1.3. Official Development Assistance and health cooperation

Maurizio Murru, Fabrizio Tediosi

The beginning

Theoretically, the logic behind so-called "Official Development Assistance" (ODA) lies in the enormous and unjust inequalities between the standards of life in rich and poor countries. Definitions and concepts of "development" changed for several decades. In 1990 the concept of "human development" appeared in the first "Human Development Report" published by United Nations Development Programme (UNDP). In this document we read that "*[this term] denotes both, the process of widening people's choices and the level of their achieved wellbeing*"[1]. ODA from rich countries should, by definition, contribute to the *human development* of the populations in poor countries.

During the Colonial era sporadic and disjointed activities were carried out by individuals and organizations "in favour" of the people in colonized countries. After World War II the British and French governments earmarked funds for their colonies' "development" (whatever this meant at the time). Between 1945 and 1955 the British Government spent, to this aim, the equivalent of about US$ 840 million and the French the equivalent of about 1,108[2]. The birth of the United Nations in 1945 boosted the ideals of universalism and solidarity.

The first significant and structured example of ODA is the "Marshall Plan" which, between 1948 and 1951, channelled US$ 13.812 billion, about 2% of the American Gross Domestic Product (GDP) of the time, from the United States to 16 European countries[3].

"… We must embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvements and growth of underdeveloped areas. More than half the people of the world are living in conditions approaching misery. Their food is inadequate. They are victims of disease. Their economic life is primitive and stagnant. Their poverty is a handicap and a threat both to them and to more prosperous areas. For the first time in history, humanity possesses the knowledge and the skill to relieve the suffering of this people". Harry Truman pronounced these words on January 20th 1949, as part of the inaugural speech of his presidency[4]. The speech contains some of the recurrent themes, the illusions and the declared good intentions of the "*International Aid System*".

We do not wish to discuss the different and complex aspects of the Marshall Plan here. It is acknowledged that it had humanitarian, strategic and economic objectives.

Today's ODA, too, has a wide range of motivations: from the noblest aspirations to universal solidarity and social justice to the meanest considerations of political and commercial convenience. All this, passing through a thick grid made of honesty and hypocrisy, professionalism and amateurism.

What is meant by ODA?

According to the World Bank, "*Development assistance encompasses both financial and non financial instruments that are aimed at supporting the recipient country's efforts to accelerate growth and reduce poverty. […] Resource transfer is an important part of development assistance […]. But finance is only one of the instruments used to support development and, in some situations, it is not even the most useful one. Development assistance also includes analysis, advice and capacity building*"[5].

The Organization for Economic Cooperation and Development (OECD) was created in 1961 to replace the Organization for European Economic Cooperation (OEEC), formed in 1948 to manage the Marshall Plan funds. It gathers countries committed to democracy and free market economy. It has 30 member states, and others are in the process of becoming members. The OECD deals with the majority of issues related to development cooperation with developing countries. These include the management of ODA through the Development Assistance Committee (DAC), which comprises 22 of the 30 current OECD members. According to the most commonly accepted definition, introduced by DAC, financial transfers from rich to poor countries, to be considered "Official Development Assistance", must satisfy at least three conditions[6]. They must:

1. come from the public sector;
2. have as their main objective the promotion of economic growth and social welfare;
3. be released as "grants" or, if released as loans, have a grant component of at least 25% of their total amount.

Financial flows

Data on ODA financial flows are fragmented, incomplete and debatable. For instance, up to 1993, when this was forbidden by DAC, the USA's ODA statistics included the forgiveness of debts incurred by poor countries to buy American weapons. Even today, administrative costs of delivering aid are counted as "aid". The most accurate and complete data are those on the funds released by the 22 DAC countries. They are released each year with graphs, comments and clarifications. As for the funds released by China, India, oil-rich Arab countries, etc. the available estimates are inaccurate, not least because these countries are not keen to release this sort of information.

In 1956 ODA amounted to US$ 3.2 billion. This amount increased gradually in absolute terms, especially in the second half of the 1970s and between 1985 and 1992. From 1992 ODA funds decreased gradually in absolute terms. They

started to grow again in 1998, reaching their peak in 2005 with US$ 106.5 billion. This was 0.33% of DAC countries' GDP, up from 0.24% in 2004[7]. It is worth noting that the 2005 record amount, when calculated as donor countries' GDP, was the same as in 1992. In 2006 the ODA flows from DAC countries decreased to US$ 104.4 billion, equal to 0.31% of their combined GDP[8]. In 2007 the DAC ODA further decreased to US$ 103.65 billion, equal to 0.28% of the combined GDP of the DAC countries (see **Graphs 1 and 2**). This contraction is due to the fact that, in 2005 and 2006, DAC countries forgave significant amounts of debt, mainly to Iraq and Nigeria. The growth of ODA in the last few years (about 11% per year between 2001 and 2005) was mainly due to debt forgiveness (about 70%); only 25% was due to the release of new funds[9]. With less debt to be forgiven, and because of the global economic crisis, ODA is likely to witness a further decrease in the next few years. In 2007, although in the framework of an overall decrease, the ODA cash flows increased by 2.4%. The OECD forecasts increases in cash flows, although smaller than those promised at Gleneagles in 2005 (see **Graph 3**).

In absolute terms, in 2007 the USA was (as always) the biggest donor with US$ 21.75 billion. However, when considering ODA as a percent of GDP, in the same year the USA was last (together with Greece) with a mere 0.16% (see **Graph 2**).

In 1969 the United Nations Commission on International Development, chaired by Lester Pearson, proposed that rich countries earmark 0.7% of their GDP to ODA every year. This objective was approved by the General Assembly of the United Nations in 1970 and was accepted by DAC members with the exception of the USA and Switzerland. Currently, only five of the 22 DAC countries respect this commitment: Denmark, Luxembourg, the Netherlands, Norway and Sweden.

Numerous countries not belonging to the DAC group channel increasing funds to ODA. According to the International Development Association (IDA), the World Bank branch responsible for allocating soft loans to countries with an annual GDP per person lower than US$ 965, the ODA funds from countries belonging to OECD, but not to DAC, are currently about US$ 1 billion and could double by 2010[10].

ODA funds from countries not belonging to OECD, like Brazil, China, India, the Russian Federation, Saudi Arabia, etc., were about US$ 5 billion in 2005, about three times as much as in 2001.

To these funds we must add those provided by individual citizens, religious groups, Non- Governmental Organizations (NGOs) and various Foundations (Bill and Melinda Gates, Clinton, Rockefeller, Soros, etc.). Documenting financial flows coming from private sources is extremely difficult. The World Bank estimates that, in 2005, this amount was about US$ 14.7 billion, more than twice the amount of 2001.

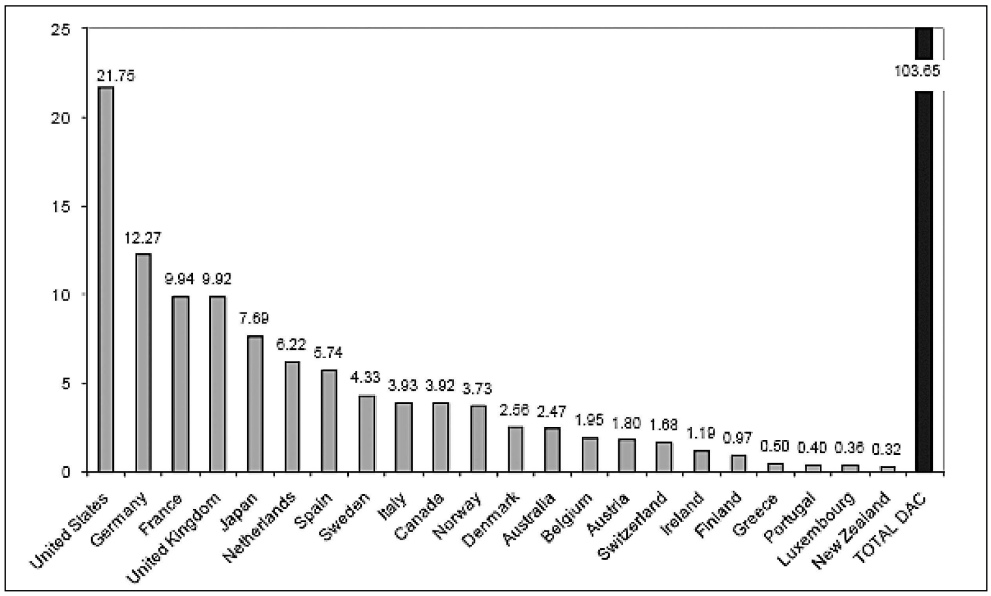

Figure 1. ODA funds of the 22 DAC countries in 2007 (in US$ billion).
Source: http://www.oecd.org/dataoecd/27/55/40381862.pdf

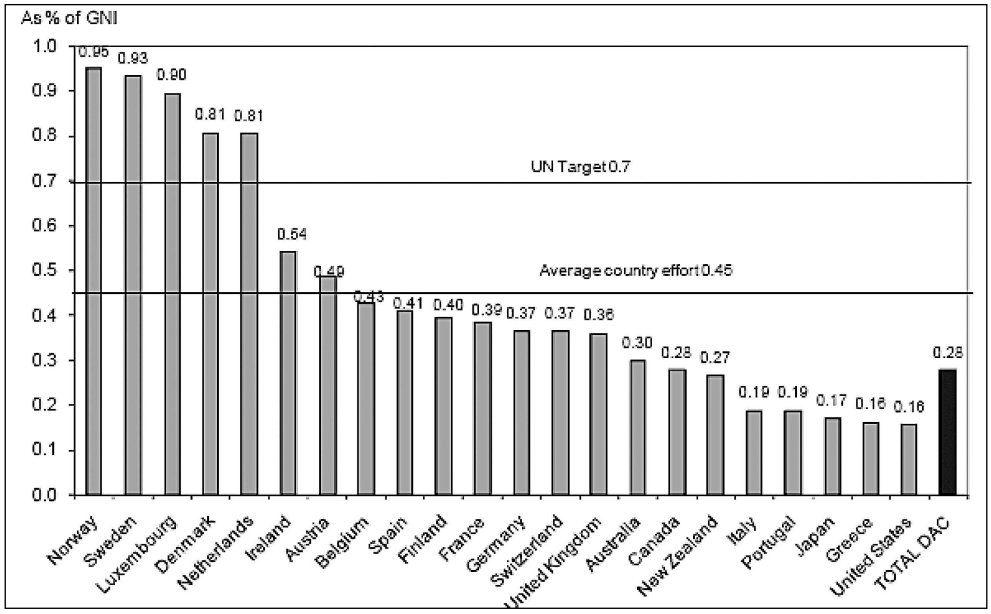

Figure 2. ODA of the 22 DAC countries in 2007 expressed as percentage of their GNI.
Source: http://www.oecd.org/dataoecd/27/55/40381862.pdf

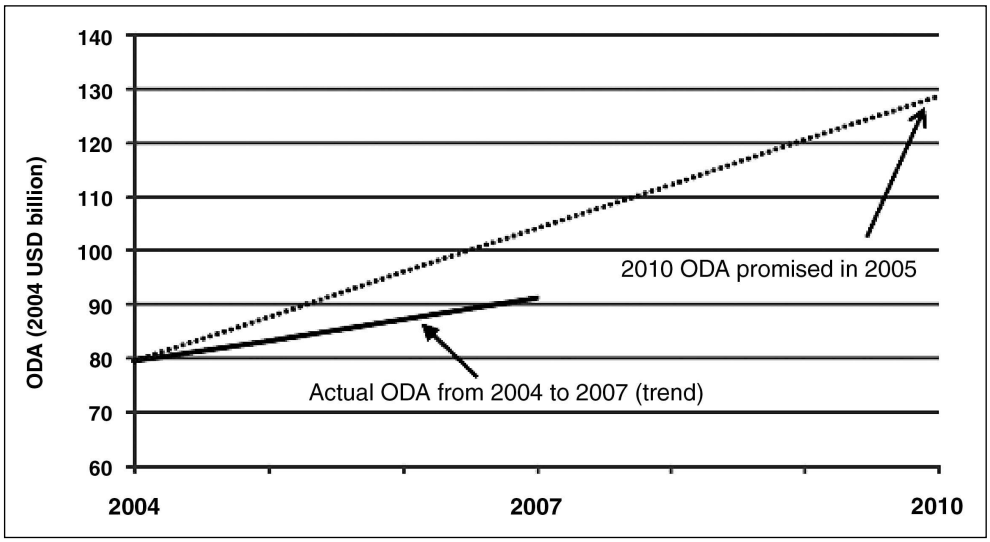

Figure 3. Trend of the 22 DAC countries ODA compared to the promises made at the G8 meeting at Gleneagles in 2005.

Note: The Graph excludes the exceptionally high funds representing debt forgiveness in 2005 and 2006 (especially to Iraq and Nigeria). Source: http://www.oecd.org/dataoecd/27/55/40381862.pdf

Other financial flows to poor countries

ODA represents only one of the financial flows to poor countries. Foreign Direct Investment (FDI) is significant for many countries and has been growing for the last few years. It is very selective and its effectiveness in promoting equitable development is debatable. In 2006, out of a total of about US$ 800 billion, FDI in Africa was about US$ 38 billion and was mostly directed to countries rich in oil and other natural resources[11].

Perhaps more significant in promoting development and fighting poverty are the remittances from migrants. They were estimated at about US$ 31 billion in 1990 and about US$ 150 billion in 2005[12]. These are uncertain estimates. Significant amounts of money are moved through informal channels and they can only be guessed. The World Bank estimates that the amount not captured by official statistics could be equal to 50% of the official one or, more likely, even higher. This would bring remittances to a total of more than US$ 250 billion[13]. This amount is more than twice that of ODA, its transaction costs are much smaller and it reaches the beneficiaries without intermediaries.

Aid distribution

Countries receiving DAC funds are divided in four categories[14]:

1. least Developed Countries;
2. other low-income countries (Gross National Income per person and per year less than US$ 825 in 2004);
3. Lower-middle-income countries and territories (Gross National Income per person and per year between US$ 826 and US$ 3,255 in 2004);
4. Upper-middle-income countries (Gross National Income per person and per year between US$ 3,256 and US$ 10,065 in 2004).

The first category (Least Developed Countries) has been used by the United Nations since 1971. It is not only based on income criteria and includes countries judged "… structurally disadvantaged in their development process and, more than other countries, at risk of failing in their effort to escape poverty". This group currently includes 50 countries, 34 of them in Africa[15].

The percentage of ODA channelled to the first two categories has been around 60% from the 70s onwards and reached 67% between 2001 and 2005.

Between 2001 and 2005 Sub-Saharan Africa received about 38% of DAC countries' ODA (in the 1960s it was about 20% and in the 1970s about 22%); Southern and Central Asia received about 15%; the Middle East and North Africa 14% and East Asia 11%.

The distribution of aid funds is not homogeneous and not always equitable. Political and commercial interests play an important role. Political considerations were of paramount importance during the Cold War. They still are. Even though the total amount of ODA increased by about 55% between 2001 and 2005, only 18 of IDA eligible countries have seen their aid grow by 50% or more. Afghanistan, the Democratic Republic of Congo, Liberia, Nigeria, the Republic of Congo, and Sudan have seen the most significant increases.

Aid to fragile states

"Fragile states" is a sort of euphemism used to define those not able (or not willing) to provide their citizens with basic rights such as security, education, health, and development opportunities in general. They are often states plagued by protracted armed conflicts or social crises, ruled by corrupt, despotic and inefficient governments. In 2005 the World Bank identified 25 low-income countries that, analyzed according to the criteria of the so-called Country Policy and Institutional Assessment (CPIA) could be defined as "fragile states". About 500 million people live in these countries. Their infant mortality rates are one third higher than those of other low-income countries, their maternal mortality rates 20% higher and their life expectancy at birth 12 years shorter[16].

During the last few years ground has been gained by the idea, based on facts and common sense, that aid works better in countries ruled by governments functioning reasonably well and that, therefore, it should be given *selectively*. It seems obvious that aid given to a country well administered and in peace, like Costa Rica, is likely to achieve better results than aid given to a country led by a failed government like Zimbabwe, or to a country virtually without a government like Somalia.

There is, however, an increasing, although hesitant, agreement that it is wrong to ignore the fragile states. On one side it is deemed iniquitous to forget about 500 million people living in abysmally poor conditions. On the other hand, it seems right to engage with fragile states and try to contribute to their normalization, also because of the negative effects that they have on neighbouring countries. It seems a matter of political farsightedness. According to a study published in October 2007 by IANSA, OXFAM International and Saferworld, in the African Continent alone conflicts cost about US$ 18 billion per year (plus other costs defined as "intangible"). Furthermore, an armed conflict in one country reduces the GDP in neighbouring countries by about 0.9% per year[17]. The logic of engaging with these countries, therefore, with all the difficulties involved, seems to be based not only on humanitarian considerations, but also on considerations of international security.

The effectiveness of this aid is disappointing. Sometimes it seems possible to achieve something marginally useful at local level such as a functioning health unit, food that is distributed, small communities that, in some way, remain in contact with the external world. In 2005 fragile states received about US$ 20 billion in aid. Excluding debt forgiveness and emergency aid, this amount comes down to US$ 10 billion. In a 2002 article William Easterly (an economist at the New York University) stigmatized the decision by the International Monetary Fund (IMF) and the World Bank to grant further debt forgiveness to Burkina Faso "*It would be interesting to know more about how much the poor were newly empowered in a one-party state that has been in power since 1987, which was in the worst fifth of the world in corruption in 2001, and which supported rebel warlords that perpetrated tragic atrocities in Sierra Leone, Liberia, and Angola*"[18]. This is a complex issue with no simple solution. There are only feeble illusions, weak hopes and sometimes embarrassing compromises.

How aid is disbursed

Aid can be disbursed in several ways: directly from the government of a donor country to the government of a recipient country (bilateral aid) or through international organizations like the various United Nations Agencies and Funds, the European Union, Regional Development Banks and Regional Development Organizations (multilateral aid). In theory, multilateral aid should be less linked to the specific interests of the donor countries.

In 2006 about 70% of DAC countries' ODA was disbursed as bilateral aid and the remaining 30% through multilateral channels; about 90% of multilateral aid was disbursed as grants.

Aid can fund specific projects or contribute to the state budget of the recipient country or to the budget of specific sectors (health, education, transport, etc.).

General Budget Support (GBS) should allow for a more flexible and efficient use of aid funds. Disbursement of GBS funds takes place on the basis of policies and plans jointly agreed by donors and recipients; monitoring and evaluation are carried out together and accounting is done using a single system, usually the one

of the recipient country. At least theoretically, this way of disbursing aid funds should promote donor coordination, alignment of donor and recipient objectives, smaller transaction costs, as well as greater transparency and accountability.

In practice, as always, things are slightly more complex. Donors who are no longer acting separately to support specific projects but acting together to discuss policies and plans, can constitute a formidable cartel, much stronger and much more capable of exerting influence and pressure. Moreover, many donor countries keep various options open: they put some of their funds in budget support and use other funds for specific projects.

Arguably, the overwhelming influence of a "cartel of donors" could be counteracted by the governments of recipient countries if they were represented by a critical mass of officers with competence, commitment and integrity (as happened in the Uganda health sector between the end of the 1990s and the beginning of the new century). Transparent budget support is likely to be easier when the governments of recipient countries are trusted for their competence, transparency and honesty.

A study on budget support efficiency and effectiveness, commissioned by 19 bilateral cooperation agencies, 5 international agencies and 7 governments of recipient countries, published in 2006, reached fundamentally positive conclusions on this way of disbursing funds[19]. More and more donors are choosing budget support. In 2001 aid funds disbursed as budget support were 8% of the total DAC countries' ODA funds. In 2004 this amount was 20%.

According to recent estimates, aid funds directed to social sectors such as education, health and water supply increased from 29% in the 1990s to 52% between 2000 and 2004; and from 33% to 60% respectively in Sub-Saharan Africa. The increase of funds directed to social sectors coincided with an increased tendency of many donors to link their funds to specific sectors (a sort of conditionality).

Proliferation and fragmentation of the aid system

In this context, "proliferation" means the increase in the number of donors, while "fragmentation" refers to the number of activities funded by a single donor.

In the last few years the number of donors increased enormously. This not only makes the whole scene more complex, but makes it much more difficult to coordinate the use of aid funds effectively. In the 1940s, there were fewer than a dozen bilateral donors. Today there are more than 50. Even the number of International Organizations, specific Funds and Programs increased rapidly: it is estimated that there are more than 230 but an updated and accurate census is impossible. The average number of donors present in a single recipient country increased from about a dozen in the 1960s to more than 30 in the period between 2001 and 2005. Since the end of the Cold War the number of recipient countries with more than 40 donors, including governments, international organizations, vertical funds, foundations, etc., increased from 0 to 40. The health sector is the most affected by proliferation, with about 100 major organizations active in it.

The fragmentation of activities funded by a single donor is the other face of this

problem. Things are made worse by the fact that many of these activities, often of short duration, are "Technical Assistance" (TA), which is expensive and often irrelevant. In 2004 alone, more than 20,000 TA missions were funded by various donors, often linked to small, short-term disbursements: more than one per day in each and every one of the recipient countries.

It is easy to understand the problems posed to the administrations of structurally weak countries. This high number of actors, with their own priorities, their own monitoring and accounting systems, their own fragmented activities and often unrequested TA missions, lead to a high level of bureaucratization, confusion, duplications and waste. It increases the costs and decreases the effectiveness of aid. To this must be added the volatility of aid: most donors, of whatever type and nature, commit themselves only for short periods of one or two years.

The example of Tanzania gives a good idea of the crazy situation of many recipient countries. In 2005 the majority of aid funds received by this country financed more than 700 projects, managed by about 60 parallel "implementation units". Half of the aid reaching the country funds activities not coordinated with government ones. Again in 2005, the country received 541 missions sent by various donors and only 17% of them involved more than one donor[20].

Conditions always imposed on recipient countries…

For the last 60 years or so, rich countries have put forward a flurry of theories on development, its meaning, its objectives and the best policies to achieve it. Such policies must then be adopted by poor countries as a "condition" to receive aid. The idea of "conditionality" is often (and rightly) associated to the *modus operandi* of the International Monetary Fund (IMF) and the World Bank (WB). However, in one way or another, more or less strongly, all donors have conditions to impose. For many years the bulk of these conditions concerned mainly economic policies. In this regard, structural adjustment programmes are a sort of paradigm. Neo-liberal economic policies, such as devaluation of the national currency, downsizing of the public sector, cuts to spending in social sectors including education and health, have been imposed on poor countries with a "blanket approach", without taking into account the different contexts. Little or no attention has been paid to the social consequences.

The policies imposed on recipient countries, stemming from the different theories on development, were always thought to be right and immune to flaws.

We saw the state supported as the main actor in promoting development, especially of infrastructure, in the 1950s and 1960s; then we saw the "basic needs" approach in the 1970s; then the structural adjustment programmes in the 1980s and 1990s with the role of the state cut down in favour of the market; then, the emphasis on democracy and good governance, the fight against poverty and against gender disparities from the second half of the 1990s up to this day.

The main problem with conditionality does not lie in the nature of the conditions themselves. It lies in the arrogant will to apply them dogmatically, disregard-

ing the different realities in different countries and without a careful and concerned analysis of their immediate and long-term consequences.

Furthermore, often the obligations linked to "new" development objectives and "new" policies to achieve them do not completely replace the previous ones but just add to them. This leads to an excess of bureaucratic and formal procedures complicating the action of recipient countries, overwhelming field actors with requests as useless as they are irritating and slowing down the flow and the effectiveness of aid.

In the last few years many governments and the Bretton Woods Institutions have acknowledged the problems linked to conditionality, but this habit is hard to break. The IMF and the World Bank keep imposing conditions (especially of an economic character) on the governments of recipient countries and many donor countries approve, more or less explicitly[21].

We would like to end this paragraph with a quote from a speech that the President of Mali, Ahmadou Toumani Touré, delivered in 2005 at a forum on development held in Washington: "True partnership supposes autonomy of beneficiary countries in requesting aid and determining its objectives […] Often programmes are imposed on us, and we are told it is our programme […] People who have never seen cotton come to give us lessons on cotton […] No one can respect the conditionalities of certain donors. They are so complicated that they themselves have difficulty getting us to understand them. This is not a partnership. This is a master relating to his student".

The quote is taken from a short essay published by Oxfam International in 2006. This short essay sharply criticizes the enduring imposition of economic policies by IMF and World Bank. At the same time, it recommends the adoption of the so-called "*outcome based conditionality*", linked to progress made towards the achievement of the Millennium Development Goals (MDGs). Very often even these "agreed upon" outcomes, irrespective of their adequacy or achievability, are presented by donors to recipients as "*the outcomes you intend to achieve*".

In another document OXFAM and other international organizations criticize the IMF and the WB not only for the conditions they impose, but also for not evaluating their negative effects on the poorest strata of the population, as well as for the total lack of responsibility for the mistakes made and for their consequences[22]. The relationship between donors and recipients is, by its very nature, unbalanced. Conditionality will never disappear.

… and promises never kept by donor countries

Donors not only impose conditions to recipient countries. They also make a series of promises and take a series of commitments on the amount of aid, on the way this will be delivered and on the results that will be achieved. As William Easterly (a stern critic of international aid) observes in his last book, rich countries have a strong tradition for pompous declarations and glorious objectives to be achieved within time limits constantly moved forward[23].

We can quote the commitment taken in 1977 to ensure universal access to drinking water by 1990 (now moved to 2015) and the one taken in 1990 to achieve universal primary school enrolment by the year 2000 (this, too, moved to 2015). The list could be painfully long. It is worthwhile mentioning the commitment taken by rich countries in 1970 to deliver at least 0.7% of their GDP in aid and the one taken by the G8 countries in July 2005 to double aid to Africa by 2010.

The first, after almost 40 years, has only been achieved by five countries; the second, according to the World Bank, is far from being achieved since aid to Africa, in perspective, does not seem likely to increase. According to OXFAM, if the current trends do not change, the G8 countries, by 2010, will have disbursed in aid US$ 30 billion less than promised[24]. According to other estimates made by the OECD in April 2008, the difference between the amounts promised and those disbursed will be US$ 40 billion[25].

Declarations, conferences and round tables

The amount of aid is not the only important aspect. Also important is the way in which it is disbursed and used. Even in this respect donors' promises and commitments flourish. One of the latest declarations on these issues is the *Paris Declaration on Aid Effectiveness*, delivered on March 2nd 2005 at the end of the High Level Forum on Aid Effectiveness, which started in Paris on February 28th of the same year[26]. The signatories (representatives of more than 100 governments of donor and recipient countries and various international agencies, including IMF, World Bank, United Nations, DAC, Regional Development Banks - African, Asian, European and Inter-American) committed themselves to pursue higher aid effectiveness. The five cornerstones are the basis of the Paris Declaration: 1) ownership, 2) harmonization, 3) alignment, 4) managing for results and 5) mutual accountability. None of these concepts is new. In a way, it is symptomatic that, after more than fifty years and US$ 2.3 trillion spent in aid, these concepts must, once more, be dealt with in solemn declarations and be the object of yet "new" commitments. As the World Bank acknowledges, the results so far achieved to satisfy the commitments taken in Paris "*… are poor*".

The Paris Declaration has been preceded and followed by other similar ones. It is explicitly inspired by the Declaration on Aid Harmonization made in Rome in February 2003 and by the principles adopted in a Round Table on aid management that took place in Marrakech in February 2004. The same principles are contained in many guidelines produced by the DAC, in the notes to the eight MDGs and in many more documents, produced by as many conferences, round tables and forums. All of them, obviously, of "*High Level*".

This plethora of declarations, where the commitments taken and not respected in previous meetings are recycled to become the body of following ones, is depressing. Even the Secretary General of the United Nations, Ban Ki-Moon, stated flatly that "*the world doesn't want new promises*" and that it is mandatory to keep those already made[27].

Effectiveness: does aid help?

Aid effectiveness is an issue as important as it is debated. Books and articles on it are countless. Pessimistic views are more frequent and, arguably, stronger, than optimistic ones. A useful synthesis of the different positions is contained in an essay written by Steven Radelet and published in July 2006 by the Center for Global Development[28].

Action Aid International published two interesting reports, in 2005 and 2006, where it tried to quantify "real aid", i.e. effectively reaching poor people, and "phantom aid", i.e. counted as "aid" by donors but not reaching poor people: either because it goes back to where it came from or because it is literally wasted.

These estimates are often debatable. Nevertheless, they are a bold step in the right direction. According to Action Aid International, in 2004 about US$ 37 billion, that is 47% of DAC countries' ODA for that year, were "phantom aid".

More precisely, US$ 6.9 billion were not directed to fight poverty; 5.7 billion were counted twice (as aid and as debt forgiveness); 11.8 billion were spent in unrequested, ineffective and overpaid TA; 2.5 were wasted because linked to disadvantageous purchases of goods from the donor country; 8.1 were lost because of lack of coordination between donors; 2.1 were spent within the donor countries in measures linked to immigration; and at least 70 million went in administrative costs[29]. As we said, many of these estimates are somewhat arbitrary (as recognized by the authors themselves) because of their complexity and because data are scarce. It is nonetheless worth mentioning them because they contain useful elements deserving attention and reflection.

Common sense, which is not common at all, is enough to accept the need to monitor activities and assess their impact. There is more and more emphasis on the need to monitor not just the activities but their concrete results (impact evaluation rather than process evaluation).

The World Bank published a thick manual on how to do this[30]. The manual clearly states that it is not enough to verify that the planned activities were carried out. It is equally necessary to ascertain that the desired results have been achieved. For instance, in the health sector it is necessary to ascertain that the activities delivered led to decreased mortality levels.

This sort of evaluation is only apparently logic. In poor countries with multiple risks of disease and death, the results achieved in one sector are strictly linked to those achieved at the same time in other sectors. In order to reduce mortality (infant, child, maternal, general) it is not enough to expand the coverage of and the accessibility to health services. Equally needed is progress in agricultural techniques, education, water supply, transport, etc. Evaluating the activities of a single project, or programme, in a single sector in isolation may be misleading.

ODA and wider political coherence

ODA evaluation is often limited to the financial flows and/or to the achievement

of specific objectives. This is a narrow approach.

A laudable effort to widen the scope of evaluation, making it much more meaningful, has been made in the last few years by the Center for Global Development (CGD), a think-tank based in Washington. In 2003 the CGD introduced the Development Friendliness Index, later renamed Commitment to Development Index (CDI). This assesses policies and actions by the countries studied in seven areas, all related to "human development", and is understood as improvement of the quality of life of all the members of a given population. ODA, which is assessed for quantity and quality, is only one of the areas analyzed.

The others are: 1) trade policies (in particular, openness to poor countries' products); 2) policies to promote investment in poor countries; 3) immigration policies; 4) environmental policies; 5) policies to improve global security (in particular, contributions to United Nations peace keeping operations in terms of people and funds); 6) policies to promote and expand research and use of new technologies (including pharmaceutical research especially concerning the so-called "neglected diseases" mainly affecting poor people in poor countries).

In 2007 the CGD studied 21 of the 22 DAC countries (the exception was Luxembourg) to assess their overall political coherence to promote human development. Not surprisingly, the Netherlands, Denmark, Sweden and Norway top this league[31].

Health cooperation

In the framework of international cooperation, health cooperation occupies a special place. Contributing to the achievement of better health in the poorest populations is seen as a particularly worthy objective by everybody. Health cooperation embraces all the cooperation activities aimed to increase the production and the accessibility of quality health services. How much this can actually contribute to improving the health status of entire populations is often debatable. This is an aspect often ignored, or neglected, by a great share of public opinion. The contribution of the health sector to improving the health status of entire populations is marginal. Their good health depends on the availability of food, water, education, sanitation facilities, housing, and transport, much more than on good quality health services. Keeping this in mind should qualify the hope too often put on health services alone. Achieving objectives like a decrease in infant mortality depends less on health services and more on the good functioning of the other sectors mentioned above. Another widespread misconception is that, in poor countries, people fall sick and die because of diseases like diarrhoea, measles, acute respiratory infections, and malaria that can be 'easily' prevented and treated. If these diseases were really 'easily' preventable and treatable, they would be 'easily' prevented and treated. They are not. And they are not because 'simple' measures are problematic and expensive in situations of abject poverty were a few litres of water of dubious quality cost four, six, even eight hours of walking, food is rarely sufficient, homes are unhealthy huts, hygiene is a luxury, and education is lacking. When these (and oth-

er) factors are redressed according to justice and decency, then the diseases that kill the poor of this world will be 'easily' prevented and treated. Only then. Not before.

The reasons behind health cooperation

In addition to the idealistic reasons behind health cooperation, at least two additional ones are often mentioned. The first one is a reaction to the greater ability to travel that has developed in the last decades. According to the United Nations World Tourism Organization (UNWTO), 846 million people travelled for tourism in 2006. This figure is expected to double by 2020[32]. In addition, every year about 200 million people migrate in search of better conditions of life[33]. The appearance of new infectious diseases, like SARS and AIDS, and the threat of pandemics such as avian influenza (whose fear is more or less justified) contributed to making many (though not everybody) understand that health is a global good. Strengthening the health systems of poor countries, apart from being a due act of justice, contributes to the protection of everybody. The other reason often mentioned for promoting health cooperation is that healthier populations are more productive and, therefore, can better contribute to economic growth. Put in nobler terms, this contributes to fighting poverty[34]. Both reasons make sense. Both, however, run the risk of minimizing the fact that better health for everybody must be pursued because it is a value in itself and health is a fundamental human right. And this is an additional reason, arguably the most important one, behind development cooperation in general and health cooperation in particular.

The iniquitous inequalities in the distribution of diseases and of the resources to fight them, iniquitous because avoidable, are well known. For instance, the Americas, with 10% of the world disease burden, have 37% of world health workers and are responsible for 50% of world health expenditure. Africa, with 24% of the world disease burden, has 3% of world health workers and is responsible for 1% of world health expenditure[35]. According to the database of the Creditor Reporting System (CRS) of the OECD, the ODA targeting health (Development Assistance for Health, DAH) has significantly increased in the last few years. It was US$ 2.5 billion in 1990 (0.016% of donor countries' GDP, or 4.6% of the total ODA) and US$ 13 billion in 2005 (0.041% of donor countries' GDP, almost 13% of the total ODA)[36]. The increased DAH contributed to the increased health expenditure in poor countries, which doubled, in absolute terms from US$ 170 billion in 1990 to US$ 351 in 2002 (from 4.1% to 5.6% of these countries' GDP)[37]. As often happens, everything that glitters is not gold. The increased health expenditure by poor countries includes, in the majority of cases, donors' funds disbursed as budget support. Furthermore, health expenditure increased in poor countries as a whole, but decreased in a few countries, especially in many of the so-called fragile states.

Health cooperation and health systems

A system is a set of integrated components working together to achieve a given objective. Acting on one component also affects all the others. Thinking systemically means considering the whole and the possible effects on all components of actions targeting only one or a few of them. Thinking systemically is exactly what many donors and many organizations do not do when they intervene in the health systems of poor countries. The health sector is the one with the highest number of actors in the framework of the so-called "aid system". In this sector, proliferation and fragmentation reach their highest levels. The picture is made even more complex by the fact that, in receiving countries, not all health-related activities are under the responsibility of the Ministry of Health. The training of health workers is, in many countries, under the responsibility of the Ministry of Education; salary and disciplinary matters are under the Ministry of Public Services; the Ministry of Defence and the Ministry of Internal Affairs manage important health units and research centres; the Ministry of Labour manages health insurance (where it exists); the responsibilities of the central and local authorities are often blurred and interpreted in different ways by different people.

At least 100 identifiable organizations operate in the health sector, but financial flows and initiatives are in the thousands. The range goes from small organizations sending people with a lot of goodwill, but very little competence, to carry out activities of dubious use, to organizations of world importance with huge amounts of funds managed by highly qualified officers pursuing policies more or less discussed and approved by local governments. The first ones increase confusion and often waste funds and energies; the second ones, equally often, exercise very strong pressure on local governments to promote pre-conceived policies. Such pressure leads to the health policies of many poor countries becoming almost the same. It is certainly true that many of their health problems are also the same. But it does not seem plausible that the best ways to face them, with minimal differences, are the same in every situation: diminished role of the state, increased role of the private sector, decentralization, hospital autonomy, user fees, health insurance, etc. These are some of the measures universally suggested to the governments of poor countries. Not all of them are necessarily always wrong. But, undoubtedly, they cannot be universally good. Coming from rich donor countries, their adoption is more often than not a pre-condition to obtain financial aid. Including those that led to mainly negative results, such as user fees and a diminished role of the state. Only strong governments with competent, honest and committed officials, with clear and evidence-based ideas, can try to resist the imposition of these measures.

Vertical approach and limited objectives

Donor funds to health sectors are often directed towards the control of specific diseases like AIDS, Tuberculosis, Malaria, Poliomyelitis, etc. Between 2000 and 2004, the funds to fight HIV/AIDS doubled, while those for primary health ser-

vices halved[38]. Donors often fund vertical programmes, not integrated in the local health systems, with their own structures and management systems. The money spent in this way is not always useful to the recipient countries. In a 2003 study, the Ugandan Ministry of Health analysed the use of funds of five important international organizations: DANIDA, DFID, GTZ, SIDA, and USAID. It was found that only 32% of those funds contributed to the implementation of the National Health Sector Strategic Plan. The remaining 68% went on administrative overheads, unnecessary (and often harmful) refresher courses, unrequested TA[39]. According to a 2005 study, only 25% of the health cooperation funds support National Health Plans[40]. This is a particularly serious matter since donors' funds may lead to a decrease in the national funds made available for health. This happens where, like in Uganda, the Treasury, inspired by the IMF, for debatable macroeconomic reasons, fixes financial ceilings for the single ministries, and such ceilings include donors' funds. This means that many governments, in the presence of significant external funds for the health sector, reduce their own contributions to keep health expenditures within the fixed ceiling. The perversity of such a system is evident. In spite of the good intentions expressed in the Paris Declaration, the vertical use of funds continues. An often used justification is the administrative and managerial weakness of the recipient countries. This is a vicious circle: national systems are weak, therefore many parallel systems are created and they further weaken the national ones. In reality, the easiest, safest and most visible option is adopted. It is not the one that can produce the best and the most sustainable results. Often, however, it is the one that can ensure quick results easily attributable to the funds used: vaccination campaigns, building of new health units (whose recurrent costs are always left to the local governments), refresher courses, etc.

Global Health Partnerships

The vertical approach has been strengthened in the last decade by the mushrooming of Global Health Partnerships (GHP). These are partnerships between international and national organizations and various private foundations. There are many: GAVI (Global Alliance for Vaccines and Immunizations), GFATM (Global Fund to fight AIDS, Tuberculosis and Malaria), GPEI (Global Polio Eradication Initiative), Global Partnership to Stop TB, RBM (Roll Back Malaria), GAIN (Global Alliance for Improved Nutrition) and many others. There isn't an accurate census of them, but it is estimated that there are between 70 and 100, depending on the definition adopted[41]. And their numbers are increasing. About 65% of those identified deal with HIV/AIDS, Tuberculosis and Malaria. They differ a lot as for size, importance and effectiveness. All of them increase the complexity of an already complex environment. In many cases they succeed in drawing public attention to the importance of fighting against certain diseases and in mobilizing huge amounts of funds. In the last decade the majority of the increased funds for health cooperation were disbursed through GHP, going to the fight against specific diseases rather than to the strengthening of health systems. It is hard to tell if such

funds are additional. In other words, it is hard to tell whether they have been made available thanks to the GHP, in addition to the funds that would have been made available anyway for health cooperation, or (as it is more likely) whether they hijacked the available funds for the achievement of the GHP objectives.

The proliferation of GHP strengthened the vertical approach. Attention has been focused on specific problems, thus losing sight of the overall situation and neglecting the systemic effects of specific actions. Injecting funds for the execution of certain activities, often as staff incentives, has ensured their execution to the detriment of other activities equally (if not more) important and necessary. This is what happened with the incentives offered for vaccinations. Even more harmful effects are produced by the incentives offered for participation in refresher courses, seminars, workshops of any kind, all funded with remarkable generosity: a real epidemic with extremely negative systemic effects, as denounced also by WHO[42]. A 2005 study based on interviews with 350 officers in 20 different countries, confirmed that GHP, with their multiple, parallel managerial systems, are too onerous for the weak managerial systems of recipient countries; that the communication between the GHP and the recipient countries' officers is unsatisfactory: that little attention is paid to the systemic effects of their actions; and that the transaction costs of their activities are too high[43]. With their abundant funds, their high media visibility, their considerable political influence, without a systemic approach, they can seriously compromise the success and the sustainability of National Health Plans. They can distort priorities, monopolize the scarce human resources, create wasteful duplications and favour the proliferation of structures and sub-systems for the delivery of health services. The actions of many GHP led to the introduction of effective, but very expensive, measures like the antiretroviral drugs and some new vaccines. It is hard to think that, in the foreseeable future, poor countries will be able to meet the high costs required to sustain such interventions. The situation is made even worse by the unpredictability of aid funds. This means that the recipient countries cannot forecast their availability of funds for a reasonable span of time. They cannot foresee which promises will be kept and which will not. They cannot formulate mid- and long-term plans with a reasonable guarantee of funding for them.

A critical situation requiring better quality aid

In spite of the increase in funding for health activities, the health indicators of poor countries, especially in Sub-Saharan Africa, have not improved significantly, have remained stagnant or, in some cases, have even worsened. The statistical tables annexed to the UNICEF State of the World's Children 2008 show that, between 1990 and 2006, the infant and child mortality rates worsened in 11 countries (10 of them in Sub-Saharan Africa) and the life expectancy at birth decreased in 24 countries (18 of them in Sub-Saharan Africa)[44]. Obviously, the aid system cannot be blamed for this deterioration. It is nevertheless clear that, faced with such a situation, those dealing with health cooperation should concentrate on a few key as-

pects that we already touched on when discussing cooperation in general. This could, at least, minimize the waste of scarce resources and the implementation of harmful activities. This requires a true alignment of objectives and interventions with those of the governments of recipient countries, i.e. effective coordination between donors to avoid duplications and unreasonable administrative and bureaucratic burdens for the recipient countries; constant, frank and transparent monitoring of activities; and constant commitment to strengthening the health systems of recipient countries.

Conclusions

It seems reasonable to think that, for the foreseeable future, the so-called "aid system" will keep wading through the marshes of its contradictions, illusions, delusions, failures and partial successes, as it has done for the last 50 years.

Nevertheless, something has changed and keeps changing. There is an increased awareness of the mistakes made by many donors, agencies, and organizations, their incoherencies, their hypocritical and paternalistic arrogance, their inefficiencies and the regrettable lack of responsibility and accountability. This increased awareness, however, does not eliminate the problems.

Reforming the "aid system", which is not a "system" but a sort of cauldron containing almost anything, from good to bad and worse, is a long and slow process.

What remains is the unbearable injustice of the iniquitous inequalities between those who have and those who have not. What remains is the intrinsic goodness of the idea that those who have must promote a change leading towards more justice, towards a more bearable human condition for all.

To say that development aid has failed to lift poor countries to the desired levels of human development is true. At the same time, it is naive and narrow-minded: development aid will never lift poor countries to the desired levels of human development. More realistically, if well used, it can contribute to doing so. The objective is too ambitious for a 'system' that mobilizes about US$ 100 billion per year (and wastes about 40% of it).

In the conclusion to his last book, Easterly launches a devastating attack on aid because, after 50 years "twelve cent medicines do not reach children dying of malaria […] four-dollar bed nets do not get to the poor to prevent malaria". Such levels of oversimplification are astonishing, especially when they come from authors who, because of their experience and knowledge, should give us much deeper and more articulated analyses.

It is certainly true that drugs and bed nets do not reach where they should. But this is not only the result of the failure of development aid.

This is the result of a much wider and much more serious failure. To make sure that drugs and bed nets (and much, much more) change the life and destiny of millions of people who die of poverty, it is the fight against poverty that must be fought and won. Aid is but a very small instrument in this fight. Often it is just a sort of alibi, a fig leaf for governments and ordinary people in rich countries to

hide the shame of unbearable and unjust inequalities. Aid is certainly not enough.

Much wider and coherent policies are needed at international level, policies embracing, as briefly mentioned above, international trade and investment, environmental protection and technical innovation, migration and arms control.

Condemning the "aid system" for its inefficiency, corruption and ineffectiveness is legitimate and, often, right. To say that the inhuman life conditions of billions of people are a consequence of the failure of the "aid system" is short-sighted at best and the hypocritical search for an easy scapegoat at worst.

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