

# USAID's health challenge: improving US foreign assistance

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*This is the fourth in a series of articles on leadership in international health. The series was coordinated by Kent Buse.*

On 19 January 2006, United States Secretary of State Condoleezza Rice announced fundamental changes to US foreign aid assistance. In an effort to promote effectiveness, the current United States Agency for International Development (USAID) Administrator, Randall Tobias, would now also serve as the first Director of Foreign Assistance. The position assumes a status level of Deputy Secretary of State, with the organization's activities and management more closely aligned with the State Department. This bold move reverses the Foreign Assistance Act of 1961,<sup>1</sup> which established USAID as a separate entity.

As an independent federal agency, USAID's original mandate at the height of the Cold War was twofold: to further America's foreign policy interests by expanding democracy and opening markets to American goods while improving the lives of the citizens in the developing world. Development was always a 'principal objective of the foreign policy of the United States,' as section 101 of the Foreign Assistance Act 1961 states, but played second fiddle to more obvious foreign policy concerns.

USAID is still charged with prioritizing western values in foreign policy as well as meeting humanitarian need. Secretary Rice declared that policies are being reoriented to 'build and sustain democratic, well-governed states that will respond to the needs of their people and conduct themselves responsibly in the international system.'<sup>2</sup>

Yet USAID's mission in health has often been obscured. Access to basic health care in poor countries, a robust proxy for development, remains unacceptably low, and USAID had little to show for its efforts.<sup>3</sup> HIV/AIDS, diarrhoeal diseases, tuberculosis and malaria are the deadliest diseases on the planet, claiming at least 6 million lives each year.<sup>4</sup> These infectious diseases are preventable and treatable with increasingly cheap measures. In spite of the near tripling of US foreign assistance from US\$10 billion in 2000 to US\$27.5 billion in 2005,<sup>5</sup> it is not a trivial matter to assess how much was actually spent on combating disease or on health in general.<sup>6</sup>

Until recently there was only one foreign aid health account, called Child Survival and Health, which addresses maternal health, vulnerable children, family planning, malaria, tuberculosis and other infectious diseases and is overseen entirely by USAID. But since the inception of the President's Emergency Plan for AIDS Relief (PEPFAR) in 2003, the Global HIV/AIDS account was created, which is now considerably larger than Child Survival and Health. Their budgets in fiscal year 2006 were: Global HIV/AIDS US\$2.38 billion, Child Survival and Health US\$1.64 billion. Other accounts with health components include the Economic Support Funds, which makes accurate calculation of total health spend practically impossible. Nevertheless, it is fair to say that Child Survival and Health and Global HIV/AIDS take up the bulk of health funding, which has increased from about US\$1.6 billion in 2001 to just over US\$4 billion in 2006,<sup>7,8</sup> giving USAID's health program a considerably larger budget than that of the World Health Organization (WHO).

USAID rarely measured its performance, and as other actors—notably the Department of Health and Human Services—developed strong international programs in the 1990s, these growing efforts and perceived problems at USAID persuaded the President to house PEPFAR outside USAID even though USAID would have been its logical home. Neither was USAID the home for the Millennium Challenge Account, a new US\$3 billion/year aid program to support growth measures in those countries adopting the institutions of a free society (e.g. rule of law, property rights, and limited government). The State Department also lobbied unsuccessfully for the Millennium Challenge Account to be housed within its doors, leaving the Millennium Challenge Account to become an independent agency. Indeed, only the promise of significant alterations, given by previous Administrator, Andrew Natsios, led to USAID finally being given a new health project, last summer's President's Malaria Initiative.<sup>9</sup>

USAID provides technical guidance to poor countries' health departments in public health policy and pharmaceutical procurement—as well as very strong support for family planning programs. But it has not been that effective, and a key reason is that the Administrators of USAID have always had their hands tied in several ways.

After the Cold War, the conservative hold on US Congressional power meant that foreign assistance was

largely justified by ensuring that it benefited US taxpayers and employed the competitive advantages of the private sector. But this approach has unintentionally backfired.

As concerns about serious corruption in developing countries led USAID away from 'budget support' and similar programs, USAID was reoriented to employ primarily US contractors and continue to source development commodities in the US. These for-profit organizations understandably refused to lower chances of future contracts by actually building local capacity in any meaningful way. And without the resources or political will at USAID to measure performance, contractors also neglected to purchase key commodities and demonstrate efficacy. They simply promoted, and often did not actually buy, the drugs to treat disease. Furthermore, as the contractors became larger and more able to exploit the contract system of USAID, tendering became less competitive.

To make matters worse, the ability of the current Administrator, Randall Tobias, to effectively juggle USAID's health priorities among eighteen separate aid accounts addressing health issues and food aid programs, as well as navigate counter-narcotics assistance and military training, is by no means assured—especially since he does not control all of them. The apparent systemic incoherence among US aid programs makes the likelihood of further fragmentation within USAID's disease control programs, as well as the politicization of aid delivery, quite possible.<sup>10</sup> Randall Tobias may well possess the coherent vision and sound technical knowledge that his position requires, but it is possible that, amid competing demands in the US's ever-evolving foreign aid policy, success may evade him.

## USAID'S MALARIA CONTROL EFFORTS

### Lessons from the mismanagement of a key disease program

Malaria kills at least a million people each year, mostly children under the age of five and pregnant women. USAID joined the WHO, the World Bank and other donors in 1998 in a renewed international commitment to halve malaria deaths globally by 2010, named the Roll Back Malaria Partnership. But the Partnership was poorly conceived and badly led. No new strategy was introduced to curb the increasing transmission of malaria, and despite its main target being specifically numerical, none of the Roll Back Malaria partners acknowledged that global baseline data for malaria cases and deaths were not measured properly. The partners also avoided highly effective indoor residual spraying programs and continued to fund chloroquine and sulphadoxine-pyrimethamine, even as resistance to these drugs increased.<sup>11</sup>

Prompted by anti-malaria advocates, the US Congress led a series of investigations into USAID's malaria control

programs between September 2004 and January 2006. These hearings found almost no monitoring and evaluation of performance, no ability to account for spending with any meaningful precision, and the promotion of poor public health and clinical practices. Contractors were able to decide what information to redact from contracts, so that researchers could not ascertain how budgets were spent. Of the money accounted for, most went to general advice-giving programs and consultants who were seemingly incapable of building sustainable local capacity. Only approximately 8% of USAID's US\$80 million financial year (FY) 2004 budget was used to purchase actual life-saving interventions, such as insecticide-treated bednets, insecticides, or effective drugs such as Artemisinin-based combinational therapy.<sup>12</sup>

Technical advice and training play a crucial role in sustainable development, but USAID could provide almost no evidence to show that programs actually helped save lives or even build sustainable local infrastructures. Available reports<sup>13</sup> plainly reflected USAID's failure to provide effective interventions or cooperate with other agencies. USAID's measurements focused almost entirely on inputs, such as the number of insecticide-treated bednets distributed, drugs purchased or health workers trained in a certain locale, rather than outcomes.

Senator Tom Coburn (Republican, Oklahoma), host of several of the key hearings exploring USAID's regrettable failings, once likened the new criticisms to bursts of 'sunlight' shining on the malaria program. The Senate Subcommittee hearing in May 2005, coupled with persistently unfavourable coverage in the academic and popular press,<sup>14</sup> marked a turning point for the Global Health Bureau.

### Reforms to USAID's malaria control program

USAID worked with the Office of the President to change malaria practices. On 30 June 2005, President George W Bush launched the President's Malaria Initiative, a US\$1.2 billion initiative to halve malaria in 15 countries by 2010. It initially funded Angola, Tanzania and Uganda for FY2006, focusing on effective management, best practices, transparency and accountability.

This initiative did not apply to regular program funding for malaria control, so six months after the Initiative's inception, and in his final days as USAID Administrator, Andrew Natsios announced momentous and largely unprecedented reforms to USAID's malaria program.<sup>15</sup> USAID promised to shut down all minor programs for malaria control that spent less than US\$1.5 million annually. This was a welcome change, as USAID had previously spread funds too thinly. While half its FY2005 budget was spread between 21 African country-level

programs and three regional offices, over two-thirds of its FY2006 budget went to 17 African countries and one regional office. USAID also promised to allocate nearly half of its budget to buying commodities, such as insecticide-treated bednets, insecticides for indoor residual spraying and effective drugs.

At the close of FY2006, USAID's malaria program is achieving many of its targets. Initial feedback suggests that USAID has improved cooperation with other development organizations within the President's Malaria Initiative countries. For example, the Global Fund to Fight AIDS, TB and Malaria procured 1.1 million treatments of Coartem through the WHO for distribution across Angola. When the President's Malaria Initiative experienced a temporary localized delay in its own procurement for Angola, the Angolan National Malaria Control Program cooperated with the Global Fund and USAID to pool Coartem resources and ensured a constant supply to target provinces.<sup>16</sup> Additionally, USAID lent both insecticide and spray pumps to indoor residual spraying projects being run by other outfits in Namibe Province, allowing them to begin training and early implementation before their own commodities arrived.<sup>17</sup>

Malaria is only one disease, but it has been the flagship program for USAID's health portfolio over the past year, and the beneficial changes show what can be achieved. The Global Health Bureau seems to have learned the lesson that technical assistance is important, but only when programs with sufficient budgets are tailored to specific countries' needs for life-saving interventions.

### Areas still needing improvement

The 'Buy American' practice persists. Hudson spray pumps are the only malaria control commodity the Global Health Bureau purchased from America, but some American condom manufacturers are still almost solely dependent on government financing to stay in business,<sup>18</sup> even though any leading Asian manufacturer could produce the same output for half the resource cost. It seems that where economic depression affects whole Congressional districts, in eastern Alabama for example, elected officials are compelled to try to protect local industry.

Similarly, there appear to be no efforts to disengage USAID from supporting large beltway contractors (such as Academy for Educational Development, Management Sciences for Health and the Research Triangle Institute), which is hard to square with USAID's stated commitment to build country capacity and foster sustainable development. At least within the President's Malaria Initiative there is change, with Research Triangle Institute training district and sometimes national health officials to manage implementation and make decisions about budget, wages and spraying locations.

USAID has not updated its public registry of all Agency contracts<sup>19</sup> since 2001, which makes one think that the transparency efforts of the Global Health Bureau's malaria program may not be a model for change across USAID. However, a new Act, which will require the disclosure of all Federal contracts and grants on an easily accessible web site,<sup>20</sup> may force change anyway.

Many of USAID's problems stem from the organizational structure as a whole. Under the January reorientation, there are no apparent signs of an increase in DC staff, which means that oversight and measurement of program results are likely to remain spotty at best. Moving USAID under the State Department is unlikely to change this. Perhaps more importantly, it risks the capture of USAID and US foreign assistance more broadly by foreign policy interests. Diplomatic concerns can conceivably trump program performance where the State Department is concerned. One way to limit this is to improve monitoring and evaluation, making funding of politically useful but developmentally poor projects more transparent.

### TOBIAS' LIMITED BUDGET CONTROL

The appointment of Randall Tobias, whose main interest is in health care, should have calmed some of the fears that the new foreign assistance act was a ploy for extended foreign policy ambition. For example, while running PEPFAR he was the first to waive the 'Buy American' regulations.<sup>21</sup>

In his position as Director of Foreign Assistance, Tobias provides 'coordination and guidance to all foreign assistance delivered through other agencies and entities of the USG [United States Government], including the Millennium Challenge Account and PEPFAR.<sup>22</sup> His mandate includes the 'monitoring and evaluation of program results against goals and objectives.' As he testified on 26 April 2006, 'the new foreign assistance framework and operational plans will improve accountability by allowing stakeholders, such as Congress, to track progress against investments across countries, programs and partners based on a defined set of goals and indicators.'<sup>23</sup>

However, Tobias' ability to move forward may be hindered by several organizational stipulations. For example, while having organizational influence over the Millennium Challenge Account and PEPFAR, he will not control aid dispersed by either body, which are separate entities reporting directly to Secretary Rice.<sup>24</sup> Indeed, the Millennium Challenge Account, is chartered by Congress so that its board of directors makes decisions on funding only on defined developmental criteria rather than on narrow US foreign policy objectives. Furthermore, several other domestic agencies, as well as the Department of Defense, control a large percentage of the funding. The Congressional Research Service estimates that in FY2005, the

Director of Foreign Assistance would have controlled only 55% of US foreign aid (with the Department of Defense controlling 19% and other departments and agencies controlling the remaining 26%). The situation is slightly more optimistic than these figures present, since a large portion of this 26% includes food aid, which is coordinated by USAID with the US Department of Agriculture, which has budgetary control.

In addition, the Director of Foreign Assistance is constrained in other ways, since congressional spending earmarks make it difficult to shift funds across accounts within USAID and the State Department to where it might do most good.<sup>25</sup>

Without these capabilities, Tobias' power to alter and improve aid policy will be greatly stunted.

### WHERE TO NOW?

Due to the major reworking of US foreign assistance, Randall Tobias has been given the chance to enact considerable reforms. Though institutional obstacles persist, he has made significant strides toward increasing transparency, accountability and performance measurement where USAID's programs are concerned. The Global Health Bureau's reforms on malaria control financing and management are a model for increasing accountability and effectiveness. The Bureau should be commended for aligning its FY2006 malaria control financing with key results-oriented principles, and once again re-establishing the United States as a global health leader. Indeed, an improved and performance-based USAID, working effectively in disease control programs, could potentially revitalize lacklustre efforts in aid programs elsewhere.

Tobias could increase the chances that this effort will be replicated for other programs by aggressively promoting transparency. The Federal Funding Transparency and Accountability Act recently passed into law will certainly boost his endeavour. This would give aid experts the opportunity to make more substantive critiques and recommendations. It would also highlight where non-competitive contractual tendering is taking place, and encourage overseas groups (more attuned to aid recipient country conditions) to apply to USAID for funds. Tobias must also expand his DC staff enough to take control of contract information: it is unacceptable that contractors currently decide what financial and supplemental information is redacted from contracts. Yet Tobias alone cannot ensure that this effort is not a waste of time and resources—Congressional support will be crucial. With the Democrats taking control of Congress, bipartisan approaches will be necessary for improvements in accountability, and this currently doesn't look likely. One probable area of battle is PEPFAR's funding reauthorization

in autumn 2007: Republicans want to continue pushing brand-name, FDA approved drugs and abstinence messaging, whereas Democrats demand generic drugs, more support for the Global Fund and a move away from abstinence messaging. If political agreement can be found, Congress should also withdraw its insistence on buying American commodities for international development and supporting armies of US contractors abroad.

At this crucial juncture in American foreign aid policy, with many competing national security concerns afloat, it is possible that, following Rice's proposals, aid may become even more a tool of US foreign policy. The simple fact that funds for malaria and TB eradication are being given to African countries with oil resources (such as Angola) and that serve as allies in the war on terror (such as Ethiopia) has not escaped anyone's notice, especially since these countries are not necessarily those performing best on institutional or human rights grounds, making something of a nonsense of the endeavours of the Millennium Challenge Account. With the exception of the malaria program, USAID's health programs are also often ineffectually small. Tobias should streamline its programs and operate in fewer countries—hopefully those more deserving countries doing well on Millennium Challenge Account-defined criteria.

Having said that, reform has driven USAID into adopting sensible lines of responsibility and operational plans that are marginally more transparent and certainly more achievable than before. Of course some of the objectives are highly debatable. It is ironic that the religious right has often promoted ideology over science, notably in the tackling of HIV, but is also a major reason that the malaria program has improved and that transparency and accountability are promoted today within USAID. Transparency and a clearer mission should also bode well for its collaboration with other international agencies such as the Global Fund and World Bank. Comparative advantage is hard to identify if respective skills are unclear.

Despite all its shortcomings, USAID occupies a unique position in global health development today. As the world's largest bilateral donor, equipped with the means and resources to tackle critical global health needs, it can accomplish a great deal. To fully realize this mandate, USAID must focus on employing effective disease control mechanisms and following through on promising reforms. Ultimately, USAID must continue to emphasize the creation and support of flexible, responsive and, where appropriate country-driven programs in all its disease control initiatives. If it can succeed in doing so, USAID will prove to be a significantly more influential and effective organization.

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