HIV/AIDS in Heavily Indebted Poor Countries and Global Finance

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The paper puts an issue of public health into the context of global finance with a particular reference to Highly Indebted Poor Countries (HIPC) Debt Initiative. The discussion focuses on HIPCs with an adult prevalence rate of HIV above 4%. Thus, emergent case of public health issue is situated in a global finance perspective. The purpose is to show that even with such a devastating problem the international commitment to address global public health problems is not yet adequate. The paper emphasizes the importance of the international organizational and procedural framework for dealing with a global public problem like HIV/AIDS.

The HIPC Initiative

The HIPC Debt Initiative was launched by the World Bank and the IMF in 1996 as the first attempt for a comprehensive effort to eliminate unsustainable debt in the world's financially poor and most heavily indebted countries. The goal of the HIPC Debt Initiative was "to reduce HIPC debt burdens to levels that can be serviced without recourse to further rescheduling, in the context of a sound growth and development program" [World Bank 2000, 62]. The World Bank coordinates 20 multilateral institutions in operating this program. The International Monetary Fund (IMF) coordinates with the bilateral creditors.

To qualify for HIPC assistance, a country must be eligible to borrow from the IMF's Poverty Reduction and Growth Facility (PRGF), formerly known as the Enhanced Structural Adjustment Facility (ESAF). PRGF loans carry an interest rate of 0.5 % per year, and are repayable over 10 years with 5.5 years of grace period on principal payments. Each country must have established a track record of adjustment and reform supported by the IMF and the World Bank. Eligible countries are those who face an unsustainable debt load after full application of existing debt relief mechanisms [World Bank 2000, 56].

Sustainable debt level means "a country is able in all likelihood to meet its current and future external obligations in full without resorting to rescheduling in the future or accumulation of arrears" [World Bank 2000, 55]. Sustainability in this case is a pecuniary category and does not refer to elements of livelihood. For example, Angola and Kenya were announced to be sustainable cases, although both countries are among the 28 countries with a HIV prevalence rate above 4 %, and have a need to dedicate adequate financial resources to public health.

Countries are considered eligible for HIPC assistance after maintaining a three yearlong track record of macroeconomic, structural, and social policy reforms, monitored by the World Bank and the IMF. A country's eligibility for assistance is determined by

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the Boards of the Bank and the IMF on the basis of debt sustainability analysis undertaken by the country's government and Bank and IMF staff. Toward the end of the three-year performance period required for a country to be considered for a stock-of-debt operation *(the decision point)*, an analysis is made of whether this operation, together with comparable action by other non-multilateral creditors, would be enough to achieve debt sustainability after another three years *(the completion point*, noted in following tables as CP*)*. Only 4 out of 41 HIPC countries have reached the completion point as of 2002 – Bolivia, Mozambique, Tanzania, and Uganda. Countries for which existing debt relief mechanism would not achieve sustainability in the three years following the decision point would receive enhanced relief under the initiative, adequate to achieve debt sustainability by the end of that period. In addition, continued compliance with the austere policy reform is expected [World Bank 2000, 58].

Thus, eligible countries qualify for debt relief in two stages. In the first stage, the debtor country needs to "demonstrate the capacity to use prudently the assistance granted by establishing a satisfactory track record, normally three years, under the International Development Association (IDA) - and IMF-supported programs" (World Bank, 2001). The World Bank is concerned about a potential "moral hazard" in the international payment system.

> The performance period addresses the potential moral hazard problem that could arise if debt relief were seen as a reward for poor economic policy performance. The requirement of track record also provides some assurance that debt relief will be provided in a context in which the resources released as a result will be used for sound development purpose [World Bank 1998, 56].

In the second stage, after reaching the decision point under the Initiative, the country "will implement a full-fledged poverty reduction strategy, which has been prepared with broad participation of civil society, and an agreed set of measures aimed at enhancing economic growth." During this stage, IDA (which is a lending institution, part of the World Bank Group) and the IMF grant *interim relief*, provided that the country stays on track with its IDA - and IMF-supported program. In addition, creditors "are expected to grant debt relief on highly concessional terms" [World Bank 2001].

At the end of the second stage, when the floating completion point has been reached, IDA and the IMF will provide the remainder of the committed debt relief, while Paris Club creditors will enter into a highly concessional stock-of-debt operation with the country involved. World Bank recognizes that, "…multilateral and bilateral creditors will need to contribute to the debt relief on comparable terms" [World Bank 2001].

An initiative that is seen by the international organizations as a complementary to HIPC is the Poverty Reduction Strategy Paper (PRSP) initiative. PRSP is also is seen to be a tool that can be used to mainstream the fight against HIV/AIDS [Hecht 2002]. The PRSP is simply an initiative that sets out a country's approach to poverty reduction in the form of documents in which low-income countries describe the policies and programs they *expect* to put in place and the associated external financing needs. The hope is that

PRSP documents can be used by the donor community as a framework for technical and financial support.

To qualify for debt relief under the HIPC Initiative, 40 low-income countries took the first steps toward elaborating a full PRSP during 2000-01 by preparing an interim PRSP in which they began to analyze the extent and causes of poverty and the main actions needed to combat it. By the end of 2001, 8 countries had completed and published full PRSPs.

The UNAIDS (a UN Agency focused on AIDS) Secretariat reviewed the first 25 full and interim PRSPs prepared by Sub-Saharan African countries in order to see how they are dealing with HIV/AIDS [Hecht et al. 2002]. The review was based on four criteria: (1) analysis of the relationship between AIDS and poverty; (2) inclusion of the main strategies from the country's national AIDS plan; (3) use of medium-term AIDS prevention and care goals and indicators for monitoring poverty; and (4) incorporation of monitorable short-term actions [Hecht et al. 2002]. According to these criteria PRSP is a responsibility of each country, i.e. in the evaluation of the PRSPs there are not criteria for international commitment for dealing with HIV/AIDS, and hence they do not reflect public health issues as global problems, which the international community will have to address.

Trends in HIV/AIDS and Decline in Official Development Aid

ODA declined despite high incidence of poverty and public health problems like increased infections with AIDS. Table 1 shows the trends in official flows (loans and grants from government agencies and multilateral institutions) to LDCs (Least Developed Countries). There are currently 40 million people with HIV, and about 95 % of them are in developing countries. Seventy percent of all adults living with HIV are in Africa. Just 0.1 % of the 28.5 million of people living with HIV/AIDS in Africa have access to HIV/AIDS drugs. Of all the 760,000 people worldwide who have access to antiretrovirals, 500,000 live in high-income countries. Of all new infections in 2001, 68 % were in Sub-Saharan Africa. In the past two decades average life expectancy for all Africans has fallen by 15 years as a direct result of HIV/AIDS (UNDP 2001). During the 1990s, 11 LDCs experienced reversals in their life expectancy trends. The HIPC countries among them which have a HIV Adult Prevalence Rate larger than 4% were: Zambia, Malawi, Central African Republic, Burundi, United Republic of Tanzania, Burkina Faso, Ethiopia, Togo, Uganda Democratic Republic of Congo (Table 1). The AIDS epidemic was a major contributor in these reversals [UNCTAD 2001, 9].

Table 1. Countries Participating in the HIPC Initiative, with > 4 % HIV Adult Prevalence Rate

Country	**Adult Rate %**	**Adults and Children**	**Adults (15-49)**	**HIPC Status (April 2002)**
Zambia	21.52	1 200 000	1 000 000	DP reached
Kenya	15.01	2 500 000	2 300 000	Sustainable
Malawi	15.00	850 000	780 000	DP reached
Mozambique	13.00	1 100 000	1 000 000	Completion
Central African Republic	12.90	250 000	220 000	DP not yet
Cameroon	11.83	920 000	860 000	DP reached
Cote d'Ivoire	9.65	770 000	690 000	DP not yet
Rwanda	8.88	500 000	430 000	DP reached
Burundi	8.30	390 000	330 000	DP not yet
Tanzania	7.83	1 500 000	1 300 000	Completion
Sierra Leone	7.00	170 000	150 000	DP reached
Burkina Faso	6.50	440 000	380 000	DP reached
Ethiopia	6.41	2 100 000	1 900 000	DP reached
Togo	6.00	150 000	130 000	DP not yet
Angola	5.50	350 000	320 000	Sustainable
Uganda	5.00	600 000	510 000	Completion
Democratic Republic of Congo	4.90	1 300 000	1 100 000	DP not yet

Sources: UNAIDS 2002 published in UNDP *HIV/AIDS Statistical Fact Sheet;*
IMF and IDA: *HIPC Initiative: Status and Implementation*, April 12, 2002.
DP: Decision Point
CP: Completion Point

HIV/AIDS is devastating not only in enormous human suffering, but also in terms of threatening food security and access to education and employment. These conditions of deepening human poverty further spread the epidemic, which is already a threat to global public health.

Since 1992, the United Nations (UN) have set targets (called The Millennium Goals) with regards to improving indicators of hunger, schooling, gender disparity, and child mortality. Despite the increasing danger of spreading HIV/AIDS and the UN commitment to Millennium Goals for reduction of poverty, since 1992, ODA flows to the 28 countries with the highest adult HIV prevalence rates have fallen by one third, from $12.8 to $8.4 billion in the period from 1995-2000 [UNDP 2001]. For example, net ODA

or Official Aid per capita to Zambia fell from US $226 in 1995 to US $79 in 2000 (Table 2). This happens although Zambia ranks sixth among the 28 countries with HIV adult prevalence rates larger than 4% (21.52 %). Zambia lost 1,300 teachers due to AIDS in the first ten months of 1998 - the equivalent of two thirds of all new teachers trained annually. Two thirds of urban households in Zambia that have lost their main breadwinner to AIDS experienced a loss of income of 80 %. In addition, 61 % of these households moved to cheaper housing, 39% lost piped water, and 21% of girls and 17% of boys dropped out of school [UNDP 2001]. In 14 out of 17 HIPC countries with HIV adult prevalence rate above 4% the net ODA fell from the period of 1995 to 2000. This happened in the period when these countries became eligible to participate in the HIPC program. It can be suggested that HIPC initiative has been seen as "financial flows," going or projected to be going to countries when they reach the final stages of the procedure. Hence, there has been a compensatory decrease in ODE financing going to these countries.

Table 2. HIPC Countries with > 4 % HIV Adult Prevalence Rate: Net ODA or Official Aid *per capita* for 1995 and 2000

Country	**HIPC Status (April 2002)**	**Net ODA or Official Aid *per capita* 1995 (US $)**	**Net ODA or Official Aid *per capita* 2000 (US $)**	**Present Value Of Debt/ Exports* of LDCs (a) 1998-2000 (%)**
Zambia	DP reached	226	79	537
Kenya	Sustainable	28	17	-
Malawi	DP reached	47	43	314
Mozambique	Completion	67	50	187
Central African Republic	DP not yet	50	20	356
Cameroon	DP reached	33	26	-
Cote d'Ivoire	DP not yet	87	22	-
Rwanda	DP reached	110	38	628
Burundi	DP not yet	47	14	985
Tanzania	Completion	30	31	395
Sierra Leone	DP reached	46	36	800
Burkina Faso	DP reached	49	30	210
Ethiopia	DP reached	39	47	343
Togo	DP not yet	49	15	199
Angola	Sustainable	37	23	170
Uganda	Completion	43	37	138
Democratic Republic of Congo	DP not yet	4	4	797

Source: World Bank, *2002 World Development Indicators: Aid Dependency.*

UNCTAD 2002, ***The Least Developed Countries 2000 Report***

Table 3 shows the percentage of children at or below the malnutrition weight for children less than 5 years of age and the mortality rate per 1000 live births before the age of 5. The improvement of these indicators among the HIPCs with HIV adult prevalence rate above 4 is not by much, which may be a result of increasing incidence of orphanage and unemployment due to AIDS.

Table 3. HIPC Countries with > 4 % HIV Adult Prevalence Rate: Some Millennium Goals Indicators, years 1990 and 2000

Country	**Child Malnutrition weight for age % of children under 5** ***1990***	**Child Malnutrition weight for age % of children under 5** ***2000***	**Under-5 mortality rate per 1000 live births** ***1990***	**Under-5 mortality rate per 1000 live births** ***2000***
Zambia	25	24	194	186
Kenya	-	22	97	120
Malawi	28	30	234	193
Mozambique	-	26	238	200
Central African Republic	-	23	-	152
Cameroon	15	22	141	155
Cote d'Ivoire	-	24	150	180
Rwanda	29	27	-	203
Burundi	-	-	180	176
Tanzania	29	29	178	149
Sierra Leone	29	-	323	267
Burkina Faso	-	34	229	206
Ethiopia	48	49	211	179
Togo	25	25	142	142
Angola	20	41	-	208
Uganda	23	26	165	161
Democratic Republic of Congo	-	34	155	163

Table 4 shows that the projected trajectory, which is required to reduce the death of infants by two thirds by 2015 is not met for all of the HIPCs with prevalence HIV rate above 4%, which coincides with the general decrease in ODA despite the launching of the HIPC Debt Initiative in 1996.

Table 4. HIPC Countries with > 4 % HIV Adult Prevalence Rate, in which Infant Mortality Millennium Goals have not been Met

Country	Infant Mortality per 1000 live births Actual Trajectory 1990	Infant Mortality per 1000 live births Actual Trajectory 1998	Infant Mortality per 1000 live births Projected Trajectory* 1998
Zambia	107.3	113.7	84.4
Malawi	135.4	133.8	106.5
Mozambique	150.4	134.5	118.3
Central African Republic	102.2	98.4	80.4
Rwanda	132.4	123.1	104.2
Burundi	118.8	118.8	93.5
Sierra Leone	189.0	169.0	148.7
Burkina Faso	105.4	104.0	82.9
Ethiopia	124.2	106.8	97.7
Togo	81.0	78.2	63.7
Angola	130	123.6	102.4
Democratic Republic of Congo	95.8	90.3	75.4

* The projected trajectory is the trajectory required to reduce the death of infants by two thirds by 2015.

Source*:* UNCTAD secretarial calculations based on World Bank *World Development Indicators 2000. UNCTAD, The Least Developed Countries 2000 Report.*

The decrease in ODA occurred despite the commitments by donors to increase aid to the LDCs. Among the members of the Development Assistance Committee (DAS) of the Organization for Economic Cooperation and Development (OECD), only five countries met the 0.15% target at the United Nations Conference on the Least Developed Countries in 1990.

The World Bank emphasizes the role of the "efforts to improve the effectiveness of aid by allocating a greater share to countries with *better policies*." for the decline in net concessional flows to developing countries.

> Continued improvements in aid effectiveness will be critical to ensure benefits for developing economies and will provide the most convincing argument for

> maintaining or increasing concessional assistance in the face of further planned cutbacks by major donors [World Bank 1997, 49].

Along with the concern about moral hazard, the bias toward export-oriented growth is cited as an excuse for declining ODA. For example, in his address the managing director of the International Monetary Fund (IMF) Horst Köhler emphasizes the approach of self-help.

> But I also want to be very clear: while more aid is needed, we need to work first and foremost on trade. Providing better opportunities for African countries to expand and diversify their exports is the best form of help for self-help [May 3, 2002].

However as Julio Marcelino Bessa, a spokesman of Africa Group I Constituency, points out, African countries are primarily commodity exporters and have problems with market access because of agricultural subsidies and restrictive trade practices in developed countries and the fall in commodity prices [September 28, 2002]. Unlike the World Bank spokesmen he states:

> …we cannot overcome these challenges alone, NEPAD[1] considers that action undertaken at the domestic level should be complemented by action at the international level with regard to increased ODA, accelerated debt relief and greater market access opportunities for African products [Bessa, September 28, 2002].

While there is a decline in ODA, as discussed above, the outstanding external debt of the LDCs as a share of their GDP grew to 89% [UNCTAD 2001, 55]. Twenty-nine LDCs had an unsustainable external debt in 2000, according to the sustainability criteria of the enhanced HIPC Initiative (the ratio of the net present value of debt stocks to exports of 150%) [UNCTAD 2002, 14].

Indebtedness goes hand in hand with conditionality for loans and grants. In the position of high indebtedness, countries are under pressure by the leveraging ability of international creditors. In countries coping with levels of high indebtedness, policy packages consisting of austere structural adjustment reinforce the inability of the country to cope with public health issues.

The decline in real terms in government expenditure on health means that the quality of sexually transmitted infections (STIs) management is compromised. With the shortage of medication, STIs are either inadequately managed, or not managed at all. STIs being co-factors for HIV means sub-standard management of infections results in increased transmission of HIV. Table 6 shows that the percentage of debt service paid to social expenditures is growing in Zambia (76% to 99%), Malawi (31% to 49%) and Burkina Faso (38% to 40%) – countries classified as HIPCs/LDCs which have HIV adult

[1] New Partnership for Africa's Development

prevalence rates respectively 21.52%, 15.00% and 6.50%. In addition, the ratio of debt service paid to social expenditures in 6 out of the 11 of HIPCs/LDCs with HIV adult prevalence rates below 4% is also growing. These countries are Mauritania, Senegal, Chad, Guinea Bissau, Niger, and Sao Tome and Principe. This trend is disturbing, because it may contribute to an increase in the HIV prevalence rates in these countries.

Table 5. Ratio of Debt Service Paid to Social Expenditure in Selected HIPC-LDC, (a) 1999 and 2000.

(Percentage)

Country	Date of decision Point	Debt service paid/ Social exp. (%) 1999 (b)	Debt service paid/ Social exp. (%) 2000 (c)	HIV Adult Prevalence Rate (End 2001)
Countries reaching decision point in first half of 2000				
Mauritania	Feb. 00	95	100	< 4 %
Mozambique	Apr. 00	23	8	13.0
Senegal	Jun. 00	57	63	< 4 %
Utd. Rep. Of Tanzania	Apr. 00	67	44	7.83
Uganda	May 00 (d)	32	22	5.00
Countries reaching decision point in third quarter of 2000				
Benin	Jul. 00	57	50	< 4 %
Burkina Faso	Jul. 00	38	40	6.50
Mali	Sep.00	82	65	< 4 %
Countries reaching decision point in end 2000, 2001 and 2002				
Chad	May 01	16	17	< 4 %
Ethiopia	Nov. 01	47	21	6.41
Gambia	Dec. 00	83	59	< 4 %
Guinea	Dec.00	155	167	< 4 %
Guinea-Bissau	Dec. 00	9	15	< 4 %
Madagascar	Dec 00	68	46	< 4 %
Malawi	Dec 00	31	49	15.00
Niger	Dec.00	18	20	< 4 %
Rwanda	Dec.00	63	42	8.88
Sao Tome and Principe	Dec.00	25	63	< 4 %
Sierra Leone	Mar. 02	247	213	7.00
Zambia	Dec.02	76	99	21.52

Source: UNCTAD, The Least Developed Countries Report 2002:UNCTAD secretariat estimates based on IMF/IDA data (2001)

(a) The list includes all HIPC-LDCs which had reached decision point/completion point by the end of September 2001.

(b) Debt service paid.

(c) Debt service due after the full use of traditional debt service mechanism and assistance under the Enhanced HIPC Initiative.

(d) Completion point.

On the other hand, there are developing countries who are not qualified for the HIPC Debt Initiative and have a large prevalence rate, such as: Botswana (38.80 % adult prevalence rate), Zimbabwe (33.73 %), Swaziland (33.73 %), Lesotho (31.00 %),

Namibia (22.50 %), South Africa (20.21 %), Congo (7.15) and Haiti (6.10 %). In this sense the IMF suggestion that HIPC is a tool to fight HIV/ AIDS is too optimistic. In addition, two cases of adult HIV prevalence above 4 % (Angola – 5.50 and Kenya – 15.01 %) of the 41 HIPC countries in 2000 were declared sustainable cases, which means that these countries are expected to rely just on export oriented growth to deal with their debt payments in a situation when ODA flows are falling.

Is HIPC Initiative a Realistic Way to "Finance" Public Health Objectives?

The IMF Staff [Hetch et al. 2002] is optimistic about the HIPC Initiative as a source of new resources in the fight against AIDS, and is expressing concern that according to PRSPs in some HIPCs, no money from debt-relief proceeds has been specifically promised to HIV/AIDS.

> On an annual basis, these countries will pay about $0.8 billion less in 2001-03 than they did in 1998-99. How much of these savings are going toward health care—keeping in mind that all eligible HIPCs must prepare PRSPs to ensure that savings go toward poverty reduction? [Hetch et al. 2002.

However, the possibility that HIPC countries may pay $0.8 billion less in 2001-03 in debt service does not mean that they will be able to cope comprehensively with the global pandemic AIDS. What is considered as "savings" is just a cancellation or postponing of an obligation to pay, and does not necessary represent a capability of the country to increase expenditures on public health. So using debt relief to fight AIDS may be necessary in the current international financial settings but is not sufficient.

The United Nations Conference on Trade and Development (UNCTAD) *2001 Trade and Development Report* calls the current expectations about the economic impact of the HIPC Initiative on countries, which have reached decision point "unrealistic" [UNCTAD 2001, 55]. First, the additional fiscal resources to be released by HIPC may not be substantial to implement development policies and to secure public heath provisioning. Second, the medium-term forecasts of a durable exit from the debt problem assume high rates of economic and export growth, sustained over a long period. However, this presupposes that HIPC countries are going to be able to diversify exports and to move away from being commodity exporters. In addition, this presupposes that they will be able to obtain market access, which means that either agricultural subsidies and restrictive trade practices in developed countries will be eliminated, or that technology and blue prints will be generated in or transferred to the HIPC country. Second, UNCTAD is concerned that with the provision of HIPC assistance, there may be a general reduction in financial resources flows to Less Developed Countries (LDCs). UNCTAD points out that for 14 of the 17 African LDCs in 2000 who have reached decision point, official flows fell considerably between 1996 and 1999 [UNCTAD 2000, 55]. Finally, UNCTAD points out that the underlying economic problems of LDCs are manifold, and debt write-off alone are likely to be insufficient to solve them.

Conclusions

The focus of the paper has been on the HIPCs with HIV adult prevalence rate above 4%. In 14 out of 17 of these countries the net ODA fell from the period of 1995 to 2000. This happened in the period when these countries became eligible to participate in the HIPC program. It can be suggested that HIPC initiative has been seen as a potential for "financial flows," going or projected to be going to these countries when they reach the final stages of the HIPC procedures. Hence, there has been a compensatory decrease in ODA to these countries.

It can be recommended that there is a need to make a difference between reconstruction and development. Fighting the pandemic of AIDS is an act of reconstruction, which is the basis for development. While the UN has emphasized the reconstruction approach, the international financial institutions' approach has been one suited for development of already reconstructed economies at full employment.

Since UN has no financial decision-making authority, The UN Millennium Goals for reduction of poverty is an initiative separated from the initiatives and loan conditionalities of the financial institutions. International financial decision powers are concentrated at institutions such as IMF and WB, as well as in private creditors. Hence, UN's commitment to the Millennium Goals cannot be expected to have a fundamental impact on any global public health issue like HIV/AIDS. National and International financial commitment is necessary especially in dealing with a global pandemic. This presupposes a delegation of financial power to UN.

The response of the international financial system to the AIDS pandemic gives a reason to question the instrumentality of the existing international financial system in facilitating livelihood globally. If international procedures have predominantly pecuniary character and motives and are not oriented toward instrumental solving of public health problems, and in fact are contra active to public health, then one can suggest that there is a need for structural change in the international financial system by giving financial discretion to organizations whose work is directly focused on providing conditions for entitlement to public health. In order for national public health to be approached as a public good, the interrelationships among domestic public health problems should be conducted not only on national but also on global level through delegating financial authority to particularly designed institutions whose goal is provisioning of and entitlement to livelihood through sustaining full employment at the global level.

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