



An accountable approach to aid

By Jeffrey Sachs

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The report last week of the United Nations Millennium Project lays out a strategy for cutting extreme poverty and disease in the world's poorest countries. The idea is to increase investments in people (health, education, nutrition, family planning), the environment (soils, land, water, biodiversity) and infrastructure (roads, electricity, ports), based on the specific needs of each country. The investment plans should be ambitious enough to achieve the project's Millennium Development Goals (MDGs).

Private markets will not provide the needed investments. The poorest of the poor hold no appeal for private suppliers of such investment. Nor can low-income governments provide the investment solely from domestic budget revenues. Simply put, these vital investments must be co-financed by rich and poor countries alike. The rich countries have long promised such help, to the target of 0.7 per cent of their gross national product, but have fallen notoriously short since that commitment was set in 1970.

But times are changing. Europe is getting serious about increasing its aid levels. Five countries are at 0.7 per cent of GNP (Denmark, Luxembourg, Netherlands, Norway and Sweden), and six more have recently pledged to achieve that level before 2015 (Belgium, Finland, France, Ireland, Spain and the UK). Germany is likely to announce its own target soon, in a decisive breakthrough for a European-wide commitment. The US and Japan could join this effort. The policy debates are therefore shifting from whether to increase aid to how best to deliver it.

In its call for results-based management of foreign assistance, the report recommends first that aid be designed and evaluated against the quantitative targets set for 2015 in the internationally agreed MDGs. Goals such as reducing child mortality rates by two-thirds by 2015 can help ensure donors and recipient countries do not shirk responsibilities as they have in the past.

Second, aid in each sector should be delivered against measurable interim benchmarks on a clear calendar basis. In fighting malaria, for example, interim benchmarks would show the proportion of rural families receiving free mosquito nets and anti-malaria medicines by certain dates. In treating HIV/Aids, the benchmarks would include the numbers of people on anti-retroviral treatment. In the health sector generally, benchmarks would include the construction and operation of hospitals and the proportion of doctors and health workers in each district. Third, governments, donors and civil society should prepare specific compliance guidelines that include spot audits, evaluation and publication of performance indicators. Leading civil society organisations such as Transparency International and private accounting firms should help ensure that the increased aid flows to the targeted areas. Only governments willing to sign on to such rigorous compliance would receive the increased aid.

Fourth, the specific investment plans should be crafted by developing country governments in partnership with local organisations, donors and international institutions, to ensure they respect local realities. Plans will vary by country according to conditions such as disease ecology (such as the presence or absence of malaria), agronomic conditions (such as rain-fed versus irrigation-based farming), and transport conditions (such as landlocked versus coastal regions).

Sceptics argue that the project's goals are too ambitious. That is no doubt true in countries where governments are uninterested in meeting the goals, but it is not true where governments are keen. In Kenya, Ethiopia and other countries, the Millennium Project worked with the governments to measure detailed investment needs and outline 10-year investment programmes. This is a practical step that the sceptics have never tried. The naysayers are irresponsible in their casual assertions about what is and is not possible. The UN Millennium Project identified specific investment measures that can overcome the worst bottlenecks in areas such as food production, disease prevalence and other barriers to poverty reduction.

In Kenya, for example, where a new democracy is committed to the country's development, agronomists, health and education specialists and engineers identified problems and recommended solutions across many sectors. Once donors commit to making resources available, conditional on their good use, it is possible to draw up ambitious plans to scale up investments. At a meeting of donors and Kenyan officials two weeks ago, an agreement in principle was reached to prioritise five quantitative targets this year, from hiring 4,000 nurses to putting 100,000 Aids patients on treatment and paying and training tens of thousands of village health workers. These goals are practical and directly respond to Kenya's health challenges.

This year donors in Europe, now entering a new era of development co-operation, should identify a number of fast track countries such as Kenya, Ethiopia, Ghana, Tanzania and Senegal, that have governments ready to accept enhanced transparency and accountability. The donors and recipient countries should champion several "quick wins" such as malaria nets, Aids treatment, school meals and soil nutrient replenishment, which when applied in Africa's villages, will offer a way out of desperation and early death for hundreds of millions of people.

*The writer is director of the Earth Institute at Columbia University and directs the Millennium Project, which last week delivered its report on achieving the Millennium Development Goals, and 13 companion volumes of analysis, to the United Nations Secretary General;
www.unmillenniumproject.org*

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