Taking Stock of Foreign Aid

JONATHAN WEIGEL, MATTHEW BASILICO, PAUL FARMER

In the early 2000s, foreign aid outlays for global health and development projects increased at an unprecedented rate. Within a decade, development assistance for health nearly tripled, from $8.42 billion in 1997 to $21.79 billion in 2007 (see figure 10.1).\(^1\) AIDS funding increased twenty-five-fold in less than two decades, from $200 million in 1990—with almost none of it supporting treatment at that time—to $5.1 billion in 2007.\(^2\) Moreover, total development assistance (including, but not limited to, health) more than doubled between 2000 and 2010, as figure 10.2 illustrates.

In light of such outlays, the past two decades have given rise to a lively debate over the efficacy of aid. Has foreign assistance improved the lot of its intended beneficiaries? Although some doubt the utility of aid per se, substantial evidence demonstrates that development assistance for health—when delivered strategically—can help to raise the standard of care and improve health outcomes, even in some of the world’s poorest settings. We also have working models of effective global health delivery, as chapters 6 and 7 describe. The guiding question of this chapter, therefore, transitions from “does aid work?” to “how does aid work?” Are there principles of effective aid delivery?

Two names that often frame the public discussion are Jeffrey Sachs, an economist at Columbia University, and William Easterly, a former World Bank economist currently at New York University. In his book The End of Poverty: Economic Possibilities for Our Time (2005),
Sachs estimates that $135 to $195 billion in foreign aid could help end extreme poverty by 2015. Although this may seem like a large sum, Sachs points out that it amounts to only 0.54 percent of the rich world’s gross national product—less than the 0.7 percent target proposed by the UN Millennium Project. (The Millennium Development Goals advanced by this project are introduced in chapter 11.) Sachs’s argument rests on the theory of poverty traps. Many poor families, he contends, are unable to reach the first rung of the development ladder because they spend all of their income on basic survival and are therefore unable to begin saving and investing in productivity enhancements (such as better farming technologies or higher-yield seeds), education,

health care, and other preconditions of escaping poverty. Three development scholars sum up the logic of the poverty trap: “you can’t pull yourself up by your bootstraps if you have no boots.” Foreign aid, according to Sachs, could help supply the missing resources between the poor and the first rung of development.

In addition to poverty traps, another factor Sachs stresses is the differential burden or blessing of geography: a country that struggles with a large disease burden because it has a tropical climate, or a country that faces high transportation costs because it is mountainous, landlocked, or without navigable rivers, encounters significant barriers to economic activity and growth. With adequate investment, countries can overcome such barriers; Switzerland’s prosperity offers one example. But many cash-strapped developing countries may be unable to make the necessary investments without foreign assistance. Pointing to poverty traps and geography as roots of economic stagnation challenges the common perception that the principal roadblock to develop-


ment in poor countries in Africa and elsewhere is corrupt or incompetent governance. Although Sachs agrees that corruption can stymie development, he argues that the link between governance and growth is often overstated, as figure 10.3 highlights. Ultimately, Sachs is optimistic, but cautiously so: aid can help reduce poverty, he argues, only if it is overhauled into an efficient, transparent, and accountable system that effectively channels resources to the people who need them most.

In his 2006 work The White Man’s Burden: Why the West’s Efforts to Aid the Rest Have Done So Much Ill and So Little Good, Easterly rebukes Sachs’s optimism about aid. Easterly writes the history of foreign assistance as a sequence of failed grand schemes. Using cross-sectional statistics to compare and analyze aid delivery programs, Easterly argues that not only has aid failed to promote growth (see fig-

ure 10.4), but it has bred dependency and corruption in poor countries. For example, he claims that Paul Biya, the president of Cameroon since 1982, siphons off 41 percent of the foreign aid his country receives.10 Easterly also highlights how much aid money is consumed by operating costs: in some cases, aid agencies spend more money on overhead such as salaries and transport costs than they spend on aid projects.11

According to Easterly, the underlying problem with aid is that its initiatives are hatched by “planners” in the United States and Western Europe—aid officials seeking to impose top-down solutions to poverty and other problems of development. But such blanket cures will not trigger economic growth and social developments, he argues. Growth and progress are instead attributable to the work of “searchers,” individuals in poor countries who start businesses or find creative solutions to reducing poverty and solving social problems. Muhammad Yunus pioneering microcredit in Bangladesh and commercial sex workers in Calcutta’s red-light district educating fellow workers about condom use and the dangers of AIDS are two of his examples. Easterly’s argument is that markets work, but not when planned from the top down; democracy also works, he adds, but it too must emerge from the bottom up to avoid capture by dictators and predatory elites. “The dynamism of the
poor at the bottom,” he writes, “has much more potential than plans at the top.”

Easterly’s conclusions offer few easy takeaways for foreign aid agencies, but the overall message is that they must shift their focus from increasing overall sums of aid to scrutinizing how (if at all) aid can spur growth. He thinks this means bypassing governments and allowing resources to flow directly to the private sector.

Amartya Sen has critiqued Easterly’s approach, commenting that his claims are often overstated and ignore the heterogeneous effects of foreign aid:

To arrive at his negative view of economic aid, Easterly draws on large-scale cross-sectional statistical analysis as well as on case studies of particular plans and programs. Such intercountry comparisons have become fashionable as a way of isolating solid connections between causes and effects, but they are seriously compromised by the difficulty of comparing diverse experiences: countries can differ significantly in variables other than those that are brought under cross-sectional scrutiny. Many such studies are also impaired by difficulties in identifying what is causing what. For example, a country’s economic distress may induce donors to give it more aid—which may, in terms of associative statistics, suggest a connection between aid and bad economic performance. But using such a correlation to prove the bad effects of aid turns the causal connection on its head. Easterly tries to avoid such pitfalls, but the statistical associations on which he draws for his comprehensive pessimism about the effects of aid do not offer a definitive causal picture.

Despite the limitations of his methodology, however, it must be acknowledged that Easterly’s emphasis on critically examining the effects of foreign aid is a welcome demand of an industry that has long escaped rigorous scrutiny.

The Sachs-Easterly debate is often boiled down to simple optimism and pessimism about aid. But polarizing the debate by asking the question “does foreign aid work?” misses the point, which is to interrogate facile claims about causality concerning health and well-being for those left behind by development. Sachs and Easterly both put forward thoughtful and mixed diagnoses explaining the failures of foreign aid. In fact, they both encourage the question we posed at the start: “how does foreign aid work?”

This question has been taken up by a number of scholars and practitioners seeking to examine and improve the machinery of foreign aid. One example is the Abdul Latif Jameel Poverty Action Lab (J-PAL) at the Massachusetts Institute of Technology. Led by Esther Duflo and
Abhijit Banerjee, who co-wrote *Poor Economics: A Radical Rethinking of the Way to Fight Global Poverty*, the development economists at J-PAL and its many partner organizations have pioneered the use of randomized controlled trials in development economics. By implementing a development intervention as a “treatment” and comparing it to a “control” in a comparable population that does not receive the intervention, RCTs enable economists to measure the specific effects of that intervention.

For example, an RCT conducted in Kenya by economists Michael Kremer, Edward Miguel, and colleagues found that children who were given deworming medications stayed in school longer and had 20 percent higher earnings as young adults than those who did not receive such medications. The study estimated a lifetime income increase of $3,269 from deworming. By comparing Kenyan schools that provided deworming drugs with similar ones that did not, the RCT isolated the specific (and profound, in this case) effect of the intervention under scrutiny. Duflo, Banerjee, and a growing number of other development economists have launched thousands of RCTs across the developing world to evaluate interventions pertaining to health, education, agriculture, microfinance, family planning, and other facets of development. Their work has added nuance and rigor to our understanding of the mechanics of implementing development programs, financed by foreign aid or national governments.

RCTs, despite their well-known limitations in medical research, offer one useful if imperfect tool for development researchers and policymakers. But they raise troubling questions in development work, too. In a number of cases, global health and development interventions have already been proven effective and deliverable in resource-poor settings. People with life-threatening diseases like HIV or cancer or cholera need treatment, which, as chapter 6 illustrates, can be delivered anywhere in the world. How do we deliver it better? How do we create a science of delivery? Today, more than ever before, there is a growing armamentarium of proven interventions for health and education and other components of development. Once we know what works, the question becomes more focused: how do we bring effective delivery models to scale? Or, more broadly, how can we build systems that will provide quality care in the long term—indeed, of foreign aid flows—and trigger virtuous social cycles and suitable economic development?
THE ACCOMPANIMENT APPROACH AND AID REFORM

One approach to this challenge has been discussed and supported by examples and case studies throughout this book: *accompaniment*. The accompaniment approach means supporting developing country partners—public and private—until they have the capacity to deliver services and improve livelihoods in the long term. It entails patience, flexibility, and commitment to doing whatever it takes to help the poor and their allies in the public and private sectors to build effective systems for economic development and health care delivery. Above all, it acknowledges (and seeks to redress) unequal development and the effects of large-scale social forces linked to history and geography.

In addition to informing service delivery for specific projects, accompaniment offers a strategy for foreign assistance in general, including global health initiatives. Foreign contractors and international NGOs could find ways of accompanying their intended beneficiaries on development projects of all kinds. Sometimes this might mean providing budgetary support for beleaguered and underfunded government health and education authorities, or investing in local firms, or procuring goods and services locally. There is no one-size-fits-all package. As we know, all social action risks unanticipated consequences. So too does inaction. Accompaniment offers a means of preparing for the unforeseen: by adapting to the local context and by following the lead of local partners, the accompaniment approach enables aid groups to tackle challenges nimbly.

What, exactly, is accompaniment? We start by distilling the accompaniment approach into eight principles:

**FAVOR INSTITUTIONS THAT THE POOR IDENTIFY AS REPRESENTING THEIR INTERESTS**

Accompaniment starts with listening, to determine which institutions the intended beneficiaries believe to be acting in their interests. The poor endure the local context and have learned from it; they have watched past aid projects succeed or fail. They often know what development opportunities exist and what combination of institutions—public and private, local and international—will be most likely to deliver aid effectively. Accompaniment hinges on finding good partners, and the poor are necessary consultants for that task.

**FUND PUBLIC INSTITUTIONS TO DO THEIR JOB**

One unintended and harmful consequence of foreign assistance—noted by Paul Collier and others—is that funding NGOs can effectively drain the
public sector of resources and skilled personnel. For example, of the $2.4 billion in humanitarian aid disbursed in Haiti after the January 2010 earthquake, less than 1 percent went to the Haitian government. Although at times—and a devastating quake in a setting of poverty may be one of those times—governments are not the only partners for development work, they should be protagonists in such efforts whenever possible. Large-scale implementation usually requires partnering with national and local governments; sustainable development also usually requires working in the public sector, which will still be there long after aid workers have packed their bags. Donors concerned with corruption or lack of capacity on the part of recipient governments often unwittingly fuel a self-fulfilling prophecy. The best way to build capacity and combat corruption is to support the development of systems of accountability and transparency (see the discussion of Haiti’s General Hospital later in this chapter)—that is, by practicing accompaniment.

**MAKE JOB CREATION A BENCHMARK OF SUCCESS**

Donors for all sectors of development—health, education, environment, energy, infrastructure, trade, finance—and all those engaged in global health equity should prioritize local job creation and transfer of capacity to local partners. Beyond 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 stimulate local economies and strengthen the national tax base—two cornerstones of a robust public-sector health system.

**BUY AND HIRE LOCALLY**

Most foreign aid projects procure goods, services, and personnel outside beneficiary countries, which misses an opportunity to stimulate local development and can even weaken local economies (by importing goods and services at artificially low prices). A year and a half after the Haiti earthquake, only 2 percent of reconstruction contracts had been awarded to Haitian firms. But buying and hiring locally can help create jobs, develop local markets, boost tax revenues, and stimulate entrepreneurship. Some commodities can also be sourced locally. For example, so-called ready-to-use therapeutic foods (especially important for maternal and child health, as chapter 11 describes) can be manufactured in resource-poor settings using produce from local farmers.

**CO-INVEST WITH GOVERNMENTS TO BUILD STRONG CIVIL SERVICES**

Workforce development in the public sector proceeds best with platforms of transparent hiring and firing, including performance reviews, continuing training programs for civil servants, and the ability to assess workforce needs. This applies as much to a health workforce as to any other. But instead of strengthening civil services, aid programs often erect parallel (or
competing) structures and provide technical assistance (usually an expert or two from donor nations) without helping to develop robust training programs that can build in-country capacity. 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. An accompaniment approach seeks to shore up and modernize existing human resource systems.

**WORK WITH GOVERNMENTS TO PROVIDE CASH TO THE POOREST**

A growing body of evidence suggests that cash transfers can be a useful, complementary tool to reduce poverty, boost demand for goods and services, and thus stimulate local economies. In South Africa, for example, cash transfers have been highlighted in helping to reduce the poverty gap. Mexico’s conditional cash transfer program—which requires that, among other things, families bring their children to a clinic for a basic package of health interventions—has been credited with improving child health. Cash transfer programs are no panacea and can accomplish little without decent institutions and service-delivery platforms. But they can help empower “searchers,” to use Easterly’s term, and complement the toolkit for development assistance and global health equity.

**SUPPORT REGULATION OF INTERNATIONAL NONSTATE SERVICE PROVIDERS**

The status quo in foreign assistance often involves contracting with nongovernmental organizations—local and international—instead of the governments of recipient countries. Thousands of NGOs are operating in Haiti, a country of 10 million. A majority of NGOs (in Haiti and elsewhere) do valuable work, but without coordination and regulation, they run the risk of being duplicative, inequitable, and unaccountable to the communities they serve. We add up to less than the sum of our parts. Cash-strapped ministries of health—and the public clinics and hospitals they run—cannot compete with better-funded NGOs, leading to an internal brain drain that is at times as pernicious as the global one. Harmonizing foreign aid efforts increases their likelihood of helping to generate meaningful, lasting change for their intended beneficiaries.

**APPLY EVIDENCE-BASED STANDARDS OF CARE THAT OFFER THE BEST OUTCOMES**

Rich and poor settings are almost always separated by different standards of health care. Budgets and funding streams, rather than strategy to increase value and quality of services, too often drive implementation, which usually means paltry health care 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.
What does accompaniment mean in practice? We can look, for example, at the efforts of the American Red Cross to strengthen the largest public-sector hospital in Port-au-Prince. After a disaster, the Red Cross typically spends a large proportion of its resources working with NGOs. But after the January 2010 earthquake, the General Hospital in Port-au-Prince, which itself sustained major damage, was swamped with patients seeking care for crush injuries and other associated complications. Even before the earthquake, it had faced one of the highest caseloads in the country, and its employees received lower salaries than competing private hospitals and NGO outfits. In an effort to help the beleaguered staff at the General Hospital, the Red Cross agreed to spend $3.8 million on a salary support program. Starting this program was no easy task: the hospital lacked modern bookkeeping and adequate computing systems to keep track of staff work hours, as American accountability norms require. Installing or upgrading computer systems was not what the Red Cross had signed up for, but in this particular time and place, accompaniment demanded the patience to overcome snags as they arose and an investment in solving the root problems—in this case, an underdeveloped “infrastructure of transparency.”

This approach is premised on the idea that the hard work and open-ended commitment of accompaniment are worthwhile because a stronger and more durable health system will provide better care for all maladies, despite the ebb and flow of foreign aid through programs such as the President’s Emergency Plan for AIDS Relief and the Global Fund to Fight AIDS, Tuberculosis and Malaria. Though a contingency plan was developed a few months later, the 2011 decision that the Global Fund would be unable to approve new projects until 2014 was a reminder not only of the importance of health system strengthening but of the need for long-term assistance guided by these basic principles of accompaniment.

Beyond Red Cross support of a crumbling public hospital, there are many other examples of foreign aid projects that follow an accompaniment approach: nonstate health providers who coordinate their efforts with local ministries of health; international groups that purchase food and supplies in-country from local farmers instead of importing them; donors who prioritize job creation or contract local initiatives alongside foreign ones. One initiative seeking to systematize and disseminate information about such programs is the Global Health Delivery
Project, described in chapter 7. Led by a small team at Harvard, GHD develops case studies of health programs in resource-poor settings around the world in an effort to help build a science of global health delivery. But such initiatives are still the exception, not the norm, in the business of foreign assistance. The accompaniment approach thus entails significant reform—new rules of the road—of the machinery of foreign aid.

Even proponents of increased aid, such as Jeffrey Sachs, argue for fundamental changes to the existing systems of foreign assistance. “If we are to get agreement by the rich world’s taxpayers to put more aid through the system,” he writes, “we first have to show that the plumbing will carry the aid from the rich countries right down to where the poorest countries need it most—in the villages, slums, ports, and other critical targets.” As Easterly and others highlight, the majority of foreign assistance is fragmented, nontransparent, and diluted by high overhead costs; and it often comes with strings attached that suit the interests of donors more than those of the intended beneficiaries. In short, most aid programs are nowhere near as effective as they could be.

The accompaniment approach can help guide foreign aid practitioners in designing projects that are adaptable to diverse local settings, durable over the long term, and therefore more likely to move closer to a broadly shared vision of ending extreme poverty. It also outlines an answer to Easterly’s call for aid programs that work from the bottom up: accompaniment starts (and ends) with listening to the problems and priorities described by the intended beneficiaries. Chapter 7 outlines a framework for delivering health care in poor settings; the accompaniment approach is a strategy for implementing that framework effectively. And the accompaniment approach can be leveraged in most types of development work. Unlike traditional aid modalities, accompaniment is a long-term pledge to walk with the poor, to help strengthen and improve existing public and private efforts to promote health and equitable development—replace them with a parallel aid architecture.

**MORE (GOOD) AID**

Guided by models of effective aid delivery, including the accompaniment approaches, development assistance could be strengthened and expanded to meet these goals. Although aid outlays have increased in the past few decades, they remain small compared to the basic deficits
in most poor countries. The authors of this book—along with many policymakers, scholars, and practitioners, not to mention intended beneficiaries—believe that, overall, available evidence suggests the utility of increasing foreign assistance, even as its machinery needs reform. These approaches can be informed and complemented by social justice efforts, both “grassroots” and large-scale, to promote equitable and just development. In particular, aid for global health projects, when delivered according to principles such as those outlined in this volume, has been proven effective in saving lives and mitigating suffering around the globe.

Estimates of the gap between aid provided and aid needed typically range from $40 billion to $52 billion per year. Sachs estimates that an additional $40 billion per year in foreign aid could provide primary health care for the billion poorest people on the planet (who live on less than $1 per day). That is 40 percent of what the United States alone has spent each year on the war in Afghanistan, and less than 5 percent of the 2008–2009 bank bailouts.

For many, even those casting a gimlet eye on foreign aid, health projects occupy a privileged position in the spectrum of development assistance. In a 2009 survey conducted by the Kaiser Family Foundation in the United States, 52 percent of respondents thought the government was spending too much on foreign aid. When asked about “efforts to improve health for people in developing countries,” however, this number dropped to 23 percent; when asked about efforts to fight AIDS, it dropped to 16 percent. Thirty-nine percent supported maintaining U.S. government spending on global health, and 26 percent favored increasing spending.

There is also reason to believe that many more Americans would support expanding U.S. global health programs if they understood how little the government currently spends relative to other budget items and relative to the contributions of other high-income countries. A 2010 study found that many Americans thought foreign aid constituted up to 25 percent of the federal budget and suggested reducing it to 10 percent (see figure 10.5); another study found that 69 percent of Americans thought the United States gave a greater percentage of its gross national income than other high-income countries did. But in 2008, aid actually accounted for about 1 percent of the U.S. budget (the equivalent of one-thirteenth of annual defense spending), and the United States in fact spent the lowest percentage of gross national income on foreign aid among all high-income countries: 0.18 percent,

well below the 0.7 percent target set by a 1970 UN General Assembly resolution.42 (A number of high-income countries, including Denmark, Sweden, and Norway, have already surpassed the 0.7 percent target, which was reaffirmed by the UN in 2002.) Sachs estimates that the United States could provide primary health care to the “bottom billion” for $40 billion and still remain shy of the UN target, which in any case is much less than the levels of foreign aid that most Americans deem acceptable in opinion polls.43

Strategies for closing the gap between perceived and actual global health aid—and between promises and delivery—are explored in the final chapter of this book. Of course, the governments of developing countries are the protagonists in the movement for global health equity, and many have begun devoting more resources to health. In 2001, dozens of African leaders signed the Abuja Declaration, pledging to increase government health spending to 15 percent of total expenditures. Ten years later, median annual government health spending in African Union countries had increased from $10 to $14 per person in real terms; twenty-seven African Union countries spent a larger portion of their budget on health in 2009 than in 2001.44 In Rwanda, the government’s successful National AIDS Control Commission paved the way for increasing government investments throughout the health sector; it is one of the only countries in the developing world close to universal access to AIDS care (see chapter 6). Rwanda—one of two African
countries to have reached the Abuja target by 2010, and the only one on track to meet the Millennium Development Goals—has emerged as a model of health system strengthening by channeling tax revenues and more of its foreign assistance from public and NGO sources into a stronger public health system. Other governments in Africa and across the developing world will likely need to increase expenditures on health care if global health programs are to have large-scale and long-lasting impact.

There is only so much, after all, that cash-strapped government ministries can accomplish without support—or accompaniment—from wealthy countries or from a healthy tax base. The budget of one Harvard-affiliated teaching hospital far exceeds that of the government of Haiti. After the 2010 earthquake, some international health NGOs raised more than twice the total budget of the Haitian Ministry of Health. In other words, there remains great need for foreign aid for the work and resources of international NGOs and other partners in equitable development. The accompaniment approach provides one model of how to make foreign assistance more needs-based, adaptable, and sustainable in the long term.

SUGGESTED READING


