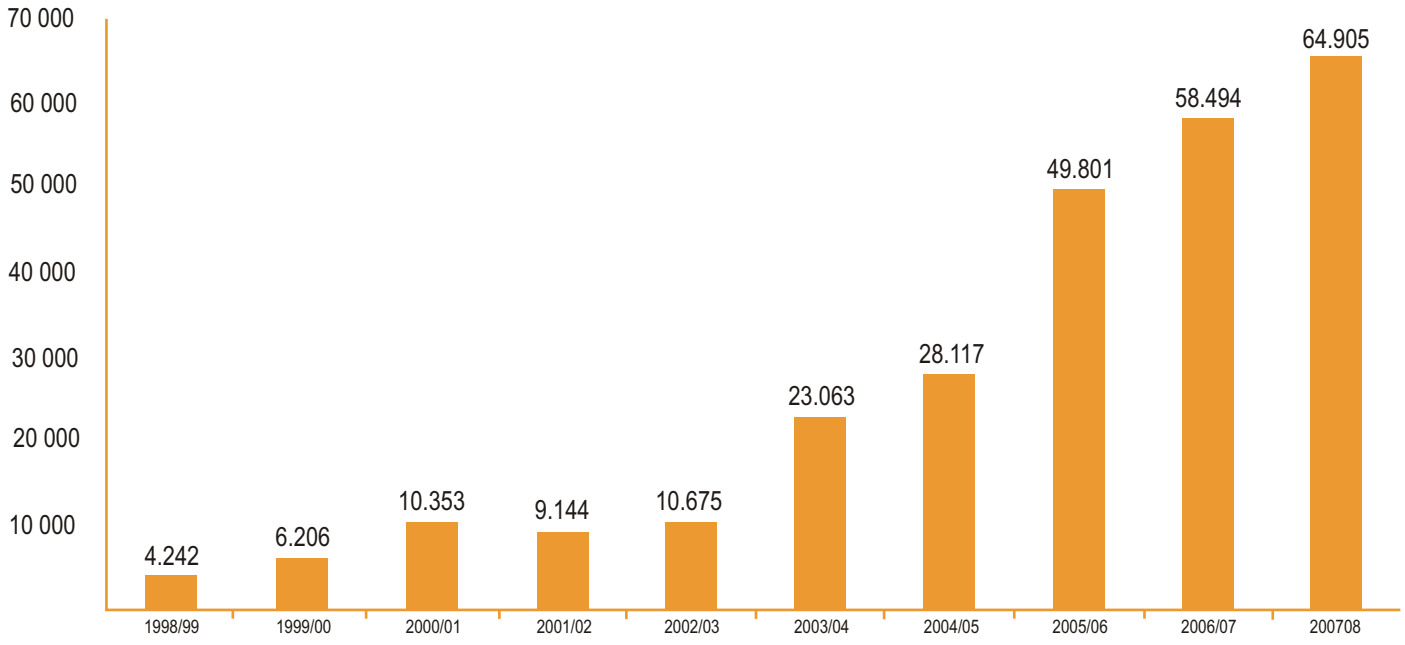
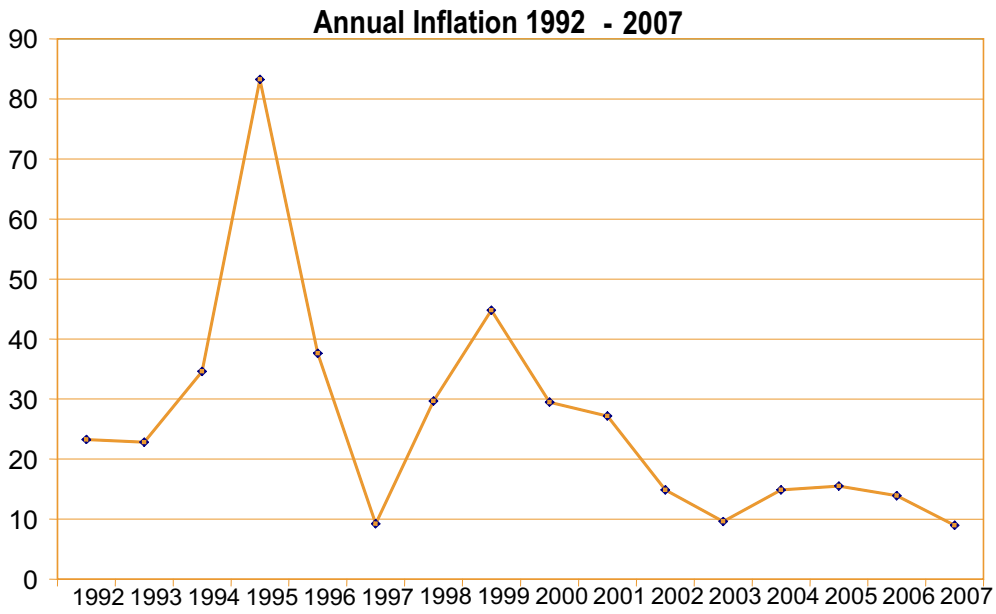


Chart 4.2 Historical Trend of Malawi's Inflation Rates



4.1 Evaluation of Fiscal Space

While it does concede that macroeconomic fundamentals appear to be stable, the International Monetary Fund (2007) asserts that Malawi has experienced increased fiscal space as a result of debt relief. Table 4.1 details average domestic revenues and net foreign financing as a percentage of GDP, and Table 4.2 identifies its sector destination over the same period.

Table 4.1 Sources of Fiscal Space, % GDP

	1998/99 – 2005/06	2006/07 – 2009/10	Change
Domestic Revenues	20.4	24.7	4.3
Net Foreign financing	11.0	19.4	8.4
Domestic Interest Payments	-4.8	-3.0	1.8

Table 4.2 Allocations of Fiscal Space, % of GDP

	1998/99 – 2005/06	2006/07 – 2009/10	Change
Wages	6.2	7.7	1.5
Other current spending	14.5	15.0	0.5
Development	9.4	17.2	7.8
Domestic Debt Reduction	-3.6	1.2	4.8

Sources: Malawian authorities and Fund staff projections.

Malawi is currently under a PRGF program sponsored by the International Monetary Fund (IMF). The first PRGF arrangement signed in 2000 was suspended and expired in 2004 after only one review was completed(2). The authorities negotiated for a Staff Monitored Program covering the period July 2004 June 2005. Upon the successful completion of the SMP, Malawi qualified for a new PRGF programme beginning 2005. The programme has undergone three consecutive successful reviews and is due for a fourth review in September 2007. The arrangement is for SDR 38.2 million, 55 percent of quota. It was approved on August 5, 2005 (Country Report No. 05/285), of which SDR 15.3 million has been disbursed.

(2) Malawi has had more than 8 arrangements with the IMF since 1983. These included Stand-by arrangements Structural Adjustment Facility (SAF) , Enhanced Structural Adjustment Facility (ESAF) and the current PRGF. So far, only two arrangements were successfully completed with all the disbursements made before expiry of the facility. In all the other cases, Malawi failed to utilise all the resources of the Fund because of failure to meet IMF conditionalities.

At the centre of the IMF programme is the underlying dogma of voluntary contraction of public expenditure in a bid to contain overall demand in the economy. The monetarist approach which supports deflationary fiscal and monetary policies is under great attach from critics who claim that it is not applied with realism or human face. This approach is supporting other schools of thought that calls for governments not to spend all the resources at their disposal following an upsurge of aid. Instead, they are called upon to spend some of the aid but not to absorb it all at once. The method by which this might be done is called expenditure smoothing or building reserves or saving some of the aid for future use.

In the present scenario, where a lot of resources are needed to combat the HIV/AIDS upsurge, the level of spending and absorption need to be agreed by the authorities in support of the required fiscal space. However, the method by which country programmes are conceived and reviewed leaves little room for the authorities to demand or get the adequate fiscal space that is necessary.

The following are some quarterly quantitative targets in Malawi's PRGF arrangement and Malawi's performance against them as of September 2006.

- The floor on net foreign assets of the monetary authorities. This benchmark is monitored on a quarterly basis. The adjusted target floor on net foreign assets of monetary authorities is 58.1 million Kwacha. Malawi successfully applied for a waiver of this target, as its net foreign assets amounted to 44.2 million Kwacha.

In order for the GoM to meet the required targets, it directed NAC 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 with 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 6 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 in that these resources were meant to service.

- Make budget ceilings module in payment system. In order to fulfil this benchmark, the Ministry of Finance through the Accountant General (AG), introduced the 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 NAC grants facility procedure that requires all grants to be managed though dedicated bank accounts. As a result the majority of grants disbursements to the public sector were suspended for a period of over 9 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.

- Ceiling on central government wages and salaries. The IMF requires a ceiling of 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 heath sector that is struggling to utilize and absorb the huge financial resources that are earmarked for HIV and AIDS.

The adjusted ceiling target on central government wages and salaries is 26.030 million Kwacha. Based on the budget for the 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 precariousness of the situation can not be overstated. In Malawi, there is only one doctor per 60,000 people, whereas the universal standard is 1: 5,000. There are only 100 doctors in public hospitals, serving a population of 12 million.

In addition, the opportunity costs of not addressing the health crisis sooner than later are astounding. A research from the College of Medicine at the University of Malawi estimated that the country loses up to $26 million for every nurse that leaves to go abroad; the exact loss depending on the category and experience of nurse. The costing exercise was exhaustive, taking into consideration the expense of recruiting and training a replacement as well as the time period normally spent abroad by Diaspora, approximately 30 years. The report makes the assessment that the

scaling up of ARV treatment is and will remain constricted due to shortages of health staff to administer and monitor progress (IRIN, 2006).

- Further consolidation of domestic debt to below 10 percent of GDP is still the key medium-term fiscal objective, as this would free resources for the private sector. Malawi's total public sector resource requirements, including for the MGDS, need to be clearly articulated and expenditures prioritized according to projected resource flows. In this regard, IMF staff cautioned that Malawi may not have enough absorptive capacity to accommodate the large increase in development spending, though the authorities felt this would not be a major concern. The government also thought that civil service salaries might continue to be misaligned, especially compared to the private sector.

The adjusted target for the ceiling on central government expenditures is 1.174 million Kwacha. The NAF alone has a finance gap of $277.6 million (38,586.4 million Kwacha), and only 30% of the funds required for the $1.67 billion Universal Access plan has been committed.

Malawi's PRGF arrangement also has a number of structural benchmarks, which include:

- On the basis of the PFM action plan (structural benchmark for end-October 2006), the government will continue phasing-in the IFMIS and will strengthen budget comprehensiveness, internal controls and reconciliation in budget execution, and audited financial reports. The government will also centralize the payment of utility bills of all central government entities to prevent future utility arrears (performance criterion for end-March 2007) and will strengthen control of the wage bill by compiling monthly reports of payroll execution (structural benchmark for end-March 2007).

- The new travel policy, focusing on accountability and transparency, is expected to be issued shortly (structural benchmark for end-September 2006). It aims to reduce government travel spending from 5½ to 3 percent of total expenditure.

In addition to the benchmarks above, it was cited by the IMF review team that Malawi's public utilities were operating below desired efficiency. Malawi's utility companies are owned and controlled by government. They operate on a commercial basis but also have government mandated social obligations in providing these services to the poor. IMF staff urged the GoM to clarify the boundaries between utilities' commercial and government-mandated social functions and to ensure that the latter are adequately and transparently financed by the budget, which is in turn limited by a ceiling as stated above.

Lastly, Malawi's PRGF arrangement has a large number of reporting requirements to the IMF alone. There are currently 3 daily reports, 3 weekly reports, 24 monthly reports, 10 quarterly reports, and 2 annual reports. This was one of the concerns addressed by the GoM that its donor partners had not harmonised the administrative, monitoring and evaluative aspects of delivering aid, which is one of the target indicators of the Paris Declaration, of which the IMF is a signatory.

4.2 Predictability and Volatility of Aid

Malawi is aid dependent country, and this raises concern regarding the sustainability of all the initiatives currently taken together with the donor community. The question is even more pertinent when one considers interventions in the health sector; particularly to HIV/AIDS. For instance, the ARV treatment, which, once started, cannot be discontinued with possibilities for one to take more expensive drugs as the malady gets more serious. What are the commitments of the donors to continued assistance in this sector? Further, the returns on investments in the health sector are long-term, as a longer-living population becomes more productive. The present commitments within the Global Fund arrangement do not go beyond 2008 leaving countries like Malawi to wonder what would happen if all donors were to scale down their aid before then.

Table 4.3 below presents the commitments to HIV/AIDS in the recent past.

Table 4.3 Donor Commitments to HIV/AIDS, time series

Year	USD, Millions	% Total Net ODA Disbursements
2000	13.08	
2001	24.68	
2002	20.86	4.42
2003	100.53	17.63
2004	21.51	4.29
2005	40.5	7.21

Source: Walters, 2007

The predictability and volatility of aid is tied to its composition. When it is comes in the form of debt relief, then it is highly predictable and involatile; though it does force recipient governments to spend existing foreign capital reserves. Loans are predictable and involatile. Grants are both predictable and volatile. They add to the recipient country's foreign capital reserves and can have a variety of effects depending on how it is spent.

Volatility of aid is a major problem that is more disruptive to the macroeconomic policies of a country than the dangers of Dutch Disease. An indication of the volatility of aid emanates from analysis of Malawi's central government operations. Net lending, which was 61 million Kwacha in the fiscal year 2002/03 and zero in 2003/04, jumped to 589 million kwacha in 2004/05. Total net foreign financing went from -730, to 425, to 6,102; respectively.

The disparity between commitments and actual disbursements contributes to the delay in planning and implementation of programmes. It has been suggested by Walters (2007) that donors can alleviate this uncertainty by signalling the intent to deliver exactly what was committed. This includes restructuring the form the aid takes to include a larger percentage of debt relief, formal long-term agreements rather than ad hoc arrangements, and reducing the percentage of aid that is tied.

Table 4.4 Main Donors to Malawi, USD millions

	2004/05	2005/06	2006/07
DfID*	27,869,059.38	44,209,392	37,726,741.73
EU	Not recorded	36,673,178.24	20,601,116.52
World Bank**	24,618,230.00	54,405,943.16	0
Norway	6,681,731.12	8,350,237.63	7,938,685.514
Total	59,169,020.51	143,638,751.07	66,266,543.76

Notes

** World Bank support for 2004/05 includes a FIMAG loan $25 million. Support for 2005/06 includes another $25 m for FIMAG as well as $30m for Emergency Support. These were classed as BOP loans by the IMF.

The percentage change in external financing for HIV/AIDS in Malawi was 282% between 2002 and 2004 (McKinley and Hailu, 2006). The development partners of Malawi vary in their consistency and predictability. DFID aid is predictable, having a positive variance of 9% in the 2005/06 financial year. EU aid is not predictable. In the 2005/06 financial year, the variance between projected and actual disbursements was minus 19% for project support and minus 22% for budget support.

5 Links Between Oda, The HIV/AIDS Pandemic and Malawi's Indebtedness

Malawi's level of indebtedness has been increasing steadily in recent years. Tables 5.1 and 5.2 detail both the volumes and percentage increase in loans since the year 2000.

Table 5.1 Net Disbursement Of Aid (Grants And Loans) Tc Malawi (US$ MILLION)

	2000	2001	2002	2003	2004	2005	2006	2007
Total Official Grants and Loans	415.0	352.3	443.3	376.0	384.1	493.5	612.0	678.8
Gross Official Assistance	281.7	225.3	339.3	270.0	298.8	387.7	511.1	556.7
Official Grants	148.4	98.3	235.3	164.0	213.4	281.9	410.1	434.6
Balance of payments support	78.4	51.0	12.8	41.7	64.3	97.2	62.0	79.0
Other	69.9	47.3	222.5	122.3	149.2	184.7	348.1	355.6
Loan Disbursements	133.3	127.0	104.0	106.0	85.3	105.8	100.9	122.1
IMF	8.4	0.0	23.0	9.3	0.0	8.3	14.4	27.6
Balance of payments support	31.4	55.0	0.0	18.4	35.2	18.1	24.5	40.0
Project support	93.5	72.0	81.0	78.3	50.1	79.4	62.0	54.5
Private Capital (Net)	-107.7	25.5	153.5	73.6	145.7	283.6	63.7	60.0
TOTAL AID	**307.3**	**377.8**	**596.8**	**449.6**	**529.8**	**777.1**	**675.7**	**738.8**

Source: Malawi Government and IMF Staff (2007 figures are estimates)

Table 5.2 Total ODA, Percentage Growth

	2000-2003	2004-2007
	Average Growth rate	
Total Official Grants and Loans	-1.5	16.4
Gross Official Assistance	3.4	20.3
Official Grants	25.1	28.4
Balance of payments support	38.4	24.1
Other	97.6	34.1
Loan Disbursements	-7.0	5.2
IMF	-53.2	16.4
Balance of Payments Support	-8.3	35.3
Project support	-4.6	-2.9
Private Capital (Net)	108.7	27.3
TOTAL AID	18.8	15.2

Loan disbursements have increased at an average of 5% in recent years, the IMF loans at an average increase of 16.4%.

But external debt is only part of the picture. 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 2003/03 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 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. 86 percent of Malawi's external debt was owed to multilateral creditors while bilateral and commercial creditors accounted for 13.5 percent and 0.5 percent, respectively.

Malawi has borrowed from the IMF large amounts in recent years. Table 5.3 summarizes that activity.

Table 5.3 IMF Activity with Malawi, USD millions

	2002	2003	2004	2005	2006	2007
Loan Disbursements	-6.2	-9.3	-13.7	-18.9	-27.3	
Repurchases and repayments	23.0	9.3		8.3	25.3	27.7

Source: IMF, 2007
Empty boxes: information not available

- Why has Malawi's borrowing increased despite being a graduate of both MDRI and HIPC initiatives? Improving food security and access to water and sanitation services is a part of Malawi's universal access strategy, but it is being financed through loans. Specifically, the MGDS lists the following activities as some of what should be undertaken to contain the HIV/AIDS epidemic and further social development:
  Rehabilitate construct and maintain health structures, namely buildings, medical equipment, telecommunication, electricity, and water

- Introduce VIP latrines and other appropriate rural water sanitation technologies

- Promote sustainable income generation and advocacy for microfinance programmes for those affected

The GoM is undertaking the rehabilitation of these essential services via loan financing.

Two examples of such are the Second National Water Development Project, approved May 2007, is jointly financed by IDA and IBRD (US$50 million), AfDB (US$15 million), CIDA, EIB (US$20 million), European Commission, OPEC, and UNDP. Another is the Irrigation, Rural Livelihoods and Agricultural Development Project, approved in November 2005, which is a US$40 million credit from IDA. Both projects are expected to close by 2012.

Appendix 1 Universal Access Annual Budget by Priority Area

PRIORITY AREA	NAF (2005 - 2009)	UNIVERSAL ACCESS ANNUAL COSTS						UNIVERSAL ACEESS	%
		Year 2	Year 3	Year 4	Year 5	Year 6	Year 7		
		2006	2007	2008	2009	2010	2011		
	COST (US$)							COST (US$)	
Prevention and Behaviour Change	*245,317,196*	51,657,108	76,033,842	58,655,682	67,025,438	72,840,966	71,759,349	***397,972,383***	34.1
Treatment Care and Support	*205,285,840*	39,949,710	69,012,610	83,595,710	101,944,560	120,051,960	119,446,860	***534,001,410***	45.8
Impact Mitigation (Socio-economic and Psychosocial)	*102,547,830*	21,956,420	28,646,260	31,770,760	26,850,140	28,327,660	27,931,860	***165,483,100***	14.2
Mainstreaming, Partnerships and Capacity Building	*8,957,740*	1,710,420	1,732,210	1,511,660	932,860	752,410	692,510	***7,332,070***	0.6
Research and Development	*21,740,620*	4,541,490	4,426,240	5,972,590	4,790,590	5,487,490	5,061,840	***30,280,240***	2.6
Monitoring and Evaluation	*17,764,090*	4,919,360	1,832,350	5,071,010	1,168,160	1,069,760	899,960	***14,960,600***	1.3
Resource Mobilisation and Utilisation	*1,669,750*	59,000	588,100	223,000	66,100	27,000	66,100	***1,029,300***	0.1
National Policy Coordination and Programme Planning	*16,338,600*	1,835,500	3,556,855	3,295,500	2,290,000	1,935,000	2,159,000	***15,071,855***	1.3
GRAND TOTAL	**619,621,666**	**126,629,008**	**185,828,467**	**190,095,912**	**205,067,848**	**230,492,246**	**228,017,479**	**1,166,130,958**	100

6 Conclusion

Malawi has recognized in its MGDS that HIV/AIDS is a multi-faceted problem, which requires a multi-sectoral approach. As a result, it has included projects such as rehabilitation of roads, water, health facilities, communications, etc.

The Government of Malawi has budgeted for the fight against HIV/AIDS in its National Action Framework (2005 2009) and again for the higher Universal Access targets (2006 2011). The NAF has a funding shortfall of US$277.6 million, which was financed via borrowing. The UA budget has only received commitments for 30% of total resources required; leaving a gap of $US633 million.

Existing aid modalities in Malawi include the Global Fund, debt relief, pool funding, grants, and debt-financing. There appears to be no empirical link between ODA, fiscal spending and inflation in Malawi.

Malawi is currently under a PRGF arrangement, which has a number of benchmarks and targets that must be met.

- The floor on net foreign assets promoted borrowing on Malawi's part in order to meet it, as evidenced by the increase in domestic debt. It also resulted in a delay of disbursement of funds from the Pool Fund, as other development partners preferred to have the funds in commercial banks rather than at the Reserve Bank.
- The ceiling on government wages/salaries is far below what is specified in the MGDS as being necessary to combating HIV/AIDS.
- The ceiling on domestic debt is not in alignment with the ceiling on central government expenditures. It essentially reduces the options of the GoM to address the finance gap of the NAF and UA.
- There is pressure from the IMF to re-organise its utility companies on a for-profit structure contrary to the observations made in the MGDS, which is that lack of these basic amenities has contributed to the pandemic. Further, in order to carry out the improved provision of these essential services, Malawi has taken IDA and IBRD loans.
- Though the IMF expressed concern over Malawi's absorptive capacity, its loans to Malawi have increase 16%.

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Table 2.3Universal Access Indicators And Targets For Malawi

Source: Government of Malawi, 2007; m: males, f: females

			MIDTERM		ENDTERM	
INDICATORS	**2000**	**2004**	**NAF2007**	**UA2008**	**NAF2009**	**UA2010**
1. Sero-prevalence amongst pregnant women attending ANC clinics	19.5%(2001)	16.9%(2005)				14.0 %
2. Sero-prevalence among young people 15-24yrs of age (15-24 years pregnant women)		14.3%(2005)				12.0%
3. AIDS related deaths (if no country data is available , see UNAIDS global report, 2004)		86,592				79,284
4. Sero-prevalence among vulnerable groups, in case of concentrated epidemic (please indicate concerned population group)						
5. % of people (15-49 years of age who are HIV infected	14.4%(2003)	14.2%	14.0%	13.5%	13.5%	12.8%
1.1 PREVENTION						
Indicators						
% of sexually active respondents who had sex with more than one partner the last 12 months	33% m	26% m	23% m	22% m	18%m	18%m
	8% f	8% f	6.5% f	6.5% f	5% f	5% f
% of sexually active population using condoms at last high risk sex (sexual intercourse with a non regular sexual partner or non-cohabiting partner	39%m	47% m	55% m	55% m	60% m	60% m
	29% f	30% f	35% f	35% f	40% f	40% f
Median age at first sex among 15-24 years olds	17.7 yrs m	18.1 yrs m	18.6 yrs m	18.6 yrs m	19.0 yrs m	19.0 yrs m
	17.1 yrs f	17.4 yrs f	17.7 yrs f	17.7 yrs f	18.0 yrs f	18.0 f
% of young people aged 15-24 who had sex with more than one partner in the last 12 months (by gender , residence)	56.4% m	13.3% m	12.0%	12.0%	10.0%	10.0%
	16.4% f	1.7% f	1.5%	1.5%	1.2%	1.2%
% of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and who reject major misconceptions about HIV transmission		37% m	40% m	50% m	60% m	75% m
		25% f	28% f	40% f	60% f	75% f
% of people in general population exposed to HIV and AIDS information		80% m	90% m	90% m	95% m	95% m
		66% f	70% f	70% f	75% f	95% f
% of school with teachers who have beentraine in life-skills-based HIV/AIDS education and taught it during the last curriculum year (by type of school [primary/secondary] school proprietor [public/private] and school location [urban/rural]	6% (2002)		50%	100%	100%	100%
# of young people aged 15-24 exposed to life skills based HIV/AIDS education		1,419,065	2,000,000	2,000,000	2,500,000	2,500,000
# of condoms distributed by social marketing agencies to retail outlets or clinics		28,000,000 (M)	28,000,000	31,000,000	35,000,000	34,000,000
		1,150,000 (F)	2,800,000	3,100,000	3,500,000	3,400,000

PMTCT						
% of HIV + pregnant women and their infants receiving a complete package of PMTCT services to reduce the risk of MTCT	2.0% (2003)	2.3% (7% in 2006)	22%	35%	50%	65% (75% in 2011)
% (#) of health facilities with ANC services providing at least the minimum package of PMTCT services	3.6% (2003)	7%	100%	100%	100%	100%
% of pregnant women who have been counselled in PMTCT, tested and received their sero-status		8.7%	100%	100%	100%	100%
% of HIV + pregnant women and lactating women and women on HAART who have been referred from PMTCT		8%	8%	8%	10%	10%
SEXUALLY TRANSMITTED INFECTIONS (STIs)						
% of patients with STIs at health facilities who have been managed according to national guidelines			70%	70%	90.00%	90.00%
% of heath facilities with STI drugs in stock and no STI drugs in stock outs >1 week (by district) (An STI tracer drug to be selected)		35%	70%	70%	90%	90%
% of pregnant women who tested positive for syphilis (Syphilis is proving not to be a major problem linking it with						
BLOOD SAFETY AND UNIVERSAL INFECNTION PREVENTION						
% of transfused blood units screened for HIV , HBV and syphilis		98%	98%	98%	98%	98%
% of health facilities that apply national guidelines for blood screening , storage ,distribution and			90%	98%	98%	98%
% of health facilities that apply national standards for infection, prevention and health care waste storage		8%	90%	98%	98%	98%
HIV TESTING AND COUNSELLING						
# of HIV testing and counselling sites (integrated and standalone)		146 (286 in 2006)	350	435	520	600
# of sexually active population (15- 49) years tested for HIV at VCT sites and received test results	127,917 (2003)	177,726 Tested	760,000 tested	900,000	950,000	1,000,000
		37% receive	100% receive	100% receive	100% receive	100% receive
% of sexually active population (15-49) years ever tested for HIV and received test results (population based survey and mainly DHS)		14.9% males	30%	45%	55%	75%
		7.0% females	30%	45%	55%	75%

1.2 – TREATMENT						
# (%) of persons with advanced HIV infection receiving ARV therapy (by age group, gender , and by type of health facility (public/ private)	3.8% (2003)	13,183 (6.6%)	90,000	130,000	170,000	208,000
% of those starting treatment are under 13 years		5% (6% in 2006)	7%	8%	10%	12%
% of health facilities with drugs for OIs in stock and no stock outs of more than 1 week (district)		35%	70%	70%	90%	90%
% of health facilities where ART services are being offered with no ARV drug stock outs		100%	100%	100%	100%	100%
% of HIV infected TB cases who receive HAART (by gender, age)		17.8% (30%)		40%	40%	50%
% of adults and children with advanced HIV infection still alive 12 months after initiation of ART		81%	80%	80%	80%	80%
1.3 - CARE AND SUPPORT, INCLUDING CHILDREN AFFECTED BY HIV						
Percentage of OVC whose households receive free basic package of care in caring for child		60,000 (32.5% in 2006)	45.5% (500,000)	60% (660,000)	70% (770,000)	80% (880,000)
Ratio of current school attendance among orphans to non - non o rphans among the 10-14 yrs olds (by		0.94	0.98	0.98	0.98	0.98
% of population accepting attitudes towards PLWHAs (by gender and level of education)	males	31%	40%	50%	60%	75%
	females	32%	40%	50%	60%	75%