Institutional Influence: The Role of International Donors in Shaping Development Goals, Implementation and Effectiveness

Anne L. Buffardi

A dissertation submitted in partial fulfillment
of the requirements for the degree of

Doctor of Philosophy

University of Washington

2011

Program Authorized to Offer Degree: Evans School of Public Affairs

University of Washington
Graduate School

This is to certify that I have examined this copy of a doctoral dissertation by

Anne L. Buffardi

and have found that it is complete and satisfactory in all respects,
and that any and all revisions required by the final
examining committee have been made.

Chair of the Supervisory Committee:

_____
Mary Kay Gugerty

Reading Committee:

_____
Mary Kay Gugerty

_____
Sanjeev Khagram

_____
Peter J. May

Date: _____

In presenting this dissertation in partial fulfillment of the requirements for the doctoral degree at the University of Washington, I agree that the Library shall make its copies freely available for inspection. I further agree that extensive copying of the dissertation is allowable only for scholarly purposes, consistent with “fair use” as prescribed in the U.S. Copyright Law. Requests for copying or reproduction of this dissertation may be referred to ProQuest Information and Learning, 300 North Zeeb Road, Ann Arbor, MI 48106-1346, 1-800-521-0600, to whom the author has granted “the right to reproduce and sell (a) copies of the manuscript in microform and/or (b) printed copies of the manuscript made from microform.”

Signature _____

Date _____

University of Washington

Abstract

Institutional Influence: The Role of International Donors in Shaping Development Goals, Implementation and Effectiveness

Anne L. Buffardi

Chair of the Supervisory Committee:
Associate Professor Mary Kay Gugerty
Evans School of Public Affairs

Previous research on development assistance highlights the importance of the recipient country implementing environment in mediating the impact of aid; however, little is known about the donor side of the donor-recipient relationship. This dissertation fills this gap in understanding by characterizing and assessing the role of this powerful yet neglected set of stakeholders and their influence on aid goals, implementation and effectiveness. It investigates: what are the salient dimensions along which donors differ, how these differences influence health coverage and outcomes, and what features of the domestic policy process shape which approaches donors pursue. I examine these questions using mixed methods: analyses of Congressional hearings, a comparative case study of international donors in the health sector in Peru, and quantitative analyses of the cross-national Development Assistance for Health dataset.

This body of work offers three key insights for development assistance, related to recipient country ownership, donor type and goal alignment. First, the most prominent difference across donors was the extent to which they formally involved recipient country public, private and civil society sectors in problem identification, resource administration,

program design, implementation and governance. The Peruvian context revealed three ownership patterns: 'doctor knows best', 'empowered patient' and 'it takes a village' models, highlighting the dominance of foreign actors and the central government in development activities. The cross-national data support wide variation in donor perception of the capability and roles of recipient country actors, indicating very low levels, infrequent and inconsistent allocation of budget support financing, in which funds are channeled directly through recipient institutions.

Second, rather than observing systematic differences between bilateral and multilateral donors, there was greater variation *among* rather than *across* donor types. Actors along the aid implementation chain identified multiple entities to whom they were accountable. Third, although there existed considerable goal alignment among stakeholders within donor countries and between donors and recipients, there was little harmonization or coherence across these very wide sets of goals. Taken together, these findings highlight the unrealized potential to substantially expand the formal involvement of recipient country actors, and the need to prioritize among broad sets of foreign assistance and development goals.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

ACKNOWLEDGEMENTS

This work would not have been possible without the sustained support of countless individuals. First, I would like to express my appreciation to the Evans School of Public Affairs, particularly my committee Chair, Mary Kay Gugerty, and committee members Sanjeev Khagram and Peter May for their mentorship and support over the last four years. Special thanks also to Joe Zunt, for his continued support throughout the years.

My fieldwork would not have been possible without funding from Thomas Francis, Jr. Global Health fellowship. I extend my deepest thanks to everyone who shared their insights and expertise and to the instituions who helped to facilitate this work: Agencia Peruana de Cooperación Internacional, Ministerio de Salud Oficina General de Cooperación Internacional, Universidad Peruana Cayetano Heredia Facultad de Salud Pública y Administración, US Agency for International Development, Ada Mejia, Ada Pastor, Ana Barreto, Ana Guevara, Antonieta Paredes, Ariela Luna, Armando Cotrina, Blanca Guerrero, Carlos Acosta, Carlos Centurión, Carlos Cosentino, Carmen Solar, Cesar Carcamo, Clara Buendía, Claudia Caldas, Claudia Morales, Claudio Ecco, Crissthian Olivera, Cristina Magan, Dani Fumia, Danilo Fernandez, Edgar Ramírez, Elsa González, Ender Allain, Esthela Cusco de Fuertes, Fernando Cisneros, Fredy Canchihuaman, Gabriela Elgegren Vásquez, Gaby Ildefonso, George Liendo, Giovanni Bonfiglio, Giovanny Romero, Hamilton Garcia, Humberto Esteves Añi, Ian MacArthur, Isaac Alva, Jaime Chang, Jose Castro, Jose Viñoles, Julia Campos Guevara, Julio Cesar Cruz, Julio Gomez, Julio Mejia, Julio Pedroza, Karl-Heinz Vogel, Ketty Luis, La Familia Blas, La Familia Campos, Lalo Perez, Leonor Suarez Ognio, Liliana La Rosa, Lourdes Murillo, Lucy del Carpio, Luis Castañeda, Luis Garcia, Luis Morales, Luis Santana, Magaly Blas, Magdalena Quepuy, Marcos Cabrera, Maria Valderrama, Maricielo Pena, Marina Chiappe, Mark Oi, Melina Zevallos, Midori de Habich, Mónica del Pozo Rivas, Pablo Campos, Patrick Gallard, Patricia Garcia, Patty Malma, Pilar Mazzetti, Raul Rasgada, Renate Ehmer, Reyna Aranda, Ricardo Chuquimia, Ricardo Zuñiga, Robinson Cabello, Rocio Pariahuaman, Rocio Pejerrey, Rodolfo Valedez, Roger Salduana, Rosa Galvan, Sayda La Rosa, Shalini Jain, Soledad Bernuy, Susel Paredes, Taki Robles, Tito Bracamonte, Tula Ynes Mendoza Echegaray, Victor Echeandia, Violeta Noa, Virginia Baffigo, Walter Bedriñana, Walter Hinojosa, William Eulatth, Yessy Catherine Ruiz, Yuka Takasi, and Ziad Zaghrout. Agradecimientos especiales a Gladys Leon.

I thank my good friends and colleagues on the fourth floor of Parrington, at FASPA, and fellow students in Political Science, Social Work, Math and Public Health. Our conversations spurred my thinking; the camaraderie sustained my spirit. From the chain rule by the smoking pole to random effects at Olympic, Dani, I couldn't have gotten through this without you (twss) – what a deficit it would have been! From snow to stones, Ziad, thank you for the witty and wise life lessons.

I thank many cohorts of masters students in the Schools of Public Affairs and Social Work for their enthusiasm and for helping me to see my work in new ways. I am enormously grateful to Pat Dobel and David Harrison for their incredible mentorship in teaching.

Other professors who contributed to my understanding of my work and to my overall professional development included Steven Rathgeb Smith, Robert Pekkanen, Ann Bostrom, Maureen Pirog, Aseem Prakash, Chris Adolf, Gunner Almgren, Marieka Klawitter, Sara Curren, and King Holmes. I thank Elizabeth Bukusi and Lisa Manhart for their longstanding mentorship over the years and for encouraging me to pursue doctoral work. My sincere gratitude goes to Joe Zunt, Mary Fielder and Paul Waddell for making it possible for me to return to Seattle.

I was fortunate to have had the opportunity to present my work at professional conferences through funding from the UW Graduate & Professional Student Senate, Evans School of Public Affairs, Association for Research on Nonprofit Organization and Voluntary Action, and the International Studies Association.

I express my heartfelt appreciation and love to my family: my teacher-parents who taught me the value of education, and my grandfather who left high school to become a barber to support his family.

Finally, to the thoughtful, generous people I have met over the last two decades in Latin America, Europe, Africa and the Middle East who have shaped my view of the world and my place in it, I thank you.

DEDICATION

To all those whose life opportunities are cut short by circumstance,
and to those who take thoughtful action to reduce such injustice.

INTRODUCTION

For over sixty years, development assistance has been apportioned in an attempt to reduce poverty and stimulate economic and social development. Despite more than $2.3 trillion in aid disbursed over the last half century, population-level analyses have failed to demonstrate consistent results linking aid inputs to improvements in development outcomes. In response, the past decade has witnessed a proliferation of new donor initiatives: 2000 UN Millennium Development Goals, 2000 GAVI Alliance, 2002 Global Fund to Fight AIDS, Tuberculosis and Malaria, 2003 President's Emergency Fund for AIDS Relief, 2004 Millennium Challenge Corporation, and the 2005 Paris Declaration on Aid Effectiveness. While laudable for the awareness and resources these new programs have generated, they have essentially been evolving experiments in the field.

Previous research has highlighted the importance of the recipient country implementing environment in mediating the impact of aid, yet little is known about the donor side of the donor-recipient relationship. Development donors have not yet been classified or evaluated in a systematic way to be able to identify what specific donor approaches under what conditions are most effective in reducing poverty and disease. From a theoretical perspective, the role of the principal in this principal-agent/donor-recipient relationship and the nature of the contracting institution have been neglected. From an empirical perspective, better understanding the influence of donors may help to account for decades of

disappointing development aid results. In short, development scholarship needs to catch up with the international political momentum of the previous decade.

This dissertation research aims to fill these gaps in understanding by characterizing and assessing the role of this powerful yet neglected set of stakeholders and their influence on aid goals, implementation and effectiveness. It investigates: what are the salient dimensions along which donors differ, how do these differences influence health coverage and outcomes, and what features of the domestic policy process shape which approaches donors pursue. I examine these questions using mixed methods: analyses of Congressional hearings, a comparative case study of development donors in Peru, and quantitative analyses of the cross-national Development Assistance for Health dataset.

Shaping development goals

Chapter One begins upstream in the development assistance pathway to examine how donor approaches are configured and subsequently modified (or not), focusing on issues, interests and institutions within a single donor country. This paper asks: *what characteristics of the domestic policy process account for the current structure of US international assistance and the failure of numerous efforts to refocus the Foreign Assistance Act to better reflect the post Cold War political and economic context*? Traditional policy process frameworks suggest four potential explanations: competing issue definitions, contesting advocacy coalitions, mobilized opposition within the aid bureaucracy or among members of Congress, or lack of a sufficient institutional base. My analysis of Congressional hearings from 1980-2008 finds that none of these explanations account for the perpetuation of the

policy status quo in the face of exogenous foreign policy shocks. Rather, the data reveal sustained, widespread agreement, but on very broad of foreign aid goals. This case demonstrates how narrow interest involvement under conditions of policy uncertainty can impede policy change even when there is substantial agreement on policy goals and the need for reform.

Distinguishing donor approaches

The subsequent three chapters aim to characterize and compare differences across donors. Chapter Two presents formative research to answer the question *how do donor institutional characteristics and practices differ*? Through a comparative case study of four influential and diverse donors in the health sector in Peru, this chapter examines variation in donor agencies' relationships to both domestic and recipient country stakeholders. I find substantial variation across donors, with ownership structure – the ways in which donors formally engaged different recipient country stakeholders in different capacities – emerging as the most prominence difference across donors. Contrary to expectations, donor approaches did not vary in a systematic way according to donor type, whether they were bilateral or multilateral agencies. Rather, informants identified multiple groups to whom they were accountable, with greater differences depending on the informant's position within the organization and the organization's position in the aid chain. Furthermore, informants from both donor and recipient sides offered many examples of alignment of their goals; however, there was little harmonization or coherence of goals across donors themselves.

Given the importance of ownership structure as a distinguishing feature among donors, Chapter Three provides a new analytical framework for expanding beyond a singular concept of 'country ownership.' This typology assesses the extent to which donors engage five sets of recipient country actors – the government (central, regional/municipal), private sector (for-profit, non-profit) and civil society organizations – in five distinct development activities: problem identification, program design, resource administration, program implementation and program governance. In the Peru context, this typology revealed three dominant patterns in the way donors differentially related to the *same set* of recipient country stakeholders: 'doctor knows best', 'empowered patient' and 'it takes a village' models. The comparative advantages of public, private and civil society sectors only partially explained the conditions under which each ownership model was applied, suggesting greater opportunities to enhance recipient country involvement than are currently taking place.

Impacting outcomes

Chapter Four complements the qualitative findings in the previous two chapters with recently available cross-national quantitative data from the Development Assistance for Health dataset. This chapter examines two new donor financing approaches: channeling aid as budget support through recipient country accounts, intended to improved country ownership, and earmarking aid for specific diseases. The data reveal very low levels and inconsistent allocation of budget support, but higher levels and greater predictability of funding earmarks for HIV. Donors exhibited greater variation in their financing approaches among rather than across bilateral, multilateral and private donor types.

Next, the chapter tests predictive models to determine *what is the association between funding earmarks for HIV and tuberculosis and subsequent changes in health care coverage and outcomes?* These analyses demonstrate some support for the positive impact of HIV earmarks in reducing subsequent HIV prevalence, depending on country prevalence rates. There is less support for the impact of TB earmarks on subsequent TB detection, treatment or prevalence, perhaps in part due to the very low level of aid earmarked for TB.

Key findings

Taken together, this body of work offers four key insights for development assistance. First, **recipient country ownership**, the formal involvement of local actors in different capacities, was the most distinct difference across donors, who varied widely in their perception of the capacity and roles of the *same set* of local actors. Second, although there exists considerable **goal alignment** among stakeholders within donor countries and between donors and recipients, there is little harmonization or coherence across a very wide set of goals. Third, **bilateral and multilateral donors** exhibited greater variation *among* rather than *across* donor types, with actors across the aid chain identifying multiple lines of accountability regardless of the domestic principals to whom they report. And fourth, **targeted or earmarked aid** for specific diseases may need to be allocated at a sufficient threshold to observe changes in disease outcomes.

Implications

These findings hold significant implications for both research and policy. Methodologically, development scholars and practitioners must refine the underspecified term of 'country ownership' and instead identify *who* is formally involved in *what* capacities. The typology proposed in Chapter Three provides a useful template to do so. While development donors can be readily distinguished by their differential involvement of recipient country actors, donor type (bilateral versus multilateral) appears to be too blunt a measure to detect differences across donors. Similarly, when a small amount of aid is earmarked for specific diseases or is channeled as budget support, these earmarks may not be sensitive measures to observe changes in outcomes when they are given at low levels. Such allocations may need to reach a certain threshold before their impact can be evaluated.

Given the breath of goals that development assistance is trying to achieve, even within a single sector, aid effectiveness should be assessed using aid inputs that are specific to the goal the aid is intended to improve. The Development Assistance for Health dataset represents a significant contribution in this regard, but similar disaggregated data do not exist for aid to other sectors. Since budget support by nature is flexible in its use, evaluating its effectiveness may be most appropriate at the country-level, rather than cross-nationally, in order to better match inputs with outputs and outcomes.

More generally, the field of international development needs to conduct and disseminate more timely comparative assessments. As noted at the outset, experimentation in practice has far outpaced scholarship in this area, leading to large policy shifts with little empirical base. For example, at the millennium development donors provided unprecedented

increases in funding earmarked HIV. Several years later, in response to critiques that funding earmarks were creating disease silos, the Joint Funding Platform for Health Systems Strengthening was launched. Despite widespread donor commitment to 'country ownership' in the Paris Declaration, the miniscule amount of aid channeled as budget support is not widely known or acknowledged. More timely comparisons of different aid approaches would help to ground development assistance policy in evidence rather than speculation.

Specifically, these findings highlight the unrealized potential to substantially expand the formal involvement of recipient country actors. Their involvement is particularly underrepresented in problem identification, which health and development concerns should take priority, and in the administration of resources. Increasing the amount of aid channeled through recipient country budgets is a logical way to expand the latter, targeting scale-up based on standardized criteria like country governance indicators, rather than solely on donor perceptions.

Finally, the breadth of foreign assistance and development goals currently being pursued by donor agencies suggests the need to prioritize among these many objectives. Advocates trying to influence domestic policy processes should more firmly articulate poverty reduction and human development goals and mobilize their domestic constituencies to press for such change. Recipient countries could better prioritize their specific needs and more actively direct donors into these areas, rather than attempting to simultaneously address a countless number of development issues through hundreds of discrete projects. Donors

could harmonize their efforts by participating in basket fund initiatives with a lead donor and by channeling more funds through recipient country institutions.

These policy recommendations provide immediate, tangible steps in moving forward. The methodological considerations offer an opportunity for development scholars to better understand the conditions under which aid can be most effective. For donor agencies who want their money and time efficiently spent, but particularly for communities in recipient countries for whom the unfulfilled promise of development threatens their daily survival, the opportunity cost of inaction may prove too costly to bear.

Chapter 1

FAILURES TO REFORM US FOREIGN ASSISTANCE POLICY: WHEN PROBLEM AGREEMENT IS NOT ENOUGH

Policymaking is often a story of conflict and opposition – rival interests competing to advance their respective problem definitions and accompanying policy solutions. Indeed, clashes among interest groups and between political parties, turf battles among branches of government and across departmental agencies can block attempts to change or enact new policy, effectively preserving the status quo. As such, successful policy reform typically requires the minimization, if not resolution, of conflict through negotiation, coalition building and compromise.

Rather than conflict or compromise, this article examines the often overlooked case of problem *agreement* and its potential downside for the prospects of reform. On the surface, such a situation would appear to be ideal for policymakers, bureaucrats and advocates. It offers the increased possibility of producing a more coherent, effective policy solution and the opportunity to delve into policy details rather than simply wrangling over rhetoric. However, as the prolonged persistence of US foreign assistance policy demonstrates, under certain conditions – a narrow set of interests attempting to achieve a broad set of goals without a clear policy solution – widespread agreement may actually have the perverse effect

of perpetuating policies well beyond their relevant political context, serving to stymie rather than stimulate desired policy change.

Without dramatic conflict and the corresponding attention such issue areas receive, lower profile yet persistent policy problems may go largely unnoticed for years, leaving legislation to languish due to the lack of a readily available policy solution and lack of external pressure to take action. The opportunity cost of maintaining legislation whose design is widely acknowledged to be outdated and ineffective represents enormous hidden costs to government, when such resources could potentially be more effectively spent if allocated in a more appropriate way. These types of policy problems, characterized by sustained policy inaction despite agreement among stakeholders of underlying problems, remain a neglected area of study. We know little about the dynamics of the policy process that enable such policy stagnation.

US foreign assistance policy offers one such example, resisting reform for decades despite substantial agreement on both the need for policy reform and on a set of desirable policy goals; thus, it serves as a useful case with which to examine the forces driving prolonged policy persistence. Unlike defense and diplomatic policies, which have evolved to better reflect the contemporary political and economic context, why numerous attempts to refocus foreign assistance policy have failed? The results suggest that traditional conflict-oriented explanations do not sufficiently account for the lack of reform. Ironically, a key condition that has limited conflict, the presence of a narrow set of stakeholders, has also limited reform. Narrow interest involvement has led to institutional path dependence, where

a closed group of policy elites engage in seemingly endless technical debates about how best to craft an appropriate policy solution for the broad problem definition they have identified.

These findings extend previous work on policy change, identifying conditions under which widespread agreement, rather than conflict, can impede reform. Moreover, this case highlights the need to expand our attention beyond highly contentious policies to include lower profile, yet persistent policy challenges.

Conceptual foundations

Policy process frameworks and organizational theory identify specific conditions under which policy change is more and less likely to occur. The literature suggests that policy reforms can be impeded when conflict, driven by organizational- and self-protectionist forces, dominates a policy area. These forces are manifested in *issue, interest* and *institutional* dynamics. First, reforms may fail to be enacted due to competing conceptions of the underlying policy problem or *issue*, as different groups strategically frame conditions so they are perceived as problems (Kingdon, 1995), crafting convincing causal stories that attribute responsibility in such a way to necessitate public intervention (Stone, 1989). The various ways in which a policy problem, target population and solution are framed creates the possibility of multiple problem definitions for a single condition (Rochefort & Cobb, 1993). In the case of foreign assistance, for example, is aid intended to address the problem of global poverty and poor health? Threats to national security? Global environmental harms? Unequal competition in international markets for US business?

Second, conflict among stakeholder groups representing divergent *interests* outside and within the government may impede policy change. Policy 'publics', professional, producer and public interest groups engaged in issue debates, may pressure elected officials to pursue policy solutions aimed at addressing different policy problems (May, 1991). Commercial interests seeking to gain material benefits for their members may conflict with humanitarian interest groups pursuing value-based, purposive goals (Clark & Wilson, 1961). The potential for conflict and deadlock becomes heightened as interest groups form opposing advocacy coalitions, which serve to reinforce divergent core beliefs (Sabatier & Weible, 2007) – the role of the US in the international arena, for example.

Third, at an institutional level, bureaucratic interests may resist change as they respond to coercive, mimetic, normative and selection pressures in an attempt to maximize legitimacy, influence and internal cohesion. Agency employees may have strong motivation to maintain the status quo as a result of staff incentive structures, professional norms or fear of uncertainty (DiMaggio & Powell, 1983; Hannan & Freeman, 1984). Organizations may be entrenched in patterned behavioral responses that fit within their existing repertoires and that make it difficult to change their operating practices (Halperin et al., 1974; Allison, 1971). Within the government, competitive intra and inter-organizational bargaining among units like the Departments of State and Defense may inhibit policy restructuring that elevates one group above others (Lindsay, 1994; Allison, 1971). Congressional committees may struggle over jurisdictional claims of a policy issue (Baumgartner & Jones, 1993; King, 1997), weakening the coherence of policy solutions and diffusing momentum for policy change (May, Sapotichne & Workman, 2006).

In sum, the nature and interplay of issues, interest and institutions may create conditions that limit agreement in a particular policy area. Enactment of policy reforms may thus be stymied because of unresolved conflict over issue definitions and advocacy group interests, or because of protectionist interests of individuals and institutions.

Conversely, policy reforms are more likely to be enacted when there exists a strong enough majority to override the opposition of minority groups, such as the passage of new legislation following a change in party control and the perception of an electoral mandate (Grossback, Peterson &. Stimson, 2007). Even when sweeping political momentum does not exist, policy change can be facilitated by: 1) exogenous shocks and dramatic focusing events that attract enough attention to an issue area to stimulate policy adaptation to a new external environment (Kingdon, 1995; Baumgartner & Jones, 1993; Sabatier & Weible, 2007; Birkland, 1997); 2) a negotiated agreement brought about by what Sabatier and Weible (2007) term a 'hurting stalemate', when the policy status quo is sufficiently undesirable for all parties that it incentivizes opposing advocacy coalitions to reconcile in some way; and 3) policy learning, whereby new information offers insights into the underlying policy problem and/or possible solutions (Sabatier & Weible, 2007). Using a case in which policy change would be expected to occur, based on these facilitating factors, I test potential explanations related to issues, interests and institutions in an attempt to account for the prolonged persistence of US foreign assistance policy over the last half century.

Policy background

Since the passage of the 1961 Foreign Assistance Act, multiple foreign policy shocks have occurred which could have served as focusing events to stimulate policy change: very high profile events of both a geopolitical, security-oriented nature, like the end of the Cold War and the September 11th attacks, and of a humanitarian nature, including famines, natural disasters and the global HIV pandemic. Indeed, legislative modifications have been proposed during every presidential administration since the end of the Cold War, including several attempts at major overhaul. These recurrent efforts suggest that there has been sufficient attention on foreign aid policy to place the issue on the political agenda and sustained motivation for policy change over several decades. Therefore, the failure to enact comprehensive foreign assistance reform does not appear to simply be a case of complacency or inadequate attention.

Rather than legislative change, supplementary programs have been added to the Foreign Assistance Act over time, which in its current form pursues 33 goals, specifies 75 priority areas, and presents 247 directives, ranging from reducing infant mortality to encouraging private US investment abroad (Brainard, 2007; US Agency for International Development, 2006; Congressional Budget Office, 1997). More recently, new aid initiatives like the 2003 President's Emergency Plan for AIDS Relief and the 2004 Millennium Challenge Corporation have been launched by the Executive Branch, rather than being integrated into existing structures or legislation. Over the years, the complex and unwieldy foreign assistance system has faced sharp criticism from policymakers, practitioners and

scholars alike (Brainard, 2007; Easterly, 2006; Easterly, 2008; Moyo, 2009), suggesting that it is a less than desirable arrangement for multiple stakeholders.

Thus, despite the presence of factors which should facilitate policy change – profound shifts in the political and economic environment and expressed dissatisfaction of the policy status quo from a variety of actors – repeated attempts at policy change over the last several decades have all failed. Ground in the conceptual foundations above, I explore four potential explanations, questioning whether the perpetuation of the policy status quo can best be accounted by: 1) competing issue definitions of what constitutes foreign assistance policy (issues), 2) presence of contesting advocacy coalitions supporting different target beneficiary groups (interests), 3) mobilized opposition against restructuring from within the existing aid bureaucracy or the broader populace (interests), or 4) turf battles among agencies or branches of government (institutions).

Given the lack of policy change, I would expect to see well mobilized advocacy coalitions presenting clearly differentiated conceptions of the policy problem and opposing policy solutions that reward different target groups, strong resistance to reform by members of the existing aid bureaucracy or in the broader population, and/or conflict over which entity should serve as aid's institutional home. Furthermore, I would expect focusing events and changes in party control to influence issue definition; for example, I would anticipate that foreign aid hearings would emphasize national security following the September 11th attacks and during Republican-controlled eras of Congress, democracy promotion immediately

following the end of the Cold War, and poverty reduction when Democrats held the majority in Congress.

I find that none of these conflictual or protectionist explanations adequately explains for the state of foreign assistance policy, which is characterized by shared goals, narrow interest involvement, weak opposition to reform and a centralized institutional base. Rather, this case of prolonged policy persistence demonstrates the drawbacks of issue diversity when a small set of stakeholders is unable to identify a clear policy solution. Thus, this case offers an alternate explanation for the lack of policy reform, uncovering a neglected subset of persistent policy problems, entrenched in internal stagnation and overshadowed by higher profile conflict-oriented issues, that warrant increased attention.

Methods

This analysis is based on data from Congressional hearings on foreign aid from 1980-2006. This date range spans four presidential administrations and changes in Congressional leadership, and encompasses time points before and after the Cold War and the September 11th attacks. Hearings were identified through the Policy Agendas Project[1], which classifies hearings into 19 major topics and 225 subtopics. The subtopic of 'US foreign aid' returned 390 hearings in the date range, seven of which did not address international assistance, resulting in a total of 383 hearings. Based on the hearing list generated by the Policy

[1] The data used here were originally collected by Frank R. Baumgartner and Bryan D. Jones, with the support of National Science Foundation grant number SBR 9320922, and were distributed through the Department of Government at the University of Texas at Austin and/or the Department of Political Science at Penn State University. Neither NSF nor the original collectors of the data bear any responsibility for the analysis reported here.

Agendas Project, hearing summaries were retrieved through Lexis-Nexis Congressional Universe.

Measures

Each hearing summary was coded to extract four pieces of information: dominant issue focus, geographic focus as a proxy for policy targeting, witness affiliation and Congressional committee. Only one dominant issue code was assigned to each hearing from among eleven options: annual budget authorization and appropriations, food aid, humanitarian assistance, democracy promotion, poverty reduction, economic growth for recipient countries, market expansion or investment opportunity for US business, military aid, environment, human development, and overall system reform. Hearings addressing health, population growth, education and drug prevention were relatively infrequent so these topics were collapsed in the human development category to avoid an unwieldy number of categories. Overall system reform hearings were those which dealt with broader organizational and strategic planning considerations, that critically examined the current structure of US foreign aid and that discussed potential options for reform.

Geographic focus was identified through the mention of a specific country or region, or lack thereof, in which case the hearing was classified as having no geographic focus. Witness affiliation was classified as one of the following nine categories: USAID official, other State Department official, other federal official, non-governmental organization (NGO), business, think tank, academic, member of Congress testifying before, rather than a

member of, the committee holding the hearing, or 'other' affiliation. The name of the Congressional committee holding the hearing was documented as listed in the hearing summary.

Detailed analysis of testimony from system reform hearings

Given the primary question motivating this analysis – what policy process dynamics have led to the failure of comprehensive aid reform – I also examined in greater depth the testimony of hearings dealing with overall system reform. Twenty three hearings were coded as addressing overall system reform from the original set of 383, with the first appearing in 1986. In order to include more recent data, these hearings were supplemented with eleven additional reform hearings, identified through a Lexis-Nexis Congressional Universe search for 'foreign aid' and not 'appropriations' from January 2007 – December 2009.

The testimony for each of the 260 witnesses appearing in this subset of 34 hearings was then coded for issue focus and tone. Issue focus was classified according to the same list of topics presented above. To gauge the breadth of foreign aid objectives for each witness was advocating, every issue mentioned by the witness was recorded, rather than restricting issue focus to one dominant topic.

Witness testimony was also coded according to the tone towards i) the current structure of foreign aid and ii) system reform. Tone was rated as negative (-1) or positive (+1) if the witness spoke out against or in favor of the current system or system reform. For example, testimony including the statement '*The Administration is deeply disturbed by the budget and reorganization proposals being considered by this committee with regard to our*

international affairs operations'[2] was rated as negative and testimony including the statement '*I strongly support the goal of you and others here, Mr. Chairman, to rewrite the Foreign Assistance Act*'[3] was rated as positive. Tone was rated as neutral (0) if no explicit position was stated regarding the current aid system or its reform.

Findings

The following presentation of findings systematically constructs a profile of US foreign assistance policy over the last three decades, corresponding to the frameworks discussed above. I consider issue definition, interest involvement, policy targeting and the institutional configuration overseeing foreign aid policy. Results are presented in aggregate across all foreign aid hearings (n=383), and among two subsets of hearings: non-appropriations hearings which dealt with issues other than annual budget appropriations (n=137) and system reform hearings that dealt specifically with the topic of overall system reform (n=34). The latter subset is of particular relevance in understanding the dynamics among issues, interests and institutions that have contributed to the failure to enact foreign aid reform.

[2] Testimony by J. Brian Atwood to the House of Representatives Committee on International Relations, May 9, 1995 (95-H461-29)
[3] Testimony by M. Peter McPherson to the House of Representatives Committee on Foreign Affairs, June 25, 2008 (2008-H381-89)

Wide, but shared, issue definition

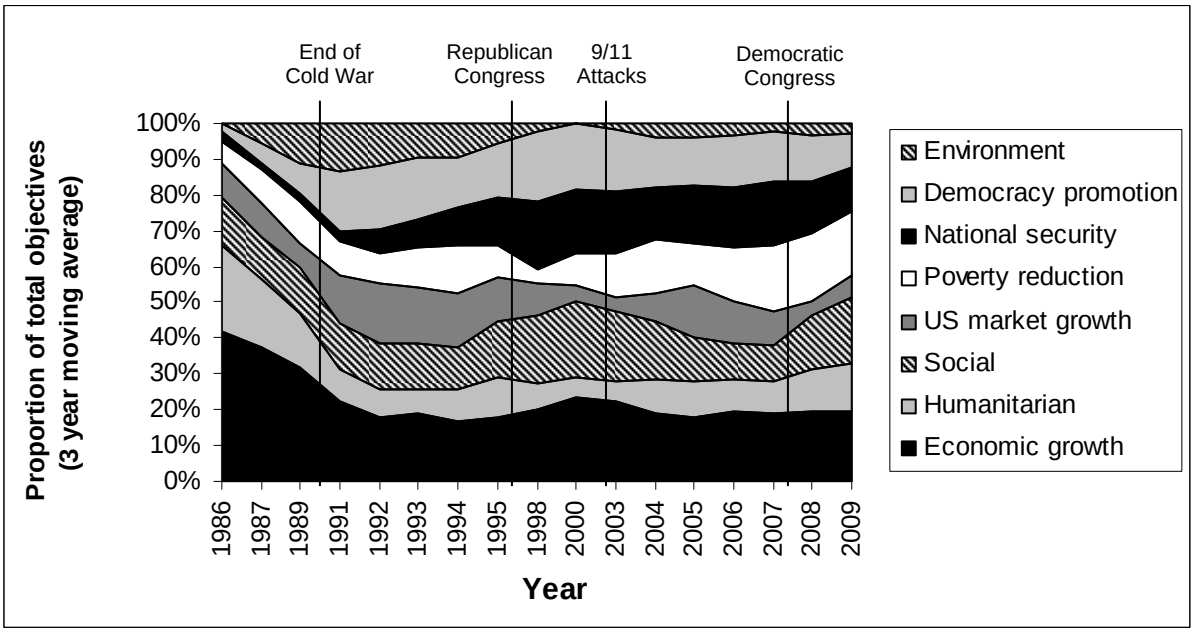
Tracking foreign aid issue themes over time reveals remarkable issue diversity, evidenced by the wide range of topics on which hearings were coded. Among all hearings, annual budget requests dominated, comprising 62% of all hearings. Of the hearings that dealt with topical issues rather than budget appropriations, food aid and humanitarian assistance accounted for more than one third (37%), followed by reform hearings (21%), military (13%), economic growth (11%), democracy promotion (8%), human development (6%), environment (3%) and US market expansion (3%).

Rather than different issues rising and falling in prominence over time, however, issue foci demonstrated remarkable consistency, with a very broad definition of what constitutes foreign assistance persisting across decades. With its multiple goals, foreign aid policy appears to be an expandable agenda space, with no apparent limit to what would be excluded from this policy area. For example, while emergency food aid and humanitarian relief were most common among hearing topics, they still have not crowded out longer-term goals of economic growth and democracy promotion.

Figure 1.1 illustrates the frequency of each issue component among the smaller subset of system reform hearings over the last two decades. The number of foreign aid objectives discussed each year ranged from four to eight, with economic growth, humanitarian aid, human development, poverty reduction, national security and democracy promotion serving as consistent themes across time. Emphases on economic growth and humanitarian aid have declined over time, while national security and poverty reduction have received greater notice; however, major changes in aid foci do not appear to have resulted from either internal

changes in party control or external foreign policy shocks. Democracy promotion did not spike after the end of the Cold War, nor did national security rise after the September 11th attacks.

Figure 1.1 Foreign aid foci: Relative emphasis of aid objectives over time identified in system reform hearings



Even among individual witnesses there was consistent mention of multiple foreign aid policy objectives. The average witness mentioned 3.4 issues in his/her brief testimony. While business representatives tended to promote economic growth and investment, and NGO witnesses emphasized poverty reduction and human development, there were no clear factions advocating one objective over another. The discussions reviewed here were largely technical in nature, with little assessment of upstream conditions that create the need for

external aid in the first place, which may be more likely to uncover differences in core beliefs (Sabatier & Weible, 2007).

Rather than debate *causal conditions* or *goals* of foreign aid, witnesses proposed different *means* by which to achieve shared goals, as demonstrated in testimony below [bold added to highlight shared goals]:

> *'What precisely do we want to achieve? I think all of our foreign assistance programs should be geared to meeting at least one of four different objectives. They should either enhance our **national security**, they should be **promoting economic growth** and **poverty reduction**, they should be helping to **consolidate political change and democracies** around the world, or they should be providing **humanitarian assistance** in crises programs. All of them should be geared to at least one of those.'*
>
> Steven Radelet, Senior Fellow, Center for Global Development
> House Committee on International Relations, February 26, 2004

> *'In line with the President's 2002 National Security Strategy, foreign aid presents us with an opportunity to extend freedom across the globe by providing incentives for countries to pursue policies that **promote rule of law** and **economic freedom**, thereby generating **growth** and **development**. While the United States should always provide assistance in times of **humanitarian need**, a general strategy that moves countries toward self-generated prosperity is the most viable and measurable long-term plan to contribute to strengthening our **national security**.'*
>
> Marc Miles, Director
> Center for International Trade & Economics, Heritage Foundation
> House Committee on International Relations, February 26, 2004

These two witnesses testifying at the same foreign aid reform hearing represent think tanks from different ends of the ideological spectrum. Common among them, however, are shared goals of national security, economic growth, promotion of democracy and humanitarian assistance. The identification of a diverse set of foreign aid objectives by these

external actors also aligns with the broad goals articulated by the government, as exemplified US State Department's mission to '*advance freedom for the benefit of the American people and the international community by helping to build and sustain a more democratic, secure, and prosperous world composed of well-governed states that respond to the needs of their people, reduce widespread poverty, and act responsibly within the international system'* (US Department of State and US Agency for International Development, 2007, p. 9).

Clear diagnosis, uncertain solution

Although this broad set of goals appears to be widely agreed upon, so too has been the recognition of the negative implications of such issue diversity in hindering aid effectiveness, as highlighted by the testimony below:

> *'The first sort of impediment or constraint that I see is a multiplicity of foreign assistance goals. …What is it that we are supposed to do? Are we supposed to reward our friends and punish our enemies? Are we support to stop drug trafficking, protect human rights, stop abortion, bring down population growth? Who is [US]AIDS's constituency? The private sector in this country? In the developing countries? Contractors here and abroad?'*
>
> Cornelia Flora, Professor of Sociology, Kansas State University
> Testimony before the Senate Committee on Foreign Relations, Apr 23, 1986

> *'My study was only the most recent in a series to note the US foreign aid suffers not from lack of direction, but from too many directions all at once. Each one of the foreign aid goals is individually laudable. In aggregate, they served a political purpose, forging a broad coalition to support the overall program. However, this has also led to internecine warfare among supporters, leading them to question the value of overall program.'*
>
> Mark Lowenthal, Senior Specialist
> US Foreign Policy, Congressional Research Service
> Testimony before the Senate Committee on Foreign Relations, Sept 30, 1992

> *'For too long, our foreign assistance programs have lacked focus, addressing instead a thousand agendas. There's an old saying that if you are not clear about where you are trying to go, all roads lead there.'*
> Randall Tobias, US Foreign Assistance Director & USAID Administrator
> Testimony before the House Committee on Foreign Affairs, Mar 8, 2007

Despite the continual acknowledgement of the negative implications of such issue diversity, there was a notable absence in witness testimony of tangible strategies to bring greater coherence to the breadth of goals foreign aid is expected to achieve. This diagnosis, observed over more than two decades, was not accompanied by specific policy solutions to address the very problem that has been identified, highlighting the persistent uncertainty in how best to approach system reform. Thus, while problems with the current approach have been well diagnosed, clearly articulated policy solutions to address them remain elusive.

Narrow interest involvement

The shared set of broad policy goals may be reflective in part of the players involved in the debate. The classification of witness affiliations illustrated in Table 1.1 suggests that foreign aid represents a relatively closed policy subsystem, dominated by bureaucratic and implementation experts, predominantly generalists who did not represent other policy subsystems or specialize in one particular aid sector (e.g. health, agriculture, environment). Nearly one half of all witnesses at reform hearings came from within the government, with designated federal agency officials appearing before Congress by far the most often. No witnesses came from outside of the United States and none represented citizens groups. Although nationally representative poll data indicate that two-third of respondents support US spending on development aid (Program on International Policy Attitudes, 2005), they are

not organized to advocate for this cause. Even among the many non-governmental organizations that have testified at reform hearings across the years, only two organizations have appeared more than three times: InterAction, the national coalition of development agencies, and the World Wildlife Fund.

The distribution of witness affiliation across organizational categories was comparable among the wider sample of witnesses testifying at all non-appropriations hearings (n=948), with two exceptions. In the wider sample, witnesses affiliated with think tanks only represented 6% of the total number of witnesses, proportionally less than half as many as the 14% participating in reform hearings. Instead, business representatives constituted 12% of witnesses in all non-appropriations hearings, compared with only 5% in reform hearings. The larger proportion of witnesses testifying on behalf of US business can be largely accounted for by the participation of national agricultural associations in hearings addressing food aid policy. These relatively minor differences notwithstanding, the wider sample of all non-appropriations hearings was also dominated by federal agency officials, secondarily by NGO representatives, with business, think tanks, academics and non-committee members of Congress comprising a much smaller share of total witnesses.

Table 1.1 Classification of witnesses testifying at foreign aid system reform hearings*

Witness Affiliation	Witness Appearances†	
Federal agency	109	(43%)
USAID	48	
State Dept	32	
Treasury Dept	6	
Defense Dept	4	
GAO	4	
Other federal agency	15	
NGO	69	(27%)
InterAction	9	
World Wildlife Fund	4	
Other NGO	56	
Think tank	35	(14%)
Overseas Development Council	7	
Center for Global Development	7	
Heritage Foundation	5	
Center for International & Strategic Studies	4	
Other think tank	12	
Academia	19	(7%)
Business	14	(5%)
Member of Congress	10	(4%)
Total number of witnesses	256	(100%)

* Foreign aid system reform hearings: n = 34

† Witness affiliation listed for organizations appearing more than three times

Weak, diffuse policy targeting

By its very nature, foreign aid policy targets a diffuse, distant population: individuals, communities and governments across the globe. Through the breadth of its issue definition, policy beneficiaries could be expanded further to include two additional, broad groups: US

business, who benefit from investment and market growth opportunities, and US residents, who benefit indirectly from reduced national security risks.

Even more notable than the diffuse nature of policy targeting was its absence, the infrequency with which specific beneficiaries or target countries were mentioned. Among all hearing summaries, only one third referenced a specific country or region. Even those that targeted a particular geographic region did so in broad terms, most commonly addressing food aid to Africa, followed by assistance to Eastern Europe and the former Soviet Republics, the Middle East and Central America.

Paralleling the expansive and often unarticulated beneficiaries of US foreign aid policy is the wide distribution of its burden. The financial cost of US foreign aid is dispersed across the US population and represents a very small proportion of the national budget: 0.19% of gross national income in 2009 (Organization for Economic Cooperation and Development, 2010). Thus, with diffuse benefits and burdens, foreign aid policy could be classified as majoritarian politics, with no prominent interest groups advocating for or against its policies (Wilson, 2000).

Centralized institutional base

As evidenced above, the foreign aid policy subsystem enjoys a stable set of actors and a shared set of ideas. Institutionally, it has a centralized organizational base in both the legislative, and to a lesser extent the executive branch. Among all non-appropriations hearings in the House of Representatives, more than half (57%) were held before the Foreign

Affairs Committee and in the Senate, 62% of hearings were held before the Foreign Relations Committee (Table 1.2). An additional fifth in each house were held before the respective Hunger and Agriculture committees which oversee US food aid. Among reform hearings, an overwhelming 86% took place in the House Committee on Foreign Affairs and 83% in the Senate Committee on Foreign Relations. Thus, there do not appear to be ongoing turf battles among different Congressional committees as to who retains jurisdiction over foreign assistance policy.

Table 1.2 Congressional committees holding foreign aid hearings

Committee	Hearing Type			
	Non-appropriations*		System reform†	
	Number	Percentage	Number	Percentage
House of Representatives				
Foreign Affairs	53	57%	19	86%
Hunger (select)	11	12%	1	5%
Agriculture	8	9%		
Appropriations	6	6%		
Government Reform	5	5%	1	5%
Financial Services	3	3%	1	5%
Interior & Insular Affairs	2	2%		
Other	5	5%		
Total	93	100%	22	100%
Senate				
Foreign Relations	26	62%	10	83%
Agriculture, Nutrition & Forestry	9	21%		
Appropriations	3	7%	1	8%
Labor & Human Resources	2	5%		
Other	2	5%	1	8%
Total	42	100%	12	100%

* 1980-2006, n=137; sample excludes hearings which dealt with annual budget requests in the
† 1986-2009, n=34; sample includes all hearings that dealt with overall reform of the US foreign
Note: Two non-budget hearings were held by Joint Congressional committees so totals add to 135 instead of 137.

Within the Executive Branch, the US Agency for International Development, an independent agency housed within the State Department, serves as the bureaucratic home for foreign assistance. That said, the structure and management of USAID has been a longstanding criticism and a primary target for reform[4], which has eroded the agency's legitimacy and leadership in advocating for US foreign assistance. Both resulting from and exacerbating USAID's marginalized status, aid programs are located within more than 20 federal agencies, scattered across the Departments of Agriculture, Commerce, Defense, Energy, Health and Human Services, Interior, Justice, Labor, State and Treasury (Brainard, 2007; US Agency for International Development, 2006; Congressional Budget Office, 1997). However, representatives from all of these departments are not actively engaged in reform debates. USAID and State Department officials represented nearly three quarters (80/109) of agency officials testifying at system reform hearings (Table 1.1). Thus, a centralized institutional base for foreign assistance policy exists in the legislative branch and is present but weaker in the executive branch, with these measures suggesting little evidence of heated turf battles among Congressional committees or agency officials engaged in aid reform.

[4] Accountability and Control over Foreign Assistance (GAO/NSIAD-90-25, March 1990); Foreign Assistance: Management Problems Persist at the Agency for International Development (GAO/NSIAD-92-31, May 1992); Foreign Assistance: AID Strategic Direction and Continued Management Improvements Needs (GAO/NSIAD-93-106, June 1993); Foreign Assistance: Status of USAID´s Reforms (GAO/NSIAD-96-241BR, September 1996); Major Management Challenges and Program Risks: US Agency for International Development (GAO/OGC-99-16, January 1999, GAO-01/256, January 2001, GAO-03-111 January 2003; Foreign Assistance: US Agencies Face Challenges to Improving the Efficiency and Effectiveness of Food Aid (GAO-07-616T, March 2007), Foreign Aid Reform: Comprehensive Strategy, Interagency Coordination, and Operational Improvements Would Bolster Current Efforts (GAO-09-192, April 2009), among others.

Ambivalence toward reform

If foreign aid represents an institutionally bounded policy subsystem and it has not been outside interest groups or jurisdictional jockeying that have blocked legislative proposals, perhaps then resistance has come from within the aid community itself. Of the 236 witnesses in reform hearings for whom testimony was available, only 3% voiced their opposition to foreign aid reform, compared to more than one third (35%) who supported it. Eleven percent of all witnesses spoke in favor of the current foreign aid system, whereas more than twice as many (28%) expressed dissatisfaction with the status quo.

With one exception, all of the witnesses who opposed reform spoke at a single hearing in 1995 reviewing the American Overseas Interest Act, which proposed to consolidate USAID, the US Information Agency (USIA) and the Arms Control and Disarmament Agency (ACDA). This instance was the only evidence of agency directors opposing restructuring in an attempt to protect their employees' jobs and their agencies' autonomy. For most hearings, the tone (positive, negative or neutral) within was consistent within in a given hearing. There were only a few instances in which witnesses displayed opposing views within the same hearing, underscoring the lack of competing advocacy coalitions and the widespread agreement among stakeholders in this policy subsystem.

Rather than support for or opposition against foreign aid reform, most witnesses did not express a strong opinion favoring either side, with nearly two thirds of testimony classified as having a neutral tone. Even in the context of a reform hearing, most witnesses discussed the technical details of potential restructuring efforts rather than advocating

passionately for or against proposed reforms. There was little evidence of a consistent, charismatic policy entrepreneur advancing a specific policy proposal.

Moreover, as noted earlier, annual appropriations hearings comprised nearly two-thirds of all hearings on foreign aid, with hearings specifically addressing overall system reform representing only 8% of the total. The topic of foreign assistance itself did not feature prominently on the Congressional agenda from 1980 – 2006, comprising only 0.2% of all Congressional hearings at its lowest point in 1998 and only 1.5% of hearings at its high in 1980 (median: 0.9%). These proportions represent a fraction of the attention devoted to defense during the same time period, which ranged from a relative low of 5.5% in 1997 to a high of 10.0% of all hearings in 2005 (median: 7.6%).

Discussion

These hearing data portray a bounded foreign aid policy community dominated by experts who largely agree both on a wide set of policy objectives and on the need for foreign aid reform. Returning to the four potential explanations posed at the outset, it appears that none of the traditional conflict-oriented explanations concerning competing issue definitions, contesting advocacy coalitions, mobilized opposition within the existing aid bureaucracy or the broader populace, or institutional turf battles have blocked such reform. Moreover, exogenous foreign policy shocks and internal changes in Congressional leadership have been insufficient to induce the desired reforms.

Foreign aid is best understood as a policy without a public: dominated by technocratic experts with limited interest involvement, addressing public rather than private risks, with problems placed on the government agenda through inside rather than outside initiative (May, 1991). It is within this context that ambivalence towards reform and uncertainty regarding appropriate policy solutions have been able to stymie foreign aid policy for decades.

While there exists little opposition to policy reform, there also appears to be insufficient momentum for its manifestation. No obvious policy entrepreneur has yet emerged to champion foreign aid as an issue necessitating greater Congressional attention, or raise the profile of one of aid's many goals (e.g. poverty, security, environment). The historically maligned status of USAID no doubt contributes to this void. Beneficiary groups who presumably receive the greatest benefits are situated in different governance systems. Domestic commercial and humanitarian interest groups may not receive sufficient benefits to become more strongly engaged (Salisbury, 1969). In hearing testimony, although more witnesses expressed support for policy reform than opposed it, the majority did not articulate a strong opinion either way regarding the current aid structure or prospects for reform. Indeed, the overwhelming predominance of hearings devoted to annual budget appropriations suggest that the current system is considered adequate, if not optimal.

The lack of momentum regarding system reform may be partially explained by professional interests that policy change could potentially jeopardize, providing some support for organizational preservationist claims. Seventy five percent of witnesses in system reform hearings represented government agencies, NGOs or businesses involved in managing and

delivering aid. Nevertheless, individual or institutional self-interest has not prevented witnesses from actively opposing reform or from articulating their concerns with the current system. These calls for change from within the foreign aid policy subsystem itself suggest that this is not simply a case of a structure-induced equilibrium in which dominant stakeholder groups are using their institutional power to resist reform (Baumgartner & Jones, 1993).

Rather than combative or protective, witnesses appeared perplexed, struggling to identify appropriate policy solutions to achieve the broad mandate they have established for themselves. The lack of sufficient pressure from outside of this closed policy subsystem has enabled these unresolved technical deliberations to persist even as the legislation has outlasted its original raison d'être. Two decades after the end of the Cold War, the simultaneous acknowledgement of the negative implications of issue diversity and steadfast adherence to a stable set of broad goals raises doubts about the ability of this policy subsystem to enact reform on its own. Ironically, bringing greater focus to US foreign assistance policy may require expanding rather than restricting the boundaries of the policy subsystem to encourage the involvement of new stakeholders who can disrupt the internal inertia and provide a stronger impetus for change.

More generally, the case of US foreign assistance policy demonstrates the perils of policies without publics, identifying conditions under which narrow interest involvement can impede rather than facilitate policy reforms. Previous work on policies without publics has highlighted the challenge of gaining adequate momentum for change as a primary obstacle to

policy implementation (May, 1991). These results extend this observation to the policy design stage as well, demonstrating that policies without publics around which there is much uncertainty regarding how best to achieve desired policy goals can also obstruct change, even when the underlying problem is well defined.

Furthermore, this case of a persistent policy problem around which there is agreement but no action, exposes a subset of policy issues overlooked by previous studies that represent important variation in the broader narrative about policy change and stagnation. A range of policy topics could fall into this category of neglected policy problems. This subset may include topics like critical infrastructure policy whose technical nature limits broader engagement of non-experts, leaving it vulnerable to protracted internal debate. It could encompass issues with complex causal chains that do not face outright opposition but around which there is great uncertainty regarding appropriate policy solutions, like previous 'wars' on drugs and poverty.

Future work on policy reforms should compare cases that are characterized by narrow interest involvement, issue diversity and accompanying policy uncertainty, by one condition and not the others, and by wide interest involvement, narrow goals and relative policy certainty to test the conditions around which this phenomenon of agreement but inaction are present. Analyses of both foreign and domestic policy issues would help to clarify the extent to which the findings observed here are influenced by the existence of a large beneficiary group that does not have direct access to the US policy process. While Congressional hearings represent an established primary data source to study policy change, their formal, somewhat manufactured nature may underestimate deeper disagreement among stakeholders that may be

taking place outside of Congressional chambers; therefore, future analyses could contribute to this line of research by identifying new data sources to supplement existing measures of stakeholder interests.

At a minimum, these results suggest that shared goals and a common understanding of the policy problem may be a necessary but insufficient condition for enactment of policy reforms. Moreover, in some situations this agreement can actually impede, rather than facilitate policy change, adding further explanation for why it can be so hard to achieve.

Chapter 2

FROM MONOLITHIC TO MULTIFARIOUS: HOW DO DEVELOPMENT DONORS DIFFER?

Guided by the 2000 UN Millennium Development Goals and the 2005 Paris Declaration on Aid Effectiveness, the past decade has witnessed unprecedented financial and political commitments to reduce poverty and disease across the world. Much of these increased resources have been channeled through new donor structures that have emerged alongside traditional bilateral aid agencies, multilateral development banks and UN programs including the 2000 GAVI Alliance, 2002 Global Fund to Fight AIDS, Tuberculosis and Malaria, 2003 President's Emergency Plan for AIDS Relief, and 2004 Millennium Challenge Corporation, among others. While laudable for the awareness and resources these new initiatives have generated, they have essentially been evolving experiments in the field.

Scholars and practitioners alike acknowledge that the contexts in which development programs are implemented vary widely across recipient countries. Why then does the development community continue to treat donors as monolithic? Unlike previous research on the role of recipient country institutions, development donors have not yet been classified or evaluated in a systematic way. For recipient countries, differentiating among donors is important to determine which approaches are most appropriate for their unique context. For donors themselves, understanding how their model(s) fit into the broader aid landscape can help agencies better target their assistance, rather than trying to be all things to all countries.

From a theoretical perspective, the role of the principal in the principal-agent relationship and the nature of the contracting institution are poorly understood. From an empirical perspective, systematic examination of the role of international donors may offer important insights to help explain decades of disappointing development results that have failed to consistently link aid inputs to sustained improvements in economic and human development. In short, scholarship on development assistance needs to catch up with the international political momentum of the previous decade.

This article is the first to identify key causal mechanisms through which donors may influence development outcomes. I begin by characterizing trends in the contemporary aid landscape. Grounded in principal-agent theory and participatory development frameworks, I then test to extent to which donor agencies' relationships with both domestic and recipient country stakeholders explain variation in their practices. Specifically, I examine the extent to which variation in donor type (bilateral versus multilateral) and ownership structures is evidenced in practice through a within-country cross-donor comparison of development donors in the health sector in Peru. The article concludes by discussing implications of these results for development practice and identifying methodological considerations in order to more systematically incorporate donor-side variables into the study of development assistance.

I find substantial variation across donors, even within a single sector in a single country. Ownership structure, the ways in which donors formally engaged different recipient country stakeholders in different capacities, was the most salient difference across donors.

Contrary to expectations, donor type did not represent a meaningful category by which donor programs varied in a systematic way.

Proliferation & experimentation: Contemporary trends in development assistance

The past decade has witnessed marked changes in the scope and structure of development initiatives, with both the proliferation of and experimentation by donor agencies. In terms of financial commitments, the total amount and proportion of aid relative to countries' gross national income (GNI) has increased from a historic low of 0.22% GNI in 1997 to 0.32% GNI in 2010, totaling $127.5 billion (Organization for Economic Cooperation and Development, 2010) in official development aid. Much of this growth in funding has been directed towards addressing global health concerns (Piva & Dodd, 2009).

Paralleling increases in funding has been a progressive increase in the number of donors. As measured by the Herfindahl index of industry concentration[5], donors have provided funding to an increasing number of recipients; reciprocally, recipient countries have received assistance from an increasing number of donor agencies (Easterly, 2007; Easterly & Pfutze, 2008; Knack & Rahman, 2008). Kharas and Linn (2008) estimate that there exist 563 official aid agencies implementing approximately 60,000 publicly funded aid projects. In 2000, a typical recipient country received assistance from 15 bilateral and 10 multilateral organizations (Reinikka, 2008), figures which likely underestimate the number of donor-recipient linkages today. In the health sector specifically, while bilateral agencies still account for the majority of total funding, the proportion distributed by multilateral donors has

[5] The Herfindahl index of industry concentration takes the sum of squares of the market (aid) share of each firm (donor agency). The index ranges from 1/N to 1 where N represents the number of firms (donors), with lower numbers indicating greater fragmentation.

significantly increased over time. The share from bilateral donors and development banks has declined (Ravishankar, et al., 2009).

Many of these new donor agencies explicitly aim to set themselves apart from traditional bilateral (e.g. USAID), multilateral (e.g. UNDP), and development bank models, and structure their support in ways that attempt to correct perceived deficiencies of such programs. Prominent among these persistent donor critiques have been: the provision of insufficient, unpredictable and restrictive financial support, allocation of aid based on political and commercial considerations, use of inflexible implementation strategies that are poorly integrated into local systems, and reliance on process-oriented rather results-based outcome measures (Birdsall, 2008; Easterly, 2002; Easterly, 2006; Kharas & Linn, 2008; Paul, 2006; Radelet, 2004; Radelet & Levine, 2008; Sachs, 2005; Svensson, 2008; Wane, 2004). In response, the series of High Level Forums resulting in the 2003 Rome Declaration on Harmonization, 2005 Paris Declaration on Aid Effectiveness and 2008 Accra Agenda for Action developed benchmarks to improve predictability of funding, strengthen recipient country ownership, enhance donor alignment with recipient country priorities and systems, improve harmonization across donor activities, incorporate results-based measurement, and reduce prescriptive aid conditions and levels of tied aid that must be spent on goods and services in donor countries.

Twenty-first century donor agencies like the GAVI Alliance, Global Fund to Fight AIDS, Tuberculosis and Malaria, and Millennium Challenge Corporation have formally incorporated many of these elements directly into their organizational structures. The former

two require the establishment of recipient country coordinating bodies as a way to enhance local ownership (Biesma, et al., 2009). All three emphasize performance-based management and use recipient country income levels as exclusion criteria for funding receipt (Lucas, 2007; Radelet & Levine, 2008). Thus, the contemporary development assistance landscape is characterized by an increase in the amount of funding and number of donors, growing presence of multilateral agencies, and creation of new organizational structures that aim to better align aid allocation to recipient country needs, enhance local ownership and measure outcomes in addition to processes.

Incorporating donor dimensions into the study of development assistance

Given the recent experimentation among development donors and the strong desire to improve aid effectiveness, in response to decades of disappointing development results (Boone, 1996; Doucouliagos & Paldam, 2009; Easterly, 2006; Kenny, 2008; Moyo, 2009), the lack of research on the donor side of the donor-recipient relationship is surprising. Considering the potentially profound impact these powerful actors could have in shaping the goals, implementation and effectiveness of their aid programs, systematic examination of development donors is long overdue. The growing diversity in donor types and approaches offers greater variation to be able to pursue just this type of comparative work among this influential yet neglected set of stakeholders.

A fundamental step in incorporating donors into the study of development assistance is the identification of distinguishing features among donor models, analogous to what has been done with recipient countries (Acemoglu, Johnson, & Robinson, 2001; Banerjee & Iyer,

2005; Burnside & Dollar, 2000; Collier, 2002; Collier & Dollar, 2004; Congressional Budget Office, 1997; Easterly, 2006; Knack, 2000; Kosack, 2003; McGillivray, Feeny, Hermes, & Lensink, 2005; World Bank, 1998). Here I examine donor agencies' relationships with both domestic and recipient country stakeholders, looking upstream as well as downstream in the aid chain. More specifically, I examine i) donor type and ii) ownership structure as potentially meaningful dimensions along which donors may vary. Both reflect prominent themes in the development literature as well as major trends in development practice. Donor type (bilateral versus multilateral) defines the stakeholders on whom the donor agency is dependent for sources of revenue and legitimacy as a legal entity, those to whom the agency must justify its actions in order to receive continued financial and political support. A related yet distinct concept is that of ownership, who makes strategic and operational decisions regarding the scope of the development program.

How different donor agencies configure relationships with both domestic and recipient country stakeholders establishes boundaries within which program officers, implementing agents and beneficiaries relate to the development program and to one another. Both donor type and ownership structure therefore reflect elements embedded in donors' unique institutional structures – that is, the formal rules and informal norms that constrain the environment within which organizations and individuals act (North, 1991; North, 1990). These distinct approaches, in turn, interact with characteristics of the implementing environment (nature of the good, recipient country institutions), to produce potentially distinct development outcomes.

Donor type

A substantial body of empirical evidence has consistently demonstrated that individual country governments use foreign assistance to achieve political, commercial, development and humanitarian goals (Alesina & Dollar, 2000; Berthelemy & Tichit, 2002; Collier & Dollar, 2004; Meernik, Krueger, & Poe, 1998; Milner & Tingley, 2010; Trumbull & Wall, 1994; USAID, 2002; Wang, 1999). Domestic aid contractors and suppliers in donor countries seek to maintain their revenue flows, and may pressure policymakers to divert resources from being invested directly in recipient countries (Svensson, 2008).

Unlike bilateral donors, representing a single country (albeit with many constituent parts), multilateral donor decisions represent compromise decisions of multiple stakeholders, most often state governments. Due to their diverse membership, multilateral organizations may be more insulated from domestic pressures and may be able to leverage competition among members to produce more transparent and cost-effective practices in the procurement of goods and services. These factors should enable them to pursue more development-oriented, rather than political objectives (Martens, 2002). Moreover, members of multilateral organizations join the group based on an expressed commitment to common goals and joint decision-making processes, rather than to advance particular national interests. Thus, we should expect multilateral donors' aid goals to better align with recipient country priorities, compared to their bilateral counterparts who pursue multiple national objectives (presuming that aid recipients are more concerned about development goals than the commercial and political interests of other countries)[6].

[6] This dichotomous donor type classification excludes private entities like foundations and non-governmental organizations (NGOs), in large part because of the small proportion of development aid these groups fund

Differences in donor type can be conceptualized as distinct principal-agent arrangements, reflecting differences in the stakeholders to whom aid agencies are dependent upon for revenue and legitimacy. In practice, aid agencies serve as 'agents' of domestic taxpayers and multilateral member governments, the 'principal' actors who essentially contract agencies to design, implement and evaluate foreign aid programs on their behalf[7] (Gibson, Andersson, Ostrom, & Shivakumar, 2005; Martens, 2002). These principals attempt to influence the behavior of agents by establishing guidelines and conducting oversight. However, principals are limited by the extent to which the agents' actions are observable and principals have sufficient information to judge the agents' performance (Eisenhardt, 1989; Miller, 1992; Wilson, 2000), both of which are compounded in the context of international assistance.

In the case of bilateral development agencies who work on behalf of their state government, the agent may face more pressure and scrutiny to respond to a single principal's directives than to the national interests of any one of multiple principals, as with multilateral

---

compared to bilateral and multilateral donors – the major exception being the Bill & Melinda Gates Foundation. In addition to having substantially smaller annual budgets, many NGOs serve more in an implementing capacity, receiving funds from bilateral and multilateral donors to execute aid projects, rather than being financed predominantly by private donations.

[7] This principal-agent chain is further complicated when donor aid agencies in turn contract local and international NGOs, firms and recipient country governments to implement their aid programs. Indeed, the same entities often serve in multiple capacities, as an agent to some and a principal to others. For examples, donor agencies may act as both agents of donor taxpayers and members, as well as principals of recipient country governments and aid contractors. Recipient country governments may be involved as implementing agents, as is the case with budget support when donors transfer aid directly to country accounts. They may be considered to be the primary beneficiaries of development projects which aim to strengthen government capacity to better meet the needs of its citizens. Or, recipient governments may be bypassed altogether when donor agencies themselves or through aid contractors deliver goods and services directly to individual citizens. Additional layers of implementation may exist between agency headquarters and field offices, and within recipient governments between central and regional levels, and Ministry of Finance and line ministries.

agencies. For example, bilateral agency directors are routinely required to justify their budgets and actions before their national parliaments, whereas heads of multilateral agencies directly report to individual member governments infrequently, if ever. The presence of multiple principals, therefore, may offer the agent greater leeway to implement compromise decisions of its many members rather than the particular interests of any one principal.

Ownership structure

While donor type refers to aid agencies' relationships to their domestic or upstream principals, ownership structure relates to their relationships with downstream recipient country stakeholders, the extent to which donors involve these actors in strategic and operational decisions. The normative principle of donor-recipient partnership is a central feature of the Millennium Development Goals (Barnes & Brown, 2011). Recipient country ownership is also a key element of the Paris Declaration on Aid Effectiveness, which calls on donors to align their support with country development strategies and local systems.

The participatory development literature highlights the benefits of local ownership for effectiveness, efficiency and equity reasons. Involving those who are closest to the problem can improve *effectiveness* by reducing information gaps. More accurate information, in turn, can lead to more effective, internally coherent project designs that better fit community needs and to more precise targeting of groups in greatest need. Reducing information asymmetries can produce more appropriate and timely feedback, lead to higher quality monitoring and greater application of learning to make mid-course improvements.

Increased involvement of local stakeholders can enhance *efficiency* by reducing resistance to externally imposed programs and perceptions of national sovereignty infringement, which can undermine development efforts regardless of their potential benefits. Rather, local involvement can facilitate implementation by increasing support, legitimacy and transparency, improving longer-term sustainability (Brinkerhoff & Crosby, 2002; Chambers, 1997; Gibson, et al., 2005; Killick, Gunatilaka, & Marr, 1998; Mazmanian & Sabatier, 1983).

Beyond the potential instrumental benefits of local engagement, rights-based development and human capability scholars emphasize the normative or substantive elements of recipient participation. They view participation as expanding individual freedoms and improving *equity* in the process of decision-making and ownership. This perspective considers empowerment as an end in itself, not simply a means by which to achieve development goals (Sen, 1999; Uvin, 2004).

Despite these potential advantages, increasing local ownership entails some loss of control by donors. Sharing decision-making with recipient country stakeholders may make it more difficult for aid agencies to fulfill the goals of their principals or measure their contributions to a joint program. Given donors' unique constituencies and historical experiences with foreign assistance, they may exhibit a range of risk taking or aversion and therefore may retain or relinquish control to varying degrees. Indeed, despite expressed enthusiasm for shared ownership, the latest Paris Declaration monitoring report indicates that progress has been slow and parallel donor systems remain common (OECD, 2011).

In sum, based on previous empirical analyses, and principal-agent and participatory development frameworks, I expect donor agencies' relationships with their domestic principals and with recipient country actors – as manifested through donor type and ownership structure – to represent systematic and meaningful differences across donors. By systematic, I mean that I expect bilateral agencies to behave more similarly to other bilateral agencies than to multilateral agencies. And by meaningful, I expect these two dimensions to be perceived as important distinctions to stakeholders along the development assistance chain.

Methods

In order to investigate the extent to which variation in donor type and ownership structures are evidenced in practice and do indeed represent meaningful distinctions among donor agencies, I conducted a comparative case study of four diverse and influential donors in the health sector in Peru. Comparative case studies are a valuable but underutilized methodology in development studies (Gibson et al.'s cross-project comparison of SIDA-funded common pool resource programs being a notable exception). Case studies allow for equifinality and multifinality, which characterize the complex pathways and interaction effects of development programs – both the multiple channels through which human development can be achieved, and the multiple development outcomes that donor assistance can produce (Bennett & Elman, 2006; George & Bennett, 2005). Case studies are particularly relevant for studying development donors given the nascent stage of this line of

inquiry and the need to indentify appropriate indicators and uncover casual mechanisms through which different donor approaches aim to influence development.

By conducting an in-depth examination of specific cases, I am able to identify plausible variables and detect anomalies that refute existing theoretical predictions (Geddes, 2003). By making structured comparisons, I am able to test potential variables across multiple cases, which individual project evaluations and randomized controlled trials do not allow. At the same time, by holding constant two major characteristics of the implementing environment identified as important in previous work, the nature of the good (health) and the recipient country context (Peru), I am able to ensure that any observed differences cannot be attributed to either of these factors.

Site selection

Compared to many aid recipient countries, Peru is classified as having relatively stable institutions (Freedom House, 2010; Kaufmann, Kraay, & Mastruzzi, 2010). It has a long history of aid receipt dating back to 1946, with continued funding from traditional bilateral and multilateral agencies, as well as from newer aid initiatives of the previous decade. In total, Peru received just over half a billion dollars in official development assistance in 2007, the latest year for which data is available (Agencia Peruana de Cooperación Internacional, 2009). With a per capita GNI of $4,200, sustained economic growth since 2002 (World Bank, 2011) and a Gini Index of 50.5 (UNDP, 2010), Peru does not lie at either extreme of the developing country continuum. It is neither a highly indebted

poor country embroiled in civil conflict and struggling to provide basic necessities to the majority of its population, nor is it a large, upper middle income G20 or G8+5 member country like Brazil or Mexico. Its trends in the Human Development Index closely parallel trends in the average HDI for Latin America and the Caribbean (UNDP, 2010).

As such, Peru's profile suggests that carefully targeted aid could help catalyze their economic transition to achieve sustainable gains in human development. Peru's latest MDG scorecard confirms the yet-unrealized potential for this transformation, demonstrating mixed results across indicators, with the country classified as 'on-track' to achieve universal primary education and gender equality goals, considered to have the potential to achieve extreme poverty and hunger, child mortality and maternal health goals, but 'off-track' to meet infectious disease control and environmental sustainability targets (UNDP, 2007).

Sector selection

Compared to other sectors, health is one around which many new development initiatives have mobilized, including GFATM, GAVI Alliance and three of the eight Millennium Development Goals. There exist a core set of evidenced-based health interventions including vaccinations, medication and condom provision, so there is less uncertainty over policy solutions. The health sector also has well established output and outcome measures to assess implementation and performance: coverage of prevention and treatment campaigns, prevalence and incidence of disease, and mortality rates. In this sense, health is a sector in which the purpose and measurement of aid is relatively straightforward, compared to assistance aimed at political reform. Foreign assistance for health is less likely

to be undermined by other donor policies such as agriculture policies that impose import quotes on exports from aid recipient countries. Finally, compared to poverty reduction, disease control better represents a pure public good for which collective action is typically required (Chen, Evans, & Cash, 1999). Individuals cannot be excluded from the benefits of low infectious disease rates, which lower the probability of disease acquisition, and the benefits are non-rival, in that one person's 'consumption' of low disease rates does not prevent others from using this good.

Case selection

To conduct this comparative donor case study, I first mapped the networks and resource flows in the Peruvian health sector to identify the major stakeholders and their relationships to one another. As part of this mapping, I attended the Ministry of Health's Cycle of Technical Meetings with donor organizations, a five-week series of public presentations in which all major donor agencies presented an overview of their current activities in the sector. I also gathered statistics on aid flows to the health sector from the Peruvian Agency for International Cooperation and Ministry of Health General Office of International Cooperation, as well as from publicly available national and international sources.

This mapping revealed that within this one sector in a single country, there exist a large number of stakeholders involved in the chain of development assistance, and wide variation within, across and over time in donors' development portfolios. For example, of

the $40 million in official development assistance Peru received in 2007 that was classified as supporting MDG #6 (infectious disease control), these funds were contributed by 70 donors from 15 countries and allocated to 63 separate recipient groups to support 150 individual projects.

On a project-level, donor initiatives varied in terms of *budget size,* varying on order of magnitude of 1:160 ($200,000 to $32 million); *geographic scope* from neighborhood-level to citywide, regional, national and cross-national projects; *level of targeting*, focusing on specific diseases (HIV) or population groups (children) or conceptualizing health through a broader lens of poverty reduction; and *duration and nature of the project,* whether it was a discrete, one-time intervention, such as an H1N1 vaccination campaign, or a health issue requiring continuous inputs, like multi-pronged strategies to improve nutrition or sanitation.

Based on this mapping I selected four large donors that together accounted for 46% of official development assistance to the health sector. As well are being *influential* in terms of their proportion of external financial assistance, these donors also provided *diversity* in donor type and ownership structure (Gerring & Seawright, 2007). They also range in terms of their founding date and presence in the country, represent both traditional and twenty-first century development agencies.

Donor types varied as to whether or not donor agencies worked on behalf of a single (bilateral) or multiple (multilateral) principals. For case selection, I used financial model as a proxy for ownership structure. I distinguished between budget support, in which donor funds are transferred directly to government accounts, and project support, in which aid projects are managed and implemented by third party for-profit or non-profit contractors. By their

nature, budget support financial models are intentionally integrated into recipient country systems and therefore are one way to measure greater country ownership. All four donor portfolios included some project support, but two also engaged in budget support, and for these donors, budget support was a prominent feature of their presence in Peru. Thus, with variation in both donor type and financing model, one donor fit into each cell of the following 2 x 2 case selection table (Figure 2.1).

Figure 2.1 Donor case selection

		Ownership structure (using financial model as proxy)	
		Budget support Implemented through the state	**Project support** Implemented by NGOs/firms
Donor type	**Bilateral**	Islandia Agency for International Development (IAID)	Terra Development Agency (TDA)
	Multilateral	Unitas	Disease Free Together

Donor profiles

As background, the Islandia Agency for International Development (IAID)[8] is a bilateral agency engaged in budget support through the Ministry of Health. Their aid agreements are crafted through high level political negotiations with the Peruvian Agency for International Cooperation and are implemented through a technical development agency that is physically and functionally separate from the donor country's diplomatic unit. IAID has

[8] The names of the donors listed here are fictitious in order to preserve the anonymity of the actual donors included in this case study.

worked in the country for nearly a half century, and concentrates its assistance in a few key sectors, including health.

Unitas is a multilateral agency engaged in budget support through the Ministry of Finance. Like IAID, their country development plans are also negotiated with the government through political and diplomatic channels. This donor has granted development assistance to the country for more than thirty years.

Both the Islandia Agency for International Development and Unitas have small in-country staffs of less than fifteen to oversee all of their development activities, not simply those related to health. As providers of budget support, they have small aid implementation chains since they work directly with the government. Both donors approach health through a broader lens of poverty reduction rather than an emphasis on particular health conditions and target a large proportion of their aid in the poorest regions of the country.

Terra Development Agency is a bilateral agency that has been engaged in project support in the country for more than a half century. TDA is actively involved in multiple sectors, but has a specific health unit to oversee the NGOs and for-profit management firms that this donor contracts to implement their programs. Terra Development Agency works in more regions in the country than IAID or Unitas but fewer than Disease Free Together. Like IAID and Unitas, this donor creates their development plans through high level political negotiations. Their programs have typically focused on health system strengthening rather than on particular health conditions. However, this country recently launched a separate development initiative, which TDA is responsible for implementing, where they solicit proposals from recipient country governments

address a few targeted development areas, thus adding sub-variation to their current project portfolio.

Disease Free Together, a multilateral agency granting project support, is by far the newest of the group, having worked in the country for less than a decade. It is the only donor in which political negotiations are not explicitly part of the country agreement process; rather, Disease Free Together releases calls for proposals, in which potential aid recipients respond with proposals designed to reduce specific diseases, within a set of parameters established by the donor. A multi-stakeholder coalition headed by the Minister of Health and including other government ministries, NGOs and civil society associations, write and submit proposals. This group must include representatives of populations affected by the target diseases. When grants are awarded, the multi-stakeholder group then establishes a bidding process to select an NGO, private firm or government agency to manage project implementation. The managing entity then subcontracts implementation activities to scores of other organizations, who in this case were predominantly local, established NGOs but which ranged from civil society associations with only a few paid staff members to a large state health care facility.

Disease Free Together maintains no in-country staff who work directly from a donor agency field office, but rather devolves these functions to the multi-stakeholder coalition and the managing entity, making it the longest implementation chain of the four donors. It also has the widest geographic scope, with active projects in all 24 regions of the country. As providers of project support, both Terra Development Agency and Disease Free Together

contract third party agents to implement their activities and consequently have very large implementation staff sizes of over 100 employees each.

Compared to all donors in the health sector, these four donors have large budgets, ranging from tens of millions of dollars to hundreds of millions of dollars over the course of a five year country contract period. In descending order, Disease Free Together has by far the largest budget, followed by Terra Development Agency and Unitas. The Islandia Agency for International Development is considerably the smallest of the four in terms of both financial and human resources.

Data collection

Within these four donor implementation chains, I conducted semi-structured interviews with 69 purposively selected informants along the chain of implementation: donor program officers, implementing entities, civil society groups representing project beneficiaries (e.g. People Living with HIV/AIDS groups), and central and regional government officials. The purpose of this study was to uncover meaningful differences among donors as they manifest themselves in practice. I therefore did not interview the principals furthest upstream in the aid implementation chain: taxpayers contributing to bilateral aid and multilateral member organizations; rather, I interviewed in-country donor officers who work on their behalf.

For the budget support donors with the smallest chains of implementation, the Islandia Agency for International Development and Unitas, I interviewed 5 and 6 people respectively. For the project support donors, Terra Development Agency and Disease Free

Together, I interviewed 8 and 26 informants respectively. Since the chain of implementation for Disease Free Together was so large, I concentrated my interviews in the largest of four sub-components in their most current contract in order to achieve a comprehensive sample from all of the organizations involved in one sub-component, rather than a partial, dispersed sample of organizations involved in all four sub-components. Since Disease Free Together delegates fund disbursement, monitoring and oversight tasks to the multi-stakeholder group and the managing organization, I considered these informants as proxies for in-country donor officials. This classification was consistent with how these groups presented themselves in the Ministry of Health's Cycle of Technical Meetings and with how subcontracting implementation agents perceived these two groups.

In addition to informants directly affiliated with each donor, I also interviewed 15 central government officials, 7 regional government officials and three additional stakeholders affiliated with other organizations active in the health sector. This set of informants had contact with multiple donor agencies throughout their years of service, enabling them to provide important cross-donor comparison information. The total number of informants associated with each donor agency is slightly underestimated for the first three, because of the role government officials played in their implementation chains. For budget support donors, Islandia Agency for International Development and Unitas, the government served as their implementing entity. For Terra Development Agency, the government was considered a primary beneficiary, unlike Disease Free Together, which had clearly identified citizen beneficiaries with whom I spoke and added to the number of informants affiliated

with their implementation chain. Informants' positions fell into four categories: senior managers overseeing multiple programs, mid-level managers supervising a specific project, front line workers responsible for day-to-day implementation with the greatest contact with end users, and citizen beneficiaries.

Interviews were held in informants' offices and lasted approximately one hour in length. Questions were open-ended and followed a semi-structured interview guide covering themes of: accountability, ownership, targeting (continuum of vertical/targeted to horiztonal/integrated implementation approaches), effectiveness, relationships among actors in the health sector, differences among donors, sectors and programs, the role of development assistance and changes in donor mandates over time.

To assess perceptions of ownership, I used Gibson et al's 2005 four-component project ownership typology, developed in the context of common pool resource projects in the energy and natural resource sectors, as way to operationalize this concept for measurement. This typology aims to assess the extent to which aid recipients are involved in: 1) *enunciation of demand*, determining what type of project is needed, 2) *participation in production*, providing tangible contributions as part of implementation, 3) *participation in consumption*, the traditional role of aid recipients, and 4) *participation in termination decisions*, whether and how the project will be continued. Finally, to supplement primary data from interviews, I also conducted a document review, examining signed aid agreements, annual reports, evaluations, and website content.

Data analysis

Detailed interview notes and transcriptions of audio recordings were hand coded according to dominant a priori (donor type, ownership) and emergent themes. Responses were classified according to donor type, donor financial model, informant position and organizational placement in the aid implementation chain. Preliminary results were shared with informants at two public presentations and on the research project website.

Results

This first ever comparative case study of development donors revealed four key findings: remarkable diversity within and across donor profiles within the same sector in the same country; the salience of ownership structure – the ways in which different donors formally engaged the same set of recipient country actors in different activities – as the distinguishing characteristic among donors; weak importance of donor type; and considerable alignment between donor and recipient objectives in the health sector. Rather than distinctions between bilateral or multilateral agencies or between donor and recipient goals, I observed patterns based on informants' position within their organization and the organization's position within the aid implementation chain.

Remarkable diversity within and across donor profiles

As evidenced by the initial sector mapping described in the case selection section, there was substantial diversity within and across among the full set of donors in the health

sector in terms of their budget size, geographic scope, level of targeting, and duration and nature of the project. Across donors, budget size tended to be a more consistent characteristic, with fairly stable trends in individual donor financial allocations over time. There was a preference for projects with a regional scope, coinciding with Peru's current decentralization of health services, and a geographic preference for working in poorer regions of the country. Except for these two trends, there was little evidence of donor specialization or continuity over time in their activities. This large variation within and across donor activities in a single sector in a single country is itself a notable finding, one which holds significant implications for country transaction and coordination costs, and for the methods necessary to conduct cross-donor research. With this remarkable donor diversity as background context, I now turn to the results related to differences across the four donors included in the cross-donor comparison.

Salience of ownership structure

By far the most prominent difference across donors was the ways in which they related to recipient country actors – *who* they involved in *what* capacity. While informants on both donor and recipient sides spoke at length about collaboration, the ways in which donors *formally* engaged the same set of recipient country actors varied substantially across donors.

Operationalizing ownership: formal involvement in development activities

In this sector and setting, donors formally involved four sets of Peruvian actors: central government officials, regional government officials, non-governmental organizations and civil society associations. The Peruvian for-profit private sector was not actively engaged in development activities. These four sets of local stakeholders were engaged to greater and less extents in five distinct capacities: i) problem identification, who decides what health issue needs to be addressed, ii) program design, who writes the proposal identifying what strategies to employ and which population groups to target; iii) resource administration, who manages the funds; iv) program implementation, who executes the activities; and v) program governance, who makes strategic decisions about the project.

Some of these activities map onto Gibson et al.'s project ownership typology: enunciation of demand, participation in production, consumption and termination decisions. However, their typology overlooks important elements of ownership, conflates multiple components that warrant disaggregation, and includes a category not perceived to be relevant by most development stakeholders. The typology excludes problem identification, which proved to be a salient activity in which donor involvement of recipient country actors varied. Gibson et al.'s 'enunciation of demand' category refers to 'participation in provision by articulating what asset, project, or program is needed and deciding how resources should be mobilized' (p. 16). This definition aligns more with program design than the prior step of problem identification; that is, which issues from among the multitude rise in prominence on the agenda and are considered sufficiently problematic to warrant intervention.

Gibson et al.'s 'participation in production' category combines multiple activities in which different stakeholders could be and were involved: program design, resource administration and program implementation through the provision of goods and services. 'Participation in consumption' is a useful way to identify which recipient country stakeholders are considered the intended beneficiaries (i.e. individual citizens or country institutions), but it was not perceived by informants to reflect ownership.

Finally, participation in decisions regarding program continuity or termination was not perceived to be relevant by most stakeholders interviewed here. Informants cited contract start and end dates when asked about termination decisions, suggesting it was rare for a project to end early or be extended in the same form beyond the original contract dates. On the other hand, health services offered by the state were not perceived to be time bound. Components of development projects later assumed by the state were considered separate from their externally-funded origins.

What was most striking was the wide variation in donors' formal involvement of recipient country actors. Given the *same set* of local stakeholders, donors varied markedly in their assessment of the capacity and roles of these individuals and institutions. While some donors judged government ministries and NGOs to be capable of managing funds and overseeing implementation, other donors did not.

This delineation of different stakeholder roles raised an important distinction not initially expected: donor agencies do not necessarily consider the same groups as beneficiaries of their development assistance. For some informants, they clearly identified the end user of the health interventions as intended beneficiaries: mothers attending prenatal

visits, children being vaccinated, sex workers receiving condoms. For other informants, they perceived government officials, health care workers and broader health systems as the target beneficiaries of development aid, aiming to improve the functioning of organizational structures as a way of improving population health.

Across donors, bilateral versus multilateral donor type was not associated with differences in ownership structure. Bilateral agencies did not systematically involve or exclude specific recipient country actors in different ways than multilateral agencies. By its very nature, the budget support financial model was affiliated with ownership structure, representing programs in which the central government took the lead in all five activities identified above. However, the two donors employing project-based financial models engaged local actors in very different ways. Therefore, financial model only partially predicted formal ownership structure as it manifested in practice.

Perceptions of ownership: greater variation by position

While formal involvement of recipient country actors varied substantially across donors, informants' perceptions of ownership varied more by their position within the organization than by donor agency. Unprompted, nearly all donor and government officials mentioned the Paris Declaration on Aid Effectiveness in their interviews, signaling the perceived importance of this international commitment to recipient country ownership. Informants more directly involved in implementation, however, perceived ownership in more practical, contractual terms. They referenced the terms of their contract with the donor

agency, citing pre-specified deliverables as conditions under which their involvement was structured. Rather than abstract concepts of country ownership, more relevant for these informants was frequency of communication with donor officials and the extent to which original contract terms could be modified as implementation conditions changed. These respondents overwhelmingly indicated a preference for closer relationships with donor officers and flexibility within a structured scope of work.

Little variation across donor type

While formal ownership structure was markedly different across donors, donor type was not a distinguishing characteristic in terms of donors' work in the health sector. Informants in the implementation chain of bilateral donors did not disproportionately refer to their relationships with domestic principals or obligation to fulfill national interests, compared to those affiliated with multilateral donors.

When asked to whom they were accountable, informants readily identified specific individuals and organizations, suggesting strong familiarity with the concept of accountability. *All* respondents cited lines of institutional accountability, their responsibility to report to superiors and/or to bodies that authorized financial support for their organization. Nearly two-thirds of informants mentioned more than one entity to whom they felt accountable, indicating that the majority of people involved in the management and delivery of development aid and health services must balance the expectations of multiple stakeholders, as illustrated below:

'We are directly accountable at two levels. One is the institution itself, the membership of the institution… and the movement of people living with HIV. …This, on one hand, is the first level and on the second level [is accountability] to our donor agencies. We have put considerable emphasis on [a particular donor] because they give us institutional support. We are informing them of all of the advances and critical points.'

- Executive Director, Implementing NGO

'[We are accountable] to the whole world (laughs). Indeed, it is not rhetorical. We are very committed to accountability to the public and to anyone who asks us because we work with donated funds…, so when I tell you the whole world it is not a joke. Within the framework of this program and the rules, we are accountable first to the development agency because we are in charge of this program because they do not have a program office here…they have contracted us so we have to be accountable to those who contracted us. On the other hand, we are very conscious that those who have designed this program have been from the Ministry so we should be accountable and work closely with the Ministry. We should satisfy the client. In the context of decentralization, the program is primarily implemented in the regions so you can't enter a stranger's house to do what he wants to do, you understand? So one has to be accountable to the landlord of the house, which is the region[al government], but to enter one has to knock on the door, explain, implement and also be accountable. On the other hand, the country has chosen a group of people from the presidency and the Council of Ministers to represent them in the development of this program, so as a policy, in order to maintain a good relationship with them, when they ask us for information that is authorized by the agency, we give it to them.'

- Senior manager, Implementing firm

Rather than differing by donor type, response patterns varied more by informants' organizational affiliation and their position within the organization. Informants who were affiliated with the government and mid-level managers were less likely to mention more than one entity to whom they felt responsible, compared to donor officials, implementation contractors, senior managers and front line staff.

Only one third of informants mentioned accountability to specific population groups (i.e. People Living with HIV/AIDS) or the broader populace, and another third mentioned the Peruvian government. Front line staff and respondents working for implementation contractors and were more likely to mention specific population groups, as were informants affiliated with Disease Free Together, which formally includes representatives of these groups as part of its governance structure. Respondents who served as senior managers and who worked for implementation contractors were more likely to mention the Peruvian government as a stakeholder to whom they perceived themselves accountable.

This question was asked in an open-ended format and the sample size is not large, so these proportions should not be interpreted as precise calculations. However, they do reveal distinct trends in who different actors in the health arena perceive themselves to be accountable. All informants were cognizant of their personal lines of accountability within their organizations and most felt responsible to multiple entities. Substantially fewer mentioned accountability to citizens and the recipient country government. Across the four donors, the key informant interviews revealed no obvious patterns in perceived accountability by donor agency or donor type, with one exception. As noted, respondents affiliated with Disease Free Together were more likely to mention population groups to whom they were accountable, compared to respondents affiliated with the other three donors.

Alignment of donor and recipient objectives

Related to informants' relationships with stakeholders in both donor and recipient countries was another surprising finding: the extent of alignment and lack of conflict between

donor and recipient objectives. Studies of aid allocation, which typically use aggregate aid figures across all sectors, indicate that bilateral donors grant assistance to fulfill political, development, commercial, and humanitarian goals. As noted, one would therefore expect bilateral donors to pursue interests that are more disparate from those of recipient country stakeholders than multilateral donors, who because of their diverse membership may be more shielded from domestic political pressure.

Contrary to these expectations, however, there was no evidence of explicit goal conflict between local implementing agents, government officials and any of the four donors. Instead, multiple informants from both the donor and recipient government sides described looking for 'points of coincidence', projects that would both satisfy donor goals *and* address country health concerns. Recipient country stakeholders acknowledged that each donor had their own mandate. Reciprocally, donor officers and implementation staff spoke at length and with great earnestness about improving health outcomes. Rather than working at odds with one another, both sides appeared to try to maximize their impact, given the constraints within which they were bound:

> *'[The donor agency* officials*] came and said they wanted to work with us and we presented to them the activities on which we were working. Many of the issues we worked on coincided with those they work on. So it is not that they say to me 'I have to do this and this is what we want to do with you.' Rather, 'what is it that you as an agency need now?' We told them and there were things that they had already considered doing and so fortunately we coincided.'*
>
> - Mid-level manager, Central government health agency

> *'In practice, the projects are generally based on and subject to the needs of the country. They are also subjected to what is possible through foreign assistance and according to their (donors') priorities. It also [depends] on what they can support, accept.'*
>
> - Senior official, Ministry of Health

Given the breadth of health issues, there were no examples of donor-funded activities that did not in some way contribute to the needs of this sector. However, there was little continuity across goals and activities of donor themselves, diffusing their potential impact with many actors and activities spread out across the health sector. Thus, in Paris Declaration terms, there exists greater *alignment* between donor and recipient development priorities, but weak *harmonization* across donors themselves.

Discussion

This foundational comparative case study of development donors confirms the wide variation among donor projects and approaches, even within a single sector in the same country. This finding itself confirms both the need to characterize salient differences among these varied approaches and the importance of doing so in a controlled manner by holding sector and country contexts constant. Among the many ways in which individual projects and broader donor approaches differed, ownership structure clearly emerged as the most prominent distinction. Contrary to expectations, donor type did not represent a meaningful category by which donor programs varied in a systematic way. These findings represent a significant advancement in development scholarship by: justifying a new focus on donors as a unit of analysis, identifying a key causal mechanism through which donors may influence development outcomes (ownership structure), refining how this concept should be measured

(specifying *who* is involved in *what* capacity), and casting doubt upon a theoretically-predicted variable of interest (donor type).

Framework for future donor research

Building upon this work, further refining and testing typological theories (George & Bennett) of the influence of different donor approaches across development sectors and recipient country contexts is a logical next step. The development community must first move from the vague concept of 'country ownership' to an operational definition measuring the extent of involvement of specific stakeholders in problem identification, resource administration, and program design, implementation and governance. In terms of donor type, the simple distinction between bilateral and multilateral donor agencies may be too crude a measure to capture more complex relationships donor agencies have with their domestic principals. Or, it may be that such relationships manifest themselves at an organization or position level, than at the donor level, as observed here.

Conducting additional cross-donor comparisons in different sectors and settings would strengthen the external validity of these findings and potentially uncover additional dimensions along which donors systematically differ. Across development sectors, one would expect the education sector to be more similar to health than natural resource and rural development sectors, due to the nature and provision of these goods. The opportunity for alignment between donor and recipient interests may be particular to the health sector, with a seemingly endless variety of needs to be addressed and well-documented, widely supported

policy solutions like childhood vaccines and anti-retroviral medication for people living with HIV. Health programs also produce fewer visible, negative consequences, compared to interventions in other policy sectors. Health programs are rarely directly harmful to beneficiaries; that is, the biggest drawback of a health program may be the opportunity cost of pursuing one strategy rather than another that could potentially yield a greater impact. In contrast, economic policy interventions like those required as part of previous conditionality policies, can produce spillover effects (increase in food prices, cuts to basic services) which are more broadly felt across the population and which may generate greater contestation.

These findings were observed in a relatively stable, middle income, Latin American country currently in the midst of a process of decentralization of health financing and services, and an epidemiological transition in which the country is facing a double burden of both infectious and chronic diseases. These two transitions entail a greater number of stakeholders, as regional and municipal governments are brought into the fold, and a broader range of health concerns with which donors have been able to align their activities. Cross-donor comparisons of the same set of donors in a different recipient country institutional setting would permit researchers to determine the extent to which donors adapt their practices in the field, and not just their allocation of aid, based on recipient context. Conducting cross-donor comparisons in a single sector and country in which the presence and level of funding of private donors is comparable to that of bilateral and multilateral donors, would enable important comparisons between public and private funding sources.

Characterizing donor differentiation across different sectors and settings is a critical step in understanding what donor approaches are currently applied in what contexts. Of

ultimate interest, however, is how these different approaches influence the implementation of intended activities and development outcomes: sustained improvements in health and wellbeing. Previous aid effectiveness analyses have typically linked the amount of total official development aid to population level outcomes, such as economic growth, the human development index and infant mortality rates (Boone, 1996; Burnside & Dollar, 2000; Kosack, 2003; World Bank, 1998). Incorporating donor-side predictor variables into these analyses will require more disaggregated donor programmatic and financial data over time by sector and by country than currently exists. As such, cross-donor quantitative analyses may be best conducted within individual countries rather than sweeping cross-country comparisons at the global level.

Implications for policy and practice

Although this study represents just the first step in an expansive research agenda incorporating donor dimensions into the study of development assistance, the findings have several immediate implications for development policy and practice, related to ownership, harmonization and accountability. First and foremost, it is imperative that donors specify who is, or is intended to be, involved in what capacity, rather than continuing to conflate all recipient country actors into a single entity with the catch-all concept of 'country ownership', ubiquitous in international declarations and development discourse. Structuring development programs through the Ministry of Health versus a multi-stakeholder coalition, for example,

represent very different configurations of country ownership, likely with different implications for development.

In this study, the wide variation across donors in the perception of the roles and capability of the *same set* of local actors suggests that at least to some extent, ability is in the eye of the beholder. This observation confirms that donors exhibit a range of preferences and levels of risk aversion in response to an identical situation. In addition to recipient country actors that donors involve in strategic and operational capacities, this study revealed that donors have different conceptions of the intended beneficiaries of their assistance. For some, specific populations like unvaccinated children were the primary target. For others, government institutions represented the intended beneficiary, in order to strengthen their capacity to respond to their citizenry.

Second, while the alignment of donor and recipient country interests is encouraging, the lack of harmonization across donor activities is problematic. The sheer number of actors and projects and the lack of continuity among them supports previous observations of the high transaction costs that development aid poses for recipient countries (Birdsall, 2008; Brautigam & Knack, 2004; Easterly, 2007; Easterly & Pfutze, 2008; Paul, 2006; Reinikka, 2008). In this setting, these costs were disproportionately borne by the Ministry of Health and Peruvian Agency for International Cooperation, who were primarily responsible for aid coordination. For recipient country governments, this finding underscores the importance of identifying a select number of priorities rather than a laundry list of needs, and of more proactively directing donors into existing initiatives.

The final implication relates to accountability mechanisms. Most stakeholders in the aid implementation chain, including donor officers themselves, feel accountable to multiple entities, with their more proximate lines of institutional accountability most prominent in their minds. In comparison, only one third mentioned the government or specific population groups. For donors, the salience of institutional accountability suggests the need to include beneficiaries – whether identified as the government or other local stakeholders – as part of donor agencies' formal accountability structures. For example, donors could form Community Advisory Boards analogous to those used in research studies, submit formal reports to the Ministry of Health, or include representatives of beneficiaries in governance bodies, as Disease Free Together has already done.

With significant implications for development policy and practice, the role and influence of donors has been overlooked for far too long. The expansion and experimentation of donor approaches over the last decade offers a timely opportunity to more systematically incorporate donor dimensions into development research. Moving forward, this new agenda will require collecting more disaggregated donor data, including involvement of recipient country actors in specific activities, and conducting carefully controlled cross-donor comparisons across a range of sectors, settings and donor types. Although an ambitious and potentially politically contentious endeavor, more systematically examining the role of donors may be the key to unlocking the black box of aid effectiveness that has puzzled the development community for so long.

Chapter 3

CHARACTERIZING COUNTRY OWNERSHIP CONFIGURATIONS: PATTERNS OF DONOR-RECIPIENT RELATIONS

In the last decade, the donor community has signaled greater recognition of the importance of country ownership in development (Barnes & Brown, 2011). The 2005 Paris Declaration on Aid Effectiveness and subsequent 2008 Accra Agenda for Action assert that leadership by 'partner' recipient countries over their national development policies is fundamental to the realization of sustainable development. Donor signatories have committed to aligning assistance with these priorities and to supporting broad, inclusive partnerships among donors, governments, civil society and the private sector (Organization for Economic Cooperation and Development, 2005/2008). Increased country ownership is also a distinguishing characteristic of recent global health initiatives, with the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and GAVI Alliance requiring recipient country coordinating groups with representatives from multiple sectors as a pre-condition of funding (Atun & Kazatchkine, 2009; Radelet & Levine, 2008).

Paralleling these calls for greater ownership and more inclusive partnerships has been a proliferation in the number and type of local[9] actors involved in the development arena, including secular and faith-based non-governmental organizations (NGOs), civil society associations, and regional governments. Despite this increase in actors and an expressed

[9] Here I use the term 'local' to refer to non-foreign entities, actors and organizations that are based in the recipient country. These actors may operate at a municipal, regional or national level.

desire to engage them in a more meaningful way, country ownership remains an inconsistently applied and underspecified term. Neither the development literature nor international declarations offer much conceptual clarity on the abstract notions of development partnership and ownership, or guidance as to who specifically should be involved in what activities and what types of country ownership configurations are most appropriate under what conditions. For these reasons, Buiter (2007) argues that the term country ownership is so unhelpful and misleading that it should be dropped from development discourse altogether.

This article takes a different approach, aiming to expand beyond a singular concept of 'country ownership' by identifying multiple ways in which country ownership can be configured. Rather than being created in the abstract, these ownership models are based on the differential involvement of local actors in specific development activities as they were observed in practice. From a research perspective, it is necessary to identify valid measures in order to examine different ways in which country ownership is manifested in different contexts. From a practitioner perspective, it is important to clarify what country ownership entails so we know the extent to which it is being achieved.

Through comparative case research, I find three dominant ways in which development donors related to recipient country stakeholders, embodying 'doctor knows best', 'empowered patient' and 'it takes a village' models. What is most striking about these ownership configurations was the wide divergence in perception among donors regarding the capability and roles of the *same set* of national, sub-national and non-state actors. The

'doctor knows best' model represents the traditional relationship between donors and recipient country stakeholders where donors take the lead in problem identification, resource administration, and program design, implementation and governance. 'Empowered patient' is essentially the opposite approach, whereby the central government in the recipient country assumes leadership for all aspects of the development, with the donor supporting the expansion of a pre-existing government program to improve development program. The 'it takes a village' model, on the other hand, divides some responsibilities and shares others among the donor, government, NGOs and civil society associations in these different capacities. Grounded in the public administration literature, I then compare the conditions under which we would expect to find these three ownership models with the way in which they were actually manifested in practice.

Multiple meanings of 'country ownership'

The conceptual imprecision surrounding the notion of country ownership is reflected in a lack of consensus on a common definition or operationalization of the concept. In a private sector context, ownership of property or other assets is defined legally when the rights to such goods are transferred to a named individual or organization. In a development context, however, many programs intended to improve health and human development do not generate tangible products for which legal rights can be acquired by a single beneficiary. For example, community health interventions intended to reduce women's risk of maternal mortality do not produce a good that an individual woman can necessarily own. In such

cases, ownership may relate more to involvement in development *processes* than the *possession* of or rights to a particular good, making it more difficult to define.

Over the last fifteen years, development banks and agencies have attempted to characterize and judge, if not measure, the abstract concept of country ownership, as displayed in Table 3.1. These typologies were developed to explain ownership in different settings and as such, are not directly comparable. For example, World Bank and United Nations Conference on Trade and Development (UNCTAD) criteria refer to country ownership of macroeconomic policies required as part of loan conditionality, and of subsequent poverty reduction strategies (Entwistle & Cavassini, 2005; Johnson & Wasty, 1993; Johnson, 2005). Gibson et al.'s (2005) four-part typology of project ownership, on the other hand, was developed to assess grant-supported common pool resource projects in the energy and natural resource sectors.

Table 3.1 Definitions and indicators of country ownership in a development context

Definitions

Organization for Economic Cooperation & Development (1996, p. 14)
"As a basic principle, locally owned country development strategies and targets should emerge from an open and collaborative dialogue by local authorities with civil society and with external partners, about their shared objectives and their respective contributions to the common enterprise."

US Millennium Challenge Corporation (Phillips-Mandaville, 2009, p. 7):
'Country ownership of an MCC compact occurs when a country's national government controls the prioritization process during compact development, is responsible for implementation, and is accountable to its domestic stakeholders for both decision making and results.

United Nations Conference on Trade and Development (Johnson, 2005, p.3):
'Ownership, from the perspective of the typical citizen, we believe, is more about (i) the right of the country representatives to be heard in the process of diagnosis and programme design, and (ii) the freedom and ability of the country to choose the programme to be implemented, without coercion, than about (iii) who designs the programme. …Broadly speaking, we shall say that country ownership exists when there is general belief by citizens of the country as well as by noncitizens that the country representatives freely chose the programme to be implemented, and when there is at the same time general acceptance of the citizens of the country of full responsibility for the outcome of the programme chosen.'

Indicators & Criteria

Paris Declaration on Aid Effectiveness ownership indicator (2005, p. 9):
Partners have operational development strategies – Number of countries with national development strategies (including Poverty Reduction Strategies) that have clear strategic priorities linked to a medium-term expenditure framework and reflected in annual budgets.

Project ownership typology used in assessing common pool resource projects funded by the Swedish International Development Agency (Gibson et al., 2005, p. 16):
1. Enunciation of demand, who identifies what type of project is needed
2. Participation in production through time and other resources
3. Participation in consumption of project benefits
4. Participation in termination decisions, whether or not a project should continue

World Bank intensity of ownership criteria (Johnson & Wasty,1993, p. 4):
1. Locus of initiative – who formulates the policy
2. Level of intellectual conviction among key policymakers – degree of consensus on the nature of the problem and appropriate solutions
3. Expression of political will by top leadership
4. Efforts toward consensus-building among constituencies

Subsequent good practice indicators to assess country ownership of poverty reduction strategies
17 indicators in total (Entwistle & Cavassini, 2005, p. 10), grouped by:
1. Leadership within and participation across the executive
2. Role and impact of national institutions
3. Government-stakeholder dialogue
4. Role and impact of internal partners
5. Role and impact of external partners
6. Political and economic shocks

Taken together, previous definitions highlight several core elements of ownership: involvement in decision-making, issue prioritization or problem identification, implementation and assumption of responsibility for results. Although most definitions acknowledge a role for civil society, the formal criteria more often place government in a dominant position (Zimmermann & McDonnell, 2008). Existing typologies attempt to broadly identify *what* country ownership entails and *who* it may involve, but offer few specifics on the relationship *between* actors and activities. This lack of clarity is increasingly problematic with the proliferation of sub-national and non-state entities who could potentially be involved in a range of development activities. Given the dynamic, multi-componential nature of ownership, rather than attempting to collapse all actors, processes and settings into a single concept, the field of development may be better served by characterizing and evaluating patterns of relationships between donors and local actors based on the activities in which each is involved.

Country ownership in practice: Patterns of donor-recipient relations

Based on the comparative case study of development donors in the health sector in Peru[10] presented in Chapter 2, I observed three distinct patterns of the ways in which country ownership was configured in practice, embodying 1) 'doctor knows best', 2) 'empowered

[10] Compared to many countries receiving development assistance, Peru is classified as having relatively stable institutions (Freedom House, 2010; Kaufmann, Kraay, & Mastruzzi, 2010), which should increase donor willingness to engage local actors. Its trends in the Human Development Index closely parallel trends in the average HDI for Latin America and the Caribbean (United Nations Development Program, 2010). As such, Peru's profile suggests that development assistance, particularly if structured in a way to maximize country ownership, could help catalyze their economic transition to achieve sustainable gains in human development (United Nations Development Program, 2007).

patient' and 3) 'it takes a village' models. These patterns were based on the ways in which donors related to four different sets of recipient country stakeholders: central government, regional governments, NGOs and civil society organizations. In the health sector in Peru, the local for-profit private sector did not play a major role. To greater and lesser degrees, donors engaged local actors in five distinct development activities: i) *problem identification*, who decides the health problem to be addressed; ii) *program design*, who identifies what strategies to employ and which population groups to target; iii) *resource administration*, who manages the funds; iv) *program implementation*, who executes the activities; and v) *program governance*, who makes strategic decisions (Table 3.2).

These relationships were documented through field research, which including network and resource mapping, document review of signed aid contracts, organizations' annual reports, evaluations, and website content, and semi-structured interviews with 69 purposively selected informants along the chain of implementation: donor program officers, implementing entities, civil society groups representing beneficiaries (e.g. people living with HIV/AIDS groups), and central and regional government officials.

Table 3.2 Country ownership configurations

	Role of external & recipient country actors in development activities				
Model	*Problem identification*	*Program design*	*Resource administration*	*Program implementation*	*Program governance*
'Doctor knows best'	Non-local entity	Non-local entity	Non-local entity	Non-local entity	Non-local entity
'Empowered patient'	Central government	Central government	Central government	Central & regional governments	Central government
'It takes a village'	Non-local entity	Central government, NGOs & civil society associations	NGO	NGOs & civil society associations	Central government, NGOs & civil society associations

Doctor knows best

The first model represents the absence of recipient country ownership and characterizes the traditional relationship between donors and recipient governments. In the 'doctor knows best' approach, donor agencies related to the Peruvian government as a beneficiary, with central and regional governments themselves the recipients of health interventions. Analogous to a doctor-patient relationship, donors sought to use technical expertise to improve the functioning and quality of the health care system in order to better address the needs of Peruvian citizens. Donor agencies and their foreign implementing agents managed funds and implemented programs designed to build the technical capacity of these local institutions.

In this pattern, while the government may contribute ideas regarding design, resource allocation, implementation and governance, donors retained responsibility for all of these areas. Donors did not have direct relationships with Peruvian NGOs or civil society associations. Although in this case the government was considered the intended beneficiary of the donors' expertise, the 'doctor knows best' relationship could feasibly be extended to local for-profit, non-profit and civil society associations as well.

Empowered patient

In the second pattern of donor-recipient relations, the government took the lead, assuming ownership over all aspects of the development program from problem identification and resource administration to program design, implementation and governance. To continue the health analogy, under this model the doctor acknowledges that

despite her best intentions to advise the patient what she believes to be the best course of action, in the end the patient will have to live with the consequences of his actions. Although he may sacrifice some long-term gains for short-term benefits, healthy behaviors will not be sustained unless they are initiated and embraced by the patient himself.

Donors embodying an 'empowered patient' model used a budget support funding mechanism in which they channeled their assistance through the central government, in this case either the Ministry of Health or Ministry of Economy and Finance. These external resources provided supplemental funding to expand an existing government program. Although programs were targeted to specific regions of the country, central government agencies were responsible for problem identification, program design, resource allocation and governance, with regional governments more involved in the implementation stage. Donors advised in each of these areas and selected which existing program they wanted to support, but the government retained authority over the program. Programs were evaluated using existing government metrics, rather than separate donor evaluation measures. Similar to the 'doctor knows best' model, donors did not formally engage with local NGOs or civil society associations.

It takes a village

In the final pattern, responsibility for different aspects of the development program was divided, and in some cases shared, among the donor, government, NGOs and civil society associations. Unlike the 'empowered patient' model, the government was *among* but

not *the* primary actor. In the 'it takes a village' model, a multi-sector coalition of representatives from the government, NGOs and civil society associations was responsible for program design and governance. Rather than a narrow doctor-patient, donor-government relationship, this model represents the concept that 'it takes a village' to improve health and wellbeing. It recognizes that despite disagreements of opinion, hierarchies and contestation over roles among members of society, everyone is ultimately bound together and therefore has a stake in the development process.

Compared to the other two relationship patterns, the donor was the least involved here. The donor maintained no physical presence in the country, devolving primary management responsibilities to multiple local actors. The donor was only directly involved in problem identification, selecting a few specific diseases it would fund. In addition to program design and governance, the multi-stakeholder coalition was responsible for coordinating the bidding process by which the entity responsible for oversight of resource administration and program implementation was selected. In this case, an international NGO was chosen to fulfill this role, which in turn contracted with dozens of other NGOs and civil society associations to implement specific components of the program. Rather than the relationships between the donor and the government being the central focus, this pattern was characterized by the negotiation of roles and priorities among local actors themselves. As such, it was by far the most inclusive, but paradoxically, this inclusive configuration of country ownership was externally mandated by the donor.

Comparative advantages and disadvantages of different sectors

What was most remarkable about the differences in these donor-recipient relationship patterns was their divergence given the *identical set* of government, NGO and civil society actors with whom donors could involve. Although the roles of different local actors has not yet been well defined in a development context, the public administration literature offers insights into the conditions under which we would expect to see one ownership configuration or another based on the functions of different sectors.

The literature distinguishes the roles of public, for-profit and non-profit sectors predominantly by the nature of the good provided, population served, and stakeholders to whom the entity is accountable. The public sector specializes in the provision of public goods and the establishment of a minimal threshold of services aimed at the median voter, to whom public officials are accountable (Moore, 1995; Wilson, 2000). Conversely, the for-profit sector, accountable to its shareholders, provides private goods for consumers with the ability to pay. Pursuing a social purpose and accountable to its donors, the non-profit sector offers specialized or controversial services targeting marginalized groups (Oster, 1995). In order to maximize profits, for-profit producers will work to minimize project costs. Since non-profit organizations are unable to distribute profits, they will instead maximize activities within a fixed budget constraint (Martens, 2002).

Building upon these sector distinctions, Table 3.3 expands beyond public, private and non-profit groupings to six categories in order to include all actors relevant in a development context: central government, regional governments, for-profit private sector, non-

profits/NGOs, civil society associations, and non-local entities. Here I separate the public sector into central government and regional governments to indicate differences in the geographic and population size of each constituency. I distinguish NGOs from civil society associations, characterizing the latter as comprised predominantly, if not exclusively, of members from distinct population groups (e.g. mothers, People Living with HIV/AIDS), with fewer external sources of funding and professionally trained, paid staff than NGOs[11].

In addition to these five types of local actors, the table also includes a single category for non-local entities. Given the emphasis of this article on recipient country ownership, this final category collapses all actors whose headquarters are based outside of the country where the development program is being implemented, whether donor agencies are providing goods and services directly or are employing foreign for-profit or non-profit contractors. The examples provided in the table are from the health sector, but could be expanded to include other development arenas as well.

[11] NGOs and civil society groups could be further distinguished as local chapters of international NGOs, locally founded but internationally networked organizations, local NGOs headquartered in the capitol with regional branches throughout the country, local NGOs with a single branch, self-identified social movement organizations, and faith based versus secular organizations, for example.

Table 3.3 Comparative involvement of development actors under different conditions

Actor		Comparative advantages	Disadvantages & potential unintended consequences	Development examples	Contextual conditions in which most feasible	
					Predicted	In practice
Public Sector	Central Government	• Provision of public goods • Redistribution of resources • Establishment of minimal threshold of services • Institutionalization & standardization of activities • Achievement of economies of scale	• Cyclical turnover of leadership & priorities • Political motivations distorting priorities	• Infectious disease prevention & public health promotion (childhood vaccine, tuberculosis control)	• Stable institutions	• Macroeconomic stability • Adequate management of public finances • Development program with: - Specific goals & indicators - Political support beyond a single administration - Established budgets & monitoring systems - Directed towards a persistent social concern - Good/service traditionally provided by the government
	Regional Government	• Regional problem identification • Experimentation	• Inconsistencies across regions based on resources & commitment	• Responses to regional disease outbreaks	• Stable institutions	• Demonstrated ability to manage funds and activities
Private Sector	For-profit	• Provision of private goods • Minimization of costs • Achievement of economies of scale	• Reduced access • Forced tradeoffs among essential services • Increased personal debt	• Contraception, medication	• Economically diversified customer base	n/a
	Non-profit/NGO	• Specialized services • Controversial services • Maximization of activities • Experimentation	• Funder motivations distorting priorities • Displacement of government or establishment of parallel services	• Reproductive health (abortion)	• Absent, inadequate or stigmatizing public or private provision	• Demonstrated ability to manage funds and activities
Civil Society Associations		• Local problem identification • Greatest access to hidden populations	• Financial & human resource sustainability • Repression by government • Increased stigma & discrimination in society because of exposure	• HIV prevention with sex workers and men who have sex with men	• Critical mass of mobilized individuals	• Sufficiently organized to identify representatives and articulate their perspectives
Non-local Entity		• Institutional stability • Replication of successful initiatives elsewhere	• Inaccurate problem identification • Financial dependence • Erosion of political legitimacy	• Emergency provision of minimal services for basic survival (refugee camps)	• Absent or weak institutions • Rapid turnover of local leadership • High levels of civil society repression	• Institutional capacity building, particularly at regional level

Based on the comparative advantages and disadvantages of each of these groups, as identified in the public administration literature, development donors should be more likely to involve the local public sector in the provision of public goods, such as infectious disease prevention through childhood vaccination and tuberculosis control programs. They should more often engage the central government when such diseases are widespread and affect large proportions of the population, and involve regional governments to handle disease outbreaks that are more geographically concentrated. Previous studies on aid effectiveness suggest that the extent to which donors involve the local public sector may also depend on the institutional quality and capacity of local governments (Burnside & Dollar, 2000; Collier & Dollar, 2004; Kaufmann, Kraay, & Zoido-Lobaton, 2000; Rodrik & Subramanian, 2003). Political motivations and cyclical turnover of leadership may distort public sector priorities, which could disadvantage central and regional government involvement relative to other actors. In addition, involving sub-national governments may lead to inconsistent provision of goods and services when resources, capacity and commitment vary across region.

In contrast, donors should be more likely to engage the for-profit private sector in the provision of private goods. An active for-profit role is most feasible for private goods for which a sufficiently large and economically diversified customer base exists, when high sales volume enables companies to achieve economies of scale so prices are not prohibitively expensive for low income consumers. Involving the private sector in development, however, may reduce access and increase personal debt, forcing low income households to choose between one essential service and another.

Both NGOs and civil society associations hold their comparative advantage in working with outlier population groups who do not receive goods or services because of absent, inadequate or discriminatory public or private provision. Therefore, donors should be more likely to involve NGOs and civil society associations in development activities that target hidden or stigmatized population groups, such as people living with HIV, commercial sex workers, and the transgender community. When NGO activities are restricted due to preferences of their own funders, civil society associations may be the only provider for outlier population groups. Conversely, NGOs may fill a service gap when a critical mass of affected individuals has not yet mobilized to form civil society associations or when their size or funding level are not adequate to meet the need. A disadvantage in involving these groups is the potential displacement of public services and creation of parallel systems within the same country.

Bypassing recipient country actors altogether may result in inaccurate problem definition and the imposition of inappropriate interventions if political and economic motivations of non-local entities distort their priorities. It can leave recipient countries financially dependent on external sources of funding and erode the political legitimacy of the local government (Levi, Sacks, & Tyler, 2009). At the same time, political, economic and security conditions in some recipient countries may dissuade donors or restrict the ability of local actors from being engaged in development activities. In settings where public institutions are weak or absent, where there is frequent turnover of political leaders, or where there are high levels of civil society repression, non-local entities may be the preferred

provider. In such cases, external actors can provide emergency relief to establish basic services for survival, refugee camps being a prime example, but country ownership is not established.

Conditions of country ownership configurations

Comparison of predicted and observed ownership

Based on the comparative advantages of each set of actors outlined above, we should expect to see the government-led 'empowered patient' ownership model applied to development issues involving public goods. We would expect the village model which engages NGOs and civil society associations to be used for programs that target marginalized population groups. Finally the 'doctor knows best' model should be most common in conflict settings, those with weak institutions and/or high levels of civil society repression – none of which strongly characterize the contemporary Peruvian context in which this research took place. Therefore, we would expect this model, representing the absence of country ownership, to be observed least frequently.

In practice, the 'doctor knows best' model was the most common of the three ownership configurations. Within the context of decentralization of health care services across the country, there was a particular focus on strengthening the capacity of regional governments, who historically had not been responsible for the management, resource administration, and delivery of health care. The 'empowered patient' approach was relatively new in Peru, but expanding over time both in terms of the amount of funds being transferred to state institutions and the number of donors employing this strategy. 'It takes a

village' represented the newest and least frequent ownership model, with only a single example in practice.

Country ownership configurations partially, but not exclusively corresponded to the comparative advantages of different sectors. Development programs using the 'empowered patient' model aimed to provide comprehensive health care that was principally preventative in nature and affected a large number of low-income individuals, as would be expected. The donor using the 'it takes a village' model, funded programs targeting a disease disproportionately affecting a few select, stigmatized subpopulations, but also addressed diseases that affected broader segments of the population.

The predictions above overestimated the actual role of recipient country actors, particularly private and civil society sectors. Moreover, the predictions significantly underestimated the involvement of non-local entities. The development programs in which donors and foreign contractors took the lead, as characterized in the 'doctor knows best' model, were by no means restricted to emergency relief or the provision of minimal services for basic survival.

Practitioner perspectives on model conditions

Among the three donor-recipient relationship patterns, the 'doctor knows best' model was perceived to be the most flexible. The other two models, those that formally engaged recipient country actors in development activities, had specific conditions under which practitioners felt each model was most appropriate.

As noted, the ‘empowered patient’ model used a budget support financing mechanism in which funding was transferred to government ministries. Donors allocating budget support required that the country demonstrate macroeconomic stability and adequate management of its public finances as a prerequisite of funding. With donor support, Peru undertook a Public Expenditure and Financial Accountability (PEFA) assessment, a standardized tool endorsed by the World Bank and European Commission, among others, to formally evaluate its national financial systems.

Even more important than monetary and fiscal policy, was the careful selection of the development initiative that donor support was helping to expand, according to informants from both the donor and recipient government sides. They emphasized that an appropriate program is one that is clearly articulated with specific goals and indicators, that currently exists in practice rather than simply on paper, with established budgets and monitoring systems. Further, they advised that it be directed towards a long-term, persistent health concern and one that has political support beyond a single administration.

Practitioners indicated that this ownership model with the government as lead was most appropriate in sectors in which goods and services are provided by the government, compared to sectors with greater private sector involvement. In this sense, health and education may be a better fit than the natural resource sector for example. Given these conditions, practitioners generally agreed that an ‘empowered patient’ model, at least the budget support component, was not suitable as the singular way in which donors relate to the recipient country government for all health programs or development programs.

The final model, ‘it takes a village’, was the most complex of the three relationship patterns because of its involvement of different sets of local actors in multiple capacities. This approach required that recipient country actors be able to demonstrate the capacity and experience to manage funds and activities, which may not always be possible with smaller NGOs and civil society associations. Moreover, because the structure entails that multiple stakeholders work together to design and govern programs, it requires civil society groups that are sufficiently mobilized to select representatives and articulate their perspectives to other local actors who may be unaccustomed to sharing decision-making. This multi-stakeholder model has become increasingly popular with newer donor initiatives, but poses challenges not faced by traditional state-centered programs, including those of collective action, role definition, role conflict and representative participation, discussed in detail elsewhere (Buffardi, Cabello, & Garcia, 2011). The complexities involved in this pattern suggest that countries may not have sufficient capacity within public, NGO and civil society sectors to replicate this model as currently configured, with separate multi-stakeholder coalitions for a large number of development issues.

Differences in perceived roles of the state and civil society

Among recipient country stakeholders, there was a clear preference that donors engage domestic rather than foreign entities, with some informants openly critical of non-local contractors implementing programs as part of the ‘doctor knows best’ model. However, a consensus did not emerge regarding the roles that national, sub-national and non-

state actors should assume. Multiple practitioners emphasized the centrality of government in institutionalizing development programs so they are sustainable once external funding ends:

> *'If the Ministry doesn't do [the development program] itself, later the donor does it – it may be an interesting initiative, but one that remains in a document, that ends up as something that ultimately is not assumed by the entity or the state.'*
>
> - Senior official, Ministry of Health

> *'In the end, donors will leave and tomorrow the state will continue.'*
>
> - Bilateral donor official

> *'One should think of what is most efficacious, including the money and what generates institutionality in the country; you have to see where the country is going and what we want. If we want a country where services are tertialized in the private sector, then perhaps it is good to strengthen civil society, because in the end they are going to implement state funds. Or if it is going to be the state, we will have to strengthen it because through this model we are fulfilling this role already.'*
>
> - Senior official, Ministry of Economy & Finance
>
> -

Many civil society representatives expressed a strong desire for, indeed *right* to broad participation in the governance of public health programs: '*We are the direct beneficiaries, the purpose of these interventions. We should have a direct voice…. We don't need intermediaries because we are not second class citizens and our voice should be [part of governance bodies] in a direct way*.' At the same time, other civil society representatives reflected on the complexities of doing so: *'I think that some technocrats imagined affected populations without contextualizing the effective weight of exclusion and vulnerability. …I*

think that the difficulties or limits of these projects is in their capacity to be able to dialogue with current social and political processes for populations most affected.'

To a certain extent, the lack of consensus among local actors themselves reflected differences of opinion among donors regarding who should be involved in what development activities. No one ownership model stood out as preferred among the majority of informants, suggesting that each fulfills different needs in the Peruvian health sector at this time.

Discussion

Within the same sector in the same country, development donors related to local actors in three dominant ways, pursuing 'doctor knows best', 'empowered patient' and 'it takes a village' approahces. Overall, there were fewer examples of country ownership (however configured) than would have been predicted, given the relative institutional stability of the country. The three unique patterns of donor-recipient relationship reflect marked differences in perception regarding the capability and roles of the same set of national, sub-national and non-state actors. These differences may be explained in part by the greater complexity of the 'empowered patient' and 'it takes a village' models, which pose greater restrictions on the types of programs donors can support compared to when the government itself is the beneficiary and the donor pursues a 'doctor knows best' approach.

At the same time, the perception of recipient country actors as beneficiaries by some donors and as primary authorities by others suggests that at least to some extent, ability is in

the eye of the beholder. Some donors perceived the central government, NGOs and civil society associations to be more capable than others. This divergence in donor perceptions raises the question of how best to establish criteria or thresholds by which local actors can demonstrate their capabilities to donors and assume a greater leadership role in development programs. In this case, the Public Expenditure and Financial Accountability assessment appeared to be an inadequate screening mechanism for some donors.

Among the six sets of potential development actors identified above, the central government and non-local entities were formally engaged in development activities most often, and NGOs and civil society associations least frequently. Despite growing enthusiasm for public private partnerships and global trends toward the marketization of development, in this setting the local for-profit private sector was not involved. The dominance of the public sector relative to other actors may be explained in part by the case selection and focus on public rather than private development donors[12]. Countries and sectors receiving a greater proportion of total aid from international foundations and international NGOs (generated through private donations rather than government aid contracts) may exhibit greater involvement of local NGOs and civil society associations.

Among the five activities in which different actors were involved – problem identification, resource administration, and program design, implementation and governance – the greatest diversity of recipient country actors were engaged in the latter three activities. Only within the 'empowered patient' model was problem identification conducted by an in-country actor and it was done so solely by the central government.

[12] Private development funds, while growing, still represent a small proportion of total development assistance (Ravishankar, et al., 2009), which is why the focus here was on bilateral and multilateral donors.

The inclusion of the recipient country government in all three donor-recipient relationship patterns suggests that donors acknowledged the importance of strengthening public institutions, although they chose to do so in very different ways. Under the 'doctor knows best' model, when donors treated the government as the primary beneficiary, public sector strengthening took the form of training, capacity building and technical assistance. On the other hand, through the 'empowered patient' model, the public sector was strengthened through firsthand experience and a structured mentoring process.

As evidenced in the quotes above, practitioners recognized both the positive contributions of previous donor programs, and the subsequent failure of such programs to be integrated into national health systems when the government was not formally involved in design, resource administration, implementation or governance. This observation illustrates the micro-macro paradox of development programs whereby individual projects demonstrate positive outcomes but aggregate analyses often fail to link aid inputs to improvements in economic and social development on a population level (McGillivray, Feeny, Hermes, & Lensink, 2005; Mosley, 1986). Furthermore, it underscores the importance of substantive recipient country involvement whenever possible in order to facilitate the sustainability of development interventions. The findings here suggest that such involvement could be done more often than occurs in practice.

It is important to note that these three ownership patterns were observed in a relatively stable, middle income, Latin American country currently in the midst of a process of decentralization of health financing and services, and an epidemiological transition in

which the country is facing a double burden of both infectious and chronic diseases. These two transitions entail a greater number of local stakeholders, as regional governments are brought into the fold, and a broader range of health concerns. The context was also characterized by high turnover of government officials, an issue raised frequently during interviews, a substantial presence of both international and local NGOs, and several highly mobilized segments of civil society, particularly HIV and sexual diversity movements.

While this comparative case study enabled comparisons across donor approaches, its cross-sectional nature precludes comparisons over time. In some interviews, practitioners commented on the increasing involvement of local actors; however, substantive conclusions require more systematic analyses. Given the transitions noted above, the diversity of donor-recipient relationship patterns may decrease over time as the roles of local actors become more established within the country. Longitudinal research examining a set of donors over time would help to identify factors facilitating and hindering ownership transitions, as donors shift from perceiving the government as a beneficiary to the primary driver of development and as donors expand interactions with non-state actors.

In different contexts, other donor-recipient relationship patterns likely exist. Using the actor and activity classification applied here as a guide, future work should examine other ways in which donors engage with recipient country actors in sectors with a different mix of public and private sector goods (e.g. education, agriculture, environment). Patterns should be examined in different country contexts, including those with weaker public institutions, high aid receipt and greater involvement of the local for-profit private sector. Compared to the middle income, relatively stable institutional context examined here, one would expect

less variance in donor involvement of local actors in countries with weaker or absent government institutions and potentially greater variance in donor perception of local stakeholder capacity in stable, low income countries. Conflict settings may identify additional patterns that exclude the government altogether. The formal involvement of local non-state actors may exhibit a curvilinear pattern, where their engagement is highest when local governments are at the weakest and strongest ends of the continuum. Finally, the complex, multi-stakeholder 'it takes a village' model, popular among recent global health initiatives but uncommon in most high income countries, warrants greater attention.

If recent development trends are any indication, donors will likely continue to relate to recipient country actors in variety of ways. As such, calls for country ownership require greater precision and contextualization in specifying who it is most appropriate to involve in what activities under which circumstances. Rather than providing yet another conceptual reformulation of country ownership, this paper characterizes three ownership configurations, and identifies the scope conditions of each as they are observed in practice. For research, this categorization offers models which can be used to systematically compare country ownership patterns across settings and over time. For development practice, these distinctions can help donors to make more deliberate decisions about who to involve in what activities to fulfill their stated commitments to country ownership. Finally, these classifications can guide recipients in selecting and negotiating preferred roles and relationships with different development donors, all with the ultimate aim of enhancing longer-term sustainability of health and development gains.

Chapter 4

TO THE SECTOR OR TO THE SPECIFIC: PREDICTORS OF DONOR FINANCING CHOICES AND THEIR ASSOCIATION WITH HEALTH INDICATORS

Funding to address global health concerns has increased dramatically in recent years, rising more than 50% in real terms since 1980 (Piva & Dodd, 2009), and fourfold from $5.6 billion in 1990 to $21.8 billion in 2007 (Ravishankar, et al., 2009). In addition to the unprecedented growth in health aid, international donors have also experimented with two different ways of channeling their assistance: providing health sector budget support and earmarking funding for specific diseases or activities. The 2005 Paris Declaration on Aid Effectiveness encourages donors to align their assistance with recipient country priorities, and financial and procurement systems (Organization for Economic Cooperation and Development, 2005/2008). This alignment can be fostered through the provision of budget support, whereby donors channel their funds directly through Ministries of Health. At the other end of the spectrum is health aid targeted towards individual diseases or types of health interventions, characteristic of many new global health initiatives including the 2000 GAVI Alliance, 2002 Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and 2003 President's Emergency Plan for AIDS Relief (PEPFAR) (Biesma, et al., 2009).

While not inherently contradictory, these two approaches to channeling international assistance represent distinct perspectives on how best to improve development outcomes. Budget support is flexible, enabling recipient countries to identify their own health priorities and

manage funds directly. On the other hand, funding earmarks are focused, making it easier to link aid inputs to improvements in health care coverage and outcomes. Despite the professed popularity of budget support and disease earmarks, however, we still know comparatively little about these two approaches in practice: their distribution and magnitude across donors and recipient countries, and the extent to which these financing mechanisms differentially influence development outcomes.

Examining the magnitude and effectiveness of different financing approaches is particularly timely given the global economic downturn and domestic pressures for donors to reallocate their resources internally. Moreover, with just three years before the Millennium Development Goals end date of 2015, the dual demands of reduced resources and an intensified focus on demonstrable results elevate the need to ensure that development assistance is channeled in such a way to maximize its impact. Although applied in a development context here, questions regarding the tradeoffs and impact of different financing mechanisms also hold relevance for the field of public management as well: whether and under what conditions funds should be allocated in a flexible or a focus way.

Here I explore sector budget support and funding earmarks specific to development assistance for health (DAH). The health sector has been a leader in experimenting with these two types of financing mechanisms and as such can offer lessons for development aid in other sectors and for the allocation of funds for public services more generally. Using recently available data on DAH, this paper aims to first characterize aid channeled as health sector budget support and earmarked for HIV and tuberculosis, to identify factors associated with the provision of each, and to determine their subsequent influence on health indicators.

Development assistance for health

Previous studies on development assistance for health have tracked trends in funding over time. They have reported large increases in absolute and relative funding for HIV over the last two decades, compared to other diseases (Ravishankar, et al., 2009; Shiffman, 2008; Shiffman, Berlan, & Hafner, 2009). In contrast, while aid channeled as health sector budget support has increased in absolute terms, it remains a small relative share of overall health aid (Piva & Dodd, 2009; Shiffman, 2008). These trends are important to capture, particularly as donor commitments shift over time, first with the creation of disease-focused global health initiatives at the turn of the new millennium and then later the 2009 launch of a joint Health Systems Funding Platform by the Global Fund, GAVI Alliance and the World Bank (Hill, Vermeiren, Miti, Ooms, & Van Damme, 2011).

Studies that have focused specifically on recent global health initiatives (GHIs) have largely been descriptive, detailing the characteristics of their organizational structures and how they relate to country health systems (Atun & Kazatchkine, 2009; Biesma, et al., 2009; Feachem & Sabot, 2006; Grundy, 2010; Steven Radelet & Levine, 2008; The Global Fund to Fight AIDS, 2008; World Health Organization Maximizing Positive Synergies Collaborative Group, 2009). Previous studies that have conducted predictive analyses report implementation outputs for individual GHIs, identifying financial, programmatic and country characteristics associated with GFATM grant disbursement (Lu, Michaud, Khan, & Murray, 2006) and evaluation scores (Radelet & Siddiqi, 2007), and GAVI Alliance vaccination coverage (Lu, Michaud, Gakidou, Khan, & Murray, 2006).

Several studies in the broader aid effectiveness literature have examined the impact of development aid on health outcomes, rather than outputs or coverage; yet, they have yielded conflicting results, with aid levels associated with improvements in life expectancy (Bueno de Mesquita, 2003) and child mortality (Fielding, McGillivray, & Torres, 2006) in some studies, but not others (Boone, 1996). None have used aid inputs disaggregated by sector, but rather overall official development assistance (ODA) figures, which may partially account for these discrepant findings. Aggregate ODA figures conflate aid flows that are often intended to achieve multiple donor objectives: political, commercial, humanitarian *and* development goals. As such, it is not surprising that political or commercial aid does not have a direct, positive impact on health.

Multiple studies have underscored the importance of the recipient country implementing environment in mediating the effect of aid on vaccination coverage (Lu, Michaud, Gakidou, et al., 2006), national economic growth (Burnside & Dollar, 2000; Collier, 2002; Collier & Dollar, 2004; Congressional Budget Office, 1997; Easterly, 2006; Knack, 2000; World Bank, 1998), and Human Development Index ratings (Kosack, 2003). However, these cross-national comparisons have focused exclusively on the recipient side of the donor-recipient relationship, essentially ignoring the role that different donor financing approaches – i.e. health sector budget support and disease earmarks – may have on the effectiveness of development assistance for health.

The analyses presented here advance previous quantitative analyses on health aid in three ways. First, they employ recently available time-series data on development assistance for health from 1990-2007 to link aid inputs, outputs and outcomes that are all specific to the health sector. Second, these analyses examine donor financing approaches as predictor variables to complement previous cross-national analyses of recipient country factors influencing aid

effectiveness, and third, do so in a comparative way across different donors, rather than limiting the analysis to a single donor or global health initiative.

Donor financing approaches

Health sector budget support

Health sector budget support is channeled directly through recipient country accounts. Budget support grew out of frustration with traditional project-based aid, whereby donors funded discrete, short-term projects, creating a splintered set of structures that were often not explicitly linked to more comprehensive, long-term policy goals. Thus, budget support aims to reduce the existence of parallel structures and increase the likelihood that aid investments will be sustained over time since they are integrated into existing government systems (Koeberle & Stavreski, 2006).

Furthermore, budget support is intended to be both a symbolic and practical way of enhancing recipient ownership. It can signal donor trust of recipient government financial systems, and also provides recipient governments the opportunity to manage larger budgets. By nature, budget support is flexible, enabling recipient countries to better target resources to their unique country health profiles and to address disease outbreaks and emergent health concerns. It can be used for broader health system strengthening to develop workforce and infrastructure capacity that serves to support multiple disease control and prevention programs (Eichler & Glassman, 2008; Foster, Brown, & Conway, 2000; Ooms, Van Damme, Baker, Zeitz, & Schrecker, 2008; Koeberle & Stavreski, 2006).

On the other hand, the flexible nature of sector budget support makes it much more difficult to directly link financial investments to changes in specific outcomes. The fungible nature

of aid, the freeing up of government resources that can be used elsewhere, may have the perverse effect of reducing recipient country expenditures on health (Deverajan & Swaroop, 2000; Lu, et al., 2010; World Bank, 1998). Indeed, descriptive evaluations of budget support programs identified low fiduciary risk, the extent to which actual expenditures differ from authorized expenditures, and the capacity of recipient governments to management public finances as key to effective budget support (Lawson, Booth, Msuya, Wangwe & Williamson, 2006; USAID Development Information Service, 2006). Therefore, for this analysis, I hypothesize that donors will be more likely to employ a budget support financing mechanism in countries with lower levels of corruption and more robust and reliable government institutions. Moreover, I expect recipient country governance indicators to mediate the effect of aid, with greater amounts of sector budget support associated with greater gains in health in countries with stronger governance indicators and no effect or a negative one in countries with poor governance indicators.

Disease earmarking

Rather than being flexible as is the case with sector budget support, disease earmarks are focused. Funds are restricted to a specific disease (HIV) or activity (vaccinations). As such, disease earmarks can provide clearer links between financial inputs and health care outputs and outcomes, facilitating results-based measurement. Targeted attention towards one disease may make it easier to garner initial public and political support, and with more visible results, easier to sustain support over time. Indeed, the risk of dispersing resources and attention are among the primary concerns that have been raised regarding a proposed Global Health Fund (Bermejo, 2009; Ooms, et al., 2008).

The prominence of disease earmarks emerged as a global response to HIV, with the intent of creating a large influx of dedicated resources to slow or reverse crippling HIV epidemics. At the same time, earmarked funding has been critiqued for creating disease silos and siphoning away resources for lower profile issues like population and maternal health (Behague & Storeng, 2008; Epstein, 2009; Levine, 2008; Shiffman, 2008; Shiffman, et al., 2009; Waddington, 2004). Narrowly targeted earmarks can neglect health system concerns including workforce, infrastructure and maintenance, on which earmarked interventions depend for successful and sustainable implementation (Eichler & Glassman, 2008; Foster, et al., 2000; Ooms, et al., 2008). Given the potential of disease earmarks to affect the population-level impact of a single disease, I hypothesize that donors will channel higher amounts of earmarked aid to countries with the highest burden of high profile diseases, in this case HIV and tuberculosis. Furthermore, I expect earmarked aid to demonstrate greater improvements in health care coverage and outcomes of those specific diseases than overall aid levels.

Methods

Data

These cross-national analyses take advantage of the publically available Development Assistance for Health Integrated Project-level Database (Ravishankar, et al., 2009), which provides data on annual financial disbursements specifically for health in current US dollars. It tracks DAH from 22 bilateral donors, four multilateral development banks, three multilateral

agencies[13] and the Bill & Melinda Gates Foundation to 172 countries from 1990-2007. I exclude aid disbursed to regional groups.

This dataset uses financial data from the Organization for Economic Cooperation and Development Creditor Reporting System as a base, with corrections for underreporting and double counting, and the addition of private health aid data for the Gates Foundation. In addition to total disbursements, the dataset includes the amount channeled as health sector budget support and earmarked for HIV and TB. The DAH dataset also includes several country-level variables: gross domestic product (GDP), region and population size, which I use as control variables.

The dataset is structured with a separate row of information for each donor in each country each year. Donors are only included in the dataset if they provided support to at least one recipient country in a given year. For example, the Global Fund to Fight AIDS, TB and Malaria first appears in 2003 because this multilateral agency did not disburse aid prior to this year. The structure of this data fits my questions well since I am concerned with *how* donors channel DAH, not whether or not they grant any kind of development assistance.

My primary interest is the impact of health sector budget support and disease earmarking on health care coverage and outcomes. However, given the lack of information on the magnitude and distribution of these two relatively new financing mechanisms, I first examine budget support and disease earmarking as dependent variables to identify factors associated with

[13] *Bilateral Donors:* Australia, Austria, Belgium, Canada, Switzerland, Germany, Denmark, Spain, Finland, France, Great Britain, Greece, Ireland, Italy, Japan, Luxembourg, The Netherlands, Norway, New Zealand, Portugal, Sweden, USA; *Multilateral Development Banks*: Asian Development Bank,Inter-American Development Bank, World Bank International Bank for Reconstruction and Development, World Bank International Development Association: *Multilateral Agencies*: European Commission, GAVI Alliance, Global Fund to Fight AIDS, Tuberculosis and Malaria

their allocation. Subsequently, I test levels of budget support and disease earmarking as independent variables, examining their association with health care coverage and outcomes.

To predict the allocation of budget support, I use country-level Worldwide Governance Indicators (WGI) as explanatory variables to capture recipient country institutional capacity, a key variable for health sector budget support. WGI data provide a much more comprehensive source than the World Bank's Country Policy and Institutional Assessments. The WGI variables are available from 1996 onwards and are represented through six composite indicators. While related, the six indicators aim to capture distinct dimensions of governance: *government effectiveness*, capturing perceived quality of public services, policy formulation and implementation, and independence of civil service; *control of corruption*, the extent to which public power is used for private gain; *voice & accountability*, freedom of expression and association, free media and democratic elections; *political stability and absence of violence*; *regulatory quality*, ability of the government to formulate and implement policies promoting private sector development; and *rule of law*, quality of contract enforcement, property rights, policy and the courts (Kaufmann, Kraay, & Mastruzzi, 2010). The first two, government effectiveness and control of corruption, are most relevant in assessing recipient countries conditions that would affect aid channeled as budget support. The WGI are purposefully intended to enable comparisons across countries and over time and as such are well suited to these analyses. The scores, which range from -2.5 to 2.5, were rescaled to a non-negative scale ranging from 0 to 5.

To test the impact of disease earmarking on health care coverage and outcomes, I use data from the World Development Indicators (WDI): TB detection and TB treatment (measuring

health care coverage), TB prevalence and HIV prevalence (measuring health outcomes). The availability of extensive data on TB detection and treatment enable me to examine three steps in the causal chain, linking health aid inputs to health outputs and health outcomes. Unfortunately, the data on condom use are too incomplete to include outputs for HIV so I can only test the association between HIV earmarks and the outcome of HIV prevalence.

The World Development Indicators aggregate country-level data on an annual basis. For health indicators, the WDI dataset reports estimates calculated by the World Health Organization based on data reported by national health authorities, adjusted using epidemiological models and statistical standards in order to improve reliability and facilitate international comparability (World Bank, 2007). Ideally, I would also include recipient country health expenditures and health infrastructure variables, but again these data are too incomplete to include. Disability-Adjusted Life Year (DALY) estimates would offer a more comprehensive measure of countries' burden of disease than overall disease prevalence rates. Unfortunately, DALYs are only available for five of the eighteen years in the time frame and their estimates are not comparable across years, so I am unable to test DALYs over time as dependent variables.

Improving data quality has been an explicit aim of recent global health initiatives, with donors funding improved data collection systems at country and international levels. Weak data collection systems are more likely to miss rather than overcount actual cases of disease, leading to underestimates of true prevalence in earlier years and more accurate estimates in later years as data collection improves. Thus, significant results represent conservative estimates of disease reduction, lending greater confidence to their validity.

Statistical analyses

Descriptive statistics and univariate and multivariate regressions were conducted using SAS 9.2 (Cary, NC) and STATA 11 (College Station, TX). Here I report logged values of development assistance for health, earmarks, country population and per capita gross domestic product adjusted for purchasing power parity (GDP/PPP). I tested alternative measures of aid, including the total amount, moving average, central moving average, percent change, and difference in aid disbursements. I also ran separate models for each region.

I report results with a one year time lag between aid disbursements and my output (TB detection, TB treatment) and outcome variables (HIV prevalence, TB prevalence). Epidemiological models suggest that it is reasonable to expect population-level changes within a year of implementing disease reduction initiatives like improved testing and treatment (Abbas, Anderson & Mellors, 2006; Dye, Garnett, Sleeman, & Williams, 1998; Granich, Gilks, Dye, De Cock & Williams, 2009; Jahn, et al., 2008). As a sensitivity check, I also tested models with 2, 3, 4 and 5 year time lags, but these models did not appreciably change the results.

As would be expected with country-level aid, health and governance indicators over time, the Durbin-Watson test suggests serial autocorrelation so I ran regression models with country fixed and random effects in addition to OLS. Due to heteroscedasticity, I present robust standard errors.

Results

Trends in health sector budget support

As displayed in Table 4.1, budget support was first recorded in this dataset in 1995, rising from a total of $5.9 million worldwide (0.3% of annual health aid) to a high of $937.5 million (7.7%) in 2007. Across this time period, an average of 18% countries received budget support in a given year, though the proportion of countries receiving any budget support increased progressively over time from a low of 1% in 1996 to 13% in 2002 to 65% in 2007. The average disbursement was very low, just under $55,000. From 1995-2007, health sector budget support represented just 1% of countries' annual health aid on average.

With the exception of the European Commission, which provided the highest total amount of budget support, bilateral donors were dominant in providing budget support, both in terms of frequency and total amount. No health sector budget support was recorded from several prominent actors in the global health arena, including the Gates Foundation, GAVI Alliance, Global Fund and the World Bank; however, the time period ends in 2007, two years prior to the launch of the joint Health Systems Funding Platform by the latter three donors.

Table 4.1 Amount and frequency of DAH channeled as budget support and disease earmarks

	Budget support	Disease earmarks	
		HIV	Tuberculosis
Year began	1995	1990	1990
Average annual percent of countries receiving (range)	18% (1% - 65%)	46% (15% - 80%)	26% (6% - 61%)
Number of countries never receiving	57 (34%)	27 (16%)	61 (35%)
Average* amount by disbursement (n = 45,746)	$54,898	$398,128	$46,373
(range)	($0 - $119,300,000)	($0 - $619,513,728)	($0 - $136,647,118)
Average* proportion by disbursement	0.86%	5.65%	0.92%
Average* amount by country (n = 3,051)	$823,125	$5,969,433	$695,302
(range)	($0 - $119,353,443)	($0 - $1,111,021,726)	($0 - $172,978,780)
Average* annual proportion by country	1.38%	9.95%	1.30%
Recipient countries			
Receiving most frequently	Mozambique (47)	Tanzania (186)	India (58)
(number of separate disbursements)	Tanzania (32)	Uganda (177)	Tanzania (41)
	Zambia (32)	Kenya (157)	China (37)
	Uganda (22)	Zimbabwe (151)	Ethiopia (37)
	Nicaragua (21)	Mozambique (148)	Philippines (37)
Receiving highest total amount	Ghana (20%)	India (15%)	India (4%)
(proportion of total DAH)	Iraq (22%)	Kenya (47%)	China (11%)
	Mozambique (13%)	Uganda (43%)	Russia (13%)
	Pakistan (10%)	South Africa (73%)	Indonesia (3%)
	Bangladesh (7%)	Nigeria (45%)	Peru (8%)
Donor agencies			
Disbursing most frequently	Spain (156)	USA (857)	GFATM (309)
(number of separate disbursements)	Norway (119)	Norway (585)	Belgium (198)
	Italy (94)	GFATM (440)	Great Britain (148)
	New Zealand (58)	Great Britain (386)	Norway (104)
	Netherlands (55)	WB IDA (358)	Netherlands (92)
Disbursing highest total amount	EC (21%)	USA (39%)	GFATM (16%)
(proportion of total DAH)	Great Britain (8%)	GFATM (58%)	BMGF (8%)
	USA (2%)	WB IDA (15%)	Great Britain (3%)
	Netherlands (12%)	Great Britain (23%)	WB IDA (1%)
	Norway (19%)	BMGF (19%)	Belgium (10%)
No disbursements	ADB, BMGF	GAVI Alliance	GAVI Alliance
	GAVI Alliance, GFATM		IDA
	Luxembourg, Portugal		New Zealand
	WB IBRD, WB IDA		

* Median & mode = 0; Donor acronyms – European Commission, GFATM: Global Fund to Fight AIDS, TB & Malaria, BMGF: Bill & Melinda Gates Foundation, ADB: Asian Development Bank, WB IDA: World Bank International Development Association, WB IBRD: World Bank International Bank for Reconstruction & Development, IDB: Interamerican Development Bank

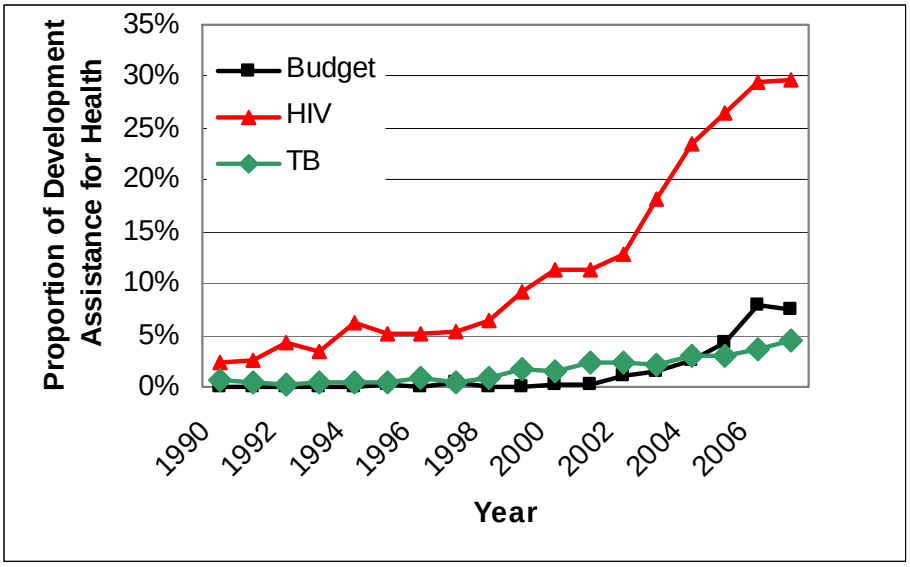
Trends in disease earmarking

Compared to health sector budget support, funding earmarks for HIV were much more common and represented much higher proportions of health aid. On average from 1990-2007, nearly half (46%) of all countries received funds earmarked for HIV in a given year. An average country received nearly $6 million, representing nearly 10% of all health aid granted during this time period. For some countries in sub-Saharan Africa, such as Kenya, Nigeria and Uganda, HIV earmarks represented nearly half of their total health aid. For South Africa, it represented an overwhelming 73%.

In contrast, funding earmarks for tuberculosis exhibited similar disbursement patterns as those for budget support: low amounts representing just 1% of aid, as displayed in Figure 4.1. Fewer countries received funding earmarks for TB (65%), compared to those for HIV (84%). It is important to note that the median and mode of all summary statistics presented in Table 4.1 was zero, indicating that a typical disbursement and country did not receive any health aid channeled as budget support *or* earmarked for specific diseases.

Among donors, the Global Fund, Gates Foundation, Great Britain and the World Bank International Development Association provided the highest amounts of earmarked aid. Among recipient countries, Tanzania ranks among the top two countries most frequently receiving health aid earmarked for HIV and TB, as well as aid channeled as health sector budget support.

Figure 4.1 Trends in health sector budget support and disease earmarking over time



Factors associated with allocation of health sector budget support

Contrary to expectations, recipient country governance indicators were inconsistently associated with health sector budget support disbursements. Among the top countries that received health sector budget support from 1995-2007, Iraq has one of the lowest percentile rankings of government effectiveness and control of corruption in the world (average rankings of 2 and 4 respectively on a 100 point scale); yet, nearly a quarter (22%) of their health aid was channeled as budget support. Mozambique, who received health sector budget support most frequently over this time period, fares better, with average percentile rankings of 36 and 42, but still does not have outstanding governance indicators that would suggest that this country would be a priority for this type of financing mechanism.

Chile, on the other hand, which has one of the highest average rankings of government effectiveness and control of corruption (86 and 90), only received a single health sector budget

disbursement during this time period in the amount of $17,550, less than 0.0001% of its total DAH. It is worth reiterating that these figures represent DAH channeled as health sector budget support, not overall levels of aid. Political economy factors may account for much higher levels of overall aid to Iraq compared to Chile, but they do not account for such large discrepancies in levels of *budget support*.

Due to the low levels and infrequency of health sector budget support and disease earmarking, I performed logistic regressions to determine whether or not donors gave *any* budget support or earmarked their aid, rather than linear regressions to estimate the amount of each. In multivariate analyses controlling for country income, region and population size, perceived political stability was positively associated with an increased likelihood of receiving any budget support, as displayed in Table 4.2. On the other hand, perceived control of corruption was inversely associated with budget support, suggesting that higher scores on this governance indicator was associated with *reduced* likelihood of receiving health sector budget support. The remaining four governance indicators were not significantly associated with the allocation of any health sector budget support, but the direction of their relationships is inconsistent as well. Overall, the effect of higher governance indicators is very small (1-3% change in the predicted probability of receiving any budget support), indicating their minimal influence in donors' budget support allocation decisions.

Table 4.2 Multivariate logistic regression predicting receipt of any budget support[a] from 1995-2007

Explanatory Factors	Co-efficient (Std. error)	Effect analysis[b]
Worldwide Governance Indicators:		
Control of corruption	-0.66*	-0.03
	(0.34)	
Government effectiveness	0.17	0.01
	(0.44)	
Rule of law	-0.29	-0.01
	(0.42)	
Voice & accountability	0.25	0.02
	(0.21)	
Political stability & absence of violence	0.39*	0.02
	(0.20)	
Regulatory quality	0.13	0.01
	(0.32)	
Annual DAH (logged)	0.87***	0.19
	(0.12)	
Year	0.63***	0.21
	(0.05)	
Country Characteristics:		
Population (logged)	-0.21*	-0.02
	(0.09)	
Per capita GDP/PPP (logged)	-0.14	-0.01
	(0.16)	
Region[c]		
East Asia & Pacific	-0.27	-
	(0.32)	
Eastern & Central Europe	-1.50***	-
	(0.37)	
Latin America & Caribbean	-0.53	-
	(0.34)	
Middle East & North Africa	0.73	-
	(0.40)	
South Asia	0.15	-
	(0.43)	
Intercept	-1273.8***	
	(106.9)	

Notes: * p < 0.5, ** p < 0.1, *** p < 0.001; n = 1,173, Wald Chi-Square Test = 240.0 (15)***, Pseudo R^2 = 0.60

[a] Dependent variable is whether a recipient country received any health sector budget support from a given donor in a given year

[b] Each cell shows the change in the probability of receiving any health sector budget support. These probabilities are computed by evaluating the change in predicted probabilities for a given factor when moving from the value at the 25th percentile to that of the 75th percentile of all countries while evaluating other variables at their mean values.

[c] Regional reference category: sub-Saharan Africa

Disease prevalence rates were significant predictors of earmarked aid (Table 4.3). These findings indicate that countries with higher HIV and TB prevalence rates in one year had an increased likelihood of receiving earmarked funding for that disease in the following year. HIV prevalence was more strongly associated with an increased likelihood of receiving HIV funding than was country TB prevalence in increasing the likelihood of aid earmarked for TB. Higher HIV prevalence rates (comparing countries in the 75^{th} percentiles with those in the 25^{th} percentile) increased the likelihood of receiving HIV earmarks by 7%, everything else equal. Higher TB prevalence rates increased the likelihood receiving TB earmarks by 3%.

Larger amounts of total DAH, larger population and smaller per capita GDP/PPP also increased the likelihood of countries receiving any earmarks for HIV and TB. Relative to sub-Saharan Africa, Latin America and the Caribbean and the Middle East and North Africa were significantly less likely to receive aid earmarked for HIV and TB, even when accounting for country prevalence rates, population size and per capita GDP/PPP. I also ran models which included Worldwide Governance Indicators as potential variables predicting receipt of disease earmarks. However, their inclusion reduced the sample size by half and did not appreciably change the estimates so only the baseline model is presented here.

Table 4.3 Multivariate logistic regression predicting any funding earmarks from 1990-2007

	Any HIV earmarks[a]		Any TB earmarks[b]	
Explanatory Factors	Co-efficient (Std. error)	Effect analysis[c]	Co-efficient (Std. error)	Effect analysis[c]
Disease Prevalence:				
HIV	0.20*** (0.05)	0.07	-	-
Tuberculosis	-	-	0.001** (0.00)	0.03
Annual DAH (logged)	0.54*** (0.08)	0.14	0.62*** (0.07)	0.27
Year	0.21*** (0.02)	0.24	0.24*** (0.02)	0.20
Country Characteristics:				
Population (logged)	0.12 (0.07)	0.03	0.30*** (0.06)	0.07
Per capita GDP/PPP (logged)	-0.34*** (0.10)	-0.09	-0.62*** (0.09)	-0.10
Region[d]				
East Asia & Pacific	-0.26 (0.34)	-	-0.39 (0.22)	-
Eastern & Central Europe	-1.64*** (0.32)	-	0.02 (0.23)	-
Latin America & Caribbean	-0.63** (0.25)	-	-0.64** (0.23)	-
Middle East & North Africa	-2.74*** (0.37)	-	-0.78** (0.28)	-
South Asia	-0.28 (0.60)	-	0.52 (0.31)	-
Intercept	-433.2*** (41.78)	-	-488.5*** (35.27)	-
n	1,473		2,267	
Wald Chi-Square Test	280.63 (10)***		492.95 (10)***	
Pseudo R^2	0.54		0.59	

Notes: * p < 0.5, ** p < 0.1, *** p < 0.001

[a] Dependent variable is whether a recipient country received any HIV earmarks from a given donor in a given year.

[b] Dependent variable is whether a recipient country received any TB earmarks from a given donor in a given year.

[c] Each cell shows the change in the probability of receiving HIV/TB earmarks. These probabilities are computed by evaluating the change in predicted probabilities for a given factor when moving from the value at the 25th percentile to that of the 75th percentile of all countries while evaluating other variables at their mean values.

[d] Regional reference category: sub-Saharan Africa

Associations between disease earmarks and subsequent disease outcomes

The expectation of health aid is that it will ultimately improve health care coverage and reduce disease. One of the primary justifications of funding earmarks is to better link aid inputs to improved health outcomes. In the first regression model predicting HIV prevalence in the subsequent year, HIV earmarks and overall DAH were both positively associated with higher HIV prevalence, the opposite of what would be expected (Table 4.4). However, in the model interacting HIV earmarks with HIV prevalence rates, the interaction term is inversely associated with subsequent HIV rates. This finding suggests that greater investments in HIV did contribute to reductions in disease, depending on the initial prevalence level. In models testing the impact of HIV earmarks by prevalence quartiles, countries with the highest HIV prevalence rates exhibited the weakest influence of HIV earmarks. Thus, HIV earmarks appear to have been more successful in reducing subsequent prevalence for countries with low to moderate HIV prevalence rates.

Table 4.4 Random effects models predicting HIV prevalence in the subsequent year

	Co-efficient (Std. error)	Co-efficient (Std. error)
Explanatory factors	(1)	(2)
Development Assistance for Health:		
Amount earmarked for HIV (logged)	0.01**	0.02***
	(0.01)	(0.01)
Amount earmarked x HIV prevalence	-	-0.01***
		(0.00)
Total annual amount (logged)	0.00	0.00
	(0.00)	(0.00)
HIV prevalence	0.97***	1.12***
	(0.01)	(0.04)
Year	-0.04***	-0.04***
	(0.01)	(0.01)
Country Characteristics:		
Population (logged)	-0.04	-0.02
	(0.02)	(0.02)
Per capita GDP/PPP (logged)	0.14**	0.13*
	(0.05)	(0.05)
Region[a]		
East Asia & Pacific	-0.34***	-0.32***
	(0.09)	(0.10)
Eastern & Central Europe	-0.34**	-0.25*
	(0.11)	(0.12)
Latin America & Caribbean	-0.49***	-0.44***
	(0.13)	(0.14)
Middle East & North Africa	-0.32**	-0.23*
	(0.11)	(0.12)
South Asia	-0.26***	-0.27***
	(0.07)	(0.08)
Intercept	80.24***	76.00***
	(20.28)	(17.90)
Wald Chi-Square Test	64776.9 (11)***	47858.78 (12)***
R^2	0.99	0.99

Notes: * p<0.05, ** p<0.01, *** p<0.001; n = 1,468
Models include robust standard errors
[a] Regional reference category: sub-Saharan Africa

The associations between funding earmarks and TB indicators were all in the expected direction, but were not statistically significant in any of the models. The relationship between TB earmarks and TB detection was positive in random effects models, suggesting that higher TB earmarks in one year was associated with better detection in the subsequent year (Table 4.5). Increasing TB earmarks by 50% increased TB detection by 2%, everything else equal. Countries receiving higher levels of overall DAH, with smaller populations, higher GDP/PPP and located in a region other than sub-Saharan Africa also predicted higher rates of TB detection.

Similarly, the relationship between TB earmarks and TB treatment was positive but weak. TB earmarks were negatively associated with subsequent TB prevalence, indicating that higher earmarks helped to reduce prevalence levels. In the models predicting TB prevalence, the co-efficients on the regional dummy variables were extremely large, suggesting large differences between sub-Saharan Africa and the other five regions, much more so than was evident with TB detection, TB treatment or HIV prevalence.

Again, while the associations between TB earmarks and the three TB indicators (detection, treatment and prevalence) were in the expected direction, the effects were very small. Moreover, in fixed effects models, the signs on each changed, although the associations were still not significant. The sensitivity of these results to model specification suggests that these models are underspecified and are missing additional explanatory variables.

Table 4.5 Random effect models predicting TB indicators in the subsequent year

	Co-efficient (Std. error)	Effect analysis[a]	Co-efficient (Std. error)	Effect analysis[a]	Co-efficient (Std. error)	Effect analysis[a]
Explanatory Factor	**TB detection**		**TB treatment**		**TB prevalence**	
Development Assistance for Health:						
Amount earmarked for TB (logged)	0.05	0.02	0.03	0.01	-0.04	-0.02
	0.04		0.06		0.18	
Total annual amount (logged)	0.17*		0.04		-0.22	
	0.08		0.13		0.12	
TB indicator (detection, treatment, prevalence)	0.83***		0.54***		0.98***	
	0.03		0.05		0.01	
Year	-0.06		0.42***		0.24	
	0.05		0.13		0.20	
Country Characteristics:						
Population (logged)	-0.52**		-0.38		0.26	
	0.18		0.26		0.44	
Per captia GDP/PPP (logged)	1.77***		-1.07		-3.60*	
	0.49		0.58		1.56	
Region[b]						
East Asia & Pacific	1.31		5.83***		-19.71***	
	0.88		1.58		2.96	
Eastern & Central Europe	4.66***		2.70		-17.01***	
	1.08		1.43		3.14	
Latin America & Caribbean	1.43		2.59		-15.39***	
	0.97		1.49		3.23	
Middle East & North Africa	3.21**		7.08***		-14.64***	
	1.08		1.56		3.49	
South Asia	2.34*		4.45*		-21.64***	
	0.99		2.07		2.97	
Intercept	117.72***		-785.37**		-427.57***	
	100.59		252.12		403.44	
n	2,107		1,346		2,258	
Wald Chi-Square Test	5896.39 (11)		586.53 (11)		73524.49 (11)	
R^2	0.82		0.48		0.98	

Notes: * p<0.05, ** p<0.01, *** p<0.001, models include robust standard errors

[a] Each cell shows the change in TB detection, treatment and prevalence, respectively, given a 50% increase in TB earmarks, holding all else constant.

[b] Regional reference category: sub-Saharan Africa

Discussion

Since 1990 health aid has disproportionately favored the specific over the sector, channeling substantially more funding earmarked for HIV, than funding provided as health sector budget support. In this sense, donors are prioritizing the visibility of results over efforts to strengthen recipient country ownership, establishing externally defined indicators rather than giving countries the authority to manage funds and the flexibility to allocate them according to their judgment of the country's needs. While the number of countries receiving budget support has increased substantially over the last thirteen years, health sector budget support still remains a relatively infrequent occurrence, constitutes a small proportion of overall health aid, and is allocated through very small individual disbursements.

A synthesis report on sector budget support (Williamson & Dom, 2010) advises that health sector budget support be allocated on a large enough scale to expand public services commensurate with need. Current donor practices clearly fall short of this minimum threshold level. Moreover, actual disbursement levels stand in stark contrast to the professed commitment in the 2005 Paris Declaration to increase program-based support by 66% by 2010 (Organization for Economic Cooperation and Development, 2005/2008).

Despite concerns regarding the potential misuse of health sector budget support, its allocation was not consistently associated with country governance indicators. This finding suggests that there remains great potential to considerably scale up the amount and frequency of health aid provided in this way, targeting countries with strong ratings of government effectiveness and control of corruption. For example, there are 59 countries receiving health aid that are more highly ranked in terms of their government effectiveness governance than

Mozambique, who has received budget support the most often. This subset of countries is a logical group with which to expand health sector budget support.

Worldwide Governance Indicators are aggregate measures of perceive governance based on a range of sources. What may perhaps be more important than general perceptions, are the views of donor officials themselves regarding the capacity of recipient country governments to manage funds. The qualitative data presented in Chapters 2 and 3 suggest that donors exhibit wide variation in their perceptions of the capability and roles of the *same set* of local actors and institutions. Given the micro level of these perceptions, this information would be difficult to capture at a cross-national level. However, the length and nature of donors' relationships with recipient countries over the course of their aid history together may provide one way to assess donor perceptions in future quantitative analyses.

Compared to health sector budget support, disease earmarks were allocated much more frequently and in more predictable ways. The findings confirm a positive relationship between disease prevalence rates and funding earmarks, with stronger associations for HIV than for TB. These results support previous work observing a positive relationship between country disease burden (DALYs) in a single year and the amount of earmarked aid (Ravishankar, et al., 2009).

For HIV only, larger funding earmarks were also associated with reduced prevalence rates in the following year when taking into account current year prevalence rates. Together, these results indicate that higher initial HIV prevalence rates increase the likelihood of receiving funding earmarked for HIV, and that higher amounts of earmarked aid, in turn, reduce subsequent disease rates for countries with low to moderate prevalence rates.

The surprising positive association between HIV earmarks in countries with very high rates of HIV and subsequent HIV prevalence may in part be a reflection of timing and threshold levels. HIV earmarks are a very new phenomenon, gaining prominence well after many countries in sub-Saharan Africa were experiencing severe, generalized epidemics. Providing dedicated HIV funding at this point may have been too little, too late to reverse very high prevalence rates. This observation does not imply that HIV earmarks have had little influence. A large proportion of HIV earmarks from PEPFAR and the Global Fund have funded expanded access to anti-retroviral therapy. Therefore, a more sensitive outcome measure may be AIDS deaths, rather than HIV prevalence.

Unlike HIV, none of the TB indicators were statistically significant. The total amount of development assistance for health earmarked for TB was considerably smaller than that earmarked for HIV, which may help to account for their weak effect. Again, there may be a threshold earmarks need to surpass in order to achieve population-level impacts.

At the country level, it is remarkable that Tanzania appears among the top two recipients of both health sector budget support *and* earmarks for all three diseases, among the 172 countries who received health aid from 1990-2007. The prominence of this one country in all four categories suggests that country visibility may also play a role in aid allocations, with a large number of donors investing in high profile countries and not solely based on country health, demographic and governance factors alone. This pattern also lends support for the donor perception proposition, which warrants future study. While the existence of these apparent 'donor darlings' is problematic for need- and country capacity-based aid, the relatively high frequency

with which both types of financing mechanisms have been employed offers a unique opportunity to compare these two donor approaches in greater depth at the individual country level.

In terms of donor preferences, although bilateral, multilateral and private donors have different constituencies to whom they must report, there appeared to be greater differences in donor financing approaches *within* rather than *across* donor type. That is, the extent to which donors provided health sector budget support and disease earmarks varied more across individual bilateral donors, and between multilateral entities like the European Commission and the Global Fund, for example, than it did between bilateral, multilateral and private donor types. Across all donors, Great Britain channeled funds through health sector budget support and earmarked funds for all three diseases more frequently than most other donors. As such, its funding portfolio may serve as a useful case to examine the influence of these different financing choices on health care coverage and outcomes in the countries in which they provide substantial amounts of health aid. Moreover, the recently launched Health Systems Funding Platform warrants careful study to provide a complementary perspective on disease-specific focus pursued to date by the Global Fund, GAVI Alliance and the World Bank.

The findings presented here build upon previous reports of global trends in health aid by providing a finer level of detail at the disbursement, country and donor level (Piva & Dodd, 2009; Ravishankar, et al., 2009; Shiffman, 2008; Shiffman, et al., 2009). As more data become available, future work should examine the influence of donor financing decisions on indicators that better capture the implementation of health care programs (i.e. access and quality across different population groups), not simply population-level outcomes at the country level. Comparative case studies across countries with similar health and income profiles would help to

elucidate the differential impacts of various aid allocation approaches. If recent trends are any indication, donors will continue to experiment with the ways in which they grant health aid. As global economic conditions threaten the sustainability of international aid commitments, it is imperative to evaluate these different approaches in a continued effort to maximize investments in health.

REFERENCES

Abbas, Ume L., Roy M. Anderson, and John W. Mellors. 2006. "Potential impact of antiretroviral therapy on HIV-1 transmission and AIDS mortality in resource-limited settings." *J Acquir Immune Defic Syndr, 41,* 632-641.

Acemoglu, Daron, Simon Johnson, and James A. Robinson. 2001. "The colonial origins of comparative development: an empirical investigation (effect of institutions on economic performance)." *American Economic Review* 91 (5):1369(33).

Agencia Peruana de Cooperación Internacional. 2009. "Cifras de la cooperación internacional no reembolsable: Situación y tendencias 2007-2008." Lima, Peru: Author.

Alesina, Alberto, and David Dollar. 2000. "Who gives foreign aid to whom and why?" *Journal of Economic Growth* 5:33-63.

Allison, Graham T. 1971. *Essence of decision: Explaining the Cuban missile crisis*. Boston, MA: Little.

Atun, Rifat, and Michel Kazatchkine. 2009. "Promoting country ownership and stewardship of health programs: The Global Fund experience." *J Acquir Immune Defic Syndr, 52 Suppl 1*, S67-68.

Banerjee, Abhijit, and Lakshmi Iyer. 2005. "History, institutions and economic performance: The legacy of colonial land tenure systems in India." *American Economic Review* 95 (4):1190-213.

Barnes, Amy, and Garrett Wallace Brown. 2011. The idea of partnership within the Millennium Development Goals: Context, instrumentality and the normative demands of partnership. *Third World Quarterly, 32*, 165-180.

Baumgartner, Frank R., and Bryan D. Jones. 1993. *Agendas and instability in American politics*. Chicago: University of Chicago Press.

Behague, Dominique P., and Katerini T. Storeng. 2008. "Collapsing the vertical-horizontal divide: An ethnographic study of evidence-based policymaking in maternal health." *Am J Public Health, 98,* 644-649.

Bennett, Andrew, and Colin Elman. 2006. "Qualitative research: Recent developments in case study methods." *Annual Review of Political Science, 9,* 455-476.

Bermejo, Alvaro. 2009. "Towards a global fund for the health MDGs?" *Lancet, 373*, 2110.

Berthelemy, Jean-Claude, and Ariane Tichit. December 2002. "Bilateral donors' aid allocation decisions: A three-dimensional panel analysis." In *UNU-WIDER discussion paper No. 2002/123*. Helsinki, Finland.

Biesma, Regien G., Ruairi Brugha, Andrew Harmer, Aisling Walsh, Neil Spicer, and Gill Walt. 2009. "The effects of global health initiatives on country health systems: A review of the evidence from HIV/AIDS control." *Health Policy Plan, 24*: 239-252.

Birdsall, Nancy. 2008. "Seven deadly sins: reflections on donor failings." In William R. Easterly (Ed), *Reinventing foreign aid*. Cambridge, MA: The MIT Press.

Birkland, Thomas A. 1997. *After disaster: Agenda setting, public policy, and focusing events*. Washington, DC: Georgetown University Press.

Boone, Paul. 1996. "Politics and the effectiveness of foreign aid." *European Economic Review 40* (2):289-329.

Brainard, Lael, Ed. 2007. *Security by other means: Foreign assistance, global poverty, and American leadership*. Washington, D.C.: Brookings Institution Press.

Brautigam, Deborah A., and Stephen Knack. 2004. "Foreign aid, institutions, and governance in sub-Saharan Africa." *Economic Development & Cultural Change* 52 (2):255(31).

Brinkerhoff, Derick W., and Benjamin Crosby. 2002. *Managing policy reform: Concepts and tools for decision-makers in developing and transitioning countries*. Bloomfield, CT: Kumarian Press.

Bueno de Mesquita, Bruce. 2003. *The logic of political survival*. Cambridge, Mass.: MIT Press.

Buffardi, Anne. L., Robinson Cabello, and Patricia J. Garcia. 2011. "The Chronicles of CONAMUSA: Institutional strategies to overcome shared governance challenges." Paper presentation at the *International Studies Association Annual Convention*. Montreal, Canada, March 16-19, 2011.

Buiter, Willem H. 2007. "Country ownership": A term whose time has gone." *Development in Practice, 17*(4-5): 7-652.

Burnside, Craig, and David Dollar. 2000. "Aid, politices and growth." *The American Economic Review, 90,* 847-868.

Chambers, Robert. 1997. *Whose reality counts? Putting the first last*. London, England: ITDG Publishing.

Chen, Lincoln C., Time G. Evans, and Richard A. Cash. 1999. "Health as a global public good." In Inge Kaul, Isabelle Grunberg and Marc A. Stern (Eds). *Global public goods: International cooperation in the 21st century*, New York, NY: United Nations Development Programme.

Clark, Peter B., and James Q. Wilson. 1961. "Incentive systems: A theory of organizations." *Administrative Science Quarterly 6* (2):129-66.

Collier, Paul. 2002. "Making aid smart: Institutional incentives facing donor organizations and their implications for aid effectiveness." Washington, DC: World Bank.

Collier, Paul, and David Dollar. 2004. "Development effectiveness: What have we learnt?" *Economic Journal 114* (496):F244-F71.

Congressional Budget Office. 1997. "The role of foreign aid in development." Washington, DC: Author.

Deverajan, Shanta, and Vinaya Swaroop. 2000. "The implications of foreign aid fungibility for development assistance." Washington, DC: World Bank.

DiMaggio, Paul J., and Walter W. Powell. 1983. "The iron cage revisited: Institutional isomorphism and collective rationality in organizational fields." *American Sociological Review* 48.

Doucouliagos, H., and M. Paldam. 2009. "The Aid Effectiveness Literature: The Sad Results of 40 Years of Research." *Journal of Economic Surveys 23* (3):433-61.

Dye, Christopher, Geoffrey P. Garnett, Karen Sleeman, and Brian G. Williams. 1998. "Prospects for worldwide tuberculosis control under the WHO DOTS strategy." *Lancet, 352*, 1886-1891.

Easterly, William R., Ed. 2008. *Reinventing Foreign Aid*. Cambridge, Mass.: MIT Press.

———. 2007. "Are aid agencies improving?" *Economic Policy* (October):635 - 78.

———. 2006. *The white man's burden: Why the West's efforts to aid the rest have done so much ill and so little good*. New York: Penguin Press.

———. 2002. "The cartel of good intentions." *Foreign Policy* (131):40.

Easterly, William R., Ross Levine, and David Roodman. 2004. "Aid, policies, and growth: comment." *American Economic Review* 94 (3):774(7).

Easterly, William R., and Tobias Pfutze. 2008. "Where does the money go? Best and worst practices in foreign aid." *Journal of Economic Perspectives* 22 (2):29(4).

Eichler, Rena, and Amanda Glassman. 2008. "Health systems strengthening via performance-based aid: Creating incentives to perform and to measure results." In *Brookings Global Economy and Development working paper series*. Washington, DC: Brookings Institution.

Eisenhardt, Kathleen M. 1989. "Agency theory: An assessment and review." *Academy of Management Review* v14 (n1):p57(18).

Entwistle, Janet, and Filippo Cavassini. 2005. "An operational approach for assessing country ownership of poverty reduction strategies. Volume I: Analysis and implications." Washington, DC: World Bank.

Epstein, Helen. 2009. "Towards a global fund for the health MDGs?" *Lancet, 373*, 2110-2111.

Feachem, Richard G. A., and Oliver J. Sabot. 2006. "An examination of the Global Fund at 5 years." *Lancet, 368*, 537-540.

Fielding, David J., Mark McGillivray, and Sebastian Torres. 2006. "A wider approach to aid effectiveness: Correlated impacts on health, wealth, fertility and education." *Helsinki, Finland: UNU-WIDER Research Paper, 2006/23*, 1-16.

Foster, Mick, Adrienne Brown, and Tim Conway. 2000. "Sector-wide approaches for health development: A review of experience." Geneva, Switzerland: WHO.

Freedom House. 2010. Freedom in the World: Peru. Washington, DC: Author. [cited September 14, 2010]. Available from http://www.freedomhouse.org/template.cfm?page=363&year=2010.

Geddes, Barbara. 2003. *Paradigms and sand castles: Theory building and research design in comparative politics*. Ann Arbor: University of Michigan Press.

George, Alexander L., and Andrew Bennett. 2005. *Case studies and theory development in the social sciences*. Cambridge, Mass.: The MIT Press.

Gerring, John and Jason Seawright. 2007. Techniques for choosing cases. In *Case study research: Principles and practices*. New York: Cambridge University Press, p. 86-150.

Gibson, Clark C., Andersson Krister, Ostrom Elinor, and Shivakumar Sujai. 2005. *The Samaritan's dilemma: The political economy of development aid*. New York: Oxford University Press.

Granich, Reuben M., Charles F. Gilks, Christopher Dye, Kevin M. De Cock, and Brian G. Williams. 2009. "Universal voluntary HIV testing with immediate antiretroviral therapy as a strategy for elimination of HIV transmission: A mathematical model." *Lancet, 373*, 48-57.

Grossback, Lawrence J., David A.M. Peterson, and James A. Stimson. 2007. "Electoral mandates in American politics." *British Journal of Political Science* 37:711-30.

Grundy, John. 2010. Country-level governance of global health initiatives: An evaluation of immunization coordination mechanisms in five countries of Asia *Health Policy & Planning, 25,* 186-196.

Halperin, Morton H., Priscilla A. Clapp, and Arnold Kanter. 1974. *Bureaucratic politics and foreign policy*. Washington,: The Brookings Institution.

Hannan, Michael T., and John Freeman. 1984. "Structural inertia and organizational change." *American Sociological Review* 49:149-64.

Hill, Peter S., Peter Vermeiren, Katabaro Miti, Gorik Ooms, & Wim Van Damme. 2011. "The Health Systems Funding Platform: Is this where we thought we were going?" *Global Health, 7,* 16.

Jahn, Andreas, Sian Floyd, Amelia C. Crampin, Frank Mwaungulu, Hazzie Mvula, Fipson Munthali, Nuala McGrath, Johnbosco Mwafilaso, Venance Mwinuka, Bernard Mangongo, Paul E.M. Fine, Basia Zaba, and Judith R. Glynn. 2008. "Population-level effect of HIV on adult mortality and early evidence of reversal after introduction of antiretroviral therapy in Malawi." *Lancet, 371,* 1603-1611.

Johnson, John H., and Sulaiman S. Wasty. 1993. "Borrower ownership of adjustement programs and the political economy of reform." *World Bank Discussion Papers, No. 199*. Washington, DC: World Bank.

Johnson, Omotunde E. G. 2005. "Country ownership of reform programmes and the implications for conditionality." *G-24 Discussion Paper Series, No. 35*. Geneva. United Nations: Convention on Trade and Development.

Kaufmann, Daniel, Aart Kraay, and Massimo Mastruzzi. 2010. "The Worldwide Governance Indicators : A summary of methodology, data and analytical issues." In *World Bank Policy Research Working Paper No. 5430* Washington, DC: The World Bank.

Kaufmann, Daniel, Aart Kraay, and Pablo Zoido-Lobaton. 2000. "Governance matters: From measurement to action." *Finance and Development, June*, 10-13.

Kenny, Charles. 2008. "What is effective aid? How would donors allocate it?" *The European Journal of Development Research* 20 (2):330-46.

Kharas, Homi, and Johannes F. Linn. 2008. "Better aid: Responding to gaps in effectiveness." In *Brookings Policy Brief 2008-06*. Washington, DC: Brookings Institution.

Killick, Tony, Ramani Gunatilaka and Ana Marr. 1998. *Aid and the political economy of policy change*. New York: Routledge.

King, David C. 1997. *Turf wars: How Congressional committees claim jurisdiction*. Chicago: University of Chicago Press.

Kingdon, John W. 1995. *Agendas, alternatives, and public policies*. 2nd ed. New York: Longman.

Knack, Stephen and Aminur Rahman. 2008. "Donor fragmentation." In William. R. Easterly (Ed), *Reinventing foreign aid*, Cambridge, Mass.: MIT Press, p. 333-347.

Knack, Stephen. 2000. "Aid dependence and quality of governance: A cross-country empirical analysis." Washington, DC: World Bank.

Koeberle, Stephan, and Zoran Stavreski. 2006. "Budget support: Concept and issues." In Stephan Koeberle, Zoran Stavreski, and Jan Walliser (Eds), *Budget support as more effective aid? Recent experiences and emerging lessons*. Washington, DC: World Bank. p. 3-28.

Kosack, Stephen. 2003. "Effective aid: How democracy allows development aid to improve the quality of life." *World Development* 31 (1):1-22.

Lawson, Andrew, David Booth, Meleki Msuya, Samuel Wangwe, and Tim Williamson. 2006. "Does general budget support work? Evidence from Tanzania." In Stephan Koeberle, Zoran Stavreski, and Jan Walliser (Eds), *Budget support as more effective aid? Recent experiences and emerging lessons*. Washington, DC: World Bank. p. 121-136

Levi, Margaret, Audrey Sacks, and Tom Tyler. 2009. "Conceptualizing legitimacy, measuring legitimating beliefs." *American Behavioral Scientist, 53*, 354-375.

Levine, Ruth. 2008. Healthy foreign policy: bringing coherence to the global health agenda. In N. Birdsall (Ed.), *The White House and the world: A global development agenda for the next US president*. Washington, DC: Center for Global Development. p. 43-62.

Lindsay, James M. 1994. *Congress and the politics of U.S. foreign policy*. Baltimore: Johns Hopkins University Press.

Lu, Chunling, Catherine M. Michaud, Emmanuela Gakidou, Kashif Khan, and Christopher J.L. Murray. 2006. "Effect of the Global Alliance for Vaccines and Immunisation on diphtheria, tetanus, and pertussis vaccine coverage: An independent assessment." *Lancet, 368*, 1088-1095.

Lu, Chunling, Catherine M. Michaud, Kashif Khan, and Christopher J.L. Murray. 2006. "Absorptive capacity and disbursements by the Global Fund to Fight AIDS, Tuberculosis and Malaria: Analysis of grant implementation." *Lancet, 368*, 483-488.

Lu, Chunling, Matthew T. Schneider, Paul Gubbins, Katie Leach-Kemon, Dean Jamison, and Christopher J.L. Murray. 2010. "Public financing of health in developing countries: A cross-national systematic analysis." *Lancet, 375*, 1375-1387.

Lucas, Sarah. 2007. "Lessons from seven countries: Reflections on the Millennium Challenge Account." Washington, DC: Center for Global Development.

Martens, Bertin. 2002. *The institutional economics of foreign aid*. Cambridge, U.K: Cambridge University Press.

May, Peter J. 1991. "Reconsidering policy design: Policies and publics." *Journal of Public Policy* 11 (2):187-206.

May, Peter J., Joshua Sapotichne, and Samuel Workman. 2006. "Policy coherence and policy domains." *Policy Studies Journal* 34 (3):381(23).

Mazmanian, Daniel A., and Paul A. Sabatier. 1983. *Implementation and public policy*. Glenview, Ill.: Scott, Foresman.

McGillivray, Mark, Simon Feeny, Niels Hermes, and Robert Lensink. 2005. "It works; it doesn't; it can, but that depends...: 50 years of controversy over the macroeconomic

impact of development aid." *Helsinki, Finland: UNU-WIDER Research Paper* 2005/54:1-21.

Meernik, James, Eric L. Krueger, and Steven C. Poe. 1998. "Testing modes of US foreign policy: Foreign aid during and after the Cold War." *The Journal of Politics* 60 (1):63-85.

Miller, Gary J. 1992. *Managerial dilemmas: the political economy of hierarchy*. New York: Cambridge University Press.

Milner, Helen V., & Dustin H. Tingley. 2010. "The political economy of US foreign aid: American legislators and the domestic politics of aid." *Economics and Politics*, 22(2): 200-232.

Moore, Mark H. 1995. *Creating public value: Strategic management in government*. Cambridge, Mass.: Harvard University Press.

Mosley, Paul. 1986. Aid-effectiveness: The micro-macro paradox. *Ids Bulletin-Institute of Development Studies*, *17*, 22-27.

Moyo, Dambisa. 2009. *Dead aid: Why aid is not working and how there is a better way for Africa*. New York: Farrar, Straus and Giroux.

North, Douglass Cecil. 1991. "Institutions." *Journal of Economic Perspectives* 5 (1):97-112.

———. 1990. *Institutions, institutional change, and economic performance*. Cambridge: Cambridge University Press.

Ooms, Gorik, Wim Van Damme, Brook K. Baker, Paul Zeitz, and Ted Schrecker. 2008. "The 'diagonal' approach to Global Fund financing: A cure for the broader malaise of health systems?" *Global Health*, *4*, 6.

Organization for Economic Cooperation and Development, Development Assistance Committee. 2010. "Aid statistics: Official Development Assistance over 50 years." Geneva, Switzerland: Author.

———. 1996. "Shaping the 21st century: The contribution of development co-operation." Paris: Author.

Organization for Economic Cooperation and Development. 2011. "Aid Effectiveness 2005-2010: Progress in implementing the Paris Declaration." Paris: Author.

———. 2010. 50 years of official development assistance. Geneva, Switzerland: Author. [cited May 4, 2011]. Available from http://www.oecd.org/document/41/0,3746,en_2649_34447_46195625_1_1_1_1,00.html.

———.2005/2008. "The Paris Declaration on Aid Effectiveness and the Accra Agenda for Action." Geneva, Switerland: Author.

Oster, Sharon M. 1995. *Strategic management for nonprofit organizations: Theory and cases*. New York: Oxford University Press.

Paul, Elisabeth. 2006. "A survey of the theoretical economic literature on foreign aid." *Asian-Pacific Economic Literature*, 20(1): 1-17.

Phillips-Mandaville, Alicia. 2009. "MCC's approach to country ownership. Working paper: A draft for comment and discussion." Washington, DC: Millennium Challenge Corporation.

Piva, Paolo, and Rebecca Dodd. 2009. "Where did all the aid go? An in-depth analysis of increased health aid flows over the past 10 years." *Bull World Health Organ, 87*, 930-939.

Pritchett, Lant, and Michael Woolcock. 2008. "Solutions when the solution is the problem: Arraying the disarray in development." In William R. Easterly (Ed), *Reinventing foreign aid.* Cambridge, Mass.: MIT Press.

Program on International Policy Attitudes. 2005. "Americans on Addressing World Poverty." Washington, DC: Author.

Radelet, Steven, and Bilal Siddiqi. 2007. "Global Fund grant programmes: An analysis of evaluation scores." *Lancet, 369*, 1807-1813.

Radelet, Steven, and Ruth Levine. 2008. "Can we build a better mousetrap? Three new institutions designed to improve aid effectiveness." In William R. Easterly (Ed). *Reinventing foreign aid.* Cambridge, MA: The MIT Press.

Radelet, Steven. 2004. "The Millennium Challenge Account: Transforming US foreign assistance policy?" *Agenda* 11 (1):51-67.

Ravishankar, Nirmala, Paul Gubbins, Rebecca J. Cooley, Katie Leach-Kemon, Catherine M. Michaud, Dean T. Jamison, and Christopher J. Murray. 2009. Financing of global health: tracking development assistance for health from 1990 to 2007. *Lancet, 373*, 2113-2124.

Reinikka, Ritva. 2008. "Donors and service delivery." In William R. Easterly (Ed). *Reinventing foreign aid.* Cambridge, MA: The MIT Press.

Rochefort, David A., and Roger W. Cobb. 1993. "Problem definition, agenda access and policy choice." *Policy Studies Journal* 21 (1):56-71.

Rodrik, Dani, and Arvind Subramanian. 2003. "The primacy of institutions (and what this does and does not mean)." *Finance and Development, June*, 31-34.

Sabatier, Paul A, and Christopher M Weible. 2007. "The advocacy coalition framework: Innovations and clarifications." In Paul A. Sabatier (Ed), *Theories of the Policy Process*, Boulder, CO: Westview Press.

Sachs, Jeffrey D. 2005. "The development challenge." *Foreign Affairs* 84 (2):78-90.

Salisbury, Robert H. 1969. "An exchange theory of interest groups." *Midwest Journal of Political Science* 13 (1):1-32.

Sen, A. 1999. *Development as freedom*: New York, NY: Alfred Knopf.

Shiffman, Jeremy. 2008. "Has donor prioritization of HIV/AIDS displaced aid for other health issues?" *Health Policy Plan, 23*, 95-100.

Shiffman, Jeremy, David Berlan, and Tamara Hafner. 2009. "Has aid for AIDS raised all health funding boats?" *J Acquir Immune Defic Syndr, 52 Suppl 1*, S45-48.

Stone, Deborah. 1989. "Causal stories and the formation of policy agendas." *Political Science Quarterly 104*:281-300.

Svensson, Jakob. 2008. "Absorption capacity and disbursement constraints." In William R. Easterly (Ed). *Reinventing foreign aid*, Cambridge, MA: The MIT Press.

The Global Fund to Fight AIDS, Tuberculosis and Malaria. 2008. "Lessons learned in the field: Health financing and governance. A report on the Country Coordinating Mechanism model." The Global Fund Implementer Series. Geneva, Switzerland.

Trumbull, William N., and Howard J. Wall. 1994. "Estimating aid-allocation criteria with panel data." *The Economic Journal 104* (425):876-82.

United Nations Development Programme. 2010. Human development report: Peru. New York, NY: Author. [cited May 11, 2011]. Available from http://hdrstats.undp.org/en/countries/profiles/PER.html.

———. 2007. *MDG monitor: Peru progress by goal*. Author [cited September 23 2010]. Available from http://www.mdgmonitor.org/country_progress.cfm?c=PER&cd=604.

US Agency for International Development. 2006. "USAID primer: What we do and how we do it." Washington, DC: Author.

———. 2002. "Foreign aid in the national interest: Promoting freedom, security, and opportunity." Washington, DC: Author.

US Agency for International Development Information Services. 2006. "General budget support: Key findings of five USAID studies." In Stephan Koeberle, Zoran Stavreski, and Jan Walliser (Eds), *Budget support as more effective aid? Recent experiences and emerging lessons*. Washington, DC: World Bank. p. 105-116.

US Department of State and US Agency for International Development. 2007. "Strategic plan: fiscal years 2007-2012." Washington, DC: Author.

Uvin, Peter. 2004. *Human rights and development*. Bloomfield, CT: Kumarian Press, Inc.

Waddington, Catriona. 2004. "Does earmarked donor funding make it more or less likely that developing countries will allocate their resources towards programmes that yield the greatest health benefits?" *Bulletin of the World Health Organization, 82,* 703-706.

Wane, Waly. 2004. "The quality of foreign aid: Country selectivity or donors incentives?" *Policy Research Working Paper Series No: WPS 3325*. Washington, DC: World Bank.

Wang, T. Y. 1999. "U.S. foreign aid and UN voting: An analysis of important issues." *International Studies Quarterly* 43 (1):199-210.

Williamson, Oliver E. 2000. "The new institutional economics: taking stock, looking ahead." *Journal of Economic Literature* 38 (3):595(1).

Williamson, Tim, and Catherine Dom. 2010. "Sector budget support in practice: Synthesis report." London, England: Overseas Development Institute.

Wilson, James Q. 2000. *Bureaucracy: What government agencies do and why they do it*. New York: Basic Books.

World Bank. 2011. World Development Indicators: Peru. Washington, DC: Author [cited May 11, 2011]. Available from http://data.worldbank.org/country/peru.

———. 2007 World Development Indicators. Washington, DC: Author.

———. 1998. *Assessing Aid: What Works, What Doesn't, and Why*. New York, NY: Oxford University Press.

World Health Organization Maximizing Positive Synergies Collaborative Group. 2009. "An assessment of interactions between global health initiatives and country health systems." *Lancet, 373*, 2137-2169.

Zimmermann, Felix, and Ida McDonnell. 2008. "Broader ownership for development." In Development Committee of the Organization for Economic Cooperation and

Development (Ed.), *Financing Development 2008: Whose Ownership?* Paris: Author. p. 17-38.

VITA

Anne L. Buffardi earned a Bachelor of Arts in Psychology, with Minors in International Studies and Sociology from Wake Forest University. She holds a Master of Social Work Degree, a Graduate Certificate in International Development & Policy Management, and a Doctor of Philosophy Degree in Public Policy & Management from the University of Washington. Born and raised in Virginia, she has studied, worked and volunteered in Latin America, Africa, Europe, and the Middle East. As of February 2012, she will be the Evaluation Advisor for Global Campaigns and Advocacy at Oxfam International, based at the Secretariat in Oxford, England.