

## D2.I US foreign assistance and health

The unparalleled military, economic and cultural power of the United States gives it the capacity to impact hugely on global health, both negatively and positively. Many people feel that the balance sheet is negative despite the large amounts of aid the US has given to the developing world. They cite, among other things, US influence over the design of a global political economy that has widened inequalities and obstructed poverty alleviation; multiple examples of US foreign policy undermining democracy and fuelling conflict; the use of military force and other means to secure control of strategic natural resources; the hindering of efforts to tackle climate change; and opposition to the International Criminal Court.

This view of the US is at odds with its image of itself and the role it projects onto the global landscape – that of the leader of the free and democratic world; benevolent and principled; and the largest contributor of official development assistance. This chapter provides a contribution to this discussion by looking at various aspects of US foreign assistance, as well as US policy in certain priority global health challenges. A longer and more detailed version of this chapter is available from the GHW website.

### **An introduction to US foreign assistance**

#### *The organisation of foreign assistance*

A number of definitions are used to describe and measure aid. The term *official development assistance* (ODA) refers to the definition used by the Organization for Economic Cooperation and Development's (OECD) Development Assistance Committee (DAC), which counts only non-military grants and low-interest loans to low- and middle-income countries. The

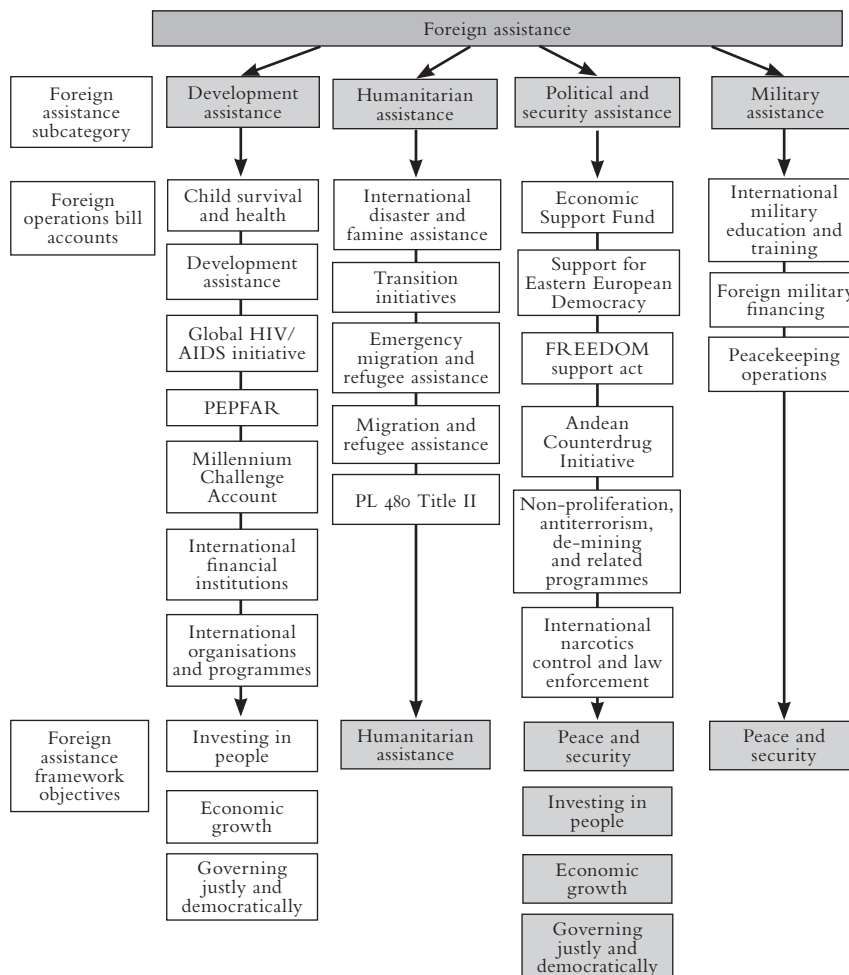
term *foreign assistance* refers to the full range of programmes funded by the US Foreign Operations Bill (also known as the Foreign Assistance Bill), including military assistance and aid to high-income countries. As a result of these differing definitions, the figures for the US's contribution to development often appear contradictory.

Foreign assistance appropriated by the Foreign Operations Bill is commonly divided into four subcategories. These are:

- *Development assistance*, which includes support for health, education and other development programmes. Until recently, Child Survival and Health used to be the primary health account of US foreign assistance, but there are new initiatives now for HIV/AIDS through the President's Emergency Plan for AIDS Relief (PEPFAR) and malaria. Development assistance funds are also split between bilateral assistance to countries and multilateral assistance that is channelled through organisations like the World Bank and the World Health Organization (WHO). The Treasury manages the bulk of multilateral aid, whilst most of the bilateral assistance is administered by USAID, the State Department, PEPFAR, the Millennium Challenge Corporation (MCC), and other smaller agencies such as the Peace Corps.
- *Humanitarian assistance*, which consists of responses to humanitarian emergencies, is mainly administered through USAID's Office of Foreign Disaster Assistance (OFDA) and Office of Transition Initiatives. A proportion is also administered by the State Department's Bureau of Population, Refugees and Migration.
- *Political and security assistance*, which is designed explicitly to support the economic, political or security interests of the United States and its allies, and includes finance to help countries economically, as well as programmes to address terrorism, narcotics and weapons proliferation. The most prominent instrument for administering these programmes is the State Department's Economic Support Fund.
- *Military assistance*, which refers to the provision of equipment, training and other defence-related services by grant, credit or cash sales. Most of this is administered by the Department of Defense (DoD).

Foreign Assistance funding is allocated to a number of accounts that are administered through a convoluted system involving multiple agencies (see Figure D2.1.1). At the last count, 26 different agencies were conducting aid programmes, although the majority of US foreign assistance is managed by USAID, the Department of Defense (DoD), the Department of State and the Department of Agriculture (which administers the US food aid budget). See Figure D2.1.2.

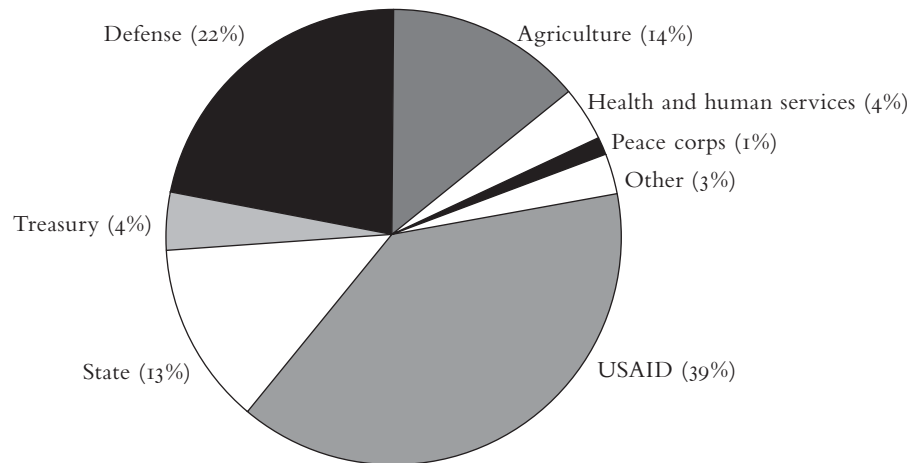
FIGURE D2.1.1 **The structure of US foreign assistance**



**The key agencies**

Historically, USAID has been the main agency for implementing US programmes in health, education, humanitarian relief, economic development, family planning and agriculture. It currently operates in about ninety countries, but its share of foreign aid is declining: from 50.2 per cent of total ODA in 2002 to 39 per cent in 2005 (OECD 2006a). One cause of this decline has been the increase in foreign assistance disbursements to the DoD, up from 5.6 per cent of the ODA budget in 2002 to 21.7 per cent in 2005 (OECD 2006a).

FIGURE D2.I.2 Management of US ODA by agency, 2005



Source: OECD 2006b.

The arrival of the DoD in the development arena has been one of the most conspicuous policy events of recent years, representing vividly the extent to which the US government is blurring the boundaries between defence, diplomacy and development. The DoD now accounts for nearly 22 per cent of United States' ODA but also works in the provision of non-ODA assistance, including training and equipping of foreign military forces in fragile states.

A large proportion of DoD funding and activities is accounted for by massive reconstruction efforts in Afghanistan and Iraq and humanitarian relief after the Indian Ocean tsunami (OECD 2006b). However, it has also expanded its remit to include activities that might be better suited to USAID or other civilian actors. This includes being a contractor to PEPFAR in Nigeria, work in HIV/AIDS vaccine research, and the building of schools and hospitals in Tanzania and Kenya. These activities and the announcement of a US military command for Africa, AFRICOM, 'raise concerns that US foreign and development policies may become subordinated to a narrow, short-term security agenda at the expense of broader, longer-term diplomatic goals and institution-building efforts in the developing world' (Patrick and Brown 2007).

The role of the State Department, the US equivalent of a Ministry of Foreign Affairs, in development and humanitarian relief is also a cause for controversy. The State Department is traditionally and increasingly accorded a higher status than USAID. Under the Bush administration, it has acquired

a lead role in HIV/AIDS interventions through the location of PEPFAR within the State Department, consolidated its longer-term management over funds for the UN system and has seen its Economic Support Fund budget expand. The Economic Support Fund is used to promote the economic and political interests of the US by providing assistance to allies and countries in transition to democracy, supporting the Middle East peace negotiations, and financing economic stabilisation programmes (US Department of State and USAID 2005). However, the State Department has limited development expertise and has often relied on USAID to implement the development aspects of its politically negotiated assistance programmes.

Another reason for the decline in USAID's share of the budget has been the introduction of new agencies in the delivery of aid, such as the MCC and various presidential initiatives, including PEPFAR. The MCC, established in January 2004, has been described as the 'most important foreign aid initiative in more than 40 years' (Radelet 2003). This is because of its large budget (originally promised to stand at \$5 billion a year by 2006, although it is currently falling far short of this) and its unique approach to foreign assistance, namely that it only awards assistance to countries that have met minimum standards in relation to three aspects of development: ruling justly, investing in people and encouraging economic freedom.

The indicators that have been established to assess country eligibility include measures of civil liberties, political rights, control of corruption and rule of law; indicators of health and education coverage; and various indicators of trade, commercial regulation and fiscal policy. Although it is the closest the US comes to giving budget support to developing-country governments, there are concerns that the criteria and standards used by the MCC to determine eligibility are designed to push through a set of reforms that will maximise US corporate and foreign policy benefits. In addition, the MCC's lack of consultation with other donors, overemphasis on measurable results and short-term horizons (the MCC limits countries to one five-year Compact) are likely to be prejudicial towards aid harmonisation and sustainable development.

The other big new agency is PEPFAR. First announced by Bush in his 2003 State of the Union address, the five-year \$15 billion prevention, care and treatment initiative for AIDS relief started in early 2004. Its management is independent from USAID, with lines of reporting that go to the secretary of state, but in-country implementation is often carried out in conjunction with USAID. PEPFAR's budget is now considerably larger than the Child Survival and Health account of USAID. In the fiscal year (FY) 2007, the PEPFAR budget was US\$3.14 billion while the Child Survival and Health budget was US\$1.59 billion (US Department of State 2007).

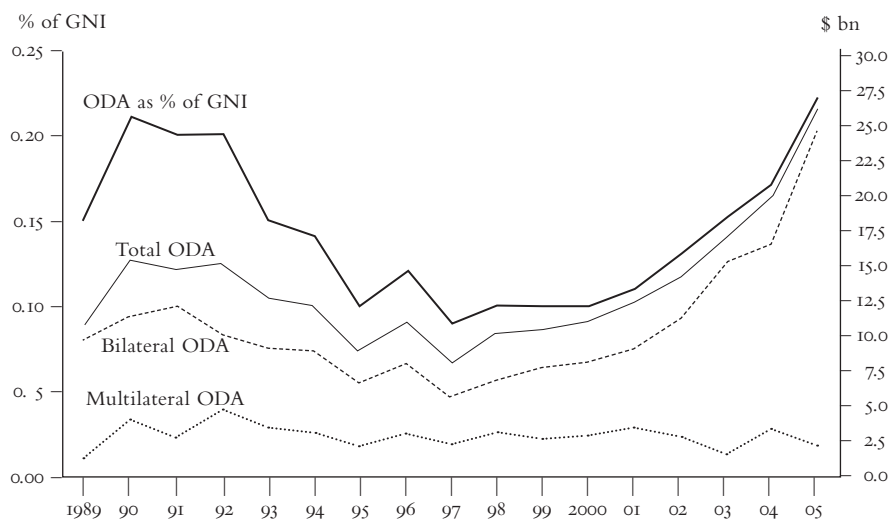
Finally, reforms to the architecture of US foreign assistance also appear to involve USAID being increasingly drawn into the orbit of the Department of State (Patrick 2006). It is believed that this will ensure that USAID's traditional focus on development will come under the greater influence of the Department of State's focus on foreign policy. The head of USAID (who is appointed by the president) now also acts as director of foreign assistance (DFA), an office that carries some responsibility for the coordination of State Department foreign aid programmes. The post is at the level of deputy secretary of state and marks another sign of the growing strategic importance of foreign aid.

**Expenditure**

The United States aid programme is the largest in the world. In 2005, it contributed almost twice as much ODA as Japan, the next largest donor. Contrary to expectation, the Bush administration increased spending on foreign assistance. Much of this can be attributed to expenditure in Iraq and Afghanistan, and debt relief (particularly to the Democratic Republic of Congo and Nigeria). Aid to sub-Saharan Africa (SSA), particularly for HIV/AIDS, also accounts for some of the increase.

The exact amount of foreign assistance spent on health is difficult to calculate because of the convoluted system of accounts and agencies. However, the Child Survival and Health and Global HIV/AIDS accounts

**FIGURE D2.I.3 US net ODA disbursement**  
(at constant 2004 US\$ billion and as share of GNI, 1989–2005)



Source: OECD 2006b.

take up the bulk of health funding. Overall, US spending on health has increased from about US\$1.6 billion in 2001 to just over US\$4 billion in 2006, giving the US's foreign aid health programme a considerably larger budget than that of the WHO. Compared with other DAC members, the US also allocated a higher percentage of its total ODA to health – 18 per cent compared with a DAC member average of 13 per cent in 2002–04 (OECD 2005).

However, whilst it donates large amounts in absolute terms, the US has one of the lowest rates of aid as a percentage of gross national income (GNI), a mere 0.22 per cent in 2005. Although this is its highest level since 1986, it is well below the DAC average of 0.47 per cent of GNI, and the US has failed to set a timetable for reaching the 0.7 per cent target of the UN.

#### *Who gets US foreign assistance?*

It has long been the case that aid recipients are often selected on the basis of their strategic value to the US. However, several of these countries are also in need of assistance. For example, Sudan and Ethiopia are important for geopolitical reasons but are also desperately poor. It is also noteworthy

TABLE D2.I.1 **Top ten recipients of US foreign assistance**  
(as % of total ODA 1984–2005)

|             | 2005 |             | 1994 |                   | 1984 |
|-------------|------|-------------|------|-------------------|------|
| Iraq        | 25.1 | Israel      | 10.9 | Israel            | 14.1 |
| Afghanistan | 3.8  | Egypt       | 7.1  | Egypt             | 13.0 |
| Egypt       | 2.7  | El Salvador | 4.1  | El Salvador       | 2.5  |
| Sudan       | 2.1  | Somalia     | 3.6  | Bangladesh        | 2.3  |
| Ethiopia    | 2.0  | Haiti       | 2.7  | Turkey            | 2.2  |
| Jordan      | 1.3  | Philippines | 1.8  | Costa Rica        | 2.1  |
| Colombia    | 1.3  | Colombia    | 1.4  | India             | 1.9  |
| Palestine   | 0.8  | Jordan      | 1.3  | Northern Marianas | 1.7  |
| Uganda      | 0.8  | Jamaica     | 1.3  | Philippines       | 1.6  |
| Pakistan    | 0.8  | Bolivia     | 1.2  | Sudan             | 1.6  |
| % of total  | 40.7 |             | 35.4 |                   | 43.0 |

Source: OECD 2006a.

FIGURE D2.I.4 Recipients of US foreign assistance by region



Source: US Department of State 2007.

that Israel and Egypt are receiving less ODA than previously. Furthermore, only three of the 1994 top ten appear in the 2005 top ten, and only four of the 1984 top ten appear in the 1994 top ten.

In 2005, the United States directed 29 per cent of its ODA to low-income countries and 70 per cent to middle-income countries, in contrast to the DAC member average of 53 per cent and 47 per cent respectively (OECD 2006a). When the Foreign Operations budget request for FY 2008 (which includes 'military assistance' and aid to high-income countries) is analysed, more than 15 per cent of the funds are earmarked for high-income countries such as the United Arab Emirates, Qatar, Singapore and Israel.

Under the new Foreign Operations FY 2008 budget request, Africa experiences the biggest increase in funding – up 54 per cent on FY 2006. Over 75 per cent of the resources for Africa will be focused on development programmes, mainly to do with HIV/AIDS. The largest recipients in Africa are Sudan, South Africa, Kenya, Nigeria and Ethiopia, followed by Liberia, the Democratic Republic of the Congo and Somalia. These eight



countries claim over 56 per cent of the budget for Africa, but account for 65 per cent of the population in the region. In overall terms, the largest recipients of 'development-focused aid' will be Iraq, Afghanistan, South Africa, Kenya and Nigeria.

A large proportion of each regional budget is concentrated in a small number of countries. In the East Asia and Pacific region, Indonesia, Vietnam and the Philippines claim 79 per cent of the total budget but only account for 21 per cent of the population of the countries to which US aid is given in the region. In the Near East, Israel, Egypt, Iraq and Jordan account for 93 per cent of the region's budget and again account for a disproportionately low percentage of the total population of US aid-recipient countries in the region, in this case 40 per cent. Only in South and Central Asia, where Afghanistan, Bangladesh, India and Pakistan receive 93 per cent of the budget, does this reflect the share of the population. Across the total proposed FY 2008 budget, the top ten recipients receive 63 per cent of the total resources, leaving a mere 37 per cent for the remaining 143 recipient countries of US foreign assistance (Bazzi et al. 2007).

### **Many agendas, many drivers**

#### *Self-interest and aid*

The US is open about the way it combines self-interest with aid, stating on its website that 'US foreign assistance has always had the twofold purpose of furthering America's foreign policy interests ... while improving the lives of the citizens of the developing world.' These two aims do not have to be in conflict with each other, but often are. The election of George W. Bush and the ascendancy of a reactionary, neoconservative administration, combined with the events of 9/11, have resulted in self-interest and the security of the US becoming paramount within its foreign assistance programmes. The 2002 National Security Strategy also formally added 'development assistance' to the two traditional bastions of foreign policy: 'defence' and 'diplomacy'.

Not only is aid being increasingly used to achieve geopolitical objectives, but underdevelopment and ill-health are being framed as security threats. For example, during Bush's first election campaign, no new initiative to deal with the HIV/AIDS crisis was announced and the efforts of Clinton were actually disparaged. After 9/11, AIDS became an issue of relevance and the groundwork for establishing PEPFAR was laid by identifying the need to secure public health as part of the Global War on Terror. The increased coupling of 'aid' and 'global health', driven largely by the US, is discussed in greater detail in Chapter D2.3.

TABLE D2.1.2 **The foreign assistance framework**

| Five objectives of foreign assistance framework | Categorisation of countries |
|---|-----------------------------|
| 1. Advancing peace and security                 | 1. Rebuilding               |
| 2. Promoting just and democratic governance     | 2. Developing               |
| 3. Encouraging investments in people            | 3. Transforming             |
| 4. Promoting economic growth                    | 4. Sustaining partnership   |
| 5. Providing humanitarian assistance            | 5. Restrictive              |

A new US Foreign Assistance Framework crystallises the aim of building and sustaining ‘democratic, well-governed states’ into five new objectives and five different categories of countries (see Table D2.1.2). Funding for objectives 2, 3 and 4 are described collectively as ‘development-focused aid’.

Two other observations about the new framework are worth noting. One is the conspicuous lack of focus on poverty reduction. Unlike other donors, the US has no international poverty reduction policy. In fact the framework contains only one mention of poverty reduction and even this had been absent in earlier versions. Second, the categorisation of countries is perplexing – what, for example, makes Tanzania a ‘transforming state’ but its more developed neighbour Kenya a ‘developing state’?



***From the American people?***

According to the USAID logo, American foreign assistance is a gift ‘from the American people’. The administration believes that this logo has a positive impact on the minds of people overseas and helps fulfil public diplomacy goals. But do the American people see US foreign assistance as their gift to the developing world?

In reality, US public support for foreign assistance is weak and always has been, in part due to the low levels of knowledge and understanding about the root causes of poverty, global inequity, as well as the positive and negative dimensions of the aid industry. Findings from poll after poll reveal

that most people have an incorrect and overinflated perception about the generosity of the United States, thereby leading to opposition to requests for increased aid budgets. Attitudes to aid are also complicated by the common perception that much US aid is wasted by recipient countries and fails to reach the poor. Unsurprisingly, in one poll, 64 per cent of Americans support helping poor countries as a measure to combat international terrorism, whilst aid for poverty reduction is less popular (Chicago Council on Foreign Relations 2004).

### *Congress*

In the US system of government, Congress exerts considerable influence over foreign assistance. It can review and block proposed policy; attach earmarks and directives to accounts; and request oversight investigations and policy reviews. The influence of Congress opens up foreign assistance plans to the influence of myriad special interest groups. The scope and specificity of these influences have increased so much over the years that the Foreign Assistance Act has been likened to a 'Christmas tree' of different whims and special interests (Raymond 1992).

The ability of Congress to specify precisely how much money USAID and other agencies can spend on any programme area in the upcoming year means that USAID missions and other programmes abroad find it very difficult to adjust and adapt their activities according to changing circumstances and local conditions.

### *NGOs: abroad and at home*

The delivery of aid through non-governmental organisations (NGOs), of which private voluntary organisations (PVOs) are a component, is a prominent feature of the US approach to international development.<sup>1</sup> During the 1990s, USAID's overseas presence shrunk as part of efforts to streamline government. This had the consequence of further changing the character of USAID from being an implementing agency to being a contracting agency.

By 1996, 34 per cent of USAID's assistance was channelled through PVOs and NGOs (OECD 2006b). Today the figure is almost certainly much higher, with USAID reporting channelling \$2.4 billion through PVOs in FY 2007 (USAID 2007). Globally this trend is reflected by the percentage of ODA being channelled through NGOs increasing from 0.18 per cent in 1980 to 6 per cent in 2002, according to the OECD (2005).

Currently, USAID works with more than 200 national PVOs and around 30 international PVOs as primary grantees or contractors (USAID 2007). However, the relationship is tightly controlled and includes having

to comply with complicated grant agreements and contracts, including 'branding and marking' guidelines. For example, during the 2004 tsunami aftermath, some NGOs were reprimanded by USAID for not sufficiently publicising its contribution. PEPFAR also has requirements regarding the branding of its HIV/AIDS programmes, even if this might accentuate the stigmatisation of the recipients of support.

Within the US, a striking feature about the PVO community is its greater reliance on government funding compared with European NGOs' relationship with their national governments. This reliance is reflected in a more muted and uncritical interaction between PVOs and the US government. Although a few PVOs play a courageous role in questioning the US's role in holding decision-makers to account, many pursue a more 'pragmatic' line of self-censorship and avoid the role of campaigning for a more just and fair US impact on global development and health.

Stafano Prato, of the Society for International Development, notes that donors are increasingly engaging NGOs as implementing agents of government agendas. As a result of a growing financial dependency, NGOs are being co-opted into governmental policies and limiting their capacity to be more active and freely expressive in important political spaces (Prato 2006).

In contrast to Europe, there is reduced effort on the part of civil society organisations to inform the public about the purposes or achievements of aid or to act as a watchdog of their government's policies. Worryingly, the constant invocation of patriotism, 'Anti-Terrorist Financing Guidelines', the prosecution of several Muslim charities, and restrictions placed on the freedom of speech of PVOs operating in Iraq represent concerted attempts by the administration to further close down the space for civil society debate and dissent. In a newspaper article, a UK parliamentarian described this as part of the new American imperium: 'you not only invade countries, but also charities' (quoted in Maguire 2003).

#### ***Making a profit from poverty***

The aid industry is good business for many American companies. The reconstruction effort in Iraq is a prime example of the murky way in which foreign assistance budgets have been channelled into the bank accounts of corporations with close connections to the Bush administration. US food aid is another example of business interests trumping development (see Box D.2.1.1). Specifically, business has been a persuasive lobby for the 'tying' of aid to the purchase of US goods and services. According to a former USAID administrator, 'foreign assistance is far from charity. It is an investment in American jobs, American business' (quoted in Bate 2006).

**BOX D2.1.1 US food aid**

The US accounted for 59 per cent of international food aid between 1995 and 2003 (Congressional Research Service 2005). In FY 2006 it delivered food aid to over fifty countries (US Government Accountability Office 2007). However, complaints are made about US food aid:

- A large proportion is channelled bilaterally rather than through the coordinated and multilateral system of the World Food Program (WFP).
- US law specifies that 75 per cent of all food aid transported must be handled by shipping companies carrying the US flag, which has the effect of inflating costs.
- Very little of the US contributions to the WFP is as cash, which would give the WFP more opportunity to purchase food from sources that are closer to where the need is.
- The dumping of US food aid distorts local markets, undermines local agriculture, contributes to long-term food insecurity and increases delivery costs.
- Food spoilage is common due to poor management.

At the root of these problems is the use of food aid to subsidise US agribusiness (e.g. Cargill, Louis Dreyfus, ADM/Farmland, and Kalama Export Company) and open up markets for their expansion. Unfortunately, the 2007 Farm Bill, which proposed that a quarter of emergency food aid should consist of crops purchased from other countries, was blocked by the agriculture and shipping business sectors and charities dependent on selling US food aid for their income.

*Source: Oxfam 2005.*

According to the OECD, only 3 per cent of total US bilateral ODA to least developed countries was untied (OECD 2006a), despite the negative impact of tied aid (OECD 2001). The OECD (2001) estimates that by excluding non-US firms from contracts, tied aid raises the costs of goods and services by between 15 and 30 per cent (OECD 2001). Untying American aid could have added an extra \$4.37 billion to the aid effort in 2005, a sum of money that could have been used to provide health care for nearly 135 million people a year in developing countries. Tied aid also results in projects that are capital-intensive or that require US-based technological expertise rather than in projects that are based on local priorities and needs assessments.

*Onward Christian soldiers*

America is a nation that has experienced a steady erosion of the boundary between the seats of public office and the pulpits of Christian churches. The influence of evangelical Christian groups has not left foreign assistance programmes untouched. Kent Hill, a well-known conservative evangelical with no formal qualifications in medicine or health, is USAID's head of Global Health. In 2001, President Bush launched the Faith-Based Initiative as an embodiment of his philosophy of 'compassionate conservatism'. This entailed advocating the role of Christian organisations in delivering health, education and welfare services in the US and overseas. Whilst this was another embodiment of Bush's hostility towards public institutions, it was also a reward to the Christian groups for their part in his election victory.

According to the *Boston Globe*, between FY 2001 and FY 2005 more than \$1.7 billion was allocated to 159 faith-based organisations (FBOs) (Stockman et al. 2006). FBOs accounted for 10.5 per cent of all USAID dollars to NGOs in 2001 and 19.9 per cent in 2005. This growth in FBO grantees has not only increased the undue influence of religious doctrine on sexual and reproductive health programmes, but has also incorporated inexperienced and unqualified agents into the health sector, some of whom seem more interested in the use of government money for proselytisation.

*Forget the UN*

US foreign assistance is also characterised by a long history of mistrust and hostility towards the UN and multilateralism. This has manifested itself in a decline in the share of America's ODA to multilateral organisations from almost 26 per cent in 2002 to 8 per cent in 2005 (OECD 2006b).

The Bush administration's relationship with the United Nations Population Fund (UNFPA) is emblematic of its lack of enthusiasm for multilateral organisations and the imposition of national values on to the international stage. In July 2002, US funding to UNFPA was cut off because its presence in China was said to imply tacit support for China's family-planning policies, which include coercive abortion and involuntary sterilisation. Four separate investigative teams, including one sent by the US Department of State, concluded that UNFPA was in fact working to end coercive population control. However, the US continues to withhold funding.

According to Ilona Kickbusch, unilateralism has not only changed US policy but has also influenced the way health advocates frame the global health agenda: 'The subtle but definite shift in orientation and language is very evident, and indeed many international documents read as if they have been written for members of Congress rather than for the broader global

health community. This is clearly an expression of American hegemony' (Kickbusch 2002).

### **The United States in global health**

Notwithstanding the self-serving agendas of US foreign aid, the US is the largest international donor of global health assistance and its spending on health has increased since 2000. Health care reaching millions of people is sustained by US aid. But it is questionable whether this funding is used in a way that maximises benefit, efficiency and equity.

#### *The primary agents of US global health*

The two primary agents of US foreign assistance for health are USAID and PEPFAR. Within USAID, its Bureau for Global Health plays the biggest role with an annual budget of around \$1.6 billion and presence in USAID Missions in approximately sixty countries. A substantial amount of funding for health in disaster and emergency situations (\$79 million in FY 2006) is also provided through USAID's Office of Foreign Disaster Assistance (OFDA).

USAID also has inter-agency arrangements with the National Institutes of Health (NIH), the US Department of Health and Human Services (DHHS) and the Centers for Diseases Control (CDC). These agencies possess specialist skills in epidemiology, disease surveillance and biomedical research and have seen large increases in funding since 2002. In 2005, USAID was also handed responsibility for administering the President's Malaria Initiative (PMI).

The five-year PMI was launched in 2005 to reduce malaria deaths by 50 per cent in fifteen focus countries with a budget of \$300 million in FY 2008, which will grow to \$500 million in 2010. In recipient countries the PMI is led by USAID in collaboration with the US Department of Health and Human Services and CDC. It implements activities in four areas: indoor spraying of homes with insecticides, provision of insecticide-treated mosquito nets, provision of anti-malarial drugs, and treatment to prevent malaria in pregnant women.

Whilst the PMI's profile has been low compared with that of PEPFAR, it has won praise for its measured approach and desire to learn from past mistakes. However, critics counter that the same initiatives could have been incorporated into existing institutions such as the Global Fund and the Roll Back Malaria Campaign, and that the insistence upon setting up a parallel programme has reduced the overall potential impact. There have also been criticisms of specific aspects of PMI's programme, such as the

overly complicated voucher systems used to distribute insecticidal nets and the use of DDT pesticide in indoor spraying.

PEPFAR was set up as a separate administration to USAID. It received a five-year \$15 billion budget for HIV/AIDS prevention, care and treatment in 2004. As of March 2007, PEPFAR reports having supported antiretroviral treatment for approximately 1.1 million in its fifteen focus countries. Figures from 2006 show that up to 2 million orphans and vulnerable children and another 2.4 million people living with AIDS were provided care services from PEPFAR.

However, PEPFAR has garnered much criticism for its undue and ineffective emphasis on abstinence programming; restrictive policies surrounding the distribution of condoms and the purchase and use of generic medicines; ineffectual procurement and distribution mechanisms; lack of investment in health systems strengthening; excessive focus on targets, which have turned health projects into a 'numbers game'; burdensome application and reporting requirements; and lack of harmonisation with other actors working in the sector.

Finally, PEPFAR is severely limited by a requirement for it to spend not less than 55 per cent of its funds on treatment activities, of which at least 75 per cent should be spent on the purchase and distribution of antiretroviral pharmaceuticals. Only 20 per cent of budgets can be spent on prevention, of which one-third must be used to promote abstinence; 15 per cent is earmarked for palliative care of individuals with HIV/AIDS; and only 10 per cent for assistance to orphans and vulnerable children. Such an arbitrary and top-down allocation of funds, with a clear bias towards treatment and pharmaceuticals purchasing, fails to meet even the most basic requirements of needs and evidence-based public health planning.

#### *Harmonisation and country support*

Although the US endorsed the Paris Declaration on Aid Effectiveness in 2005, it has made limited progress towards its goals, particularly in the areas of aid harmonisation and predictability. In many countries, there is even poor coordination between the various US agencies operating in-country, let alone with other donors.

One of the major deficiencies of US assistance for health stems from its annual appropriation cycles, which constrain the potential for long-term planning. A strong emphasis on measurable results and the potential for financial penalisation if results are not achieved can also have negative effects on sustainability and the setting of appropriate targets. For example, at a 2007 PMI conference in Tanzania, it was made clear to implementing partners that it would be difficult to convince Congress to authorise the



following year's budget if they could not present strong results for this year, even though it was recognised that many of the required interventions would take longer than a year to show effect.

The US also provides little support for general budget support (GBS) and sector-wide approaches (SWAs) because of its preference for earmarking resources, attributing results to US funding and operating through NGOs. Often the result is a portfolio of project-based activities that run in parallel to on-budget activities supported by recipient governments and other donors through a more harmonised approach.

The absence of support for government processes also limits the United States' ability to support crucial aspects of health systems development, such as the recurring costs of personnel. Although US-funded health programmes employ many local people in their projects, there is a need to distinguish short-term workforce expenditure from longer-term investment in human capacity development that can only be done effectively through harmonised and predictable aid modalities.

#### ***Health priorities***

Given its strong unilateralism, the US has a particular responsibility for ensuring that its health spending matches the needs and requirements of the people in recipient countries. However, there has been limited evaluation of the appropriateness of US development assistance for health.

The rapid increase in the funding of PEPFAR and PMI has also encroached upon the budgets of more traditional conduits of health assistance and concentrated aid in a smaller number of 'focus' countries. It also appears to have contributed to a decline in spending on maternal and child health, which is 22 per cent less than it was ten years ago (Daulaire 2007).

Others have also questioned the appropriateness of the way HIV/AIDS and malaria have dominated the United States' development assistance for health (Mathers et al. 2006; Global Health Council 2006; MacKellar 2005). Shiffman (2006) argues that research into different diseases is also prioritised according to the potential profit for pharmaceuticals companies.

#### ***Health systems***

The United States' record on health systems strengthening (HSS) is poor. During the 1980s and 1990s, USAID supported many of the neoliberal reforms that contributed to the dysfunctionality of many health systems (Ruderman 1990). Non-participation in SWAs, the disproportionate funding of NGOs, short-term financing and support for vertical disease-based initiatives continue ultimately to hinder comprehensive and coherent health systems development.

USAID does have some HSS projects, including a \$125 million five-year flagship programme called Health Systems 20/20 and the Quality Assurance/Workforce Development (QA/WD) Project. The Agency is also promoting community-based health financing in a number of countries. However, a closer analysis reveals several shortcomings. For example, 'Health Systems 20/20', which only works in eleven countries, includes a focus on HIV/AIDS in three countries and consists of a portfolio of work that is piecemeal and lacking in any substantial commitment to HSS.

Finally, USAID's leaning towards market-based health systems and privatisation remains evident. For example, a recently published manual for conducting a comprehensive 'health systems assessment' emphasises the benefits of expanding private-sector delivery without any mention of the potential disadvantages. When regulation is discussed, it is in relation to creating an environment that promotes private-sector development, rather than in relation to regulation that will curtail harmful private-sector practices.

#### *Intellectual property and generic production*

Under the current international intellectual property rights regime, the supply of affordable medicines is hindered by pharmaceuticals oligopolies. It was hoped that the 2001 'Doha Declaration on the TRIPS Agreement and Public Health' would allow poor countries easier access to generic medicines. These safeguards centre upon the use of compulsory licensing agreements; parallel importing; and permitting manufacturers to conduct regulatory tests before a patent has expired to speed the entry of generic drugs into the market.

However, the US in particular has put pressure on developing countries not to utilise the safeguards provided in the Doha Declaration. Furthermore, the US has enforced even stronger standards of intellectual property protection through bilateral and regional trade agreements. The Peruvian Ministry of Health has calculated that under the terms of its free-trade agreement with the US, Peru will incur additional medicine expenses of \$199.3 million within ten years (Oxfam 2006).

When Bush acknowledged in his 2003 State of the Union Address that lower-cost antiretrovirals could 'do so much for so many', it was hoped that the US stance towards generic drugs would be softened, at least for PEPFAR programmes. Instead, a burdensome and inefficient system limits access to medicines (Health Gap 2005). This includes:

- the establishment of a parallel approval system for generic AIDS drugs that duplicates the WHO pre-qualification programme and undermines national policies and protocols;

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- the approval of only a small number of generic AIDS drugs for procurement;
- a reliance on single-source suppliers that has led to shortages and stock-outs of essential medicines.

The US also imposes strict procurement rules and regulations on non-PEPFAR grants and contracts with USAID. Prior approval must be obtained for the procurement of pharmaceuticals and must be restricted to the list of US-approved products. Waivers to these regulations can be awarded but many PVOs avoid providing pharmaceuticals as part of their USAID-funded programmes because of the complicated rules and regulations associated with their procurement.

#### *Human resources for health*

The global health crisis is fuelled by a well-documented shortage of health workers in many countries. Much of this crisis stems historically from the structural adjustment programmes implemented by the World Bank and the IMF, and supported by USAID. Caps on salary levels, ceilings on the number of public-sector health workers, and limits to investment in higher education and training were all advocated (Ruderman 1990).

Today, the US does little to support the development of a public workforce of health providers in poor countries. Instead, the US actively encourages the recruitment of foreign-trained health personnel and international medical graduates. In 2002, more than 23 per cent of doctors practising in the US had come from abroad, the majority from low- or lower-middle-income countries (Hagopian et al. 2004), while the share of nurses from low-income countries grew from 11 per cent in 1990 to 20.7 per cent in 2000 (Polsky et al. 2007).

US-based training programmes for foreign health workers have been presented as a form of human capacity development for low-income countries. However, the benefits of this form of aid are undermined by the fact that few of the trainees return to their home countries (Mick et al. 1999). A more effective approach is USAID's American Schools and Hospitals Abroad (ASHA) programme, which provides grants to private, non-profit universities and secondary schools, libraries and medical centres abroad.

Finally, the HR crisis in poor countries is aggravated by the strong US support for stand-alone disease-based initiatives and preferred use of NGOs, which has resulted in an internal brain drain of public workers into the private sector. In Tanzania, for example, a focus country for PEPFAR and PMI, competition for skilled health workers is intense and has resulted in the movement of doctors from clinical practice into NGO programme

management. A local health programme manager working for an NGO on a PEPFAR or PMI-funded project gets paid around \$30,000 a year, compared to around \$8,000 a year as a general practice doctor.

### *Sexual and reproductive health policies*

Sexual and reproductive health policies are among the most controversial issues in US foreign assistance. Since 1973, the US approach to abortion, contraception and sexual health promotion has become increasingly conservative and ideological.

One of the most polarising policies is the 'Global Gag Rule', which restricts foreign NGOs that receive US family-planning assistance from advocating for or providing abortion-related services, even with their own resources and even if abortion is permitted by local laws. Organisations that provide information about abortion services forfeit all family-planning assistance from USAID and the Department of State.

In an amendment to the original 1984 policy, Bush's 2001 legislation does not prohibit the use of population funds for post-abortion care. It also permits referrals for abortions or abortion services that are performed with the NGO's own funds in order to save the life (but not the health) of the mother and if the mother was made pregnant by rape or incest. Nonetheless, there is evidence that the Rule leads to an overall loss of life. The International Planned Parenthood Federation (2006) estimates that of 19 million women who had an unsafe abortion in 2006, approximately 70,000 died as a result.

The Global Gag Rule also impacts on comprehensive reproductive health services by either forcing clinics to stop providing access to abortion or to cut back on their services when they forfeit US funding. For fear of falling foul of the Rule, many organisations have been discouraged from activities that are actually permissible, such as providing post-abortion family planning or conducting research on the consequences of illegal abortion. It can thus deny women access to contraception, counselling, referrals and accurate health information, causing more unwanted pregnancies and more unsafe abortions.

The common misconception that US agencies are prohibited from purchasing, distributing or promoting condoms and other contraceptives is not true. The US government is the largest distributor of condoms in the world and provides more than a third of total donor support for contraceptive commodities (UNFPA 2005).

However, the mark of social conservatives can be seen through the increasing credence given to views that condoms are ineffective and encourage immoral behaviour. USAID has diluted its advice on the effectiveness of

condoms in preventing HIV transmission, and the CDC has edited its fact sheets to remove instruction on how to use condoms and how to compare the effectiveness of different kinds of condom. The Bush administration has also tried to restrict sex education in schools on the false understanding that it would promote underage sex.

PEPFAR's relationship with condoms also illustrates the influence of the Christian right lobby. Where PEPFAR supports condom promotion, there are restrictions aimed at limiting condom provision to high-risk populations, ignoring the interaction between high-risk populations and the general public.<sup>2</sup>

The 'Anti-Prostitution Pledge' prohibits PEPFAR funds from being spent on activities that 'promote or advocate the legalisation or practice of prostitution and sex trafficking'; and from being used by any group or organisation that does not explicitly oppose prostitution and sex trafficking. However, because the pledge does not clearly define what it means to 'oppose' prostitution, many organisations have avoided all health activity related to commercial sex in order to avoid any difficulty.

Many experts argue that the best way to reduce the negative health impacts of the sex industry is to decriminalise sex work and enable better access for clinical and public health services. The moralising approach of the current administration, however, does the opposite by reducing access for health workers and stigmatising the very individuals who need to be reached with health care.

Despite implicit opposition to the Anti-Prostitution Pledge, most NGOs have adopted the 'pragmatic' approach of altering their programmes to protect their funding. However, three courageous US-based organisations (DKT International, the Alliance for Open Society, and Pathfinder International) have filed two separate lawsuits against USAID arguing that the Pledge violates rights to free speech and is unconstitutional.<sup>3</sup>

### **Conclusion and recommendations**

The US tendency to favour unilateralism, short-term gain and commercial interests, and to assuage the immediate demands of the country's security complex, make elusive the longer-term approaches necessary for lasting change for the world's poorest and most vulnerable. In the words of the former head of the Division of Global Health at Yale University School of Medicine, these approaches

indicate the close interplay between the global-health debate and the wider political and economic context within which the United States defines its role. American unilateralism weakens international organisations and mechanisms,

and its hegemonic power defines strategies proposed in the global forum. The global-health challenge is increasingly defined in economic and managerial terms rather than as a commitment to equity, justice, democracy, and rule of law. (Kickbusch 2002)

In response to this assessment of United States aid, the following recommendations are made to health advocates:

- *Lobby for greater US aid effectiveness* The United States should fully adopt and adhere to the standards set out in the Paris Declaration on Aid Effectiveness. This would contribute to making American aid more transparent, predictable and effective. It incorporates re-engaging with the multilateral system and promoting better coordination with other donors; untying aid and disentangling the nation's foreign assistance from the bottom lines of powerful US business interests; providing more long-term and predictable aid; and streamlining the bureaucratic architecture responsible for the appropriation and management of foreign aid.
- *Reclaim poverty reduction as the primary goal of aid* It is vital that the US targets its development and humanitarian assistance where the need is greatest, rather than according to the US's own national security concerns. The US should reorient its aid agenda to have a more explicit poverty focus and emphasis on the attainment of the Millennium Development Goals.
- *Insist that the large vertical disease-based health initiatives do not eclipse other US technical assistance and funding to the health sector* The tendency towards vertical programming and the lack of support given to the overall development and sustenance of health systems, human resources and training are detrimental to the efficacy and long-term impact of initiatives such as PEPFAR and the PMI.
- *Question whether the agents and agencies of US aid are suitable and effective* The move towards securitising and politicising aid and the concomitant marginalisation of USAID vis-à-vis new initiatives and actors in development such as the MCC, PEPFAR and the Department of Defense must be closely monitored. USAID is not an agency without flaws but it, and other development-focused agencies, should be strengthened rather than abandoned. The movement towards a much greater role for the Department of Defense in US humanitarian and development work is undesirable.
- *Assess the appropriateness of domestic agendas for international policies* Policies that are motivated by parochial or localised concerns should not be allowed to translate into international policies affecting the lives of

millions of people around the world. Inappropriate religious and moral agendas should not be pursued. The United States' own health-care-worker demands should not outweigh those of developing countries; and US business interests should not dictate the terms of aid at the expense of the right of all people to health.

- *Encourage greater levels of knowledge and engagement about development among the American public* Currently, the voices of single-issue or ideologically charged interest groups are disproportionately heard whilst the majority of the American public remains uninformed and disengaged from the foreign aid and development debate. Greater efforts are required to make foreign assistance an accessible issue for the broader US public, ensuring that the tyranny of the minority ceases to define US aid policy.

These are ambitious aims for a more humane and poverty-focused agenda for American foreign assistance. NGOs and international bodies are beginning to engage more vocally with these debates. In today's politicised and securitised environment it is inevitable that they will come up against considerable opposition from the vested interests who profit, either in soft or hard financial and power terms, from the current structures of US foreign assistance. But it is important that these issues are understood, discussed and debated. It is only with knowledge that civil society and global health advocates around the world will be able to stand up and demand from the United States and other donors the reforms and policies that will make the right to health and the right to the conditions necessary for health a reality for all people.

## Notes

1. USAID defines a PVO as a tax-exempt, non-profit organisation working in, or intending to become engaged in, international development activities. These organisations receive some of their annual revenue from the private sector (demonstrating their private nature) as well as contributions from the public (demonstrating their voluntary nature). Non-governmental organisations include any entity that is independent of national or local government. These include for-profit firms, academic institutions, foundations and PVOs. The US uses the term 'NGO' for local and partner-country NGOs only.
2. For details of the activities permissible under PEPFAR funding, see *PEPFAR Guidelines for Implementing the ABC Approach, 2006* at: [www.pepfar.gov/guidance/c19545.htm](http://www.pepfar.gov/guidance/c19545.htm)
3. See the Brennan Center for Justice at New York University for details of *Alliance for Open Society vs. USAID* and the legal case that applies to both cases. [www.brennan-center.org/stack\\_detail.asp?key=102&subkey=8348](http://www.brennan-center.org/stack_detail.asp?key=102&subkey=8348) [www.soros.org/initiatives/health/focus/sharp/articles\\_publications/publications/pledge\\_20070612/antipledge\\_20070612.pdf](http://www.soros.org/initiatives/health/focus/sharp/articles_publications/publications/pledge_20070612/antipledge_20070612.pdf).

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