



CENTER FOR GLOBAL DEVELOPMENT

HIV/AIDS:

MONEY, BOTTLENECKS, AND THE FUTURE

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C O N T E N T S

Introduction and Welcome:

MAUREEN LEWIS

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Development

Moderator:

NANCY BIRDSALL, President, Center for
Global Development

Featured Speakers:

H.E. EZRA SURUMA, Finance Minister,
Uganda

H.E. DONALD KABERUKA, Minister of Finance and
Economic Planning, Rwanda

Panel Discussion:

DAVID ANDREWS, Assistant Director, African
Department, International Monetary Fund

HOLLY BURKHALTER, United States Policy
Director, Physicians for Human Rights

PETER HELLER, Deputy Director, Fiscal Affairs,
International Monetary Fund

JEAN-LOUIS SARBIB, Senior Vice President,
Human Development Network, World Bank

KEITH HANSEN, World Bank

P R O C E E D I N G S

DR. LEWIS: [In progress] --is doing a series on AIDS. We had one on AIDS Watch a few months ago. This is now looking at some of the issues of having resources. Now that the issue is on the international agenda, it's a priority, money is being spend and there is a priority for these issues that go beyond simply the health sector, it's become a much more serious and a much broader issue.

There are a couple of things that were distributed. One is a paper on the technical issues and outlying some of the major concerns, and a survey that we conducted through IAEN where we had about 350 respondents to a survey on perceptions on what is important in terms of macro and fiscal constraints and spending for AIDS because of the large amounts of money that are coming in.

I think there are two things that are probably useful to remark on. One is that 74 percent of the respondents felt that HIV/AIDS spending should be done suspending or at least lessening the importance of the macro economic and fiscal constraints. And secondly, the big bottlenecks were lack of money, weak political will and the lack of national AIDS strategies.

This is a relatively controversial issue. There are views that are quite diverse: who is to blame, why it has happened. I think our panelists are in a unique position to address some of these issues, and some of those views are quite divergent. So I hope that that will provide us with a rich set of points for discussion and then for some follow-up questions.

Just to summarize some of the issues on the bottlenecks, one of the things that's happening is that funding for AIDS has become quite erratic, but quite high in many countries especially in some of the smaller sub-Saharan African countries that are particularly affected.

One of the things that we've found is that the increase is rather staggering. Between 2001 and 2003, Zambia's money for AIDS rose 698 percent, and Lesotho and Swaziland's rose about 1,000 percent. So you're getting enormous amounts of money in countries that are expected now to spend it. If we compare that to the U.S. that increased its budget by 30 percent and then has taken 3 years to figure out how to spend it wisely, we do have a comparative that we need to worry about.

I think the second point that's quite important is that AIDS money is swamping the health budget. We now know that in 2003, Ethiopia's budget for public health is equivalent to the money that's coming in for AIDS, and in Uganda and Zambia it's not quite twice as much, but getting there. So you have a lot of money. You have it for one sector.

So there are some issues: How do you spend it? What are the macro economic implications, if any? How do you scale up? And how do you deal with the institutional issues, because that's where one of the biggest bottlenecks lie that probably is less well understood and less well defined.

One is outreach to human resources, but it goes beyond that. One of the big issues I think on the table is as we scale up for AIDS do we just do it as AIDS? What happens to the public health system? And what does that do to institution building which we're seeing as the cornerstone of development across the sectors? So I think these are challenges that we have to be facing and that AIDS is particularly at the forefront of dealing with.

I would like to throw out two suggestions that I hope that the panel can pursue. One of them is the idea of having an AIDS fund in the way that you have oil funds where you sequester money. It is for AIDS but it can be used over time. And it's important in general, we've seen many countries with natural resource boons and they've put money away to use over time. That has allowed them to do this in an orderly fashion, to have money over time, and to be able to have a continuum for their programs.

This is particularly important in AIDS as the resistant strains of the HIV virus are a particular problem which is not something that we face with an oil fund, but it's something that we have to worry about in terms of AIDS to make sure that funding is sustainable over time. That's one of the things that I'd like to suggest that we look at.

The second thing is, how do we make sure that with all the money coming in for AIDS that some of that money is also used to bolster the health system, because you can't really divorce them? The opportunistic infections, the overlaps that you have in terms of counseling, testing and information are such that if you just do one and not the other, what happens to the bulk of the population who is relying on a health system?

With those I will close and I would like to introduce Nancy Birdsall, President of the Center for Global Development, who will be moderating this session.

MS. BIRDSALL: Thank you very much, Maureen. Let me also welcome all of you here to this lovely room on a beautiful Monday morning and apologize for our late start.

We're going to start with a surprise. For those of you who don't know **Minister Kaberuka** from Uganda, I have a surprise for you because we have sitting here **Minister Suruma** from Uganda. We hope that **Minister Kaberuka** will manage to come in a few moments.

Let me introduce **Minister Suruma** and ask him to start the conversation with some remarks. Dr. Suruma was appointed just 2 months ago to be the Minister of Finance in Uganda. He is a former managing director of the Uganda Commercial Bank and a former deputy governor of the Central Bank, and deputy secretary of the Treasury. So he is a man who knows his banking and his finances.

He continues in what I hope will be a long tradition for the Center for Global Development which is he's following in the footsteps of Minister Sendola (ph) who also several times gave us the privilege of appearing on panels and working with us on some of the critical issues facing sub-Saharan Africa. **Minister Suruma?**

[Applause.]

MINISTER SURUMA: Thank you very much, Nancy. I am very grateful to be invited to be here with you this morning. I bring you greetings from Uganda.

The first point I would like to make is that I hope that we are all clear over the need for medicines for AIDS. The need is extremely great. It's not something that's made up. It's a reality that we live with in Uganda and I'm sure elsewhere.

We have been struggling extremely hard to cope with HIV/AIDS. We are now coping with more than 10 million orphans resulting from the HIV scourge. This is an extremely heavy burden for many families who have taken from three to six extra children where both parents are dead or the remaining parent is not able to cope with the children.

Of course, I would like to reduce the rate at which people are dying and suffering. So the issue of the need I think is not in dispute. The availability of medicines and other requirements for treatment is the issue, that we don't have the medicines for treatment. Many people cannot afford the medicines. So the fundamental question is how can we assist these people who are in need but are not able to afford the medicines that they need to stay alive or to ameliorate their pain which they are suffering.

The news that some of you are willing to assist us with funds has always been very good news. But what came as a great surprise was that you have money available to assist us, but we are told that we are not able to absorb this money. When I go to cabinet meetings I need additional security because my fellow cabinet members want to beat me. They say, What kind of people are you in the Ministry of Finance? We hear that money is available and you don't want it. What's the problem? Why don't you want this money? Are you not aware of the problems? By the way, I am not the deputy secretary of the Treasury. Never have been. The deputy secretary of the Treasury is sitting there and is one of the most unfortunate people in Uganda. And I'm trying to maintain my impartiality by saying that we will definitely absorb this money and we will find a way.

I think this is my message today, that if the need is not in doubt and the suffering is not in doubt of the people and the money is available, thank God, because before the money was not available. So that was clearly a big problem. If the money is available and you say that solves the problem, that means that something is wrong somewhere.

My view would be that it's the job of the technical people, the macroeconomic experts to solve the problem so that suffering can end. I think that it's not to make light of the impact on exchange rates and interest rates, although we have been coping with these problems for a very long time, long before the money for AIDS came along. We had high interest rates for a long time and would like them to come down, but I'm not sure that money for AIDS is entirely to blame for this problem because it has been there for at least the last 20 years as far as I can remember.

We've had exchange rate problems also for a long time. There have been some improvements in our management of it, but it seems to me that we need to find a solution of these problems and this is the work of you, the experts, to assist us on how to manage this money.

It seems to me that foreign exchange that's available needs to be invested in health facilities, it needs to be invested in equipment, it needs to be invested or used to purchase to bring in drugs. I don't think that we have all the drugs we need; far from it. Many people in rural areas come and they say, Where do we find these medicines? Where are these medicines? Can you tell me where I can go and get medicine? And I don't have an answer.

I have a neighbor of mine who actually works in the Joint Center for Research where much of the work on AIDS is going on. I call him sometimes when I get someone that I think needs help. He says, Is he working? I say no. In that case I can't help him. There are all sorts of problems that crop up when you have an actual case that needs treatment and you find that you can't find a solution to that particular person's problem because things are too complicated.

My appeal is that we uncomplicate these things and we get the help where it needs to and we overcome the technical problems that get in the way of people who desperately need treatment. Thank you very much.

MS. BIRDSALL: Thank you, **Minister Suruma**. So it's just a matter of managing the wealth, you might say in this case, or managing the scarcity.

We do have **Minister Kaberuka** as you can see. You'll see from his bio that like **Minister Suruma**, he has spent time in the private sector and has held distinguished positions in the public sector, including as State Secretary in the Ministry of Budget and Planning, and he was chief economist of the Interafrica Coffee Organization, and prior to that a commodity analyst. So he has moved from coffee work to budget planning to the hot seat in Rwanda. **Minister Kaberuka**, could you give us a few words to get us started?

MINISTER KABERUKA: Thank you very much, Nancy. The problem of coming late which is a frequent problem I have is that you don't know what has been said, and I have a feeling that Dr. Suruma has said what I wanted to say. Since I don't know what he said, please allow me to say my peace.

At least I heard him say something which I think is very important. There are technical problems that are institutional issues related to accessing resources and utilizing resources for HIV/AIDS programs. You are saying that we should find a way of addressing those issues so that they don't get into the way of ensuring that the desperate people who need treatment get treatment.

This morning we are saying good-bye to President Wolfensohn in the morning, and we were talking about the next agenda for Africa. As you know, the African agenda is very long, but I want to make sure that if we succeed in mobilizing additional resources from the international community, say from the summit if we get \$25 billion, we'll still be facing the problem in Africa of capacity, capable states to ensure that we can indeed expend the scaled-up resources. It is a problem. If we increase resources and there are no systems to manage the increased resources, clearly there are issues to be addressed.

It absolutely serves no purpose to build a capacity and then you see half the people who have trained die. You could build a capacity in accounting, in auditing, even doctors, and then you see half of them die which is happening in some African countries. So this is the primary issue which we have to address.

I am carrying with me frankly by accident a beautiful article by **Mr. Heller** from the Fund on fiscal space. I have been for a long time myself a champion of fiscal space. That is to say, to have our budgets accommodating as far as possible additional resources for programs like HIV/AIDS.

I am very glad that now we are getting there. Fiscal space is being provided. We are discussing how to do the technical issues. I want to recommend that paper to those of you who are economists in this room because it raises the issues which I think may provide a way of technically managing the increased resources for programs such as HIV/AIDS.

So Nancy, I should stop here and listen, and if I have something to say I can say it later. Thank you very much.

MS. BIRDSALL: Thank you very much. I can only commend both ministers for being as brief as you were. Many good politicians have one problem, they sometimes talk too much.

Let me introduce the members of the panel. Then we are going to have some discussion, some questions and conversation on the stage, and then we'll turn to you after a short period.

In the order in which they are sitting starting on the far right you have David Andrews who is the Assistant Director for the African Department at the IMF. He is an important member of the conversation today because he has been the Mission Chief for the IMF in Zambia for some time.

Next to him on his left is Holly Burkhalter who is the U.S. Policy Director of Physicians for Human Rights. You'll see from her bio that she has had a long and distinguished career in the human-rights area.

Next to Holly is Peter Heller. He is Deputy Director for Fiscal Affairs, also at the IMF. He is an old friend of mine and of the Center's, and I commend to you his book published 1 or 2 years ago called *Who Will Pay: Coping with Aging Societies, Climate Change and Other Long-Term Fiscal Challenges*.

Next to Peter is Jean-Louis Sarbib. He is the Senior Vice President for what I think of as the most important network at the World Bank, the Human Development Network. He has been in that position since July 2003. He in that position is active in many of the global programs to deal with the AIDS pandemic, and in particular, it's under his guidance that comes the World Bank's own program called the MAP.

Minister Suruma needs to leave early, and Jean-Louis Sarbib needs to leave early as well. Let me start with a couple of questions to them.

Minister Suruma, you're new in the Finance Ministry but not new to the issues at all. I wonder if you could put yourself in the shoes of the Health Minister and say a few words about how you as the Health Minister see the challenge of talking to the Finance Minister in the next 6 months as Uganda faces the challenge of absorbing and using effectively the big new infusions of resources to deal with AIDS which I noted you meant you welcome wholeheartedly.

MINISTER SURUMA: Luckily for me Minister Harris (ph) was here with me in the last few days and we had very useful exchanges. We had an agreement. You see, the resources we are talking about are resources coming from outside and we would like these resources to come in.

Of course, the more resources that comes in from outside, the less I have to give him from the inside, hopefully. So we entered an agreement that these resources should come.

So I think of course there are some people who believe that these resources create a problem for the macroeconomic framework, so they would like to be sure that they know the resources are coming in will not create problems.

So my answer to your question, therefore, is that I will certainly give maximum cooperation to the Minister of Health in terms of accessing resources. But more importantly, in creating a framework, an environment in which the resources are coming in such a way that they don't disturb the macroeconomic system.

We are interested of course in a stable macroeconomic framework. We are interested in exchange rates that are ahead of our exporters. We are interested in lower interest rates. We don't want this to get--than they already are. But we think that we can argue the same case with the Health Minister, that as much as possible the medicines are used to bring in medicines and equipment and minimize the internal expenditures of this fund which seems to be the problem of absorption.

MS. BIRDSALL: Maybe I could interject a little and interrupt and ask Peter Heller to explain for any of the noneconomists in the room what the Minister is referring to when he says he'd like to see as many of the resources as possible used for importing equipment and medicines.

MR. HELLER: What he's referring to is the challenge like the governments like Uganda face when they get significant external resources, and those are external resources which are used to purchase goods domestically which really aren't imported. If you get a substantial amount of such external resources used that general demand internally, it can have inflationary effects. It can have effects on the exchange rate, the tradeoff between the price of foreign currency and the price of domestic currency.

That can create problems for him. One of the things he has to worry about is at the Ministry of Finance is he has to worry about inflation, he has to worry about maintaining the exchange rate at a level which he thinks is appropriate in terms of maintaining the competitiveness of his country's exports. So if he finds that he gets a lot of external resources coming in and the effect is to generate a lot of demand, it can increase inflation, it can lead to an appreciation of his exchange rate implying a reduction of the prices that his exporters get for their goods and reducing their incomes. If you're a coffee farmer and you get lower prices, it means you're getting a lower income and there are a lot of poor people in the coffee sector in Uganda.

So his concern is if I can get these external resources and I can get the Ministry of Health to use these external resources to buy antiretrovirals, to buy foreign nurses, to buy foreign doctors, to buy imported goods that don't put pressure on domestic demand, then it's a win-win solution. In other words, he can allow the Ministry of Health to use these resources to expand the delivery of services in Uganda, but at the same time minimize the macroeconomic impact on prices and on the exchange rate.

MS. BIRDSALL: The solution is to import in a turnkey way. One solution is to import your health system, you might say, even your health infrastructure. Of course, we know that's difficult.

Let me go back one more time. Maybe it's a little unfair that you should be asked to wait and then to come back later, **Minister Suruma**, but Uganda is the famous case where for some period resources that were available from the Global Fund to Fight AIDS, TB and Malaria were held, I believe, in the Central Bank while there was a long discussion about how to manage those resources. I don't know if you have some insight for us into how eventually the dilemma was resolved and how eventually those resources have been applied.

MINISTER SURUMA: I think I'll ask the Deputy Secretary of the Treasury. Is he still around?

MS. BIRDSALL: Why don't we wait on that? We'll leave that question in the air. I think probably there is some idea from other members of the panel, Jean-Louis or Peter, how that might have been worked out.

Jean-Louis, do you want to comment on that particular issue?

MR. SARBIB: I was not part of that particular issue, but what I want to say having read Maureen's draft yesterday was that I was really very troubled at the end as a policy adviser by saying, How do I reconcile the urgency of action with preventing the negative impacts that in many ways have a disproportionate effect on the poor? I think that we have seen that inflation and bad misalignment of

exchange rates are worse for the poor so that if these indeed are part of the unwanted results of having a lot of influx, then how do we make this jibe with the fight against poverty?

I was really very uncomfortable because I think that both sides are right. There is urgency and there is a need to do it in a way that does not add to poverty. So I think **Minister Suruma** is saying that it's a technical problem. Yes, it is, but it's a technical problem under which we have to light the fire so it gets solved very quickly. Part of the solutions that are proposed don't meet the urgency. I think I'll come back later on this maybe on Uganda. I don't know, Peter, if you know more than I do on the specific question that Nancy was asking.

MS. BIRDSALL: Go ahead, Peter.

MR. HELLER: No, I don't know the answer to the specific question. I believe it was ultimately reconciled, that the Global Fund money was allowed to be spent, but in a way that's a short-term answer.

I think the fact of the matter is that countries like Uganda and Rwanda, it's both an exciting time and a difficult time and a difficult time and it isn't completely a technical problem. There are hard policy choices that ministers like yourselves are going to have to face in terms of reconciling what's possible.

In a way it's funny. When you listened to the Development Committee yesterday, for instance, you saw that there's an awareness that the scaling-up has to be gradual, that there may be a limit to how fast you can absorb external resources. You need to build up capacity to absorb it. You need to remove bottlenecks that get in the way.

In principle, getting a lot more resources is a great thing. If you can expand your supply within the economy to respond to the increased demand, you're not going to have a problem. The problem is that you do have bottlenecks, and whether it's in transport or in availability of manpower, and the real challenge is how to address those bottlenecks in a way that allows you to absorb more resources. It's not something that can happen really overnight and there are limits to turnkey kinds of projects.

So it's a challenge that we all have to address, whether it's the World Bank and the IMF or it's the donor community that's providing these resources motivated by good intentions. But even most important, it's the developing countries themselves that have to weigh the tradeoffs in the short term and medium term.

MS. BIRDSALL: Holly, I saw you looking unhappy about the solution. I don't think Peter meant it as a full solution, but looking unhappy about the idea that if you could import the system you could solve the problem. What's your unhappiness about that?

MS. BURKHALTER: Also some unhappiness with my friend Maureen's suggestion about holding the resources, to let them flow more slowly, though of course it's a sensible solution if we were talking about anything except mass death from HIV/AIDS.

I guess from a health perspective, not from an economist's perspective at all, it's worth saying that the difference between HIV/AIDS as a great killer and cholera or diarrhoeal disease or famine is that in those other tragedies, the little ones and the old ones go first. Those diseases will usually leave you with your core of adults in their productive and reproductive years to keep a country going and to build it back up from the ashes.

Of course, in the case of AIDS as you all know better than I, it is not the babies that go first or the old people for that matter, it's exactly the people around whom economies are built, and crops get brought in and little ones are raised up. The extent at which adults are dying in some of these countries, countries that 30 to 40 percent adult prevalence are not going to make it as countries.

Some people look at places like Swaziland and think how can they survive. All of us are talking about solutions for survival. I'm not the only one who cares about this, no one more so than my fellow panelists. But I think that means looking more radically at solutions.

Just within the framework of what we were speaking, some economists think that you have to do a heck of a lot more spending on health to get the bad effects of inflation and balance of payments troubles that we're into. I don't know whether there's an example on the African Continent of a country that has managed to provide treatment on demand and get its health work force up and running that is now suffering from spiraling inflation, but I bet not. Too much money is not Africa's biggest problem.

The real key I think in terms of the very real problem of capacity and my making faces about importing it is that health worker capacity is simply not there. It's not there. And it can't get there by taking skilled workers from another country. Africa is losing their skilled work force faster than they can graduate them, and many of them are dying from AIDS as the Minister remarked.

I think at a minimum there have to be some kind of agreements in this emergency environment between the major donors and the national governments to open the floor under the drain of health workers, get them on treatment and get the health care quickly that they need. Stop the brain drain by giving them reason to stay.

I think DFID, the British aid agencies' dramatic provision of millions of dollars, \$100 million, to Malawi to double every health worker's salary is what I'm talking about. They're so poor that they literally can't even start thinking about treatment or saving moms who die childbirth or all of the other things that are destroying particularly the poor.

I wouldn't want to ever substitute my judgment as a noneconomist for my expert friends, but something to stop the hemorrhage of death and the loss of health workers quickly I think should be on the table and the experts in the room can help us figure out what that looks like.

MS. BIRDSALL: Your point is that on the issue absorptive capacity, it's kicking oneself in the foot to undermine potential absorptive capacity through deaths in order to preserve a gradual buildup of absorptive capacity in the health system.

You're also suggesting I think that we haven't really tested what the inflationary effects might be if there were a big increase in domestic spending.

Maybe we could turn to David Andrews. He has experience in Zambia where there was a controversy which perhaps made the IMF into a scapegoat or perhaps the IMF was the problem. It had to do with this issue of the health workers and the local infrastructure for delivering health services. David, why don't you say a word about your view on that. There is section in Maureen's paper, a very nice box, that describes the problem. So you can later compare your reading of Maureen's box to whatever David might say.

MR. ANDREWS: Thank you very much. I must say I'm pleased that so far in this discussion there has been no suggestion that the problem in not being able to use these resources, absorb these resources, is somehow IMF-imposed policies. That's something I want to lay out clearly in the Zambian case.

There have been allegations that somehow there have been limits on hiring in the health sector under fund-supported programs. There haven't. There has never been a limit on hiring in the health sector. What there have been are problems in controlling the wage bill which emerged principally in 2003. There is a lot of detail, but I think the central story is important.

Parliament had passed a budget including a wage bill at 8 percent of GDP which is relatively high. The wage bill had risen sharply in Zambia over the previous 2 years. This was the budget for 2003. Subsequently it transpired that wage increases and a new housing allowance were granted during the course of 2003 so that the budget would have been comprehensively broken.

We're not talking here about external resources geared to, for example, strengthening the health sector. This was an across-the-board wage increase, across-the-board housing allowances, so it wasn't targeted to these concerns that we're talking about now. It wasn't externally financed. So all of that meant that it would have to be financed either through higher inflation, and Zambia still has a relatively inflation rate. They're doing much better, but it's still close to 20 percent. That would have had as others have said today adverse consequences for the poor. Alternatively, had they tried to finance it without it being inflationary, interest rates would have risen to even higher levels, jeopardizing Zambia's economic recovery which is now reasonably strongly underway. Over the last 5 years they've grown by about 5 percent which is dramatically better from the previous two decades.

MS. BIRDSALL: I'll make note that this is not completely unlike the point that Holly told us about, that DFID will be financing the doubling of salaries in one sector. It's something we have to come back to.

MR. ANDREWS: To underline, this wasn't targeted to a particular sector. It was an across-the-board increase.

In unwinding this difficult circumstance there were some problems. Politically, the government agreed that they couldn't pay these wage increases and they back to renegotiate at least the housing allowances to bring it down to a more manageable level.

It also illustrates I think something that we'll come back to a lot, the importance of good management and good budgetary management. One of the consequences of this was that after these wage increases had been paid, individual ministries found that they didn't have the resources available to conduct the policies that they wanted to. They had in mind in all ministries some degree of hiring.

The wage increases that had been granted did leave room for hiring to take place. It squeezed it out. So that it was during 2003 a problem that emerged principally because of controlling wage increases.

That led to, and it was a very difficult situation, there were a lot of criticisms about what happened, and one of the things that's been repeated and I want to say again is not the case, there was nothing within the IMF-supported program which restricted hiring. The government itself in individual ministries stopped hiring, but this was not in any way a condition that we had imposed.

Now moving forward from that, 2004 was a year of adjustment from this process. In the 2005 budget there are resources specifically available for health and education within the overall macro framework. One thing I want to stress, there has been a lot of discussion which I think is the right focus about capacity and the availability of locally trained personnel, in the Zambian context, the budget increases for the health sector, focusing on that sector, would broadly speaking allow for additional recruitment of about 10 percent, an additional 900 nurses, an additional 60 doctors.

One could argue that the needs in the sector are much bigger, and one statistic I think draws that out. At the end of last year there were something like 15,000 people on antiretroviral treatments. The government's policy is to bring that to 100,000 by the end of this year. That's a huge stepping up, and there are undoubtedly external resources available to do that. There are very large increases in funding particularly from the U.S. PEPFA program.

I think people are beginning to realize that a key constraint is the availability of training people to deliver these services. In the short term there is an immediate constraint in Zambia, How can they hire more people who are not trained and available at the moment? What's going into the budget for 2005 is as best can be estimated a sum which should allow them to hire existing trained people who haven't been hired for whatever reason.

Even with that it's clear that there will be the people available. As Holly has said, there is a lot of competition with people being recruited outside the country to work in Europe especially in the health sector.

Another factor is also, and this I think comes to the importance of trying to build up the domestic health system, there is a lot of competition now from nongovernmental organizations who are receiving funding from PEPFA and other organizations that are able to pay considerably higher salaries. Within those organizations I'm sure that means they can help to distribute the antiretroviral drugs. But what's that doing to the health sectors if they're then losing their trained personnel to private organizations?

MS. BIRDSALL: Let me turn to some of the others to pursue this new tradeoff we're hearing about. In addition to the tradeoff between the macro programs and absorbing resources to deal with the pandemic, there may be a tradeoff inside the health sector. Jean-Louis, do you want to say anything about that? I see the World Bank as the champion in the sense of building up the institutional capacity in sectors like health and education, working with countries to do that. How has this dilemma, this tradeoff, that David mentioned, been affecting the way the World Bank sees these issues in the countries that are suffering the most from the pandemic?

MR. SARBIB: I think like everyone else, we're trying to struggle and make sense of it all. I think there are two ways to look at it in my view.

One way is to say that certainly on the prevention side, having more and more community involvement and relying on civil service organizations, relying on faith-based organizations, has proven to be very effective in allowing the messages of prevention which remain very important even as we focus on health and treatment to work.

I think the MAP program is funding tens of thousands of community organizations which very often do not take away from the formal health systems because these are community health workers.

What I see as a problem, and this is the second point, is for treatment. For treatment I think my physician friends, and I'm not an expert, tell me that treating a patient with HIV is not a simple matter, that you really need to make sure that the treatment is the right one. In addition, there is the possibility of resistance if the treatment is not done right.

For this I think there is competition between the private sector and the public sector with the private sector having much more ability to pay higher salaries. That's why in my discussions with my friend Peter Piat (ph) I've always encouraged him to think about a fourth one which is one channel for finance. Not only do you have the problem of competition between the private sector and the public sector with very often, whether it's PEPFA or whether it's the Global Fund, going outside the channels that the government has some control over and that makes the job of the Minister of Finance even more difficult. Not only do you have funding, but you have also parallel sources that may actually not always respect the macroeconomic policies or the policies that you're putting in place. That's another issue.

We don't have a solution because if you look back at where the reforms have been the most difficult to lead to success, it's in civil service reform. What we're talking about is civil service reform. It's great that DFID is going to multiply the salaries of Malawian health workers by two. How long is it before the teachers who say we want our salaries multiplied by two? How long is it before other groups are going to say we also want our salaries multiplied by two?

So I think what we haven't really translated into policy terms and quite prepared to accept the exceptionalism of HIV/AIDS you've argued, but what we haven't found yet is the mechanism by which in policy terms we are translating this exceptionalism into exceptional measures that may have to do with one thought that I was having last night, maybe because it was last night it's not going to be a very good one, is to externalize this report in some ways to say why don't we have a global mechanism to subsidize or to buy medicines in bulk and that way the countries can pay for a subsidized price within the confines of what remains a much more affordable and much more manageable macro framework?

I think it's very different from having these global funding sources go directly to the countries where the absorptive capacity problem is posed. Can we think of a mechanism? I don't know that it's--

[End Tape 1, side A, begin side B.]

MR. SARBIB: [In progress] --might give results very quickly until the other groups in civil service wake up and want the same thing in which case you're going to have the problems of inflation in spades.

MS. BIRDSALL: Everybody wants to talk now. I can see all of the panelists getting excited. I think the problem may be exceptionalism in dealing with the politics of civil service reform. But before I turn back, I want to give **Minister Kaberuka** a chance to say a few words in light of the conversation about how Rwanda is not only managing its AIDS problem, but let's put it this way, how is Rwanda managing the IMF, the World Bank, the Global Fund to Fight AIDS, TB and Malaria, the PEPFA program, DFID, USAID, et cetera?

MINISTER KABERUKA: Thank you very much. You used the words how am I managing, I'm not managing this. I'm not managing. It's a tough one.

I think that really comes at the center of what the colleagues are saying and I know Maureen's excellent paper points out. The macroeconomic effects are there. However, they are not the only thing.

These internal tradeoffs are very important. The Minister of Health is already very poorly staffed. Doctors are leaving the Ministry of Health, nurses are leaving the Ministry of Health, to go to work at NGOs which are handling these funds because these funds are not under the control of the government.

Each donor has their own way of handling the particular situation. So the next thing you see doctors resigning. So there are even tradeoffs within the Ministry of Health.

And our donors say wait a second. We will not be able to address this issue unless we take the whole problem of building these institution together. So that is, I'm not managing.

MS. BIRDSALL: It sounds as though you're going in the right direction. They may not be responding adequately, but it's a start let's hope.

MINISTER KABERUKA: There is another complication of course with the countries in the program like mine in Uganda and in others. This is what I was calling the fiscal space issues and the whole management of the programs. Let me explain.

Two years ago I had a problem with a fund. It was a technical problem that I usually had. They looked through the national accounts, they looked through the monetary flows and the fiscal flows. They see a discrepancy. A huge discrepancy. Something like 6 billion francs. They could see a huge gap. Because of the way the fund works, the country is really suspect and I have to get a team of auditors from an international company to explain the discrepancy.

A big chunk of the discrepancy was due to these resources which completely I did not control. Money is coming in, it is being spent so it's flowing through the economy, but me looking at the government operations--eventually we sorted it out, but I became extremely thereafter. And I've insisted on some degree of sterilization until we could agree on how the resources are administered--the paper Botswana says diamonds still has some of the money, so money can come in and agree to the arrangements. That is one of the ways of doing it.

But it sounds terrible when you tell people I have money to buy drugs, the drugs are not enough, but the money is sitting in the account in London. It is a very difficult one.

So I think what we need to do, again as Maureen's paper has said, is through the issue comprehensively. It is not simply about the resources coming in. It is how fast are they coming in, how they're being managed, can the donors agree to work together.

It is about the size of the economy for sure. My economy is much smaller than Uganda's. The dependence on aid may be smaller than Uganda's. So it is a country-specific situation.

So I'm not managing on this one, but I think the donors are going to contribute a lot if they're to work together through the national systems. By that we suppose the national systems exist and they are robust enough for that to happen.

I think I have answered your question.

MS. BIRDSALL: Very well. Let me try to summarize at least part of what I've heard so far.

First, there was a time when we were blaming the IMF for restricting the use of new resources, but it turns out that at least in some respects it's more complicated.

Then we had some discussion of blaming the donors as a group, I think this is one of the things that **Minister Kaberuka** raised right now, for bringing in resources in a way that sidesteps the government and complicates the problem not only of fiscal management, revenue management and budget management, but even of managing the health sector itself.

Then we've heard a little bit about blaming the well-intentioned NGOs who may be undermining the medium-term challenge of developing the institutions in the health sector that are so critical to absorbing resources well and delivering services.

Then I think of the survey which Maureen at our colleagues at the Center conducted, I think those survey results are in your packet, which suggest that respondents both in Africa and across all of the regions where people were surveyed blame two other things. One is political will in the countries. The second is the difficulty within the health sector itself which in many countries will has its own problems, corruption, absenteeism of workers and so forth. It's a tough dilemma.

Let me go back to Peter, Holly and David because they all wanted to respond to something that one other of them had said. Starting with Peter.

MR. HELLER: I think the first thing I want to say that the macroeconomic issue as the Minister I think quite rightly put it is a real one. It's a serious issue. There are limits. There are constraints and one can try in a technical way to get around them, but there are essentially some limits that are involved.

MS. BIRDSALL: Just to remind people of something that Jean-Louis said, it's too easy to think of the macroeconomic issues as concepts, abstract, IMF-style stuff. But Jean-Louis pointed out that those who suffer most the effects of inflation are the very poor.

MR. HELLER: The point I wanted to make is precisely that. We can advise in the IMF, but ultimately it has to be the Ministry of Finance, the government as a whole that has to make the ultimate decisions as to what are the tradeoffs that they're willing to accept.

We have to abide by that. To address AIDS, I've read many volumes that talk about the importance of dealing with transport systems, dealing with education. There are many other priorities that have to be addressed even just to deal with AIDS, but also to reduce poverty and to deal with growth. Ministers of Finance have to weigh these tradeoffs in judging how much they can accept and what are the macroeconomic consequences.

The first point I want to make is simply that we can advise, but ultimately the hard choices have to be made by the countries themselves and they are making horrible decisions because they may be making decisions that you don't like because of the consequences in terms of life and death, but it's not for you and it's not for me, frankly, to be able to make those decisions. It has to be the countries themselves.

The second point I want to make is that you pointed to a real problem which is the absorptive capacity in the health sector. There is no magic bullet. Raising salaries may be one way to do it, providing health care to the nurses and doctors themselves who are HIV positive certainly helps. We know that doubling

salaries can make a difference. They've done this in Ghana. It hasn't made that much of a difference, frankly, in Ghana. They can double the salaries in Malawi, but I can guarantee you that the Botswana medical authorities that are hiring doctors from Tanzania, from Zambia and from Malawi are paying much more than double. They're paying five or six times the salary are getting in Tanzania and Malawi. If you think that that's going to necessarily stop the brain drain even within Africa, it won't.

In a way what I was saying earlier is there is a sequencing issue. Malawi may need to spend a lot more money in terms of training workers now in order to expand significantly the supply of medical workers in the system. They may need to be innovative about the kinds of medical workers they train so that they're not as susceptible to being recruited away. We're talking about intermediate workers, the kind of things that were pioneered by Uganda and Kenya in the '60s, the medical auxiliary types.

You're talking about conceivably importing workers. The Botswanans are doing it, the Swazis are going it. You may want to import doctors and nurses from Sri Lanka or from the Philippines and pay them what's required in order to augment initially supply until you can train your own workers.

MS. BIRDSALL: Peter before you go on, I want to go back to your first point. I'll let you finish. You said it's up to the countries.

MR. HELLER: Right.

MS. BIRDSALL: Many of us sometimes have the impression that to benefit from an IMF program, a country has to meet certain targets and undertake certain tough steps.

MR. HELLER: Right.

MS. BIRDSALL: Let me ask either of our Ministers if they want to make a very quick comment. Do you feel that it's always truly in your hands and that the IMF is relatively powerless to push you around? Or do you see the IMF as sometimes imposing if not decisions about how to spend your resources, constraints that limit your choices?

MR. HELLER: Let me just simply say that, yes, there are certain limits as to how far we will go and we will have trouble. If a country has relatively limited inflation and wants to inflate the economy to go to 15 or 20 percent inflation, we would probably have trouble supporting that because we don't think it's conducive to basic macroeconomic stability.

MS. BIRDSALL: What is the rate of inflation in Zambia? David mentioned that it was rising.

MR. ANDREWS: It's actually come down. It's currently just below 20 percent, at 17 percent.

MS. BIRDSALL: It's 17 percent now?

MR. ANDREWS: At 17 percent which is high compared with the average for sub-Saharan Africa which is now about 9 percent.

MS. BIRDSALL: In the period that you were referring to when things were sensitive, it was approaching 20 percent?

MR. ANDREWS: That's right.

MS. BIRDSALL: That was kind of serious worrying point and that's when inflation takes off.

MR. ANDREWS: That's a sort of, if you like, a threshold point. If it moves significantly above that, you can rapidly have very serious problems spiraling out of control.

MS. BIRDSALL: I know that I'm making a mess of your interjections, but I'm going to go back to Peter in a moment.

First, I think that **Minister Suruma** is getting a note from his good staff telling him he's got to go. So I want to be sure to give you the last word or a word before you leave, to comment on anything you've heard.

MINISTER SURUMA: Yes. Thank you very much. I understand the complexity of this issue, and I will just say that of course the purpose of economics is to help people. If economics finds itself in a paradox where people are dying and we can't find a way to help them, then of course some laws of economics need to be broken so that it can come out of itself and be able to assist people.

I see from time to time economics not being advanced enough, not being able to solve these problems. I'm glad I'm talking to young people--so that they can come out and solve these problems. Sometimes the old people are too much in a box to come out of that box and find solutions to these problems.

People are dying or they're on their death beds. They need some medicine. You say, I'm sorry, the inflation--so I can't give you the medicine. This is not acceptable. Something has to give.

So I think partly I blame economic science for not having the solutions and it just has to grow up a little bit faster, a little bit better so that we can help people. You just can't say I'm sorry. I can't help you. The macroeconomic framework is too tight. That's not acceptable.

So with all due respect to macroeconomists and scientists, they have to find a solution so that we can help people, and I'm sure the solution will be found.

MS. BIRDSALL: It's always a pleasure to blame the economists. Thank you very much.

Minister Kaberuka wants to answer the same question.

MINISTER KABERUKA: I must say that on this issue it is always easy to blame the International Monetary Fund. At one time I was also bashing myself with the Fund.

The issue which is already mentioned is very, very important. If there is a macroeconomic breakdown like you have in one or two African countries, it is the very poor who suffer including families of people suffering HIV/AIDS. We have no interest in doing things which could cause a macroeconomic breakdown. So this is one consideration.

Is the IMF forcing things on us? I have two answers. There was a time when ownership was a problem. I think times are changing. Ownership is increasing. The rate which it increases depends on the capacity of the country, the cost of institutions and so on. I think because of the dialogue whereby the cannot impose things. We discuss within limits of what are considered to be reasonable economic management.

This said, I refer to the paper by **Mr. Heller** here about fiscal space which I think I want the Fund to develop further because it gives ways in which we can create--expenditures for these types of things.

Let me just give you an example for just one minute, Nancy. Think of a situation where a country gets \$100 million to spend on HIV/AIDS and you find

a macroeconomic solution for that. You begin your program of antiretroviral treatment but you don't know for how long you are going to have this money. Is it 2 years? Is it 3 years? Is it 10 years?

If it is for 3 years and then you stop the treatment, what happens to these very poor people? Number one, we need to know before we ratchet up expenditures whether these resources are available and over what horizon. Often we don't have that answer.

MS. BIRDSALL: You don't have that answer really ever?

MINISTER KABERUKA: We don't have that answer. We don't.

MS. BIRDSALL: Beyond 2 years?

MINISTER KABERUKA: Precisely. Because budgets are limited, governments change. So it will be helpful very much if we could have this kind of horizon in the discussions with the Fund.

Number two, and this is equally important, the issue is one of a long-time horizon, but it's also the issue of what I've called predictability. For example, there's the Global Fund for AIDS. I don't know, now it seems to be well funded, but for how long that will be? Maybe at some point the Global Fund will no longer be interesting and it will go back to bilateral programs which are subject to international politics. So that means we have to be careful because we don't know for how long the resources are available.

Lastly, this issue of working through international systems. Many donors still want to see their flags on programs like HIV/AIDS: this is County X's HIV program for Zambia. To get them together so that we can have all these issues clarified is not easy. If that were the case again, the--the fund could be much more simple.

MS. BIRDSALL: Thank you very much. Let's go back to Peter, and then I'm going to go to Jean-Louis.

MR. HELLER: Let me give the floor to Holly.

MS. BIRDSALL: You're ceding the floor? Let me ask Holly a question, but this will also be the last round before we turn to the audience, so keep that in mind.

The question I wanted to ask you is, Holly, how do you think of addressing the problem in many countries, not necessarily Rwanda or Uganda right now, but in many countries where there is a big AIDS problem of truly poor performance of the health system, of the government system? Problems of absenteeism, problems of corruption, problems of patronage, the problems that the Minister of Finance thinks of when her Minister of Health comes asking for more resources in the health sector?

MS. BURKHALTER: That was actually what I wanted to talk about anyway, so thank you for asking.

I had a meeting with some people over at the PEPFA, the Office of the Global AIDS Coordinator, to talk about work force issues and look at ways to try to build capacity in the public sector in particular because lots of the money is going through NGOs and some of the faith-based NGOs and others have done brilliant work on the Continent and some of the services for the poorest come from the private sector.

It can't get the only answer because, A, you get bleeding from the public sector and at the end of the day, no matter how poor a government is or how poorly

performing, no country can make it without a functioning government and a functioning public health system.

So we were looking at that and for perfectly reasonable reasons they were very reluctant to talk about funneling money directly to government health workers precisely because payroll is a notorious place for money to vanish and it notoriously poorly managed. Some of that is because of corruption, but some of that is because of ability.

My colleague Eric Friedman (ph) who has done all of our work on brain drain in health workers, he does the thinking and I do the talking and sometimes there needs to be more of the one than the other as you soon will be able to tell. But he was at a conference with nurses in Africa and they had nurse representatives and health ministry representatives from 14 AIDS-burdened countries on the Continent come together to talk about the nurse work force. The nurses and the lesser-skilled workers are the Rosetta Stone for addressing not just HIV/AIDS but other infectious diseases as well as safe child birth and infant and child survival.

The Kenyan authorities described how if they could capture and get ahold of their personnel, with the savings they recognized they could hire an additional 1,200 nurses and 800 doctors a year. Not all of that is because of corruption. They don't know where they are. They don't have computerized databases.

That is a capacity issue that money can help with. The World Bank and others are building capacity, but where is it? Where is the capacity? Why aren't these health work forces on a computer database? And why don't we have that competence? There are other things that can be done, but I wanted to give that as an example. Push down health services to unskilled workers who can be given some responsibilities.

I really have to say just in answer to my friend from the World Bank very quickly, the issue of AIDS being so hard to treat is such a conversation stopper and it shouldn't be. Compared to so much of what inflicts the poor, it's a piece of cake, and you don't even have to have sophisticated laboratories.

This is not optimal, but a patient is sick, they have AIDS, you don't even need a CD4 count. Ask Paul Farmer in Haiti. The patient gets sick, you put him on antivirals, or they don't work you put him on the next work. If after about three different types they're still sick, they're in deep trouble. But the poor have as much right to disease resistance as the rich. We have those problems here, too.

If I knew there was a treatment were available and my 9-year-old daughter had a disease, I would not wait to take advantage of what was available for her this year and next because I didn't know it would be available 5 or 6 years down the road.

[Applause.]

MS. BIRDSALL: Jean-Louis also has to leave. He has asked if his colleague Keith Hansen (ph) can come up and sit in the chair. I am very pleased to have Keith do that. He worked for me once too long ago to mention, and Keith, the first time you speak you'll introduce yourself, please, what you do at the World Bank.

Jean-Louis, a last word, maybe, on this issue of building up absorptive capacity of the ease or nonease of treating AIDS patients.

MR. SARBIB: I think I agree with everything that Holly has said. The problem is how do we do this in a way that also allows me to agree with what

Minister Kaberuka has said; that allows me to agree with what I hear when I go to education meetings where I hear exactly the same thing; when I go to road meetings, when I go to energy meetings, when I go to all the places where everybody is saying, My issue is the most important.

That said, I agree that the challenge for us is to translate, and I accept the exceptionalism of HIV/AIDS, to translate this exceptionalism in an exceptional series of policies and procedures that meet the challenges that we have put on the table. The question is that we all would like to solve this problem. I think that placing and moving the blame around isn't going to help anybody. What we need to do is to recognize that they are very valid issues.

One thing that comes to mind is that in part the decimation of the health systems comes very bad policies that decimated them in the '80s and in the '90s, and these bad policies came from the fact that the countries after the period of boom of commodities continued to consume and continued to build their system and continued to pay salaries as if the money were going to continue to come. When it all crashed down, then the countries fell apart, particularly in Africa.

Let's also not forget these lessons and not put in place the policies that 15 years from now will actually make the problems even worse than they are today. Yes, HIV/AIDS is an exceptional situation that I don't think we have met before.

I am a bit concerned about the fact that we don't know yet what the results of Paul Farmer's--are going to be on the longer term. If AIDS is a global issue, we have to worry about the issue of resistance. We have to worry about making sure that we are not just dissipating whatever it is that we have in our arsenal to fight it.

I'm not a physician so I'll defer you on this, but what I would like to find is an exceptional solution to an exceptional problem, not saying that it's either you do AIDS or you do macroeconomics. We have to do both, and I trust that there is enough of the political will, there's enough of a realization that this is not simply a problem for Africa for the world, that we're going to be able to find a solution that respects both the urgency and the good economic management on which Africa is finally on the right track to do that. That's what I want to leave you with.

[Applause.]

MS. BIRDSALL: Thank you very much, Jean-Louis.

David, do you want to add something to this stew? Jean-Louis has called for real creative thinking, not just exceptionalism in the narrow that AIDS is exceptional, but exceptional policies? What about Zambia?

MR. ANDREWS: I'm not sure I'll be able to live up quite to that billing, but just a couple of thoughts.

Maureen's suggestion about this fund to pool the resources and the related question of coordination, this is I think a very basic suggestion, but it needs to be done. In Zambia they are now beginning to put together a database of what all the external support is doing: Where is it coming from? Where is going to? How much there is.

Without that basic information, I don't think anybody can do what's needed in this sector. I agree that our role as everybody else's role should be to make this happen. We're not trying to dream up obstacles for it not to work, to raise macro concerns that are not real. But in order to know how serious the concerns are, one does have to have some basic data: Are these funds going to continue to

flow? Are they being used to recruit nurses or are they being used for drugs? Are they going through the government budget or are they going through NGOs?

I'll put it to you from our work on Zambia. Right now we just don't know. That basic information isn't there. There are a lot of problems of coordination, and it's not just a lack of knowledge. I think it's also partly some of the constraints inherent in the sources of funding. Some sources of funding have a focus more on emergency relief so there are restrictions on the extent to which it can be used to build capacity. Some sources are more through government than others. That complicates what can happen.

The encouraging thing for me is, going to Zambia we always talk to the key players in this. We always sit the Ministry of Health down with the Ministry of Finance to go through these things so that we hear as far as possible both sides from their perspective. One thing that's very clear is that coordination among the main external supporters is increasing. They are acutely aware of the need for this to be done. So I see that as an encouraging sign, but I think there is still some way to go.

One other point on a rather different issue. There is a discussion of whether targets are imposed or not. I'll perhaps just leave that aside.

One key thing in Zambia which I think is applicable in many countries, what we are primarily concerned with in the fiscal targets is limiting domestic financing. In Zambia's case, that was job one with the rising domestic debt. Domestic financing of the budget, the government was borrowing too much domestically. That doesn't implicitly impose any limit on the use of external financing. Perhaps Zambia is in a fortunate position, it doesn't yet have those problems that Uganda clearly does. The focus is really on limiting domestic financing right now. I'll finish there.

MS. BIRDSALL: Let us turn now to all of you to make any comments or ideally ask questions. In doing so, please identify yourselves, and if you want to address your question to one of the specific panelists, please say so.

Let me say that my initial interim take from the conversation so far is that the issue of absorptive capacity in the health sector is absolutely fundamental and that it probably is abstracting too much from the reality of the problem when we think of Dutch disease and inflation, when we define it in macroeconomic terms and in terms of the capacity to absorb external resources, when in fact it's the capacity to create quickly enough the infrastructure of health systems so that external resources can be absorbed. The two are closely related. Please go ahead.

MS. REKE: My name is Katie Reke (ph). I'm a student here at GW and a member of the Student Global AIDS Campaign. This is directed to **Mr. Andrews**, but **Mr. Heller**, if you'd like to answer as well, that would be great.

Mr. Andrews, you had said that the IMF is not to blame for hiring caps in Zambia. **Mr. Andrews**, I'm sorry, that's simply not true. While you might not have explicit policies that limit hiring, what do you have to say about debt services that Zambia pays every year to the IMF and how do those directly affect the levels of spending for health care and education?

MR. ANDREWS: I'll go straight to the point of debt service to the IMF. During 2004 there was a new program approved with Zambia, and under that, disbursements from the IMF were very close to the amount that Zambia paid to the IMF. In net terms, it was virtually zero.

This year I'm glad to say Zambia has just reached the completion point under the HIPC initiative. That will effectively cover the payments that are due to the IMF.

I know there have been comments which compare health expenditure with debt service payments, including the IMF, but I think the basic point is it's a one-sided way of looking at it. Health expenditures that the government makes, excluding the externally financed health expenditures, are about 2 percent of GDP. Debt service the government pays is also right now about 2 percent of GDP, and it was 4 percent of GDP before the NIPC initiative started, so it's come down sharply.

At the same time, government receives at least 8 percent of GDP in new monies. So I'm not saying that no further debt relief wouldn't be useful, but I think it's important to see the wider context. I think just picking two numbers in isolation tends to exaggerate the position.

MS. BIRDSALL: We want to make sure that other people have an opportunity. Thank you for a nice hardball question. Peter, do you want to say anything on that issue?

Let me mention in this context that on the website of the Center for Global Development which is www.cgd.org/ev.org, you'll find a short piece on the benefits that would accrue if the U.S. were you approve a sale of some of the IMF's gold in order to write off all of the debt of the very poorest countries to the IMF and some discussion of how that could be done.

AUDIENCE: I'm with the Institute of Medicine at the National Academies of Science. I wanted to let people know that tomorrow we will be releasing a report called Healers Abroad which is one of the creative ways of many ideas that are out there to try to deal with the issue of human-resource capacity. It is more of a stopgap measure, but it is looking at volunteerism, Peace Corps-type volunteerism in the health area to try to deal with some of the issues in a human-resource capacity.

Also to let people know that there was recently released a report on ARV scale-up. Both of these are available through the Institute of Medicine and you can look them up on the website which is www.nas.edu.

I also wanted to bridge this question again which is a huge issue of human-resource capacity and see besides volunteerism from external resources, what means or what ideas people have about increasing medical training with the Continent.

MS. BIRDSALL: Holly?

MS. BURKHALTER: We testified at the IOM hearings on the issue of a U.S.-funded AIDS corps, Americans Volunteering to go Abroad.

My concern about that, and the speaker was right to say it was a stopgap particularly if it's aimed towards training, is that it's very expensive to send Americans abroad. I realize that that money might not otherwise be available for African healers themselves, but it should never be seen as a panacea.

I would say in terms of things that can be done in the short-term and the creative things that I think need to be looked at, our friend David talked about how--contributed ARVs or supplies that don't count against domestic spending. I think therein may lie part of the solution.

If the international donors such as the Global AIDS Fund and DFID and the U.S. also can conceive of spending and helping governments pay health workers

in the public sector. We don't mind workers in the private sector. So then you get that giant sucking sound where you instantly hire these people right off the public wards and it's happened over and over again.

In the past, donors don't want to pay recurrent costs. It's called creating dependency and it's not sustainable. Sustainability is crucial, but until African governments can train up a work force that they can keep as well and gain the government's confidence and capacity to run proper public-health systems, something must be done to put a floor under the deaths.

I think investing directly in public-health services with all of the checks, the anticorruption, the transparency and the government-to-donor pacts that can be created, the Millennium Challenge Account model, perhaps, I do think that the IMF in particular can play a role.

If you can get governments to fire workers, can't you get them to hire them? Surely. There are pressures, and some of them can be healthy and helpful. I think that if the goal were a different one and if health sustainability and an economic model of what would happen to GDP if there were more healthy workers and fewer deaths, we could get some consensus on some inputs that would not be inflationary or disrupt the big macroeconomic concerns, but at the same time help address the emergency now and in the medium term as well.

MS. BIRDSALL: Let's collect a few questions. Maybe there will be some comment on this point of Holly's.

MS. TAYLOR: My name is Anna Taylor. I'm from Save the Children U.K. I wanted to get a view, actually, from **Minister Suruma**, but it would be good to have a comment from the IMF and the Bank panelists, and that's around the issue of user fees and paying for health care which hasn't really come up so far in discussion.

Uganda took the bold step to abolish user fees and that has had a dramatic impact on utilization rates of health care which is likely to be having an important impact in terms of treatment for people with HIV/AIDS.

My question is, do you think that the current policies around user fees, user fees are in place across most of sub-Saharan Africa and the Bank has no blanket policy on user fees, to what extent do you think this is a policy bottleneck which is actually getting in the way of people getting into health centers and money which is going into health systems being utilized and to the maximum effect?

MS. BIRDSALL: **Minister Kaberuka?**

MINISTER KABERUKA: In my country which is a very small country in the middle of Africa with what people consider to be a reasonably adequate health facilities by African standards, clinics are available with access in a small country.

But people cannot afford to go there. They can't afford the medicines. There is a clinic. It has drugs. People cannot afford to go there because they have no money. They are too poor. Or if they go there, there are no nurses or doctors. These are the two problems we face.

So abolishing user fees is important, but then somebody has to pay if you're going to abolish user fees. Someone has to pay.

What has been done in my country is to encourage communities to come together and have some kind of schemes where everybody contributes very little amount of money, a little amount of money, and it is working very, very well. It

is working very well in many districts of the country. It is now able to ensure that poor people can actually access health.

So I think it should not be simply abolish user fees. If you do, the budget has to pay, someone has to pay. But in this case, empowering the communities themselves to take charge of their health seems to be working for small amounts of money.

I remind everybody here, the number one killer in my country is malaria. Treatment of malaria is not rocket science. Many poor people simply cannot afford to take the whole regime of antimalarials until the parasites have been killed. They will take the first few tablets, the temperature goes down and they think they are okay. Then their spleen started swelling up and other kinds of complications. So enabling poor people to have access to medicine is very important.

Is it by user fees' abolition? If somebody can't pay, fine. But I think empowering the communities is also very important with some assistance from the state.

MS. BIRDSALL: My own view is that the World Bank has become too much the scapegoat as being the champion of user fees.

Keith, do you want to introduce yourself and very briefly say what the Bank's position is on user fees?

MR. HANSEN: My name is Keith Hansen. I'm the head of the Bank's AIDS work in Africa.

We actually do have a policy which is not specifically on user fees, but the policy is that we oppose rationing access to medical care on the basis of price. So if the poor are unable to pay for services, then we don't want the existence of user fees to keep the poor away from them.

I think much of the problem of user fees has been in the administration rather than in the idea itself. There have been many successful examples of user fees where the money was retained at the local level where the community had full transparency about how much they were paying and what it was used for and whether it was plowed back into quality or inventory.

There have been an equal or greater number of disastrous experiments with user fees where it simply became an administrative bureaucratic bottleneck to access. So it's never as simple as just the user fees.

There is also the cost of transport to get to the clinic, there's the quality of service when patients arrive, whether the drugs are there, the very attitude of the health workers. We did a huge survey in Zimbabwe some years ago and user fees was about seventh on the list of complaints of patients, well behind some of these other things.

I think in the case of AIDS, at this point there are so many more grand problems that we're facing that user fees is not high on the list, but it's something that we're constantly aware of and trying to improve in our own support.

MS. BIRDSALL: In Maureen's paper or in other work of hers, I'm not sure I can remember where it is, Maureen also discusses the problem when you take away user fees, that you often get pressure on users for under-the-table payments which are even less transparent and more offputting and more discouraging for people's use of health services.

MR. AMERICA: Richard America (ph), Georgetown University School of Business where we've created an Africa Initiative. The first priority in it was to help the business schools in Africa organize and move towards accreditation. Along the way, the African Medical School Association got in touch with us and said we heard about what you're doing with business schools. We'd like your help in finding resources for medical schools. Are you aware of the African Medical School Association existing? They've been able to organize, but they need resources simply to do a few basic evaluation steps. It's something you might write them a check for.

I was at the University Teaching Hospital in Zambia last summer, and that's a pretty good example of why better medical training is high on the list.

The African Public Health Association or the Schools of Public Health are also trying to organize and move in the same direction. So those two would seem to be logical priority targets for funding.

MS. BIRDSALL: Thank you very much. I want to mention here that in the United Nations Millennium Report, also known informally as the Sachs Report, there is one recommendation that has not been sufficiently discussed in my view which is that there be a major donor push on some sort of global program of capacity building. I think the question that Richard raised is a tough one for anyone from the World Bank because the Bank has instruments, a mission and a mandate which directs it to lending and grants mostly at the country level, and that's where its mainstream business is.

One of the creative things that we might think of for the future is some new emphasis on a global effort of financing and provision of--

[End Tape 1, side B, begin tape 2A.]

AUDIENCE: [In progress] --spearheaded discussions in the last several months on how to expand capacity in the macro manpower--

MS. BIRDSALL: There is also a Dutch initiative that's concerned especially with capacity building.

Let's go to a couple more.

MR. DUBERWALSKI: My name is David Duberwalski (ph). I work for Family Health International, the Institute of HIV/AIDS, and I've been working for the last 3 years as an Associate Director of Capacity Development which I've come to the conclusion is a term that's very difficult to operationalize unless we clarify the levels of capacity that we're trying to build.

The question I'd like to pose, looking at the survey that was done and the first four results coming out of the survey, political will, poor national coordination, shortcomings of health-care delivery systems and absorptive capacity constraints.

MS. BIRDSALL: Nothing to do with the IMF or the World Bank.

MR. DUBERWALSKI: No, I was going to look at the tradeoffs between capacity and coordination capacity and implementation capacity, two or three things that have not surfaced yet in the discussion. I'm going to make a few comments and then I'll try to come to a very quick question.

Swaps or swap-like approaches. I think swaps are probably dead in the water, but building on the need for data can we at least map out how this HIV/AIDS money is hitting the system and what are the effects on capacity.

MS. BIRDSALL: You're referring to sector-wide programs?

MR. DUBERWALSKI: Sector-wide approaches to programming because this is more than a health-sector response. Clearly, most countries have national AIDS strategies.

The other term I want to introduce is decentralization, and therein is the question, because levels of capacity, maybe the question should be best posed to our distinguished Finance Minister from Rwanda, what is the best level to begin the coordination and to expect coordination of an HIV/AIDS response and financial flows? The money can come in from the top, you can do the coordination at the level, but it's known I believe in terms of implementation that the closer you can have the implementation at a local authority, the lowest functional administrative units that can perform this coordination function, would they have the power, would they have the political support to get all the players around the table, to do some action planning to operationalize these national strategic plans to map how the money is flowing into the system and to make resource allocation decisions?

The question would be in a sense, what is the appropriate level at which you can have adequate coordination capacity which in turn will create these working systems to then handle this money coming in, make the appropriate resource allocations decisions between drugs, between health workers, between local coordinators and NGO implementors?

I think has been a very valuable conversation and speaking from an implementation point of view, this is the core issue of this whole debate and we need to push it further so all these factors can be looked at from the point-of-view levels and decentralization swaps. Then of course, the three 1s principles (ph) which donors agreed to but we'd like to operationalize.

MS. BIRDSALL: Minister Kaberuka, in decentralization the answer?

MINISTER KABERUKA: I've talked about two levels of coordination. There's coordination of resources coming from outside for macroeconomic reasons. That has to be done.

But in terms of issues that have been raising is very, very important, where the citizens participate in these programs. So it is not simply decentralization. It is also a participatory approach by the communities in managing this system.

MR. BALNIK: I'm Bruce Balnik (ph) from Nathan Associates. We've been talking about the tradeoffs between macroeconomic stability and HIV/AIDS interventions, and focusing on the HIV/AIDS interventions on the treatment part of it.

There are also tradeoffs between HIV/AIDS treatment and prevention programs, and no one has said a word about that. I am genuinely curious what the latest information is about these tradeoffs. If another million dollars were spent in Zambia, Rwanda or Uganda on prevention as opposed to, given the amount of money that's available or can be spent within reasonable macroeconomic prudence, what is the tradeoff? Would money being spend on treatment save many, many more lives than money being spent on prevention or the opposite?

I've asked this question of many people over the years. I get wildly different answers, and often I get no answer whatsoever.

MS. BIRDSALL: Thank you very much. It's an important question. I see Mead Over in the audience. I know he's thought about this. Mead, are you willing to introduce yourself and give a short answer to a very difficult, deep, long question?

MR. OVER: I think that's a very important question, and I wanted to ask a very similar question myself of the Minister of Finance.

The estimates suggest that you can save life years for in the neighborhood of \$1 to \$25 with prevention programs in Africa. The estimates suggest that it costs somewhere between \$300 and \$600 to save a life year with antiretroviral treatment.

As the Minister of Finance, every time a new person becomes infected, you know that 5 years down the road that person is going to need treatment. The effectiveness of the treatment program that we're witnessing today, we hope that what we're seeing today is the beginning of very effective treatment in Africa, that effectiveness of that treatment program is increasing the prevalence of AIDS in all the countries over what it would be in the absence of treatment. So you have a growing stock over time of people who need treatment.

In Rwanda, luckily your infection rate is not nearly as high as it is in Botswana or some of the Southern African countries. But this image of a growing proportion of the population of those countries being dependent on twice-a-day drugs that they must take absolutely at the right time of day is rather frightening to me. I would think from the Minister of Finance's point of view it would also be rather frightening.

MS. BIRDSALL: Thank you, Mead. **Minister Kaberuka**, do you want to comment, and then Keith might want to say something about that?

MINISTER KABERUKA: Maybe I should let him go first.

MR. HANSEN: This is a very difficult set of challenges which to some extent is a tradeoff because money is still scarce.

I don't think it's as much of a direct tradeoff as we believe though. We have to remember one thing: in the lives we're saving, the denominator is different. The infections we're preventing are not the same people as the lives we're saving with treatment. The issue is in no country do we make this tradeoff and say it's cheaper to prevent the next car accident than to treat those people who were just in one and, therefore, we'll let them die and we'll just put up better stop signs at the intersection.

MS. BIRDSALL: As Holly pointed out at the beginning, those people are also parents themselves and workers themselves.

MR. HANSEN: Right, and that's the other thing. There is a much larger cost involved to those people.

We have to remember something else: the price of treatment is going to fall. It's fallen 98 percent in the last 7 years. It's going to continue to fall. What matters is the price over the next 10 to 20 years to keep someone alive, not just what it's going to cost this year.

I think it is very difficult. At the Finance Ministry we should be very concerned. What I would say is, prevention programs should be funded absolutely 100 percent because every infection we fail to prevent becomes a new treatment obligation which is also an obligation, but is a much more expensive one.

So it's clear that it pays off to prevent, obviously, but it does not mean we can ignore treatment.

The other issue is I don't think there is any substance on earth right now that is as valuable per cubic centimeter as an ARV drug. So this is going to get out there. People are going to get these whether we help them or not. So the

question is, do we engage as a global community in a regulated, controlled, supported process or do we have antiretroviral chaos, and I think it's obvious which is the better outcome.

MS. BIRDSALL: Of course, when there's chaos, the poor are always last in line.

Mead, I'm not going to let you say anything because it's noon and I think we should ensure that **Minister Kaberuka** has the last word, and then I want to thank everyone. **Minister Kaberuka**, any last words? Your ratio of ideas and contribution to words has been extremely high.

MINISTER KABERUKA: This is very kind of you to give me the support I needed, but I want to say something a bit different.

In my country, during the genocide in 1994 rape was used as a weapon. There are many women in my country who were raped during the genocide and they're carrying the virus. There are many child-headed homes where the young children are heads of family some of whom also are HIV positive.

I say this to show you the importance of what--said, there cannot be a choice here between prevention and treatment. I think I've seen in my own country change. I've seen the lives of people improved by the antiretroviral treatment. I truly hope that over time the cost goes down.

The second point I think I should make to this end is that somebody said as economists you should look for an answer. I don't think it's up to the economists to look for an answer. We won't find one because the economics are the same as for anything else. We can't find an answer.

What we have to do is to challenge the international community. The resources in the world are available for us to address the issue of HIV/AIDS. As--used to say, foreign aid \$50 billion, agricultural subsidies \$320 billion, military expenditure \$900 billion. So there are resources in the world if there is enough momentum for us for more of the resources.

The second level is what we are discussing today, how do we manage those resources. I think has come that we need to scale-up what we are doing in this area while not ignoring the challenges we face in terms of the management.

MS. BIRDSALL: I think we can summarize by saying there are tradeoffs, there are dilemmas, there are challenges. We can't wave them away. Even the best economist on the one hand and on the other hand can't wave them away.

I think all of our panelists have suggested it's a matter of facing those dilemmas, dealing with those tradeoffs, managing them as well as possible.

Let me thank **Minister Kaberuka**, David, Holly, Peter and Keith standing in for Jean-Louis Sarbib, and all of you for your active participation.

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