Macroeconomic Policy Impacts on the Fight against HIV/AIDS in Ghana

AFRODAD

Preface

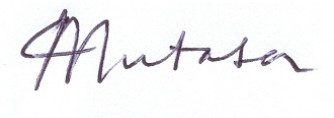
AIDS was declared an economic development crisis by the World Bank in 2000. It is been estimated that per capita growth in some of the countries in sub-Saharan Africa has fallen by 0.5%-1.2% each year as a direct result of AIDS. By 2010, per capita GDP in some of the hardest-hit countries may drop by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

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

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

The IMF role as gatekeeper and its 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/AID pandemic is an urgent human tragedy that demands immediate and concerted response from all stakeholders in all societies. The Bretton Woods institutions need to move with caution, exercise flexibility and not restrict the policy space for policy makers in developing countries. Abandoning the usual insatiable hunger for macroeconomic stability 'at all cost' and removing conditionalities will mean that the Bank and Fund will not stand in the way of developing countries' efforts to combat the disease. Concentrating investments in capacity development-increase personnel and better remuneration should be a priority for any HIV/AIDS strategy in developing countries especially in Sub-Saharan Africa.



Charles Mutasa
Executive Director
AFRODAD

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Table of Contents

List of Tables

Acronyms and Abbreviations

AGI	Association of Ghana Industries
AIDS	Acquired Immune Deficiency Syndrome
APOW	Annual Programme of Work
ART	Antiretroviral Therapy
ARVS	Antiretroviral Drugs
BCC	Behaviour Change Communication
BoG	Bank of Ghana
CEM	Country Economic Memorandum
CD4	Immune/Helper Cells
CID	Centre for International Development
CBOs	Community Based Organizations
CGD	Centre for Global Development
CHO	Community Health Officers
CHPS	Community Based Health Planning Services
CSOs	Civil Society Organizations
DANIDA	Danish International Development Agency
DAs	District Assemblies
DFID	Department for International Development
FAO	Food and Agricultural Organization of the United Nations
FBO	Faith Based Organizations
GAC	Ghana AIDS Commission
GAPP	Ghana AIDS Partnership Programmes
GBCAs	Ghana Business Coalition against AIDS
GCM	Ghana Chamber of Mines
GDP	Gross Domestic Product
GEA	Ghana Employers Association
GES	Ghana Education Service
GFAMT	Global Fund for AIDS, Malaria and Tuberculosis
GoG	Government of Ghana
GPRS	Ghana Poverty Reduction Strategies
HAART	Highly Active Anti-retroviral Therapy
HIPC	Highly Indebted Poor Country
IDRC	International Development Research Centre
IFIs	International Financial Institutions
IMF	International Monetary Fund
ISODEC	Integrated Social Development Centre
ISSER	Institute of Statistical, Social and Economic Research
KII	Key Informant Interviews
MDAs	Ministries Departments and Agencies
MDBS	Multi-Donor Budget Support
MDGs	Millennium Development Goals
MOF	Ministry of Finance
MOFA	Ministry of Food and Agriculture
MOFEP	Ministry of Finance and Economic Planning
MSHAP	Multi-Sectoral HIV/AIDS Programme
NACP	National STD/AIDS/STI Control Programme
NFS	National Strategic Framework
NIPMGs	National Inter Agency on Poverty Monitoring Groups
NDPC	National Development Planning Commission

NGOs	Non-Governmental Organizations
NHIS	National Health Insurance Scheme
NMIMR	Noguchi Memorial Institute for Medical Research
ODA	Official Development Assistance
PEF	Private Enterprise Foundation
PLWA	People Living with AIDS
PMTCT	Prevention of Mother to Child Transmission
PRGF	Poverty Reduction Growth Facility
PRSs	Poverty Reduction Strategies
PRSP	Poverty Reduction Strategy Paper
SSA	Sub-Saharan Africa
SSNIT	Social Security and National Insurance Trust
SWAP	Sector Wide Approach
TUC	Trade Union Congress (TUC),
UN	United Nations
UNDP	United Nations Development Programme
UNMP	United Nations Millennium Project
USAID	U. S. Agency for International Development
VAT	Value Added Tax
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

Executive Summary

The HIV/AIDS pandemic has been perhaps the worst health challenge in recent history killing approximately 22 million people. In 2005, 3.1 million people died of AIDSrelated illnesses; an estimated 2 million come from Sub-Saharan Africa. Significantly, 65 percent of all infected cases come from Sub-Saharan Africa (SSA).

The epidemic has had a devastating impact on the African continent. Most of those afflicted are young people within the age category 15 49 years. HIV/AIDS is not only a public health concern, it is a development issue; as it has struck Africa's most productive core. The implication is that fighting HIV/AIDS requires a broad socio-economic and political framework, requiring the input of all line ministries and all levels of political administration.

Development partners must also recognize that addressing this state of emergency requires non-traditional aid modalities; that traditional restrictive macroeconomic policies and budget ceilings have constricted some recipient governments from giving HIV/AIDS the attention it deserves.
This study attempts to provide fundamental evidence of macroeconomic policy constraints to HIV/AID spending in Ghana by examining the roles of International Financial Institutions (IFIs), donor agencies, local policy makers and the citizenry.

In what follows is a description of the extent and depth of the HIV/AIDS epidemic in Ghana and an examination of the national strategy to combat it. There is a description of the GoG financing strategy and an assessment of the finance gaps. There is then an examination of the macroeconomic implications of increased fiscal spending in this regard as well as an assessment as to whether fiscal space has been constricted by financing partners, namely international financial institutions. In the final section, there are key observations and a conclusion.

Key Findings

HIV/AIDS had initially been treated as a disease in Ghana. After realizing that the virus was attacking productive segments of the population, Ghana re-evaluated its national strategy. In its Growth and Poverty Reduction Strategy II, Ghana places HIV/AIDS in the broader category of Human Resource Development; along with all other health issues, gender, and education. The underlying theme being that the development of a knowledgeable, well-trained, and healthy population are fundamental to meeting the Millennium Development goals and economic growth. The HR Development pillar of the GPRS cites among its main constraints poor road networks, lack of facilities and their poor location and communications technology.

The National Strategic Framework II, which operationalizes the HIV/AIDS part of the GPRS II, created a bi-modal aid delivery mechanism. Donor partners may engage directly with either the national government via the Ghana AIDS Commission or the District AIDS Committees. However, in seeking to comply with the Paris Declaration, donor partners have increasingly directed funds to the GAC and programme budget. The switch to general budget support notwithstanding, the NSF II has a resource gap of approximately US$82 million; the years 2009 and 2010 being grossly under-funded.

Donor partners have discouraged the growing domestic debt stock, but have not curbed their own lending to Ghana. New loans to Ghana are four times the amount of debt relief in the form of HIPC assistance.

Ghana is currently under an IMF facility, the PRGF, which entails a number of benchmarks. The IMF has expressed concerns over the government's wage bill, citing high opportunity costs; though payments going to external debt service (approximately 3 trillion cedis) are greater than pension, social security, gratuities and the national health fund combined. Furthermore, despite graduation from the HIPC programme, the volume of Ghana's debt stock has increased. The higher opportunity costs of external debt service payments constrain the fiscal space available for social development planning. Lastly, the IMF has identified investments in large infrastructural projects as potentially being the cause of future inflationary trends and cautions Ghana not to undertake additional non-concessional loans. The linking of inflationary trends to fiscal spending has not taken into consideration price volatilities of leading export commodities and the high volume of remittances spurring domestic consumption.

The paper recommends that donor agencies and development partners should support without conditions macroeconomic policies targeting the attainment of the MDGs and pro-poor programmes. Timely and regular release of funds by donor agencies will go a long way in assisting policy makers to achieve these dreams. There is however,

the need for government to increase its revenue base through effective taxes to reduce dependence on donors for health care support. The research suggests the need to decentralize HIV/AIDS treatment so that rural communities can have access to treatment and reduce barriers to health care delivery. Above all, the paper recommends multi-stakeholder strategies in planning the fight against HIV/AIDS. The paper also recommends the need for active involvement of civil society organization in advocacy matters, in order to effect changes in macroeconomic policy for the benefit of the poor and vulnerable members of the society.

1 Introduction And Background

The HIV/AIDS pandemic has been perhaps the worst health challenge in recent history killing approximately 22 million people and leaving behind 36 million more affected victims in its trail by the year 2001. Currently, over 40 million people are living with HIV globally. In 2005, 3.1 million people died of AIDSrelated illnesses; an estimated 2 million come from Sub-Saharan Africa with more than 500,000 being children(1). Since its discovery in the early 1980s, the majority of victims of the HIV/AIDS epidemic have come from developing countries constituting 95 percent.

Significantly, 65 percent of all infected cases come from Sub-Saharan Africa (SSA). Most of those afflicted are young and productive people within age category 15 49 years. This implies that HIV/AIDS constitutes a serious developmental challenge to policy makers. Thus, HIV/AIDS should be considered within the broader socioeconomic and political framework. Most African governments are signatories to the Abuja Declaration in April 2000, which considers HIV/AIDS as "a state of emergency" deserving high priority in national development planning. Behind the access to treatment, are restrictive macroeconomic policies and budget ceilings that have constricted health sectors from giving HIV/AIDS the attention it deserves.

The key challenge is putting HIV/AIDS at the centre of national poverty reduction strategy, in view of the fact that it represents significant challenge to development, stability, and growth of many developing countries. The spread erodes human capacity, through a reduction of human productivity, increase in private, public consumption through a reduction of incomes and savings especially in developing countries. AIDS strips families of income earners thereby impoverishing the poor and vulnerable of society. Economically, HIV/AIDS has brought an additional pressure to bear on the health sector of most developing countries(2). Effective curtailment of the pandemic requires unified effort and huge amounts of resources which are often lacking in many developing countries. In spite of the relative drop in prices of anti-viral drugs in recent times, health budgets in many developing countries including Ghana are less than $10 per person which makes even discount drugs out of reach of those infected with HIV. Paradoxically, global funding for the pandemic has been less than satisfactory. The establishment of a global chest by industrialized nations in 2001 to fund HIV/AIDS attracted a US $1.2 billion which even falls short of the United Nation's target of $10 billion a year (Sternberg, 2001, p1)(3).

1.1 Extent and Depth of HIV/AIDS Pandemic in Ghana

The first case of AIDS in the country was diagnosed in 1986, and by the year 2004 an estimated 380,000 adults and 14,000 children were HIV-positive (UNAIDS, 2004a). By 2004, the cumulative number of people diagnosed with AIDS was 36,000 (Figure 3). Prevalence rates increased from an estimated 2.6 percent in 2000, to 3.6 percent in 2003, and 3.1 percent in 2004 (National AIDS/STD Control Programme, GHS, 2005)*(4)*. The nature of the epidemic in the country has exhibited a different pattern from that found in Eastern and Southern Africa where prevalence rates have exceeded 25 percent within a short period (Ghana National AIDS Strategic Framework, 2005).

Nevertheless, the number of new AIDS cases has increased dramatically over the last 10 years from an estimated 5,500 in 1994 to 36,000 in 2004 (Figure 3). Both the annual number of new AIDS cases and the annual number of AIDS deaths are projected to increase to over 45,000 by 2015. In addition, the estimated number of AIDS orphans (children under the age of 15 who have lost one or both parents to AIDS related causes) is likely to double over the next 10 years increasing from 132,000 in 2004 to 291,000 by 2015 (NSF, 2005).

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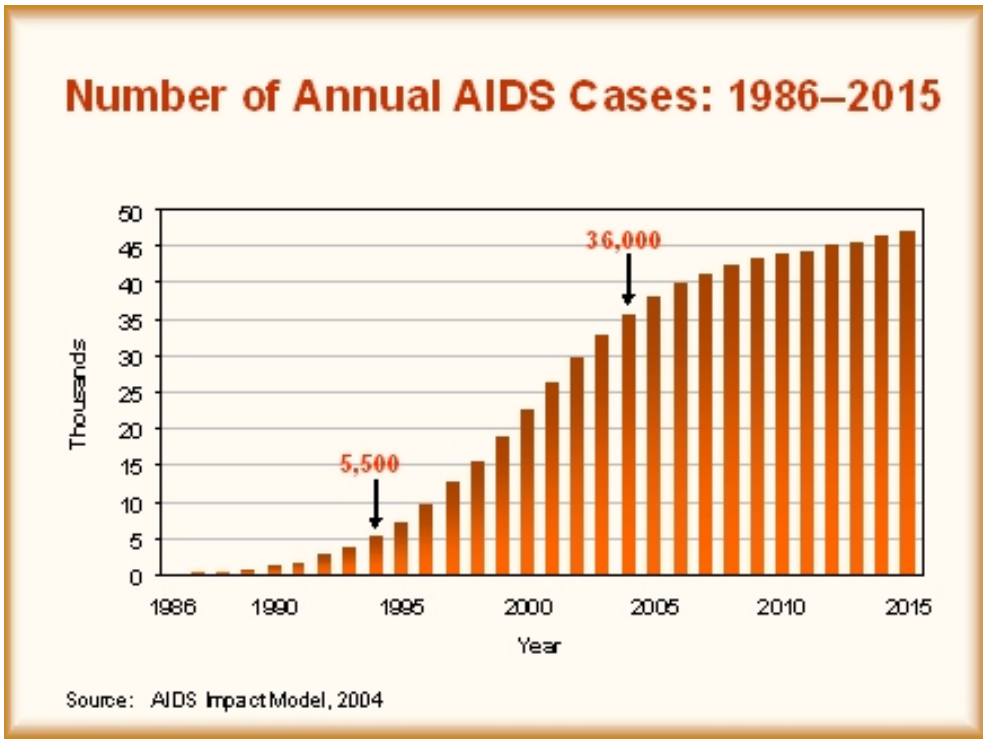
(1) See especially, UNDP Annual Report (2006).
(2) For further reading see report by Avert International (2004) titled "the Impact of HIV and AIDS on Africa".
(3) International organizations such as Global AIDS Alliance, the United Nations, the World Health Organisation (WHO) and Doctors without
Boarders and a host of other civil society organizations have expressed their outrage over the inadequacy of resources to tackle a major global health problem. See for instance Centre for International Development Report (CID), Harvard University July, 2003.
(4)In contrast, prevalence rates in Southern and Eastern Africa expanded much more rapidly over the same period, exceeding 25 percent in some countries. Neighbouring Cote d'Ivoire has shown still another pattern, generally maintaining a rate between 10 and 15% for most of the period.

Chart 2.1 Actual and Projection of AIDS Cases in Ghana



Cote et al. (2004) have estimated that transactional sex accounts for about 84 per cent of HIV infections among males aged 1559 years in Accra. In addition to sex workers and their clients, other groups believed to have above-average prevalence rates include uniformed service personnel, teachers, and miners, prisoners, long-distance truck drivers, national service volunteers, cross-border traders, and female long-distance traders (Anarfi et al., 1997 cited in Ghana AIDS Commission, 2003, p. 9). Female STI clinic attendees at Adabraka (in Accra), a clinic that also serves sex workers in Greater Accra Region, had a prevalence rate of 39 percent in 1999, reinforcing the well documented close association between HIV and other sexually transmitted infections (UNAIDS, 2002).

The available evidence indicates that over 70 per cent of HIV/AIDS infected persons are aged 20-39 years due mostly to high sexual risk-taking behaviour by individuals or their partners/spouses. Results from the 2003 GDHS also points to a new pattern of infection. According to the results, employed, middle income persons and those with primary or junior secondary education were disproportionately infected (Ghana, 2004). These are people in their economically productive period, and HIV infection among this population has implications for the national economy. It will affect the proportion of the population available for work, training, and the pace of work. The economic costs of HIV/AIDS to employers in terms of care, absenteeism and retraining, are high and will continue to increase if the trend is not reduced. Thus, the current pattern of HIV/AIDS infection poses a threat to the economy of the country.

Unlike other public health crises, logistics and access to treatment are critical to stem the pandemic. In Ghana, aside from cultural rigidities and the social stigma of being infected with HIV, there are high costs associated with travelling to HIV treatment centres and costs of getting treatment of opportunistic infections. As such, there were 33,000 AIDS-related deaths in 2004 (IRIN, 2006).

The cost of actually receiving treatment is also prohibitive. ARVs average US$5 per course. The number of Ghanaians that need to be on ARVs, according to national estimates, is 71,000 (IRIN, 2006). The HIV prevalence rate is 3.4% of the total population (IRIN, 2007). In 2001, the GoG set up the National Health Insurance Scheme, which exempts the poor from making financial contributions to the system. The target in the PRSP is to devote 7% of total government expenditures to health, which is what is required to ensure a minimum of $10 per capita on health care in 2005, while the internationally recommended level is $30 - $40 (Ghana PRSP II). Regarding health facilities specializing in HIV/AIDS, geographical coverage is not good. Ghana only had five treatment centres in 2005. The country has plans to increase that number to 32.

Table 1.1 Ghana HIV/AIDS Profile

Estimated Number of Adults and Children Living with HIV/AIDS (end 2004)	404,000*
Total Population (2004)	21,377,000**
Adult HIV Prevalence (end 2003)	3.1%**
Adult HIV Prevalence by HIV Sentinel Survey (end 2003)	3.61%*
Estimated Adult HIV Prevalence and Projection Package Software (end 2003)	3.57%*
Number of AIDS -Related Orphans and Vulnerable Children (2004)	132.000*
HIV-1 Sero-prevalence in Urban Areas Population most at risk (i.e. sex workers and clients, patients seeking treatment for sexually transmitted infection, or others with known risk factors) Population least at risk (i.e. pregnant women, blood donors, or others with no known risk factors) *Source: NACP Bulletin, January 2005 ** UNAIDS, US Census Bureau*	47.0%** 3.2%**

1.2 Research Objectives and Methodology

This study attempts to provide fundamental evidence of macroeconomic policy constraints to HIV/AID spending in Ghana by examining the roles of International Financial Institutions (IFIs), donor agencies, local policy makers and the citizenry. The main objectives of the study include the following:

- Assessing the linkages between donor influence and domestic policy on HIV/AIDS management
- Examining the extent to which policy space is shared amongst International Financial Institutions (IFIs),policy makers and the citizenry
- Providing evidence of the interaction between macroeconomic policy framework and social spending, and in particular the fight against HIV/AIDS in Ghana
- Reviewing the major channels through which fiscal and monetary policies impact on public expenditurean policy regarding people living with HIV/AIDS (PLWA)

Following logically from the objectives outlined, this desk study of macroeconomic policy impact on the fight against HIV/AIDS in Ghana is largely qualitative, although materials from quantitative studies have also been used to strengthen the evidence provided. Key Informant Interviews (KII) were conducted on relevant themes with key persons including government officials, IFIs, Development partners, people living with HIV/AIDS (PLWHA), CSOs, CBOs and FBOs. The interviews were focused on budget ceilings in the Ghana health sector and their impact on HIV/AID financing. A bulk of the literature comes from a reanalysis of secondary materials from ministries, agencies and institutions working on HIV/AIDS, economic and financial matters in Ghana. The interviews were conducted in three geographical locations including Northern, Ashanti and Greater Accra regions.

In what follows is a description of the extent and depth of the HIV/AIDS epidemic in Ghana and an examination of the national strategy to combat it. There is a description of the GoG financing strategy and an assessment of the finance gaps. There is then an examination of the macroeconomic implications of increased fiscal spending in this regard as well as an assessment as to whether fiscal space has been constricted by financing partners, namely international financial institutions. In the final section, there are key observations and a conclusion.

2 National Strategy to Fight HIV/AIDS

HIV/AIDS was first managed as a disease in Ghana. The national response was directed by the Ministry of Health. In 1985, the Advisory Commission on AIDS (NACA) was formed to advise the government on HIV/AIDS issues and was placed within the jurisdiction of the Ministry of Health.

> Since then, it has become obvious that the complexity of the pandemic requires a developmental, holistic, coordinated, multisectoral approach to address the multi-faceted, multi-dimensional nature of the epidemic" (NSF I, 2000).

And so, the Ghana AIDS Commission (GAC) was established in 2002 by an act of Parliament. It is the highest policy decision-making body on all matters relating to HIV/AIDS and is charged with the following functions, as contained in the Act 613:

- Advise the Government on policy issues relating to HIV/AIDS;
- Provide high-level advocacy for HIV/AIDS;
- Expand and coordinate the total national response, including the formulation of national plans and guidelines;
- Monitor and evaluate all on-going HIV/AIDS activities; and
- Identify, mobilise and manage all funds and other resources for HIV/AIDS and related programmes.

Essentially, the GAC provides leadership in the management and coordination of the national response to HIV/AIDS, and the activities of the GAC are guided by the National HIV/AIDS Strategic Framework.

2.1 National Strategic Framework I (2001 2005)

The objectives of NSF I were to reduce new infections among the 15-49 age-group and other vulnerable groups, to improve service delivery and mitigate the impact of HIV/AIDS, to reduce individual and societal vulnerability and susceptibility to HIV/AIDS through the creation of an enabling environment for the implementation of the national response, and to establish a well-managed multi-sectoral and multi-disciplinary institutional framework for coordination and implementation of HIV/AIDS programmes in the country.

The NSF I identified five strategic interventions in the context of the above objectives:

1. To substantially reduce new infections, with a budget of US$48.81 million
2. To improve service delivery and mitigate the impact of HIV/AIDS, with a budget of US$43.98 million
3. To reduce vulnerability and susceptibility to HIV by creating enabling environments, with a budget of $1.14 million
4. To put in place effective and efficient coordinating mechanisms, with a budget of $22.6 million
5. To implement the strategic framework, with a budget of $2.4 million

The GoG had undertaken an evaluation of the NSF I and identified gaps in the national response to the epidemic. The role of the media and the need for promoting information sharing, dissemination and documentation were not adequately addressed in NSF I. Secondly, while the NSF I dealt with behaviour change directed toward the general public and specific vulnerable groups, the issue of the division of proportionate efforts was inadequate, and attention to specific targeted interventions required greater focus. The use of evidence-based interventions in guiding the response at various geographic levels was not as extensive as expected. Thirdly, the private health and business sectors were not adequately included in NSF I, although they account for a large proportion of employed persons. Fourthly, the increase in the number of infected people and developments in new prevention and treatment technologies created demand and the need for expanded care and support activities. Lastly, the NSF I was developed concurrently with some sectoral plans, a situation which did not make it possible for specific guidelines to be given to the stakeholders for sector-wide planning. Some sectoral plans did not adequately map out priority geographical areas and target populations. In addition, the skills for monitoring performance were limited. Further, the mechanisms for coordination of HIV/AIDS activities within and across ministries, departments, and agencies were also not adequately detailed in NSF I.

2.2 Ghana's Second Generation PRSP: the Growth and Poverty Reduction Strategy II

In the Growth and Poverty Reduction Strategy (GPRS) II, HIV/AIDS is addressed along with other health issues (e.g. malaria), education and gender under the broader category of Human Resources Development. The GPRS II states candidly, that

> "Whether Ghana realizes the higher or only the lower ends of her growth potential will depend on two factors; namely, (i) the implementation of a broad-based human resource development strategy including the measures envisaged in both the education and public sector reform programmes; and (ii) opening of the channels between Ghana and the global capital markets so that both loanable funds, and equity investment which carries in its train the skills of management, science and technology, will flow more freely into the economy".

The development of the human resources of the country is one of the three key pillars of the GPRS II, and all health, education and gender targets fall under that pillar. The main goal is to ensure the development of a knowledgeable, well-trained, disciplined and healthy population with the capacity to drive and sustain the private sector-led growth strategy. An essential component of the GPRS II is to ensure the right to basic social services such as health care, safe drinking water and sanitation and decent housing that improve the well being of all Ghanaians. An equally important aspect of the human resource development strategy is to ensure the protection of the rights of the vulnerable members of society, especially children, women, people with disabilities, the elderly and rural communities.

With respect to specifically addressing the HIV/AIDS pandemic, the main objectives are to prevent the spread of HIV/AIDS in order to keep the prevalence rate below 5%, reduce new HIV/STI transmission, reduce the impact of HIV/AIDS related vulnerability, morbidity and mortality; and enhance the coordination and management of the national HIV/AIDS response.

The HR Development pillar cites as its main constraints, which affect access to health care, as being geographical and financial barriers, service delivery and broad socio-cultural barriers including gender. The GPRS II, Ghana's prevailing development strategy, proposes to fight HIV/AIDS through a number of ways. It has observed that, in spite of the improvement in health care delivery, there are still significant regional and socio-economic differences across the country in some health indicators including HIV/AIDS. The GPRS II identifies those factors that contribute to poor geographical access as being 1) low capital investment in health facilities, 2) poor feeder road network in the country, 3) poor location of facilities, 4) human resource constraints (brain drain), and 5) the lack of communication facilities.

Aside from the specific objectives to contain the epidemic as noted above, the GPRS II also proposes to strengthen the Ghana AIDS Commission (the central agency from which activities are implemented and evaluated), promote youth education and strengthening multi-sectoral, multi-disciplinary institution co-ordination and collaboration.

2.3 National Strategy Framework II (2006 2010)

The second phase of the National Strategy Framework was thus informed by the PRSP II and identifies seven key intervention areas with respect to HIV/AIDS:

1. Policy, advocacy and enabling environment
2. Coordination and management of decentralized response
3. Mitigation of social, cultural, legal and economic impacts
4. Prevention and behavioural change
5. Treatment, care, and support
6. Research, surveillance, monitoring and evaluation
7. Mobilization of resources and funding arrangements

It also establishes a Partnership Forum, meant to strengthen the coordinating function of GAC. It includes government development partners, CSOs, academic and research institutions, and it also promotes dialogue on programming. The NSF II was operationalized through the 2006 Annual Programme of Work.

The 138 districts of the country represent different and unique environments and sets of circumstances. The available epidemiological data indicate the existence of different and specific local epidemics resulting from a complex

combination of factors. Also, districts and local communities have different levels of capacity to support the local response to HIV/AIDS, different traditional set-ups, financial capabilities and vulnerable groups. Each district also has its own set of developmental priorities as articulated in District Development Plan. All these combine to create specific contexts within which districts and communities will react to the management and implementation of the national HIV/AIDS response.

Therefore, intervention area #2 has taken the form of District AIDS Committees (DAC). The District Chief Executive chairs the DAC, a multi-sectoral Committee whose members include representatives of all the decentralised agencies (MDA), NGO, religious and traditional leaders, youth and women's groups, private sector institutions, people living with HIV/AIDS (PLWHA) and individuals involved in developmental issues. The NSF II aims to develop the capacity of DACs, enabling them to become more effective within the decentralized institutional framework. The formation of the DAC is unique to the aid modality experience of the country. According to the PRSP II and the NSF II, development partners are meant to interact directly with the GAC and DACs, as well as NGOs and the private sector.

3 Financing the Fight Against HIV/AIDS

Funding for HIV/AIDS activities from 1987, when the National AIDS/STD Control Programme (NACP) was established under the Disease Control Unit of the Ministry of Health (MOH), was mainly through the Sector-Wide Approach (SWAp) of the MOH. Since then, funding of the national response has gone through changes up to the current system that emerged with the development of the National HIV/AIDS Strategic Framework in 2000 and the establishment of the Ghana AIDS Commission in 2001.

In June 2002, the GAC set up a $25 million fund known as the Ghana AIDS Response Fund (GARFUND) with the support of the World Bank. This fund has ensured a multi-sector response to HIV/AIDS in Ghana by supporting activities of a broad spectrum on stakeholders including MDA, NGO (local and international), CBOs, FBOs, academic institutions, traditional authorities and religious bodies. Major new funding sources have emerged since the setting up of the GARFUND. These include a £20-million Ghana AIDS Partnership Programme (GAPP) from DFID to complement GARFUND, $4.5 million from the Dutch Government, $4.9 million from the Global Fund, and a commitment of $7 million per year for five years from USAID. The UN and its agencies have also contributed funds and technical support.

3.1 Government Expenditures in Health Sector

A recent historical analysis (table 4.1) of GoG spending in the health sector shows an increase in fiscal spending on health from 2005 and an increase in the percentage of donor funds that are ear-marked.

Table 3.1 National Health Budget Indicators *(5)*

Indicators		2001	2002	2003	2004	2005	2006	2007
1	% GOG budget on health	8.7	9.3	9.1	8.2	15	18	15
2	% GOG recurrent budget on health	10.2	11.5	11.2	11.9	14.5	14	14
3	% GOG recurrent health on non-salary items (2+3)	8.1	5.9	6.9	5.4	6.6	7	9
4	% spending on districts and below, items 2+3	NA	40.9	35.4	37.9	36	40	NA
5	% Earmarked / total DP	62.3	32.8	39.5	26.3	40	61	NA
6	% IGF from pre -payment schemes	3	NA	NA	NA	NA	NA	NA
7	% Recurrent funds from GOG+HF allocated to CSOs	1.2	NA	NA	NA	3.1	NA	NA
8	% Recurrent funds. On exemptions	3.6	NA	NA	NA	8	2.2	3
9	Per capita expenditure on health (USD)	6.3	8.1	10.5	13.5	19	25.4	28.1

(5) Item 1 measures total allocation, which includes donor, internally generated (IGF) and statutory funds. The total allocation therefore includes private contributions (IGF), and nondiscretionary expenditure, such as the NHIS. If GoG contributions alone are analysed, the proportion (of GoG allocations to health, out of total GoG public expenditure) is lower: 13% in 2006 and 12% in the 2007 budget. Source: Ghana Ministry of Health, 2007.

Tables 4.1 and 4.2 below reveal some interesting trends. The first is that aid to the Health Fund has declined after 2004, as donors shifted to programme support; which is the cause of the significant increase in per capita health expenditure. This was anticipated, as donors become increasingly Paris Declaration compliant. Paradoxically, however, the year of the highest percentage of debt relief, 6% of health sector funding was also the year of GoG's lowest contribution, 40% in 2004.

3.2 Health Sector Funding

Table 3.2 Share of health sector funding, by source, 2002-6

			Donor				Financial	Project
Shares	GOG	Donor HF	earmarked	IGF	HIPC	NHIS	Credits	funding
2002	49%	19%	0	14%	0		10%	8%
2003	47%	13%	0	13%	4%		9%	14%
2004	40%	24%	0	12%	6%		11%	7%
2005	43%	15%	0	12%	0%		15%	14%
2006	53%	8%	9%	12%	5%	5%	8%	0%

Source: financial statements, 2002-6

The overall picture is of public finance sources dominating the GoG funding, together with HIPC and the NHIS make up 63% of sector funding with internally generated funds (IGF) remaining an important component and aid reducing in importance.

Table 3.3 Percentage change in revenue, by source, 2005-6

		Donor	Donor			Financial	Total
	GOG	HF	earmarked	IGF	HIPC	Credits	
Real	54%	-36%	-18%	25%	3112%	-30%	26%
increase							

(Source: financial statements, 2005 & 2006)

This increase in GoG funding, as a proportion of the total funding for health in 2006, reflects a number of factors, including the addition of extra-budgetary funds from the government and from a World Bank credit in the middle of the year and the switch from the HF into MDBS by some large DPs, which augments government expenditures and therefore potentially also allocations to health.

As shown in Table 3.3, the GoG funding line increased by 54% in real terms over 2005-6. Taking GoG funding alone, health was due to receive 19% of the budget for 2006 and 12% of the budget for 2007.

Direct DP contributions to the sector have dropped significantly in 2006. The Health Fund decreased by 36%, and earmarked funding dropped by 18% in real terms (comparing earmarked funds to project support in the financial statements). The Health Fund is actually suffering a two-fold squeeze. On the one hand, DPs are shifting to budget support: the EU left first, in 2005; then the World Bank, in 2006; the remaining health fund contributors are discussing a shift in 2008 to some form of budget support (possibly tied to the health sector, though channeled through the MoF). On the other hand, other DPs, such as DANIDA, have reacted to concerns over financial management and prioritization by earmarking their support within the HF in the latter part of 2006. DANIDA is providing only earmarked funds for 2007. DFID has not yet committed itself, either in terms of amounts or channels, for 2007. While these larger bilaterals are reducing or shifting their mode of support, global initiatives are increasing in importance. The Global Fund, for example, in 2006, provided 4.26% of total health sector funding, compared to 5.14% from the Royal Netherlands Embassy, 3.08% from DFID and 1.52% from DANIDA.

After a lull in 2005, HIPC funds were once again allocated to the health sector in 2006. Although 200 billion Cedis were allocated in the budget, actual expenditure was 250 billion (5% of total expenditure). Thirty (30) billion Cedis were allocated to exemptions and 1 billion Cedis were allocated to guinea worm eradication, with the remainder used for rehabilitation of KATH (Ghana Ministry of Health, 2007).

Since the implementation of NSF I, which had an original budget of US$118.9, new dimensions of the management of the epidemic and priorities have emerged in such diverse areas as ARV, care and support for PLWHA and OVC,

prevention of MTCT, deepening of BCC activities and provision of more VCT centres. These emerging priorities have enormous resource implications for the national response, requiring significant increases in resources committed to HIV/AIDS activities. For instance, 750,000 women become pregnant each year. The annual cost of providing Nevirapine to all pregnant women who are HIV-positive in order to prevent MTCT has been estimated at US $1.2 million (NACP/GHS, 2004). It is also estimated that about 71,000 PLWHA require ART yet only a small number of them are currently receiving treatment. The estimated annual cost of extending ART to all PLWHA who need treatment is between $47 and $80 million (NACP/GHS, 2004). These, together with other priorities such as blood safety, BCC, infrastructural development, equipment, institutional development, training and capacity development, research and development, monitoring and evaluation have extremely large resource implications for the national response.
Given the new realities of the national response and inherent resource implications, a proactive approach to resource planning, mobilisation and funding arrangements is required. This underscores the need to strengthen the resource mobilisation capacity of the national response to guarantee resource availability on a sustainable basis (NSF II). During Programme of Work I (1997-2001) and II (2002-2006), a partnership between MOH and DPs was built up, around the principles of a sector-wide approach (SWAP). The key elements of this approach were a clear nationally-owned sector policy and strategy; a medium term expenditure programme that reflects the sector strategy; systematic arrangements for programming the resources that support the sector; a performance monitoring system that measure progress and strengthens accountability; broad consultation mechanism that involve all significant stakeholders; a formalized government-led process for aid-coordination and dialogue at sector level; and, an agreed process for moving towards harmonized systems for reporting, budgeting, financial management and procurement.

Common Management Arrangements (CMA) stipulated the agreed procedures for doing business. Although this set-up certainly has had teething problems, it appears that confidence in the process has been growing among the key stakeholders. The Donor Pooled Health Fund has been an essential instrument to not only strengthen the policy dialogue, but also to strengthen basic health services and systems on the ground, by making available un-earmarked funding for important day-to-day activities, such as supervision of health centres, on-the-job training, HMIS, et cetera.

The donor community has made significant contributions to the Government of Ghana (GOG) health budget. The principal donors include the World Bank, DFID, USAID, the Royal Netherlands Embassy, the UN system, Denmark and Japan. Through grants and donations, the major partners directly provide support towards the Ghana health sector reform. The existing variety of aid modalities within the country is uncoordinated, as the assistance is being received at two different level of public administration (GAC and DAC) in addition to the private sector. A government official in the Ministry of Finance summed it all when he made the following observations:

Several organizations both local and international are working on the HIV/AIDS programme in this country in an uncoordinated manner. Our development partners also compound the problem when they make financial commitments to Ministries, Sectors and NGOs without the full knowledge and involvement of our ministry. This makes tracking of HIV/AIDS budget difficult.

Since the commencement of the implementation of PRSP II, the government of Ghana has earmarked 15% of its health budget for HIV/AIDS activities, and all ministries have been requested to create an HIV/AIDS budget line. In 2006, the Annual Programme of Work (APOW) committed a sum of US$52 million to HIV/AIDS activities while the total resource requirement for the period stood at over US $77.4 million. Table 3.4 lists the main priority areas and the respective annual budgets.

Comparison of needed funding of NSF II (Table 4.4) and projected aid disbursements to Ghana for Health (Table 3.5) reveals a total finance gap of US$82,245,781; specifically for 2009, $31,860,868 and for 2010; $50,384,850.

In fact, the IMF PRGF Review (2006) acknowledged as much.

> Accordingly, the authorities have prepared a broad outline of their scaled-up investment plan, which is consistent with the objectives of the GPRS II and in line with the above approach. This includes upgrading Ghana's infrastructuretransport, utilities, and energyand providing an environment conducive to private sector-led growth. In addition, resources will be directed at social servicesschools, health facilities, and preventive health care (such as universal medical vaccination)and governance (judiciary, immigration, and police). The authorities' preliminary estimate indicates that additional resources of about 4 percent of GDP a year would be required to support these initiatives during 2007-10. The relief from the MDRI has expanded

the resource envelope, and the authorities welcomed the associated debt-service savings. However, the preliminary projections incorporated in the baseline scenario suggest that prospective resources (from bilateral and multilateral sources) would be significantly insufficient to achieve the objectives.

Table 3.4 Resource Requirement of the NSF II by Thematic Areas of Focus

Thematic Area	2006	2007	2008	2009	2010	Total
Policy, Advocacy and Enabling Environment	$1,968,286	$2,330,822	2,762,840	3,154,090	3,553,852	13,769,890
Prevention and Behavioral Change	$26,963,324	$30,846,257	34,878,517	39,062,130	43,405,562	175,155,790
Treatment, Care and Support	$13,663,116	$22,357,509	33,246,814	42,646,575	52,177,273	164,091,287
Social, Cultural, Legal/Economic Impacts	$24,983,097	$24,940,304	23,969,320	23,427,623	22,878,902	119,749,246
Coordination and Management of Decentralised Response	$2,624,381	$3,107,763	3,683,786	4,205,453	4,738,470	18,359,853
Monitoring and Evaluation, Surveillanceand Research	$6,560,954	$7,769, 407	9,209,465	10,513,633	11,846,174	45,899,632
Resource Mobilization and Funding Arrangement	$656,095	$776,941	920,947	1,051,363	1,184,617	4,589,963
Total	**$77,419,253**	**91,679,002**	**108,671,688**	**124,060,868**	**139,784,850**	**541,615,661**

Source: Ghana AIDS Commission 2007

Table 3.5 Projected Aid Disbursements to Ghana

Aid Instruments / GPRS II Pillars and Sectors	Total Projected Disbursement (US$ mn)				
	2007	2008	2009	2010	2007 2010
Total Projected Disbursements	**1,292.7**	**1,382.9**	**1,434 .7**	**1,255.0**	**5,365.3**
of which:					
Budget Support (MDBS)	**293.6**	**354.6**	**378.1**	**361.2**	**1,387.5**
Direct Support to Civil Society	**16.8**	**16.1**	**12.9**	**11.9**	**57.7**
Sector and Investment Support	**982.3**	**1,012.2**	**1,043.7**	**881.9**	**3,920.1**
of which:					
Pillar 1: Private Sector Competitiveness	**596.6**	**583.1**	**626.5**	**519.4**	**2,325.6**
Agriculture (incl. NRM)	200.6	244.5	235.2	190.2	870.5
Private and Financial Sector Devt	91.5	78.4	56.0	36.6	262.5
Energy	76.6	48.5	53.7	57.7	236.5
Transport	227.9	211.7	281.6	234.9	956.1
Pillar 2: Human Development & Basic Services	**315.0**	**330.6**	**307.7**	**273.3**	**1,226.6**
Health (incl. HIV/AIDS)	115.3	116.4	92.2	89.4	413.3
Education	99.2	110.2	103.5	98.0	411.9
Water and Sanitation	100.5	104.0	112.0	85.9	402.4
Pillar 3: Good Governance & Civic Responsibility	**70.7**	**98.5**	**109.5**	**89.2**	**367.9**
Public Financial Management	5.4	7.4	6.0	5.5	24.3
Public Sector Reform	7.9	8.6	6.7	4.7	27.9
Decentralization	29.5	45.8	63.2	60.7	199.2
Other Governance (incl. M&E)	27.9	36.7	33.6	18.3	116.5

Source: Ghana Joint Assistance Strategy

4 Impacts on Public Expenditure Frameworks and the Macroeconomy

In recent years, there has been increasing concerns about macroeconomic policy constraints interfering with the ability of many African governments from increasing health sector spending, and getting access to urgently needed funds for HIV/AIDS human resource development. The International Financial Institutions (IFIs) and, in particular, the IMF have been accused of undermining health care systems in many developing countries through conditionalities that favour budgetary ceilings as panacea for macroeconomic stability. The economic policies sometimes affect overall spending, resulting in caps on the health sector, salary and recruitment for health workers and the acceptance of large amounts of financial assistance. IMF policies often require that countries forgo significant grants for health care in order to ensure macroeconomic stability*(6)*.

Ghana's fiscal policies have been more focused on ensuring effective control of public expenditure and the reduction of domestic debt*(7)*. Emphasis in recent times has also been on increasing the revenue base. Thus, broad base taxation was widened to cover incomes and property. As can be expected taxes from domestic goods and services have exceed those of the previous year by 3.2%. Value added tax is also an area government fiscal policy has given a lot of attention in view of its contribution towards revenue generation.

Table 4.1 Macroeconomic Indicators for Ghana

	2001	2002	2003	2004	2005	2006
Inflation rate	21.3	15.2	23.6	11.8		
Tax revenue / GDP	17.2	18.2	20.2	21.8	20.6	19.6
GDP growth	4.2	4.5	5.2	5.8	5.9	6.2

But government expenditure has also been on the rise. Total government expenditure and net lending stood at 8.3% of GDP. The stock of domestic debt increased by ¢186.7 billion to ¢22,013.6 billion representing an increment of 0.9 % over domestic debt stock. (BoG, 2006). Development partners (e.g. IMF and World Bank) have urged the curbing of the growing domestic debt stock, but have not curbed their own lending to Ghana.

Overall the performance of structural and macro-economic reforms has been good over the past 15 years with an average annual growth rate of 4.5% (as compared with 2.9% for sub-Saharan Africa), but such growth has been largely concentrated in finance, construction and gold and cocoa exports. Ghana has also experienced periodic declines in the quality of macro-economic management during election years (1992, 1996, and 2000) that caused cycles of inflation and devaluation in the subsequent years (USAID, 2007). Since the attainment of HIPC completion point, real GDP growth has been strong about 6% on annual basis inflation has declined appreciably, and the ratio of domestic debt to GDP is said to be on track to reaching the target level by the end of the year (IMF, 2005). It is worth mentioning that the macroeconomic policies and structural reforms in the past two decades are tied to commitments to development partners whose contributions to the national budgets are very significant. Not surprisingly, national budgets have often been structured along policy prescriptions provided by development partners including the IMF and the World Bank. The 2005 budget targeted debt domestic stabilization in the face of an increasing wage bill, as well as domestic debt service commitment, reducing inflation to single digits and poverty.

In spite of the institutional recognition of the link between macroeconomic policies and broad social development goals, there has always been a tendency to design macroeconomic policy with a focus on market-based criteria and financial concerns. This tendency always leads to a situation where social and human development and equity concerns take a back seat to financial consideration. Desired social and human rights objectives, such as equity, provisioning of health care needs covering HIV/AIDS and other communicable diseases need to be central to macro-economic policymaking if we are to advance a people-centred development or rights-based approach to development.

(6)A large coalition of NGOs representing people living with HIV/AIDS in 38 countries wrote a petition to the IMF and World bank managing directors in August 2004, demanding assurances that there will be no imposition of strict adherences to budget ceilings and inflation target and that there will not be blockade of funds available for the fight against HIV/AIDS. The petition signified major concerns of civil society organizations about the impact of the activities of IFIs on policy constraints in developing countries.
(7)See for instance Azeem and Odamtey (2006).

4.1 Some Handicaps to Government Planned Interventions

Following HIV/AIDS funding shortfalls during the last decade, the government of Ghana has embarked upon extensive consultations with stakeholders including civil society and the private sector to finding alternative strategies to ensuring macroeconomic stability without impediments to social spending. This is also with a view to finding sustainable alternatives of footing the social spending bill even where donor support is less than satisfactory. In 2006, the estimated budget for HIV/AIDS programme in Ghana stood at US $77,419,253 as against US $54,000,000 total amount received in form of grants from multilateral and bilateral agencies. In view of this, the 2007 budget has introduced a beverage tax to ensure that there is adequate revenue to tackle extra budgetary requirements of the health sub-sector and in particular the treatment, care and management of HIV/AIDS in the country. Sources from the Ghana Ministry of Health indicate that other strategies that are being considered include integrating the traditional medical care to orthodox medicine in order to reduce cost of treatment and additional health budgets. This inward looking strategy reduces the danger of extra budgetary inflows distorting macroeconomic stability (Ghana Ministry of Health, 2007).

Table 4.2 Medium Term Expenditure Framework (2005-2009)

(a) Total Payments (in billion cedis)

		2006	2007	2008	2009
2005 Proj. Outturn (Q1-Q4)		Budget Estimate	Projected Estimates	Projected Estimates	Projected Estimates
Total Payments	35,672.2	38,972.9	44,767.4	49,828.7	55,135.9
Statutory Payments	12,217.6	13,993.2	13,035.1	13,637.4	14,775.1
External Debt Service	**3,610.0**	**4,537.4**	**3,404.5**	**3,417.5**	**3,898.6**
Principal 1/	2,608.0	3,473.1	2,452.9	2,447.1	2,778.4
Interest	1,002.0	1,064.3	951.6	970.3	1,120.1
Domestic Interest	2,470.6	2,426.8	1,607.9	1,187.4	848.5
District Assemblies Common Fund	1,069.9	1,204.3	1,443.7	1,607.8	1,780.4
Transfers to Households	2,927.8	3,340.6	3,789.4	4,280.8	4,759.7
Pensions	613.8	705.9	804.5	911.0	1,012.9
Gratuities	356.0	409.4	466.6	528.4	587.5
Social Security	618.8	711.6	793.2	887.9	987.2
National Health Fund (NHF)	1,339.2	1,513.7	1,725.1	1,953.5	2,172.1
Education Trust Fund	1,175.6	1,386.3	1,538.4	1,727.1	1,912.7
Road Fund	883.3	1,068.9	1,251.2	1,416.8	1,575.3
Petroleum-related Fund	80.3	28.9	0.0	0.0	0.0
Discretionary Payments	23,454.6	24,979.7	31,732.4	36,191.4	40,360.9
Personal Emoluments (MDAs-Item 1)	8,683.1	9,990.0	11,129.7	12,458.2	13,851.9
Administration (MDAs-Item 2)	1,613.0	2,186.8	2,507.0	2,853.0	3,184.0
Service (MDAs-Item 3)	969.6	808.8	927.3	1,055.2	1,177.6
Domestic Investment (Item 4) (Excl.					
Statutory Funds)	1,427.9	1,684.8	3,200.3	4,783.7	8,484.4
Net Lending	98.0	39.5	0.0	0.0	0.0
New Loans	98.0	39.5	0.0	0.0	0.0
Loan Recoveries	0.0	0.0	0.0	0.0	0.0
Foreign-financed Investment (Item 4)	5,790.0	6,251.8	8,279.3	9,646.9	10,791.0
Strategic Oil Stocks	145.0	145.0	145.0	145.0	145.0
VAT refunds	72.0	100.0	111.0	124.6	138.0
Outstanding Commitments	1,117.7	347.0	97.0	0.0	0.0

Roads	100.0	100.0	0.0	0.0	0.0
Non-roads	1,017.7	247.0	97.0	0.0	0.0
Utility Price Subsidies	412.0	0.0	0.0	0.0	0.0
o/w TOR's Under-recovery	412.0				
Other Transfers	350.0	350.0	398.9	451.8	502.2
Safety net for petroleum deregulation	250.0	250.0	284.9	322.7	358.7
Lifeline consumers of electricity	100.0	100.0	114.0	129.1	143.5
HIPC-financed Expenditure	1,614.8	1,822.1	2,193.8	2,114.3	2,086.8
Divestiture Liabilities	0.0	0.0	0.0	0.0	0.0
Repayment of Domestic Debt	**996.2**	**1,167.7**	**2,740.0**	**2,558.7**	**0.0**
Redemption of Deferred Interest					
Payments on inflation-indexed Bonds	165.3	86.2	3.1	0.0	0.0
Discrepancy	0.0	0.0	0.0	0.0	0.0

(b) Total Receipts					(in billion cedis)
		2006	2007	2008	2009
2005 Proj. Outturn		Budget	Projected	Projected	Projected
(Q1-Q4)		Estimates	Estimates	Estimates	Estimates
Total receipts	35,672.5	38,972.9	44,767.4	49,828.7	55,135.9
Total Revenue (domestic tax					
and non-tax)	24,116.2	26,411.3	29,902.3	33,303.9	36,872.0
Grants	5,354.8	5,099.3	7,400.3	8,467.6	9,104.3
Project	2,840.0	2,505.9	4,028.1	4,866.6	5,443.7
Programme	1,354.0	1,388.0	2,091.5	2,351.8	2,630.7
HIPC Assistance	**1,160.8**	**1,205.4**	**1,280.7**	**1,249.2**	**1,029.9**
Loans	**4,437.0**	**5,383.4**	**6,018.6**	**6,767.7**	**7,570.3**
Project Loans	2,950.0	3,746.0	4,251.2	4,780.4	5,347.3
Programme Loans	1,487.0	1,637.5	1,767.3	1,987.3	2,223.0
Divestiture Receipts	150.0	335.0	0.0	0.0	0.0
Domestic Financing (Borrowing)	0.0	0.0	0.0	0.0	93.1
Deferred Interest Payments on					
Inflation-indexed Bonds	66.7	14.8	0.0	0.0	0.0
Exceptional Financing (HIPC Debt					
Relief)	1,547.8	1,729.1	1,446.2	1,289.6	1,496.3
Memo items					
Overall Cash Balance (including					
Divestiture)	-2,281.7	-2,400.4	-2,268.8	-3,051.4	-6,381.2
percent of GDP	-2.4	-2.1	-1.8	-2.1	-4.0
Domestic Revenue	24,116.2	26,411.3	29,902.3	33,303.9	36,872.0
percent of GDP	24.9	23.5	23.4	23.0	22.9
Domestic Primary Expenditure	21,522.4	24,156.1	28,635.7	33,018.2	39,597.9
percent of GDP	22.2	21.5	22.4	22.8	24.6
Domestic Primary Balance	2,593.8	2,255.3	1,266.7	285.7	-2,726.0
percent of GDP	2.7	2.0	1.0	0.2	-1.7
Nominal GDP (billion cedis)	97,018.0	112,320.3	128,012.8	144,960.7	161,177.3

There are currently major handicaps in the government's planned interventions on HIV/AIDS in Ghana. Indeed, funding in this sector has been woefully inadequate. Macroeconomic policy framework has ensured economic ceilings for social spending. The Annual Programme of Work (APOW) for HIV/AIDS 2007 indicates that "one of the major challenges for operationalizing the NSF II has been mobilizing enough funds". The report admits that less than half funding required to implement the activities to achieve the target for universal access has been secured for 2007. Consequently, the Ghana AIDS Commission*(8)* considers the year 2007 as the year of fund raising (APOW, 2007, p24).

Thus funding shortfall has been identified as one of the major handicaps of planned intervention. Not surprising the Ghana AIDS Commission(8) has pegged funding ceiling for NGO and Faith Based Organizations (FBOs) at ¢30,000,000 (US$3,333) and ¢12,000,000 (US$1,333), respectively. Indeed, the funds allocated for HIV/AIDS intervention programmes per year for most NGOs and CBOs can hardly, cover a weekly activity. Based on the level of funding already committed by the national government and its donors, the World Health Organization (WHO) estimates a funding gap of over US $12.8 million for HIV/AIDS activities in Ghana. Currently all aspects of HIV programmes in Ghana including prevention, treatment, care and support, behavioural change, coordination, monitoring, evaluation and surveillance are under-funded.

Furthermore, there are also infrastructural constraints as most interventions areas, especially in the rural parts of the country, which are not easily accessible by road. In addition, storage facilities for antiretroviral drugs are often lacking. The poor infrastructural conditions in rural areas have also proven to be impediments the posting of qualified health personnel to rural areas. In view of this, there is also the problem of inadequacy of personnel to cover all the intervention areas.

Table 4.3 Expected Number of ART Sites and Clients for 2006 and 2007

Type of Facility	Number of Facilities 2006	No. of Patients 2006	Number of Facilities 2007	Number of Patients 2007
Sites as at the beginning of the year	5	6,972	28	19,132
Regional Hospitals	10	5,000	-	-
District Hosp/Quasi Govt.	10	1,800	20	4,200
Tap and Private Clinics	7	1,260	-	-
Total	**32**	**15,032**	**48**	**23,332**

Source: Ghana AIDS Commission

In Ghana agencies that continue to support the national sentinel surveillance and control programmes with public health laboratories to monitor the prevalence of HIV/AIDS include USAID, the Noguchi Memorial Institute for Medical Research (NMIMR); a biomedical research facility at the University of Ghana, the Teaching Hospitals, and major regional hospitals spread across the country. The research findings in these sites provide national policy makers information on levels and trends of the disease. In addition, the research findings also enable policy makers to design activities towards behavioral change with targets towards vulnerable and high risk groups. However, the weakest link in the policy feedback chain is the District Assemblies (DAs) where rural hospitals under their control and management are often not well equipped. In particular, the laboratories often do not have the facilities as well as qualified medical personnel to facilitate proper care and treatment as well as comprehensive feedback to policy makers.

4.1.1 Treatment of HIV/AIDS, Supply of Equipment and Service Delivery

Currently, the linkages between Ministries Department and Agencies (MDAs), academic institutions, Private sector and civil society in the effort to ensure effective and efficient supply of equipment and delivery of services across the nation are weak. Indeed, as a senior health personnel interviewed in Greater Accra Health Service explained:

(8) The Ghana AIDS Commission plays a leadership role by coordinating and managing the national response to HIV/AIDS. Yet it is handicapped in terms of human and material resources at its disposal given the quantum of problem the commission is trying to tackle.

Budgetary constraints and high cost of equipment have deprived most sentinel sites across the country of basic testing equipments to enhance service delivery to the local communities.

The concern expressed by the health personnel is not a solitary one. In fifteen (15) out the twenty (20) interviews conducted there was general consensus about inadequacy of medical equipment and poor coverage of service delivery across the country. Health facilities in Ghana are mal-distributed with more access in the southern half of the country*(9)*. Generally, health service delivery in Ghana is poor. It is estimated that nearly 40 % of Ghanaians live more than 15 kilometers from the most basic health services.

Table 4.4 HIV/AIDS Related Services in the Ten Regions of Ghana 2006

Region	PMTCT/VCT	ART	CD 4	Sentinel Site
Ashanti	46	7	5	4
Greater Accra	35	10	5	5
Brong Ahafo	31	1	3	4
Western	28	3	5	3
Upper West	8	1	1	3
Upper East	15	2	2	4
Eastern	36	5	6	5
Northern	7	1	2	4
Central	23	1	2	3
Volta	18	3	4	4

Source: NACP Bulletin September 2006

Up to the end of the year 2004, there were only four sites in Ghana where patients had access the antiretroviral therapy, surprisingly, all the sites were located in the southern part of the country. The location of HIV/AIDS care and treatment sites is illustrated in Table 6.

It is worth mentioning that Highly Active Anti-retroviral Therapy (HAART) treatment sites have been expanded from 5 in December 2005 to 34 by September 2006. The current figures indicate that a total number of 404, 000 people were afflicted by the disease by the first quarter of 2007, out of which only 15, 000 have access to anti-retroviral treatment. Notwithstanding the improvements and low prevalence rates, the overall performance of HIV/AIDS service delivery can be described as less than satisfactory. It is significant to mention that out of the 34 Art sites the three northern regions of Ghana have only 4 sites as illustrated in Table 6. This calls for a more geographical access in the distribution of HIV/AIDS related facilities across the country.

4.1.1 Investment in Human Capital Development and the Hiring of Health Personnel

According to the 2006 World Health Report on Human resources for health, 57 countries world-wide have a critical shortage of health professionals. Of this figure, 36 countries are in Sub-Saharan Africa. In Africa alone, there is a shortfall of 1 million health professionals (DFID, 2007). Human resource development for the health sector has been a major problem for the government of Ghana in its quest to provide quality health care for the people in order to achieve the Millennium Development Goals (MDGs). Despite producing an average of 150 doctors per year, the doctor patient ratio remains abysmally poor at one medical personnel to twelve thousand patients (1:12,000) in urban areas. There are also serious variations with rural areas which are often the worst affected parts recording an average of one medical personnel to sixty five thousand patients (1:65, 000). The northern sector of the country which has 30% of the population has only 20% of total health personnel. Thus in terms of quality of staff, the three northern regions of have only 6 % of medical doctors in the country. Paradoxically, 50% of all medical doctors in Ghana are based in the national capital, Accra thus revealing a huge imbalance in the distribution of health personnel across the country.

In a bid to curb the shortfall in medical personnel previous governments entered into a medical exchange agreement with the Cuban government in 1982 with an initial figure of 17 medical doctors. Since then, the Cuban

(9) For further details on the distribution of health facilities in Ghana, see especially, the Ministry of Health Medium Term Strategic Framework for Health Development in Ghana, 1996- 2000, Accra, Ministry of Health 1995.

government has assisted various Ghanaian governments with a steady supply of medical doctors. In June 2007 the total number of Cuban medical doctors serving in the country stood at 180. Nevertheless, there is still a huge shortfall in the need for medical doctors; a situation that has compelled the current administration to request for additional Cuban medical doctors*(10)*.

Table 4.5 Brain Drain of Health Workers, 1999 2004

Category	1999	2000	2001	2002	2003	2004*	Total
Doctors	72	52	62	105	117	40	448
Pharmacists	49	24	58	84	95	30	340
Allied Health Workers	9	16	14	12	10	8	69
Nurses/Midwives	215	207	235	246	252	82	1,237

Source: Ministry of Health

While HIV/AIDS has resulted in the need for additional qualified health workers, poor working conditions in the Ghana health sector has triggered a massive exodus of medical personnel overseas for greener pastures. Between 1999 and 2004 total number of 448 medical doctors left the country representing more than half of the total number trained in the country during the same period. Like the medical doctors, approximately, 340 pharmacists left country. The situation was worst amongst nurses and midwives where 1,237 followed the trail of their medical colleagues on the exodus train (see Table 7). It is disheartening to note that the ugly scenario is on the ascendancy.

Distribution of medical personnel across the country is negatively skewed against rural areas. The rural urban imbalance implies that the ratio of medical doctors in urban and rural areas is approximately 10:1. Many doctors will rather prefer working in urban centres where basic facilities such as portable drinking water and electricity are available. One of the main reasons cited for the brain drain of health personnel was "poor remunerations" in the health sector. In order to curb the negative brain drain syndrome that has hit the medical sector and to entice health personnel to rural areas, through remunerations such as the "additional duty hours allowance" and the provision of cars to entice medical doctors to rural areas*(11)*. In spite of these incentives and attractions, the allure of greener pastures elsewhere has made curbing the brain drain difficult task that confronts that Ghana Ministry of Health.

4.1.3 Behavioral and Attitudinal Changes toward HIV/AIDS

AIDS- related stigma and discrimination are the obstacles to progress that often exclude most people who need help from being able to get it (DFID, 2007). All too often, persons perceived to be living with HIV/AIDS face exclusion, abuse and denial of care in their communities and work laces. In a bid to curb HIV stigma in Ghana, the national Strategic Framework (NSF II) has embarked on intensive national campaign targeting prevention and behavioural change communication (BCC) for the period 2006 and 2010. Public education campaigns through the mass media, billboards, and in schools have been intensified to improve knowledge about the disease. In line with this is the development of the next generation of interventions will focus on changing individual risky sexual behaviour as well as community perceptions about HIV/AIDS and people living with HIV/AIDs (PLWHA). Objectives of the behavioural change campaign include the following:

- Developing, implementing, and managing targeted behavioural change in communication and other prevention programme
- Increasing the proportion of sexually active population that practice faithfulness, or use of condoms
- Promoting programmes to ensure increase age at sexual debut among young people
- Promoting the utilization of quality STI, VCT, and PMTCT, and PEP services to vulnerable/high risk group and the general population
- Minimizing the risk of HIV transmission through blood and blood products
- Reducing the incidence of occupational exposure to HIV and other infections

(10)The Bua News June 18th Edition reports that the Ghana government had made request for additional Cuban Medical doctors. Invariably, the vice Predsident of Ghana made request for the raising of the current figure to 200 medical personnel annually.
(11) See ISSER Report on the state of the Ghana economy 2005.

Since the inception of the national strategic framework and its accompanying pursuance of attitudinal and behavioural change policy several organizations have taken up the challenge to manage community and work place programmes aimed at changing behaviours and attitudes towards HIV/AIDS. Some of the organizations include the Trade Union Congress (TUC), the Ghana Business Coalition Against AIDS (GBCAs) PEF, GEA, Chamber of Mines, Association of Ghana Industries (AGI), Association of Bankers, CSOs, CBOs, FBOs, GES and the GSFM. Following the activities of these organizations, prevention efforts in community and in the workplace are being promoted. Paradoxically, the institutions and agencies working on attitudinal and behavioural change are not coordinated and work independent of each other. Most of the time, the organizations appear to be competing among themselves for the limited financial resources. Although, awareness levels have reached 97 % in the urban areas and overall stigmatization of HIV/AIDS victims is on the decline, there is still a sharp contrast in rural areas where awareness levels are still low and stigma against HIV/AIDS afflicted persons remains high. It is worth mentioning that the 1% to 4 % decline in the number of new HIV infections in recent times is attributed to the success of mass media campaigns but this has to be linked to other interventions in order to yield positive results. The challenge however, remains in bridging the awareness gap between rural and urban communities across the country.

4.1.4 Provision of Social Security to Affected Persons and the Unemployed

The literature on HIV/AIDS indicates that it poses a serious impact on social security. Fundamentally, social security should be an essential component of health care system, but this is not the case in many developing countries including Ghana. The main social security scheme operated in the country is the Social Security and National Insurance Trust (SSNIT), established in 1972, covers only wage employees. Self-employed persons have the option of joining, but this is rare. Interestingly, the social security scheme does not cover health care. This implies that there is no sickness or maternity benefits provided, however employed persons receive worker's compensation. The ILO's preliminary data (2007) shows that “for old age, disability and survivor pensions, slightly more than 10% of the economically actively population contributes to a pension scheme in Ghana, Zambia and just over 5% in Senegal. These figures reflect the fact that only a small minority of workers are in the formal economy, while most workers in the informal economy are not covered” (Vanguard, 2007).

In Ghana, pensions are funded by 5% contributions from employees and 12.5% contributions from employers. The minimum pension is set at 50% of the average annual salary. Agricultural workers and subsistence farmers are excluded from coverage in this scheme. The poor and the vulnerable are also mostly excluded. This implies should there be pro-longed illness such as caused by HIV/AIDS, or even death, there are no social safety nets for orphans and spouses. Adult unemployment rate in Ghana is very high, and estimated around 20%. In view of widespread unemployment, the main option of support for most HIV/AIDS victims is the family. Presently, the National Health Insurance Scheme operated by the government of Ghana is not clear on its coverage for HIV/AIDS afflicted persons. The absence of effective social security coverage implies that the burden of health care lies squarely on the family. Indeed, the need for social security coverage for the sick and unemployed cannot be overemphasized. HIV infections levels in Ghana are highest in middle income and middle educational groups, with the poor and unemployed less affected*(12)*. The fact that income earners are widely affected by HIV/AIDS in Ghana has wide implications for poverty and development. Poverty reduction strategies in Ghana and elsewhere in Africa must begin to address social security coverage for HIV/AIDS afflicted persons so that, it will make meaningful impact on the lives of the citizenry.

4.1.5 Support and Protection of Vulnerable Groups

In most parts of Sub-Saharan Africa including Ghana, women are disproportionately affected by HIV/AIDS. It is estimated that for every 10 adult men living with HIV, there are 14 adult women affected (UNAIDS, 2006, pp 88). Children under the age of one constitute just 4 % of Ghana's population, yet account for 15 % of HIV/AIDS cases. This shows that the prevalence rate among children is quite high. Ghana's system of HIV surveillance for women attending antenatal clinics has functioned relatively well since 1994 when it was first established. Sentinel survey in 2002 reveals a prevalence rate of 3.2 % amongst pregnant women. Support and protection of vulnerable groups especially women and children has been enhanced through the Prevention of Mother to Child Transmission (MTCT) programme. Consequently, this has resulted in a decline in the number of new infections from mother to child to 14% in 2006. The prevention of mother to child infection has reduced to a considerable extent and child mortality rate has significant implication on the country's quest towards reaching the Millennium Development Goals (MDGs). As of June 2004, only 2,000 of an estimated 52, 000 adults needing immediate HIV/AIDS were receiving ARV drugs.

(12) See USAID Report on the Health Profile of Ghana 2005.

Currently, 15, 000 out of an estimated 404, 000 people nation-wide are receiving ARV -related attention. This calls for action in the expansion of the support base by all stakeholders including the Ghana AIDS commission, multilateral and bilateral partners for the vulnerable groups such as women and children.

4.1.6 Participatory and Multi-stakeholder Processes to Address the Pandemic

Because of its devastating nature and the tendency to plunge society further into poverty, the need to pursue a multi-stakeholder approach to address the HIV/AIDS pandemic in Ghana has become imperative. Here the participation of donor agencies, policy makers, local organizations and institutions, CSOs, CBOs, FBOs, and People living with HIV/AIDS (PLWHA) is very crucial. Currently, multilateral and bilateral partners, nongovernmental organizations (NGOs) and civil society organizations (CSOs) are actively implementing HIV/AIDS programmes in Ghana. Very often, the need to beat timelines provided by development partners often compromise grassroots participation in local policy making. Furthermore, there appears to be a fragmentation of the participation process which is skewed against people living with HIV/AIDS especially in rural areas. These frustrations were revealed during an interview with an HIV/AIDS victim in Tamale - Ghana:

> The talk about access to medication remains a gimmick to some of us. We only hear about free access to antiretroviral drugs on radio, but as to whether we have real access to drugs is another thing entirely. I have spent all my savings on treatment, I have lost my job and marriage as a result HIV/AIDS and I have been reduced to beggary status in order to survive. Tell the authorities to do more if only they are serious about assisting us.

Although, there are national, regional and district agencies and institutions dealing with the epidemic, yet the approach is largely top-down. Decision making in the fight against HIV/AIDS in Ghana is seen by many as a prerogative of IFIs and policy makers. Evidence from Ghana shows that it is not how much is budgeted for HIV/AIDS, but also, crucial question remains on how to achieve national full coverage of HIV/AID programmes in Ghana. Of particular significance will be the inclusion of grassroots and vulnerable groups in the decision making process of the district and rural health care system. The multi-stake holder participation will require the building of capacities of rural health institutions, district assemblies (DAs) CBOs and NGOs and well PLWHA on tracking and monitoring of HIV/AIDS resources.

4.2 Share of Donor off Budget Funding of HIV/AIDS and its Impacts

In recent times, the share of donor funding on HIV/AIDS in Ghana has been on the upsurge. Nevertheless, this is not enough to meet the total financing requirements for the annual programme of work on HIV/AIDS. Donor contribution is nearly 80 % of the entire HIV/AIDS budget. Public contribution accounts for 15 % whereas private contribution accounts for 5 percent. Invariably, three types of funding have been identified for the support of the HIV/AIDS programme which includes the following:

- Foreign or International Funding from, IFIs, bilateral, multilateral, international NGOs etc
- Public, from Central Government, Regional and District Assemblies (DAs)
- Private corporate bodies, personal savings, household and family support.

Thus funding can also be direct or indirect. In the direct funding, the funding is provided to agencies and institutions working on HIV/AIDS. Agencies such as DANIDA, DFID, United Nations and the World Bank provide support through the Sector Wide Approach (SWAP) or indirectly through Multi-Donor Budget Support (MDBS) and government budget process (Azeem and Adamtey, 2006). Sometimes donor agencies also maintain monies in their offices and Embassies while working closely with local CSOs and CBOs. Between 2000 and 2002, Ghana received a total of US $ 35 million from bilateral and multilateral donors for AIDS control*(13)*. Part of the support came from the Global Fund managed by the United Nations (UN). The World Bank alone contributed US $ 25 million for the management of HIV/AIDS programme in Ghana. Currently, the country is in the second phase of donor funding involving a multi-sectoral pool which covers 2006 and 2010. During the projected period, the World Bank has pledged support of US $ 20 million while DFID's pledge is €7.5 (Euro) for a period of three years. DANIDA pledges US$1.195 while expected contribution from the Multi-Sectoral HIV/AIDS Programme (MSHAP) stands at $7 million. The Government of Ghana (GoG) will contribute US$2.8 million during the period.

The overwhelming support from external sources has had some negative impacts on HIV control. Indeed, donor

(13) For further reading on global sources of HIV/AIDS funding, see for instance Guthrie (2006) "Overview of Existing Resource Tracking Effort", September.

support is always accompanied by restrictions "not only where the funds can be spent but also on how the sector can be run" (opcit, 2006). There has been significant shortfalls in donor pledges for instance in spite of US $20 million pledge of support from DFID, only 500,000 US dollars came as direct contribution to HIV/AIDS programme in the country in 2006. Similarly, only half of the pledge of US $70 million from the Global Fund was made available to the government.

4.3 Mechanism by which HIV/AIDS has affected Service Delivery and Public Expenditure

The HIV/AIDS has affected social service delivery in Ghana in several ways. Firstly, in terms of prevention, care, treatment and management of HIV/AIDS this has brought additional pressures to bear on an already overstretched health sector. The spread of the epidemic since the early 1990s has implied that in the face of mass exodus of health personnel out of the country, the health care system has come under severe test.

Table 4.6 Sectoral Resource Allocations (2004 2006) (¢000, 000)

Sector	2004	Percentage allocation	2005	Percentage allocation	2006	Percentage allocation
Social Sector	5,048.51	38.82%	5,705.12	39.10%	13,200.01	44.8%
Administration	2,229.84	17.15%	2,512.58	17.20%	4,286.26	14.5%
Public Safety	1,517.99	11.67%	1,728.93	11.85%	1,893.06	6.4%
Infrastructure	1,420.93	10.93%	1,525.48	10.46%	5,183.61	17.6%
Economic	1,160.72	8.92%	1,262.99	8.66%	2,152.82	7.3%
Contingency	920.77	7.08%	1,048.59	7.18%	N/A	
Revenue Agencies	387.62	2.98%	442.47	3.03%	N/A	
Utilities	319.00	2.45%	364.14	2.50%	N/A	
Grand Total	**13,005.38**	**100.00%**	**14,590.30**	**100%**	**29,483.98**	

Source: Annual Budget Statements (2004 2006)

In particular, HIV/AIDS has brought additional pressures to bear on obsolete and inadequate medical facilities across health centres. The creation of PMTCT, VCT, STI, and sentinel surveillance centres have taken an increasing toll on public expenditure in recent times. In 2001, government's total expenditure stood at 9%. However, the spread of HIV and other communicable diseases have compelled the government to allocate 15% of the Ghana health budget. The estimated annual public expenditure for meeting MDG target in Ghana is US$77 million. Perhaps in the absence of HIV/AIDS the monies could have diverted to other poverty reduction activities such as the improvement of agricultural sector, road network and access to portable drinking water. In addition off-budget donor support for HIV/AIDS campaign is quite substantial and would have yielded significant impact on deteriorating public utilities and indeed the energy sector.

The social sector has received the largest share of budgetary allocation accounting for 38.2 % in 2004, 39.1 % in 2005 and 44 % by 2006 (see Table 4). Of this allocation the Health Sector has received the largest share of the social sector budget followed by education. The increase in health sector allocation is a direct result of the GPRS commitments, and debt forgiveness that has not only reduced debt servicing but also made more funds available for government projects. Ghana received a debt relief of US $ 3.7 billion in 2002, to finance its health, education and rural sectors. Paradoxically, most the aid that has come in form of grants and loans will cover a period of twenty years. Consequently, the trickle-down effect of this relief has yielded rapid positive impacts as has been expected.

4.4 Assessing the Link between Achieving the MDGs and Indebtedness

Ghana has achieved significant debt relief in recent years after reaching the HIPC status in July 2004. Approximately US$2.186 billion in HIPC assistance was committed by all its creditors (IMF, 2006). Under the G8 multilateral debt relief, Ghana is to be forgiven an additional US$ 4.2 billion by the middle of 2006*(14)*. However, despite the tremendous debt relief does not mean that the country has no other external debts. From an external debt of $5.9 billion in 2001, Ghana's current debt in 2007 is estimated around US$3.546 billion. Prior to the attainment of HIPC status, Ghana had an enormous debt servicing costs which required over 70% of 2001 government revenue (US $560 million).

Table 4.7 Key Debt Sustainability Indicators

	2002	2003	2004	2005	2006
Real GDP	4.5	5.2	5.8	5.8	6.0
Government Revenue, excluding grants, % change	27.5	56.2	38.2	21.9	14.1
Total Grants (billions cedis)	1,533	3,119	5,080	5,100	6,348
Total Expenditure, % GDP	25.9	28.8	33.3	30.8	32.4
External Debt Service due, % government revenue	37.0	23.2	21.2	17.7	12.9
Net domestic debt (billions cedis)	11,690	12,089	12,133	10,461	9,799

Source: IMF, 2006

Examination of Table 4.7 reveals some interesting fiscal habits of Ghana. GDP has remained more or less unchanged. In fact, since 1985, it has hovered between 4% and 5.8%, with only four years when it fell below 4% (Ghana GPRS II). Its revenue has increased as a result of wider and deeper tax base. Not surprisingly total expenditures have increased as a proportion of GDP, an attempt to meet the Millennium targets. What is alarming is the level of domestic debt stock and external debt service.

Despite being a HIPC graduate and qualified for debt relief with the International Development Association and the African Development Fund, Ghana is the recipient of a new Poverty Growth and Reduction Facility (PRGF), amounting to SR 184.5 million, which is fifty percent of its quota with the IMF!

The HIPC initiative as it is currently constituted is inadequate since it does not address debts that are owed by HIPC countries to non-Paris Club creditors and which have not been rescheduled or serviced at all for a long period of time. Consequently, the debt-sustainability ratio for these debtor countries is misleading, since the actual debt situation of most developing countries including Ghana is worse than is apparent.

Admittedly, the prevalence of HIV in Ghana is quite low when compared to other African countries. Nevertheless, the GoG, through the GPRSII, that stemming the HIV/AIDS pandemic could only be done via a multi-sectoral approach and that targeting certain groups (women, rural poor, youth) in order to make them less vulnerable to contracting the virus, which included economic empowerment initiatives, the provision of basic social services, extension of education and incentives to attend school and vocational training centres.

Under the HR development Pillar, there are five projects that account for 22% of total lending from the World Bank. The Board approved the financing for the Education Sector Project in February 2004 (IMF, 2006). Table 4.8 lists the IDA Credits to Ghana.

(14)See highlights of Ghana budget 2006.

Table 4.8 Financial Relations with the World Bank Group

(Active portfolio as of 18 April, 2007 millions of U.S. dollars)							
Credit/Grant Number	**Fiscal Year**	**Project Name**	**IDA Credit**	**IDA Grant**	**GEF Grant**	**IDA Guar.1**	**Undis-**
20412-GH	1998	GEF Forest Biodiversity			8.7		0.2
31140-GH	1999	Trade Gateway and Investment	50.5				17.3
33740-GH	2000	Rural Financial Services	5.1				0.0
34050-GH	2001	Agricultural Services	67.0				0.0
35540-GH	2002	Road Sector Development	220.0				0.6
50723-GH	2002	GEF Northern Savanna			7.6		2.2
37310-GH	2003	Health Sector Program II	57.6	32.4			0.0
H0190-GH							
38170-GH	2004	Land Administration	20.5				12.3
38650-GH	2004	Education Sector Project	78.0				52.7
38890-GH	2004	2nd Urban Environment and Sanitation	62.0				58.2
TF 50723	2004	GEF Community-based Int. Nat. Res. Mgt.			0.85		0.3
H1320-GH	2005	Urban Water		103.0			85.6
39710-GH	2005	Small Towns Water Supply	26.0				15.9
39640-GH	2005	Community-Based Rural Development	60.0				31.5
41250-GH	2006	Multisectoral HIV/AIDS program	20.0				16.3
41860-GH	2006	PRSC 4	143.1				0.0
41240-GH	2006	Economic Management Capacity Building	25.0				22.1
41390-GH	2006	Micro, Small, and Medium Enterprise	45.0				43.0
		Development					
42260-GH	2007	e-Ghana	40.0				39.5
Total (number of credits/grants: 18) 2			919.80	135.4	17.15		397.7
N.A.	2005	West Africa Gas Pipeline				8.0	

Total (number of partial risk guarantees: 1)						8.0	
H1050-GH	2004	Regional HIV/AIDS Treatment Acceleration		14.9			7.3
40920-GH	2005	West Africa Power Pool APL-1 Phase 1	40.0				38.0
42130-GH	2006	West Africa Power Pool APL-1 Phase 2	45.0				45.0
Total (number of regional credits/grants: 3)			85.0	14.9			93.4
Total (all operations)			1,004.8	150.3	17.15	8.0	488.0

Source: World Bank

1 IDA partial risk guarantee up to US$50.0 million (of which 25 percent is IDA commitment) to protect commercial parties against sovereign risk.

2 Cumulative commitments for active projects total US$1.04 billion.

There are huge gaps in infrastructural needs. The Global Competitiveness Report in 2004 ranked the quality of infrastructure in Ghana 66th out of 104 countries. The relevance of infrastructural services to efficient health service delivery cannot be down-played. The timely delivery of antiretroviral and other relevant drugs depends on efficient road networks. Indeed smooth access to rural areas is a determining factor for attracting qualified health personnel and access to health care centres is a determining factor for PLWHA to receiving treatment. Estimates of budgeted infrastructure spending is about 1 percent of GDP in 2005 (Estache and Vigliasindi 2007), which is very inadequate according to the parameters of global institutions.

5 Evaluation of Fiscal Space

The Pre-Paris Declaration aid disbursement mechanism in Ghana was bi-modal. Donor partners could either engage directly with DACs and NGOs or with the GAC. Agencies such as DANIDA, DFID, United Nations and the World Bank provide support through the Sector Wide Approach (SWAP) or indirectly through Multi-Donor Budget Support (MDBS) and government budget process (Azeem and Adamtey, 2006). Sometimes donor agencies also maintain monies in their offices and Embassies while working closely with local CSOs and CBOs. Between 2000 and 2002, Ghana received a total of US $ 35 million from bilateral and multilateral donors for AIDS control*(15)*. Part of the support came from the Global Fund managed by the United Nations (UN). The World Bank alone contributed US$25 million for the management of HIV/AIDS programme in Ghana.

Currently, the country is in the second phase of donor funding involving a multi-sectoral pool which covers 2006 and 2010. During the projected period, the World Bank has pledged support of US$20 million while DFID's pledge is €7.5 (Euro) for a period of three years. DANIDA pledges US$1.195 while expected contribution from the Multi-Sectoral HIV/AIDS Programme (MSHAP) stands at $ 7 million. The Government of Ghana (GoG) will contribute US $2.8 million during the period. The overwhelming support from external sources has had some negative impacts on HIV control. Indeed, donor support is always accompanied by restrictions “not only where the funds can be spent but also on how the sector can be run” (opcit, 2006). There has been significant shortfalls in donor pledges for instance in spite of US$20 million pledge of support from DFID, only 500,000 US dollars came as direct contribution to HIV/AIDS programme in the country in 2006. Similarly, only half of the pledge of US$70 million from the Global Fund was made available to the government.

A recent independent evaluation of the CMA II found that policy dialogue between the Ministry of Health and donor partners had become tense. It is not easy to identify the underlying factors for this. One reason for misunderstandings between MOH and DPs is likely to be the observed loose relationship between formulated budgets and budget execution (budget discipline), and diverging views on setting priorities and reflecting those in budget formulation (budget credibility). Another possible reason may be that discussions on reasons why agreed intentions (such as described in the detailed aide memoires and during business meetings) have not been followed-up may not always take place in a business-like manner. Yet another reason may be that the aid structure itself is changing, with trends a) towards shifting DP resources through sector budget support, and towards more ownership by GOG, and b) towards a stronger 'verticalisation' of programme execution and financing. Lastly, the pressure by GOG, and by some DPs - to achieve results, also in terms of 'outcome' (morbidity and mortality reduction), and different expectations about the 'performance' of the sector as a whole, may also put some stress on the policy dialogue (Ghana Ministry of Health, 2007).

Overall the performance of structural and macro-economic reforms has been good over the past 15 years with an average annual growth rate of 4.5% (as compared with 2.9% for sub-Saharan Africa), but such growth has been largely concentrated in finance, construction and gold and cocoa exports. Ghana has also experienced periodic declines in the quality of macro-economic management during election years (1992, 1996, and 2000) that caused cycles of inflation and devaluation in the subsequent years (USAID, 2007). Since the attainment of HIPC completion point, real GDP growth has been strong about 6 % on annual basis inflation has declined appreciably, and the ratio of domestic debt to GDP is said to be on track to reaching the target level by the end of the year (IMF, 2005). It is worth mentioning that the macroeconomic policies and structural reforms in the past two decades are tied to commitments to development partners whose contributions to the national budgets are very significant. Not surprisingly, national budgets have often been structured along policy prescriptions provided by development partners including the IMF and the World Bank. The 2005 budget targeted debt domestic stabilization in the face of an increasing wage bill, as well as domestic debt service commitment, reducing inflation to single digits and poverty.

In spite of the institutional recognition of the link between macroeconomic policies and broad social development goals, there has always been a tendency to design macroeconomic policy with a focus on market-based criteria and financial concerns. This tendency always leads to a situation where social and human development and equity concerns take a back seat to financial consideration. Desired social and human rights objectives, such as equity, provisioning of health care needs covering HIV/AIDS and other communicable diseases need to be central to macro-economic policymaking if we are to advance a people-centered development or rights-based approach to development.

(15) For further reading on global sources of HIV/AIDS funding, see for instance Guthrie (2006) “Overview of Existing Resource Tracking Effort”, September.

In recent times, there have been claims about rapid resource inflows putting pressure on institutions in developing countries often ill-equipped to deal effectively with quick disbursement of funds (Lewis, 2005). In contrast, some analyst believe that given the magnitude of the HIV pandemic in hardest hit countries, the resources can be said to be paltry (Burkhalter, 2004). Perhaps due to low prevalence rate, Ghana has not experienced a jump in external funding of HIV/AIDS as was the case in Lesotho and Swaziland (1000%), and Zambia (560%). Nevertheless a 4 % aid inflow into Ghana between 1984 and 1988 is believed to have triggered 30 % inflation (Younger, 1992). Overall the health budget has not been swamped by donor funding to create macroeconomic instability*(16)*. As a result, there is has neither been significant appreciation of exchange rate nor inflationary tendencies in the economy as depicted on table 2. Significantly, the aid flows that come to Ghana have been absorbed across the sectors appropriately without negative consequences to macroeconomic stability. Indeed, the evidence in Ghana shows that in spite of significant improvements in health spending, the budget still falls short of the MDG requirements.

In recent times, the IMF has been supporting a wage-freeze policy to curtail macroeconomic instability. According to IMF May Report 2007, public sector wage overruns stemmed from large wage increases in the health sector in the first half of the year, aimed at retaining skilled labor, which led to demands for additional wage increases in the rest of the public sector later in the year. It also recommends a streamlining of the wage-setting process and speeding up civil service reform which in some way includes job cuts across all sectors including health. The recent report by IMF indicates that the progress in public and civil service sector reforms has been slow. Conversely, the IMF would have preferred much faster reforms in the Ghanaian economy which would have affected social service delivery including health service delivery and the fight against HIV/AIDS. Although, the IMF favours Tariff increases for electricity and water, and monthly reviews of petroleum product pricing introduced in April 2006, these measures are in no small way affecting the poor and vulnerable who continue to absorb transport hikes and prohibitive water bills as a result of this policy. The IMF has also been in favour of the reinstatement of full cost recovery of the utility tariff regulation as a means of accelerating divesture, a key to easing future burdens on the budget. Thus, far the IMF recommendations for policy reform in Ghana often include austere economic measures that portend negative consequences on social service delivery. Regardless, of macroeconomic performance, the impact can be negative if it fails to pay attention to national priority, which is poverty reduction and social service delivery.

Following HIV/AIDS funding shortfalls during the last decade, the government of Ghana has embarked upon extensive consultations with stakeholders including civil society and the private sector to finding alternative strategies to ensuring macroeconomic stability without impediments to social spending. This is also with a view to finding sustainable alternatives of footing the social spending bill even where donor support is less than satisfactory. In 2006 the estimated budget for HIV/AIDS programme in Ghana stood at US $77,419,253 as against US $54,000,000 total amount received in form of grants from multilateral and bilateral agencies. In view of this, the 2007 budget has introduced a beverage tax to ensure that there is adequate revenue to tackle extra budgetary requirements of the health sub-sector and in particular the treatment, care and management of HIV/AIDS in the country. Sources from the Ghana Ministry of Health indicate that other strategies that are being considered include integrating the traditional medical care to orthodox medicine in order to reduce cost of treatment and additional health budgets. This inward looking strategy reduces the danger of extra budgetary inflows distorting macroeconomic stability.

Nevertheless, a prudent policy framework has ensured that inflation has been kept in check in recent times. Headline inflation, measured year on-year changes in consumer price index dropped significantly from 14.8 % in 2005 to 10.5 % in 2006, just above single digit target set for the year 2006. By the end of the first quarter of 2007, inflation has reduced further to 10.2 %. The ultimate goal is to have single digit inflation before the end of the year 2007. But it is feared that this will yield negative impact on social service delivery. Part of the strategy for reducing inflation includes drastic cuts in domestic debts and government expenditure social services. It is in this context that the delivery of social services can be negatively affected.

5.1 Government Expenditures and Priority Differences with IFIs

Work on the 2007 World Bank Country Economic Memorandum (CEM) identified four policy challenges that have constituted constraints to growth in Ghana. This includes a relatively fragile macroeconomic environment that needs to be strengthened, improving productivity and innovation, closing the infrastructure gap, and strengthening the investment climate (Bogetic et al, 2007). Consequently, the IFIs think that given the relatively high inflation rate, financial development has not contributed to growth. The World Bank CEM Report notes that high inflation may have

(16) For further reading on the fiscal ramifications of external funding on HIV/AIDS on fragile heath systems in Sub-Saharan Africa see the CGD Report (2005).

slowed down financial deepening in Ghana. Invariably credit constraint has hindered both investment and agricultural growth. In particular, the IFIs think that the private sector has not lived up to its bidding as the "engine room for growth".

Huge gaps in infrastructural need were identified by the IFIs, which also believe that cost recovery pricing in utilities are becoming very difficult in the current environment. The report also observes intermittent electricity supply and inability to extend water services to new customers. Consequently, infrastructural constraint is seen by the IFIs as a major problem to development in Ghana. Estimates of budgeted infrastructure spending is about 1 percent of GDP in 2005 (Estache and Vigliasindi 2007), which is very inadequate according to the parameters of the IFIs. In contrast to the current government expenditure, the World Bank estimates that achieving infrastructure MDG targets as specified in the Ghana poverty reduction strategy would cost the nation 8 percent of GDP (Briceno et al 2004). Not surprisingly, the Global Competitiveness Report in 2004 ranked the quality of infrastructure in Ghana 66th out or 104 countries. The relevance of infrastructural services to efficient health service delivery cannot be down-plaid. The timely delivery of antiretroviral and other relevant drugs depends on efficient road networks. Indeed smooth access to rural areas is a determinant factor for attracting qualified health personnel.

One major priority area observed between Ghana and IFIs is on budget ceilings on remunerations of health and medical personnel. While the government wants to pay competitive salaries to retain the health workers, the IFIs on the other hand think that salary increases have inflationary tendencies that may create macroeconomic instability. This is indeed, one key area which the government will have to resolve with development partners in order to maintain a vibrant health sector capable of winning the fight against HIV/AIDS epidemic. The World Bank 2007 report notes that the extent to which government wants to link its wages with those of large manufacturing firms implies that the wage policy might affect competitiveness of manufactured exports a growth. The IFIs have noted lose ends in budgetary implementation and consequently, have suggested the tightening of the links between MTEF and budget implementation.

On HIV/AID expenditure, one area of the priority difference in the insistence by partners the Ghana Annual Progamme of Work (APOW) will be approved on condition that "arrangements are made for full funding of condom procurement and distribution within the APOW budget at an estimated cost of US $ 1.3 million dollars. A ministry of finance official interviewed observed that "while, the government would have loved to use these funds in public education and other areas of poverty reduction, development partners are insisting on condom purchases". Indeed, priority setting in HIV/AID will yield more fruitful results if they are done in consultation with development partners and relevant government agencies and institutions.

5.2 The Poverty Reduction and Growth Facility

Ghana's three-year PRGF arrangement was approved in 2003 for SDR 184.5 million (about US$272.8 million). So far, Ghana has drawn SDR 105.4 million (about US$155.8 million) under the arrangement.

Table 5.1 Financial Relations with the IMF

	2002	2003	2004	2005	2006
IMF PRGF Disbursements (US$ millions)	68	74	39	39	115
Total Enhanced HIPC relief (billions cedis)	759	1163	2117	2155	2280

Source: IMF (2006); 9,138.8 cedis = US$1

The IMF, through its reviews of Ghana's performance, has expressed some concern with certain macroeconomic indicators related to the performance criteria and indicative targets imbedded in the arrangement.

5.2.1 Ghana's public wage bill

IMF staff expressed concern that real increases in government wages could have an adverse effect on those of the private sector. IMF staff also expressed concern that the wage bill, which was estimated to be 40% of tax revenue, had a high opportunity cost in terms of foregone essential investments and outlays to fight poverty (IMF, 2006).

However, the payments currently going to external debt service are greater than the total amount combined going to pensions, social security, gratuities and the national health fund.

5.2.2 Net Present Value of External Debt

IMF staff maintains that the projected net present value (NPV) of external debt at end- 2006 of about 12 percent of GDP is about one-third the level of end-2002 (Figure 1), and the NPV of total government debt of 34.4% of GDP at end-2006 compares with 87.8% in 2002. Thus, the relief under the HIPC at the completion point, combined with the relief under the MDRI, created a significant space between the existing position and most established threshold points for prudent debt management. The conclusion being that this has provided Ghana with some cushioning against external shocks.

The NPV of its external debt has indeed declined, but this is due to the significant drop in inflation rates (15.2% in 2002 and 8.3% in 2006) and not the stock of external debt, which was 2,345 billion Cedis in 2002 and 3,473.1 in 2006.

Further, Ghana being an agriculture-dominated economy, external shocks would most likely result from falls in commodity prices, lowering the expected amount of foreign capital reserves. This would indeed inhibit Ghana from making its currently exorbitant external debt service payments ($4,537.4 billion cedis in 2006), while having contracted new loans amounting to 5,383.4 billion cedis in the same year.

5.2.3 Concerns Regarding Ghana's Debt Sustainability

IMF staff cautioned Ghanaian authorities against contracting non-concessional debt given continuing vulnerabilities and that care would have to be taken to ensure that the public and external debt do not become unsustainable in the future, and that all resourcesincluding foreign assistanceare used efficiently and transparently. Furthermore, the staff observed that preliminary indications are that there is not much support from donors for accessing the international markets so soon after the MDRI relief and before a comprehensive set of guidelines to ensure long-term debt sustainability is established.

However, the need to access international markets is based on Ghana's desire to meet its development targets. The GPRS II estimates that a resource envelope of US$8.6 billion is required to do so; indicating an overall funding gap of $1.79 billion. Furthermore, accessing international markets will keep Ghana within the ceiling for net domestic financing and the floor for net international reserves; both of which are performance criteria of the IMF.

5.2.4 Concerns Regarding Fiscal Spending and Inflation

IMF staff noted that there was a risk that bunching large investment projects may create supply bottlenecks and wage pressures that could jeopardize macrostability. This was important because inflation is still about 10 percent and because pressures for additional fiscal spending may re-emerge on the way to next year's presidential elections (IMF, 2007).

In another report, IMF officials observed that Ghana had previously used aid flows to build up it international reserves, as per the performance criteria. It was following the IMF's policy of “don't spend, don't absorb”. The document cited that in 2001 2003, when Ghana experienced an increase in aid flows, it used its improved fiscal position to pay off its domestic debt (IMF, 2007(a)).

The link between increased fiscal spending and economy-wide inflation is unsubstantiated. Ghana's history of inflation notwithstanding, it can not be viewed in isolation of external price shocks of its leading export commodities, nor remittances which spurred consumption, nor the IMF pressure to increase tariffs of essential services like water and electricity.

Large infrastructural projects are needed to remove supply bottlenecks in the energy sector and infrastructure. This will go a long way in helping to ease the upward pressures on prices that inevitably come from increases in demand; leading to the improved absorption of aid. Most of the investments referred to are thermal and hydro-generation projects as well as improvements in utilities, which are IDA credits.

6 Conclusion

HIV/AIDS had initially been treated as a disease in Ghana. After realizing that the virus was attacking productive segments of the population, Ghana re-evaluated its national strategy.

Ghana's second generation PRSP, the Growth and Poverty Reduction Strategy II, places HIV/AIDS in the broader category of Human Resource Development; along with all other health issues, gender, and education. The underlying theme being that the development of a knowledgeable, well-trained, and healthy population are fundamental to meeting the Millennium Development goals and economic growth. The HR Development pillar of the GPRS cites among its main constraints poor road networks, lack of facilities and their poor location and communications technology.

The National Strategic Framework II, which operationalizes the HIV/AIDS part of the GPRS II, created a bi-modal aid delivery mechanism. Donor partners may engage directly with either the national government via the Ghana AIDS Commission or the District AIDS Committees.

In seeking to comply with the Paris Declaration, donor partners have increasingly directed funds to the GAC and programme budget. The switch to general budget support notwithstanding, the NSF II has a resource gap of approximately US$82 million; the years 2009 and 2010 being grossly under-funded.

Donor partners have discouraged the growing domestic debt stock, but have not curbed their own lending to Ghana. New loans to Ghana are four times the amount of debt relief in the form of HIPC assistance.

Ghana is currently under an IMF facility, the PRGF, which entails a number of benchmarks. The IMF has expressed concerns over the government's wage bill, citing high opportunity costs; though payments going to external debt service (approximately 3 trillion cedis) are greater than pension, social security, gratuities and the national health fund combined. Furthermore, despite graduation from the HIPC programme, the volume of Ghana's debt stock has increased. The higher opportunity costs of external debt service payments constrain the fiscal space available for social development planning. Lastly, the IMF has identified investments in large infrastructural projects as potentially being the cause of future inflationary trends and cautions Ghana not to undertake additional non-concessional loans. The linking of inflationary trends to fiscal spending has not taken into consideration price volatilities of leading export commodities and the high volume of remittances spurring domestic consumption.

6.1 Recommendations

6.1.1 Need for the Decentralization of HIV/AIDS Treatment

There is indeed a major problem regarding geographical access to health in Ghana. Evidence gathered from this study shows that rural communities and in particular those far away from the national capital Accra, and indeed other regional capitals are those worst affected by this problem. Invariably, there is big gap in access to anti-retroviral treatment for HIV/AIDS patients in rural communities across the country. Even where the community health clinic is available, there is often inadequacy of medical supply or a total lack of antiretroviral drugs for HIV/AIDS patients. Policy levers must be put in place to induce competent physicians to serve in rural areas where very often HIV/AID and patients of other common ailments such as tuberculosis and malaria are left to seek alternative access to traditional medicine or left in the lurch to die. Consequently the quest towards reaching the MDG target of universal access to basic primary health care is greatly compromised. Direct state intervention is imperative to make the goal of universal access to health in rural areas in Ghana possible. Not surprisingly even some International Financial Institutions are in favour of the provision of additional incentive to entice medical personnel in developing countries to rural areas*(17)*.

(17) A vast amount of literature in the health sector is in favour of the optimal pay and additional incentive to physicians operating in under difficult circumstances. In many developing countries including Ghana, the rural- urban imbalance in basic infrastructure and social services makes it imperative for additional incentive for the health worker, operating under such circumstances. For further reading on incentives for rural health care providers see report by Development Economic Research Group of the World Bank (2001).

6.1.2 Ensure Wider Linkages with Rural Communities through Provision of Doorstep Services to Underserved HIV/AIDS Victims

In spite of the deployment of over 310 auxiliary and paramedical nurses to rural communities in recent times through the CommunityBased Health Planning Services (CHPS), there are still major gaps in the delivery of doorstep services. Indeed, most of the doorstep services provided by Community Health Officers (CHO) are antenatal and maternity oriented services. Invariably, HIV/AIDS patients are hardly covered by rural doorstep health service. There is therefore urgent need to extend the delivery of doorstep services to HIV/AID victims as well. It is heart-warming to note that the practice has already started in some East African countries including Zambia.

6.1.3 Need for a Multi-Stakeholder Strategic Planning

There is ever growing need for strengthening the relationship among donor organizations, civil society, policy makers and the citizenry to ensure that resources meant for the health sector and in particular HIV/AIDS are utilized in an optimum manner to ensure effective prevention, treatment and care of HIV/AIDS victims. The current structures do not promote grassroots participation in the policy making process. We therefore suggest that for the process to become more participatory it must involve extensive consultations amongst development partners, policy makers, for poor people at the grassroots who are often at the receiving end of bad policies.

6.1.4 Need for Timely Fulfillment and Delivery of Pledges by Donors

Predictability and constancy of annual allocation of funds enhances the sustainability of aid-funded government programmes. Timely delivery of funds especially for the health sector is essential for the delivery of comprehensive health policy for the underprivileged and vulnerable groups. Nearly two years after pledging a doubling of AID to US $ 50 billion by 2010, foreign assistance to African countries has not been as regular as has been expected. Thus far, resource flows are lagging behind. Net official flows of aid to Africa dropped to US $ 35.8 billion in 2005 to US $ 3.1 billion in 2006. Thus apart from debt reduction, African countries have not realized the full benefits promised at the G8 summit at Gleneagles nearly two years ago*(18)*. This lack of fulfillment of pledges distorts macroeconomic planning and in particular health budgeting in developing countries including Ghana. It is hoped that the recent pledge of US $ 60 billion to fight HIV/AIDS, malaria and tuberculosis in Africa will be fulfilled to make macroeconomic planning more stable for the sake of the poor and vulnerable groups.

6.1.5 Need for Education of the Citizenry on How to Monitor Macroeconomic Policies and Social Service Budgeting

Civil society in Ghana has a Herculean task of educating the citizenry to monitor macroeconomic policies and their impacts on social services in Ghana. In this sense the need to build capacities of vulnerable groups at the grassroots level to monitor macroeconomic policies and be able to make inputs for corrective measures to be taken by relevant authorities. This capacity which is currently lacking and it will require extending education in the local languages to bring ordinary people at a level of understanding macroeconomic policies and pave the way for engagement with policy makers on issues that may hurt them.

6.1.5 Need for strong CSO Advocacy for Favourable Macroeconomic Policies

A strong advocacy base can become a veritable tool for transforming domestic policy in a way that will benefit the poor. Civil Society and Community based organizations in Ghana need to work extra hard through advocacy and lobby to ensure that domestic macroeconomic policies have a human face so that social services will be delivered to the needy. There are currently over one thousand NGOs, and CBOs working on HIV/AIDS related themes in Ghana. These NGOs have quite a large support base to be able mobilize their constituencies in a way that will positively influence change in macroeconomic policy decisions and health care delivery in Ghana and in particular HIV/AIDS.

6.1.7 Scaling-up Must be Backed with Improvement of Existing Capacity

In spite of the quest for scaling-up HIV/AIDS financing in Ghana, this in itself alone is not enough unless it is backed up with the improvement of existing capacity. We have observed that the current capacity of the main institutions working on HIV/AIDS in Ghana is weak and need to be strengthened in terms of dearth of skill and in size. The entire number of

(18) World Bank (June 3, 2007) Pre-G 8 Assessment in Heiligendamm Germany observes that donors are failing Africa fulfillment of pledges to improve infrastructure and combat diseases such as malaria and HIV/AIDS.

qualified medical, administrative, and other allied personnel is woefully inadequate and needs to be increased to cope with a pandemic that is on a national scale. In particular, the regional and district health centres must be improved, with additional incentives to attract qualified medical personnel. Indeed, the provision of antiretroviral drugs (ARVs) requires more time and training than is currently available in Ghana. There is urgent need to integrate primary heath care response, with those of secondary and tertiary health care in relation to the tackling the pandemic.

6.1.8 Proper Structures Must be in Place to Ensure that ARVs Get to Patients

Finally, we suggest that proper delivery structures must be put in place to ensure that ARVs and medicines and vaccines targeting HIV/AIDS patients get to them. The present way of distribution does not favour people living in rural areas. In view of this, the Ghana AIDS commission and allied institutions working on HIV/AIDS must make it a deliberate policy to maintain regular supply of much needed ARVs to rural communities through district health centres, CSO, and CBOs for the benefit of the poor.

6.2 Conclusions

The relevance of any policy is its ability to yield positive dividends to its targeted populace or constituency. Thus, regardless of the economic benefits of meeting inflationary targets reducing the size of domestic debts and stabilizing exchange rates, a macroeconomic policy can hardly be termed successful if it fails to address the social needs of the poor. Development partners must begin to appreciate that in developing countries where the poor are in overwhelming numbers, social service delivery matters a great deal especially for the marginalized individuals and groups of the society. Consequently, there is urgent need for development partners to show a human face in their dealings with governments in developing countries. In particular, development partners along with local policy makers must begin to appreciate the crucial nature of health care delivery to poverty alleviation. Thus far, placing budget ceilings and caps on health care delivery negates the philosophy of poverty reduction strategy and other related programmes championed by the IFIs.

The study demonstrates that even in the case of Ghana where social service delivery and particularly HIV/AIDS funding have increased over the years, this has not resulted in macroeconomic instability, rather the economy is said to be among the finest in Sub-Saharan Africa; according to recent World Bank Report (May 2007). Consequently, it will be fair to conclude that scaling up social services does not necessarily disrupt the macroeconomic environment and hence, should be supported. The Ghanaian experience makes a strong case for the scaling up of resources in the health sector. It also makes a case for the relaxation and total removal of conditionalities and caps on health budgets by development partners. Indeed, there is also increasing need for the Ghanaian government to look more inward in its bid to deliver social services and in particular quality health-care services to the poor and vulnerable groups. This is the only way of weaning herself from the IFIs and avoiding the imposition of unpopular policies to the citizenry.

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