# Major Additional Funding for the MDGs: A Mixed Blessing for Capacity Development

## Ole Therkildsen[*]

## 1 Introduction

Let us assume – and hope – that the optimists are right: substantially more funds to assist less developed countries (LDCs) to reach the Millennium Development Goals (MDGs) and other ambitious targets will soon be available. As a result, selected public sector agencies, non-governmental organisations (NGOs) and private firms in qualifying poor countries will experience annual budget growth rates of 10–20 per cent or even more over an extended period of time. Successful high-tech private companies often expand equally fast but this puts considerable capacity strains on them. It can be anticipated that many public sector organisations in poor countries, most of which are presently resource starved, will also experience serious growth pains should major additional funding materialise.

The general argument in this article is that "fast-growing funding" for MDG-relevant activities combined with "very ambitious time-bound targets" will contribute significantly to the already considerable challenges of capacity development in poor countries where organisations often operate in very difficult and unconducive environments. The MDG approach seriously underestimates the difficulties posed by the social and political context for implementation on the ground. The likely unintended consequences of the MDG approach therefore, may outweigh its benefits in some sectors and countries. Moreover, there is a real risk that attempts at a rapid build-up of organisational capacity will undermine both existing capacity and the prospects for sustaining capacity beyond the ten-year horizon that is implied by the 2015 goals. Given past poor performance on capacity development by both recipient and donor countries,

these are formidable challenges for which rapidly expanding budgets are a mixed blessing. It would actually be 'without meaningful historical precedent' if capacity increases sufficient to reach the MDGs were generally to occur – especially in Africa (Clemens *et al.* 2004: 11).

This article deals with some of these capacity issues in the public sector. It applies an organisational – rather than a broader macroeconomic – perspective to the MDG approach, and focuses on capacity issues. It is organised as follows. In Section 2, the MDG approach is briefly described. Based on theoretical insights from the open-systems and institutional perspectives on organisations, and drawing on lessons from implementation studies, support for the arguments above is presented in Section 3. It is supplemented, in Section 4, with a case-analysis of the likely capacity implications of a vigorous pursuit of MGD target to halt and reverse the spread of HIV/AIDS by 2015 in East Africa. Finally, some remedies are proposed (Section 5) and the dilemmas posed by the MDG approach are discussed in the final section.

## 2 The MDG approach

This approach – recently endorsed by the Commission for Africa (2005) – represents an important step forward in many ways (Black and White 2004). The goals move beyond income as a measure of progress and poverty alleviation and include a broader range of targets related to health, education, agriculture, trade relations, debt, aid, etc. Moreover, the most recent major report (Millennium Project 2005) seeks to bring a long absent 'can-do' attitude to development. The MDGs are both affordable and feasible. '[B]reathtaking

results' will result within a few years if some of the proposed Quick Wins are implemented (p. 25).

Read through institutional lenses, this report (and earlier preparatory work by its authors, Jeffrey Sachs and his collaborators) offers interesting insights about the MDG approach and thinking about capacity development and service delivery in a broad sense.

The most striking feature is that *organisational capacity* constraints are not regarded as major obstacles, but rather as opportunity for public investment (Sachs *et al.* 2004: 27; Millennium Project 2005: 43). The authors argue that it is only in a short-term view that today's absorptive capacity problems are serious. Appropriate actions and sufficient resources can overcome them within ten years. A typical recommendation is that each country should prepare 'a strategy for enhanced investments at the village, town, and city levels, a financing scenario, and a governance strategy to ensure implementation of [PRSP] with minimized corruption, based on fundamental principles of human rights' (p. 53). Apart from arguments for the necessity and desirability of this massive undertaking, there is no discussion of implementation issues or of past implementation experiences. The eyes are firmly fixed on the future and the MDGs.

Moreover, *governance* is only regarded as a serious problem in certain countries. Sachs *et al.* refute the argument that sub-Saharan Africa generally suffers from a governance crisis. They regard governance as a relative concept. Many countries are well governed considering 'the income levels and extent of poverty', but need a big push (public investments in transport, agriculture, health, technology) to overcome severe obstacles to development (Millennium Project 2005: 32). Such investments will then, the argument seems to be, help to improve governance. Apart from countries with extremely bad governance, many poor countries should therefore receive much more funds (p. 50). The report identifies a number of well-governed poor countries (called fast-track countries)[1] for which the international community should ensure that aid is not the binding constraint on reaching the MDGs (p. 43). At present, most donor countries argue the opposite: poor countries must improve their governance before they qualify for more aid so that aid can be more effectively used.

In addition, *central planning* approaches are required. Four core principles must guide activities

to meet the MDGs (Millennium Project 2005: 24; Sachs *et al.* 2004: 27–9). First, both recipient countries and donors should align their policies with the 2015 targets, as these represent globally accepted minimum standards. Second, each country should map the key dimensions and underlying determinants of extreme poverty – by region, locality and gender – as far as data allow. Third, consistent with the poverty maps, each country should calculate its funding requirements guided 'by bottom-up assessments of *needs* rather than *ex-ante* budget constraints set by the donor countries'. Fourth, each country should convert these needs into a ten-year framework for action but elaborate them with three to five-year MDG-based Poverty Reduction Strategy Paper (PRSP). This reflects a clear return to a top-down approach to planning, which was last in use in development work in the 1960s.

Finally, *increased funding* is needed. Sachs *et al.* (2004: 37) estimate that well-governed African countries need an additional US$16bn of aid per year (a doubling of present levels). A tripling of aid is needed if all African countries are to meet the MDGs. For Africa has not received too much aid, but too little. Under-investment in development, not too much money, is an important explanation for the disappointing results of aid. Future additional funds must cover both capital and recurrent costs, including salaries to recipient government staff in order to ensure sustained capacity increases (pp. 35, 39). The implicit assumption is that the key challenge to meet the MDGs is to close the financing gap – in the case of poor African countries mainly through increased aid.

How does this MDG-approach fit with recent thinking about and experiences with capacity development measures and their implementation?

## 3 Insights from capacity and implementation studies

From a capacity point of view, rapidly expanding budgets is obviously a nice problem to have – but very hard to cope with well. There are several strands to this.

First, we do not have much recent experience anywhere in the world with that kind of situation in the public sector. While a rapid survey of recent literature on 'public sector capacity' combined with 'crisis', 'scarcity', 'underfunding', 'austerity', 'down-sizing' and so on produces plenty of hits, combinations with 'rapid expansion', 'budget

**Table 1:** **Four Major Options for Organisational Change**

|  | **'Functional–rational' dimension** | **'Political' dimension** |
|---|---|---|
| **Internal dimension** | **A**. Focus on changes in task-and-work system within the organisation.<br><br>Most donor interventions have been in this category – training, restructuring, technical assistance. 'Business Process Reengineering'; 'Total Quality Management', etc. also fall in this category. | **B**. Focus on internal changes in power and authority distribution, conflicts and pursuit of different interests.<br><br>Interventions could include a focus on changing sanctions and rewards; enforcing hiring and promotions based on merit; building internal coalitions for change; introducing performance-based payments; actively discouraging rent-seeking. |
| **External dimension** | **C**. Focus on how changes in external factors and incentives will affect the task-and-work system dimensions of organisational capacity.<br><br>*Examples:* budgetary reforms to ensure predictability of flows of funds to organisations; change in legal mandates; civil service reform; strengthening of supervisory agencies. | **D**. Focus on how changes in external factors and incentives will affect the distribution of power and authority, conflicts and the pursuit of different interests in the organisation.<br><br>*Examples:* the strengthening of civil-society organisations or of political accountability; building external coalitions for change; strengthening media's role as a watchdog. |

*Source:* Boesen and Therkildsen (2005: 14).

growth', 'hyper-growth' and the like do not.[2] As far as the literature on poor countries is concerned, this is not surprising after years of structural adjustment and sluggish economic growth. But that type of literature on rich countries also appears to be very limited. For decades there have simply been very few cases anywhere of very rapid expansions in public sector budgets – except, perhaps in relation to the funding of wars.

Second, although the more specialised literature on capacity development is huge – and some of it focuses on organisations in poor countries – it is also rather diverse and general. In an attempt to develop more operationally relevant ways of analysing and changing organisational capacity, Boesen and Therkildsen (2005) suggest that capacity be defined as 'the ability of an organisation to produce appropriate outputs (services, products)'. Furthermore, based on a literature survey and a view of organisations as open systems, they argue that options for organisational capacity

enhancement should be analysed from two complementary perspectives, each with two dimensions as shown in Table 1. The four major options shown in the table are not mutually exclusive: they supplement each other by bringing overlapping capacity-relevant options to the fore.

As Table 1 illustrates, the causes of poor organisational capacity – and relevant remedies – depend on many factors both inside and outside organisations, and that these are not just technical and financial but also relate to power and politics. There is a need to arrive at an appropriate (context-specific) balance of incentives and power in favour of change, outside and inside the organisations developing capacity, which is the major challenge for any change strategy (Boesen and Therkildsen 2005: 20).

Finally, implementation studies offer interesting insights about the importance of power and politics for the success of implementation. It is obvious that conflicts about the MDGs will affect

implementation. 'For while all governments might agree on the goals, they will honestly differ on the weights they attach to each one, the sequencing of their attainment, the incidence of costs and benefits of reaching them, and a host of other issues' (Mkandawire 2005: 9).

Given the enthusiasm expressed in many quarters – also outside the Millennium Project – for providing additional funds and political support to reach the MDG targets, it is important to consider the implications of a more conducive context for the achievement of the MDGs. Although fast-growing funding for MDG-relevant activities combined with very ambitious targets will be a new and very unusual prospect for poor countries, there is some precedence from the 1960s and 1970s. This is how the situation then was described by Grindle (1980: 22–3):

> … governments in Third World countries may be subject to special conditions that influence how programme and policy goals are arrived at. Most are in a position of having to promise much to their citizens. The enormity of human and physical needs in poor countries, the desire to establish the legitimacy of the political regime by providing tangible evidence of improving conditions, the feeling that the deprivations of the colonial or neo-colonial past must be obliterated, the commitment to indigenous or 'Third Way' ideologies, the need for rapid development – all create a situation in which political leaders are likely to espouse policies that will lead to radical and rapid improvement in the conditions of life. Frequently such policies are couched in ideological contexts that may cloud the actual problems involved in executing them.

The MDG approach to development makes Grindle's description relevant today. A context in which national leaders favour ambitious programmes (the new feature is that some rich-country leaders do the same) is conducive to the successful implementation of any major programme or policy. Major changes can be pushed through by deeply committed leaders at 'historical moments'. Yet, such commitment can also be problematic as some of Grindle's co-authors show. Strong top-level political support ('will' in today's language) gives rise to the 'paradox of popularity' as Quick (1980: 56–62) labels it. While popularity of programmes with political

leaders is necessary for success, this very popularity politicises the feedback processes. This weakens the capacity of implementing agencies to respond creatively to evidence of implementation problems.

The paradox is accentuated if agencies fail to reach all of the desired and ambitious targets. Governments then have no logical way of setting priorities or organising work, since many activities can be justified in terms of some target – but the capacity to implement all of them is limited. McClintock (1980) carries this argument one step further: strong support from the national political leadership is not enough. Goals of public programmes must also be supported by administrative officials at all levels. Moreover, the credibility of programmes is important for achieving this support (Manning 2001). Finally, as Cleaves (1980: 294) wrote 25 years ago about the post-World War II period when '[g]lobal planning with quantitative methodologies was promoted in international circles … [w]idespread optimism about man's ability to achieve economic development in the most unpromising situations … led to a condescending attitude toward gradual, grass-root solutions'. The MDG approach encourages such top-down strategies. Unfortunately they have a poor historical record (Pritchett and Woolcock 2004). Very strong political support for ambitious targets is a threat to evidence-based implementation that is credible among implementers and draws on much needed broad-based popular support and engagement.

These insights from the literature on capacity development and implementation illustrate that the proposed remedies for capacity problems in the MDG literature are rather simplistic. To Jeffrey Sachs and his collaborators, for example, capacity problems are simply opportunities for investments (Section 2). It appears that their focus is largely on cell A in Table 1 dealing with technical/functional capacity constraints within organisations. Yet one of the key findings of the capacity literature is that organisational changes are very often driven (in positive or negative directions) by changes in factors external to organisations (cell C and D) and by internal power relations (cell B).

Furthermore, the analytical reference point of Sachs *et al.* is that the additional funds required to reach the MDG-targets are modest given that the present aid/GDP levels of donor countries are far below internationally agreed funding targets. This is a relevant argument for increased aid, but does

not address the implications for public sector organisations in poor countries of major budget and staff increases with respect to their capacity to absorb and utilise significant additional resources to increase relevant products and services. That issue is not really dealt with in much detail by Black and White (2004) either. Their recent and otherwise comprehensive book on the MDGs contains, for example, no index entry on capacity. Several of its contributors simply state that the MDGs can be reached given 'committed leadership, stronger participation, extra money and deeper participation by the poor' (Vandemoortele 2004: 140, on the feasibility of the MDGs). In a similar vein Skeldon, writing on HIV/AIDS, states that the 'issue is now primarily one of political will' (2004: 270). The focus is more on what should be done than on how to do it.

Maxwell's 'reflections on the new "New Poverty Agenda"' in the Black and White book is a partial exception. He provides an interesting analysis of the implications of the use of results-based management that underpins this new agenda. His argument is that targets (like the MDGs) can be useful, because they clarify objectives, help to rally support and provide an instrument to reform public services. On the other hand, a narrow focus on targets and performance indicators may oversimplify and distort development efforts because they may encourage simple approaches to complex problems, overemphasise quantitative over (equally important) qualitative indicators, distort resource allocations and undermine professional motivation (pp. 30–3). However, there is no explicit discussion of funding and capacity issues *per se*.

## 4 Capacity implications of access to HIV/AIDS treatment[3]

That major additional funding can be a mixed blessing from a capacity point of view is illustrated by the HIV/AIDS initiatives now under way in many African countries in pursuit of MDG target 7: the spread of HIV/AIDS should be halted and reversed by 2015. A key recommendation by the Millennium Project (2005: 26) is that the WHO (2004) 'three by five' initiative should be implemented. This means providing antiretrovirals (ARV) to 3 million people by 2005, compared with the 400,000 on treatment in 2004. While this particular Quick Win on ARV is not representative of all of the 17 proposed by the Millennium Project, the very real capacity dilemmas and illusions posed by the MDG

approach are clearly illustrated by this case. Some specific examples are taken from Tanzania.

### 4.1 Evidence-based policy making in exceptional circumstances

Everybody agrees that the threat of HIV/AIDS is daunting, especially in Africa. Here the pandemic has devastating effects on individuals, families and communities. The disease is a growing threat to African societies – and to many in the rich part of world as well (UNAIDS 2002; de Waal 2003). The MDG target is therefore appropriate. The need for a major effort to halt and reverse the spread of HIV/AIDS on the continent is indisputable. An exceptional disease requires an exceptional response (UNAIDS 2004: 145–6).

From a capacity point of view, two decisions are especially important.[4] One is about the balance between prevention and treatment. The other is about the balance between HIV/AIDS activities and the funding of other activities in the health sector. These issues were central to the debate at the Copenhagen Consensus Conference last year, which endorsed HIV/AIDS as an important global priority. However, Mills and Shillcutt (2004: 7), the authors of the technical background paper on communicable diseases, concluded that:

> it remains unclear whether greater priority should be given to controlling one specific disease, such as malaria or HIV/AIDS, or to a package of priority health services, and the decision will depend to a considerable degree on total funding available. However it cannot be emphasised enough that these three opportunities are not completely independent – both malaria and HIV/AIDS control must include a substantial component of strengthening health services if they are to be successful.

The key message is that *stronger national health systems* are required. The authors also state that 'as ARV prices are changing rapidly and their effects in the developing world are highly uncertain, we have considered here primarily preventive interventions'. For the life-saving potential of ARV may well be exaggerated under present conditions:

> At current planned treatment coverage, we predict that (over the next decade) in Africa … the impact of ART on reducing HIV transmission

## Box 1: Current HIV/AIDS Treatment Initiatives in Tanzania

Tanzania is a good example of a country that faces enormous challenges to halt the spread of HIV/AIDS. A number of new initiatives are now under way. Access to ARV treatment is a major one.

As a result of the new initiatives on HIV/AIDS treatment in Tanzania, planned PLWHA targets (people living with HIV/AIDS and being on treatment) have increased very significantly within a short time (Hutton 2004: 17). In February 2003, the Ministry of Health (MOH) planned for 13,000 PLWHA by the end of 2006 (i.e. 3,000 additional people per year). Half a year later, assisted by the Clinton Foundation, the MOH planned to treat 151,000 PLWHA by the end of 2006 (i.e. some 50,000 additional people per year). In the meanwhile, the WHO's '3 by 5' initiative for Tanzania is based on an even faster acceleration of treatment, namely 220,000 by the end of 2005 (i.e. almost 100,000 additional people per year). These figures are truly scary as there are very few people under ARV treatment in Tanzania at present.

The hyper-fast acceleration in targets is reflected in the National Care and Treatment Plan (NCTP). To implement this plan will require an addition of 10,000 health workers. Another 68,000 health workers are needed to reach the other health-related MDGs. The current work force in health is around 43,000 (Hutton 2004: 22–3). Spending requirements for HIV/AIDS have been revised from US$60m per annum in the original 2003 MOH plan to the latest NCTP estimate of US$200m per year (p. 11–13). Spending on HIV/AIDS drugs alone will cost almost half of the present total Tanzanian health budget. There are few firm commitments for funding yet, but some bilateral donors and faith-based organisations are positive, and substantial funds are expected from various Global Health Initiatives (GHI) – especially the Global Fund for HIV/AIDS, TB and Malaria (GFATM).[5] The main foci of these GHIs are, formally, to support advocacy, improve ARV access, and, in most cases, to increase capacity. The government itself has allocated around US$3m per year for the HIV/AIDS activities. The proposed HIV/AIDS activities will be implemented in Tanzania during the coming years, although present plans are likely to undergo considerable changes in the process.

(and prevalence) is likely to be undetectable (unless accompanied by substantial changes in behaviour) (Blower *et al.* 2005: 2).

*Behavioural changes* among the sexually active are critical.

Current initiatives, however, prioritise – *de facto* – HIV/AIDS treatment over prevention; they focus on building capacity for this treatment rather than for the health system as a whole; they emphasise clear and measurable results by specific dates; and they involve very rapid increases in funding. In 2003, funding levels for the prevention and treatment of HIV/AIDS are estimated at around US$5bn. By 2005, the financing needs will have reached US$12bn and US$20bn by 2007. About 43 per cent of these resources will be needed in sub-Saharan Africa. Box 1 illustrates some of the efforts that Tanzania is making to make ARV treatment accessible for more people swiftly. Efforts in Uganda are similar.

There are two possible reasons for these implementation choices. One is that for the proponents of a massive effort to treat HIV/AIDS, this is a matter of life and death, which does not justify concerns with possible capacity implications. The other is that the financing for a very rapid expansion of access to treatment is coming on stream.[4] But as Grindle warns, policy making under such exceptional circumstances 'may cloud the actual problems involved in executing them'. This is illustrated in Box 1.

### 4.2 Social and political context

The strong focus on the funding and treatment of HIV/AIDS seriously underestimates the social and political aspects of the pandemic. Although building sufficient capacity in national health systems *is* a technical challenge (and one which does require substantial investments), it is also a political and social one as Table 1 illustrates.

First, social stigma surrounds the disease. It often prevents politicians and religious leaders from openly addressing the subject – or from addressing it aggressively enough to provide the political leadership necessary to drive the ambitious

treatment programmes and to make the public aware of their importance. Other politicians simply do not prioritise treatment.[6] In addition, the availability of ARV treatment may well contribute to the weakening of political support for systematic public action to combat the disease. In Uganda, for example, the President was able to 'forge a coalition behind an HIV/AIDS campaign in part because the virus largely ignored the privileges of wealth and political power. With the development of antiretroviral therapy and the access that the wealthy can gain to these drugs, this basis for the broadest possible coalition to fight HIV/AIDS may be weakened in the future' (Putzel 2004, abstract).

Second, as already mentioned, behavioural change is central for combating HIV/AIDS. It is hoped that ARV treatment may induce safe-sex behaviour. Easy availability of drugs will encourage people to be tested because now victims know that they can be treated. Moreover, people who know they are HIV-positive will act responsibly – that is, start to practice safe sex. Consequently, the availability of treatment will contribute significantly to reducing the spread of HIV/AIDS. The counter-argument is that treatment may also promote HIV/AIDS risky behaviour as some people may think (wrongly) that they can now be cured if they catch the disease. However, we know little about this.

Efforts to change sexual behaviour by promoting the ABC ('abstinence', 'be faithful,' 'condom') provide no easy remedies either. The rapid decline in HIV/AIDS prevalence in Uganda since the mid-1990s is used to argue that such changes can be brought about quickly. Consequently, significant changes in gender relations and sexual practices should have occurred. However, anthropological studies have not been able to identify such changes (Tersbøl and Silberschmidt 2003). Major changes in behaviour were not found either in a major new (yet to be published) survey of a 10,000 people in southern Uganda (Wawer *et al.* 2005). The most important reason for the observed decline in HIV prevalence in the area (roughly one-third from 1994 to 2003) was deaths. If these results stand up to scrutiny – and more importantly, are born out by surveys elsewhere in Uganda – it will seriously challenge the ABC strategy. The exception, according to the Wawer study, is an increase of condom-use in casual relationships (the promotion of condom use is specifically downplayed in President Bush's AIDS programme (PEPFAR for moral/religious reasons).

What are the capacity implications of this?

Whether on the 'prevention' or 'cure' side (both of which, of course, are needed), dealing systematically with stigma, identity, power, networks, and kinship systems is not something amenable to routinization and uniform administrative management, but rather entails a legion of discretionary and highly transaction intensive decisions (Pritchett and Woolcock 2004).

This requires motivation, skills and leadership throughout a nation's health system – and political support. It *is* possible to enhance such intangible requirements for organisational capacity development, but this takes time, and major additional funding is often not of central importance as Grindle (1997) has shown. We should therefore not be surprised if top-down Quick Win approaches to the HIV/AIDS problems may not work as efficiently as everyone hopes.

### 4.3 Organisational capacity: vertical programmes and collateral damage

Unique capacity problems arise because of the speed and scaling up targets for the treatment of HIV/AIDS envisaged in countries like Tanzania and Uganda. This puts heavy demands on national health systems. ARV treatment requires significant and life-long medical attention to ensure that patients comply strictly with regular drugs intakes (95 per cent compliance has been mentioned). This is much more demanding than the relatively simple (one-pill-a-day) and short-term (18 months) treatment of leprosy, for example, that many African health systems already have substantial difficulties in dealing with. 'The complexities of lifelong multi-drug therapies for people living with HIV and AIDS are far greater' (de Waal 2003: 18).

Weak public health systems in poor countries therefore need more organisational capacity to be able to utilise large increases in aid to combat HIV/AIDS. There seems to be widespread agreement on this (de Waal 2003; Hutton 2004; Mills and Shillcutt 2004). More doctors, nurses and auxiliary staff must be hired and trained (see Box 1). Additional clinics and laboratories for testing must be built, equipped and run. Logistics must be improved so that drugs can be transported to distant treatment centres. Administrators and accountants must be

hired and trained, too. And the management to run such activities efficiently – and to secure future external funding (on which much of the HIV/AIDS aids treatment depends) – must be strengthened. It is no surprise, therefore, that all the major GHI initiatives in Tanzania – apart from increased access to treatment – also focus on capacity building. There are, however, both financial and organisational reasons to be sceptical about the actual results of this.

First, according to Hutton (2004: 19), 'it is becoming clear that funds for HIV/AIDS will not contribute to general capacity development', but will lead 'to gross inefficiencies in resource allocation'. As evidence he quotes the Public Expenditure Review (PER) on HIV/AIDS in Tanzania from 2003, which shows that while the intention is to fund the NCTP from additional money, 'donor assurances of the additionality of funding cannot be verified and should probably not be believed'. Moreover, donors stress that the total budget for NCTP should be integrated fully in the health sector budget. Since the budget ceilings are stagnant, this has already resulted in a 20 per cent reduction in allocations for preventive services, the PER shows.

Second, in addition to these direct organisational effects of targeted funding, there are likely to be equally important indirect effects. Despite GHI statements about the intent to, and desirability of, integration into existing national systems, it is very doubtful that this will happen in practice. Most GHIs are likely to be implemented as vertical projects – albeit sometimes within existing institutional arrangements. GFATM, for example, is only a funding agency and must therefore implement through existing country agencies (government, NGOs, private sector). However, the focus on specific diseases is narrow; the funding volumes are very significant compared with existing funding in the health sector; special arrangements within existing national health sector systems are needed to assure quick access to ARV; and subsequent funding depends on meeting targets within a two to three-year period because funding is allocated on a competitive basis to reinforce incentives to perform.

The pressures to achieve HIV/AIDS relevant results fast are considerable. If put under such pressure, any organisation that has little or no excess capacity to start with, will respond by shifting attention to the high-profile activities. Such goal displacement is a well-known and age-old phenomenon. The high-profile focus on ARV treatment may therefore lead to reduced performance with respect to the other health-related MDG targets (e.g. malaria, tuberculosis, child mortality and maternal health).[7]

In fact, if rapid and significant improvements were to occur in one part of the health system, it may typically be at the expense of deterioration in capacity elsewhere in the system. This is happening in Denmark, a country with strong national health system, and is also documented for Britain (see Maxwell 2004: 32). Well-funded vertical programmes that are pushed with vigour risk causing collateral damage in other parts of the health system that do not receive similar attention.

## 4.4 The labour market

Finally, major additional injections of funds for HIV/AIDS treatment have significant labour market effects. The additional staff required in Tanzania is substantial (Box 1). In some countries, such as Kenya, unemployed health staff may be available. In others, there is a substantial shortage (Action Aid International, Global Aids Alliance *et al.* 2004) – especially if the geographical dimension of the health staff labour market is considered. A substantial increase in funding for HIV/AIDS treatment is likely to have substantial effects on the way that health staff will be deployed. These will be triggered in several ways. (1) Geographically, the shortage of staff is already pronounced in the poor and marginal districts of many countries (unemployed staff may well only exist in major cities, not in rural areas). The massive staff requirement implied by the ARV treatment targets may make it even more difficult to attract staff to these areas. (2) Public sector health staff will get incentives to move out of it: with the current lack of capacity in the present government health system, NGOs and the for-profit private sector will need to be mobilised and funded to reach the ambitious treatment targets. This will attract staff from among lower paid public sector health personnel, but only as long as the HIV/AIDS funds keep flowing. There are indications that this is already happening (Action Aid International, Global Aids Alliance *et al.* 2004: 21) thereby adding to the damage that the brain drain of African health staff to the North is already inflicting.[8] (3) Within individual health facilities, staff and equipment are likely to migrate towards the comparatively well-funded HIV/AIDS activities.

In many ways, therefore, lack of money is not the biggest obstacle to combating HIV/AIDS: lack of people is (Kurowski and Mills 2004). Moreover, the clear lesson is that HIV/AIDS capacity issue should not be addressed separately from those of the national health system. Finally, staff salaries and other incentives are important for capacity development and for preventing domestic and international brain drains. Therefore, government staff incentive policies (including salaries) are central instruments for capacity enhancement.

## 5 Proposals for remedies

Major additional funds, combined with ambitious and specific targets, present daunting challenges for capacity development in public sector organisations in poor countries. While more money *does* provide important new opportunities to increase capacity, it also entails risks. Some of them have been discussed here, particularly in relation to the MDG approach to combat HIV/AIDS. This disease poses unique problems, but it also illustrates, rather starkly, that major additional funding is far from sufficient to reach the MDGs. A number of problems must be addressed:

- the difficulties in making appropriate evidence-based decisions with sudden surges in funding
- the importance of political and social contexts of both the recipients and donors involved in capacity change activities
- the very real risks of collateral damage to existing capacity (destruction, redeployment and non-sustainability) by pushing well-financed vertical programmes like the GHIs in pursuit of specific but ambitious targets
- the enormous human resource implications of the MDG targets (availability, location, motivation, brain drain).

The view advocated in this article is that major additional funds are a mixed blessing for capacity development and organisational performance. This may sound like a counsel of despair. Sachs (2004: 2087), for example, in a comment on the Copenhagen Consensus Conference (in which he refused to participate), criticises its major idea – how best to spend additional funds of US$50bn over four years to deal with urgent global problems of development – as misguided, conservative and arbitrary, given the 'real movement towards larger

sums' of aid that we now see. Furthermore, he sees aiming that low is a self-fulfilling prophecy because 'the real opportunities that large assistance could provide – bigger ticket items such as scaled-up basic health services, are downplayed compared with narrowly targeted interventions'.

Indeed, low ambitions can be self-fulfilling. Unfortunately, large ambitions are not – although urgency is necessary for development efforts to succeed. However, the Millennium Project recipe – very demanding globally set targets, major additional funding for specific investments, a ten-year time horizon plus political will – is clearly too simplistic, especially from a capacity point of view. It is therefore important to find a balance between naiveté and cynicism.

The first remedy of relevance for capacity building is to *base government–donor cooperation and funding on country-specific MDGs* that reflect the actual situation on the ground (present status, existing capacities, domestic political priorities, etc.). This is also suggested by Birdsall (2004), Clemens *et al.* (2004) and Maxwell (2004). Such country-generated MDGs may be quite different from the globally set ones. The present official discourse on MDGs – like that on the heavily indebted poor countries (HIPC) debt relief initiative – has many similarities with past central planning approaches. Despite their apparent rationality, they generally failed miserably.

Second, *capacity development in the public sector should become a core development objective* in Africa. Capacity development has so far been regarded as collateral to other development priorities, and has been pursued without clear objectives (they are, furthermore, poorly tracked). Unfortunately, 'capacity development has not yet developed as a well-defined area of development practice', despite perennial statements by recipients and donors to the contrary (Operations Evaluation Department 2005: 5). More specific and evidence-based tools and methods for capacity development should be generated. They are not available and tested on a large scale yet.

Third, *sufficient time is as crucial as adequate funding.* Impatience for fast results is the 'deadly sin' of capacity development (Birdsall 2004: 5–12), both on the donor and the recipient side. Birdsall thinks that the ten-year planning horizon suggested by the Millennium Project is appropriate, but the capacity development literature suggests that it

often takes longer to achieve major upward shifts in capacity – sometimes 20 years or more. The challenge, as argued earlier, is to find an appropriate (context-specific) and implementable balance of incentives and power in favour of change, outside and inside the organisations developing capacity. Successful capacity development is recipient-driven and the donor track record on capacity development is generally poor, as it is now generally acknowledged (Operations Evaluation Department 2005). This seems to have been completely forgotten in the MDG approach. Major reforms of donor aid modalities are therefore needed if donors are to contribute significantly to capacity development.

## 6 Dilemmas

The Millennium Project – recently endorsed by the Commission for Africa (2005) – poses real moral and practical dilemmas. On the one hand, the moral case for more aid to alleviate poverty is compelling. Compare what rich countries and their citizens spend on the military, entertainment and pets, for example, with their help to alleviate human misery. That gap is morally indefensible for most. On the other hand, such comparisons are not particularly relevant at a practical level. For '[w]eak public sector capacity is widely acknowledged to be the key impediment to the attainment of poverty reduction goals' (Operations Evaluation Department 2005: 15). Capacity constraints are therefore binding. They influence the speed and direction of implementation towards the MDGs significantly. Such constraints cannot just be done away with by major additional funds, as shown here. This raises several practical dilemmas.[9]

Funding *is* important for dealing effectively with many development problems, including inadequate capacity. Setting development targets unrealistically high *may* raise efforts and concentrate minds. Thus, global leaders, whose support is central for raising additional funds, may find it more compelling to fulfil their officially declared obligations to specific – but unrealistic – MDG targets than to more modest (and broader) development targets, which may take decades to reach and therefore not be so politically appealing.[10] In other words, proponents would argue that the MDG approach should not just be judged on its technical merits ('can it be implemented?'), but on its ability to raise additional aid money and debt relief, and to improve trade conditions ('it can be done if we want to').

The dilemma here is that the approach chosen to raise substantial additional funds for development is not necessarily conducive to the implementation of the specified goals. For, despite the technical dressing-up of the Millennium Project (2005) and the Commission for Africa (2005) reports, they offer little realistic guidance on implementation, as the earlier examples on proposed capacity development measures illustrate.

Moreover, although the MDG-approach may help to mobilise additional funds right now, the crucial need is for a substantial and predictable flow of funds for development for the next decade and beyond. By increasing expectations about what immediate additional funding for development can achieve within a short period, the risk of 'failure' some years from now is increased. Indeed, as Clemens *et al.* (2004) point out, even African countries that do well on specific MDG targets by comparative and historical standards will, nevertheless, not reach them by 2015. They are 'off track' to use Millennium Project (2005: 20) terminology – not as a result of their own under-performance but because of over-optimism on their behalf by others. This makes, yet again, African countries vulnerable to criticism: despite much more aid, they do not meet expectations – they are failures (Therkildsen 2005). This politics of blame may well have negative longer-term effects on future aid flows. The dilemma is that while the MDG approach may help to raise funds in the short run, it may also help to undermine the basis for fundraising in the longer run.

These dilemmas could be eased in two ways. The oscillations between reckless optimism and paralysing despair that have marred development theory and practice for decades are unfortunate. Instead, the challenge of state capacity should be addressed by 'hopeful realism' (Levy 2004: 29). This is certainly better than to pretend that a surge in funding will create miracles in the fight against poverty, disease and powerlessness. Moreover, the MDGs should be viewed 'not as realistic targets but as reminders of the stark contrast between the world we want and the world we have, and a call to redouble our search for interventions to close the gap' (Clemens *et al.* 2004: 1). While it is essential to maintain the urgency reflected in the MDG approach, the lessons gained over several decades about what works and what does not in development should not be forgotten.

## Notes

* I wish to thank Torben Lindquist and Dr Finn Schleimann for their help. I am solely responsible for the result.

1. There are 63 candidate fast-track countries (32 of which are African; Millennium Project 2005: 52).

2. The literature on rapidly growing high-tech companies may be useful to study.

3. Thanks to Finn Schleimann, who has directed me to some of the medical literature referred to in this section and who has commented on an earlier version.

4. Leaving aside issues about the macroeconomic implications of major additional funding for HIV/AIDS (see the recent discussion between the IMF (2004), the NGOs (Action Aid International *et al.* 2004) and UNAIDS 2004).

5. WHO's '3 by 5' initiative provides no funding. Among the other GHIs in Tanzania are the Clinton Foundation; the World Bank's multi-sectoral HIV/AIDS project; the US President's Emergency Plan for AIDS Response (PEPFAR); and the Axios Programme (funded by the Abbott Laboratories). www.eldis.org/healthsystems/dossiers/hr/hiv (accessed 20 December 2004) provides a short description of the different global HIV/AIDS initiatives/foundations. Gordon Brown, the British Minister of Finance, has just announced the launching of major new funding for HIV/AIDS.

6. South Africa is the most prominent example. Dealing effectively with capacity issues in this context is obviously difficult (see, for example, 'Counting the cost of denial', *The Economist*, 5 February 2005).

7. New research indicates that the number of clinical events of malaria is much higher (+50 per cent in Africa; +200 per cent outside) than those reported by the WHO (Snow *et al.* 2004).

8. Three-quarters of all doctors in Ghana migrate to the North within ten years of completing medical school. Only 360 of the 1,200 physicians trained in Zimbabwe were still practising there in 2001 (Rosenberg 2004: 23). See also 'AIDS overwhelms African health systems', *International Herald Tribune*, 25 February 2005.

9. The dilemma that additional aid (and increased aid-dependency) may weaken political accountability in recipient countries is not discussed here (but see articles in *IDS Bulletin* 2002, Vol 33 No 3).

10. On 24 May 2005, European Union ministers agreed a dramatic increase in help to countries in Africa and the rest of the developing world. The EU's richest states agreed to give 0.7 per cent of national income in aid by 2015. The move will mean a virtual doubling of the EU's combined aid by 2010, when the rich 15 all pass the 0.51 per cent mark.

## References

Action Aid International, Global Aids Alliance *et al.*, 2004, *Blocking Progress: How the Fight Against HIV/AIDS is Being Undermined by the World Bank and the International Monetary Fund*, London: Action Aid

Birdsall, N., 2004, 'Seven deadly sins: reflections on donor failings', *Working Paper* 50, Washington, DC: Center for Global Development

Black, R. and White, H. (eds), 2004, 'Targeting development: critical perspectives on the Millennium Development Goals', *Routledge Studies in Development Economics*, London: Palgrave

Blower, S., Bodine, E., Kahn, J., McFarland, W., 2005, 'The antiretroviral rollout and drug-resistant HIV in Africa: insights from empirical data and theoretical models', *AIDS. The Official Journal of the International AIDS Society*, Vol 19 No 1: 1–14

Boesen, N. and Therkildsen, O., 2005, 'A results-oriented approach to capacity change', *Working Paper*, Copenhagen: Ministry of Foreign Affairs, Denmark

Cleaves, P.S., 1980, 'Implementation Amidst Scarcity and Apathy: Political Power and Policy Design', in M.S. Grindle (ed.), *Politics and Policy Implementation in the Third World*, Princeton: Princeton University Press

Clemens, M.A., Kenny, C., Moss, T.J., 2004, *The Trouble With the MDGs: Confronting Expectations of Aid and Development Success*, Washington, DC: Center for Global Development: 45

Commission for Africa, 2005, *Our Common Interest*, London: Commission for Africa

de Waal, A., 2003, 'How will HIV/AIDS transform African governance?', *African Affairs,* Vol 102: 1–23

Grindle, M.S., 1997, 'Divergent cultures? When public organizations perform well in developing countries', *World Development*, Vol 25 No 4: 481–95

Grindle, M.S. (ed.), 1980, *Politics and Policy Implementation in the Third World*, Princeton: Princeton University Press

Hutton, G., 2004, *Global Health Initiatives in HIV/AIDS in Tanzania: Situation Analysis and Review of Key Issues*, Basel: Swiss Tropical Institute: 31

IMF, 2004, *A Response to ActionAid International and Other Organizations*, Washington, DC: International Monetary Fund

Kurowski, C. and Mills, A., 2004, 'Expanding access to priority interventions: the human resources challenge', *Health Economics and Financing Exchange,* Vol 28: 2

Levy, B., 2004, 'Governance and Economic Development in Africa: Meeting the Challenge of Capacity Building', in B. Levy and S.J. Kpundeh (eds), *Building State Capacity in Africa: New Approaches, Emerging Lessons*, Washington, DC: The World Bank

Manning, N., 2001, 'The legacy of new public management in developing countries', *International Review of Administrative Sciences,* Vol 67: 297–312

Maxwell, D.J., 2004, 'Heaven or Hubris: Reflections on the New "New Poverty Agenda"', in R. Black and H. White (eds), *Targeting Development: Critical Perspectives on the Millennium Development Goals*, London: Palgrave

McClintock, C., 1980, 'Reform Governments and Policy Implementation: Lessons from Peru', in M.S. Grindle (ed.), *Politics and Policy Implementation in the Third World*, Princeton: Princeton University Press

Millennium Project, 2005, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals. Overview*, New York: UNDP: 74

Mills, A. and Shillcutt, S., 2004, *Challenge Paper on Communicable Diseases*, Copenhagen: Copenhagen Consensus: 67

Mkandawire, T., 2005, 'Aid, accountability and democracy', *Workshop on Governance, Economic Policy and Public Administration* (GEPPA), Copenhagen, 10 January

Operations Evaluation Department, 2005, *Capacity Building in Africa: An OED Evaluation of World Bank Support*, Washington, DC: The World Bank

Pritchett, L. and Woolcock, M., 2004, 'Solutions when the solution is the problem: arraying the disarray in development', *World Development*, Vol 32 No 2: 191–212

Putzel, J., 2004, 'The politics of action on AIDS: a case study of Uganda', *Public Administration and Development*, Vol 24 No 1: 19–30

Quick, S.A., 1980, The Paradox of Popularity: 'Ideological' Program Implementation in Zambia', in M.S. Grindle (ed.), *Politics and Policy Implementation in the Third World*, Princeton: Princeton University Press

Rosenberg, T., 2004, 'Aids', *Foreign Policy*, March–April: 22–27

Sachs, J., 2004, 'Solving global crises: economists alone are not enough', *Lancet,* Vol 364: 2087–8

Sachs, J.D., McArthur, J.W., Schmidt-Traub, G., Kruk, M., Bahadur, C., Faye, M. and McCord, G., 2004, *Ending Africa's Poverty Trap* 81, New York: United Nations

Skeldon, R., 2004, 'The Global Challenge of HIV/AIDS', in R. Black and H. White (eds), *Targeting Development: Critical Perspectives on the Millennium Development Goals*, London: Palgrave

Snow, R.W., Korenromp, E.L. and Gouws, E., 2004, 'Pediatric mortality in Africa: *plasmodium falciparum* malaria as a cause or risk?', *American Journal of Tropical Medicine and Hygiene*

Tersbøl, B.P. and Silberschmidt, M., 2003, 'Epilogue. HIV/AIDS Treatment and Prevention: Which Way Now? A Glance of the Current Situation', in B.P. Tersbøl (ed.), *Gender, Sexuality and HIV/AIDS*, Copenhagen: University of Copenhagen: 194–204

Therkildsen, O., 2005, 'Understanding Public Management Through Neopatrimonialism: A Paradigm for all African Seasons?', in U. Engel and G.O. Olsen (eds), *The African Exception*, Aldershot: Ashgate

UNAIDS, 2004, *2004 Report on the Global AIDS Epidemic*, New York: UNAIDS

UNAIDS, 2002, *UNAIDS Releases New Data Highlighting the Devastating Impact of Aids in Africa*, Geneva: UNAIDS

Vandemoortele, J., 2004, 'Are the Millennium Development Goals Feasible?', in R. Black and H. White (eds), *Routledge Studies in Development Economics*, London: Palgrave

Wawer, M.J., Gray, R., Serwadda, D., Namukwaya, Z., Makumbi, F., Sewankambo, N., Li, X., Lutalo, T., Nalugoda, F. and Quinn, T., 2005, 'Declines in HIV prevalence in Uganda: not as simple as ABC', 12th Conference on Retroviruses, Boston, MA, USA

WHO, 2004, *Investing in a Comprehensive Health Sector Response to HIV/AIDS: Scaling Up Treatment and Accelerating Prevention*, Geneva: World Health Organization