Chapter 26

From Aid to Accompaniment: Rules of the Road for Development Assistance

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Abstract

Foreign assistance needs new rules of the road. Traditional aid modalities have proven too often inefficient and inequitable. This chapter proposes an *accompaniment* approach in which international development agencies transfer more resources and authority to the national and local institutions of their intended beneficiaries in the form of lasting partnerships. We identify eight principles of accompaniment: (1) support institutions that the poor identify as representing their interests; (2) when possible, fund public institutions to do their job; (3) make job creation a benchmark of success; (4) buy and hire locally; (5) co-invest with governments to build strong workforces and civil services; (6) work with governments to provide capital to the poor; (7) support regulation of non-state service providers; and (8) apply evidence-based standards of care. We consider each of these principles, giving “real world” examples, and suggest the accompaniment approach as a compelling way to help the poor break the cycle of poverty and disease.
Key Points

- Current aid modalities are beset by problems; funds do not reach their intended beneficiaries, initiatives are fragmented and inefficient, and local institutions are often excluded.
- Failures of policy and foreign aid are often failures of implementation.
- Donors cite corruption and lack of absorptive capacity as two reasons why they are reluctant to invest directly in governments.
- Such reluctance can be a self-fulfilling prophecy: by bypassing local and national institutions, aid efforts at best miss an opportunity to shore up systems of accountability and efficient, equitable delivery, and at worst undermine the very systems they seek to help.
- Accompaniment, based on the eight principles discussed in this chapter, offers an alternate approach that seeks to bolster local and national capacity through long-term partnerships.
- By guiding interventions to address both the biological and social determinants of health, an accompaniment approach can help break the cycle of poverty and disease.

Key Policy Implications

- Donors and aid policy-makers should put a premium on identifying and overcoming barriers to the delivery of health and development programs.
- To minimize the unintended and sometimes harmful consequences of foreign aid – including internal brain drain, weakened public-sector capacity, and patchy service delivery – donors should design aid programs within national priorities and in close consultation with national priorities while building meaningful partnerships with local organizations.
- Employing the principles of accompaniment will require lengthening donor timelines – deliverables, measurements, and outcomes should be defined in terms of longer term priorities such as building efficient and equitable systems of healthcare delivery.
- Donors should re-evaluate their incentive structures to reward staff for their commitment to localized aid.
Introduction

In her chapter, "A Rights-Based Approach To Global Health Policy," Lisa Forman outlines the landscape of human rights and global health policy (see Chapter 25). A rights-based approach begins with the assertion that access to healthcare is a human right, and then designs health programs and health systems accordingly. Realizing the right to healthcare within a population usually means, in practice, a concern for distributive justice for the poor, who are most commonly denied the fruits of modern medicine and public health (Farmer 2008). It also often means tackling large-scale social forces – the “social determinants of health” – that pattern the burden of disease and access to care around the globe. Poverty and inequality are among the strongest predictors of ill health in developing and developed countries alike. The heavy burden of disease in vulnerable populations often perpetuates poverty: one study examining why households in rural India, Uganda, and elsewhere fall into poverty found that ill health was the leading cause of impoverishment (Krishna 2010). Another study found that, among Zambian households that lost their breadwinners to AIDS, two thirds suffered precipitous economic decline (Nampanya-Serpell 2000; UN Development Programme 2002).

Human rights declarations, such as the 1948 Universal Declaration of Human Rights, create standards to which all societies and nation-states can and should aspire. In practice, however, rights declarations are enforced more fully when accompanied by the provision of services and the protection of freedoms. Who sought to protect such rights? In the absence of effective systems of policing human rights abuses, transnational public–private partnerships can help provide certain services (such as healthcare). Such partnerships, and the financial resources that undergird them, begin at the policy-makers’ table. Public policy can serve as a bridge between principles, such as healthcare as a human right, and practice. At the global level, for example, the President’s Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (the Global Fund) have together put more than 7 million people with HIV/AIDS on antiretroviral treatment (Joint UN Programme on HIV/AIDS 2010). At country level, in Rwanda, pro-poor policy-making has helped scale up access to HIV/AIDS treatment and care. In 2003, fewer than 500 people with HIV/AIDS had access to treatment in both the public and private sectors; as of November 2011, Rwanda’s public-sector health system provided care and treatment to nearly 100,000 people with the disease (Ministry of Health, Rwanda 2011).

On the other hand, policies can at times also unwittingly perpetuate inequities in access to healthcare, education, and other entitlements deemed as human rights. Structural Adjustment Programs, peddled by the International Monetary Fund and World Bank in the 1980s and 1990s, offered credit to developing country governments if they made market-based reforms, including cutting social sector spending. Structural adjustment sought to make health systems – and debt-ridden governments, in general – more efficient by shifting the burden of delivering healthcare onto private providers. In a number of countries, however, this policy inadvertently undermined access to care among poor populations, who can rarely afford to pay for health services (Kim et al. 2000). Furthermore, in most countries, such policies had little success in stimulating economic growth; some studies have documented a net outflow of resources from Africa during the structural adjustment era (Scoepf et al. 2000). Effects of these policies – run-down health infrastructure, thin public-sector health workforces – linger today. Policy failures in global health and development are perhaps more common at the country level (Case Study 26.1).
**Case Study 26.1 Policy Failure in Global Development: The Case of Haiti**

Haiti's history is rich with examples of development policy failures. The Peligre Dam, built on the Artibonite River in Haiti's Central Plateau in the 1950s, was hailed as a landmark development project; it was, at the time, the largest buttress dam in the world. But, with little warning, the project displaced thousands of people living upstream, most of whom later gathered in a squalor settlement on higher, less arable land where it was more difficult to farm and make a living (Farmer 1992). Impoverishment and ill health became the norm. Meanwhile, the region's residents did not receive electricity from the dam until the 1990s. (It primarily powered elite neighborhoods in the capital city, Port-au-Prince.)

And we need not look back to the 1950s for examples of policy failures in Haiti. Despite some US$4.01 billion of official development assistance (ODA) allocated after the January 2010 earthquake – in addition to another $2.4 billion in humanitarian aid – only 10% of the total $6.4 billion was provided directly to the Haitian authorities (UN OSE 2012).

It is easy to produce a list of grievances with development assistance (the "aid debate" is discussed in Chapter 20), which in total increased from US$54 billion to $129 billion from 2000 to 2010 (Elliott 2011: 8). A growing literature – what one commentator called "the groaning bookshelf" (Gourévitch 2010) – critiques the machinery of foreign aid, and calls for substantial reform. The current system often fails to effectively deliver resources and services to its intended beneficiaries, much less stimulate economic growth. During the famine in Darfur and Ethiopia in the 1980s, well-funded international relief efforts only met 10–12% of victims' basic needs (de Waal 1991). Few low-income, fragile, or conflict-affected countries, which are together home to 1.5 billion people, have achieved any of the United Nations (UN) Millennium Development Goals (MDGs) despite more than $50 billion in development assistance annually since 2000 (UN Development Programme 2010). Consumed by large overhead expenses of aid agencies, which sometimes spend more on salaries and transport costs than on the delivery of services – too little aid money reaches its target recipients (Bolton 2008; Easterly and Pfitzner 2008: 19).

Fragmentation of aid at the country- and sector-level further impairs overall aid effectiveness (High Level Forum on Harmonization 2003). Awarding aid contracts to foreign companies and non-governmental organizations (NGOs) – the status quo in the business of aid – can unwittingly undermine public-sector service delivery. In the health sector, for example, NGOs often offer higher salaries than their public-sector counterparts, thereby pulling health professionals from beleaguered public hospitals and clinics; without coordination, such efforts are unlikely to provide health services equitably and efficiently (Killick 2004). In fragile states, about 80% of development assistance bypasses government systems (UN OSE 2012), and only about 4% of goods and services are procured locally (OECD 2011a: 11–17; UN OSE 2012).

Most of these failings of foreign assistance hamper the effectiveness of global health aid in particular. Even during the past decade of expanding global health budgets and successful programs to combat major infectious diseases, most low-income countries lack healthcare systems capable of delivering quality and timely care to all those who need it. Poor coordination is a particularly intractable problem in global health. Foreign support
is often earmarked for specific diseases deemed priorities by donors, which may not reflect the true burden of disease in a particular context. Unless different disease-specific initiatives are integrated, they often have little effect on overall health system strengthening (see Chapters 23, 24) (WHO 2004). Disjointed efforts are wasteful and usually inequitable. Maternal and child health, the focus of MDGs 4 and 5, has been one casualty of inefficacious global health aid: 27 countries made little or no progress in reducing childhood deaths between 1990 and 2006 (UN 2008), not to mention building or rebuilding health systems.

From Aid to Accompaniment

Better aid policies — new rules of the road — might strengthen health systems in developing countries. Raising the standard of care in resource-poor settings requires shoring up derelict health infrastructure, improving supply chains, and expanding training programs for doctors, nurses, community health workers, and other health personnel. It also requires tackling the social determinants of health, including poverty, inequality, lack of access to clean water and healthful foods, and environmental risk factors.

But better policy will do little on its own. Most policies are not bad policies. The problem is delivery: providing services and opportunities — safeguarding rights — to those who need them most. In this chapter, we contend that the greatest failures of policy and foreign assistance usually result from failures of delivery. An accompaniment approach, we suggest, offers some degree of insurance against such failures.

In a mundane sense, accompaniment means walking alongside another. As an approach to global health and development policy, it signifies a perhaps more humble and certainly more long-term mode of foreign “assistance” and “aid”: supporting the poor on the road toward well-being, prosperity, peace, and — indeed — aid independence. It begins with listening to and learning from one’s intended beneficiaries, and working alongside them until they deem a task completed. Accompaniment is thus both a strategy and a basic orientation to the business of foreign assistance. The following eight principles sketch how aid might move toward accompaniment.

**Principle 1: Support Institutions that the Poor Identify as Representing their Interests**

The poor endure the local aid context and have learned from it; they have watched past development projects succeed or fail. They often know which development opportunities exist, and what combination of institutions — public and private, local and international — will be more likely to deliver aid effectively (Farmer and Gastineau Campos 2003). Accompaniment hinges on finding good partners, and the poor are necessary consultants for that task. Donors and foreign aid outfits should therefore work closely with their national counterparts and intended beneficiaries well before formulating policies and writing contracts.

**Principle 2: When Possible, Fund Public Institutions to do their Job**

In Haiti, Rwanda, and elsewhere, we have found that many of the world’s poorest people see the provision of basic services as a responsibility of the government. After the 2010
earthquake in Haiti, during a project called “Voices of the Voiceless,” interviewers fanned out across the country to ask the rural and urban poor about the country’s reconstruction and development strategy. To the best of our knowledge, this was one of the few attempts to bring the perspectives of the poor to bear on policy discussions about Haiti’s future after the earthquake. Not surprisingly, respondents expressed concern that the recovery effort was detached from the needs and interests of the poor majority (Farmer 2011). They also called on “trustworthy authorities” to manage aid responsibly and for “the state to be the state” (Farmer 2011). Although the rural and urban poor experience firsthand the failure of the Haitian government to provide basic services to its citizens, they still called for public-sector programs to improve healthcare, education, and employment opportunities. We have observed similar expectations about the role of the government in global health and development in Rwanda, Peru, Russia, and elsewhere.

There is growing consensus among official circles that if health systems are to reach the poor on a large scale and over the long term, governments must play a leading role. The 2005 Paris Declaration on Aid Effectiveness and the 2008 Accra Agenda for Action, which have been signed by over 160 nations and international organizations (including a number of major funders of foreign aid initiatives), both outlined a significant role for the public sector in managing health and development assistance (OECD 2008b).

Why support public institutions in global health and development work? First, governments are the only institutions capable of enshrining – and providing – healthcare as a right, as opposed to a commodity. International covenants such as the Universal Declaration of Human Rights might declare a right to healthcare in principle, but they do little in the way of delivering health services. Only governments can guarantee that all of their citizens, especially the poor and otherwise vulnerable, have access to the healthcare necessary to live full lives in good health. Most private health systems, which treat healthcare as a commodity that is bought and sold, are beset by market failures in resource-poor settings. When private providers lack consumers – the status quo in impoverished places where few can afford to pay for health services – they almost always relocate to markets capable of recouping costs (Pogge 2005; Sachs 2005). This relocation explains the concentration of private providers in wealthy, urban areas, and the absence of private providers in poor, rural areas. Whenever healthcare is rationed by the price mechanism of the market – as a commodity, not a right – poor people will, by definition, fall through the cracks.

Second, governments are more accountable to their citizens than are non-state healthcare providers. NGOs, for example, are dependent on and accountable to their funders. If a major donor withdraws support for HIV/AIDS programs that provide contraceptives to commercial sex workers, NGOs may be forced to cut such services, even if the population they serve will be worse off as a result. PEPFAR, for example, does not in principle support programs that engage with commercial sex workers, who are highly vulnerable to HIV infection. This policy reflects domestic political pressures in the United States that construe, or misconstrue, sex work not as a product of structural violence – poverty, gender disparities, urbanization – but of choice (Dietrich 2007; Piot et al. 2009; Charumilind et al. 2011). Governments, on the other hand, are less vulnerable to the whims of donors; they can design programs according to evidence and local needs instead of the fads du jour of global health. They are therefore charged with providing a broad scope of health services instead of specific interventions supported by donors. Governments are also expected to provide services for their citizens over the long term, beyond the ebb and flow of donor or foreign aid. They are thus often more sustainable than private-sector efforts.
Moreover, governments are often best positioned to provide services on a large, or indeed national, scale, such that vulnerable populations including the rural poor are not left out. There are latent economies of scale in healthcare delivery (Porter and Teisberg 2006; Porter 2009, 2010): based on our experiences, the best health systems are community-based, clinic-enriched, and hospital-linked. Building such tiered networks of care demands a robust supply chain, an efficient flow of resources and personnel, and swift referral capacity. Efforts to strengthen each component of an effective health system are synergistic when brought to scale (Porter 2010). Governments, by dint of their national mandate, are poised to harness these efficiencies.

Finally, governments can coordinate and integrate the efforts of diverse health providers to ensure that care is delivered efficiently and equitably throughout a given country. Without nationwide delivery strategies, private-sector healthcare providers often cluster in wealthy urban areas, as noted, and forfeit the economies of scale that come with collaboration. For example, thousands of NGOs work in Haiti; with better coordination, as Prime Minister Laurent Lamothe called for, such efforts might amount to more than the sum of their parts (Bolstad and Charles 2012). By integrating public and private healthcare efforts, governments can foster more efficient and equitable health systems.

Nonetheless, the status quo in the business of foreign aid remains: priority is given to foreign contractors and NGOs. In 2010, only 10% of aid to fragile states was channeled as general budget support; the rest bypassed public systems (UN OSE 2012). In addition to forfeiting advantages of partnering with the public sector, relying exclusively on private institutions as partners in global health and development work can unwittingly undermine public-sector capacity. As noted by economist Paul Collier and others, the proliferation of NGOs in a number of poor countries has effectively drained the public sector of resources and skilled personnel (Collier 2007: 99–123). Well-trained doctors often choose to work for NGOs because they offer higher salaries than do public-sector facilities. Parallel public and private delivery systems are difficult to coordinate and thus often lead to patchy access to care, especially among the poor.

Why do foreign aid agencies tend to eschew working with governments in developing countries? In the 1970s, development agencies and international banks often made loans to poor countries in support of anti-poverty programs. When dozens of countries defaulted on their debt in the early 1980s, however, the development discourse changed its tune. Structural adjustment – austerity, privatization, liberalization – became the order of the day; such underlying skepticism toward developing-country governments is detectable to this day. Meanwhile, stories of excessive spending and corruption were (and are) common. According to economist Bill Easterly, 41% of the government revenue of Paul Biya, President of Cameroon since 1982, is siphoned off from foreign aid (Easterly 2006: 157). In addition to ineptitude and corruption, two more often-cited reasons for donors’ reluctance to invest directly in governments are the lack of “absorptive capacity” – the infrastructure and personnel to utilize donated resources efficiently – and the uncertainty of political cycles (ODI 2004).

However, based on the experiences of a growing number of organizations that have adopted an accompaniment approach, such concerns are exaggerated, and the benefits of working in the public sector outweigh the real and imagined costs. For example, Partners In Health has for 25 years been working to provide high-quality health services to the destitute sick in Haiti’s rural reaches; today, the organization also works in a dozen other countries, including Peru, Rwanda, Lesotho, Kazakhstan, and the United States. In almost every setting, excellent public-sector partners are found – especially at the district level – with whom ranking health challenges, from HIV/AIDS to cancer to maternal health are
tackled, while also seeking to strengthen health systems in general (Walton et al. 2004). Donors concerned with corruption or lack of capacity among recipient governments often fuel a self-fulfilling prophecy. The best way to build capacity and combat corruption, we have found, is to support the development of systems of accountability and transparency—in a word, accompaniment.

What does accompaniment look like in practice? One example is the General Hospital in Port-au-Prince, Haiti. The hospital is charged with probably the largest patient load in the country, but it has too few resources and medical personnel to keep up with demand. Its staff was small and underpaid even before the January 2010 earthquake; afterward, it was overrun with patients requiring acute medical attention. Though scores of international teams worked on the General Hospital campus, providing acute care and essential surgical services, they sometimes competed for space and control over hospital facilities. Few had much interest in trying to improve the quality of care offered by the struggling public-sector hospital over the long term. When most disaster relief teams packed their bags, the hospital was still overrun, its staff still underpaid.

Our teams tried to bring together a number of international partners interested in traveling the longer road of reconstruction—in this case, helping rebuild the General Hospital. The American Red Cross agreed to send $3.8 million in “performance-based” salary support for the hospital’s beleaguered employees. This work has been difficult and slow: Haitian institutions often lack the infrastructure of transparency and platforms for evaluation (electricity, modern bookkeeping, accountants, computers) demanded by western accountability norms. But only an accompaniment approach will help develop such platforms and put them under the control of the intended beneficiaries. The Red Cross collaboration soon bore fruit: today, staff members are better paid and accountability platforms are taking root. We have come to believe that this kind of accompaniment—partnering with Haitian institutions and working through whatever obstacles present themselves—is among the best ways to help address the structural deficits preventing Haiti from rebuilding better.

Accompaniment has, in recent years, gained some traction in the business of official development assistance (ODA). General budget support has been found to reduce transaction costs associated with foreign assistance and to improve coherence of planning and delivery (OECD 2011b). According to a report by the Overseas Development Institute, for example, general budget support to the Tanzanian government enhanced its ability to coordinate ongoing foreign aid initiatives and increased the proportion of new external funds subject to the national budget process (ODI 2005). One analysis by the Organisation for Economic Co-operation and Development (OECD) concludes that even countries with low-quality public financial management systems can make good use of donor funds, so long as partner governments are committed to improving the quality of such systems (OECD 2006). In most cases, budget support has been shown to improve the efficiency and transparency of ministries of finance in managing national budgets and disbursing funds (IDD and Associates 2006: 55–69; DeRenzio et al. 2010; Williamson and Dom 2010: 78). As was the case in Port-au-Prince’s General Hospital, directing funds through national systems can strengthen the accounting capacity of national institutions, as well as the role of audit institutions (IDD and Associates 2006; Williamson and Dom 2010: 93; OECD 2011c).

Despite the observed effectiveness of direct budget support, there are still challenges to improving public financial management systems, including underdeveloped national capacity, corruption, and lack of political will. Technical assistance, which in an
accompanyment framework means helping develop such management systems and train personnel to use them, can increase the efficacy of budget support in settings that lack public financial management capacity (Caputo et al. 2011). Corruption is a much-cited concern among donors and foreign aid officials. But donors are, in fact, inconsistent about factoring it into decisions about aid allocation. There is almost no correlation between the quality of a country’s public financial management systems and the amount of aid channeled through those systems (OECD 2010a). For example, among five countries with equally low ratings for the quality of public financial management – Guinea-Bissau, Liberia, Madagascar, Nepal, and the Solomon Islands – there is considerable fluctuation in the percentage of aid directed through their country systems (OECD 2011d: 117–25). In 25 countries with only a moderate public financial management rating, donors channeled anywhere from 3% to 79% of aid through those systems (OECD 2011d).

Moreover, two donor-led evaluations have concluded that budget support is subject to comparable losses (to corruption and mismanagement) as other types of “tightly controlled” aid (Wood et al. 2011). In fact, a recent evaluation by the UK Department for International Development (DFID) found only marginal inefficiencies among public-sector partnerships: of more than £600 million in budget support in each of the last two fiscal years, it estimated losses of less than 0.016% of total spending (£96,000) (DFID 2011a; House of Commons 2011). This figure pales in comparison to the overhead costs of the great majority of aid contractors and NGOs. For example, in 2010 one international NGO, the British Red Cross, spent more than £40 million – 20% of its annual expenditures – on fundraising alone (British Red Cross 2012).

In addition to strengthening public-sector capacity, channeling development assistance through country systems almost always increases the funding available for state institutions to provide services (Williamson and Dom 2010; Wood et al. 2011). In two separate evaluations of direct budget support in a total of 15 countries, 12 of the recipient governments had increased spending in priority social sectors (National Audit Office (UK) 2008: 12; Williamson and Dom 2010). This increase was especially true in the health and education sectors; in one country case of Ethiopia, domestic spending doubled over a two-year timeframe (National Audit Office (UK) 2008). The same evaluation also found that access to social services was twice as likely to increase in countries that received budget support from DFID (National Audit Office (UK) 2008). These results are largely echoed by evaluations conducted by the World Bank, the OECD, and the Overseas Development Institute (Booth et al. 2005; IDD and Associates 2006; Lawson et al. 2007; de Kemp et al. 2011; OECD 2011c).

All that said, in some cases governments simply lack the capacity or will to provide services for their citizens. After the 2010 Haiti earthquake damaged or destroyed 28 out of 29 federal ministries, what was left of the government operated out of makeshift offices and trailers. The government clearly lacked capacity to respond to the enormous need on its own, and the surge of international humanitarian assistance almost exclusively supported NGOs and private relief and rescue efforts. In fact, only 0.9% of the $2.4 billion in post-earthquake humanitarian aid went through government channels (UN OSE 2011). This figure is almost certainly too low. How can international organizations hope to help rebuild public-sector capacity in a place like Haiti if the government is starved of resources? Nonetheless this example highlights how, in certain circumstances, governments may simply be unable to partner with international aid groups. In such circumstances, local NGOs and other private-sector initiatives are often the best available partners for global health work (Case Study 26.2).
Case Study 26.2 Partnering with Local NGOs: An Example in Chiapas, Mexico

In Chiapas, Mexico, indigenous populations have long faced discrimination, political violence, poverty, and poor health conditions. Although Partners in Health usually partners with government ministries of health, in Chiapas they have worked with a group of health promoters, Equipo de Apoyo en Salud y Educación Comunitaria (EAPSEC, Spanish for “Team for the Support of Community Health and Education”). EAPSEC, which serves marginalized communities, was established in 1985 by a group of Mexican health promoters. After first working with Guatemalan refugee communities in the Chiapas border region, EAPSEC later expanded throughout other marginalized communities in the region. This collaboration was suggested by the leaders of the indigenous communities; they asked Partners in Health to work there in 1989. In collaboration with EAPSEC, they have helped develop a network of mobile clinics to provide health education, prevention, and treatment services to some of the poorest communities in Chiapas. They have also supported efforts to use cell phones and other mobile technologies to improve healthcare delivery (Blaya et al. 2010). In recent years, EAPSEC and Partners in Health have in fact begun to explore a new partnership with the Ministry of Health. Their experiences working in Mexico underscore that even when working with governments is not initially feasible, it may become so over time. An accompaniment approach entails the flexibility to reassess and adapt programs to a changing context.

Principle 3: Make Job Creation a Benchmark of Success

In all sectors of development – health, education, environment, energy, infrastructure, trade, and finance, to name just a few – donors, policy-makers, and practitioners should prioritize local job creation and transfer of capacity. Lower indices of employment almost always correlate with stagnant poverty, even in fast-growing economies (OECD 2008a). In addition to helping individuals and families achieve autonomy and basic well-being, jobs confer dignity, self-worth, and opportunities to pursue professional development. Job creation can also boost demand and stimulate local economies. As workers earning a living wage spend money on local goods and services, the return on their employment extends from the household to the community to the local and national economy. According to the International Labour Organization, each additional Euro of worker income leads to a multiplier effect of 1.5 to 2.8 in low-income countries (Ellmers 2011). Moreover, job creation expands the national tax base, enabling governments to provide higher quality social services, improve infrastructure, and to create incentives for pro-poor development (OECD 2006). A formal tax structure can also enhance government accountability.

Yet far more people are unemployed now than in recent history (ILO 2010a, 2010b). According to the International Labour Organization, the number of unemployed people globally increased from 185 million in 2008 to over 210 million in 2009 (ILO 2010a). Moreover, among the poor who are employed, an estimated 1.5 billion people – about half the world’s workforce – have jobs in the informal sector (ILO 2010b). More than a billion people live on less than $1.25 per day.

Nonetheless, few donor agencies embrace job creation. Based on publicly available online information, the 10 biggest donors in the global development sphere (Canada, the
European Union, France, Germany, Japan, the Netherlands, Spain, the United Kingdom, the United States, and the World Bank) make little reference to jobs as a strategic priority. One example of a donor program that does prioritize job creation is the UN World Food Program’s innovative Purchase for Progress (P4P) program, which recognizes the power of food aid to promote employment and broaden access to domestic markets among the world’s poorest farmers. A five-year pilot program launched in 2008, Purchase for Progress initiates purchasing contracts with smallholder farmers while also training them in modern farming techniques.

Among the best ways to boost employment in developing countries is to foster a favorable business environment that will attract investment and private enterprise (OECD 2006). But in many developing countries, strict regulations and tax burdens, unfair competition practices, and lack of financial or planning services dampen the vitality of the private sector. In particular, developing world markets often suffer from a lack of competitiveness, without which they rarely serve the interests of the poor. One study found that 16 international cartels overcharged developing countries between $16 billion and $32 billion in 1997; prices fell by 20–40% following the break-up of the cartels (OECD 2006). Donors and foreign aid groups can work with governments and other stakeholders to reduce tax and regulatory burdens, provide financial and business development services, promote fair competition policy, and formulate other policies that are both business-friendly and pro-poor.

**Principle 4: Buy and Hire Locally**

Almost half of all ODA—which totaled $150 billion in 2010—is spent on the acquisition of goods and services (Elliots 2011). The scale of such procurement offers a substantial opportunity to boost aggregate demand, manufacturing capacity, and workforce development of beneficiary countries. Yet most foreign aid projects procure goods and services from donor countries (Wood et al. 2011). In a questionnaire on contracts awarded in 2009, OECD donors reported that out of $8.64 billion awarded through 4488 contracts, 58% of funding went to firms in OECD donor countries, 38% to firms in developing countries, and only 4% to firms in least developed countries (OECD 2011a). That same year, 89% of the United States’ aid contracts for least developed countries and heavily indebted poor countries were in fact won by US suppliers (OECD 2011e). A year and a half after the 2010 Haiti earthquake, only 2.4% of reconstruction contracts issued by bilateral donors had been awarded to Haitian firms (UN OSE 2011).

At best, failure to buy and hire locally misses an opportunity to stimulate local development; at worst, it can weaken local economies (by importing goods and services at artificially low prices). Some have argued that such “tied” aid—where all goods and services must be procured within the donor country—devalues foreign assistance by one quarter, hinders job creation, and undermines long-term growth (Killick 2004: 20). Alternatively, by buying goods and services within the recipient country, donors can increase the value of every aid dollar by creating jobs and bolstering local economics. Since the Paris Declaration and Accra Agenda, donors have begun to do more in the way of local procurement and hiring.

The P4P program showcases many of the benefits of buying and hiring locally. Instead of distorting (or damaging) agriculture in recipient nations by flooding markets with cheap or free food, P4P’s local procurement strategies have boosted demand for the produce of the world’s poorest farmers while also providing training in farming
techniques, quality control, and post-harvest handling. This approach has also led to a substantial savings; by some estimates, P4P saved $22.6 million in procurement and transportation costs in 2010 (World Food Programme 2011).

A similar initiative has borne fruit in Haiti, where as many as half of school-aged children live with food insecurity. One remedy for acute malnutrition is known as ready-to-use therapeutic food (RUTF), such as nutrient-enriched peanut paste (Defourny 2007). Instead of buying this paste from a company based in France or any other country, Partners In Health has for years made its own RUTF using mostly locally procured ingredients. The paste proved effective in treating moderate and severe malnutrition, and a more reliable market for peanuts helped local farmers. In the last few years, specialists from a US pharmaceutical company and Haitian agronomists have helped to expand this effort by building a larger scale food-processing facility. This initiative will not only provide treatment for all children diagnosed with acute malnutrition in the region, but also provide many jobs and use, whenever possible, locally procured ingredients. It ends up, therefore, being accompaniment not only for malnourished children and their families, but also for local farmers and all those seeking to improve food-processing capacity in rural Haiti.

There are many other examples of the promise of buying and hiring locally. The cost of building a kilometer of road in Ghana or Vietnam is 30–40% less when built by a local company (ActionAid UK 2011: 33). After typhoon Ketsana hit the Philippines in 2009, the American Red Cross—with $500,000 in funding from the US Agency for International Development (USAID)—reportedly doubled the number of emergency sanitation and kitchen kits it distributed among affected families by buying supplies locally (American Red Cross 2010).

In recent years, some donors have adopted new approaches to achieving long-term sustainable development. Their focus has shifted towards increasing their levels of local investments and working with host governments to strengthen internal management and implementation capacity. USAID, for example, has committed, as part of USAID Forward—its agency-wide reform agenda launched in August 2010—to increasing, from 9.7% in financial year 2010 to 30% in financial year 2015, the share of its program funds that are disbursed directly to national and local partner governments, civil society organizations, and businesses (USAID 2013).

What are the barriers to widespread adoption of similar policies? Donors often point out that issuing more small contracts would likely increase administrative costs. But as untied aid increases the value of every aid dollar, such administrative inefficiencies—equally a product of bureaucracy and dated procedure—are surely worth the multiplier effects associated with buying and hiring locally.

Policies to untie aid, while necessary, are insufficient to boost local procurement. Other policy barriers limit the ability of businesses in beneficiary countries from winning procurement contracts, including donor eligibility criteria (which often demand extensive experience that only established contractors will have), access to credit, and coverage through insurance services. Accompaniment is premised on the accumulation of shared experience and capacity; instead of excluding those that fail to meet these criteria, donors and foreign aid groups can help local businesses gain access to credit and insurance. Small contracts might also better suit startups and young businesses in recipient countries. An analysis by the UN Office of the Special Envoy for Haiti (OSE), for example, found that local businesses have better chances of winning smaller aid contracts. Of the $270 million in contracts awarded by one multilateral donor since the earthquake, Haitian firms were awarded 32.7% (or $88.2 million) of them, including 211 out of 219 contracts valued
under $1 million and only one out of seven contracts valued over $5 million (UN OSE 2012).

**Principle 5: Co-invest with Governments to Build Strong Workforces and Civil Services**

Economic and human development in any country hinges on the strength of its civil service, including frontline service providers who have a direct impact on the health and welfare of the population. Workforce development, whether it is the health workforce or any other, requires platforms of transparent hiring and firing, including performance reviews, continuing training programs for civil servants, and the ability to conduct workforce needs assessments. But there is a severe shortage of civil servants and frontline service providers in most poor countries. A 2006 World Health Organization (WHO) report estimated that there was a shortage of 2.3 million doctors, nurses, and midwives in more than 57 developing countries (WHO 2006); an additional 10.3 million primary teachers are needed to ensure universal primary education (UNESCO Institute for Statistics 2007). Few would dispute that weak human resource capacity is among the most significant factors contributing to the poor quality of services provided by developing-country governments.

The high demand for skilled labor in wealthy countries — and the promise of higher wages — continues to fan the brain drain (when professionals from poor countries seek work in richer ones). Health systems in OECD countries have become especially reliant on professionals from lower income countries. Skilled jobs in the US health sector, for example, outnumber graduates of medical and nursing schools by about 5000 positions each year (Health Resources and Services Administration 2005: 5). Such demand has profound effects on the global supply of skilled labor. Another study estimated that the emigration of doctors (whose training had been publicly subsidized) represented a loss of more than $2 billion in nine sub-Saharan African countries (Mills et al. 2011). This loss was, of course, a windfall for wealthier nations, which saved $846 million to $2.7 billion in medical training costs (Mills et al. 2011).

Increasing public-sector salaries might help boost retention. In 10 out of 23 developing countries considered in one study, the average salaries of teachers and nurses were not far from the international poverty line (UNICEF 2010). In Haiti, public-sector workers are paid on average 40% less than private-sector workers of comparable skill levels (World Bank 2008: 9). Indeed, the 2011 Paris Declaration survey notes that artificially high wages offered at international organizations functions as a sizeable barrier to maintaining a strong civil service in many developing countries.

In addition to the global shortage of service providers, there are too few skilled civil servants in poor countries (Williamson and Dom 2010). Current aid models do not help. In 2010, only 3.1% of total ODA disbursed ($147.4 billion) was reported as being invested in strengthening civil servants’ capacity through education and training (OECD Working Party on Statistics 2011; OECD 2012). Instead, aid programs often erect parallel (if not competing) structures and provide “technical assistance” (usually an “expert” or two from donor nations) without helping develop robust training programs that can build in-country capacity (Bolton 2008). According to the World Development Report 2011, a quarter of all aid targeting government capacity in Afghanistan was spent on technical assistance, but the results are mixed (World Bank 2011: 196). Technical assistance is also costly: each full-time expatriate consultant costs about 200 times the average annual
salary of an Afghan civil servant (Waldman 2008: 19). In 2002, the cost of 700 international advisors to the Cambodian government was $50–70 million, just shy of the wage bill for the country’s entire 160,000-strong civil service (ActionAid International 2005: 22; Waldman 2008).

Investments in health infrastructure are urgently needed but must be matched with investments in training and workforce development in order to take advantage of improved infrastructure. In Mali, the number of community health centers increased from 605 to 993 between 2002 and 2009, yet the country has just 0.08 doctors for every 1000 people (WHO 2006).

Long-term development of the civil service and public-sector service delivery ultimately demands significant internal reform. Donors and foreign aid groups can contribute to this process by prioritizing training and workforce development. Rwanda offers one such example. Using designated international assistance from the World Bank, the Government of Rwanda launched the Public Sector Capacity Building Project: Designed to improve service delivery, the project included a nationwide skills audit and the implementation of new salary scales based on job classifications, equity (including gender equity), and motivation to attract and retain qualified civil servants. In fact, Rwanda has the highest proportion of female civil servants in the world (Devlin and Elgie 2008).

A further example is in Uganda, where the UN supplemented the salaries of all staff in the Ministry of Finance from 1989 to 1996. The total cost of the initiative was “less than a single expatriate technical assistant,” yet by the end of it the Ministry was considered one of the strongest in sub-Saharan Africa (Manuel et al. 2012: 31).

**Principle 6: Work with Governments to Provide Cash to the Poor**

A growing body of evidence suggests that cash transfers – giving money directly to the poor – can serve as a complementary tool to reduce poverty, boost demand for goods and services, and thus stimulate local economies (Lagarde et al. 2009; Hanlon et al. 2010; Arnold et al. 2011). While some critics argue that because the transfers are “conditional,” they are coercive; in our experience, by letting poor people decide how to use such resources, cash transfers confer upon recipients greater dignity than do most other modalities of foreign assistance.

Such programs are similar to social protection efforts for the poor in high-income countries. In OECD countries, for example, almost 10% of gross domestic product (GDP) is, on average, dedicated to cash-based social assistance; over 80% of the population in these countries receive some form of such support (Farrington et al. 2005). Although a subject of debate, most data indicate that the lion’s share of such funds are used to buy essentials, such as food, clothing, shelter, and healthcare (Jaspers and Harvey 2007). In Haiti, which has no public cash-transfer program, studies on remittances – comparable to cash transfers – have found similar results: families spend more than three-quarters of remittance funds on essentials, including food, utilities, and clothing (Inter-American Development Bank 2007). A feasibility study found that many potential beneficiaries of a cash-transfer initiative intended to use the money to send their children to school (Cohen et al. 2007: 17).

The evidence in support of cash transfers in developing countries is impressive and growing. In southern Africa, where the world’s worst HIV/AIDS epidemic has disrupted families and caused the death of many caregivers, cash-transfer programs have helped keep many orphaned children in school and families together (in a region where labor
migration is, for many of the poorest, the norm) (Jaspers and Harvey 2007). In South
Africa, a cash-transfer program has been credited with helping to reduce the poverty
gap – the gap between the incomes of the poor and the income required to keep them out
of poverty – by 47% (Samson et al. 2004). Mexico’s conditional cash-transfer program –
which requires that, among other things, families bring their children to clinics for a basic
package of health interventions – has been credited with improving child health (Gertler
2004; Rivera et al. 2004; Frenk 2006). A cash-transfer program in Zambia contributed
to an increase in the ownership of goats from 8.5% of households to 41.7% (Scheuring
2008). A similar program in Bangladesh increased the value of household-owned live-
stock assets by a factor of 12 (DFID 2011b). DFID’s Social Protection Expansion Scheme
in Zambia found that the consumption of goods by cash-transfer recipients increased
by at least 50% (Scheuring 2008). Another study of a cash-transfer program in Malawi
observed a regional multiplier of 2.02 to 2.45 for every program dollar spent; traders,
suppliers, services, and other non-recipients in the local economy appear to have benefited
from the increase in aggregate demand (EuropeAid 2010; Voipio 2011).

In most developing countries, however, less than 1% of GDP is spent on cash-based
social assistance programs; such programs reach less than 10% of the workforce in Africa
and Asia (Farrington et al. 2005). By supporting cash-transfer programs, donors and aid
agencies can help stimulate microenterprise and development while also reinforcing – or
at least not undermining – the social contract between the state and its most marginalized
citizens.

Cash-transfer programs are no panacea, and can accomplish little without institutions
of growth and good governance. But they can give “searchers,” to use Bill Easterly’s term
(Easterly 2006), modest means to improve their lot or even launch small enterprises, and
complement efforts to provide healthcare, education, and other forms of social protection
seeking to break the cycle of poverty and disease.

Principle 7: Support Regulation of Non-State Service Providers

As discussed, the status quo in foreign assistance often involves contracting local and
international NGOs instead of the governments of recipient countries. In many cases, a
lack of coordination among NGOs working to provide much needed services prevents
foreign aid efforts from adding up to more than the sum of their parts. Even the best
intentioned efforts can have unintended and sometimes harmful consequences.

Haiti is a case in point. The Government of Haiti’s total revenue pales in comparison
to the foreign assistance disbursed on Haitian shores: in 2010, the year of the earthquake,
bilateral and multilateral aid roughly equaled 400% of the government’s internal revenue
(UN OSE 2011). Most NGOs (in Haiti and elsewhere) do valuable work, but without
coordination and regulation, they run the risk of being duplicative, inequitable, and unac-
countable to the communities they serve. Local organizations, including cash-strapped
ministries of health (and the public clinics and hospitals they run), cannot compete with
better funded NGOs. Harmonizing foreign aid efforts increases the likelihood that they
will help engender lasting improvements for their intended beneficiaries. National gov-
ernments are usually in the best position to act as a steward of such efforts.

The Government of Rwanda, for instance, produced a comprehensive development
plan, Vision 2020, that puts a premium on coordination of foreign aid initiatives to ensure
that all providers in the country are working toward the same goals with a unified stra-
ATEGY. NGOs that fail to work in accordance with national strategies are often asked to
leave the country. This approach, in part, explains why Rwanda is achieving some of the best health and development outcomes on the African continent (Farmer et al. 2013). By streamlining procurement systems across the country, for example, the Ministry of Health improved inventory management of HIV/AIDS treatment while bringing down associated costs (Tarrafeta 2007).

Developing-country governments might, of course, need support—accompaniment—in this role as stewards of service provision. Foreign assistance can aid national and local governments through direct support and also through requirements that grantees and contractors align their work with government priorities. This approach respects the regulatory duties of the state and helps ensure that aid does not bypass (or undermine) national accountability structures. Transparent, mutually beneficial partnerships between non-state providers and governments are a precondition of efficient and equitable delivery of basic services on a large scale (OECD and UN Development Programme 2010).

**Principle 8: Apply Evidence-Based Standards of Care**

Rich and poor settings are almost always separated by different standards of healthcare. Budgets, rather than strategy, too often drive implementation, which usually means paltry healthcare services are available in poor places. But the accompaniment approach, premised on equity, demands raising the standard of care in resource-poor settings to a level that would be acceptable in affluent settings.

Evidence-based practice is fundamental to clinical medicine. A critical feedback loop—service delivery linked with research and training—helps practitioners deliver better care and improves health outcomes among patients. Above all, it establishes standards by which doctors and nurses and other members of the allied health professions can be measured and evaluated. This approach can and should be adopted in the business of foreign assistance.

Food security, for example, is a necessary precondition of effective treatment for many diseases; mortality is two to six times higher in the first months of antiretroviral treatment for individuals who have both AIDS and malnourishment (World Food Programme 2012). But, perhaps due to the stovepiping of foreign aid—AIDS programs funded by one agency, nutrition programs by another—many HIV/AIDS control efforts in resource-poor settings do not include food support as a pillar of HIV/AIDS treatment. Rwanda again offers a model: the Ministry of Health requires that health providers supplement antiretroviral medications with nutritional support (sufficient for a family of six) for the first six months of treatment. After that initial period, providers evaluate the need for further food supplementation on a case-by-case basis while patients continue antiretroviral treatment. Most people who initiate treatment and receive care recover their ability to work after six months.

The application of evidence-based practice should hardly be controversial. Indeed, it has become jargon, and many aid outfits claim evidence-based strategy, even though they lack systems for monitoring and evaluation, not to mention the feedback loop between service delivery, research, and training. A principal barrier to evidence-based practice in foreign assistance is the “socialization for scarcity”: a lower standard is reserved for the poor precisely because they are poor. A truly evidence-based strategy seeks to close the delivery gap between rich and poor places, not maintain it in the name of cost-effectiveness. Applying evidence-based standards in rich settings and poor ones is not only humane, it will bring down long-term healthcare costs and promote economic development (see Chapter 7 on evidence-based global health policy).
Conclusions

Accompaniment is not a “quick win” approach to foreign aid. It demands long-term engagement, a commitment to genuine partnership, and flexibility to tackle whatever challenges come along. It can be at odds with process-driven accountability conventions that fetishize short-term cost-effectiveness without asking larger questions about evidence, equity, and sustainable development. We advocate a broadened definition of success in the business of foreign aid.

In recent years, the accompaniment approach has been gaining traction. The World Food Program has highlighted priority areas for “the poorest, most food-insecure people bypassed by conventional development efforts” (World Food Programme 2008). Its programs help the poor engage in education and training programs, preserve assets and gain access to credit, and find more steady employment in the agricultural sector. The US Agency for International Development (USAID) recently announced a new commitment to local procurement even when it might counter US laws on competition for bidding on contracts (USAID 2011). The European Commission is seeking to increase direct budget support to national governments. PEPFAR recently made its first sector budget-support grant to fund the Government of Rwanda’s Human Resources for Health Initiative, a seven-year program to develop delivery and training capacity through long-term partnerships with a dozen American universities. Efforts such as these suggest a newfound commitment to the Paris Declaration, and green shoots, perhaps, for the world’s poorest people.

But a commitment to the principles of accompaniment is not the same as implementation of aid efforts based on these principles. The aid enterprise has historically been resistant to investing in local and national systems directly, citing fears of corruption or lack of absorptive capacity. Such practices, however, can fuel a vicious cycle and miss a chance to strengthen the very systems that donors criticize (OECD 2010b). An accompaniment approach guides foreign aid groups to transfer more resources and authority to the national and local institutions of their intended beneficiaries in the form of lasting partnerships. It offers, we contend, a compelling strategy for helping the poor and otherwise vulnerable break the cycle of poverty and disease.

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Key Reading

References


Blaya J, Fraser H, Holt B. 2010. E-health technologies show promise in developing countries. Health Affairs 29, 244–51.


FROM AID TO ACCOMPANIMENT


Easterly W. 2006. The White Man’s Burden: Why the West’s Efforts to Aid the Rest Have Done So Much Ill and So Little Good. New York: Penguin.


