

Africa beyond aid

Edited by Holger Brett Hansen, Greg Mills and Gerhard Wahlers

Proceedings of two international conferences held under the joint auspices of The Brenthurst Foundation, the Konrad Adenauer Stiftung, and DANIDA. The first was convened in Potsdam, Germany, from 3 to 4 April 2006; the second took place in Brussels, Belgium, from 24 to 26 June 2007.

Published in January 2008 by
the Brenthurst Foundation

Tel +27 (0)11 274 2096

Fax +27 (0)11 274 2095

www.thebrenthurstfoundation.org

All rights reserved. The material in this publication may not be reproduced,
stored, or transmitted without the prior permission of the publisher.

Short extracts may be quoted, provided the source is fully acknowledged.

ISBN: 978-0-9585068-2-3

Designed and produced by Acumen Publishing Solutions, Johannesburg.

International health policy in Africa: more harm than good

Roger Bate

During the past few years, Africa has received far more support in terms of health aid than ever before. The results of this increase have been varied – generally disappointing and occasionally even counterproductive. There are several reasons for this interesting anomaly:

- Some of the cash promises have yet to materialise (eg for malaria from the World Bank).
- USAID and other aid agencies often reserve a significant amount of pledged funds to be used only by Western contractors. USAID, for example, often purchases American products at higher costs, a practice which is inefficient and has reaped less effective results.
- Immeasurable and odd targets are set, as in, for example, the UN Millennium Development Goals (MDGs).
- Aid agencies tend to operate using Western subjectivity and perspective rather than addressing local needs objectively. This often means that interventions that are politically popular with donor nations are chosen over more pragmatic solutions. For example, many Western organisations and governments are inclined to promote the use of Permethrin-treated mosquito nets as a preventive measure against malaria, over the cheaper and more effective option of using safe indoor insecticides. Another example is the Western preference for propagating sex abstinence messages as a method of HIV prevention, rather than practical programmes for improving safe injection practices and providing general sex education. The Western tendency to place popularity over practicality (eg Sierra Leone's HIV prevention and treatment programme) may entirely displace efforts that should take priority, such as the immunisation of children.
- Mission creep (at the World Bank, the WHO, etc) results in many international agencies seeming to be responsible for everything, which means, ironically, that they are responsible for nothing. Agencies should have clearly defined roles in accordance with their skills-set, rather than roles dictated by their donor base or an exhaustive mission statement.

- African nations are not demanding programmes that will suit their particular needs. In order to fully take advantage of the aid directed toward them, African nations must first put their own houses in order. This is best achieved by implementing stronger and more resilient health systems, reducing absenteeism and other forms of corruption in the workplace, and removing tariffs on essential medical interventions.

In this paper I will be expanding upon some of these issues, particularly: donor efforts, country responses to aid, and other, non-governmental, actions.

THE NON-DELIVERY OF AID FUNDS

Many agencies have failed to deliver on their pledges of aid to Africa. USAID and the World Bank have failed repeatedly to deliver on their promises to combat malaria in affected countries. For more on this specific issue, please refer to the endnotes.^{1,2}

Even more troubling than the failure of many agencies to follow through on their commitments are the actual reasons why aid has often failed to reach the people who are in dire need of it. I will use the example of the United States Agency for International Development - the most important vehicle for American aid.

USAID

USAID has failed disastrously in its mission. Impotent, and even counterproductive in its aid-giving efforts and practices, USAID suffers from an array of perverse incentives which plague its staff and contractors. Change has been long overdue and is currently in the works. On the issue of US foreign aid, US Secretary of State, Condoleezza Rice, stated recently that the changes are aimed at ensuring that foreign assistance is used as effectively as possible; that foreign assistance activities of the State Department and USAID are fully aligned; and that the administration presents itself as a responsible steward of the taxpayers' dollars. As yet it is too early to predict if anything useful will be produced from these changes.

USAID then and now

Having been established with the specific aim of being a 'soft power' during the Cold War, the fall of the Berlin Wall undermined the USAID's *raison d'être*,

with some calling for its abolition. However, it was agreed that the agency could continue, on three conditions: shrink in capacity; be held accountable to the State Department; and embrace private sector reforms.

Subsequent Clinton-era reforms enacted at USAID had an immediate impact on the character of the agency, in that it became largely a contracting organisation. USAID closed 24 missions between 1993 and 1997 and reduced its full-time professional staff from 11 150 to 7 609.³ From the perspective of its political economy, USAID supplanted its bygone national security constituency with an influential interest group of commercial supporters. Prohibited from lobbying for funds in Congress itself, USAID's practice now is to actively beseech its 'partners' (as it calls its contractors) to push for greater funding.

The contracting dilemma

Although USAID is not unique in pursuing its objectives primarily through contracting, it prefers large, for-profit, US-based organisations, most of which are located in Washington, DC. Some of these Washington-based firms rely exclusively on USAID contracts to stay in business. USAID staff, adept as they are at the contracting process, are often courted by contractors, resulting in the creation of cosy relationships that prevent a healthy competitive drive.⁴

Other criticisms of USAID persist as well. One of the most serious is that the consulting work typically performed by contractors actually undermines the local institutions, as well as the indigenous capacities the aid process is presumably trying to build. A succession of unintended consequences can explain why USAID continues to pursue this highly wasteful and demoralising policy which pays contractors US rates for work that could be done much more cheaply by local organisations. The budget cuts made at the USAID headquarters during the 1990s made the agency incapable of monitoring operations in remote locations. Consequently the agency is not familiar with local operators who are capable of doing the job at a cheaper rate. The result is that local contractors have no access to the USAID lobbying process. Without the required expert help, local contractors do not have the capacity to fulfil the regulatory requirements for aid projects. This raises a larger, related issue: the incompatibility between what the rich world wants for the developing world, and what the developing world desires for itself.⁵

For years, USAID justified its existence to Congress by stressing that foreign aid money benefited American domestic economic interests through contracts to US organisations and commodity import programmes for US products. Data from USAID's *Buy American* Report, the best available assessment, indicate that over the last decade, 70-80 per cent of funding appropriations were directed to US sources. In gross terms, the Business Alliance for International

Economic Development estimated in 1996 that foreign aid sustained 200 000 domestic jobs.

Another criticism of USAID's contracting process is its lack of transparency. USAID policy forbids the disclosure of 'proprietary' information related to its contracts, which keeps the financial details of the bidding process hidden from public view. Some of the contracts secured by USAID are for operations in geographically sensitive locations (Islamic states), or involve national security concerns. Rather than differentiating between classified and non-classified contracts - for example child immunisation projects in a predominantly Christian African nation - USAID lumps both sensitive and non-sensitive financial information together, protecting it from external scrutiny without satisfactory reason. Congressional pressure - notably from conservative Senators Brownback and Coburn - has only recently been applied to rectify USAID's opaqueness.

Other problems inherent to all self-sustaining bureaucracies, such as chronic corruption among officials involving state expenses; creating very close alliances with favoured contractors; and terminating contracts with organisations which complain or criticise the agency's practices are gradually being investigated by concerned senators. USAID is not a runaway train, but it could do a lot better.

USAID in global health policy: pathetic vertical programmes

Despite these problems, USAID is a trendsetter in global development aid practices, particularly in the health policy arena. Though its leadership role is more subtle today than it was when US funding and expertise dominated the disease eradication campaigns of the WHO, Department of State figures for 2003 show that American contributions still constitute a quarter of the organisation's budget - representing the largest single national share by far.

USAID also acts as a role model for private lending. Private donors to international causes, whose giving outpaces official US government assistance, look to USAID as the arbiter on which programmes and interventions to fund.

In the case of the Roll Back Malaria programme, which USAID shaped and continues to influence, its clout has actually harmed global health. Malaria rates have risen since 1998, when the programme was set up with the goal of halving rates by 2010, despite USAID having increased its malaria control budget from US\$8 million to US\$90 million as of 2005.

Since the agency refuses to release details of contracts, grants and co-operative agreements used to disburse malaria funds, it is difficult to pinpoint exactly what is wrong. Two congressional hearings on USAID's malaria programmes in 2004 prompted the agency to produce a document purporting to

account for its activities. However, this document was not available publicly, did not identify the contracting partners responsible for each programme, and offered no data on how these partners actually spent their funds.

From the limited available documentation, and communication with USAID staffers willing to speak off the record, as well as current and former employees of the agency's contracting firms, it is now clear that USAID actually spends little money purchasing the tools necessary to fight malaria. Three methods that have been proven to combat malaria effectively are indoor residual spraying, insecticide-treated bed nets and the use of effective therapeutic medicines (namely artemisinin-based combination therapy, or ACTs, and prophylaxis for intermittent prevention therapy). Despite the agency's claims that it takes a 'comprehensive approach', it spent less than 10 per cent of its US\$80 million budget for 2004 on purchasing these life-saving interventions (with the exception of bed nets).

USAID's lack of transparency makes accounting for the remaining 90 per cent of its malaria budget rather difficult. From available documentation, it seems that US\$10,5 million is dedicated to research and testing of a vaccine. The rest is spent on 'capacity building', 'technical assistance' and strengthening' or 'supporting' government health ministries in malaria-affected countries. USAID does not disclose details of these projects, but an agency staffer explained that many involve US consultants giving advice to government ministries. For example, the consultancy organisation Management Sciences for Health (MSH) received US\$64,3 million in 2003 (the last year for which figures are available). MSH is active on many malaria projects, and its 2003 IRS Form 990 illustrates how USAID malaria funds are typically spent: some 52-70 per cent of MSH's programme expenses are dedicated to compensation and travel, an amount which is separate from what MSH designates as overhead costs.

Aside from their considerable charges, Western consultants are often ineffective because they lack the requisite knowledge of local conditions. During a US\$5 million malaria effort in co-operation with the Ministry of Health in the Bungoma District of western Kenya, the local health staff ran into major problems because USAID's consultants never actually visited the programme area. The project subsequently failed to meet the bulk of its objectives, wasting not only money, but also the efforts of those taking part in the programme, and undermining the hope of those who might have benefited from it.

USAID claims that its comparative advantage lies in the institutional knowledge it can dispense, and in the fact that it co-ordinates its technical expertise with organisations that provide actual interventions, such as the Global Fund and UNICEF. Except in a few isolated circumstances, USAID has provided no evidence of such co-ordination. In some instances its failure to co-ordinate

effectively has turned tragic. The Vurhonga project in Chokwe, Mozambique, a USAID-funded child survival effort implemented by Save the Children, was all but wasted because no arrangements had been made to buy medicines. In the final evaluation report submitted by Save the Children, project leader Armand L. Utshudi noted that 'frequent stock-outs and unreliable supplies of essential drugs at community-based health facilities' impeded the programme's operations.⁶

Although it used the well-designed community participation technique developed at the Johns Hopkins School of Public Health, the Vurhonga project met only seven of its 36 objectives. It managed to raise the proportion of children with malaria symptoms, treated within 24 hours, from 2 per cent to 50 per cent, but it failed to reduce the number of children dying, because they were given obsolete drugs. The project's medical advisor, Peter Ernst, stated that efforts to convince USAID and UNICEF to persuade Mozambique's health ministry to change drugs failed, owing to cost concerns that USAID could easily have covered.

The fact that these details are known is highly unusual, as USAID generally does not collect enough data to evaluate its own activities.

USAID's evaluation of programme performance is also inadequate. An internal review of the substantial drop in USAID evaluations (from 529 in 1994 to 167 in 2004) found that past recommendations for improving evaluation systems have been systematically ignored by the agency's senior leadership, and that its current evaluation practice is rife with impropriety. Unacceptable practices include project managers being allowed to grade their own projects, claiming success without evidence. The evaluator of the failed Save the Children effort unaccountably recommended that the programme be 'replicated in other parts of Mozambique'.

Change or perish

If the handling of past programmes is any indication at all, USAID is clearly failing and may even be a liability. USAID can and must improve.

After the malaria battles of 2005, it is becoming apparent that some people within the Global Health Bureau at USAID want change - although recent improvements in rhetoric on malaria⁷ have yet to be matched in other areas of global health or in any other programme. Indeed, Admiral Ziemer, the new co-ordinator of the President's Malaria initiative, is improving interventions, performance and measurement. Senior USAID staff members do not have much time left in which to decide how serious they are about reform; although insiders deny it, President Bush is tiring of USAID's dismal record. The US government runs 19 separate major aid accounts, ranging from child

survival (including malaria), through strategic support for Egypt, to the Millennium Challenge Corporation. These foreign assistance accounts totalled about US\$17 billion in spending in 2005. Apparently, the administration's efforts to re-orient aid aims to make these accounts operate more coherently. This depends on the promising reforms outlined by Secretary Condoleezza Rice, and also on the ability of the new administrator of USAID, Randall Tobias, to execute that vision.⁸

It must be added that similar failures occur in other agencies, such as the World Bank and WHO. Some of those projects were approved glowingly even though access was measured in an extremely unorthodox fashion: if the bank funded a health facility, its practice was to count the number of people within a ten-mile radius and then conclude that access to clinics had been increased by this number of people. Clearly, such a flawed measuring technique should be viewed as unacceptable.

INAPPROPRIATE PRIORITIES - THE CASE OF SIERRA LEONE

By varying estimates from the WHO, the World Bank and other multilateral agencies, Sierra Leone has one of the world's worst performing health sectors. It has astonishingly high under-five child mortality rates (284 deaths/1 000 live births) and maternal mortality rates (1 800 maternal deaths/100 000 live births). Forty-six per cent of child deaths are attributed to malnutrition. With malaria rates rising alongside outbreaks of lassa fever and yellow fever, Sierra Leone is perhaps the worst place in the entire world to be a child.

Sierra Leone's HIV rate is between 3 and 8 per cent, with far higher incidence rates recorded among the military - estimated by the WHO at 25 per cent. WHO reported that, 'During the past 10 years, the displacement of hundreds of thousands of people; the breakdown of social structure; a lack of government capacity to create a national policy for HIV/AIDS; and a reluctance to speak about the disease are all factors that could induce a fast propagation of the disease.'⁹

The high military HIV rate (coupled with an appallingly high rape rate), led an already primed international community to determine that Sierra Leone needed a considerable AIDS programme. Last year Sierra Leone received about US\$8 million for HIV treatment and prevention programmes, totalling less than US\$2 per person in a country of 5,5 million people. This is a woefully inadequate amount with which to educate the mass populace on HIV prevention, as well as treat those who are infected.

HIV is not the only threat to Sierra Leone's socio-economic wellbeing. While AIDS experts say the pledged US\$8 million is not enough, US\$6 million of

that sum is allocated to all other healthcare needs. In a country with a gross domestic product of US\$1,1 billion, approximately 0,5 per cent of the budget, or US\$1 per person, is spent on non-HIV health. This feeble allocation ensures that Sierra Leone stays a long way from the United Nations target set in Abuja, Nigeria, which outlines that 15 per cent of total government budgets must go to health care in poor countries.

If one combines HIV spending with the other health expenditures, Sierra Leone spends 1,3 per cent of its budget on health. But the HIV spending is actually hurting the country as it draws attention away from other equally important health issues, such as child immunisation, respiratory infections, and malaria control. While each life lost to HIV is tragic, far more lives are lost by diverting the attention, if not actual resources, away from far more efficacious areas. Children can easily be prevented from contracting numerous killer diseases, notably through immunisation. Addressing malnutrition and malaria is warranted, given the massive returns. Spending hundreds of dollars per person per year on antiretroviral drugs seems a dreadful misallocation in a country as poor as Sierra Leone.

Child health doctors who work on HIV receive higher salaries than their non-HIV working counterparts. Is it any wonder that local doctors are switching to HIV work?

AGENCIES' MISSION CREEP

Another key problem is agency mission creep (notably at the World Bank and WHO), but also between the World Bank and the Global Fund.¹⁰

Former World Bank President Paul Wolfowitz tried to improve the Bank's performance in its role as co-sponsor of the Roll Back Malaria (RBM) campaign. RBM is a coalition of multilateral health and aid agencies, including the WHO and UNICEF, which aims to halve the malaria burden in Africa by 2010.

The World Bank, with a budget of nearly US\$20 billion, should play a pivotal role in helping to maximise a country's resources through education and training, and in building the physical infrastructure necessary for development - roads, schools, clinics, IT and communications, etc.

Indeed, for the first 30 years of its existence the WHO concentrated on mass campaigns directed at the worst scourges - it gathered health experts in particular diseases from donor countries to design programmes, and supervise local people to administer vaccines, sprays, drugs and other treatments.

Some countries did better than others in establishing primary health care facilities or adopting the 'horizontal approach' to health care development. Some countries were slow to act, but built sustainable systems as their

economies developed. Nepal, for example, took 14 years before it could support and complement the vertical malaria control programme with general health services. Others used funds to establish clinics and hospitals, but then failed to deliver long-term funding to maintain them. Eventually, the WHO lost interest in the vertical approach, programmes fell into disrepair and the malaria programme collapsed entirely.

The Bank attempted to fill the void; but since disease control is not its mission, it lacked expertise. Or so I thought until I inquired for data on the qualifications of professional staffers at the Bank in its Health, Nutrition and Population (HNP) division. Where I expected health-systems specialists, mainly health economists, consistent with the mission of the Bank, I was surprised to find that, of the 216 professional staff, only 12 per cent have advanced degrees in economics training. Another 25 per cent hold degrees qualifying them as health-systems experts. The majority - about 60 per cent - consists of medical doctors or epidemiologists. To be sure, many staffers may have compensated for their lack of systems training with field experience in development work, but it will still be in their nature to run disease-based programmes.

As one economist at the bank said, 'We all know that projects are geared towards the expertise of those implementing the projects.' This is not quite as simple as saying that a certain country will get an epidemiologically-driven project because the main agent for the bank is an epidemiologist, but more often than not, the bias comes through. As could be expected, disease-based projects have proliferated at the bank.

Building hospitals or structuring sustainable funding systems for the health sector does not have the same cachet with donors, but without material and institutional improvements in health systems, many disease-control programmes will not be maintained. There is now a growing acceptance among the donor aid community, and the government backers of the World Bank, for the need to push for effective disease control through local restructuring and capacity building of recipient countries' health sectors.

The HNP division of the World Bank is the most important division for health projects - both for lending and for grants. But mission creep has subverted the core mission of the bank - data collection is still minimal and unreliable, little monitoring or evaluation is undertaken, and informed analyses appear to be extremely rare.

The non-performance of malaria loans and grants, as well as health systems, and the entire loan and aid practice at the bank, should be overhauled. Mr Wolfowitz's first approach for malaria control was to establish a matrix of health indicators. This effort arose from good managerial instincts, but not much else.

One thing Paul Wolfowitz's successor could do is to change the Roll Back Malaria programme. The bank should work with WHO's new malaria head, the energetic Dr Arata Kochi, to push for changes in the RBM programme. Perhaps then the bank could work more on health systems by getting its partners, UNICEF and WHO, to reform their woeful vertical programme performance.

SO WHAT OF AFRICAN NATIONS?

African states have for years been their own worst enemies.

- Most nations have failed to build health systems, despite receiving billions in aid.
- Health has not been a priority for most governments. With few exceptions, African governments have signed up for the largely immeasurable and absurdly optimistic MDGs, which undermine more realistic targeting.¹¹ African leaders must take the initiative to set their own health agenda.
- Little attention has been paid to institutions and good governance.
- The private sector has taken the lead on disease treatment and prevention, but it cannot deliver massive disease control and certainly cannot be expected or allowed to take the lead in the building of health systems across a country.
- Many countries slap tariffs on medical devices and drugs destined for the poorest among their citizens. This is regressive and costly, and raises relatively little revenue. Alternative sources of revenue should be sought.¹²

Corruption

One has to focus the discussion on governance and corruption in health systems in Africa. Controlling corruption is important for African nations for several reasons, not the least of which is that it affects the optics of foreign direct investment and aid. There have been several studies showing that poor governance is correlated with poor health care.¹³ As corruption decreases and government effectiveness increases, immunisation rates rise and child mortality falls.¹⁴

In Uganda, 67 per cent of rural medical doctors were absent from work in one survey and 36 per cent of health staff were absent in a second survey. Absenteeism was lowest in the morning and in the outpatient departments. The costs represented by absent staff are not insignificant, given the high levels of absenteeism, which are consistently higher than those found in education.¹⁵ At least the data for Uganda were gathered and published. Government

inspectors can make a difference in some locations, though apparently, based on our Ugandan example, this has no impact on absenteeism at all.

As Lewis noted:

Absenteeism is symptomatic of an unaccountable and ineffective government, and leads to contempt for government, its policies and practices, and compromises both access to and quality of health care services. Unproductive or absent workers who do not receive any punishment for substandard performance and whose promotion and pay remain the same as those with better performance, undermine morale and reduce output, which in turn leads to a spiral of overall poor performance. Accountability is meaningless or doesn't exist without sanctions, and institutions suffer accordingly.¹⁶

Trust in government systems collapses entirely when public jobs are purchased. In Ghana, 25 per cent of jobs in government hospitals were allegedly bought. Twenty-one per cent of procurements in government hospitals are corrupt, and 18 per cent of the value of contracts is required as kickbacks to public officials.¹⁷ In Uganda, 20 per cent of municipal officials acknowledged that the practice occurred in the health sector. Even worse, those personnel who refuse bribes face retribution.¹⁸

In Ethiopia and Nigeria, drugs are routinely stolen from public officials and resold in the private sector. A health officer in Addis Ababa said that most health workers are involved in thefts, given their very low pay. Compounding the problem, 28 public health facilities in Nigeria did not receive drugs from the federal government during the past couple of years. Once again, Uganda does poorly, with an average of 73 per cent of drugs stolen from 10 public facilities surveyed. High-demand drugs (such as for chronic malaria) were stolen more frequently, making them even less available to dying patients.

It is simply impossible to know how many medicines are counterfeits, substandard, or repackaged (to substitute lower-cost medicines into higher-cost packaging). The health consequences of such practices are severe.

In Uganda, Mozambique and Ethiopia, where surveys have been conducted, patients have to bribe healthcare staff to conduct routine health care activities such as doctor's consultations and drug prescriptions. In one survey in Uganda, the number of patients who succumbed to this defeating practice was an astonishingly high 88 per cent.

SOLUTIONS?

Better governance must be instituted in various ways. Governments must provide the ability to audit (both in the external sense, such as with organisations like the World Bank, and internally as well). They should seek information on performance and impact. Of vital importance is the authority to reward performance; and to discipline, transfer and terminate the employment of workers who engage in abuses. Recipient governments must be prepared to answer to domestic and international stakeholders. If donors want improvements in these areas of governance, they must demand and expect to be listened to or else withdraw their support from recipient countries.

Donors have the power to encourage funding to go towards performance-related pay. But without auditing and oversight, this money will simply be abused too.¹⁹ Reforms of the health sector on their own will not be enough. Egregious structural problems (related to postings, pay and promotion) exist in all sectors of government. Simply regularising pay, and preventing unwarranted (bought) promotions, have been shown to a large extent to increase productivity.

CONCLUSIONS

Aid agencies, notably USAID, have failed in their mission to improve health. In an attempt to prevent fraud and corruption, they often use their own national agents to distribute funds, and rarely buy interventions that save lives. They follow their own favoured approaches, which distort healthcare allocations. More holistic aid agency funding would help, but recipient countries have to want to help themselves. It boils down to this: African nations have to be much more transparent in their health systems work in order to stamp out corruption. Western donors can benefit Africa the most by providing both the requisite aid to help them to do so, and the ability to withhold aid to demand better performance.

ENDNOTES

- 1 Attaran et al. The World Bank: Negligent Financial and Statistical Accounts, and Medical Malpractice in Malaria Programs. (Unpublished manuscript, *The Lancet*, forthcoming).
- 2 Bate R. & B Schwab. 2005. *The Blind Hydra: USAID Policy Fails to Control Malaria*. AEI Working Paper, May 2005. Paper also presented as government testimony before

the Senate Committee on Homeland Security and Government Affairs Subcommittee on Federal Financial Management, Government Information and International Security, May 12, 2005, Washington. Copy of testimony available at: http://www.aei.org/publications/filter.all,pubID.22508/pub_detail.asp,

3 United States agency for International Development. 1997. *Foreign Assistance: USAID's Re-engineering at Foreign Missions*. Report to the Chairman, Committee on International Relations, House of Representatives, United States General Accounting Office (GAO).

4 Berrios, Ruben. 2000. *Contracting for Development: The Role of For-Profit Contractors in US Foreign Development Assistance*. Library of Congress.

5 See Bate, R. *Abolish USAID*, The American Interest, forthcoming.

6 Utshudi, Armand. 2003. *CS-16 Mozambique Final Evaluation. The Strength Project*. Westport CT.

7 *USAID Reforms agency Malaria Programs for Greater Effectiveness*. USAID Press Release, 14 December 2005, available at: <http://www.usaid.gov/press/factsheets/2005/fs051214.html>.

8 *Remarks on Foreign Assistance* by Secretary of State Condoleezza Rice. Full text of speech available at: <http://www.state.gov/secretary/rm/2006/59408.htm>.

9 The World Health Organization, Sierra Leone (Geneva: World Health Organization November 2004), available at: http://www.who.int/hac/crises/sle/background/Sierra_per_cent20Leone_2-pager.pdf.

10 Global Fund - *World Bank HIV/AIDS Programs: Comparative Advantage Study*, Alexander Shakow, 19 January 2006.

11 Attaran, Amir. 2005. *An Immeasurable Crisis? A Criticism of the Millennium Development Goals and Why They Cannot Be Measured*. PLOS Medicine, 13 September 2005.

12 Bate, R et al. 2006. *Still Taxed to Death*, AEI-Brookings Joint Center Working Paper Series, available at <http://www.aei-brookings.org/publications/abstract.php?pid=930>.

13 Kauffman, Wei D & Wei S J. 1999. *Does 'Grease Money' Speed Up Wheels of Commerce?* NBER Working Papers 7093. National Bureau of Economic Research Inc.

14 Lewis, M. 2006. *Governance and Corruption in Public Health Systems*, World Bank Working Paper No. 78, Washington, DC: World Bank DC.

15 Ibid, p. 19.

16 Ibid, p. 20.

17 World Bank. 2000. *The Ghana Governance and Corruption Survey, Evidence from Households, Enterprises and Public Officials. Africa Region*. Washington, DC: World Bank. Processed.

18 World Bank. 2004. *Ethiopia: A Country Status Report*. Report No. 28963-ET. Washington, DC: World Bank.

- 19 Barr A, Lindelow M, Serneels P. 2004. *To Serve the Community or Oneself: The Public Servant's Dilemma*. World Bank Policy Research Working Paper 3187. Washington DC: World Bank.