OFFICIAL DEVELOPMENT ASSISTANCE: A CRITICAL OVERVIEW

Maurizio Murru
E-mail: maurimurru@gmail.com

The author is a private consultant on Health Systems in Developing Countries based in Modena, Italy and a Visiting Senior Lecturer, Uganda Martyrs University.

Abstract

Whereas 22 developed countries have pledged to contribute a paltry 0.7% of their GDP in form of Official Development Assistance (ODA) to developing countries, after 40 years of the commitment, only five countries have come close to that target. This paper argues that even then, the assistance is provided inefficiently since most of it is spent as unsolicited expensive Technical Assistance or repatriated in form of input purchase conditionalities. The paper also argues that ODA figures are artificially inflated by donors including forgiven debts as new assistance. It traces the recent history of development assistance from the Marshall Plan to the Paris Declaration on Aid Effectiveness. It singles out aid conditionalities as "master-student arrogance". It also criticises endless postponement of deadlines for achieving human development goals as tantamount to goal-shifting. Finally, it concludes that external aid cannot deliver a country from poverty, since the amounts committed are too small, the commitment too little, the donor agendas too many, and argues that only fair trade can contribute meaningfully to lifting the poor in recipient countries to acceptable levels of human development.

The beginning

Theoretically, the logic behind the so called "Official Development Assistance" (ODA) lies in the enormous and unjust inequalities between the standards of life of rich and poor countries' populations. Definitions and concepts of "development" have 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 "*[human development] denotes both, the process of widening people's choices and the level of their achieved wellbeing*" (UNDP, 1990). ODA from rich countries should, by definition, contribute to the *human development* of poor countries' populations.

Even during the colonial era, sporadic and disjoined activities were carried out by individuals and organizations "in favour" of colonized countries' people. 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 about US$ 840 million and the French spent about US $ 1,108 million (Biroli, 1994) for this purpose. 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 so called "Marshall Plan" that, between 1948 and 1951, channelled from the United States to 16 European countries US$ 13.812 billion, about 2% of the American Gross Domestic Product -GDP- of the time (Mammarella, 1986).

In his US presidential inaugural speech on January 20th 1949, Harry Truman said "… *We must embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement 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*" (Truman, 1949).

The speech contains some of the recurrent themes, the illusions and the declared good intentions of the "*International Aid System*" (which, by the way, is not a "system" at all). We do not want to discuss the different and complex aspects of the Marshall Plan here. However, it is, for now, acknowledged that it had humanitarian, strategic and economic objectives. Today's ODA, too, has a wide range of motivations: from the noblest aspirations to 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, and of 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*" (World Bank, 2002). According to the most commonly accepted definition, introduced by the Development Assistance Committee (DAC), an organ of the Organization for Economic Cooperation and Development (OECD) responsible for following up and improving aid effectiveness, any financial transfers from rich to poor countries to be considered "Official Development Assistance" must satisfy at least three conditions:

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 (Dengbol-Martinussen et al. 2003)

The OECD was born in 1961, when it replaced the OEEC (Organization for European Economic Cooperation) founded in 1948 to manage the Marshall Plan funds. Currently the OECD member states are 30 (not all of them are, also, DAC members) and others wait to join.

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 included, in their ODA, the forgiveness of debts incurred by poor countries to buy American weapons. However, administrative costs of delivering aid are still counted as part of the aid. The most accurate and complete data are those on the funds released by the 22 DAC member countries. These data 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, even because these countries do not seem very keen to release this sort of information.

In 1958 ODA amounted to US$ 3.2 billion. This amount increased gradually in absolute terms, especially in the second half of the 70s and between 1985 and 1992. From 1992 ODA funds decreased gradually in absolute terms (Dengbol-Martinussen et al. 2003). They started to grow again in 1998 reaching their peak in 2005, at US$ 106.5 billion. This was 0.33% of DAC countries' GDP, up from 0.24% in 2004 (OECD, 2006). It is worth noting that the 2005 record amount in absolute terms, when calculated as donor countries GDP, was the same as in 1992. In 2006 the ODA flows from DAC countries decreased to US$ 103.9 billion, equal to 0.3% of their combined GDP (OECD 2007). In absolute terms, in 2006, the US was the biggest donor, with US$ 22.74 billion. However, by considering ODA as a percent of GDP, the USA are next to last, with a mere 0.17%. In 1969 the United Nations Commission on International Development, chaired by Lester Pearson, proposed that rich countries earmark, every year, 0.7% of their GDP to ODA. 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 (OECD, 2007).

The growth of ODA in the last few years (about 11% per year between 2001 and 2005) was mainly due debt forgiveness (about 70%); only 25% was due to the release of new funds (IDA, 2007).

Numerous countries not belonging to the DAC group channel increasing funds to ODA. According to IDA (International Development Association, the World Bank's branch responsible for giving 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 (World Bank, 2007). ODA funds from countries not belonging to OECD, like Brazil, China, India, Russian Federation, Saudi

Arabia, etc. were about US$ 5 billion in 2005, about three times as much as in 2001 (World Bank 2007). 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.). However, 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 (World Bank, 2007).

Other financial flows towards poor countries

ODA represents only one of the financial flows towards 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 only about US$ 38 billion and was mostly directed towards countries rich in oil and other natural resources (UNCTAD 2007).

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 (ILO 2006). These are only estimates. Significant amounts of money are moved through informal channels and they can only be "guesstimated". The World Bank estimates that the amount not captured by official statistics could be equal to (or, even, higher than) 50% of the official one. This would bring remittances to a total of more than US$ 250 billion (World Bank, 2006a). 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 (DAC 2007):

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) is used by the United Nations since 1971. It is not only based on income criteria and it includes countries judged "… *structurally disadvantaged in their development process and, more than other countries, at risk of failing in their effort to escape poverty*" (UNCTAD, 2005). This group currently includes 50 countries, 34 of them in Africa. The percentage of ODA channelled to the first two categories has been around 60% from the 70s onwards and achieved 67% between 2001 and 2005 (IDA, 2007). Between 2001 and 2005 Sub-Saharan Africa received about 38% of DAC countries' ODA (in the 60s it was about 20% and in the 70s about 22%); Southern and Central Asia received about 15%; Middle East and North Africa 14% and East Asia 11% (IDA, 2007).

The distribution of aid funds is not homogeneous and does not always reflect equity criteria. Political and commercial interests play an important role. Political considerations, which were of paramount importance during the Cold War, still are. Even if the total amount of ODA increased by about 55% between 2001 and 2005, only 18 of IDA eligible countries have seen their aid growing by 50% or more. Afghanistan, the Democratic Republic of Congo, Liberia, Nigeria, the Republic of Congo, Sudan, have seen the most significant increases (World Bank, 2007).

Aid to Fragile States

The euphemistic term "fragile states" refers to those countries not able (or not willing) to deliver to their citizens basic rights such as security, education, health, and development opportunities in general. They often are states plagued by protracted armed conflicts or social crisis, 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 CPIA (Country Policy and Institutional Assessment) 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 (World Bank, 2006b).

During the last few years, based on facts and common sense, the idea that aid works better in countries ruled by governments functioning reasonably well and that, therefore, it should be given *selectively* has gained ground. 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 even 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, only in the African Continent do 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 (IANSA et al, 2007). 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 than attempting to support the entire fragile country. In 2005 the "fragile states" received about US$ 20 billion in aid. Excluding debt forgiveness and emergency aid, this amount comes down to US$ 10 billion (World Bank, 2007). In a 2002 article Easterly has stigmatized the decision of the International Monetary Fund (IMF) and the World Bank of granting further debt forgiveness to Burkina Faso as follows " … *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*" (Easterly, 2002). This is a complex issue with no simple solution. There are only weak 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 to the government of a recipient country (bilateral aid), through international organizations like the various United Nations Agencies and Funds, the European Union, Regional Development Banks and Regional Development Organizations (multilateral aid) or (increasingly) through Non-government organisations (NGOs). 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 (IDA, 2007).

Aid can fund specific projects or can contribute to the state budget of the recipient country or to the budget of specific sectors (health, education, transport, etc.). General Budget Support should allow for a more flexible and efficient use of aid funds. Disbursement for general budget support 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 ease the achievement of objectives like donor coordination, alignment of donor and recipient objectives, lower transaction costs, greater transparency and accountability.

In practice, as always, things are slightly more complex. Donors, acting not in a disjoined way, with 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 recipient countries' governments if represented by a critical mass of officers with competence, commitment and integrity (as it happened in the Uganda health sector between the end of the '90s and the beginning of the new century). A transparent budget support is likely to be easier when recipient countries' governments are trusted for their competence, transparency and honesty.

A study on budget support efficiency and effectiveness, commissioned by 19 bilateral cooperation agencies, five international agencies and seven recipient countries governments, published in 2006, reached fundamentally positive conclusions on this way of disbursing funds (Birmingham University, 2006). More and more donors are choosing budget support. In 2001 aid funds directed towards budget support were 8% of the total DAC countries' ODA funds. In 2004 this amount was 20% (IDA, 2007).

According to recent estimates, aid funds directed to social sectors like education, health and water supply,

increased from 29% in the 90s to 52% between 2000 and 2004, and from 33% to 60%, respectively, in Sub-Saharan Africa (IDA, 2007). 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 effectively the use of aid funds. In the 40s, bilateral donors were less than a dozen. Today they are more than 50. Even the number of International Organizations, specific Funds and Programs increased rapidly: it is estimated that they 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 60s 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 (IDA, 2007).

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), expensive and, often, irrelevant. In 2004 alone, TA missions funded by various donors, often linked to small disbursements of short duration, were more than 20,000: more than one per day in each and every one of the recipient countries (IDA, 2007). It is easy to understand the problems posed by this situation to the administration of structurally weak countries. This high number of actors, with their priorities, their monitoring and accounting systems, their fragmented activities and often non-requested TA missions, lead to a high level of bureaucratization, confusion, duplications and waste. It increases the costs and decreases the effectiveness of aid. To all this, one must add 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 reasonably good idea of the crazy situation of many recipient countries. In 2005 the great part 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 the ones of the government. Still in 2005, the country received 541 missions sent by various donors and only 17% of them involved more than one donor (DAC, 2006).

Conditions always imposed on recipient countries...

For the last 60 years or so, in rich countries, a flurry of theories have followed one another 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 IMF and the World Bank. However, in a 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 of this approach.

The policies imposed on recipient countries, stemming from the different theories on development, were always thought to be right and immune to criticism. We have seen the state supported as the main actor in promoting development, especially of infrastructure, in the 50s and 60s of last century; then we have seen the "basic needs" approach in the 70s; then the structural adjustment programmes in the 80s and 90s 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 90s up to this day.

The main problem with conditionality does not even lie in the nature of the conditions themselves but in the arrogant will to apply them dogmatically, disregarding the different realities in different countries and without a careful and concerned analysis of their immediate consequences. Furthermore, often, the obligations linked to "new" development objectives and "new" policies to achieve them do not even completely replace the previous ones but just add onto them. This leads to an excess of bureaucratic and formal procedures complicating the functioning 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 same Breton Woods Institutions have acknowledged the problems linked to conditionality, but this habit is hard to disappear. The IMF and the World Bank keep imposing conditions (especially of economic character) on the governments of recipient countries and many donor countries approve, more or less explicitly (OXFAM International, 2006).

We would like to end this paragraph with a quote from a speech that President Ahmadou Toumani Touré of Mali, delivered in 2005 at a forum on development held in Washington and published in a short essay by Oxfam International in 2006: "*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*" (Oxfam International, 2006). The 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 upon the poorest strata of the population and for the total refusal to take responsibility for the mistakes made and for their consequences (OXFAM International, 2007a). 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 recent book, rich countries have a strong tradition for pompous declarations and glorious objectives to be achieved within time limits constantly moved forward (Easterly, 2006).

We can quote the commitment, taken in 1977, to ensure universal access to drinking water by 1990 (now moved to 2015), 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 to mention the commitment taken by rich countries, in 1970, to deliver, in aid, at least 0.7% of their GDP 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 been achieved only 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 (Word Bank, 2007). 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 (OXFAM International, 2007b).

Declarations, conferences and round tables

The amount of aid is not the only important aspect. It is also important 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, started, in Paris, on February 28th of the same year (Paris declaration, 2005). The signatories (representatives of more than 100 governments of donors 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. Five major aspects are mentioned: ownership, harmonization, alignment, results and 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 achieved to respect the commitments taken in Paris "… *are poor*" (World Bank, 2007).

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 of the MDGs and in many more documents, produced by as many Conferences, Round Tables and For a, 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 does not want new promises* …" and that it is mandatory to keep those already made (Dept of Economic and Social Affairs, UN, 2007).

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 (Radelet 2006). Action Aid International published two reports, in 2005 and 2006, where it tried to quantify "real aid" (effectively reaching poor people), and "phantom aid" (counted as "aid" by donors but not reaching poor people: either because it goes back where it came from or because it is, literally, wasted). These estimates are, often, debatable. Nevertheless, they are a bold attempt in the right direction. According to Action Aid International, in 2004, about US$ 37 billion, that is 47% of ODA from DAC countries for that year, was "phantom aid"(Action Aid International, 2006).

More precisely, US $6.9 billion were not directed to fight poverty, US $5.7 billion were counted twice (as aid and as debt forgiveness), US $11.8 billion were spent in TA not requested for, ineffective and overpaid, US $2.5 billion were wasted because they were linked to disadvantageous purchases of goods from the donor country, US $8.1 billion were lost because of lack of coordination between donors, US $2.1 billion were spent within the donor countries in measures linked to immigration and at least 70 million went in administrative costs (Action Aid International, 2006). As said, many of these estimates are, somehow, arbitrary (as recognized by the authors themselves), because of their complexity and because data are scarce. It is nonetheless useful to mention them because they contain useful elements deserving attention and reflection. Common sense suggests that there is a need to monitor the activities implemented with donor funds and to assess their impact. There is also greater emphasis on the need to monitor not just the activities but also their concrete results (impact evaluation rather than process evaluation).

The Word Bank published a thick manual on how to do it (World Bank 2004). In the manual, it is clearly stated 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. To evaluate 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 the evaluation, making it much more meaningful, has been done, in the last few years, by the Center for Global Development (CGD), a think tank based in Washington DC. In 2003 the CGD introduced the *Development Friendliness Index*, later renamed *Commitment to Development Index* (CDI). This assesses policies and actions of the countries studied in seven areas all related to "human development" understood as improvement of the quality of life of all the members of a given population. ODA, assessed for quantity and quality, is only one of the areas analyzed.

The others are: trade policies (in particular, openness to poor countries' products), policies aimed to promote investment in poor countries, immigration policies, environmental policies, policies aimed at improving global security (in particular, contributions to United Nations peace-keeping operations in terms of people and funds), policies aimed 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 topped this "league" (CDG 2007).

Conclusions

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

Nevertheless, something changed and keeps changing. There is an increased awareness of the mistakes made, of the incoherencies, of the hypocritical and paternalistic arrogance, of the inefficiencies and of the regrettable lack of responsibility and accountability by many donors, agencies, organizations. This increased awareness does not eliminate the problems. To reform the "aid system" which is not a "system" but a sort of cauldron where one can find almost anything, from good to bad and worst, 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. It 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 state that development aid failed to lift poor countries to the desired levels of human development is true and, at the same time, naïve 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 do it. 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 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* …" (Easterly, 2006). 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 the result of the failure of development aid. Not only. 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 the 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 conditions of life of billions of people are a consequence of the failure of the "aid system" is short-sighted in the best case and the hypocritical search for an easy scapegoat in the worst.

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RECENT RELEVANT INTERNATIONAL PUBLICATIONS

COPING WITH LIFE IN REBEL CAPTIVITY AND THE CHALLENGE OF REINTEGRATING FORMERLY ABDUCTED BOYS IN NORTHERN UGANDA

***Amone-P'Olak Kennedy, 2007**:*

Journal of Refugee Studies Vol. 20, No. 4

The paper reports a study, involving 134 formerly abducted boys and conducted in four rehabilitation centres in northern Uganda, reports on the coping mechanisms used by the boys to survive their captivity. They include prayer, cooperation, obedience, vigilance, blaming others and constant preparedness to flee.

ACTION FOR CHILD SURVIVAL: ELIMINATION OF THE HEMOPHILUS INFLUENZAE TYPE B MENINGITIS IN UGANDA

***Lewis FR et al., 2007**:*

Bulletin of the World Health Organisation 2008; 86: 292 -301

The paper reports a study of the effectiveness of Hib vaccine in reducing Hib pneumonia and meningitis in 17 districts of Uganda. It shows that the vaccine protects against 28,000 cases of pneumonia and meningitis, 5000 deaths and 1000 severe sequelae every year.

SELF-SETTLED REFUGEES IN UGANDA: AN ALTERNATIVE APPROACH TO DISPLACEMENT

***Hovil Lucy, 2007**:*

Journal of Refugee Studies, Vol. 20 No. 4

This paper looks at the life of self-settled refugees in Uganda and finds that that they are in control of their lives and even planning for the day they will go back home. It concludes that self-settlement, a model used mainly in Uganda, is likely to be a more successful approach to manage refugees than other models.

AIDS-RELATED STIGMA: PERCEPTIONS OF FAMILY CARE-GIVERS AND VOLUNTEERS IN WESTERN UGANDA

***Kipp W et al., 2007**:*

World Health & Population, April 2007.

Despite the long presence of HIV/AIDS in Uganda, the disease still attracts stigma from the community. This study shows, however, that opinions about this differ, depending on whether one is a family member with a patient or just a volunteer. Volunteers seem to perceive a lot of stigma while family care-givers think it has reduced.

'I BELIEVE THAT THE STAFF HAVE REDUCED THEIR CLOSENESS TO PATIENTS': AN EXPLORATORY STUDY ON THE IMPACT OF HIV/AIDS ON STAFF IN FOUR RURAL HOSPITALS IN UGANDA

***Dieleman M, et al., 2008**:*

BMC Health Services Research 2007: 7, 205 DOI: 10 1186/1472-6963-7-205. Available from http:// www.biomedcentral.com/1472-6963/7/205

The paper reports on a study done in four hospitals in central Uganda. It found that HIV/AIDS places physical and emotional demands on health workers. Workload has increased and HIV-positive staff fear to disclose their status and other staff even fear to test due to fear of stigmatization. Organisational responses have been haphazardly implemented and staff left without morale. It highlights opportunities for improvement of staff morale such as CME and support supervision.

ASSESSMENT OF THE ADDITIONAL DUTIES HOURS ALLOWANCE SCHEME:

***Ruwoldt P et al., 2007**:*
Final Report

This report on the Additional Duties Hours Allowances (ADHA) scheme implemented by the Government of Ghana to motivate health workers shows how financial allowances to health workers can have a lot of unintended effects. Overall, they did not increase the retention of doctors but were able to attract back retired staff and those who had moved to other sectors. However, the allowance led to migration of health workers to areas with a free hand to adjust the levels of allowances and also to the categorization of health workers as the *nouveau riche* who were targets for higher prices and robbery.

TASK SHIFTING: RATIONAL REDISTRIBUTION OF TASKS AMONG HEALTH WORKFORCE TEAMS

***WHO, 2007**:*

Global Recommendations and Guidelines

In this document, the WHO, gives guidelines for health systems with staffing constraints, on how to, rationally, shift tasks to les qualified cadres of staff. Task-shifting has been recognized as a possible stop-gap measure to enable health systems to cope with a shortage of staff. Examples of task-shifting include allowing Clinical Officers to do Caesarean sections, as was done in Malawi and Mozambique. However, task-shifting has to be done very carefully, and hence the guidelines.

POST-OPERATIVE OUTCOME OF CAESAREAN SECTION AND OTHER MAJOR EMERGENCY OBSTETRIC SURGERY BY CLINICAL OFFICERS AND MEDICAL OFFICERS IN MALAWI.

***Chilopora G et al., 2007**:*

Human Resources for Health 2007, 5: 17 DOI: 10.1186/1478-4491-5-17

This study shows that carefully selected and trained Clinical Officers have comparable outcomes from Caesarean sections and other emergency and obstetric operations. In Malawi, Clinical Officers did 90% of the uncomplicated Caesarean sections, 70% of those requiring sub-total hysterectomy, 60% of those requiring total hysterectomy and 89% of those where uterine repair was required. Immediate and 24-hour post-operative outcomes were similar for doctors and Clinical Officers. It concludes that Clinical Officers are a crucial cadre and a potential substitute for doctors on some tasks.

INTENT TO MIGRATE AMONG NURSING STUDENTS IN UGANDA: MEASURES OF THE BRAIN DRAIN IN THE NEXT GENERATION OF HEALTH PROFESSIONALS

***Nguyen L et al., 2008**:*

*Human Resources for Health 2008. **6**:5 doi: 10.1186/1478-4491-6-5*

The paper presents the results of a study of the plans of nursing students at two universities in Uganda. It shows that most of them would cherish to work abroad but that some do not intend to pursue that vision. Students from a rural background were less likely to want to emigrate. Poor remuneration seems to be the major 'push' factor for the migrating nurses and the study concludes that improved remuneration might improve on the retention of nurses.

COURSES IN THE FACULTY OF HEALTH SCIENCES 2008/9

The Faculty of Health Sciences of Uganda Martyrs University invites applicants for the following one-year courses tenable in Academic Year 2008/2009:

1. Master of Science in Health Services Management (M.Sc. HSM)
2. Advanced Diploma in Health Services Management (ADHSM)
3. Advanced Diploma in Health Promotion and Education (ADHPE)

Master of Science Health Services Management (Full Time)

The M.Sc. (HSM) course gives to its participants a deeper and wider understanding of the main national and international issues in management of public health services. Our practice-oriented approach aims at developing further the participants' managerial competencies, as well as the analytical and critical thinking. Our facilitators, from a wide range of practice and academic fields like the Ministry of Health, national and international organisations and other institutions enrich the course with a wide experience. The taught courses start in the 3rd week of August and end in the second week of May of the following year. Dissertations are finalised in mid-September for graduation in November. The course comprises 10 modules including the dissertation: Primary Health Care, Health Policy, Planning and Management; Health Economics and Financing of Health Services; Management of Financial Resources and Material Resource; Epidemiology and Biostatistics; Health Systems Research Methods; Field Analysis (Field-based for 4 Weeks); Human Resources Management, Leadership and Organisations; Environmental and Occupational Health; Refugee and Emergency Health Services; Dissertation (4 months).

Part-time Programme for MSc. HSM

In 2008/9, we shall also expand our intake for the part-time MSc. HSM programme. Candidates on this programme may apply and get admitted at any time of the year. They may attend any of the above modules at a time of their choice. The modules are offered at Nkozi campus and participants are expected to be resident at Nkozi during the modules. Thereafter, they may go back to their workplace until they are able to come for their next module of choice. Staff normally advise participants on how to select the modules. Modules last 2-4 weeks and the entire set of modules must be completed within 3 years. Part-time participants may choose to pay per module to be attended.

Intending applicants for the MSc. HSM should possess a degree obtained from a recognised university and at least two years of working experience. Applicants with a degree other than medical need to have at least three years of working experience with some knowledge of the health sector. Applicants without a university degree need to have equivalent qualifications and pass a Mature Entry interview. Our past graduates are employed with the Ministry of Health, the District Health Services, the Private-not-for-profit health sub-sector and local and international health NGOs.

Advanced Diploma Programmes

These programmes have specific specialisations in either Health Services Management or Health Promotion and Education for candidates who have excelled in performance. Advanced Diploma candidates do individual research and produce a dissertation. The programmes have core modules and specialisation modules. Core modules are Computer Literacy; Writing and Reading Skills; Ethics in Focus; Primary Health Care, Health Policy, Planning, and Management; Fundamentals of Epidemiology and Hospital Statistics; Health Systems Research Methods; Project Planning and Management; and Field Attachment (4 Weeks).

Diploma in Health Services Management

Since this course addresses the needs of mid-level health services managers ranging from mid-level district managers to hospital administrators, from diocesan health co-ordinators, to officers in charge of health centres and dispensaries, from senior nursing officers to nurses in charge of hospital wards, course participants are equipped with the knowledge and competencies to manage health services as supervisors and mid-level managers. The specialisation Modules currently on offer for this course are: Health Economics and Financing of Health Services; Human Resources Management, Leadership and Organisations; Fundamentals of Accounting and Management of Financial Resources; and Management and Maintenance of Material Resources

Diploma in Health Promotion and Education

This course addresses the need for qualified and professional Health Promoters with both educational skills and a managerial orientation by the Ministry of Health, Districts and health NGOs. It also addresses a progressive international shift, in which health education is seen as a component of the wider process of health promotion. The participants are mid-level health service managers working at districts and health sub-districts, hospitals, lower-level health units, health-related organisations and other relevant institutions engaged in the practice of Health Promotion and Health Education. Qualified teachers are also eligible. The course gives the participants skills in health problem analysis, health policy issues and educational skills to convey health knowledge to individuals, families and communities effectively, to affect attitudes and effect behaviour change. Specialisation modules currently on offer are Learning and Behaviour Change; Environmental and Occupational Health; Communicating health messages; and Health Promotion and Education to children

Part-time Certificate Programmes

We offer part-time certificate courses in Health Services Management and in Health Promotion at St. Augustine Institute, Nsambya, Kampala, for people who cannot afford to be away from work for more than 1 week. The courses last a total of 5 weeks, spread 3 months apart.

APPLICATIONS

Application forms can be obtained from the Registrar, Uganda Martyrs University, P.O. Box 5498 Kampala, Uganda, Tel: (+256) 0382 410611, Fax: (+256) 0382 410100, Email: registrar@umu.ac.ug or health@umu.ac.ug from our Kampala office at: Uganda Catholic Social Training Centre – Rubaga, Tel (+256) 041 236931, Fax: (+256) 041 236931 or downloaded from the university website www.umu.ac.ug Completed forms should reach the Registrar by 15th June.

Scholarships: A limited number of scholarships are available for eligible candidates. Candidates working with the PNFP sector may apply to the Uganda Catholic Medical Bureau through their Boards of Governors or Congregations. Other interested candidates may apply directly to the Chairman, Scholarships Committee, through the Dean, Faculty of Health Sciences.