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25

Debt relief and the HIV/AIDS crisis in Africa

Does the Heavily Indebted Poor Countries (HIPC) Initiative go far enough?

HIV/AIDS poses a development challenge of unprecedented urgency, especially in Africa. Apart from the terrible personal costs, the pandemic is the single biggest threat to the attainment of the Millennium Development Goals. Over one-third of HIV/AIDS sufferers live in countries classified as heavily indebted. Repayments to creditors by these countries are diverting resources needed to break the links between ill-health and poverty. Radical reform of the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative is vital to mobilise the resources needed to protect current and future generations from the threat posed by HIV/AIDS.

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Summary

Unsustainable debt represents a huge barrier to progress in the fight against HIV/AIDS. Repayments to creditors by some of the poorest countries in the world are diverting the resources needed to respond to current suffering and protect future generations. While the pandemic inflicts suffering and hardship on countless millions, and destroys the development gains achieved over generations, debt repayment is taking precedence over human need. The willingness of rich-country governments to tolerate this state of affairs in unconscionable and short-sighted.

HIV/AIDS is an enormous development crisis. It has reduced life expectancy in sub-Saharan Africa from 62 years to 47 years. Apart from the terrible personal suffering involved, it is the single biggest threat to the attainment of the Millennium Development Goals, especially in Africa. The pandemic is reinforcing the problems that link ill-health with poverty. Effective debt relief could help to break this link by releasing the resources needed for a concerted assault on poverty.

One in three of all HIV victims – around 13 million people – live in countries classified by the IMF and World Bank as heavily indebted. These countries face some of the highest prevalence rates in the world. HIV/AIDS currently claims more than one million lives each year in heavily indebted countries. Apart from the immediate suffering of the people themselves, HIV/AIDS is devastating education systems, placing new demands on already over-stretched health sectors, increasing time demands on women, jeopardising the future of orphaned children, and reducing economic growth by almost two per cent a year in some cases. Without a comprehensive strategy to address the threats posed by HIV/AIDS, many heavily indebted countries will miss the human development targets set under the Millennium Development Goals.

Current debt-relief efforts fall far short of what is needed. **Under the Enhanced Heavily Indebted Poor Countries (HIPC) Initiative, 26 countries are receiving debt relief. Half of them are still spending 15 per cent or more of government revenue on debt repayments.** These repayments are 'crowding out' vital public investments in health, education, and other areas. Thirteen of the 26 countries receiving debt relief are still spending more on debt than on public health. These are some of the worst cases:

- Zambia and Malawi have among the highest HIV/AIDS prevalence rates in the world. But while Zambia has almost one million people affected, the country is spending 30 per cent more on debt than on health. Malawi's health budget is equivalent to its debt servicing. Child mortality is increasing in both countries.

- In Cameroon HIV prevalence rates have passed five per cent. Debt repayments amount to three-and-a-half times spending on health.

- For every $1 that Mali spends on health, $1.60 is transferred to creditors. With the highest child mortality rate in the world, Niger spends more on debt than on health.

Converting debt transfers to creditors into public investments in health could make a real difference. Effective HIV/AIDS intervention cannot take place in

the absence of enhanced service-delivery capacity in health systems. According to the Commission on Macroeconomics and Health, low-income country governments need to increase spending on health by 1.6 per cent of GNP a year to 2015 in order to move towards universal coverage. Current spending on debt servicing after Enhanced HIPC Initiative debt relief amounts to three per cent of GDP. Looking beyond the health sector, the handicap generated by unsustainable debt compromises efforts to respond to other costs imposed by HIV/AIDS, especially in education. These include the costs of replacing lost teachers, covering for absenteeism, and keeping orphaned children in school.

Notwithstanding a $1bn 'top-up' at the Kananaskis G8 summit, rich countries have consistently failed to respond to the inadequacies of the Enhanced HIPC Initiative. No attempt has been made to revise debt sustainability indicators in light of the financing requirements for addressing the HIV/AIDS crisis and achieving the Millennium Development Goals. Meanwhile, many countries are being forced back into acute debt unsustainability by a protracted decline in commodity prices, weak aid flows, and wildly over-optimistic export-growth projections by IMF-World Bank staff.

This briefing paper outlines a strategy for reforming the Enhanced HIPC Initiative. It calls for:

- A debt-servicing ceiling set at five per cent of government revenue, and less for countries that will otherwise be unable to achieve the Millennium Development Goals. This ceiling would mobilise an additional $1.6bn annually (in 2001 budget terms).
- The effective integration of HIV/AIDS strategies into national poverty-reduction plans, including the full costing of plans, realistic financing schemes, and the development of transparent and accountable public financing systems to ensure that commitments are reflected in national budgets and medium-term expenditure frameworks.
- Urgent action to mobilise the $4bn needed to implement the Education for All Action Plan endorsed in principle by industrialised country finance and development ministers
- Action to estimate the additional costs of meeting the Millennium Development Goals in the light of the HIV/AIDS crisis.

Debt relief cannot be considered in isolation.There is little point in providing more debt relief if donors reduce aid by an equivalent amount. And the benefits of releasing additional funds will be diminished if intellectual property rules enable pharmaceutical companies to create high price havens for vital medicines. More generally, debt relief has to be seen as one strategy for creating additional resources. International mobilisation through the Global Fund will remain vital if current resource gaps are to be closed.

Yet reform of the Enhanced HIPC Initiative is essential. Debt cannot be allowed to jeopardise efforts aimed at reducing child death, attacking poverty, and creating the conditions for economic recovery. Placing the claims of creditors before the needs of the current generation of HIV/AIDS sufferers and the interests of future generations is morally indefensible - and it is unnecessary. The world can afford a better deal on debt. It cannot afford to tolerate the current situation.

Background

Six years have now passed since the President of the World Bank, Jim Wolfensohn, unveiled the Heavily Indebted Poor Countries (HIPC) Initiative and pronounced it 'good news for the poor'. Important gains have been achieved. But the HIPC Initiative stops far short of what is needed. Nowhere is this more apparent than in African countries at the epicentre of the crisis. For many of these countries, unsustainable debt is a formidable barrier to the public investments needed to respond to the HIV/AIDS crisis and prevent its transmission to the next generation.

The HIV/AIDS pandemic is an unparalleled setback in human development. In the space of a few years it has rolled back the achievements of decades, destroying the lives of millions of people and compromising prospects for recovery in the process. Any assessment of the adequacy of the HIPC Initiative has to take into account the financing requirements needed to break the vicious circle of HIV/AIDS and poverty. The targets set by the 2001 United Nations Special Session on HIV/AIDS are a starting point. These include:

- Reducing HIV infection among 15-24 year olds in the worst affected countries by one-quarter by 2005.
- Lowering the proportion of infants infected with HIV by one-fifth by 2005, and one-half by 2010.
- Developing national strategies by 2003 to strengthen health-care systems and improve access to affordable medicines, along with multi-sector strategies to address the impact of the epidemic at the individual, community, and national levels.

Achieving these targets is important not only as an end in itself, but as a means to achieving the Millennium Development Goals. These include halving extreme income poverty, cutting child deaths by two-thirds, and achieving universal primary education. There is a fundamental and deepening tension between the demands of creditors and the prospects for realising these goals.

Three years ago, Northern governments reformed the original programme. The Enhanced HIPC Initiative provided for earlier and deeper debt relief, and sought to establish a close linkage between debt relief and poverty reduction. As the HIV/AIDS pandemic has tightened its grip on some of the world's poorest nations, the inadequacy of their efforts is being thrown into ever starker relief – as

is the gap between their rhetoric on development and their action (or, more accurately, their inaction) on development financing.

This paper is divided into four sections. Part 1 summarises the extent of the epidemic in countries currently covered by the Enhanced HIPC Initiative. Part 2 looks at the broader implications of the epidemic for human development. Part 3 analyses the Enhanced HIPC Initiative in the context of the development challenge posed by HIV/AIDS. It shows that, behind the large headline numbers for debt relief frequently cited by Northern governments, the World Bank and the IMF, many governments continue to labour under excessive debt burdens. Part 4 considers some of the broader reasons for reforming the HIPC Initiative, and sets out a range of policy reforms. It recommends a systemic reform of HIPC aimed at reducing the share of government revenue allocated to debt relief, allied to measures that will enhance the efficiency and equity of resource use through Poverty Reduction Strategy Papers (PRSPs).

1 The impact of HIV/AIDS on highly indebted countries

The disastrous impact of HIV/AIDS on social and economic development has been extensively documented. That impact extends beyond individuals, households, and health sectors to all levels of society. HIV/AIDS is not merely a health-policy concern. It is a systemic crisis that demands a systemic and properly financed response.

Nowhere is this more apparent than in the countries currently covered by the Enhanced HIPC Initiative. These countries are at the epicentre of the pandemic. By virtue of their high levels of poverty, low average incomes, and limited government resources, they are also among the less equipped to deal with the consequences.

The extent of the epidemic in HIPCs

There are 42 countries currently eligible for the 'Enhanced HIPC Initiative' (34 of them in Africa). At present,[1] 26 are benefiting from debt relief. Another 12 countries with unsustainable debts are either under consideration or – as in the case of Sudan and Somalia – excluded because of conflict and arrears with the IMF-World Bank.

There are some 10.2 million people living with HIV/AIDS in the 26 countries currently receiving HIPC debt relief. Including the 12 more under consideration would raise the numbers affected by 1.5 million,

or almost one-third of the global total. Were Nigeria eligible, as it should be, another 2.7 million people with HIV/AIDS would be added.

Many of the HIPC countries suffer very high HIV prevalence rates (**Figure 1**). Twenty-one countries have incidence rates in excess of one per cent, the level at which the epidemic takes hold, and 15 HIPCs have rates higher than five per cent. Within the latter group eight countries have prevalence rates of 10-15 per cent, and two (Malawi and Zambia) of more than 15 per cent. Prevalence rates remain at exceptionally high levels in Southern Africa. Over 13 per cent of the adult population in both Mozambique and Malawi are infected, rising to 20 per cent in Zambia. In West Africa, prevalence rates have passed the five per cent mark in five countries: Burkina Faso, Cameroon, Cote d'Ivoire, Nigeria, and Togo. Despite improvements in East Africa, infection rates exceed eight per cent in Tanzania, Uganda, and Ethiopia.

It goes without saying that the challenge posed by HIV/AIDS in Enhanced HIPC Initiative countries cannot be considered in isolation. The pandemic is unfolding in countries marked by deep and pervasive income poverty, with around one-half of the population struggling to survive on less than $1 a day. Other indicators make for similarly bleak reading:

- **Child mortality.** Child mortality rates average 157 per 1000 live births in the countries currently receiving or under consideration for Enhanced HIPC debt relief. This translates into some three million child deaths a year. The plight of heavily indebted countries helps to explain why sub-Saharan Africa is further off-track than any other region in terms of progress towards the 2015 goal for child mortality. In 1990, the region accounted for one-third of child deaths. If current trends continue, that share will have risen to 55 per cent by 2015, according to projections based on UNICEF data. HIV/AIDS is causing a marked deterioration in child mortality rate trends in a number of countries, partly because of the illness itself; and partly because of household income losses. Children who lose a parent to AIDS in Tanzania are about 50 per cent more likely to be malnourished than children with both parents living.
- **Maternal Mortality.** The HIPCs include countries with some of the world's highest maternal mortality rates. Sixteen have a maternal mortality ratio (MMR) in excess of 1000 per 100,000 live births, and two of these countries have an MMR of over 2000. To put these figures in perspective, the typical MMR in industrialised countries is 10-12. Sub-Saharan Africa accounts for

around one-half of the 500,000 deaths that occur each year from problems related to pregnancy and childbirth. For every death, another 30 women are estimated to suffer serious injury and infection.

- **Education.** Twenty of the sub-Saharan African HIPCs have primary school completion rates of less than 50 per cent, while the average gender gap in enrolment is around 10 per cent. In six of the African HIPCs, including Ethiopia, Mali, Chad, and Burkina Faso, fewer than one in four complete primary school. If current trends continue, highly indebted countries will miss the target of universal primary education by 2015 – and by a wide margin. Projections suggest that there will be at least 57 million children in HIPC countries not in school in 2015 – approximately three-quarters of the worldwide total of out-of-school children. It has to be stressed that this prognosis, stark as it is, takes no account of the quality of education provided to children in school.

The human and financial implications of HIV/AIDS have to be considered against the backdrop of this already bleak picture. Changing that picture for the better in the face of the challenge posed by the epidemic will require an unprecedented commitment to resource mobilisation.

2 Implications for human development

As in other countries, the AIDS epidemic in the HIPCs has far-reaching impacts for human development at all levels. Through its impact on income from the household to the national level, it is retarding the pace of income-poverty reduction. Opportunistic infections associated with HIV/AIDS claim lives, but also undermine productivity, impose new demands on women as carers, and add to the burden on already over-stretched health systems. In education, the epidemic is generating diverse but universally destructive effects. It is killing teachers and forcing families to withdraw their children from school, whether because of sickness, loss of income, or to take care of sick family members. In each case, HIV/AIDS is creating costs that extend beyond the current generation to future generations.

Women carry a double burden associated with HIV/AIDS, and bear a disproportionate share of the human costs. They account for a large share of the population affected by the virus. Over half of those infected with AIDS in Africa are women, in contrast to industrialised

countries where the disease is concentrated among males. Girls and young women are highly vulnerable for social, cultural, economic, and physiological reasons. They are at greater risk than their male counterparts because of gender-based inequalities in power, access to education, and access to resources. One UNAIDS study covering 11 countries found that average infection rates were over five times higher among teenage girls than teenage boys, and three times higher for women in their early twenties than for men. In parts of Southern Africa, antenatal clinic data suggests that HIV prevalence among pregnant women often exceeds 30 per cent in urban areas.

The second gender-specific aspect of HIV/AIDS relates to the unequal sharing of burdens within the household. Almost everywhere, the extra time demands and work generated by care are deflected onto women, notably young girls and grandparents. Thus, while the epidemic has implications for poverty and human development in general, it has specific intra-household implications that adversely impact on women.

Income poverty – and prospects for halving it

The rate of progress towards the target of halving extreme poverty is a function of two things: the rate of average income growth, and the share of any increment to growth captured by the poor. HIV/AIDS has adverse implications on both sides of the growth and distribution equation.

Various attempts have been made to model the impact of HIV/AIDS on overall economic growth. Most arrive at the conclusion that per capita incomes are reduced in the range of 0.5 per cent to 1.8 per cent a year. This is an immense drain on the economy, given that average per capita incomes in sub-Saharan Africa grew at only 0.4 per cent in 2000-01. At a household level, the costs are self-evident. On a compound basis, the per capita income losses associated with HIV/AIDS translate into a reduction of between 5 per cent and 17 per cent in household income over a ten-year period. For households living below or near the poverty line, losses on this scale have obvious implications, just as they do for national progress in poverty reduction. Taking a median point for per capita income losses associated with HIV/AIDS, and a median rate of conversion for income growth and poverty reduction, indicates that at least 1.5 million people would have escaped income poverty in Africa in 2000 in the absence of the pandemic.[2]

Aggregate growth data cannot capture the implications of income losses for the livelihoods of the poor. For rural communities, sickness translates into lower levels of agricultural output and lower incomes,

increasing vulnerability to food shortages and hunger. One study in Côte d'Ivoire found that rural household income fell by between one-half and two-thirds when a family member had HIV/AIDS. Such findings reflect the impact of the disease in eroding the most precious asset of the poor: namely, their labour. Estimates for Burkina Faso suggest that AIDS has forced one-fifth of rural households to reduce their labour. The resulting losses are cumulative, in that lower income this year translates into less investment, fewer assets, and increased vulnerability next year.

HIV/AIDS-related sickness affects income poverty not just through its consequences for income. It also imposes new expenditure demands, especially for health treatment. Research in Rwanda suggests that households with HIV/AIDS patients spend some 20 times more annually on health care than households without such patients. Because of the progressive nature of the disease, those infected suffer repeated sickness episodes. One survey in Zambia found that 12-14 such episodes were typically experienced before terminal illness. Spending on the treatment of these illnesses obviously reduces income available for food and other items of household expenditure. The loss of income and costs of health care associated with just one sickness episode can throw a whole family back into poverty.

While HIV/AIDS affects all income groups, poor households face a disproportionate burden of risk at various levels. Their lower income and greater dependence on labour means that an HIV/AIDS sickness episode will inflict proportionately larger income shocks on them relative to household budgets than for wealthier social groups. And because the poor have fewer savings, assets, and resources to draw on in times of crisis, they are less able to bear additional expenditure demands, including the purchase of essential drugs. Just one episode of illness can reduce a household to poverty and future vulnerability, especially when they have to sell assets in order to cover health costs. In addition, malnutrition, limited access to clean water, and restricted immunisation leave poor households more vulnerable to recurrent opportunistic infection. Thus while HIV/AIDS affects all social groups, it is reinforcing the poverty and malnutrition at the heart of health inequalities between rich and poor.

Implications for public-health systems

Health systems are coming under intense pressure. AIDS and AIDS-related health demands are rising, without a commensurate increase in financial resource availability.

The full extent of the financial impact of HIV/AIDS is difficult to capture, partly because of the weaknesses of reporting systems, but mainly because most sickness occurs in the form of opportunistic infection and extended recovery time. In Zambia, the incidence of tuberculosis has increased five-fold since the early 1990s, with 4,000 new cases reported each year. Other opportunistic infections such as diarrhoea, respiratory tract infection, meningitis, and measles are also on the increase. On current trends it is projected that AIDS patients will utilise nearly half of all hospital beds by 2014. Current costs of hospital treatment for AIDS sufferers admitted to hospital amount to around $200, compared with average spending of around $3 per capita per year on health.

With limited access to basic services and affordable medicine, poor households face especially grave problems. In a number of HIPC countries, HIV/AIDS has resulted in child mortality rates either stagnating at very high levels, or – as in Malawi and Zambia – increasing. Projections for Malawi suggest that child mortality rates in 2015 will be 60 per cent higher than they would have been without HIV/AIDS.

Current shortfalls in financing the Global Fund to fight HIV/AIDS, malaria, and tuberculosis are not only hampering efforts to finance comprehensive programmes of treatment, care, and prevention, but they are adding to burdens on national budgets. According to the Commission on Macroeconomics and Health, the annual *incremental* costs of extending effective HIV/AIDS coverage to 70-80 per cent of the population in low-income countries amount to around $5 per capita per year, or almost 0.5 per cent of GNP. While this may seem a modest amount, it has to be placed in context. In most HIPCs, average per capita spending on health by government amounts to between $3-12. Some countries – among them Malawi, Zambia, and Burkina Faso – would have to double per capita spending just to respond to the HIV/AIDS crisis.

HIV/AIDS and the crisis in education

Prospects for accelerated progress towards the 2015 goal of universal primary education have deteriorated rapidly as a result of HIV/AIDS. The disease has devastating consequences both on demand for education and the supply of education services.

On the demand side, families often remove children – especially young girls – from education, either to care for sick relatives or to generate income to compensate for the losses caused by illness. Girls are frequently the last into school for cultural reasons, and invariably the first to be taken out during HIV/AIDS episodes. Girls are more

likely than boys to be retained at home for domestic work, such as caring for sick relatives, looking after younger siblings, or carrying water.

Loss of parents can have catastrophic consequences for primary school attendance. Evidence increasingly points to a negative correlation between school attendance and loss of parents, especially for children from poor households. This is especially true for children that have lost both parents. Given that an estimated 7-10 per cent of Africa's children are now orphans, the threat to school enrolment and completion rates is readily apparent. It follows that strategies to increase demand for education among orphaned children by reducing financial pressures have to be a central feature of strategies to achieve universal primary education by 2015.

On the 'supply side', the HIV/AIDS epidemic has ravaged education systems, principally through sickness and death among teachers, sector administrators, and planning officials. In 1999 alone, Zambia lost 1,600 teachers from causes related to AIDS. Annual losses associated with AIDS-related attrition among teachers are now equivalent to almost three-quarters of the number of new teachers coming out of teacher training colleges. Every lost teacher represents not just a personal tragedy, but a loss of skills and an increase in the pupil-to-teacher ratio, which has risen from 1:37 to 1:47 since 1996. Illness also contributes to prolonged absences from the classroom and loss of education quality.

In financial terms, the cost of the HIV/AIDS epidemic threatens comprehensively to derail efforts to achieve universal primary education by 2015. Estimates by the World Bank based on a sample of 33 countries in sub-Saharan Africa suggest that on average HIV/AIDS adds between $450m and $550m a year to the cost of achieving universal primary education. This implies an increase of one-third in the total financing gap. For many HIPCs, such cost inflation cannot be accommodated within existing budget parameters.

The negative cycle emerging in education is reinforcing the linkages between AIDS and poverty. Participation in education produces multiple benefits for individuals and countries in terms of rising productivity, economic growth, and public health. No country has sustained rapid poverty reduction without improving its education indicators. Conversely, exclusion from education carries a high price in each of these areas, and the price is rising as globalisation places a growing premium on education. Failure to deal with the problems posed by HIV/AIDS today will have the twin effect of further

marginalising countries and diminishing prospects for pro-poor growth tomorrow.

There is another reason for prioritising education in anti-HIV/AIDS strategies. Education systems are in the frontline of the fight against the pandemic. Attendance at school has been shown to provide protection against HIV infection. It can help to inform children and youth about the dangers they face, promote behavioural change, and enable the next generation to exercise more control over their own lives. Given the prevalence of very large knowledge gaps this has important implications, especially for girls. Surveys of 15 to 19-year-olds in countries such as Mozambique, Zambia, Tanzania, Mali, and Niger show that the proportion of girls that do not know how to protect themselves against HIV/AIDS is at least ten per cent higher than that for boys. According to UNICEF, over 40 per cent of adolescent girls in Tanzania and Sierra Leone have never heard of HIV/AIDS. Similarly, cross-country research has found that HIV infection rates have been falling more rapidly among educated women than among those with little or no formal education. Such findings are important given the susceptibility of girls to contracting HIV/AIDS.

3 Is the Enhanced HIPC Initiative enhanced enough?

Debate on the Enhanced HIPC Initiative is marked by ritualistic exchanges. One ritual takes place at meetings of the IMF-World Bank and Group of Eight gatherings, where finance ministers and staff of the Bretton Woods institutions like to recite headline numbers for debt reduction. The problem with these numbers is that they are almost irrelevant to the financing challenges posed by HIV/AIDS and wider threats.

Levels of debt relief

Under the Enhanced HIPC Initiative, debtors receive debt relief under a two-phased process. After complying with an IMF programme and demonstrating progress towards the development of a Poverty Reduction Strategy Paper (PRSP) they reach a 'Decision Point'.[3] At this stage, calculations are made of what level of debt reduction is needed to reach sustainability, defined in terms of a range of threshold indicators. The (net present) value of debt stock is measured against exports of goods and services. If the ratio of debt to exports is greater than 150 per cent after the full application of

traditional debt-relief mechanisms, the country's debt is considered unsustainable. It then qualifies for interim debt-service relief to reduce the level below the threshold.[4] Provided that it continues to comply with an IMF programme and finalises a comprehensive Poverty Reduction Strategy Paper (PRSP), it can then graduate to 'Completion Point' and receive debt-stock relief. The arrangement is intended to provide a permanent exit from unsustainable debt.

Four countries – Bolivia, Uganda, Tanzania, and Mozambique – have so far reached Completion Point. Another 22 are receiving interim debt relief having reached Decision Point. IMF-World Bank staff reports invariably express the level of debt relief provided in terms of long-term changes in debt stock, or debt service/export ratios. For example, the April 2001 review noted that nominal debt relief for the 26 countries covered amount to $40bn (and $25bn in net present value terms). For the same group of countries, average annual debt servicing as a percentage of exports for 2001-05 was projected to fall by almost one-third from the 1998-99 level. In a similar vein, 'debt service relative to government revenue is projected to fall from an average of 24 per cent a year … to 13 per cent' over the same reference period.

The problem with this type of financial statement is that it is virtually meaningless in terms of understanding the real budget constraints on governments. Savings measured in terms of the gap between pre- and post-Enhanced HIPC Initiative projected debt servicing (much of which would not have been paid in any case) have limited relevance when it comes to real current spending capacity. Similarly, nominal debt-stock figures provide some insights into financial sustainability, but offer little information about budget resources. Since it is these resources that dictate what governments are able to finance, the sustainability of debt should be assessed against budget criteria, as well as foreign-exchange ratios.

Debt sustainability and government revenues

When measured against domestic resource mobilisation, the shortcomings of the Enhanced HIPC Initiative are painfully apparent. The problem is that debt repayments continue to absorb a large share of the limited revenue base available to governments. If sustainability is measured against the criteria of financing for human development, the debt burden of many countries at the centre of the HIV/AIDS crisis is unsustainable.

For the 26 countries receiving Enhanced HIPC debt relief in 2002, repayments to creditors were still absorbing 15 per cent of government revenue (using a simple average). While the average

figure is falling, it is projected to remain between 11-12 per cent in 2005. Of course, averages mask variations between countries. As IMF-World Bank staff point out, several HIPCs now spend less than ten per cent of revenue on debt servicing. But averages obscure differences in both directions. There are 13 countries currently spending more than 15 per cent of government revenue on external debt servicing (**Figure 2**).

What do these figures mean for real government spending capacity and service provision? One way of addressing this question is to compare debt-service obligations with current levels of spending on health. In most HIPCs, per capita spending on health is far too low to meet the cost of providing a basic health service, ranging from $3-6 per person in countries such as Mali, Chad, Ethiopia, Mozambique, Niger, and Tanzania. This is less than half of the average for low-income countries, and far short of the $30 needed to provide universal access to even a minimal level of universal health care. However, half of the 26 governments currently receiving debt relief are still spending more in repayments to creditors than on the public health of their own citizens (**Figure 3**).

- Only two of the 26 HIPCs currently receiving debt relief have debt-service payments equivalent to less than one-half of total health spending.
- Countries such as Zambia, Mali, Niger, and The Gambia all spend more on debt than education.
- Several countries – including Cameroon, Sierra Leone, and Mauritania – spend more than twice as much on debt as on education.

Individual country cases highlight the glaring discrepancy between the world created by the financial 'spin doctors' in the IMF-World Bank, and the real world as experienced by poor people. Consider the case of Zambia. According to the most recent IMF-World Bank projections, the net present value of external debt stock, expressed as a proportion of exports, has fallen by more than half since 2000. However, the proportion of government revenue allocated to debt servicing is projected to rise from an already high level of 20 per cent in 2000 to 25 per cent in 2004. This is in a country where HIV/AIDS is driving an increase in child mortality rates, where almost one million people are living with the disease, and where half a million children have been orphaned. For HIV/AIDS victims denied access to affordable treatment, and children denied access to an education, debt service/government revenue ratios matter far more than changes in the value of debt stock.

The Zambia case is striking since it has one of the highest levels of HIV/AIDS prevalence in the developing world. Unfortunately, the tensions between debt servicing and financing for basic services are not untypical. Even in HIPC countries that have benefited from significant debt-service reduction there is an acute mismatch between the claims of creditors and the resources allocated to investment in public health:

- Niger has the highest child mortality rate in the world but continues to spend more on debt servicing than public health even after HIPC debt relief.
- For every $1 that Mali allocates to public health, $1.60 is transferred to creditors
- Sierra Leone, with one of the world's highest maternal mortality rates, will spend 2.5 times more on debt servicing than on health in 2002 on current projections.

Debt repayment obligations inevitably clash with efforts to develop the type of integrated HIV/AIDS programmes called for under the UN targets. For instance, the national strategic plan for HIV/AIDS developed by the Government of Malawi plans to allocate around $24m annually from domestic resources, or $2.4 in per capita terms. Yet its capacity to undertake these investments is being compromised not just by a disastrous famine, but also by a debt-service profile that resulted in transfers to creditors of $57m in 2002, or almost $5 per capita.

Heavily indebted countries in West Africa face acute problems. National adult prevalence rates have already passed five per cent in several countries, reaching seven per cent in Burkina Faso. Even countries with relatively low debt service/revenue ratios face debt-related financing constraints. In Burkina Faso the financing provisions for the national AIDS strategy amount to approximately $0.80 cents – or one-half of the amount that every woman, child, and man in Burkina Faso currently transfer to external creditors. The case for converting these debt transfers into public investments on HIV/AIDS can hardly be over-stated. Burkina Faso is typical of countries in which high sero-prevalence rates among severely affected populations threaten to generate a rapid increase in overall rates. Nearly two-thirds of prostitutes in Ouagadougou and one-half of those in Bobo-Dioulasso are sero-positive. Child mortality rates have been increasing at one per cent a year for almost a decade.

The financing and service-delivery challenge facing HIPC governments is of daunting proportions. Like other governments, they have to focus on blocking the transmission of the virus. That

implies political leadership backed by public investment in education and raising awareness. At the same time, they have to provide effective treatment for the 13.5 million people in their countries currently living with the infection. Effective anti-retroviral therapies are now available, but not accessible or affordable to the vast majority of Africans. Indeed, relatively prosperous Botswana is the only country in Africa to begin providing anti-retroviral drugs through its public-health system. It has significantly increased public-health spending and negotiated price reductions with pharmaceutical companies. For the vast majority of HIPC countries, even with significant discounts driven by generic suppliers, prices remain too high for public-sector budgets in low-income countries. Moreover, shortages of trained health staff and the weakness of health delivery systems pose immense barriers to improved access.

Such considerations emphasise the need to consider responses to HIV/AIDS in the context of broader health sector development programmes. Effective treatment of care and promotion of preventative work require a functioning health system capable of responding to a wide range of opportunistic infections. Unsustainable debt is jeopardising the development of such systems. Estimates by the Commission on Macroeconomics and Health suggest that low-income countries need to increase spending on health by an amount equivalent to around 1.6 per cent of GNP a year to 2015 (based on 2002 costs) in order to provide effective coverage. To put this figure in context, current debt spending for the 26 countries currently receiving debt relief amounts on average to three per cent of GDP. In other words, the additional health spending could be financed to a significant degree by a transfer of resources from external creditors to domestic service providers.

As noted earlier, the financial costs of responding to the development challenge posed by HIV/AIDS cannot be considered solely in the context of public-health systems. Education systems are also under acute pressure. As the World Bank has put it: 'Education for all in a world of AIDS presents an unprecedented challenge.' That challenge includes a major resource component. For 33 African countries covered in a recent cost-estimation exercise, the vast majority of them HIPCs, the average cost of achieving education for all has increased by $450-$550m. On the supply side, budgets have to absorb higher costs for hiring and training teachers, as well as the costs of maintaining payments to sick teachers. In the case of Mozambique, these additional costs are estimated at around $50m a year.

The financial implications of HIV/AIDS for the attainment of goals in health and education point to a wider need to reassess the adequacy of the HIPC Initiative. If governments, rich and poor, are

serious about achieving agreed human development targets, they need to assess – or reassess – the costs of doing so in the light of the HIV/AIDS epidemic. And creditors need to balance their claims against the financing needs of debtor countries.

The weak case against debt relief

Various arguments have been made against the use of debt relief to help finance government interventions in HIV/AIDS and broader poverty-reduction strategies. Two of these arguments deserve serious attention, less because of their merits than because of their influence in current debates. The first is that aid is equivalent to debt relief in financial terms, and that this is where new resources are needed. The second is that debt relief is a relatively inefficient way of mobilising resources for poverty reduction.

From a financial accounting perspective, aid and debt-relief flows are equivalent in that they represent a transfer of foreign exchange. However, they are not equivalent in public expenditure terms. Aid finance is often linked to specific projects that reflect donor priorities. In Tanzania, only one-third of donor finance passes through the national budget. Meanwhile, the fiscal burden of debt repayments falls directly on the national budget, which in turn reduces the resources available to government. It follows that debt relief provides direct budget support to developing countries, reducing pressure on very limited domestic revenue bases.

From a recipient government perspective aid flows suffer from a range of additional problems. They tend to be erratic and subject to sudden cut-offs, as testified by the recent experience of several HIPCs. Because aid transfers often reflect donor priorities they weaken national ownership, while at the same time imposing very large transaction costs in the form of reporting requirements. Another problem is that aid is a less efficient form of resource transfer than debt relief. The practice of tying development assistance to the purchase of goods and services in donor countries reduces its value by between 15-30 per cent, according to OECD estimates.

Turning to the efficiency of debt relief as a mechanism for financing poverty reduction, there is little evidence to support the claims of pessimists. Although there is significant variation, spending on social sectors among recipients of HIPC debt relief has increased from six per cent to nine per cent of GDP, comparing pre-and post-debt reduction financing. World Bank estimates suggest that around 40 per cent of total savings have been directed to education and 25 per cent to health care, including investment in HIV/AIDS programmes.

Even taking into account the inevitable gaps between financing provision and service delivery, debt relief has helped to finance some important initiatives. Uganda used savings from debt relief to finance the elimination of user charges in education, and Tanzania has recently followed suit. Both countries have experienced significant increases in school enrolment. More recently, Benin has announced its intention to use debt relief to finance the elimination of fees in rural areas. Countries such as Mali, Mozambique, Burkina Faso, and Senegal have all used debt relief to increase spending on HIV/AIDS prevention programmes. In the Cameroon, where the government has set itself the goal of containing the rate of HIV/AIDS infection below the critical 10 per cent threshold, savings from debt relief are the main financing mechanism for the national poverty-reduction strategy.

Notwithstanding these positive cases, more could be done to strengthen the impact of debt-relief savings on human-development programmes. One of the aims of the PRSP process described earlier was to achieve this goal. In theory, PRSPs should provide a comprehensive framework that costs poverty-reduction goals and disaggregates planned expenditure. They are also supposed to provide a conduit for dialogue between governments and civil society over the design, development, and implementation of poverty-reduction strategies. In practice, the presentation of public expenditures in PRSPs has often been weak. That weakness is mirrored in national budgets, where classification and expenditure systems make it difficult either to track expenditure, or to establish that debt relief has generated new and additional resources for fighting poverty. Moreover, much of what passes for dialogue has been inadequate, with governments, the World Bank, and IMF paying lip service to consultation in order to meet formal reporting requirements.

These problems have been powerfully apparent in relation to HIV/AIDS. While PRSPs offer a potentially useful tool to integrate HIV/AIDS strategies into national poverty-reduction plans, few successfully capture the links between poverty and AIDS, and almost none provide a credible analysis of the financial costs of breaking these links. Most do little more than list 'health policy' responses in the form of a shopping list with no budget attached. This inevitably weakens the potential effectiveness of debt relief as a strategy for fighting the pandemic.

Yet for all of these problems the PRSP exercise does create incentives for government to focus on poverty reduction. Best-practice cases provide an important model for future policy development. In Uganda, debt relief has been integrated into a Poverty Reduction

Action Plan that is integrated into a Medium-Term Expenditure Framework that guides all public expenditure, including that financed through debt relief. Priority social-sector investments are effectively ring-fenced. The Mozambican PRSP sets out in some detail how poverty planning fits into the overall budget process. In broad terms, the policy conclusion to be drawn from past experience is an obvious one: good PRSPs cannot be built on weak poverty-reduction strategies and opaque national budgeting. What they can do is consolidate and build on good national strategies and support public-expenditure reform, providing a focal point for debate on the effective use of debt-relief resources.

4 Enhancing the Enhanced HIPC Initiative

The HIPC Initiative marked an important step forward in addressing the debt problems of low-income countries. It provided for the first time an integrated framework for dealing with all categories of debt, and it set limits on creditor demands linked to a notion of sustainability. The Enhanced Initiative provided for earlier, deeper and broader debt reduction. But as the evidence set out in this paper suggests, it has not gone far enough. The Initiative is teetering on the brink of failure in its central objective: namely, the provision of a credible guarantee that countries entering it will be provided with a once-and-for-all exit from unsustainable debt. More immediately, it is compromising national and global efforts to respond to the profound development challenge posed by HIV/AIDS.

The wider case for reform

While the impact and scope of the HIV/AIDS crisis may be unprecedented, it is not the only factor relevant to a re-evaluation of the Enhanced HIPC Initiative. As a debt-relief strategy, the benefits of the Initiative are being eroded by wider pressures and mismanagement. This is doubly unfortunate, since there is evidence that it is contributing in a powerful way to poverty-reduction efforts across a wide range of countries.

Five interacting problems are contributing to this outcome:

- **Failure to prioritise the government revenue/debt service ratio in assessing sustainability.** The Enhanced HIPC Initiative, like its predecessor, prioritises external debt indicators in assessing debt sustainability. These indicators – such as debt service/export ratios and debt/GDP ratios – are important. However, they have

a limited bearing on government capacity to finance public investment. This is because export liberalisation has meant that government revenue is increasingly derived from taxes on domestic economic transactions. From a poverty-reduction perspective, the debt service/government revenue ratio is as important as external debt indicators. The limited revenue base of governments and resource constraints operating on poverty-reduction strategies suggest that current debt service/government revenues are too high.

- **Failure to factor in low and unstable commodity prices.** For many HIPCs the debt-service ratio is a function of the world market price for primary commodities. For 17 countries, the exports of just three commodities account for more than half of total exports. Fluctuations in prices on a relentlessly downward trend have pushed a number of countries back into debt unsustainability. During 2000-01, the price of coffee fell by 60 per cent, generating acute balance-of-payments pressures for Ethiopia, Honduras, Nicaragua, Rwanda, Uganda, and Tanzania. Prices of cotton, a critical source of foreign exchange for Chad, Mali, and Burkina Faso, also fell sharply. Losses in export earnings for the HIPCs as a group have been estimated at 1.5-2 per cent of GDP, rising to 6 per cent for Uganda. The debt-to-export ratio for Uganda is projected to increase from 196 per cent in 2001 to 240 per cent for 2002. Translated into financial terms, the losses incurred by Uganda from lower coffee prices in 2001 cost roughly three times the amount that the country received in debt relief that year.
- **Persistent over-estimation of export-growth prospects by the IMF.** Levels of debt relief provided under the Enhanced HIPC Initiative are partly a function of export growth rates. Others things being equal, higher growth lowers the debt stock/export ratio – and hence the stream of debt relief needed to meet any given sustainability threshold. In April 2002, IMF projections for 24 countries then receiving debt relief anticipated export growth of 11.6 per cent, compared with outcomes of 5.8 per cent: an under-estimate of 100 per cent. Updated export growth projections suggest a growth rate of less than four per cent, compared with projected growth in excess of 10 per cent. In some cases, the over-estimates are of heroic proportions. For instance, the 2001 projection for export growth in Uganda was 15 per cent, whereas exports contracted by four per cent. Evidence strongly suggests that there is an in-built bias towards excessive export optimism. For 22 of the 24 countries covered in an April 2001 review, export-growth projections had to be lowered in the light

of actual outcomes. In the assessment of the IMF-World Bank, the gap between projection and outcome is, in large measure, a consequence of failure to implement economic reform programmes agreed with the Bretton Woods institutions. However, the pervasive nature of over-estimation suggests a serious flaw in methodology, perhaps reinforced by an undue optimism in the effectiveness of IMF-World Bank programmes.

- **Insufficient and uncertain debt-relief provision prior to Completion Point.** One of the aims of the initial HIPC reform process was to provide earlier debt relief on an interim basis equivalent to entitlements after Completion Point. However, several countries, including Chad, the Gambia, Mauritania, and Niger, have received far less than anticipated in the interim period. This is because several creditors in the Former Soviet Union and the Middle East do not provide interim debt relief. Another problem is that of compliance with IMF programmes. The IMF has either suspended or delayed interim debt relief for countries such as Burkina Faso, Zambia, Malawi, Honduras, and Nicaragua, among others, on the grounds that governments have failed to meet macro-economic targets. These cover policy reforms in a wide range of areas, including governance, privatisation, and public spending. In effect, the IMF is judge, jury, and executioner, with debtor governments having a limited right of appeal against its decisions. Uncertainties over interim debt relief undermine efforts to provide a stable financial planning framework within which to pursue poverty-reduction targets.
- **Inadequate flows of aid.** As in the case of export growth, IMF-World Bank projections have consistently over-stated aid flows to HIPCs. In 2001 the 24 countries then benefiting from HIPC debt relief received new resource inflows (that is, new loans plus grants minus debt service payments) equivalent to 10.2 per cent of GDP, or 1.4 per cent less than the projection made at Decision Point. Over-estimation of aid flows is important, since it introduces an element of uncertainty into financial planning. At the same time, the HIPCs have suffered from a generalised decline in aid transfers. In per capita terms, aid transfers to sub-Saharan Africa have fallen from $33 to $20 since 1995. Notwithstanding commitments at the Monterrey conference on Financing for Development to reverse past aid cuts, this rests uneasily with the commitment of Northern governments to the Millennium Development Goals.

The way ahead

From the outset, levels of debt relief have been dictated by what creditors deem affordable, rather than by the needs of debtors. Moreover, the criteria for determining levels of debt relief reflect a narrowly defined financial perspective, focused on foreign-exchange indicators. No attempt has been made to develop debt-sustainability indicators that reflect the financing requirements for achieving poverty-reduction goals. The inadequate weight attached to the proportion of government revenue allocated to debt servicing reflects this bias. Another problem has been the central role of the IMF in managing the Enhanced HIPC Initiative. Assessments of country performance by IMF staff that are often at best weakly related to poverty-reduction considerations have resulted in delayed disbursement of debt relief, introducing high levels of uncertainty into the framework.

Current responses to the problems posed by the Enhanced HIPC Initiative betray a short-sighted piecemeal approach. Successive meetings of G8 finance ministers have witnessed repeated wrangles over financing 'top-ups' to compensate for adverse commodity price trends – and for the reckless projections of export performance developed by IMF staff. No attempt has been made to confront the more fundamental challenge of integrating debt relief into a coherent resource mobilisation strategy for realising the Millennium Development Goals.

HIV/AIDS is one factor that demands a fundamental reform of the Enhanced HIPC Initiative. When the Initiative was designed, the full scale of the threat posed by that crisis was not widely appreciated. As new assessments emerge of the costs of containing and rolling back the epidemic through public action and public investment in health, education, and measures to protect the vulnerable, it is increasingly clear that current levels of debt relief are hopelessly inadequate. Governments seeking to grapple with the daunting task of addressing the needs of this generation and protecting the next, are handicapped by unsupportable – and indefensible – debt burdens. Can there be any justification for a policy that leaves governments in some of the countries worst affected by HIV/AIDS diverting more than 10 per cent of government revenue to external creditors?

In a civilised international community, the answer to that question must surely be no. What is needed is a bold new strategy, which should include the following elements:

1 **Assessing the financing implications of HIV/AIDS for the Millennium Development Goals.** All HIPCs need to assess the financing implications of HIV/AIDS for the attainment of the

human development goals. These financial assessments should inform evaluations of debt sustainability and levels of debt relief provided. As part of the PRSP process, all countries should cost their national AIDS plans, identify the financing gaps that could be filled through debt relief and other measures, and ensure that financing provisions are reflected in national budgets and medium-term expenditure frameworks.

2 **Deepening debt relief.** Current debt sustainability indicators suffer from two problems: they are tangentially related to resource mobilisation for poverty-reduction goals, and they are not sufficiently generous. An upper ceiling of five per cent should be set on the proportion of government revenue allocated to debt servicing. Such a limit would have mobilised an additional $1.6bn in the 26 countries currently receiving Enhanced HIPC debt relief. While this implies real costs for creditors, these costs represent less than three per cent of existing aid flows. The human costs of continuing with business as usual are beyond estimation.

3 **Broadening debt relief.** There is a strong case for broadening debt relief in response to the threat posed by HIV/AIDS and wider poverty-reduction challenges. For instance, both Kenya and Angola have been deemed 'sustainable debt' cases under the existing framework, and Nigeria is not covered. The limitations of the HIPC Initiative have been further exposed by private capital market crises. Indonesia – the world's fourth most populous country – has been allocating more than one-fifth of government revenue to debt servicing since the 1997 financial crisis, rising to over one-third in some years. No effective debt-relief mechanisms exist (despite the fact that Indonesia has a lower per capita income than Honduras, which is eligible for HIPC debt relief). This has hampered social and economic recovery. It has also undermined efforts to curtail HIV/AIDS. After more than a decade with negligible rates of HIV, the country is now seeing infection rates increase rapidly. There is an urgent need for the international community to look beyond the confines of the HIPC Initiative to provide effective protection from the claims of private capital market creditors, including negotiated debt write-offs and standstill agreements.

4 **Recruiting new gatekeepers.** The IMF and the World Bank, with the former first among equals, remain the gatekeepers to entry into the HIPC Initiative, and the arbiters of compliance with conditions during the interim debt-relief period. There is little evidence that the IMF in particular prioritises approaches to public spending aimed at achieving poverty-reduction goals. This

suggests a strong case for the involvement of other agencies, including specialised UN bodies.

5 **Strengthening and democratising Poverty Reduction Strategy Papers (PRSPs).** Most PRSPs provide little more than cursory treatment of the links between HIV/AIDS and poverty, and few set out clear estimates of the resource implications of responding to the crisis. Such estimates would help to clarify debt relief and aid needs. More generally, there is a need for a renewed emphasis on costing poverty-reduction goals, and on creating effective public expenditure management systems. Civil society could – and should – make an important contribution to debates on the use of debt relief to support HIV/AIDS strategies and wider poverty-reduction efforts.

6 **Implementing an Education for All action plan.** Increased public investment in education is urgently needed in HIPCs both to absorb the costs associated with HIV/AIDS, and to support effective preventative work. In April 2002, finance and development ministers from rich countries finally agreed to support an action plan aimed at getting all children into school by 2015. Implementation will require $4bn a year, but no financing deal has yet been agreed. This should be seen as a key element in the HIV/AIDS strategy.

Conclusion

It goes without saying that increased and more effective debt relief is just one part of a wider strategy for resource mobilisation. It is not a substitute for more decisive action by the international community. The new Global Fund to Fight AIDS, Tuberculosis and Malaria must be properly resourced and managed to support the development of health systems capable of responding to the crisis. Building capacity for appropriate service provision is as important as transferring money.

At the same time, more has to be done to bring down the prices of anti-retroviral drugs, along with drugs for treating secondary infections and poverty-related diseases such as respiratory tract infection. An imminent danger in this context is the implementation of the WTO intellectual property agreement (TRIPS). When applied to developing countries, the more stringent patent protection it provides for will artificially raise prices for vital medicines, bringing new pressures to bear on public health and household budgets. There is little merit in generating new resources through debt relief with one hand, and then absorbing these resources by inflating drugs

prices with the other. This is an area in which the health needs of vulnerable people must take precedence over corporate-led demands for inappropriate patent systems.

Reform of the Enhanced HIPC Initiative is one part of a wider jigsaw – but it is an important part. Without reform, there is little prospect of governments in some of the world's poorest countries responding effectively to a threat of unprecedented magnitude. The HIV/AIDS crisis will continue to roll back the development gains of the past and jeopardise the hopes of future generations. In financial terms, radical reform is easily affordable. In human terms, the alternative is unthinkable.

Notes

[1] As of late March 2002

[2] Estimates from various research exercises suggest that a one per cent increase in per capita income growth is typically associated with a decline in income poverty of 0.3 per cent to 0.9 per cent, depending on the distribution of income. The figure in the text is derived by using these parameters and the 1998 poverty headcount figure for Africa of 291 million.

[3] This is supposed to set out a broad strategy for achieving agreed poverty-reduction goals, including financing provisions.

[4] For very open economies, the ratio of debt to government revenues can also be taken into account, but the eligibility criteria for this window make it the exception to the rule.

Figure 1: Percentage of population with HIV/AIDS: selected Heavily Indebted Countries (2001/02)

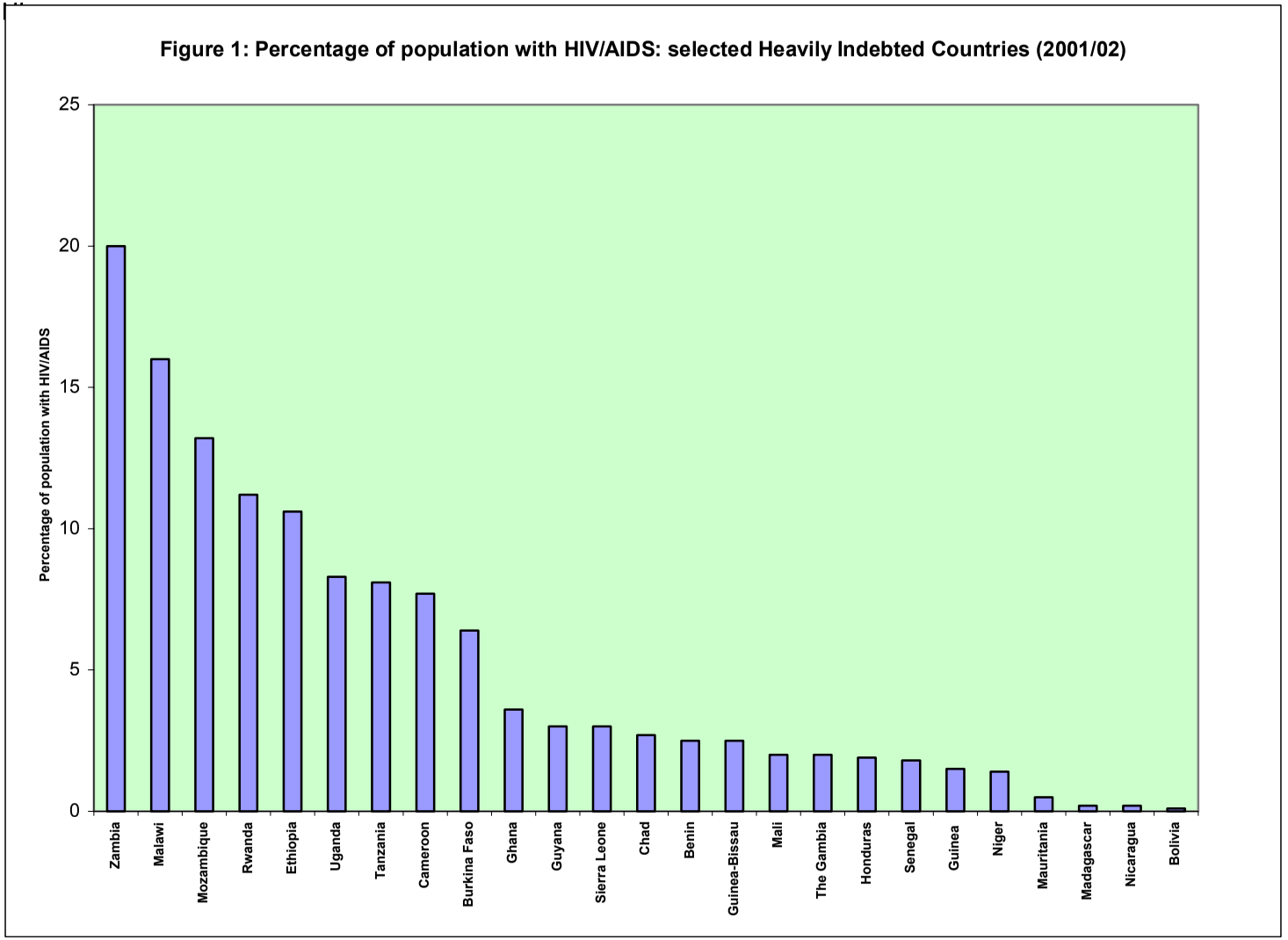


Figure 2: Debt service as a percentage of government revenue in 26 Heavily Indebted Poor Countries (HIPCs): 2001 (actual) and 2003/05 (projected average)

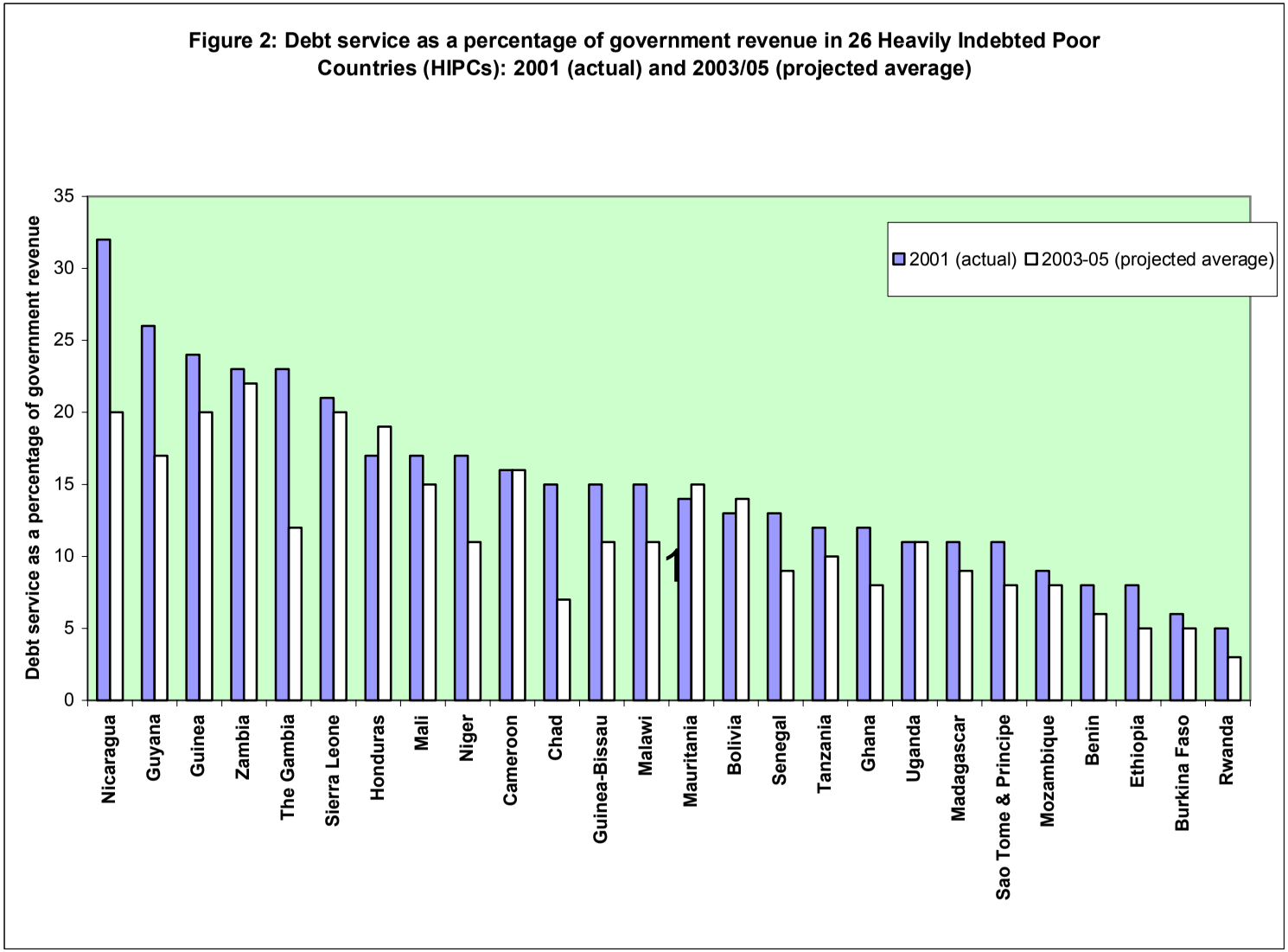
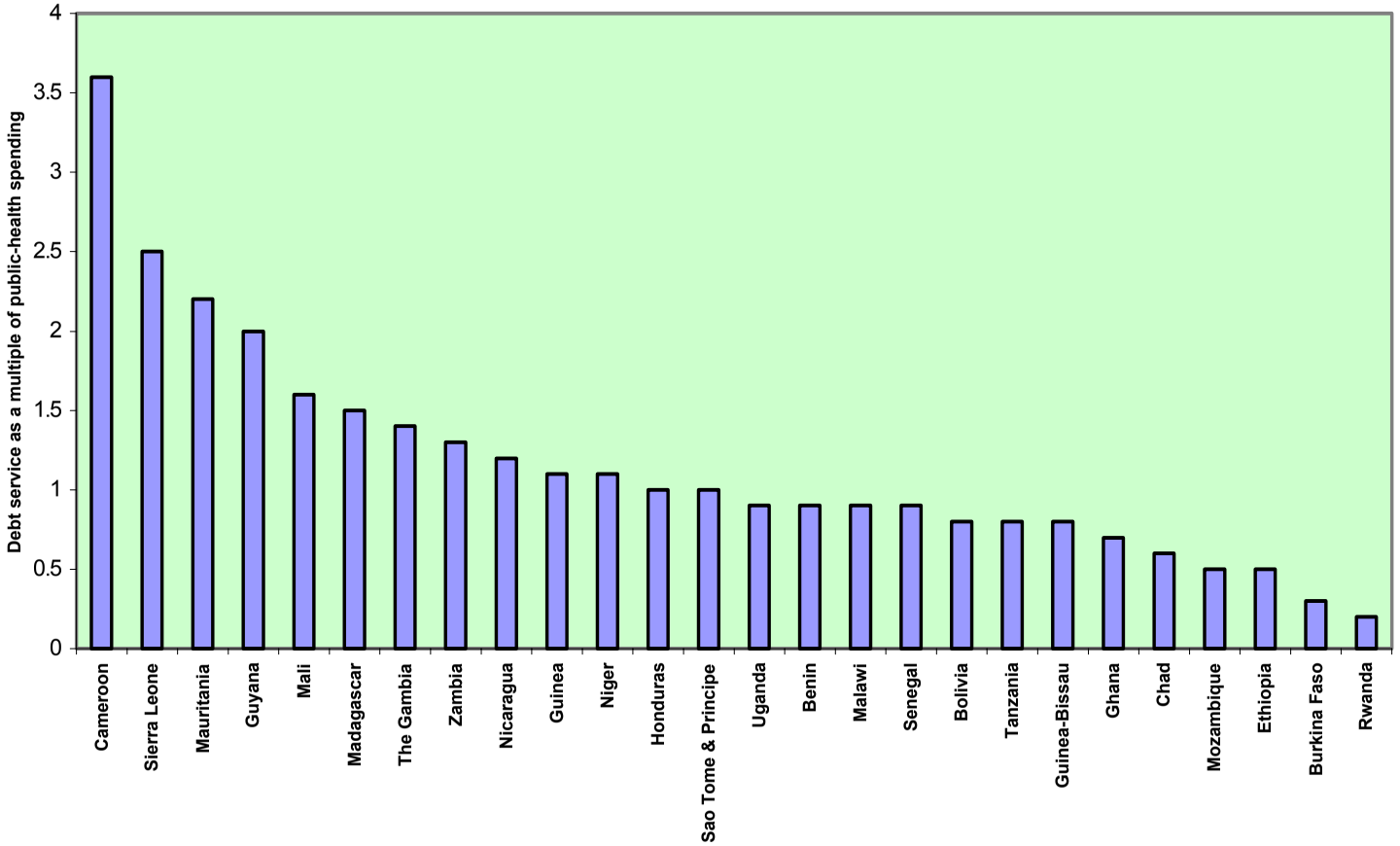


Figure 3: Debt service as a multiple of public-health spending: 26 Heavily Indebted Poor Countries (2001/02)



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