

The Macroeconomic Policy Impacts
on the Fight Against HIV/AIDS
in Ethiopia

AFRODAD



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ISBN 978-0-7974-3428-8

EAN 9780797434288

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About AFRODAD

AFRODAD Vision

AFRODAD aspires for an equitable and sustainable development process leading to a prosperous Africa.

AFRODAD Mission

To secure policies that will redress the African debt crisis based on a human rights value system.

AFRODAD Objectives include the following:

- 1 To enhance efficient and effective management and use of resources by African governments;
- 2 To secure a paradigm shift in the international socio-economic and political world order to a development process that addresses the needs and aspirations of the majority of the people in the world.
- 3 To facilitate dialogue between civil society and governments on issues related to Debt and development in Africa and elsewhere.

From the vision and the mission statements and from our objectives, it is clear that the Debt crisis, apart from being a political, economic and structural issue, has an intrinsic link to human rights. This forms the guiding philosophy for our work on Debt and the need to have African external debts cancelled for poverty eradication and attainment of social and economic justice. Furthermore, the principle of equity must of necessity apply and in this regard, responsibility of creditors and debtors in the debt crisis should be acknowledged and assumed by the parties. When this is not done, it is a reflection of failure of governance mechanisms at the global level that protect the interests of the weaker nations. The Transparent Arbitration mechanism proposed by AFRODAD as one way of dealing with the debt crisis finds a fundamental basis in this respect.

AFRODAD aspires for an African and global society that is just (equal access to and fair distribution of resources), respects human rights and promotes popular participation as a fundamental right of citizens (Arusha Declaration of 1980). In this light, African society should have the space in the global development arena to generate its own solutions, uphold good values that ensure that its development process is owned and driven by its people and not dominated by markets/profits and international financial institutions.

AFRODAD is governed by a Board of seven people from the five regions of Africa, namely East, Central, West, Southern and the North. The Board meets twice a year. The Secretariat, based in Harare, Zimbabwe, has a staff complement of Seven programme and five support staff.

Acknowledgements

AFRODAD would like to thank Dejene Aredo and Habtamu Wondimu for investing considerable time on this research project.

We also would like to thank all our AFRODAD staff for providing insightful comments and in helping to edit the paper. Many thanks go to the Research Director, Dr Nancy Dubosse, and Mr. Mandla Hadebe who is in charge of our Communication and publications department.

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 signaling 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 counseling 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/AIDS 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.



Charles Mutasa
Executive Director
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List of Acronyms/Abbreviations

ART:	Anti-retroviral treatment
EEA:	Ethiopian Economic Association
ESAP:	Extended Structural Adjustment Program
IDA:	International Development Association
IFI:	International Financial Institutions
FMoH:	Federal Ministry of Health (same as MoH: Ministry of health).
GoE:	Government of Ethiopia
ODA:	Official Development Assistance
HAPCO:	HIV/AIDS Prevention and Control Office
MoFED:	Ministry of Finance and Economic Development
PLHA:	People Living with HIV/AIDS
PASDEP:	Plan for Accelerated and Sustained Development to End Poverty
HSDP:	Health Sector Development Program
HSEP:	Health Service Extension Program
HEW:	Health Extension Workers
SDPRP:	Sustainable Development and Poverty Reduction Program

Executive Summary

Ever since 1992, when the domestic currency (the Ethiopian birr) was for the first time devalued, Ethiopia has been implementing market-led macroeconomic and sector policies in line with the structural adjustment policies of the IMF and World Bank. However, not all of the policy reforms tallied with the reality on the ground. In fact, the Federal Government has consistently resisted implementing some of the prescriptions of the IMF/World Bank such as reforms of property rights to land, across-the-board privatization of state enterprises, opening of the financial market, etc. The Government of Ethiopia has remained committed to the emerging strategies of IFI's (e.g. the Poverty Reduction Strategy Paper, PRSP). Ironically, the implementation of the PRSP is partly constrained by the very policies of those who have sponsored such a strategy.

Central to this contradiction is the issue of raising and allocating public expenditure without violating conditionalities. The issue at hand is how governments of poor countries reduce poverty and deliver basic services, without increasing public spending beyond what is prescribe by the IMF. The case of Ethiopia demonstrates the underlying contradiction of IMF/World's macroeconomic stabilization policies and poverty reduction strategies.

This report describes the extent and depth of HIV/AIDS in Ethiopia and the responses both by government and non-governmental organisations. It entails a description of the programme costs and the fiscal challenges of containing the pandemic. It provides an assessment of the macro-economic framework, a discussion of fiscal space and the interaction between the Government of Ethiopia and the World Bank and IMF.

The IMF's interventions, in particular, in Ethiopia has confirmed observations that by encroaching upon a sovereign state's right to formulate independent national policies, the IMF has denied government ownership of macroeconomic policies and a say in the prioritization of public expenditure. Further, the IMF's conditionalities have been expended into areas that have no direct bearing on the macroeconomic adjustments (e.g. privatization). In some respects, the macroeconomic framework of social spending can be a constraint to the flows of funding to priority areas. The Government has limited space to explore alternative strategies on how to balance macroeconomic stability with social spending.

Among the key observations made is that, as demonstrated by the current inflationary pressure in Ethiopia, the stabilization of program of the IMF is unlikely to work in the Ethiopian context, where the economy is highly constrained by structural problems. Therefore, the donor community should allow the government to stabilize the economy through changes in output rather than through price adjustment. Also, inflation should be discussed in context. That is, the nature and composition of the fiscal spending should be taken in to account. In Ethiopia's case, fifty percent of aid to the health programme goes to the purchase of imported medicines, which is a non-tradable good and has no monetary impact.

1 Introduction

Ever since 1992, when the domestic currency (the Ethiopian birr) was for the first time devalued, Ethiopia has been implementing market-led macroeconomic and sector policies in line with the structural adjustment policies of the IMF and World Bank. However, not all of the policy reforms tallied with the reality on the ground. In fact, the Federal Government has consistently resisted implementing some of the prescriptions of the IMF/World Bank such as reforms of property rights to land, across-the-board privatization of state enterprises, opening of the financial market, etc. The Government of Ethiopia has remained committed to the emerging strategies of IFI's (e.g. the Poverty Reduction Strategy Paper, PRSP). Ironically, the implementation of the PRSP is partly constrained by the very policies of those who have sponsored such a strategy. Central to this contradiction is the issue of raising and allocating public expenditure without violating conditionalities.

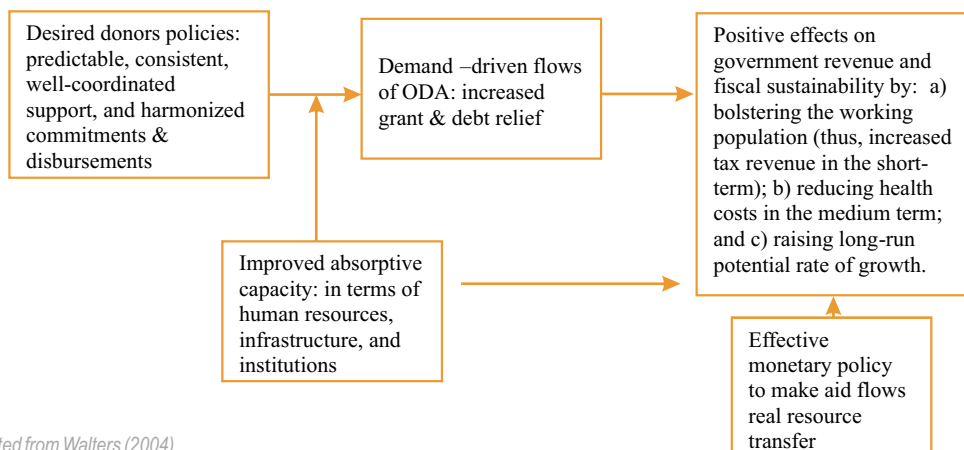
Contrary to the real conditions of sub-Saharan African countries, the IFIs assert that the “Dutch disease” is an immanent danger for poor countries. For example, in a World Bank publication, Sundberg and Lofgren (2006:4,11) attempted to demonstrate that Ethiopia may face “significant risk from macroeconomic and microeconomic effects arising from sharp increases in aid flows Dutch disease effects are clearly a serious concern.” However at the theoretical level, a number of authors question the logic of the “Dutch disease” in the context of structural constrained poor economies. In what follows, we will briefly review alternatives to the “Dutch disease” argument with particular reference to the macroeconomic effects of ODA in combating HIV/AIDS.

Walters (2006) has demonstrated that, although the danger of “Dutch disease” could be real, the problem is overemphasized. Rather according to Walters, aid directed at combating HIV/AIDS is likely to have positive short- and long-run effects on production possibilities in the recipient counties and to be complementary to the efforts to achieve MDGs. The expansion of public spending in both the recurrent and capital budget to address the continuing humanitarian crisis in sub-Saharan Africa does not imply that other objectives such as macroeconomic stability and economic growth need be compromised. However, as noted by Walters, such a scenario depends, in part, on the extent to which the volatility of aid is reduced, absorptive capacities of the aid-recipient country is improved, and to which monetary authorities are able to properly manage and accommodate aid flows. Further, it should be noted that the flows of aid should be demand- driven, i.e. the magnitude of aid flows to combat HIV/AIDS should depend on the extent and severity of the pandemic.

Figure 1, which draws on Walters (2006), attempts to summarize the counter-argument that aid flows to structurally constrained low income countries does not necessarily lead to “Dutch disease”. Rather aid can, potentially, have positive effects on government revenue and fiscal sustainability through increased tax revenue, reduced costs of health service and long-term growth of the economy.

Contemporary policy debates on the macroeconomics of aid often concentrate on short-run “Dutch disease” effects, ignoring the possible supply side impact of aid: financed public expenditure. By considering the demand-side of aid flows, Bevan and Adam (2004) have demonstrated that the argument of “Dutch disease” is doubtful, though it is possible that aid, under certain circumstances could contribute to increased income inequality. The main finding was that the relationship between enhanced aid flows, real exchange rates and welfare is less straightforward than simple models of aid suggest.

Figure 1.1 The Macroeconomic Effects of Demand driven ODA to Combat HIV/AIDS



Source: Adapted from Walters (2004)

The issue at hand is how governments of poor countries reduce poverty and deliver basic services, without increasing public spending beyond what is prescribed by the IMF. The case of Ethiopia demonstrates the underlying contradiction of IMF/World's macroeconomic stabilization policies and poverty reduction strategies.

1.1 Research Objectives and Methodology

Using evidence from Ethiopia, this report attempts to demonstrate the trade-offs between externally imposed macroeconomic policies and the provision of public services to improve the wellbeing of the poor, with particular reference to the fight against HIV/AIDS. The specific objectives of the report are:

1. To review the major channels through which fiscal and monetary policies impact on public expenditure frameworks and how this, in turn, affects the ability of the Ethiopian government to design public programmes concerning those living with HIV/AIDS.
2. To perform an assessment of the debt positions and aid management of the case studies to assess how the HIV/AIDS has impacted their financial portfolios and planning abilities
3. To assess the linkages between international financial institutions (IFIs) economic policy conditionality vis-à-vis the fight against HIV in Ethiopia and to recommend changes to those conditional ties.
4. To recommend macroeconomic policy shifts that is conducive to fighting the pandemic and economic Development.

This report draws on key documents of the government and of the IMF/World Bank as well as data provided by various departments, including Central Statistical Authority, Ministry of Finance and Economic Development (MoFED) and National HIV/AIDS Prevention and Control Office (NHAPCO).

The report is organized as follows: Chapter Two describes the extent and depth of HIV/AIDS in Ethiopia and the responses both by government and non-governmental organisations. Chapter Three entails a description of the programme costs and the fiscal challenges of containing the pandemic. Chapter Four provides an assessment of the macro-economic framework, a discussion of fiscal space and the interaction between the Government of Ethiopia and the World Bank and IMF. Chapter 5 concludes the discussion with few recommendations.

2 HIV/AIDS in Ethiopia

The purpose of this section is to present an overview of the extent and depth of the pandemic in Ethiopia and show the limited capacity of the government to fight HIV/AIDS.

2.1 The Extent and Depth of the Pandemic

HIV was first detected in Ethiopia in 1984, and the first two AIDS cases were reported in 1986. According to the most recent official report (FMoH/NHAPCO 2007), there are 1.3 million people living with the virus, 744,100 are orphaned due to AIDS, and 277,800 are in need of antiretroviral treatment (ART). The adjusted prevalence rate for Ethiopia in 2005 is 3.5% (urban 10.5% and rural 1.9%). AIDS accounted for an estimated 66.3% of all young (age 15-49) adult deaths in urban Ethiopia in 2005. Every day, there are 353 new HIV infections and 368 HIV deaths. Every day there are 30,300 HIV positive births. HIV/AIDS accounted for 32% of the estimated 141,000 TB cases in 2005. The demographics of AIDS are worrying (see Box 1). The overall HIV prevalence for Ethiopia has stabilized with the number of newly infected and dying being almost equal.

Thus, universal provision of prevention, care, and treatment to the estimated 1.32 million people and care for a huge number of orphans poses “a substantial challenge to the public health system in one of the poorest countries in the world” (FMoH/NHPCO 2007:48). The loss of young adults in their most productive years of life will affect the country's overall economic activities. The AIDS epidemic will continue to tax the limited health facilities and health workers. Further, universal access will be challenged by the fact that 50% of the people living with HIV/AIDS live in rural areas where access to communication and health care infrastructure is poor.

Box 2.1 The Demographics of HIV/AIDS in Ethiopia

The Ethiopian Demographic and Health Survey (EDHS) of 2005 (CSA 2006) has revealed the following picture of AIDS in Ethiopia

- The prevalence of HIV is higher for women than for men.
- For both men and women, HIV prevalence levels rise with age peaking among women in their late 30s and among men in their early 40s.
- HIV infection levels increase with the level of education among both men and women.
- Both men and women in the highest quintile of the wealth index have substantially higher rates of HIV infection than those in other wealth quintiles (a surprise).
- Marital status is closely related to HIV prevalence. There is significantly higher prevalence rate among men and women who are divorced, widow, or separated. The prevalence of HIV is closely associated with male mobility. That is, the number of times a man slept away from home is more closely associated with HIV prevalence than otherwise.

AIDS has adverse demographic economic and social effects that could be felt over long time. According to Ethiopia's first PRSP, HIV/AIDS could have serious demographic impact (including increased death rate increased dependency ratio, and changes in population structure) and worrying economic impacts (including reduced GDP growth rate as the active labour force experiences reduced productivity, absence from work, etc). Also, there could be increased dependency ratio as the active population is affected. In a country where there is limited health infrastructure, AIDS patients alone occupied as much as 42% of all hospital beds in the country during the year 2000.

Production loss due to AIDS could be enormous. At the micro-level, the pandemic contributes to production losses through sick leave, reduced productivity of labour and through expenditure on medical care as indicated by a study undertaken in textile factory in Ethiopia (MoFED 2002:128). In addition, the total cost of health service provision of Ethiopia (due to AIDS), between 1997-2006, was estimated at 32 to 49 million USD at low cost and at 226 to 368 million USD estimated at high cost. The per capita patient cost was estimated 12.03 USD for out patients at low cost scenario. At high costs, the respective estimates are 41 and 197 USD (MoFED 2002:128).

The Challenges of AIDS are further spelt out by HAPCO (2006) in terms of capacity limitation, shortage of funds, inefficient utilization of funds and poor accounting system, excess demand for services, delays in disbursing funds, acute problems of coordinating activities of those involved in the fight against the epidemic, passive involvement of citizens in the campaign, and a high degree of dependence on external factors.

Capacity limitations (in terms of shortage of qualified manpower, inadequate facilities, lack of institutions producing relevant technical personnel) have constrained the implementation of the multi-sectoral response at all levels. An outstanding example of capacity limitation is shortage of health work force in Ethiopia as indicated in the following table. Ethiopia has far fewer than the standard of one health worker per thousand people. For example, there are about 0.03 doctors and nurses per 1000 people. Note that the World Health Organization estimates that, to achieve the MDGS, the health system needs, at least, 2.5 health workers per 1000 people.

Table 2.1 Human Resources for the Health Sector

Category of health workers	Status in 2001/02 (population per health worker)	Target set for 2004/05 (for end of 1st PRSP)	Workers per 1000 people (on the basis of target for 2004/05)
Doctors/health officers	1:39,316	1:32,000	0.03
Nurses	1:8,461	1:6,880	0.14
Technicians	1:41,806	1:25,829	0.04
Sanitarians	1:83,792	1:46,267	0.02
Pharmacists	1:768,753	1:547,364	0.00
Frontline health workers	1:14,922	1:12,582	0.08

Source: Computed from MOFED 2002 page 103

The sustained availability and the expansion rate of services like VCT and ART may not be commensurate with the growing demand. For instance out of the 265,000 PLHA who need ARV treatment, it is only 21,220 who actually get the service at present. The gap between number of orphans and PLHA who need and those who get care and support services is quite wide. Only 13% of those who need antiretroviral treatment (ART) can access it. This could pose a serious challenge on the capacity of the government in making such services available adequately and in time.

Also, there are problems of coordination between donors, implementers and coordinating bodies like HAPCO. These are, in addition to problems related to lack of joint planning, sharing of data and mutual support. As defined in the strategic plan, the main thrust of the new implementation arrangement for the SPM is on the two prongs of enhanced government commitment, on the one hand, and community mobilization and empowerment, on the other. The government recognizes its critical role in accelerating the ongoing national multi-sectoral response and opts to organize its implementation mechanism for discharging its responsibilities in the combat against HIV/AIDS through the spearheading role of the MOH and the coordinating function of HAPCO. The departure in the strategic plan of 2004-2008 is social mobilization empowering the community for a meaningful impact on our fight against HIV/AIDS. All stakeholders need to have a clear understanding of the benefits of social mobilization and commitment to use this untapped resource effectively and efficiently.

2.2 The Government Response to HIV/AIDS

Government response to AIDS was initiated as early as 1985. The National AIDS Policy was issued in 1998 and the Strategic Framework for the National Response was updated in 2002. Both documents still serve as the basis for the multi-sectoral response to the epidemic. The National AIDS Council was established in 2000. Similar structures were formed in all the regions. The HIV/AIDS Prevention and Control Office (HAPCO) was established to coordinate and spread the multi-sectoral national response.

The current strategy of the Government includes the following control mechanisms (MoFED 2006):

- A major mass-media and community mobilization campaign, including focuses on in-school and out-of-school youth, and workplace interventions.
- Much increased social marketing of condoms, with an objective of access for all sexually active persons, and 60% use coverage (the level considered satisfactory for effective HIV prevention);

- Expansion and upgrading of voluntary testing and counselling, with VCTS integrated into all health centres, and training of more counsellors and nurses;
- Expansion of programs to prevent mother-to child transmission, with a target of 100% of HIV-positive mothers and their infants to be covered by testing and support by the end of the period;
- Improved blood safety, with expansion of blood banks, equipment, and reagents, and supply of basic protection materials and training to all health care providers and traditional birth attendants
- Increased palliative care and provision of Anti-retroviral treatment (ART), with a target of giving proper palliative care to those who reach severe stage and are bedridden; and expanded ART provision (with a target of 39% of PLWHA by 2009/10) and training of health care staffing provision of ART.
- Improved home-based care, with a target of reaching 50% of PLWHA and other support for persons living with AIDS, including help with income-generating activities

However, the implementation of this strategy is an uphill task for Ethiopia, a country where more than half of the population lives below the poverty line. Ethiopia needs more resources and commitment to scale-up existing programs, intensify and deepen the prevention of HIV/AIDS, care for infected people, and to enhance treatment efforts. This will require, among other things, “stronger commitment and increased engagement of every citizen, government, and civil society as well as assistance from partners for many years to come (FMoH/NHAPCO 2007:8).

Under the PASDEP the government plans to continue the emphasis of the last six years under the Health Sector Development Programs (HSDP I and II, and now extending into HSDP III), with a focus on poverty-related health conditions communicable diseases such as malaria and health problems that affect mothers and children. It attempts to concentrate on rural areas and on extending services outwards from static facilities to reach villages and households.

The national policy framework that guides programming in the health sector includes the National Child Survival Strategy that has set the overall objective of reducing under-five mortality to 67/1000 by 2015 to achieve the MDG. The strategy addresses the major causes of child mortality that account for 90% of under-five deaths i.e. pneumonia, neonatal conditions, malaria, diarrhoea, measles, malnutrition and HIV/AIDS. Related elements of the framework, discussed elsewhere in this document, include the National Reproductive Health Strategy, the National Population Policy, the strategic response for Prevention and Control of HIV/AIDS, and the National Policy on Women.

Despite progress to date, coverage of the system remains inadequate, and the quality of services available, especially in rural areas, is variable. The focus under PASDEP will continue to be towards primary health care and preventative services; with a big focus on extending these services to those who have not been reached, and improving the effectiveness of services, especially addressing difficulties in staffing and the flow of drugs. The major objectives during the program period include:

- To cover all rural kebeles (parish, the lowest administrative unit) with the HSEP to achieve universal primary health care coverage by year 2008;
- to reduce the maternal mortality ratio from 871/100,000 to 600 per 100,000 live births;
- to reduce under-five mortality from 140 to 85 per 1000 population, and the infant mortality rate from 97 to 45 per 1000 population;
- to reduce total fertility rate from 5.9 to 4;
- to reduce the adult incidence of HIV from 0.68 to 0.65 and maintain the prevalence of HIV at 4.4%;
- to reduce morbidity attributed to malaria from 22% to 10%;
- to reduce the case fatality rate of malaria in age groups 5 years and above from 4.5% to 2% and the rate in under-5 children from 5% to 2%; and
- to reduce mortality attributed to TB from 7% to 4% of all treated cases.

Table 2.2 Selected Targets under PASDEP

Indicator	Current Status (2003/04)	Target (2009/10)
Contraceptive Prevalence rate	23%	45%.
Deliveries attended by skilled attendants	9%	32%.
Prevalence of teenage pregnancy	20%	5%
Prevalence of unsafe abortion	50%	10%
Proportion of households with 2 bed nets, properly utilized	2%	49%
Latrine coverage	20%	80 %
Potential health services coverage	64%	100 %.

Source: MoFED (2006)

There were significant challenges that have emerged during the course of HSDP I and II, many of them related to logistics management and staffing.

- Inadequate health service utilization, and weak implementation of the referral system; Delayed implementation of a health service delivery system that is suitable for the pastoralist population; Lack of adequate capacity to implement decentralized health system at woreda level
- Shortage, high turnover and management of staff; Variable quality in training, ineffective deployment and inequitable distribution of human resources among regions;
- Difficulties in management and utilization of resources, both financial and logistic (drugs, medical equipment and supplies);
- Delays in formalizing the agreement with some partners and slow absorption of approved funds, such as Global Fund to Fight HIV/AIDS (GFATM).
- Insufficient coordination of public-private activities in the health sector
- Inadequate construction implementation capacity, leading to slow rehabilitation and maintenance of facilities.

In order to achieve the goals and objectives outlined above, HSDP-III has adopted strategies, which include the promotion of healthful living; enhancing the capacity of district health offices in the expansion of PHC facilities and services; Improving the number, skills, distribution and management of health workers; ensuring the planned training of health managers in adequate number and appropriate knowledge and skills; improving the health information system and the capacity for effective monitoring and evaluation; ensuring full community participation in the planning, implementation, monitoring and evaluation of health care; and promoting inter-sectoral collaboration and coordinate the activities of the public sector, private sector, international organizations and NGOs in health interventions.

2.3 The Response of NGOs

Because non-state actors are increasingly recognized, globally and locally, as important partners in development, they are continually invited to be involved in issues of national and global concern, such as policy dialogue, environment, civil society, good governance, etc. In Ethiopia most of the major NGOs are organized under an umbrella organization known as Christian Relief and Development Association (CRDA), the CRDA, other NGOs and civil society play a major role in policy advocacy, including advocacy concerning the need to put in place and implement strategy to fight HIV/AIDS.

In response to the pandemic, one of the contentions of the CRDA is that the Government has not fully mainstreamed HIV/AIDS into development plans:

Ethiopia's response to HIV/AIDS so far has focused on preventing new infections through advocacy, information and education campaigns, behaviour change communication, condom distribution, and risk group targeted programs. Another important part of the response has been the provision of treatment and care for people infected and affected by HIV and AIDS.

However, the bigger agenda of considering HIV/AIDS as a development issue has not been taken into account including the impact of increased mortality and morbidity on poverty reduction efforts in the country (CRDA, 2005).

The CRDA established the HIV/AIDS Forum with the objective of promoting causes of people infected and affected by the pandemic. So far, according to CRDA, the Forum has:

- Assessed media changes with responses to HIV/AIDS in Ethiopia. Findings of this assessment are believed to help for influencing decisions of the Ethiopian Ministry of Information and hopefully that of the Parliament.
- Actively participated in the coordination and financial support of development of CSOs' proposal for Global Fund-Round Five.
- Finalized preparations for a study that would assess the capacity of Forum members, particularly national NGOs to record good practices of NGOs in their response to the HIV/AIDS pandemic. The Forum believes that the findings of the study will further popularize the NGO sector as the pioneers in HIV/AIDS interventions in the country.
- Contributed to partnership and collective voice against the disease through its permanent engagement in the National Partnership Forum against AIDS in Ethiopia.
- Produced a collective paper on the integration of HIV/AIDS issues into the Strategic Development and National Poverty Reduction Programs for which a representative attended a regional training program in South Africa.

Moreover, a tripartite agreement was signed among CRDA, Irish Aid and the HIV/AIDS Prevention and Control Office (HAPCO). The overall objective of this agreement is to contribute towards the national multi-sectoral response of combating the spread of HIV/AIDS and minimize the effect of the pandemic focusing on the two regional states. As a result, 45 projects were approved in two phases covering the period 2003-2005. In addition, CRDA had signed an agreement of 20 million birr to combat HIV/AIDS and protect the environment.

All implementing partners of CRDA, one way or the other, have responded or contributed to the national HIV/AIDS strategic framework in their respective areas. By and large, their interventions revolved around: awareness raising, voluntary counselling and testing, IEC/BCC, care and support, skill training, establishment of anti-AIDS clubs, provision of drug for opportunistic infection and community empowerment. In 2005, CRDA approved 18 HIV/AIDS-oriented projects in seven administrative regions of the country the cost of which amounted to a total cost of 15.1 million birr (CRDA2005).

The CRDA has put forth recommendations to the GoE on its strategy against HIV/AIDS, which include:

- Integrate the main strategies, targets and indicators in the National HIV/AIDS Action Plan focusing on prevention, care and support.
- Emphasize multi-sectoral approach by outlining how major policies and sector development programs are required to respond to the pandemic.
- Allocate part of funds released through HIPC debt relief towards the national effort to mitigate the impact of HIV/AIDS, including the supply of antiretroviral medicines.
- Review employment legislation in order to remove the potential for stigmatizing or discriminating against PLWHA.
- Strengthen the capacity of the National HIV/AIDS Council and arrange its participation in the PRSP process.
- Mitigate the impact of AIDS on families, as the deaths of breadwinners undermine all poverty reduction efforts.

3 Funding the Fight Against HIV/AIDS

Although some improvements could be made towards existing institutional constraints and inefficiency of resource utilization, a more important problem in Ethiopia is the meagre resource envelope available for health sector development. The total health budget in the country amounts to about US\$1.50 per person per year, compared to the US\$30-40 recently recommended as an absolute minimum by the WHO's Commission on Macroeconomics and Health. Hence, greater emphasis is required to increasing health's share of total public expenditure and involvement of donors in the health sector in Ethiopia.

3.1 The Programme Costs of HIV/AIDS

The cost of combating AIDS in Ethiopia is enormous, prevention care and treatment of AIDS requires unbearable financing. In the first PRSP, the Government estimated that it required nearly one billion birr to contain the prevalence rate at 7.3% by 2005. Of the total sum, 44% was earmarked for prevention proposes (MoFED 2002). The breakdown of the cost of combating the epidemics for the period 2002/03- 2004/05 is indicated in the following table.

Table 3.1 Medium Term Program Costs for HIV/AIDS (Million birr)

	Program/ Activity	2002/03	2003/04	2004/05	Total 3 Years
1.	Capacity building	42.4	31.4	36.0	109.8
2.	Government multi-sectoral response	103.3	90.3	103.5	297.1
	Prevention	69.2	47.1	54.0	170.3
	Care and support	34.1	37.9	43.4	115.4
	Research & surveillance	0.0	5.3	6.1	11.4
3.	Emergency HIV/AIDS fund	130.7	141.3	162.0	434.0
	Prevention	88.1	78.5	90.0	256.6
	Care and support	36.8	47.1	54.0	137.9
4.	Project coordination & management	8.7	52.0	59.6	120.3
	Total	285.2	315.0	361.1	961.3

Source: National HIV/AIDS Secretariat, US\$ 1= 9.03 birr

The cost of financing the fight against HIV/AIDS is included in the Government's major policy document, the Plan for Accelerated and Sustained Development to End Poverty, PASDEP. It will cost an annual average of 351 million birr over the period 2006/07-2009/10. This comes to 9 percent of total (estimated) expenditure on health at the end of the plan period, which is 15,376 million as a total cost of health. At this juncture, it is interesting to note that the share of poverty-oriented expenditure in the total indicative program cost steadily rise from 63% in 2005/06 to 83% at the end of the plan period (i.e. 2009/10) (MoFED 2006).

Between 2002 and 2005 a total of 981,813,000 birr was mobilized to fight HIV/AIDS. Of this sum, the treasury contributed 2.2 percent (i.e. 21.7 million birr). The sources of financing for HIV/AIDS, which is now dominated by Global Fund (amounting to 444 million birr out of a total of 752 million in 2005, the year it began funding in Ethiopia), included the treasury, IDA of the World Bank and others. The Global Fund and IDA contributed 45.2 and 42 percent, respectively. The remaining 10.6% originated from different sources including NGOs. (See Figure 2)

Table 3.2 Fund Disbursed to different implementers/bodies by source of fund and year 2002-2005 (In 000 Birr)

Source of Fund	2002	2003	2004	2005	Total	%
Government	1,200.0	2,345.4	7889.2	10,243.1	21,677.7	2.2
IDA	22,625.5	78,158.1	72,078.9	239,013.6	411,876.1	42.0
GF	-	-	-	443,944.6	443,944.6	45.2
Others	-	31,225.8	14,692.5	58,396.2	104,314.5	10.6
Total	23,825.5	111,729.3	94,660.5	751,597.5	981,812.9	100

Source: HIV/AIDS Prevention and Control Office

Table 3.2 also speaks to the variability of disbursed funding to the HIV/AIDS fight. During the period 2002-03, Ethiopia experienced a change in 368.9%; from 2003-04, there was a decline of 15.27%; and from 2004-05, there was an increase in 693%.

Table 3.3 illustrates how much was spent in the various areas related to the HIV/AIDS programme. The table reveals that Ethiopia was able to adjust its activities accordingly, as the resource envelope varied.

Table 3.3 Fund Utilization by Major Intervention Areas in 000 Birr 2002-2005

No	Intervention Areas	Year					
		2002	2003	2004	2005	Total	%
1	Prevention	6,641.6	25,887.6	28,847.6	127,930.0	189,306.8	22.6
2	Treatment	-	21,160.4	22,707.6	225,472.4	269,340.4	32.1
3	Care & Support	4,755.7	16,826.6	17,790.3	113,580.0	152,952.6	18.2
4	Capacity Building	5,852.8	21,881.4	14,194.6	125,805.2	167,734.0	20
5	Management & Coordination	2,909.8	10,338.1	12,591.8	23,292.4	49,132.1	5.8
6	Monitoring & Evaluation	351.8	825.0	1585.7	7683.6	10,446.1	1.2
	Total	20,511.7	96,919.1	97,717.6	623,763.6	838,912.0	

Source: HIV/AIDS Prevention and Control Office

In the national plan (2005/06-2009/10) the Government admitted that it does not have sufficient funds to meet the requirements of the poverty oriented sectors (i.e. health & HIV/AIDS, education, agriculture, water & sanitation, and roads). The Government's five-year plan envisaged that "sectoral short falls need to be covered from donors' assistance, community contributions and NGOS as far as possible" (MOFED 2006:129) It notes that.

As indicated in the following tables within the budget allocation to health and education is quite high Education alone received equal allocation as agriculture, a sector a source of livelihoods for 80% of the population. During the five-year plan (2005/06-2009/10), the share of health and education averaged 38.4% of the total funds allocated to poverty-oriented sectors. The share of health (including HIV/AIDS) which was only 5% in the base year averaged 18.7% during the plan period. The share of education, which surprisingly enough dropped from 25.5% during the base year to 19.5% in the following year, averaged 19.7% over the plan period (see Figure 7).

Table 3.4 Capital Expenditure on Health for the Regional states, 2006/07 (Percent)

Sub-Sectors	Percent
Primary health, clinic and health stations	63.0
Hospitals	30.6
Malaria Prevention	1.7
Nurse Training	4.7
Health Total	100.0

Source: Regional State 1999 EFY Consolidated capital Expenditure Budget, Ministry of Finance and Economic Development

Table 3.5 Indicative Spending Level for Health and Education, PASDEP 2005/06-2009/10 (Percent)

Year	Health	Education	Health & education	Share of other poverty - oriented sectors	Poverty-oriented sectors
2005/06	5.0	25.5	30.5	69.5	100.0
2006/07	15.0	19.5	34.5	66.5	100.0
2007/08	20.0	18.8	38.8	61.2	100.0
2008/09	22.0	19.7	41.7	58.3	100.0
2009/10	24.0	17.2	41.2	58.8	100.0
Average	18.7	19.7	38.4	61.6	100.0

Source: Computed from MOFED 2005.

3.2 Fiscal Challenges

A profile of government's fiscal stance is as follows. The consolidated federal and regional budget for the fiscal year 2006/07 indicates that the ratio of government revenue to GDP stood at 23.1%, while tax revenue was 16.7%. Current expenditure came to 17.3% of GDP. Of current expenditure, poverty-targeted expenditure constituted the largest ratio (i.e. 6.9% of GDP). Of this, health was only 1.1%, while education stood at a higher ratio, i.e. 4.1% of GDP. Agriculture has one of the lowest ratios (i.e. 1.6% only). The ratio of capital expenditure to GDP was 20.3% (of which poverty-targeted expenditure was 15.5%)(1).

The deficit in the government budget has remained wide and worrying in spite of the government's consistent commitment to IMF's stabilization policies and prescription. In 2006/07 the over all balance (excluding grants) was -14.5% of the GDP. When grants are included in the budget, the deficit comes down to -6.6%. The deficit financing mechanisms included net external flows (3%, of which HIPC was 1.1%) and the domestic banking system (3.5%).

In 2006/2007 budgeted recurrent expenditure on health accounted for 0.9% of the total government expenditure as compared to 11.9% for education and 31.6% for defence. In the same year, health accounted for 8% of total capital expenditure as compared to 19.4% for education and 30.4% for agriculture and natural resources (FDRE 2006). Recurrent budget for National HIV/AIDS prevention and control office was budgeted for 2006/07 amounted birr 140,200. Obviously, this sum is extremely small as compared to requirement.

During the last seven years, expenditure on health has averaged only 5 percent of the total recurrent and capital expenditure of the Government, while expenditure on education averaged slightly more than three times that of health (16.8%). Agriculture received 10%; natural resources, 4.4%; and road construction, 10.2%. Together, all the components of poverty-reducing sectors received an average of 46.3% of total expenditure during the period 1999/00-2005/06 (see figure 3.).

The poverty reducing sectors (PRS) together, received increased attention following the launching of the country's first PRSP at the beginning of the decade. Accordingly the share of PRS aimed at "Poverty-targeted expenditures" increased sharply from 26.8 in 1999/2000 to 41.4% in the following year.

1. Computed from Ministry of Finance and Economic Development, Ethiopia

By 2005/06 its share rose to an all time high of 60% percent of recurrent and capital expenditure have (or 15.2% of GDP at current market price). Of the component of PRS, education got the highest priority as its share rose from 9.3% in 1999/2000 to an all time high of 21.8% in 2005/06. However health although no less important than education has received less attention in terms of budget allocation as its share marginally increased from a low of 3.2 % in 1999/2000 to a high of 6.4 % in 2000/01 and then almost steadily declined to 4.6% in 2005/06.

The health sector depends heavily on external assistance for financing recurrent expenditure, while education and training depends, mainly, on the treasury. During the budget year 2006/07, 84.5% of the recurrent expenditure for health came from external assistance. This implies that key sub-sectors, such the prevention, care, and treatment of AIDS, are likely to depend on external assistance, which is hard to come by as required.

When it comes to education, it is the treasury rather, which constitutes the bulk of recurrent expenditure. In 2006/07 education and training received 81.2% of its recurrent budget (such as salaries of teachers and trainers) from the treasury. Of recurrent expenditure, health salaries account for 70% while operating expenditure accounts for the rest are 30%, with corresponding ratios for education at 80.6% (salaries) and 19.4% (operating expenditure).

The nature of the spending should also be noted. Regarding fund utilization, during 2002-2005, we note that treatment accounted for almost one-third of the total expenditure. Prevention has received 22.6%, while capacity building received 20% care and support received 18.2%. The rest went to monitoring and evaluation and management. The HIV/AIDS prevention activities under way with 120 million USD secured from the Global Fund have been registering encouraging results, the National HIV/AIDS Prevention and Control office (HAPCO) said. Some 50 per cent of the finance would be used for the purchase of anti-retroviral drugs. The number of VCT centres during the past three years when the Fund has been functioning, has jumped from 170 to 915. Counselling and testing services thus reached 2.5 million people as the institutions were fully equipped, he added. The number of the health institutions that provide ant-retroviral drug has similarly grown from 22 to 261, according to the coordinator (Herald, 2007).

Ethiopia has secured huge sum of financial support from the Global Fund. According to a press release by an official from the HAPCO, during the last three years, Ethiopia has secured US\$ 129 from the Global Fund to run its on-going programs and has submitted a proposal requesting an additional \$40 million for the coming three years. The money will be spent on activities including HIV/AIDS prevention, treatment, care and support as well as capacity building. The official further suggested that 50% of the sum will be used for the purchase of antiretroviral drugs.

There are some challenges spelt out by the same organization, HAPCO. There have been problems regarding availability of adequate funds, fund disbursement, and settlement of expenditure. Implementing agencies, both in the public and NGO sectors, have manifested capacity limitation in fund management, utilization and settlement of expenditure.

Secondly, the major source of fund for the hitherto activities are multilateral and/or bilateral external sources either through grant or soft loan. Though it appears that the PASDEP has not experienced a finance gap, the sustainability is in questionable given the variability of financing. Ensuring adequate and timely financial resources has always been and will continue to be a challenge. Under-absorption and utilization of funds within a given period will also remain to be a challenge.

Thirdly, Ethiopia depends heavily on external finance for funding government budget. For example, during the budget year 2005/06, the Government relied on assistance and foreign loan for 34% of the total. Multilateral flows constitute the bulk of official financial flows.

4 Macroeconomic Implications of Increased Fiscal Spending

4.1 Macroeconomic Framework with Particular Reference to Public Budget

The Government's macroeconomic policies and strategies for the plan period 2005/06- 2009/10 is that the government plans to achieve a minimum of 7% of real GDP growth over the plan period. Agricultural value-added is expected to grow at an annual average real rate of about 6.2% during the plan period, while the value-added for industry and services is expected to grow at annual rates of 11.5% and 7%, respectively. The plan envisages a decline in consumption as domestic savings is projected to increase over the period 2005/06-2009/10. On the other hand, external deficit is envisaged to remain high as import is expected to remain at 31% of GDP as compared to exports, which is projected to remain at only 20% of GDP by the end of the plan period (MoFED 2006).

The plan envisages that:

The Government will continue to pursue prudent expenditure policy by continuing to restrain public expenditure on difference and non-priority sectors and protect poverty-targeted outlays and capital expenditure, while containing total spending within affordable limits (MoFED 2006: 58).

Total expenditure is expected to be financed from the following sources: external grant, external project loans, and domestic bank borrowing (MoFED 2006: 202). Further, the plan envisages that expenditure on poverty-targeted outlays be financed from debt relief initiative of Highly Indebted Poor Countries (HIPC), of which Ethiopia is one of the beneficiaries. The plan states that:

External grants are projected to increase only modestly from about 4.6 billion birr in 2004/05 to 8.6 billion birr by the end of the PASDEP period. It is hoped that a more rapid increase will take place in the spirit of scaling up to help Ethiopia reach the MDGs, but to be cautious a conservation approach is adopted here, assuming no better than the historical trend in aid receipts is forthcoming (MoFED 2006:201-202).

The plan itself states that: the projection provided here did not take into account the scaling up efforts that is being advanced globally to reach MDGs" (MoFED 2006:202). In fact, studies suggest that it is an uphill task for Ethiopia to achieve targets of MDGs (Dejene 2006).

Here, it is important to recognize that the Government's fiscal framework (i.e. public budget framework) excludes a lot of sources of finance and expenditure items, including Global Fund to Fight Tuberculosis, Malaria and AIDS, programs funded by NGOs (including the fight against HIV/AIDS by NGOs), direct financing of projects by some bilateral donors, commodity aid, etc., and various types of expenditures (MoFED 2006:202).

Coming to the financing of the fight against HIV/AIDS, the Government expects non-budgetary sources to take the lead. In fact, the Government's major policy document, PASDEP (MoFED 2006:203) recognizes that:

Almost the entire HIV/AIDS program is being funded by non-traditional external donors [such as Global Fund]; and there are substantial community, NGO, and private sector contributions in many sectors, for example, in education and rural water supply.

This implies that in the Ethiopian case the fight against HIV/AIDS will be financed largely from off-budget sources like Global Fund, NGOs, civil society organizations, and the private sector.

4.2 Fiscal Space and the IFIs

In what follows, we will attempt to highlight the macroeconomic policy regime in Ethiopia with a view to shedding light on the policy space shared by international financial institutions and the Government of Ethiopia.

4.2.1 Ethiopia and the World Bank

While it recognizes that domestic revenue as a share of GDP is fairly high, the Bank (2007) notes that revenue is overly dependent on foreign trade taxes (which accounted for 37% of domestic revenue in 2004/2005).

It is likely that the Bank disapproves such a high dependence on foreign trade on the grounds that the Government may be reluctant to further liberalize trade (i.e. significantly cut tariff rates) for fear of revenue loss.

A further worry of the Bank is that, in the medium term, “the tension between maintaining macroeconomic stability and financing Ethiopia's huge investment needs prompt concerns about inflationary and crowding out impacts of increased fiscal deficits”. Although it commends the government for “a solid record of macro-stability”, the Bank underlines that there are increasing symptoms of “macro-economic fragility including the worsening of the current account balance and trade deficit” in 2004/05 and 2005/06.

The Government's main policy document, PASDEP, envisaged that inflation, which stood at 7% in 2004/05, was projected to average below 10% per annum over the next five years; that is 2005/06-2009/10. This was due to anticipated increase in aggregate demand owing to the expected economic growth (MoFED 2006:116). However, inflation in Ethiopia was higher than expected, reading 12.3% in 2006 (World Bank 2007:36). In a recent interview with the media, the Minister of Finance and Economic Development disclosed that the inflation rate has reached 17%.

On the other hand, the causes of such a sudden inflationary pressure have remained controversial. The Government attempts to explain it in terms of excess demand for food and non-food commodities, while others attempt to suggest various factors, including supply side constraints. For example, in its latest “country economic memorandum”, the World Bank (2007:36) hypothesized the following as possible factors behind the current inflationary pressure in Ethiopia.

The Bank would like to see reduced public spending for the sake of stabilizing the economy in line with IMF's prescriptions. Accordingly, the Bank identifies “large and lumpy spending needs” of the Government as one of the factors explaining the need for external assistance, although the revenue-GDP share is high.” Of the “large and lumpy spending” that the Bank frowns against, public investment on infrastructure can be singled out as the major one. Apparently, infrastructure is a priority sector for a government, as stated in the PASDEP. As stated earlier, universal access is challenged by the fact that 50% of the people living with HIV/AIDS live in rural areas where accessibility is a primary concern.

Regarding prioritization of expenditure (an area in which the Government often disagrees with the World Bank), the policy document notes that “in the Government's view, there should not be a compromise on the targets set for the period of the PASDEP” (MoFED 2006:207). As indicated in the following table, the Government is not going to yield to pressure from major donors regarding sectors it considers as top priority (e.g. primary education, agricultural extension, and water supply). Prioritization is required due to shortfalls in aid flows, given domestic resource gap. The Government expects a huge budget deficit, amounting to 10.2% GDP, during the plan period. Thus, the plan underlines that “to the extent that the gap can still not be closed; there will be prioritization within the sectoral programs to protect spending on the highest priority interventions” (MoFED 2006:208).

4.2.2 Ethiopia and the International Monetary Fund

Currently the debate between IMF and the Government is centered on the ever-deepening inflationary pressure⁽²⁾. The IMF insists that the main cause of inflation in the country is credit expansion to the public and private sectors. On the other hand, the Government argues that the primary cause of the current inflation demand expansion due to unprecedented economic growth (10% GDP growth rate for 3 consecutive years).

In the most recent Article IV Consultation, IMF staff expressed concern over the recent spikes in inflation and declined foreign exchange reserves. It was noted that official reserves have been declining, mainly because disbursements of external assistance have been delayed and the GoE has had to use its reserves towards planned activities. However, regarding inflation, the staff cautioned that action was needed promptly to prevent expectations of high inflation from becoming entrenched. In particular, the staff stressed that remedial actions to address macroeconomic imbalances should be based on prudent fiscal and monetary policies and a more flexible exchange rate (IMF, 2007).

Ethiopia has argued that the factors contributing to the high inflation should be studied further before taking additional policy actions. A number of events have occurred that merit further analysis. Poverty expenditures have increased 30.7% and additional capital expenditures (poverty-related) has increased by 30.5% in the year 2005/06.

2. Inflation hit 19% in February 2007.

Though the former was spent on imports (mainly medications), the latter could have an inflationary effect; albeit temporarily, as a longer-run result would be an expansion of supply capacity. ODA financing of HIV/AIDS expenditures is not likely, by itself, to be destabilizing. In general, its effect will depend on both the composition and the size of expenditures. If aid for HIV/AIDS is in-kind (such as medicines), this will, by definition, have no monetary impact. If the government uses foreign currency to purchase imports (instead of converting it into domestic currency), there will also be no effect (McKinley and Hailu, 2006).

Movements in the private sector can also not be ignored as a potential contributor to inflation. Net private transfers and net foreign direct investment have experienced a marked increase. In 2005/06, the former increased by 21.1%, and the latter, by 143%. Both can have the effect of competing with domestic capital and drive up the price of local goods/services. The absolute volumes are listed in Table 4.1.

Table 4.1 Private Capital Flows in Ethiopia, USD millions

	2003/04	2004/05	2005/06	2006/07
Net Private Transfers	771	1023	1229	1501
Net Foreign Direct Investment	150	150	365	404

Source: IMF (2007)

Another area of disagreement between the Fund and Ethiopia is the pace of privatization of state enterprises. Ethiopia has already sold off some state enterprises, including 30% of the main telecoms operator. But, the Fund has kept on pressing that the GoE sells more of state enterprises. But the Government stood its ground and resisted a wholesale privatization of state enterprises. In September 2003, it was reported that Ethiopia's Prime Minister hit out at continuing pressure from international financial organizations to push forward the country's privatization process. In a speech he delivered to an investors meeting in Addis Ababa, he said that the repeated recommendations to sell loss-making state corporations was counter-productive⁽³⁾.

This is characteristic of the IMF's narrow categorization of the pandemic. Containing the pandemic requires addressing it on a number of levels, which includes physical accessibility and socio-economic factors. A significant proportion of financing should go to public investment that can expand the capacity of the health system. Otherwise, large quantities of imported medicines, such as antiretrovirals, cannot be delivered to the people who need them (McKinley and Hailu, 2006). The PASDEP identified these as being those concerned with road networks and social services (e.g. electricity and water).

4.3 Social Spending and Indebtedness in Ethiopia

Ethiopia has accumulated a huge amount of external debt over the years. In 1999/2000, Ethiopia's public and publicly guaranteed debt amounted to US\$ 5.5 billion in nominal terms (MoFED/UNCT 2004). Ethiopia's major creditors are the World Bank, the Paris Club, and other multilateral institutions.

The government's domestic borrowing, which rose to 3.5 percent of GDP in 2004/05, has remained higher than what was budgeted. The stock of domestic debt of the government stands at about 35% of GDP. The main reasons behind such as domestic debt are believed to be short falls in revenues and reduced aid flows in the aftermath of the May 2000 national election, which was marred by political conflicts⁽⁴⁾.

In 2004, the Fund and the Bank agreed that Ethiopia had made "sufficient progress" and taken necessary measures the enhanced HIPC initiative. Ethiopia's track record was rated as "strong" in implementing reforms and "prudent" in borrowing despite adverse effects of drought and low prices of coffee. Thus, Ethiopia became the thirteenth country to get approval under this initiative. The total debt service relief under the enhanced HIPC initiative from all of Ethiopia's creditors (including Russia to whom Ethiopia owed a huge sum) amounted to about US\$ 3.3 billion in nominal terms. Resources made available by debt relief under the HIPC initiative were earmarked for pro-poor expenditure programs (such health and education). Ethiopia was entitled to debt relief under enhanced HIPC after it met the programme conditions of completing and implementing the PRSP and implementation of the structural reforms put forth in the PRGF.

3. (<http://www.cropwatch.org/article>)

4. See IMF document: <http://www.imf.org/external/np/sec/pn/2006>

Debt relief as a ratio of poverty expenditure remains almost insignificant. During 2001/02-20003/04, HIPC relief as percent of poverty-targeted expenditure was just below 7 percent (MoFED/UNCT 2004:31). Table 4.2 below lists the financing flows for comparison against poverty expenditures.

Table 4.2 Comparison of Expenditures and Financing, millions Birr

Flows	2003/04	2004/05	2005/06	2006/07
Poverty Expenditures	4045	4968	6493	7690
Capital expenditures (poverty - related)	6130	9036	11796	17287
Grants	4003	4565	4721	8845
Net External Financing	2399	4649	5074	6252
HIPC	678	728	926	1154
Net Domestic Financing	180	2255	3561	3731
Debt Service	1080	1011	1054	1446

Source: IMF, 2007

From the table it can be observed that development spending has traditionally been under-resourced, with the financing gap filled by borrowing.

5 Recommendations and Conclusion

In Ethiopia, AIDS has caused havoc in terms of high prevalence rates, death, and suffering of young people. The economic and social consequence of AIDS has reached worrying proportions. Thus, Ethiopia needs substantial financial support from donors to fight HIV/AIDS. As the treasury allocates very little to the fight against HIV/AIDS, the country relies on grants from external sources, in particular from the Global Fund. However, the available fund is far from being utilized efficiently and effectively. Even if used effectively, available resources (including domestic resources and funds from Global Fund) fall short of what is required to successfully control the spread of HIV/AIDS and reverse current trends.

Obviously, official development assistance is indispensable for the campaign against the epidemic. Ethiopia, one of the poorest countries in the world, depends heavily on official development assistance (56% of the required finance) and to support public expenditure on social services. However, real per capita flows of ODA have remained not only extremely low, but also unpredictable and unsustainable. On the other hand, the country's debt burden has remained quite high, despite the recent debt relief that the country received under the HIPC initiative.

The IMF's interventions in Ethiopia has confirmed observations of Nayyar & Court (2002) which is that by encroaching upon a sovereign state's right to formulate independent national policies, the IMF has denied government ownership of macroeconomic policies and a say in the prioritization of public expenditure and the IMF's conditionalities has been expended into areas that have no direct bearing on the macroeconomic adjustments (e.g. privatization). In some respects, the macroeconomic framework of social spending can be a constraint to the flows of funding to priority areas. The Government has limited space to explore alternative strategies on how to balance macroeconomic stability with social spending.

Therefore, regarding conditionality of IMF/World Bank, and aid flows, what should be recommended that:

- As demonstrated by the current inflationary pressure in Ethiopia, the stabilization of program of the IMF (Which is based on the priciest argument of the liberal school) is unlikely to work in the Ethiopian context, where the economy is highly constrained by structural problems. Therefore, the donor community should allow the government to stabilize the economy through changes in output rather than through price adjustment (witness the recent increases in bank interest rate which, contrary to the IMF's advice, failed to reduce the rate of inflation). In a country where, in many cases, economic activities take place inside the production possibilities frontier, it is desirable to boost public spending to expand employment opportunities and increase output to a level required to meet rising demand for basic necessities including food which is a major component of household expenditure (Note: in Ethiopia the rate of inflation is positively and strongly correlated with food prices).

Coming to domestic measures to combat the spread of HIV/AIDS, one will like to recommend that the Government consider the following options:

- Improving the Utilization of already available funding to combat HIV/AIDS
- Improving transparency and accountability stance in utilizing aid money.
- Designing a more effective package of policies to fight the HIV/AIDS by drawing from the experiences of successful countries (like Thailand).

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