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Aid Effectiveness in Afghanistan: The Role of Local Human Capacity in Explaining the Health Sector's Success

Abstract

The effectiveness of development assistance is one of the most contested debates in international development studies. While some of its most ardent supporters consider aid as the key to solving the plight of the developing world (e.g. Sachs 2006), its opponents consider it as part of the problem rather than the solution (e.g. Moyo 2009). By investigating the case of Afghanistan as one of the world's largest aid recipients from 2002 to 2014, I show that one reason for arriving at such diametrically opposed conclusions lies in the narrow definition of aid effectiveness as income growth rates. When this definition is broadened to incorporate various development outcomes, however, one arrives at a more nuanced understanding of the aid effectiveness question and the conditions under which aid may be made more effective.

I situate my thesis within the contingency school that establishes the effectiveness of aid *conditional upon* certain factors. Specifically, in this theory-confirming case study (Lijphart 1971), I test the hypothesis that the pre-aid level of local human capacity is a key determinant of aid effectiveness, defined here as the attainment of development outcomes in areas such as health, education, and infrastructure. This is in contrast to prevailing arguments on the supply-side factors such as volume of development assistance (Sachs 2006) or demand-side factors such as good policy environment (Burnside and Dollar 2000).

In order to develop and test this hypothesis, I exploit the within country, cross-sector variations in the attainment of development outcomes between 2002 and 2014, as defined by the country's poverty reduction strategy paper, called Afghanistan National Development Strategy (ANDS). I find that achievements in some sectors - particularly health, education, and rural development - are far greater than those in other sectors, such as social protection and mining, although all sectors operate under essentially the same conditions. Using the method of process tracing, informed by significant desk review and fieldwork, I show that the variations in aid effectiveness across sectors are best explained by variations in local human capacity.

Focusing on health as the most successful sector as defined by ANDS, I trace this sector's success to local capacities developed through the decades of the 1970s, 1980s, and 1990s. During these decades, today's policy makers and health practitioners received their medical training and professional experience while delivering basic health care services inside Afghanistan and for Afghan refugees in Pakistan through working for different non-government organizations (NGOs). These experiences enabled them to play leadership roles in the country's development process in the early 2000s. The relatively higher levels of local capacity in medicine are not surprising in the context of Afghanistan, where certain professions, such as doctors and engineers, are highly sought-after because of their social prestige value. Furthermore, skill development in these fields is reinforced through a higher education system that admits only the best minds in these fields.

Two policy implications of the local human capacity hypothesis are especially pertinent. First, an intelligent allocation of development assistance should be informed by an extensive assessment of existing local capacities in the recipient countries. Second, while channeling development assistance in capacity-rich sectors could yield significant results, capacity-poor sectors are better served by carefully crafted investments in developing human capacity in line with Sen's (1999) capability approach.

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THE ROLE OF LOCAL HUMAN CAPACITY IN EXPLAINING THE HEALTH
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A Dissertation

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the Faculty of the Josef Korbel School of International Studies

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In Partial Fulfillment

of the Requirements for the Degree

Doctor of Philosophy

by

Ahmad Najim Dost

June 2016

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The effectiveness of development assistance is one of the most contested debates in international development studies. While some of its most ardent supporters consider aid as the key to solving the plight of the developing world (e.g. Sachs 2006), its opponents consider it as part of the problem rather than the solution (e.g. Moyo 2009). By investigating the case of Afghanistan as one of the world's largest aid recipients from 2002 to 2014, I show that one reason for arriving at such diametrically opposed conclusions lies in the narrow definition of aid effectiveness as income growth rates. However, when this definition is broadened to incorporate various development outcomes, one arrives at a more nuanced understanding of the aid effectiveness question, and the conditions under which aid may be made more effective.

I situate my thesis within the contingency school that establishes the effectiveness of aid *conditional upon* certain factors. Specifically, in this theory-confirming case study (Lijphart 1971), I test the hypothesis that the pre-aid level of local human capacity is a key determinant of aid effectiveness, defined here as the attainment of development outcomes in areas such as health, education, and infrastructure. This is in contrast to prevailing arguments on the supply-side factors such as volume of development assistance (Sachs 2006) or demand-side factors such as good policy environment (Burnside and Dollar 2000).

In order to develop and test this hypothesis, I exploit the within country, cross-sector variations in the attainment of development outcomes between 2002 and 2014, as defined by the country's poverty reduction strategy paper, called Afghanistan National Development Strategy (ANDS). I find that achievements in some sectors – particularly health, education, and rural development – are far greater than those in other sectors, such as social protection and mining, even though all sectors operate under essentially the same conditions. Using the method of process tracing (informed by significant desk review and fieldwork), I show that the variations in aid effectiveness across sectors are best explained by variations in local human capacity.

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ACRONYMS

2SLS	Two-Stage Least Squares
3SLS	Three-Stage Least Squares
ACBAR	Agency Coordinating Body for Afghan Relief
AHS	Afghanistan Health Survey
AMS	Afghan Mortality Survey
ANA	Afghan National Army
ANC	Ante-natal care
ANDS	Afghanistan National Development Strategy
ANHRA	Afghanistan National Health Resources Assessment
ANP	Afghan National Police
ARTF	Afghanistan Reconstruction Trust Fund
BHC	Basic Health Center
BPHS	Basic Package of Health Services
CDC	Community Development Councils
CGHN	Consultative Group for Health and Nutrition
CHC	Comprehensive Health Center
CHW	Community Health Workers
COD	Cash on Delivery
CPA	Country Programmable Aid
CPO	Causal-Process Observation
CTAP	Civilian Technical Assistance Program
DAC	Development Assistance Committee
DFID	Department for International Development
DH	District Hospital
DHMT	District Health Management Team
DSO	Data-Set Observations
EC	European Commission
EDA	Effective Development Assistance
EFS	Externally Funded Staff
EHP	Essential Health Packages
EIH	Easy Indicator Hypothesis
EPHS	Essential Package of Hospital Services
EPI	Expanded Program on Immunization
ESOC	Empirical Studies of Conflict
EU	European Union
FATA	Federally Administered Tribal Areas
FCH	Foreign Capacity Hypothesis
FCR	Frontier Crimes Regulations

FDI	Foreign Direct Investment
FSG	Fragile States Group
FSH	Financial Support Hypothesis
FSP	Fragile States Principles
GCMU	Grants and Contracts Management Unit
GDP	Gross Domestic Product
GNI	Gross National Income
HCTF	Health Coordination Taskforce
HDI	Human Development Index
HDR	Human Development Report
HIPC	Heavily Indebted Poor Country
HNSS	Health and Nutrition Sector Strategy
HSC	Health Sub-Center
IDP	Internally Displaced Person
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMR	Infant Mortality Rate
INCAF	International Network on Conflict Affected and Fragile States
ISAF	International Security Assistance Force
ISI	Inter-Services Intelligence
ISIS	Islamic State of Iraq and Syria
LBH	Low Baseline Hypothesis
LBH	Low Baseline Hypothesis
LICUS	Low-Income Countries Under Stress
MDGs	Millennium Development Goals
MHT	Mobile Health Team
MICS	Multiple Indicator Cluster Surveys
MMR	Maternal Mortality Rate
MoF	Ministry of Finance
MoPH	Ministry of Public Health
MOR	Murderous Outrages Regulation
MRRD	Ministry of Rural Rehabilitation and Development
NATO	North Atlantic Treaty Organization
NGO	Non-Government Organization
NHP	National Health Policy
NHS	National Health Strategy
NRVA	National Risk and Vulnerability Assessment
NSP	National Solidarity Program
ODA	Official Development Assistance
ODE	Official Development Effort
OECD	Organisation for Economic Co-operation and Development
OEF	Operation Enduring Freedom

OLS	Ordinary Least Squares
OOF	Other Official Flows
PADA	People’s Democratic Party of Afghanistan
PATA	Provincially Administered Tribal Areas
PETS	Public Expenditure Tracking Survey
PH	Provincial Hospital
PNC	Post-natal care
PPA	Performance-based Partnership Agreements
PRSP	Poverty Reduction Strategy Paper
RCT	Randomized Control Trial
RH	Regional Hospital
ROMAS	Reproductive Age Mortality Survey
SDGs	Sustainable Development Goals
SEM	Simultaneous Equations Modeling
SH	Specialty Hospital
SIGAR	Special Inspector General for Afghanistan Reconstruction
SM	Strengthening Mechanism
SWAP	Sector Wide Approach
TMAF	Tokyo Mutual Accountability Framework
UNAMA	United Nations Assistance Mission in Afghanistan
USAID	U.S. Agency for International Development
WDI	World Development Indicators

CHAPTER ONE: INTRODUCTION

Flow of resources from one country or region to another has always been an important part of the international system. However, foreign aid as we know it – or official development assistance (ODA) – dates back to the establishment of the Bretton Woods Institutions after the Second World War. ODA flows on average make about only 0.3% of donor countries' gross national income (GNI), which is far below the United Nations' 0.7% target. Regardless they play a critical role in some of the world's poorest countries that rely heavily on aid to finance development and provide basic public services such as health and education. Since 1960, more than US\$4 trillion in development assistance have been delivered. The annual volume of ODA disbursed in real terms has quadrupled from about US\$37 billion in 1960 to nearly US\$135 billion in 2014 (OECD-DAC 2014).

Afghanistan is a critical case study primarily because of the sheer volume of aid it has received in the last decade. In fact, based on the total amount of ODA received from 1960 to 2013, Afghanistan is the fifth largest recipient of development assistance, after India, Egypt, Iraq, and Pakistan respectively. However, in the post-2001 era, Afghanistan is now the second largest recipient of aid after Iraq. Together, Iraq and Afghanistan account for nearly 10% of all aid disbursed to developing countries between 2003 and 2013. Afghanistan alone has received more ODA during this period than the entire region

of Sub-Saharan Africa. At its peak in the late 2000s, Afghanistan has received nearly US\$7 billion in annual ODA, making up to 50% of its GDP and up to US\$250 aid in per capita terms. These reasons make Afghanistan a critical case study as “an extreme outlier in its dependence on aid” (World Bank 2012b, 9).

The growing volume of aid has been accompanied by a growing body of literature debating its effectiveness. In order to present a concise summary of this large and hard-to-amalgamate body of literature, I divide it into two broad clusters based on their presumed indicator of aid effectiveness. The first cluster, dominated mostly by economists with reductionist tendencies in their approach, equates aid effectiveness with the attainment of increased rates of growth in gross domestic production (GDP) in recipient countries. This characterization is in light of the claim that those with reductionist, essentialist, or determinist tendencies *reduce* causal relationships to a few determinant or essential variables, such as ODA and GDP growth rate in this example.

The second cluster adopts a broader definition of aid effectiveness, including the Human Development Index (HDI), poverty reduction, or attainment of other sector-specific development outcomes, such as life expectancy, mortality ratios, and school enrollment rates. This cluster may be called *anti-reductionist* for its refusal to reduce causal relationships – believed to be over determined by a myriad of factors – to a select few variables. Out of practical necessity, even anti-reductionist researchers may have to limit their attention to a manageable list of variables as long as they are “aware of and explicit about” the partial and incomplete nature of their analysis and results thereof (Wolff and Resnick 1987, 20).

The majority of the literature in the first cluster that equate aid effectiveness with the attainment of increased GDP growth rates may be divided into three broad categories on the basis of their hypothesized causal mechanism between ODA and GDP growth (Doucouliagos and Paldam 2009; Radelet 2006; Hansen and Tarp 2000). Those in the first category are influenced by the theories of factor accumulation and look for a relationship between ODA and growth via increased savings and investment in recipient countries. Those in the second category strive to establish the aid-growth relationship without any intermediary variables. Those in the third category, which I call *the contingency school*, estimate the relationship between aid and growth, conditional upon certain factors, such as the degree of civil liberties (Isham, Kaufmann, and Pritchett 1995), or good policy environment in recipient countries (Burnside and Dollar 2000).

The defining features of the reductionist cluster include parsimony, clarity, precision, a call to action, and universalism, thus making the categorization of the aforementioned literature easier. The anti-reductionist cluster, on the other hand, does not come with these features. In fact, it acknowledges and allows for some opaqueness and obscurity in dealing with complexity. Instead, it allows its adherents the flexibility to analyze complex issues while acknowledging the associated limitations. For example, a noted anti-reductionist thinker and Nobel Laureate, Amartya Sen (1992, 48) argues against over-precision in the domain of *wellbeing* as he considers it a “broad and partly opaque” concept.

I believe that while each of these clusters offers unique insights and advantages into social inquiry, any one approach on its own is incomplete. The combined application

of both approaches should, therefore, yield more interesting discussion and more fruitful results. As a result, this study unfolds over two distinct stages; one in line with the reductionist approach that statistically investigates the relationship between aid and GDP growth, and the other in line with the anti-reductionist approach that qualitatively investigates the relationship between aid and various development outcome indicators, such as mortality rates.

In the first stage, I undertake the conventional approach of assessing aid effectiveness in Afghanistan by attempting to show, quantitatively, whether increased volumes of aid have contributed to economic growth in the country. However, in the context of Afghanistan, where reliable data is extremely elusive, this type of quantitative analysis is extremely challenging at best. The available data, despite its fragmented and sometimes irreconcilable nature, is extracted from the World Development Indicators (WDI) (World Bank 2014), the Organisation for Economic Co-operation and Development's (OECD) and the Development Assistance Committee's (DAC) database on aid statistics (OECD-DAC 2014), complemented with data from the United Nations' National Accounts Main Aggregate Database (United Nations 2015), and the Afghan government's Ministry of Finance.

Data imperfections preclude the possibility of carrying out advanced statistical analysis. Therefore, I limit my analysis to identifying the degree of correlation between aid and GDP with some analysis using two-stage and three-stage least squares methods. The simple test reveals almost perfect correlation between levels of ODA and GDP, with the highest coefficient of 0.9473 between levels of GDP and nominal aid. This is not

surprising in Afghanistan where aid makes a significant portion of the economy and the non-stationary nature of both ODA and GDP levels over time.

Beyond the test of correlation, I use the available data to run simple time-series, ordinary least squares (OLS), two-stage least squares (2SLS) and three-stage least squares (3SLS) regressions, to analyze the direction and statistical significance of the relationship between the outcome and explanatory variables. In particular, I test five models, utilizing three measures of economic wellbeing (namely GDP growth rates, levels of GDP in current dollars and GDP per capita), and three measures of aid (namely, net ODA as a percentage of Afghanistan's GDP, net ODA in current dollars and net ODA per capita). I use different measures of aid and outcome variables to make up for the losses due to incomplete data in any one measure.

The OLS results indicate an overall positive relationship between aid and income. More specifically, I find that on average, a one percent increase in net ODA as a percentage of GDP is associated with a 0.035 percentage points increase in GDP growth rates. This finding, however, is not statistically significant. Replacing GDP growth rates with levels of GDP indicate that each dollar of foreign aid infused in the country is associated with a \$2.28 increase in levels of GDP for the period 1960-2014, and \$2.54 for the period 2001-2014. Lastly, I find that each dollar of foreign aid per capita is associated with a \$1.81 increase in GDP per capita for the period 1960-2014. However, from 2001 to 2014, each dollar of aid per capita is associated with increase of \$2.36 in per capita GDP. These results are statistically significant.

One of the key shortcomings of the above OLS estimate is the endogeneity of the aid variables and potential reverse causality. One way to mitigate this concern is to use instrument variables that are uncorrelated to the error term but are correlated with the outcome variable only through its effect on the instrumented independent variable. The secret key to this model, however, is finding the right instrument variable. Fortunately, in time series analysis, lagged variables are usually a good candidate for instrument variables (Wooldridge 2009). Therefore, using the first lagged variable of the independent variable, I run two-stage least squares (2SLS) regressions and estimate the coefficients discussed above. However, the results vary only slightly, and they fail the Hausman test to determine the superiority of 2SLS to OLS in this scenario. This is partly due to the limited number of data points given that the WDI database does not have any data for Afghanistan's GDP growth rate prior to 2002.

For this reason, I combine GDP growth rates from the UN National Accounts Main Aggregate Database (United Nations 2015), which includes data for Afghanistan's GDP growth rate from 1972 through 2014. Using this expanded dataset, I apply three-stage least squares (3SLS) to estimate the relationship between ODA and GDP growth rates. The resulting magnitude of the growth coefficient is higher than OLS estimates (0.035) and lower than 2SLS estimate (0.069). Specifically, the 3SLS estimate shows that a one percent increase in net ODA as a percentage of GDP is associated with a 0.054 percentage point increase in GDP growth rates. This relationship, however, is not statistically significant at 5% levels.

In summary, the macro level evidence yields ambiguous results about the relationship between foreign aid and economic development for at least three reasons. First, missing data for many indicators and over the course of many years significantly limit the scope and strength of statistical analysis. A larger dataset would have allowed for the possibility of running more robust tests. Second, one has to acknowledge the methodological limitations so as not to erroneously equate correlation with causation. These simple regressions only indicate correlations and the conditions for establishing causality have not been strictly satisfied. Last, all the three models (OLS, 2SLS and 3SLS) found positive, but statistically insignificant relationships between aid and growth, thus leaving the question on aid effectiveness, as narrowly defined by associated increase in GDP growth rates, unresolved.

The ambiguity of these macro results, coupled with the other significant challenges that Afghanistan continues to face, paints a grim picture of the effectiveness of foreign aid in the country. For example, Afghanistan ranks amongst the bottom 20 countries according to its Human Development Index (HDI) score (UNDP 2014). More than a third of the population continues to live below the official poverty line, three-quarters are illiterate, and more than a quarter are unemployed (World Bank 2014). Most importantly, much of the country's progress is heavily dependent on international assistance and the gains are vulnerable to threats from insecurity, corruption, and the illicit drug economy. It is therefore not surprising that even the Afghan government itself evaluates the effectiveness of development assistance as "unsatisfactory" (Islamic Republic of Afghanistan, Ministry of Economy 2014, 8).

The discussion above may leave one thinking that the billions of dollars spent through development assistance, not to mention the one trillion dollars spent on the military front (Bilmes 2013) in Afghanistan since 2002, were simply wasted or did not have significant positive impact. However, a deeper look reveals that Afghanistan has made significant strides on several fronts despite these continuing challenges. The scale and magnitude of these achievements come to the fore when one compares Afghanistan during the Taliban regime to Afghanistan in 2016. For example, some of the most important achievements of the last decade – although not all may be directly attributed to development assistance – include the introduction of new currency in 2002, public sector reform, democratic institution building, including the transfer of power through relatively peaceful and democratic elections in 2014, improved women’s participation in public life, and an extraordinary growth of the media.

On the economic front, the country has achieved an average GDP growth rate of 8.1% from 2003 to 2014, with relatively controlled levels of inflation, albeit with large fluctuations in both (World Bank 2014). The level of GDP has gone up from US\$2.4 billion in 2002 (or US\$3.7 billion in 1979, the highest in pre-2002 era) to more than US\$20 billion in 2013 and per capita income, in purchasing power parity, has more than doubled from about US\$700 in 2002 to nearly US\$1,600 in 2013 (World Bank 2014).

Gains in the areas of education outcomes are remarkable. For instance, the number of schools has more than doubled its 2001 levels, from 6,000 to more than 14,000 in 2014. Primary and secondary school enrollment has grown more than eight times its 2001 levels, from 1.1 million students to more than 8 million students in 2014, almost

40% of whom are girls. The country's higher education has also experienced significant growth, with the number of private institutions of higher education mushrooming from practically zero before 2002 to more than 150 in 2014 (World Bank 2014).

Health indicators illustrate even more progress made since the overthrow of the Taliban in 2002. As the number of health facilities has more than quadrupled from 496 in 2002 to more than 2,300 in 2014, health outcomes have dramatically improved. For example, maternal mortality rates have dropped by almost 80% from 1,600 per 100,000 live births in 2002 to 327 in 2014. Infant mortality rates were more than halved from 165 per 1,000 live births in 2002 to 68 in 2014. Mortality rates among children under 5 years of age declined from 257 per 1,000 live births in 2002 to 94 in 2014 (World Bank 2014).

How do we reconcile these signs of progress with the ambiguous results of aid-growth regressions? This is the case of the well-documented micro-macro paradox, in which Mosley (1986) found evidence of failure at the macro-level through cross country regression analyses between aid and growth. These failures coexist with evidence of success at the micro-level through ex-post project level studies that showed greater than ten percent rates of return. In the case of Afghanistan, this paradox may be interpreted in at least one of three ways. First, while Afghanistan has indeed achieved significant gains over the last decade, the gains are not large enough to account for the billions of dollars in development assistance spent in the country. Second, GDP growth rate is not the right indicator to measure the gains achieved, thus pointing to the inadequacy of the reductionist approach in answering the aid effectiveness question in Afghanistan. A third way to interpret this paradox is to accept both explanations above, yet view the micro-

level gains as an opportunity to identify differences in the performance of different sectors, thus uncovering the conditions under which aid may be more effective.

In fact, a closer look at the performance of aid across sectors in Afghanistan reveals dramatic variations in success. These variations are hard to explain given that all the sectors operate under essentially the same set of conditions that could impact their degree of effectiveness, such as (in)security, corruption, donor and government commitment, and fund availability. For example, although the country has made significant strides since 2001, particularly in basic health, education, and rural development sectors, it has fared less well in other areas such as social protection, mining, and urban development.¹ The sectors are selected from the ANDS, a document produced by the Government of Afghanistan that serves as the country's first and only Poverty Reduction Strategy Paper (PRSP) (Islamic Republic of Afghanistan 2008c).

This brings us to stage two of this study, which is complementary to the findings at the macro-level discussed in stage one. These variations in aid effectiveness across sectors can be exploited to explore answers to the main research question: why was aid most effective in the health sector in Afghanistan according to the latest evaluation of ANDS in 2014 (Islamic Republic of Afghanistan, Ministry of Economy 2014, 18). The answer to this question requires deeper analysis. The short answer posited by this study is one of the main reasons that best explains the relative effectiveness of development

¹ It may be argued that part of the differences in the performance of these sectors may be attributable to the differences intrinsic in the sectors. For example, it may be that achieving "success" in the mining sector is more difficult than that in the health sector. Although there is some merit to this critique, it has to be noted that such factors were taken into account while setting targets for each sector in the development of the ANDS document. This and other related critiques will be addressed more fully as "alternative hypotheses" in explaining the health sector's relative success in later chapters.

assistance in the health sector is the abundance of local human capacity in delivering basic health care services that have been developed over 1970s through 1990s. These findings, which form the thrust of my argument, may be generalized as follows: aid is likely to be more effective conditional upon the presence of *local human capacity* to help transform the development assistance inputs into meaningful outcomes for the recipient countries. In the specific context of Afghanistan, the argument runs as follows: the pre-aid level of local human capacity is a key explanatory factor for the relative effectiveness of aid in the health sector.

It is worth mentioning, however, that by calling the health sector the most successful, it is not to say that all health challenges in Afghanistan have been resolved. Instead, it is a *relative* description of the health sector compared to other sectors within Afghanistan. In fact, as it will be discussed in more detail in later chapters, significant challenges remain within the health sector. While the strides made at reducing maternal, infant, and child mortality ratios are indeed laudable, they continue to be among some of the highest ratios globally.

In order to identify the conditions under which aid is more effective, as in the health sector, I apply Mill's (1925) method of Concomitant Variation, which combines his method of agreement and difference. Mill's method of agreement or "most different design" involves a study with one common independent variable explaining common dependent variables. In the case of this study, this will involve the presence of a common factor that explains success in the health and education sectors. Mill's method of

difference or most similar design, on the other hand, involves a study with one differing independent variable explaining the differences in dependent variables.

In my study, this will require identifying one key explanatory variable that is present in successful sectors but absent in less successful sectors. The combination of the two, i.e. method of agreement and difference, is called Concomitant Variation and it involves the presence of a given set of explanatory variables in the successful cases (i.e. the health or education sector) and the absence of these same variables in the less successful cases (i.e. mining or urban development sector). This explains success in the former and lack of it in the latter cases. Conversely, it is well documented, including by Mill himself, that complete adherence to Mill's methods is not feasible in most studies in the social sciences. One solution is to combine Mill's method with the method of process tracing, defined as "a procedure for identifying steps in a causal process leading to the outcome of a given dependent variable of a particular case in a particular historical context" (George and Bennett 2005, 176).

I draw from both primary and secondary sources to feed into the process tracing method. In particular, this study relies on significant desk review of Afghan government and donor agency documents, including national budget documents from 2002 to 2014, national development strategy documents, national policy and strategy documents relating to the health sector – including the process of developing Afghanistan's Basic Package of Health Services (BPHS) and Essential Package of Hospital Services (EPHS) – program evaluation reports, and other related documents. In addition, primary sources of information include key informant interviews and focus group discussions with relevant

experts, such as the current health minister and others who played leadership roles in the early development process in the post-Taliban Afghanistan.

According to Mahoney (2010), the method of process tracing follows more closely the anti-reductionist approach, is fundamentally different from quantitative method because of the former's focus on causal-process observation (CPO), rather than data-set observations (DSO), which are more common in statistical analysis. While DSO refers to a general observation as understood in qualitative approaches, CPO refers to a "smoking gun" type of evidence that only comes to light with an in-depth knowledge of a particular case. This makes the method of process tracing a method of choice not only for hypothesis generating, but also for theory *testing*. In particular, Mahoney discusses three types of CPOs, which I attempt to apply in this study.

The first type of CPO is called Independent Variable CPO because of its focus on identifying the mere existence of a causally critical independent variable in the cases under investigation. In this study, I show that some of the most successful sectors, such as health, education, and rural development enjoy more abundant levels of local human capacity. Conversely some of the least successful sectors, such as mining and private sector development, suffer from lower levels of local human capacity.

Following Bayesian logic, the second type of CPO is called Mechanism CPO due to its focus on an "intervening event" that is critical in the causal chain that is posited a priori by the theory. In this study, I show that it is not just the mere existence of local human capacity that explains variations in aid effectiveness across sectors, but more importantly it's the way in which local human capacity gets organized, takes leadership

roles, and displays their ability to achieve results, which includes a focus on the sequence of events.

The third type of CPO is called Auxiliary Outcome CPO, given its focus on auxiliary “traces” or “markers” left behind by the causal explanatory variable. In my study, I show that one observable implication of the local capacity hypothesis is the reproduction of knowledge by Afghans. Afghan health experts have indeed displayed their abilities in reproducing knowledge by authoring peer-reviewed journal articles on rebuilding health systems, facilitated numerous conferences at the local and international levels, advised other developing and post-conflict country governments, and have actively promoted Afghanistan’s BPHS and contracting-out mechanism as a proven and successful model of health care service delivery in post-conflict environments. The combination of all the above three types of CPOs should provide credence in support of the local capacity hypothesis holding the key to explaining the health sector’s success.

According to Peter Hall (2006), the method of process tracing involves four steps. In the first step of “Theory Formation,” this study, situated within the contingency school of aid effectiveness literature, argues that aid is more likely to be effective conditional upon the presence of local human capacity in the respective sectors. The causal mechanism may be summarized as follows: local experts – with a deeper appreciation of local complexities and a greater sense of motivation – play leadership roles in the reconstruction of their societies and exercise leadership in the transformation of aid dollars into meaningful outcomes, thus contributing to more effective aid.

In the second step of “Deriving Predictions,” this study exploits cross-sectoral variations in aid effectiveness and predicts that aid will be more effective in sectors with relatively greater levels of local human capacity. In the third step of “Making Observations,” this study makes relevant observations on expected events, their sequence, and evidence on the causal chain. In particular, I expect a gradual, but early transfer of authority and responsibility to local experts as they earn the trust and confidence of their international counterparts in managing resources effectively and delivering results. The local experts should simultaneously display their skills, abilities, motivations, and ambitions to exercise true leadership and local ownership. In the final step of “Drawing Conclusions,” I present significant evidence to support the argument that local human capacity is indeed a central variable that determines the effectiveness of development assistance, as exemplified in the success of the health sector in Afghanistan.

In explaining the success of the health sector in particular, I consider four alternative explanations as rival hypotheses and reject them in favor of the local capacity hypothesis to increase confidence in the local capacity hypothesis (Bennett and Elman 2006). The first rival hypothesis, Financial Support Hypothesis (FSH), may attribute the success of the health sector to the massive financial support by the donor community. While the significance of donor support in reconstructing the health system in Afghanistan cannot be denied, I show that more aid alone does not make success, because some sectors with higher budgets are among lower performers and vice versa. The second rival hypothesis, Easy Indicator Hypothesis (EIH), may attribute the success of the health sector to how success was first defined by selecting easier to achieve targets and

indicators for the health sector. This argument, however, fails to explain the health sector's success relative to other sectors because a) targets and indicators were set under the same rules and conditions for all sectors, and b) the indicators selected for the health sector, were mostly set at the level of outcome and impact- such as mortality rates- are not easy to achieve. In fact, some less successful sectors have selected much easier to achieve targets and objectives at the output level in their monitoring matrices.

The third rival hypothesis, Low Baseline Hypothesis (LBH), may argue that the indicators in the health sector were at such low levels in the post-war period in 2002 that any minor push would result in significant gains, thus casting doubt on both the baseline data and the resulting magnitude of success. In fact, a seminar featuring Dr. Kenneth Hill of Harvard School of Public Health questioned if the gains in Afghan health were “too good to be true” (Center for Global Development 2012). This hypothesis, however, is not supported by data because we do not observe a significant dip in key health statistics at the time of the baseline survey. In addition, we observe consistent trends in key determinants of mortality, including lower fertility rates, improved immunization coverage, and increased rates of skilled birth attendance.

Finally, the fourth rival hypothesis, Foreign Capacity Hypothesis (FCH), may attribute the health sector's success to foreign technical assistance, or international Externally Funded Staff (EFS). I find, however, that the concentration of international EFS is not correlated with the degree of success across sectors. In fact, some of the most successful sectors, including the health sector, have some of the lowest rates of

international EFS, thus rejecting the foreign capacity hypothesis, in favor of *local* capacity hypothesis.

An in-depth process tracing of the health sector reveals that the driving force behind the success of the present-day health sector in Afghanistan lies in the decades of the 1970s, 1980s, and 1990s. During these decades, today's policy makers and health practitioners received their medical training and professional experiences while delivering basic health care services inside Afghanistan and for Afghan refugees in Pakistan through different NGOs. These capacities manifest themselves during the discussions and policy decisions of the early 2000s. In particular, the decision to adopt a contracting-out strategy, in which the task of health care service delivery was outsourced to NGOs and the Ministry of Public Health's (MoPH) role was limited to stewardship only.

Afghan experts also played key leadership roles in the development of national policies and strategies and in particular, the development of the BPHS and later the EPHS to the hospital sector. The BPHS was developed with twin purposes in mind: "(1) to provide a standardized package of basic services which forms the core of service delivery in all primary health care facilities and (2) to promote a redistribution of health services by providing equitable access, especially in underserved areas" and it served those purposes well (Transitional Islamic Government of Afghanistan, Ministry of Health 2003). Together, BPHS and EPHS defined the health system in its entirety from the health posts at the village level to specialized hospitals in key urban areas.

The argument about local human capacity explaining the top three most successful sectors – health, education, and rural development – is not surprising in the context of Afghanistan where the top three most sought-after occupations happen to be medical doctors, engineers, and educators. Consistent with the cultural preference for these fields, the Afghan higher education system further reinforces this phenomenon by admitting only the top scorers in the annual university entrance examinations, to these fields, especially in the study of medicine and engineering.

The policy implications of this finding are numerous. First, this study is an acknowledgment to the simultaneous existence of both success and failure within the debates over aid effectiveness in the context of Afghanistan. Second, this finding on the importance of local capacity in determining aid effectiveness moves the debates away from supply-side explanations to the status of local human capacity in recipient countries. Third, it informs policy by advising the international community and local governments to conduct a thorough analysis of existing capacities, including but not limited to human capacity, before deciding on aid allocation across sectors. In the relatively capacity-rich sectors, foreign aid dollars could produce faster and more tangible results. Conversely, in relatively capacity-poor sectors, foreign aid resources are better spent on developing local capacity rather than expecting aid dollars to buy outcomes without the needed local human capacity to transform those resources into valuable results. This is in line with the decades-old call for investing in human development through the annual Human Development Report, first published in 1990 (UNDP 1990), whose foundations were

built by the pioneering works of many, including two Nobel Laureates (Schultz 1981; Sen 1999; K. Haq and Kirdar 1986; M. ul Haq 1995).

The rest of this study is organized as follows. Chapter II presents the historical context of Afghanistan, because the study of aid effectiveness in a place like Afghanistan cannot ignore the country's troubled history and regional politics. This chapter will pay close attention to two key determinants of security and political stability, namely internal cleavages along ethnic and ideological beliefs and external dynamics, especially relationships with Pakistan. This relationship is believed to hold the key to security in the region through their influence in bringing insurgents to the negotiating table.

Chapter III presents an extensive review of literature on foreign aid effectiveness and debates to date on what foreign aid is, how it compares to other sources of development finance, why donor countries give aid, especially in light of scant evidence to support the claim that aid leads to economic growth, and finally how this study fits within the broader debates on aid effectiveness.

Chapter IV is an attempt to provide a macro-level quantitative analysis of the relationship between various measures of aid and economic development, in particular GDP growth. The results, however, are inconclusive owing to small number of data points. This chapter, therefore, produces a first attempt at running OLS, 2SLS, and 3SLS regressions between ODA and growth rates. The lack of conclusive results helps segue to Chapters V through VII, which seek to answer the main research question, i.e. why was aid in Afghanistan most effective in the health sector.

Chapter V provides an overview of the key priority sectors as identified through the country's Poverty Reduction Strategy Paper, called the ANDS. After presenting a ranking of the sectors according to the percentage of the targets they had achieved in 2014, this chapter delves deeper into the main objectives, targets, and indicators of the health sector, as the most successful sector in Afghanistan.

Following from the previous chapter, Chapter VI asks the following question: what explains the health sector's remarkable success, especially when all the sectors operate under essentially the same conditions and environment. Using Mill's method of concomitant variation combined with process tracing, this chapter maps out the process of rebuilding the health sector in the early 2000s after the health system was almost completely broken during the three preceding decades of war and conflict. After a careful consideration of four alternative hypotheses, this chapter concludes that the presence of pre-aid levels of local human capacity best explains the success of the health sector and by extension the variations in the degree of effective utilization of aid by all sectors in Afghanistan.

Chapter VI concludes the study by providing further evidence to test the local capacity hypothesis in the health sector, followed by a discussion of policy implications.

CHAPTER TWO: THE COUNTRY CONTEXT

The study of aid effectiveness in Afghanistan cannot ignore the country's troubled history and regional politics. The state's ability to deliver public services such as health care and education is directly related to the state maintaining authority, legitimacy, and capacity (Evans, Rueschemeyer, and Skocpol 1985). Given Afghanistan's historical context, security and development are intertwined, one affecting the other in a dynamic interaction. In particular, security becomes an essential precondition for development, and development, in turn, can have a multiplier effect on the positive spillovers of improved security. In fact, the 2011 World Development Report (World Bank 2011) focuses on the nexus between conflict, security, and development, and illustrates that based on international experiences, the absence of security – especially the protracted type like the one that has defined Afghanistan's recent history – particularly hampers prospects of development.

This chapter will set the stage by describing the country's context, focusing on what lies at the roots of the security challenges in Afghanistan, especially pertaining to their impact on aid effectiveness. In order to achieve this end, I will divide the relevant context into two time periods, pre- and post-2001 eras. This delineation is helpful because the year 2001 was a turning point for Afghanistan's development. Although Afghanistan has almost always relied on external sources of revenues to finance its

development, including significant development assistance from the Soviet Russia during the Cold War, it was not until post-2001 that Afghanistan took the center stage as one of the largest recipients of development assistance in the world.

In each time period, I focus on two overarching issues. In the pre-2001 era, the first issue worth highlighting is the internal social cleavages, particularly along ethnic and ideological lines. The second major issue is Afghanistan's external relationships, predominantly with Pakistan. Both these issues have significant bearing on the study of development in Afghanistan today with strong path-dependent effects. For example, ethnic divisions were at the roots of the 2014 election irregularities, which led to the creation of a National Unity Government headed by representatives of the two dominant ethnic groups, Pashtuns and Tajiks. Similarly, the elusive search for an end to the country's insecurity, which has overshadowed development efforts since 2002, cannot be fully understood without addressing the roots of the conflict at the local and regional levels.

In the post-2001 era, I will focus on the nature of external development assistance, making Afghanistan one of the world's largest recipients of aid. The second relevant issue is the way in which local capacities in certain fields, particularly basic health, education and engineering, manifested themselves in the process of post-2001 reconstruction of the country. As it will be made clear throughout this research, the relative abundance of technical human capacity in certain sectors is the result of two main factors. The first factor is the Afghan society's conscious efforts to value some professions, such as medical doctors, engineers, and educators, over others. The second

factor relates to the honing of these skills in the process of delivering basic health, infrastructure, and education services for Afghans in Afghanistan and for Afghan refugees in Pakistan through working for various international and national NGOs during the 1980s through the early 2000s. I refer to this as an unintended consequence of aid delivery during the decades of conflict, because capacity building was a by-product of aid delivery. The main purpose of the international engagement during this period was to provide basic essential services in response to the conflict in Afghanistan.

Background

Afghanistan is a landlocked country, with terrain characterized by rugged mountains through much of the country, and sprawling deserts to the south and west. Its geo-strategic location in the heart of Asia makes it an important transitory artery on the legendary Silk Route. A modern continuation of Afghanistan's central role in the region is under discussion on building a pipeline to transport natural gas from Turkmenistan, through Afghanistan, to Pakistan and India, thus named TAPI based on the first letter of the name of each country involved. The discovery of multi-trillion dollar natural resources² has the potential to form the backbone of the future economy of the country, but it is equally likely to become a bone of contention between different local and international groups all vying to share a piece of the pie.

According to the latest population estimation in 2015, less than a quarter of the country's 27 million people live in urban areas. The vast majority of the population is

² http://www.businessweek.com/magazine/content/10_26/b4184016388417.htm

classified as rural – where agriculture makes the primary source of income (Central Statistics Office, Afghanistan 2015).³ The two dominant ethnic groups in Afghanistan are Pashtuns and Tajiks, whose Pashto and Dari languages form the two national languages of the country.⁴ Reflecting the ethnic diversity of the country, the 2004 Afghan Constitution mentions fourteen ethnic groups by name (Islamic Republic of Afghanistan 2004).

Social Cleavages

Afghans take great pride in their over 5,000 year old shared history in the region. Invasions and expansionary wars by the Persians, early Islamic caliphate, Mongols, British and the Russians have resulted in the constant shift of people and borders. A closer look at Afghanistan's past will reveals that the country's history has been marred by a state of war, instability and armed conflict. The nature of these conflicts, however, varies from one context to another. For example, some of the most intense and sustained conflicts have included direct wars with foreign occupying forces, such as the three major Anglo-Afghan wars of the 19th and early 20th century, the Cold War and the Soviet invasion in the 1980s, and the 2001 American invasion of Afghanistan after the events of 9/11. Throughout history, one can point to only a few instances of relative stability, the longest episode of which was during King Zahir Shah's forty-year reign from 1933 to 1973.

³ The last census conducted in Afghanistan was in 1979.

⁴ These include "Pashtun, Tajik, Hazara, Uzbek, Turkman, Baluch, Pachaie, Nuristani, Aymaq, Arab, Qirghiz, Qizilbash, Gujur, Brahwei and other tribes" (Islamic Republic of Afghanistan 2004 Chapter 1, Article 4).

Fast forward thousands of years of history and zoom in on the last two centuries alone (since much of Afghanistan's present day borders and inhabitants were fixed around the mid-18th century), the internal cleavages within the Afghan society have been at the root of much of the conflicts. In particular, one pressing source of division within the Afghan society has been the domination of the public office along ethnic lines, which has led to severe grievances on the part of the minorities who feel excluded and let down by the ethnic majority in power. For example, out of the country's last 268 years since the formation of present-day Afghanistan in 1747 by Ahmad Shah Abdali (later known as Ahmad Shah Durrani and also known as Ahmad Shah Baba, as Baba is a nick name signifying respect to the ruler as the father of the nation), ethnic Pashtuns have dominated public office for the entire period with two exceptions. One was a nine-month-rule in 1929 by a non-Pashtun, Habibullah Kalkani, also known as Bache Saqao or the son of water carrier, who was hanged in Kabul presidential palace two weeks after being forced out of the palace by forces loyal to Nadir Shah. The other exception was the four-year-rule by Professor Burhanuddin Rabbani, an ethnic Tajik, during the tumultuous early 1990s. He, too, was assassinated in a suicide attack in his home in Kabul on September 20, 2011. The present-day National Unity Government is a form of Lijphart's (2004) consociational democracy with some decentralization and power-sharing between the Pashtun president, Ashraf Ghani and Tajik Chief Executive, Abdullah Abdullah.

Even within the Pashtuns, which make up the majority of the Afghan population (although exact estimates are both unavailable and unlikely to be made available given the sensitivity of the topic) central authority has been concentrated around two families,

both coming from Kandahar province. One was the Durrani family who formed the Durrani Dynasty starting from Ahmad Shah Durrani in 1747, and the other was the Barezai Dynasty starting in 1826 with Amir Dost Mohammad Khan until the end of Dawood Khan's reign in 1978. Over the many years, these cleavages have divided the population along ethnic lines and created various alliances and oppositions that continue to plague the country through to present day.

In addition to the ethnic divide, the infamous Communist coup d'état of Haft-e-Sour (the seventh day of the Afghan solar calendar month of Sour, equivalent to April 27, 1978) and the ensuing Soviet occupation of the country a year later, opened a new bloody chapter in Afghanistan's history. This has added yet another layer of estrangement to the already deeply divided Afghan society, the ramifications of which continue to haunt the country. For example, many families were torn apart as some members drifted towards the Communists and others towards the Mujahedeen in the 1980s. Even more tragic is the fact that many others who did not side with any group were assumed to belong to one group or the other on the basis of the most trivial indicators. Growing a beard, for example, could be seen as a sign of religiosity, thus siding with the Mujahedeen, or sending one's female members of the family to school as a sign of progressiveness, thus proximity to Communist ideology. Throughout the past four decades, many have been detained, tortured, killed or forced to flee the country due to these issues. Even in today's National Unity Government, many otherwise competent people are dismissed for their alleged past affiliations with certain groups. This is especially tragic today when the

country needs competent Afghan leaders in all fields to partake in the country's rehabilitation process.

The start of the Communist coup d'état in 1978 and the take-over of the country by the Mujahedeen (which toppled the government of Dr. Najibullah, the last president of the extension of the Communist rule) in 1992 share more than a mere resemblance in the date; one happened on Haft-e-Sour (the seventh day of Sour, or April 27th) and the other fourteen years later on Hasht-e-Sour (the eighth day of Sour, or April 28th). The Communist coup of 1978 by the People's Democratic Party of Afghanistan (PDPA)⁵ is marked as a dark day in Afghan history for violently ending the five-year rule of Dawood Khan and thus opening another bloody chapter in Afghan history, which continues to drag the country and its people into a state of warfare and conflict up to this day. It is important to note that Dawood Khan, Zahir Shah's cousin and brother-in-law, ended the forty-year-rule of Zahir Shah in a bloodless coup on July 17, 1973. Upon taking office, he ended monarchy and declared Afghanistan a republic. However, at the hands of PDPA officials, Dawood Khan and his entire family were executed and buried in a mass grave in Kabul's notorious Pul-e-Charkhi prison. It was not until three decades later in 2008 that they were given state funerals during the Hamid Karzai's rule.

The event of the 8th of Sour (April 28, 1992), which marked the end of the Communist rule and the beginning of the Mujahedeen take-over, is much more

⁵ The PDPA consisted of two main factions, the Khalq (or people) and Parcham (or Flag). The first year after the coup saw Khalqi dominance as Noor Mohammad Taraki, followed by Hafizullah Amin, came to power and started a crackdown on the Parchami opposition. Then, Babrak Karmal of the Parcham faction took over until he was replaced by Dr. Najibullah, the last of the Communist leaders, in 1986. Dr. Najibullah, being in staunch opposition to Pakistan, was hanged in public and his body was dragged on Kabul streets by the pro-Pakistani Taliban on September 27, 1994.

controversial. To the Mujahedeen and their supporters, it is a special day deserving much veneration for freeing Afghanistan from the yoke of Communist oppression and the victory of Islam. For its detractors, however, it is a day even worse than the Communist coup of 1978, because the in-fighting over power of the Mujahedeen in the early 1990s not only destroyed Kabul and killed and maimed thousands of people, but it did so in the name of Islam and Jihad, concepts that are near and dear to the 99% Muslim population of the country. Controversy surrounding these two dates brings about strong emotions and heated debates as the two dates are compared and contrasted each year.

Ironically, the event of Haft-e-Sour is in a sense the reason for the event of Hasht-e-Sour to take place fourteen years later. Five years after the rule of King Dawood Khan, the Communist Party of PDPA took over the government in 1978 and promoted state atheism, which paved the way for Soviet invasion a year later. It was during this time that the state was unable to satisfy the ideological needs of the majority of Afghans who opposed state atheism. It was at this juncture that saw the rise of the Mujahedeen movement, most of whom were university students then, some operating in remote rural areas and others being welcomed in neighboring countries, especially Pakistan. I refer to the major Sunni groups as the Group of Seven. The ethnic minority group of Hazaras and other Shia minorities formed their own groups under the leadership of Mohsini and Mazari. The Mujahedeen were also primarily organized along ethnic lines.

The Durand Line Agreement

On the external front, although Afghanistan shares borders with six countries (Pakistan to the south and east, Iran to the west, Turkmenistan, Uzbekistan, and

Tajikistan to the north, and China to the north-east), Pakistan remains the most important neighbor, given its role in Afghanistan's security and political stability. In fact, the mountainous region around the Afghanistan-Pakistan border has been the perfect sanctuary for extremist groups, including the Taliban and affiliates of Da'ish or the Islamic State of Iraq and Syria (ISIS). Much of the present-day political tensions between Afghanistan and Pakistan can be traced to the disputed border between the two countries, known as the Durand Line, which dates back to 1892, long before the birth of Pakistan in the 1947 partition of British India.

Afghanistan's relationships with Pakistan have remained tense for much of history. The tensions began long before the birth of Pakistan and can be traced to the 18th century rivalries between Tsarist Russia in the north and British India in the south. Much of the present day tension between Afghanistan and Pakistan can be traced to the British policies, in particular the drawing of the arbitrary line, known as the Durand Line, to mark the disputed border between Afghanistan and Pakistan. One of the reasons behind signing the Durand Agreement was to end the hostilities between Afghanistan and British India, which had previously led to several wars of expansion and in particular two major Anglo-Afghan wars in 1839 and in 1878.

The 18th and 19th century antagonism between the two great powers of the time, the Victorian England and the Tsarist Russia, resulted in a real "Great Game" in Central Asia, with Afghanistan's rough terrain being used as both the buffer zone and the battleground (Hopkirk 1994). The constant shifting of the spheres of influence of the two powers ostensibly upset Afghanistan, and by extension, the entire region. For example,

the first Anglo-Afghan war was in fact a Russian-English war of influence, fought by Afghans and Indians on Afghan soil, over the threat of the expansion of each other in the region. The armies of Rangit Singh, led by Hari Singh, had faced the Afghan army earlier in the 1920s, which led to the end of the first rule of Shah Shuja (known as the British puppet among Afghans) and the beginning of the Barekzai Dynasty led by Amir Dost Mohammad Khan. This Great Game finally ended after three major wars, almost forty years apart, each at 1840, 1880, and 1919. The third Anglo-Afghan war, also known as the war of Afghanistan's Independence, ended on August 8, 1919 with Amanullah Khan earning Afghanistan's complete independence and autonomy, especially over its foreign policy (Sidebotham, 1919).

The history of the Durand Line goes to late 19th century relations between the Afghan rulers, in particular Amir Abdurrahman Khan, and British India. In particular, Amir Abdurrahman Khan was indebted to the rulers of then British India for helping him get to power, and as a result, he would return the favor by appeasing the British representatives in some of the most important and consequential decisions. Two of the most highly consequential decisions included the accepting of the provisions of the Treaty of Gandomak (which included the relinquishing of foreign policy to the British, something which he could have renegotiated) and a decade later signing of the agreement on the Durand Line on November 21, 1893 between Sir Henry Mortimer Durand and Amir Abdurrahman Khan.

The 2,640 km line cuts through the middle of Pashtun and Baloch tribes, dividing them into two arbitrary groups now on different sides of the Afghanistan-Pakistan border.

In fact, the Baloch are scattered throughout three countries (Afghanistan, Pakistan and Iran). Since inheriting this line upon their independence from the British rule in 1947, both Pakistan and Afghanistan have been fighting over and paying a heavy price for the seed of destruction planted by the British Empire. For example, the signatories of the agreement have long been buried but their destructive legacy continues to haunt the present-day people of Afghanistan and Pakistan. Significant controversies surround the nature and fate of the agreement more than 120 years after the signing of the treaty. One theory, albeit weak in nature, suggests that the Durand Line was theoretically invalid based on the following reasons: a) Amir Abdurrahman Khan signed the agreement under pressure from the British Empire because the Amir owed his rule to them; and b) that the only signed document was the English version and the Amir could not read or understand English. Regardless of the plausibility and strength of these arguments, the people on both sides of the border have rarely treated the border more than a mere line on paper. Pashtuns on both sides of the border have always traded, migrated, inter-married, and straddled the line in defiance of the existence of the line and they continue to do so.

One of the most striking examples of Pashtun solidarity relates to the story of Khan Abdul Ghaffar Khan, a Pashtun independence activist and a close friend of Mahatma Gandhi, who at his own request, was buried across the border in Jalalabad, Afghanistan upon his death in January 1988. His burial took place at a time when the Soviet Army was still in Afghanistan and the Mujahedeen were actively fighting the then government of Dr. Najibullah. Despite the security risks, tens of thousands of mourners marched from Peshawar to Jalalabad, stepping on the Durand Line on their way in a

symbolic display of Pashtun unity. Ghaffar Khan's grandson, Asfandyar Wali Khan, a Pakistani Member of Parliament and president of the Awami National Party, is noted for making headlines for his strong stance on Pashtun solidarity on both sides of the border and for constantly echoing that the "Durand Line is not acceptable to anyone" (Afghanistan Times 2015, 1).

Another complementary theory about the Durand Line, although not confirmed by Pakistani sources, claims that the agreement would be null and void 100 years after its signing date, after which the people of the region would decide whether they want to remain under the British rule (now Pakistani rule) or the Afghan rule or choose to remain autonomous. It is not a coincidence that exactly 99 years after the passage of this agreement, i.e. in 1992, Pakistan unleashed the Mujahedeen groups that they had hosted, trained, and financed for over a decade. The idea would have been to wreak such havoc in Afghanistan in early 1990s that neither Afghanistan would be in a position to reclaim their lost territory nor would the people southeast of the border would choose to leave the relative peace of Pakistani rule and be governed under the shattered Afghan flag. In fact, former president, Dr. Najibullah had predicted this scenario before vacating the palace in 1992. The alternative scenario he had predicted was the imposition of a puppet government in power in Afghanistan that would be more Pakistan-friendly.

The rise of the Taliban, directly housed, trained and supported by Pakistan, after the Mujahedeen lent further credence to this hypothesis. The close ties between Pakistan and the Taliban, much to the chagrin of Pakistani government who try to deny it, have come to the forefront of the media now. For example, famous Pakistani author and

journalist, Ahmed Rashid (2008, LII) calls Pakistan “the base area, recruiting ground, and logistics center for both al Qaeda and the Taliban.” Furthermore, on February 13, 2015, the ex-president of Pakistan and army chief, Perves Musharraf, admitted that “Pakistani spies in the Inter-Services Intelligence directorate (ISI) cultivated the Taliban after 2001” (Boone 2015). In addition, there are many other media sources establishing the links between Pakistan and the Taliban insurgency.

Pakistan: an Insecure Neighbor

In addition to the Durand Line predicament, Pakistan has also been struggling with several other thorny domestic and regional issues, such as a national identity crisis, dominant military, including frequent exercise of Martial Law, and uneasy relationships with its neighbors, including Afghanistan to the north and west and India to the south and east. Most of the troubles in Afghanistan with Pakistani connection can be traced to one or more of these issues, which can in turn be traced to some of the practices in the colonial era. On the issue of identity crisis, Ian Talbot’s (2005, 1) opening sentence in his book on *Pakistan: A Modern History* is illustrative of the point:

Pakistan for much of its history has been in a state searching for a national identity. The overlap of regional, Pakistani and religious identities was articulated most clearly by the Pashtun nationalist Wali Khan nearly a decade ago when he declared that he has been a Pashtun for 4,000 years, a Muslim for 1,400 years and a Pakistani for forty years.

These internal rifts and regional quandaries have contributed to Pakistan viewing itself with an immense sense of insecurity and vulnerability, which has led to their adopting policies that have often backfired. Some of the most prominent examples of

such policies include a) the efforts to unify the country by forcing a common language upon all the extremely diverse pockets of the population, resulting in the separation of East Pakistan as Bangladesh in 1971, and other separatist movements especially by the Pashtun and Baloch tribes in the north and the west, b) overinvesting in the military defensive strategies at the expense of socio-economic development including developing nuclear arms, c) a conscious policy decision to create and nurture Islamic extremism as a weapon to be used against any potential foreign interference (ready to be deployed in East Pakistan before 1971, or to be deployed in Kashmir, India and Afghanistan up until today), and d) the unrelenting effort to mold public opinion against a monstrous image of the archenemy, i.e. India.

Pakistan's sense of internal insecurity is best exemplified through the extreme measures they have taken to ensure its elusive national unity. As early as 1948, prominent separatist Pashtun leaders – including Khan Abdul Ghaffar Khan⁶ – were often subject to arrest, imprisonment and in some cases even execution to nip the problem in the bud and quell any future separatist movements. This and other policies clearly backfired when East Pakistan was separated in 1971, during a horrendous liberation wars, which resulted in the death of more than three million Bengali civilians and hundreds of thousands more wounded or displaced.

One consequence of Pakistan's efforts to unify its inhabitants has been the creation of the Federally Administered Tribal Areas (FATA), which are semi-autonomous areas between Khyber Pakhtunkhwa, Baluchistan and parts of Afghanistan.

⁶ Khan Abdul Ghaffar Khan was opposed to the idea of the partition and in favor of Hindu-Muslim unity, as he is famously quoted to have said the partition to him meant throwing them “to the wolves” (Talbot 2005, 432).

FATA consists of seven tribal agencies or tribal districts and six Frontier Regions. Despite its small population of about four million people (about 2% of Pakistan's population) and its rather small size of about 10,000 square miles (about 4% the area of Texas), FATA has been the center of much controversy as the hotbed of the Taliban, Al-Qaeda and numerous other extremist groups. For example, FATA has been described by former U.S. president, George Bush, as "wilder than the Wild West" (Stolberg 2007). One of the anomalies of FATA is the Frontier Crimes Regulations (FCR), implemented in 1901 with its origins in the 1877 Murderous Outrages Regulation (MOR) enacted by the British Empire of the time. Due to the enactment of the FCR, the jurisdictions of the Pakistani Supreme Court and High Court stop at the gates of FATA and Provincially Administered Tribal Areas (PATA).

The FATA region has some of the worst socio-economic indicators, even when compared to the rest of Pakistan. For example, adult suffrage was not extended to the citizens of the region until 1996 (Fair, Howenstein, and Thier 2006). The traditional governance structures in the region have made it an ideal breeding ground for terrorism and a source of instability for the region and beyond. As a result, the region's fate, especially since 9/11, seems to be stuck in a vicious cycle of insurgent attacks with Pakistani ISI support, American criticism or drone attacks (sometimes both), Pakistani military action against the region, further anger of the insurgents, and this cycle repeats itself. It is important to note that FATA has historically been a no-go zone for Pakistani military, and the recent military attacks on FATA regions are carried out either to retaliate for Taliban attacks on Pakistani interests, such as a school shooting in 2014, or

to appease external critics. In his book, *Descent into Chaos*, Pakistani author and journalist, Ahmed Rashid (2008, 265) describes FATA in the early years after 9/11 as follows:

FATA became a multilayered terrorist cake. At its base were Pakistan Pashtun tribesmen, soon to become Taliban in their own right, who provided the hideouts and logistical support. Above them were the Afghan Taliban who settled there after 9/11, followed by militants from Central Asia, Chechnya, Africa, China, and Kashmir, and topped by Arabs who forged a protective ring around bin Laden. FATA became the world's "terrorism central."

A thorough appreciation of the complexities in Afghanistan, especially pertaining to its geo-political relations, is essential for achieving political stability and economic development (Loyn 2009). Unless the international community and the Afghan leaders develop a deep understanding of these complexities, mistakes made in the past are bound to repeat themselves and development aspirations will bear no fruits. Afghanistan's past half century offers at least three missed opportunities, which have obvious and significant implications for peace and development today.

The first opportunity of the last half century emerged in 1973 during the reign of President Dawood Khan who ended his cousin Zahir Shah's forty-year kingdom, which had maintained relative security but did not improve the economic conditions of the people. Had President Dawood Khan been more cognizant of the Soviet infiltration, he could have prevented the coup d'état of Haft-e-Sour (discussed in some detail earlier) and Afghanistan would have been on a completely different trajectory.

The second missed opportunity arose almost a decade later in 1989 when the Russian troops pulled out of Afghanistan, which was technically a victory for all key stakeholders except the Russians. One of the reasons that some Afghans are distrustful of

the post-2001 interventions in Afghanistan is their perceptions of being abandoned by the international community, in particular the United States, after the end of the Cold War in 1992, which spelt disaster for Afghanistan and the region.

The third missed opportunity occurred during the early years of the post-Taliban period when the United States' light footprint policy and the Bush Administration's refusal to engage in nation building contributed to a revival of the Taliban movement after they were almost completely vanquished. The war in Iraq was more than just a distraction, because "the billions spent in Iraq were the billions that were not spent in Afghanistan" (Kofi Annan, in Rashid 2008, XLI).

To summarize, these two issues, the internal cleavages and tensions relating to the relationships with Pakistan lie at the core of understanding the security situation in Afghanistan. The National Unity Government and President Ashraf Ghani's foreign relations (particularly with Pakistan) mirror these dynamics. In fact, President Ghani displays in-depth appreciation for these intricacies in his domestic and foreign policies. In particular, he has emphasized the explicit need for peace for both Pakistan and Afghanistan after having been in a state of conflict for the past fourteen years. According to President Ghani, the two nations must work together to address the "changing ecology of terror" that respects no boundaries and threatens both countries and the entire region. Speaking at a forum, co-hosted by USIP and the Atlantic Council, he said⁷:

First, we have to define the problem. The problem, fundamentally, is not about peace with Taliban. The problem is fundamentally about peace between Pakistan and Afghanistan. For 13 years, we have been in an undeclared state of hostilities.

⁷ The forum was streamlined live on the USIP website on March 25, 2015 and is available online at https://www.youtube.com/watch?v=yLq6_S-Sk00 accessed on June 10, 2015.

And this is the definition that we offered to our Pakistani counterparts. They have accepted this definition of the problem. That's the breakthrough. The state of Pakistan and the state of Afghanistan... must reach acceptance of each other and the necessity that we need each other to prevent the region from sinking into chaos.

Afghanistan in the Post-2001 Era

The year 2001 was a pivotal year for Afghanistan, with an outpouring of attention from the international community, especially on the military and development fronts. Following the events of 9/11 and the Taliban refusing to hand over Osama Bin Laden (the leader of the Al-Qaeda group) to the United States, the U.S.-led coalition entered Afghanistan, overthrowing the Taliban and establishing a new interim government headed by Hamid Karzai. In fact, it was just one day after the event of 9/11 that the UN Security Council adopted resolution 1368, calling on all States “to work together urgently to bring to justice the perpetrators, organizers and sponsors of these terrorist attacks” (United Nations 2001a, 1). On the same day, the North Atlantic Treaty Organization (NATO) invoked Article 5 regarding the collective-defense provisions, declaring the attack against the United States as an attack against all NATO members. Meanwhile in Afghanistan, the Northern Alliance – the last remaining opposition front to the Taliban – were ready to lend their support in ousting the Taliban regime, even though their leader (Ahmad Shah Massoud) was assassinated just two days prior to 9/11. Therefore, armed with the U.N. Security Council Resolution and NATO's article 5 at the international level, and significant on-the-ground support from the Northern Alliance, it was only a matter of weeks before the Taliban were deposed, and some of its leadership members scattered across the porous border between Afghanistan and Pakistan. Today, however,

despite the formation of a new government and the significant international support over the past fourteen years, both in terms of military and development assistance, a resurgence of the Taliban and ISIS threaten the relative stability achieved since 2001.

On December 5th, 2001, the Bonn Conference was held in Germany, which established an Afghan Interim Authority, under the leadership of Hamid Karzai, until an interim government could be formed six months later. As planned, in June 2002, a Loya Jirga was convened, which elected Hamid Karzai as the interim head of the Afghan Transitional Authority to serve for two years until presidential elections in 2004. The Loya Jirga, a Pashto term for Grand Assembly, is a deeply-ingrained informal institution, which has been formalized in the 2004 Afghan Constitution as “the highest manifestation of the will of the Afghan people” and with one entire chapter detailing its form and purpose (Islamic Republic of Afghanistan 2004 Chapter 6, Article 110).

Hamid Karzai, a little known leader before 2001, managed to stay in power for more than a decade by getting elected through general elections for two consecutive terms in office, first in 2004 and then again in 2009. Although the extent to which these presidential and other provincial council elections were truly free and fair is highly contested, they have continued to count as major achievements for their lack of precedent in the past. For example, the 2004 elections which Hamid Karzai won with 54% of the votes, notwithstanding the many allegations of fraud, is eulogized as “Afghanistan’s first democratic election” (Morgan 2007, 60). Similarly, the 2014 elections, despite the inconclusive nature of the results that led to the formation of the National Unity Government, has been “hailed as a historic step” given its first democratic transition of

power from one elected leader to the next (United Nations 2014). However, it is not surprising that democratic consolidation cannot keep pace with other developments in the country, both because democratization is a more challenging task and also because unlike popular perceptions, the incentives of local elites rarely align with those of external peacemakers in bringing about real democratic reform for Afghanistan (Zürcher et al., 2013).

One of the key ways in which the Bonn Agreement paved the way for the upcoming development of the country was a clause in which the participants in the U.N. talks on Afghanistan requested the international community “to reaffirm, strengthen and implement their commitment to assist with the rehabilitation, recovery and reconstruction of Afghanistan” (United Nations 2001b). This paved the way for a number of international meetings and conferences on Afghanistan, during which the international community and donor agencies pledged contributions to ensure the country’s future security and development. On the security front, while the U.S.-led Operation Enduring Freedom (OEF) helped dismantle Al Qaeda and overthrow the Taliban, the creation of the International Security Assistance Force (ISAF) through the UN Security Council authorization ensured the security of the interim authority in Kabul and surrounding areas. However, it wasn’t until August of 2003 that NATO formally assumed the leadership role of ISAF, and two months later ISAF’s mandate was broadened to cover any area in Afghanistan (NATO 2003). On the development front, the creation of the United Nations Assistance Mission in Afghanistan (UNAMA) in March of 2002 by the UN Security Council was another major step in the reconstruction process. UNAMA was

designed to, among other things, manage and coordinate all humanitarian and development assistance in Afghanistan.

At the international level, several conferences were held on Afghanistan, thus ensuring a constant flow of development assistance. The first important meeting was the “International Conference on Reconstruction Assistance to Afghanistan” held in Tokyo, Japan in January 2002, chaired by Hamid Karzai, and co-chaired by representatives from Japan, the U.S., the E.U. and Saudi Arabia (Tokyo Conference Co-chairs 2002). Three points are central to our thesis. First, it was the first major conference on Afghanistan in the post-Taliban era that received significant international attention. The conference was attended by representatives from 61 countries and 21 organizations. The international community pledged more than 4.5 billion USD in development assistance, 1.8 billion of which was set aside for 2002 alone. It was during this conference that the idea of a “trust fund” managed by the World Bank was discussed as a way to channel all donors’ contributions. This later became known as the Afghanistan Reconstruction Trust Fund (ARTF). Second, this conference reiterated the critical role that Afghan NGOs could play in the reconstruction process based on their years of experience delivering assistance to Afghan refugees in Pakistan and Afghans in Afghanistan during the Taliban and pre-Taliban eras. In fact, NGO representatives had a separate meeting on the first day of the conference and presented their findings to the plenary session at the conference. Third, the conference identified six priority areas, including health and education as important areas that must be prioritized and especially supported. The other four areas included administrative capacity, infrastructure, economic system, and rural development.

Table 1 Key international conferences on Afghanistan after 2001

Date	Conference Title	Key Decisions
Dec 2001	The International Conference on Afghanistan in Bonn, Germany	Establishing the Afghan Interim Authority, under Hamid Karzai's leadership
Jan 2002	International Conference on Reconstruction Assistance to Afghanistan, Tokyo Japan	4.5 billion USD in development assistance pledged
Mar - Apr 2004	The International Conference on Afghanistan, Berlin, Germany	8.2 billion USD pledged for 2004-07 as multi-year commitment for better predictability
Jan - Feb 2006	The London Conference on Afghanistan, London, England	Afghanistan Compact (2006-11) signed, and 10.5 billion USD pledged
Jul 2007	Rome Conference on the Rule of Law in Afghanistan, Rome, Italy	Special emphasis on strengthening rule of law as per Afghanistan Compact & ANDS
Jun 2008	The International Conference in Support of Afghanistan, Paris, France	20 billion USD pledged, reinforcing support for the Afghan Compact
Mar 2009	Special Conference on Afghanistan, Moscow, Russia	The regional and global impact of drug production in Afghanistan UNAMA's role emphasized;
Mar 2009	The International Conference on Afghanistan, The Hague, Netherlands	Priority sectors: governance, economy, security, especially relating to Pakistan
Jan 2010	The London Conference	Support Afghan-led political strategy
Jul 2010	Kabul, Afghanistan	Donors committed to channeling at least 50% of aid through government budget in two years
Nov 2011	The Istanbul Conference on Afghanistan, Istanbul, Turkey	Promote regional security and cooperation in the heart of Asia
Dec 2011	The International Conference on Afghanistan, Bonn, Germany	Support for the transformation decade beyond 2014
Jul 2012	The Tokyo, Japan	Established the Tokyo Mutual Accountability Framework (TMAF), and 16 billion USD pledged
Dec 2014	London, England	Afghanistan presented a reform vision of "realizing self-reliance"

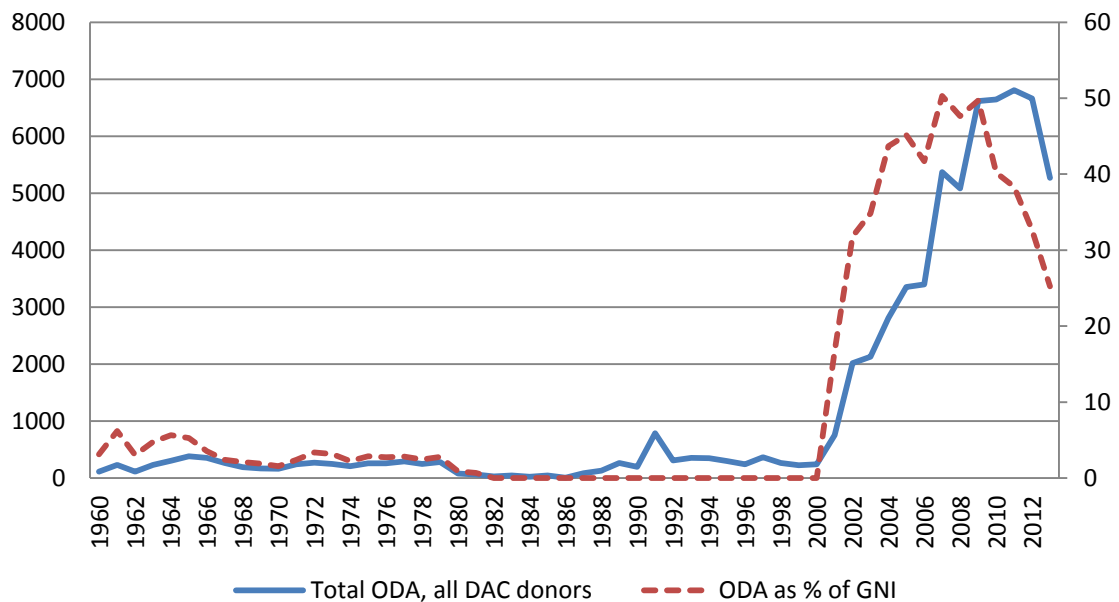
Source: Author's compilation

As Table 1 illustrates, an important feature of all of the most important international conferences on Afghanistan includes an increasingly higher commitment of development assistance by the international community as Afghanistan continues to prove its ability to spend the funds appropriately. In fact, towards the middle and late 2000s, “work in silos and ‘stove-piping’ were overcome to a significant extent” (Foreign Affairs, Trade and Development Canada 2015, 4). More and more funds were being channeled through the Afghan government in line with the sectoral priorities as identified by Afghanistan National Development Strategy (ANDS), which is the equivalent of the country’s Poverty Reduction Strategy Paper. One key turning point was the July 2010 Conference that was held in Kabul to symbolize improved local capacity and increased Afghan ownership of the development process in Afghanistan. One of the most important decisions made during this conference was a commitment by the donor agencies and countries to channel at least 50 percent of development assistance through the Afghan government's core budget within two years. This move would further ensure that development assistance was more aligned with national priorities as defined by the ANDS and Afghanistan Compact. This move also signaled increased local ownership of the development process as outlined in the 2008 Paris Declaration of Aid Effectiveness.

To put the volumes of development assistance disbursed to Afghanistan into perspective since the overthrow of the Taliban, Afghanistan has become one of the world’s largest recipients of foreign aid, whether measured in total ODA received or ODA as a percentage of recipient country’s GDP (See Figure 1). In the last decade,

Afghanistan has surpassed all countries, except Iraq, in its total volume of aid received. In terms of aid as a percentage of recipient country GNI over the last decade, Afghanistan is only surpassed by Liberia and the small island state of Micronesia. At its peak in late 2000s, Afghanistan received nearly US\$7 billion in total annual aid, aid up to 50% of its GDP and up to US\$250 aid in per capita terms (OECD-DAC 2014).

Figure 1 Aid to Afghanistan (Current US\$ Millions)

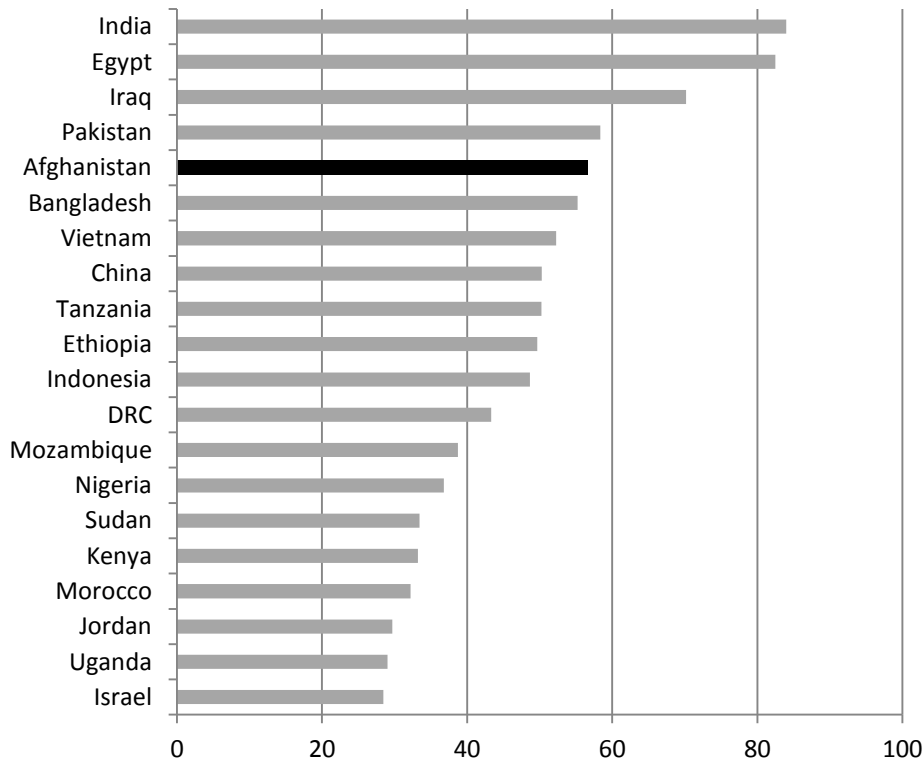


Source: OECD-DAC Aid Statistics (2014)

Afghanistan is the fifth largest recipient of foreign aid when calculated by total ODA received from 1960 to 2013. As illustrated in Figure 2, Afghanistan is only preceded by India, Egypt, Iraq, and Pakistan respectively. Pakistan has always received more aid than Afghanistan, with the exception of the last decade. Its closer ties, in both military and economic terms, with China has attracted special attention recently (Small

2015). While Pakistan received a total of US\$56 billion during the 1960-2013 period, Afghanistan received US\$56 during the same period (OECD-DAC 2014). The nearly perfect correlation between the flows of aid to the two nations is a reflection of their shared fate in the region. For example, each time there is an increase of unrest in Afghanistan, the tide of Afghan refugees flow towards Pakistan. In response to the refugee influx, Pakistan receives increased foreign assistance, both directly to Pakistani government and aid organizations and indirectly through the inflow of aid and remittances to Afghans in Pakistan.

Figure 2 Top 20 aid recipients, 1960-2013 total (Current US\$ Billions)



Source: OECD-DAC Aid Statistics (2014)

Although official statistics are hardly available, Afghanistan has received significant amounts of aid from Soviet Russia during the 1980s and early 1990s. Meanwhile, the Afghan refugees in Pakistan received substantial amounts of humanitarian assistance from the international community through multilateral aid agencies and international NGOs during the 1980s and the early 2000s. Interviews with Afghan aid workers who helped deliver these humanitarian services reveal that a significant portion of these efforts were concentrated at delivering basic services, focused in the areas of basic health and nutrition, primary education and literacy, and basic infrastructure, especially in refugee camps in the then North-Western Frontier Province of Pakistan.

In fact, it was during these decades of conflict that Afghans, both those working for NGOs in Afghanistan and those delivering humanitarian assistance to Afghan refugees in Pakistan, developed their technical, managerial, and service delivery capacities as an unintended consequence of aid delivery through a process of learning by doing. When Internally Displaced Persons (IDPs) in Afghanistan and Afghan refugees in Pakistan reached at noticeable size, the influx of humanitarian aid by the international community filled the gap created by the years of war and political unrest. After meeting basic shelter requirements, the top two priority areas were health and education.

Before 2002, the NGO and donor community were active both inside and outside of Afghanistan trying to help the poor and the disadvantaged through humanitarian services such as those delivered in the numerous refugee camps located in the Frontier

Province of Pakistan. Following the Bonn Agreement of December 2001, a lot of the Afghan refugees from neighboring countries returned home, mostly through the UNHCR repatriation programs. With the return of IDPs came the NGOs previously operating outside the country along with a whole new range of NGOs at local, international and multinational levels. For example, according to the Agency Coordinating Body for Afghan Relief (ACBAR), the number of registered NGOs increased from 280 in 2002 to 1,400 in 2008 and several thousand more by 2014 (only a few of which have voluntarily registered with different coordinating bodies or the Ministry of Planning or the Ministry of Interior Affairs). In fact, some interviewees conceded that in the early years after the Taliban withdrawal, starting a new NGO was like opening up a new business venture, because of the abundance of donor funding, the majority of which were only delivered through NGOs. To their credit, however, the NGO sector's flexibility and mobility allowed them to deliver needed services to all corners of the country at a time when the Afghan government did not have the capacity to do so. In addition to their flexible structures, their ability to offer wages much higher than the government helped them attract more qualified staff (Dost and Khan 2015).

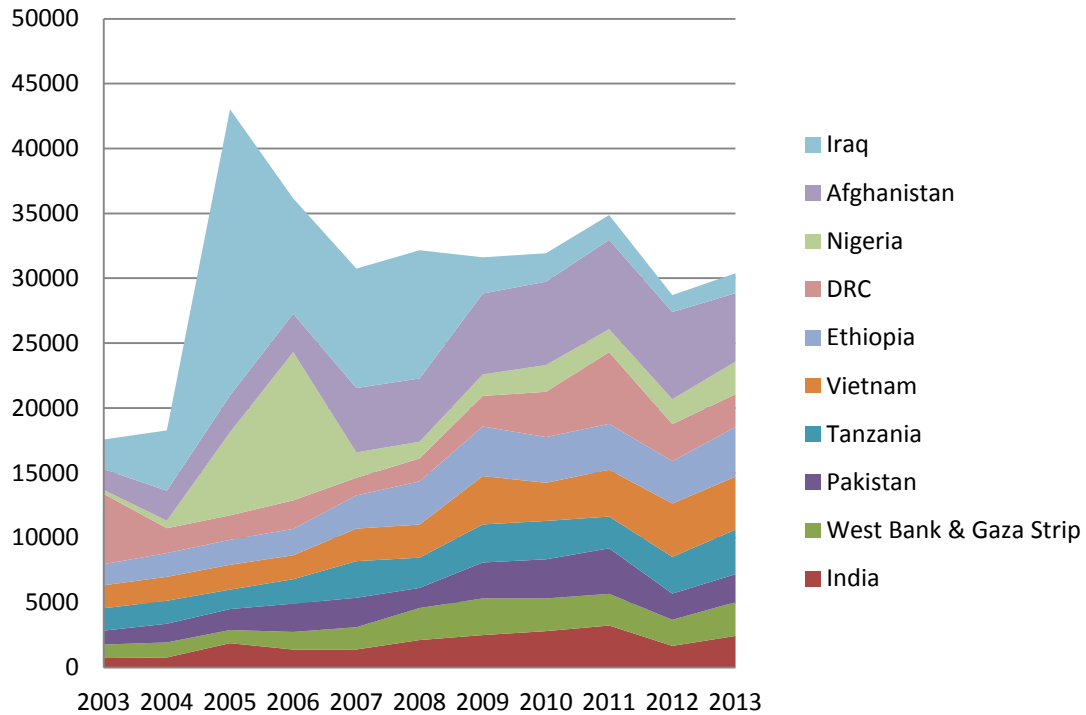
It is important to note that before 2002, the Afghan government's MoPH was in charge of direct health care service delivery. Their lack of access to remote regions, however, left the health services unequally distributed across the country, with the rural regions under-served. This, however, changed in the post-Taliban era when a conscious decision was made for the MoPH to switch from service delivery to stewardship role in the health sector, leaving the health care service delivery to NGOs. This strategy served

them well at that time because the NGOs enjoyed two features that the MoPH lacked: reasonably developed local capacity to deliver health services, and using existing network of branches across the country that allowed them easier access to remote and hard-to-reach areas.

The significantly sharp rise in levels of foreign aid in the last decade deserves closer scrutiny. The volume of aid disbursed over the last ten years (2004-2014, measured in current prices) is the same as the total amount of aid disbursed in the preceding four and a half decades. Even in real terms (2013 constant prices), the amount disbursed over the last ten years is nearly half of the entire amount disbursed from 1960 to 2004.

The turn of the millennium is also important because it brought new large recipients of aid and replaced some older ones like Egypt and India, as illustrated in Figure 3. Together, these ten countries received more than a quarter of all aid to developing countries, or US\$335 million out of a total of 1.29 billion disbursed over this period. Among them, Iraq and Afghanistan have taken center stage post 9/11 by both ranking among the world's top ten aid recipients. In fact, the two countries together received almost 10% of all the aid sent to developing countries during the 2003-2013 decade, with Iraq having received nearly US\$67 billion, and Afghanistan US\$51 billion during the same period. Afghanistan alone has received more aid during this period than the entire region of Sub-Saharan Africa, making it the second largest recipient of aid in the last decade second only to Iraq (OECD-DAC 2014).

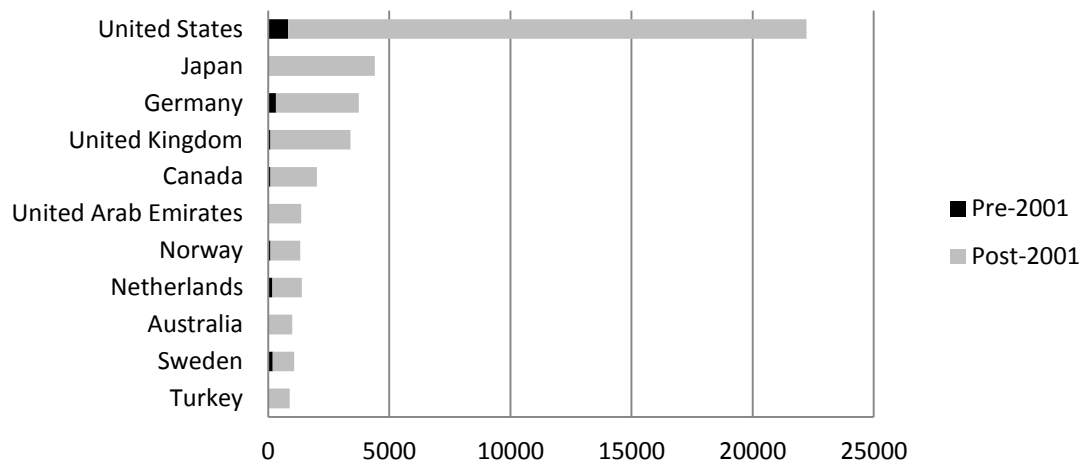
Figure 3 Top ten aid recipients of the 2003-2013 decade (Current US\$ Millions)



Source: OECD-DAC Aid Statistics (2014)

The United States is the largest donor, both to Afghanistan as well as to all other aid recipient countries. It is interesting to notice that although the United States is Afghanistan's largest donor, Afghanistan is not the largest recipient of American aid (See Figure 4). In fact, the following countries have historically received more aid than Afghanistan: Egypt, Israel, India, Iraq, Pakistan and Vietnam (OECD-DAC 2014). It is also important to note that much of the development fund flows from Soviet and other sources during the 1980s are poorly recorded and are thus not adequately reflected in these figures.

Figure 4 Afghanistan’s top 10 donors, 1960-2014 (Current US\$ Millions)



Source: OECD-DAC Aid Statistics (2014)

Afghanistan’s heavy reliance on foreign aid has earned itself the title of “an extreme outlier in its dependence on aid” (World Bank 2012b, 9). This same report exposes Afghanistan’s historical reliance on external sources of finance as follows (World Bank 2012b, 10):

Dependence on external financing—aid or other financial inflows—is nothing new for Afghanistan: it received massive amounts of Soviet aid in the 1980s and early 1990s; it was one of the highest per capita aid recipients in the world during the 1960s and 1970s; Afghan rulers received subsidies from Britain during much of the 19th century; and in its earliest years plunder from the Indian subcontinent was a main source of financing for the Afghan state. Historically, the regime rarely had to mobilize large revenues from its own people to cover costs and provide services, so this aspect of the social contract between state and society has long been missing. Instead, the historical pattern was often to use external resources to “buy loyalty” and provide security and political stability.

In fact, in analyzing the wage-differentials between civil servants and those working for development organizations in Afghanistan, Dost and Khan (2015) emphasize the threat posed by the fiscal unsustainability of the public sector in Afghanistan at the

current levels of domestic revenues. Despite the significant debt relief that Afghanistan has received historically – most recently in 2011 after officially becoming a Heavily Indebted Poor Country (HIPC) – the country lacks the ability to generate sufficient revenues to cover its costs and service its debts, which hovers around 10% of the country's GDP (World Bank 2015).

A report by the World Bank (2012), called “Afghanistan in Transition: Looking Beyond 2014,” extensively examines the sustainability of the country in the absence of foreign aid and concludes that public spending is unsustainable, both fiscally and also administratively. The future is fiscally unsustainable due to the current levels of domestic revenue-to-GDP ratio, projected to reach 17.5% in 2021/22. These numbers are based on the potential for the country's minerals wealth to start paying dividends as early as 2016/17, and are not high enough to cover the cost of sustaining the public sector. The future is unsustainable administratively, because instead of building capacity, it has been substituted by borrowing it from abroad, which has created a parallel secondary civil service. In this context, President Ashraf Ghani's policies which are aimed towards realizing “self-reliance by enhancing productivity, growth and revenues” are a welcomed change (Islamic Republic of Afghanistan 2014, 4).

Aid Effectiveness vs. Government Effectiveness

At the surface, it may appear that this study conflates government effectiveness with aid effectiveness. In order to clarify the inseparable link between the two issues, a brief discussion of the flow of funds (including ODA) may be in order. In the post-2001 Afghanistan, ODA funds flow through one of two channels, with changing proportions

between the two over time. The two channels of fund flows are referred to as “on-budget” and “off-budget” referring to whether external sources of funding are channeled through the government’s core budget or that they bypass the government altogether (World Bank 2012a). External or off-budget spending, estimated to constitute about 80% of total development assistance, refers to those funds that are directly spent by the donor agencies without passing through the hands of the Afghan government (World Bank 2012b, 49). On-budget spending, on the other hand, passes through Afghanistan’s Ministry of Finance and is therefore better aligned with national priorities and programs.

The Afghan government’s core budget, or on-budget spending, is further divided into two groups, operating and development funds. The bulk of the operating budget is earmarked to cover public servant salaries, including salaries for teachers, members of the Afghan National Army (ANA), and the Afghan National Police (ANP). It also covers non-wage expenses, such as operating and maintenance. The development budget, which is often about one-third of the government’s core budget (the operating budget making the remaining two-thirds), covers development programs identified through national priority setting exercises across sectors as in the ANDS. The majority of development budget funds are channeled through multi-donor trust funds, such as the Afghanistan Reconstruction Trust Fund (ARTF). The major source of funding for the implementation of the BPHS, for example, is the government’s development budget.

This by-passing of the government has come under criticism by many because of its perceived ineffectiveness and detachment from national priority areas (e.g. Pounds 2006; Nixon 2007; Waldman 2008). For example, Waldman (2008, 1) shows that “it is estimated [to be] a staggering 40% [of all aid spent in Afghanistan] has returned to donor countries in corporate profits and consultant salaries.” Similarly, the World Bank (2012a, 2) is most vocal about this issue by pointing the following:

Despite the large volume of aid, most international spending “on” Afghanistan is not spent “in” Afghanistan, as it leaves the economy through imports, expatriated profits of contractors, and outward remittances. The local content of external budget aid is estimated at only 10–25 percent, compared with around 70–95 percent for on-budget aid. With the bulk of aid (88 percent) going through the external budget, its local economic impact is limited.

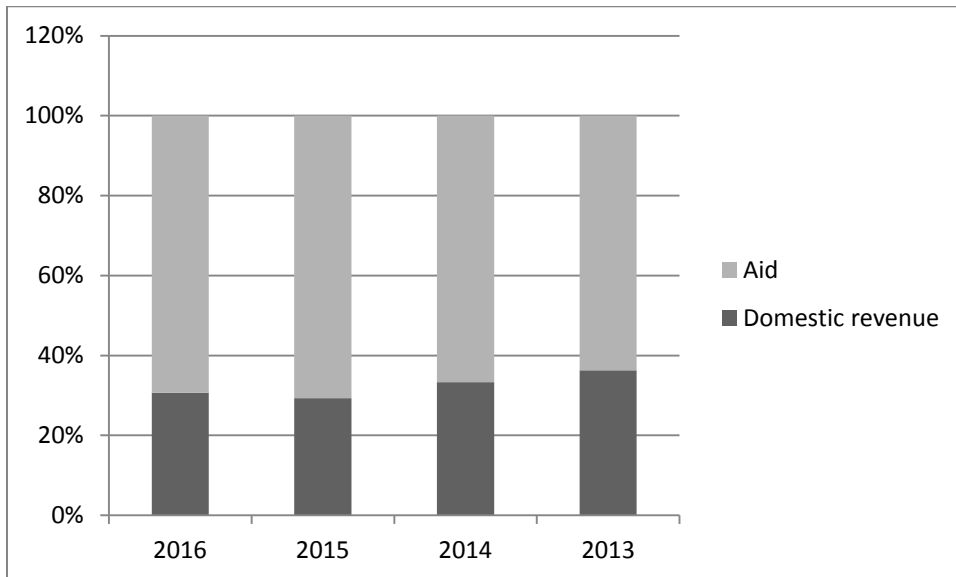
One of the challenges in this study is the relationship between a discussion of aid effectiveness across sectors and government effectiveness in policy management and service delivery. These two concepts are closely linked for two reasons. First is the critical role that the Afghan government plays in setting national priorities and coordinating aid efforts. Second is the essential role that development assistance plays in financing the operations of the government and even services offered beyond the control of the government.

At the level of public perceptions, almost all kinds of service delivery – especially in the areas of health and education – are automatically considered government provided, regardless of their source of financing these services. For example, a national survey of the Afghan people, conducted annually by the Asia Foundation, found that “when asked to identify the funder for local development

projects, Afghans are most likely to cite the Afghan government (24.5%), followed by the United States (22.6%)” (Warren and Hopkins 2015, 9). Another study conducted to assess the impact of development cooperation in North East Afghanistan finds that “in four out of eight sectors (jobs, income opportunities, schooling and access to health) respondents credit the government more often than development actors with better access to these services” (Böhnke, Koehler, and Zürcher 2015, 21).

This attribution of service delivery to the government in Afghanistan happens at a time when donor assistance consistently funds more than two-thirds of Afghanistan’s core budget, not to mention the billions of dollars of off-budget development assistance that bypasses the government budget (See Figure 5). The Afghan government, however, is not in denial of their lighter role in financing development by admitting that “the significant difference between off- and on-budget executions indicates that the Afghan Government has played little role compared to international donors, when it comes to the ANDS implementation” (Islamic Republic of Afghanistan, Ministry of Economy 2014, 7).

Figure 5 Government's core budget by source of financing, 2013-2016

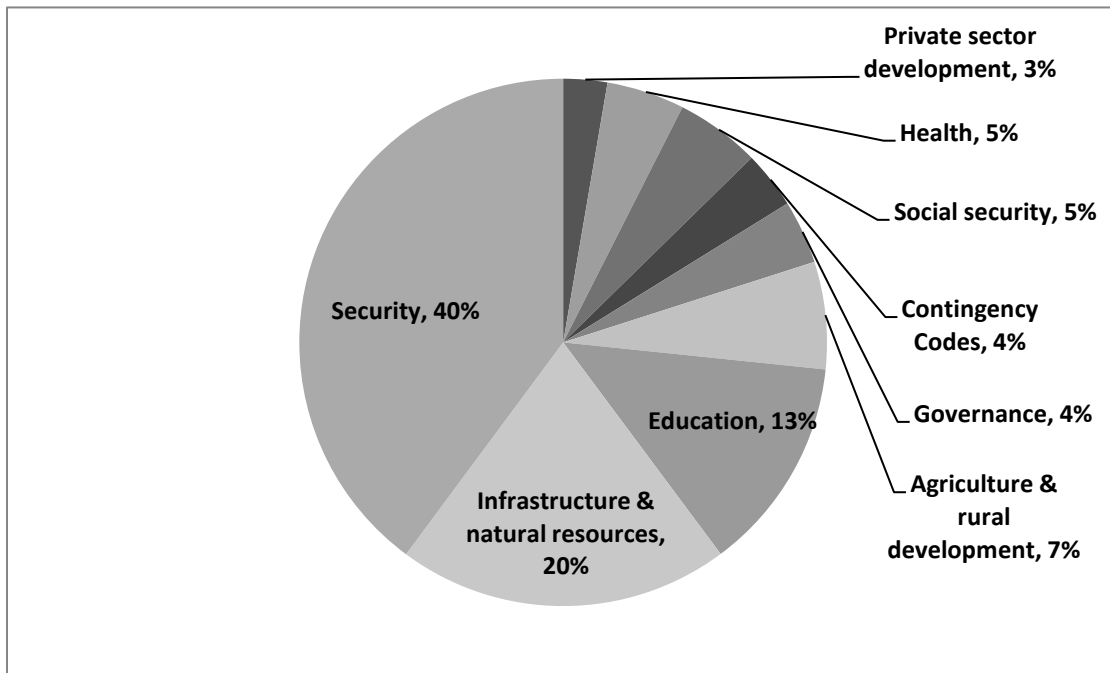


Source: National Budget Document, 2013-2016 (Islamic Republic of Afghanistan, Ministry of Finance 2016; Islamic Republic of Afghanistan, Ministry of Finance 2014; Islamic Republic of Afghanistan, Ministry of Finance 2013; Islamic Republic of Afghanistan, Ministry of Finance 2012)

Figure 6 illustrates the allocation of the core government budget across sectors for the year 2016 (Islamic Republic of Afghanistan, Ministry of Finance 2016). Given the intense security threats posed by different factions of Taliban, Da'ish and other groups, security expenditures account for 40% of the national budget. This is followed by the "Infrastructure and Natural Resources" sector that constitute 20% of the core budget, covering expenses in the areas of infrastructure, roads, dams, airports, and mineral extraction. The education sector constitutes the third largest component of national budget and most of the budget is allocated towards salaries of teachers and lecturers that fall under the Ministry of Education and the Ministry of Higher Education respectively. It is important to note that despite the success of the health sector in achieving most of their objectives compared to any other sector, it consumes one of the

lowest percentages of the national budget (Islamic Republic of Afghanistan, Ministry of Economy 2014).

Figure 6 Allocation of national budget by sectors in 2016



Source: National Budget for the year 2016 (Islamic Republic of Afghanistan, Ministry of Finance 2016)

BPHS and EPHS

At the core of Afghanistan’s MoPH strategy lies the development and implementation of the Basic Package of Health Services (BPHS) in order to standardize services, expand coverage, and address key determinants of mortality and morbidity across the country. For this reason, “the cornerstone of the emergence of a new Afghan health system is the Basic Package of Health Services, because it addresses the most common health problem at all levels and focuses on priority interventions for reducing

mortality and morbidity” (Transitional Islamic Government of Afghanistan, Ministry of Health 2003, 44).

The main purpose of the BPHS was twofold, “(1) to provide a standardized package of basic services which forms the core of service delivery in all primary health care facilities and (2) to promote a redistribution of health services by providing equitable access, especially in underserved areas” and it served those purposes well (Transitional Islamic Government of Afghanistan, Ministry of Health 2003). Since then, this package has undergone two revisions, one in 2005 and another in 2010. The first revision in 2005 elevated mental health and disability from second tier status to on par with the other five components, while also adding HIV/AIDS and blood transfusion to the package. Some of the key changes after the second revision in 2010 include the addition of eye care and two new types of health facilities, namely Mobile Health Teams (MHTs) and Health Sub-Centers (HSCs). The seven key components of BPHS are listed below, as adapted from BPHS document (Transitional Islamic Government of Afghanistan, Ministry of Health 2003):

1. Maternal and Newborn Health

- Antenatal Care
- Delivery Care
- Postpartum Care
- Family Planning
- Care of the Newborn

2. Child Health and Immunization

- Expanded Program on Immunization (EPI)
 - Integrated Management of Childhood Illnesses (IMCI)
3. Public Nutrition
 - Prevention of Malnutrition
 - Assessment of Malnutrition
 4. Communicable Diseases Treatment and Control
 - Control of Tuberculosis
 - Control of Malaria
 - Prevention of HIV and AIDS
 5. Mental Health
 - Mental Health Education and Awareness
 - Case Identification, Diagnosis and Treatment
 6. Disability and Physical Rehabilitation Services
 - Disability Awareness, Prevention, and Education
 - Provision of Physical Rehabilitation Services
 - Case Identification, Referral, and Follow-up
 7. Regular Supply of Essential Drugs
 - List of all essential drugs needed

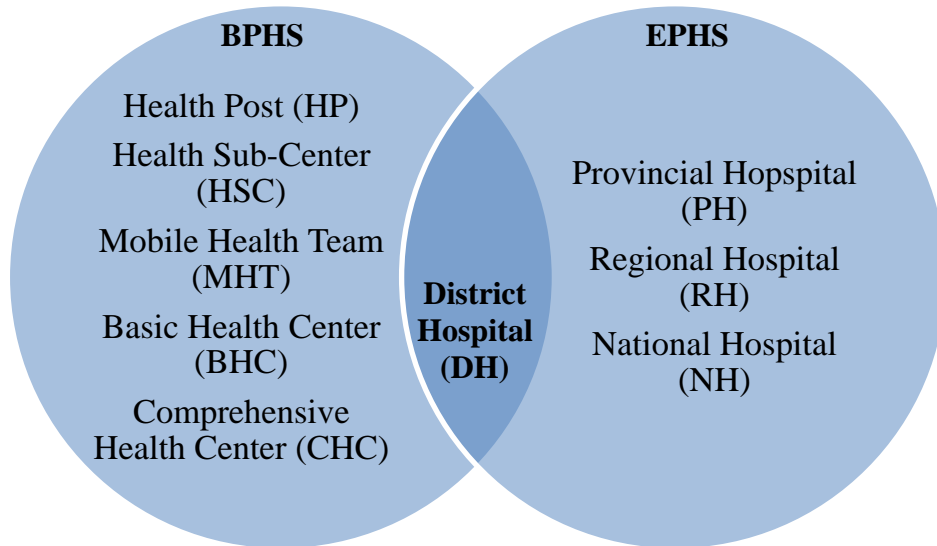
While the development of the BPHS was a high priority in the post-Taliban environment of Afghanistan, this package stopped at the level of District Hospital (DH), leaving tertiary or hospital care out of the focus. As a result, and in line with the

directions identified in the ANDS (Islamic Republic of Afghanistan 2008) and Health and Nutrition Sector Strategy (HNSS) 2008, the MoPH wanted to also develop tertiary care to complement the BPHS. Consequently, the Essential Package of Hospital Services (EPHS) was adopted in July 2005 with three main purposes:

(1) to identify a standardized package of hospital services at each level of hospital, (2) to provide a guide for the MoPH, private sector, nongovernmental organizations (NGOs), and donors on how the hospital sector should be staffed, equipped, and provide materials and drugs, and (3) to promote a health referral system that integrates the BPHS with hospitals. (Islamic Republic of Afghanistan, Ministry of Public Health 2005a, 2)

As the then minister of public health, Dr. Sayed Mohammad Amin Fatimie says in the foreword to the 2005 revised BPHS document, “these two documents, the BPHS 2005/1384 and the EPHS together define the Afghan health system’s entire referral system, from the health post at the village level to tertiary care in the major urban centers” (Islamic Republic of Afghanistan, Ministry of Public Health 2005b, vii). The relationship between the BPHS and EPHS is illustrated in Figure 7.

Figure 7 The relationship between BPHS and EPHS



Source: Adapted from BPHS Document (Transitional Islamic Government of Afghanistan, Ministry of Health 2003)

In summary, this chapter provided the necessary background to contextualize the study of aid effectiveness in Afghanistan, with particular focus on human capacity development in the health sector during the decades of conflict before 2001. It is against this backdrop that a deeper analysis of aid effectiveness in Afghanistan needs to take shape. The next chapter will outline the debates about aid effectiveness and situate my study therein.

CHAPTER THREE: THE AID EFFECTIVENESS LITERATURE

This chapter discusses the large and growing body of aid effectiveness literature, with an aim to situate my thesis within the wider debates to date on the conditions under which aid is more likely to work. In order to achieve this, I start with a broad level discussion of foreign aid as one of several financial inputs that finance development. In particular, I show that despite the increasingly overshadowing presence of other sources of finance, aid should continue to interest development scholars because of its relatively more significant role in development, especially in some of the world's smallest and least developed economies. Next, I discuss the different ways to measure foreign aid and show that the measurement choice – e.g. total aid disbursed vs. aid as a percentage of donor country income – is highly consequential for analysis, interpretation and country ranking. Then, I explore the reasons for the expansion of foreign aid volumes over time despite the lack of conclusive evidence to support the narrowly defined aid narrative, i.e. that aid promotes economic growth in recipient countries. These reasons may be classified as the strategic, humanitarian, theoretical, methodological, and ideological cases for aid.

In the next stage, I broaden the debate by discussing some of the limitations posed by relying on the narrow definition of aid effectiveness in terms of GDP growth alone. I discuss the importance of other metrics, including the Human Development Index (HDI), poverty reduction, Millennium and Sustainable Development Goals, and most

importantly sector-specific outcomes, including human development in the areas of health and education. Following a brief discussion of aid in conflict affected countries, I unpack the concept of “capacity” by defining the term and discussing various typologies. Finally, I situate my proposed thesis within the debates on aid effectiveness and show that it fits squarely within the *contingency* school as it tries to uncover the conditions under which aid may be more effective.

Aid as a Source of Development Finance

A typical developing country usually enjoys a healthy menu of options to finance its development initiatives from external sources, where aid is but just one out of several competing components. The Organisation for Economic Co-operation and Development’s (OECD) Development Assistance Committee (DAC) classifies external sources of development finance in a simple two-by-two matrix as illustrated in Figure 8. The precise definition of ODA has varied since it was first defined in 1969 by OECD-DAC and then revised in 1972. ODA’s current definition is:

- those flows to countries and territories on the DAC list of ODA recipients and to multilateral institutions which are:
- i. provided by official agencies, including state and local governments, or by their executive agencies; and
 - ii. each transaction of which:
 - a. is administered with the promotion of the economic development and welfare of developing countries as its main objective; and
 - b. is concessional in character and conveys a grant element of at least 25 per cent (calculated at a rate of discount of 10 per cent). (OECD 2008)

Other official flows (OOFs) are differentiated from ODA either because OOFs are not primarily aimed at development or because they do not meet the 25% grant

component condition.⁸ Examples of OOFs include non-concessional development loans or direct export credits. Similarly, private grants, such as a grant by the Clinton Foundation, are offered by foundations and non-government organizations (NGOs) in donor countries at concessional rates. On the other hand, private flows – such as foreign direct investment (FDI) or private export credits – are offered at market rates for commercial purposes.⁹

Figure 8 OECD-DAC classification of development finance options

	Concessional	Non-concessional
Official	ODA	OOF
Private	Private Grants	Private Flows
Other Flows	Remittances*	
	Guarantees*	

*Data on remittances and loan guarantees are not reported in OECD-DAC Statistics.

In addition to these four elements, two other sources of development finance, which have taken the center stage over the past decade given their stellar growth rates, include loan guarantees and private remittances.¹⁰ As Figure 9 illustrates, private flows

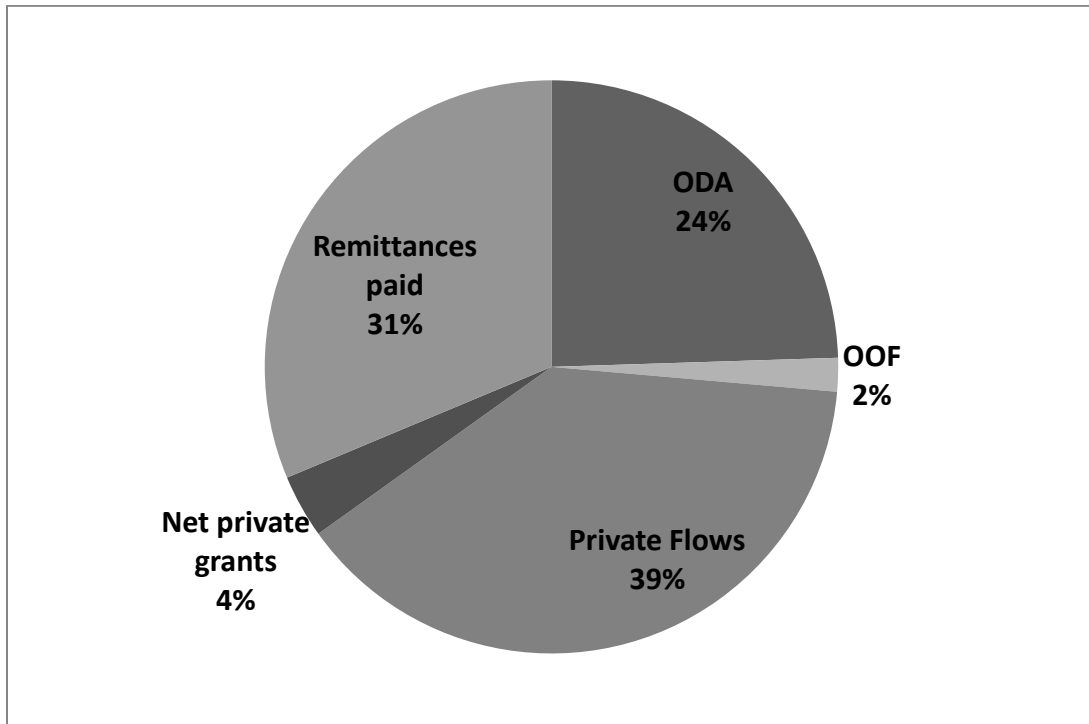
⁸ It was not until 1969 that OECD-DAC adopted the separation of ODA from OOF based on the former's exclusive emphasis on promoting the economic and social development of developing countries.

⁹ For the definition of these and other related terms, please refer to OECD-DAC's Glossary of Key Terms and Concepts online at <http://www.oecd.org/dac/stats/dac-glossary.htm>

¹⁰ The World Bank defines remittances as follows: "Personal remittances comprise personal transfers and compensation of employees. Personal transfers consist of all current transfers in cash or in kind made or received by resident households to or from nonresident households. Personal transfers thus include all current transfers between resident and nonresident individuals. Compensation of employees refers to the income of border, seasonal, and other short-term workers who are employed in an economy where they are not resident and of residents employed by nonresident entities. Data are the sum of two items defined in the

such as FDI and remittances alone make up more than two-thirds of all resources flowing from OECD member countries to developing countries.

Figure 9 Resource flows from OECD to developing countries, 1960-2013 Total (Current Prices, US\$ Millions)



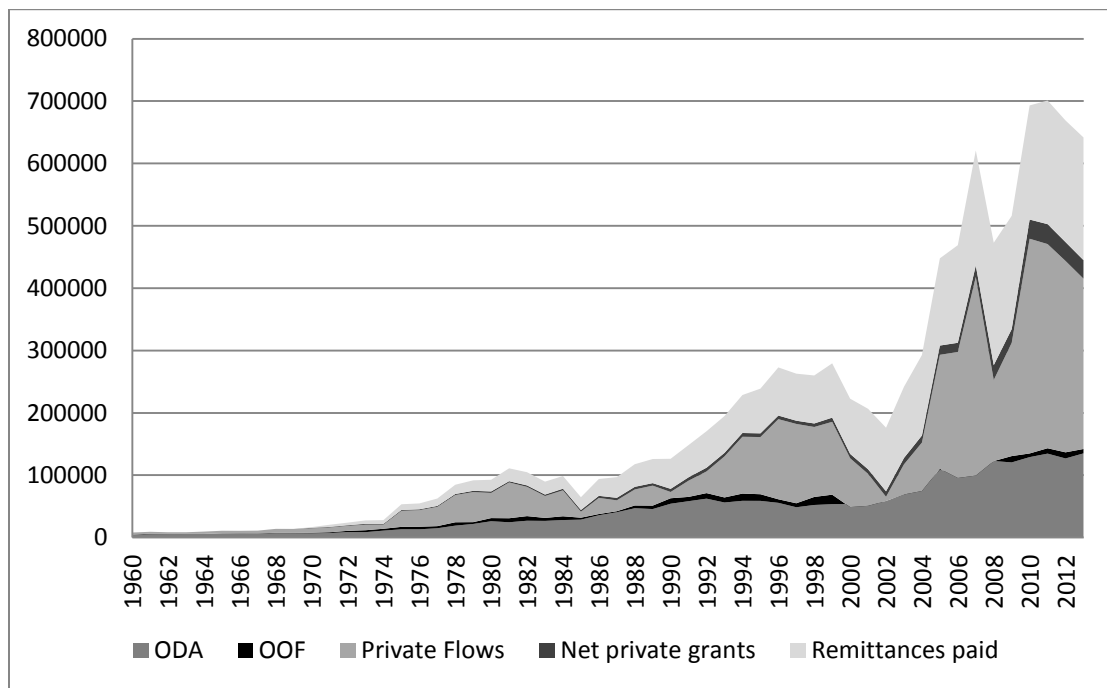
Source: OECD-DAC Aid Statistics (2014). Data on Remittances were taken from World Bank's World Development Indicators Database (2014).

Non-ODA elements emerged primarily after the 1970s, peaking once in the late 1990s and again in 2010 (see Figure 10). Private flows such as FDI and remittances have experienced the fastest growth over time, surpassing ODA levels in absolute terms. In fact, in the last decade alone, non-ODA components (OOFs, Private Flows and Net

sixth edition of the IMF's Balance of Payments Manual: personal transfers and compensation of employees. Data are in current U.S. dollars." (World Bank 2015)

Private Grants) have more than quadrupled (from US\$58.2 billion in 2003 to US\$309.9 billion in 2013). Over the same period, remittances have grown 72% (from US\$114.1 billion in 2003 to US\$196.7 billion in 2013), while ODA has grown 94% (from US\$69.6 billion in 2003 to US\$135.1 billion in 2013), pointing to the diminishing relative importance of aid as a source of development finance (World Bank 2015; OECD-DAC 2014).

Figure 10 Pattern of resource flows from OECD to developing countries, total flows, 1960-2013 (Current Prices, US\$ Millions)



Source: OECD-DAC Aid Statistics (2014)

Note: Data on Remittances were taken from World Development Indicators Database (2014).

It is important to note, however, that despite the increasingly overshadowing growth of non-ODA flows, ODA should continue to interest researchers and development

practitioners alike, mainly for three reasons. First, only ODA and private grants are given to recipient countries with the primary purpose of promoting development and improving the welfare of the developing countries. Secondly, non-ODA flows and remittances are not evenly distributed among all recipient countries. In fact, most non-ODA flows go to middle income countries and the poorest countries continue to lack the institutional capacity to attract private flows. For instance, in the year 2011, non-ODA flows constituted approximately 83% of all flows to middle-income countries, and only 17% of them to low-income countries. This is not surprising in light of the fact that private investment is rarely channeled to the least developed countries with weaker institutions, such as protection of property rights, and higher risk of investment default. In fact, Dollar and Easterly (1999) show that private investment is attracted mostly to countries that combine aid with a good policy environment, a characteristic of middle income countries and not that of the least developed countries. Thirdly, ODA alone makes up a considerably large amount of aid when put into perspective. For example, total ODA disbursed by OECD member countries alone over the past five and a half decades amounts to more than four trillion dollars in 2013 constant prices.¹¹ In addition, for certain countries, such as small island or donor darling countries, ODA makes up a significant portion of recipient country's government expenditures, often exceeding 50%. This makes aid a vital component of recipient country economies.

¹¹ This excludes all non-OECD members, such as Russia, the United Arab Emirates, Saudi Arabia and China, all of which have been increasingly important donor countries since the 1980s. Currently, there are 29 OECD-DAC members: Australia, Austria, Belgium, Canada, Czech Republic, Denmark, the European Union, Finland, France, Germany, Greece, Iceland, Ireland, Italy, Japan, Korea, Luxembourg, the Netherlands, New Zealand, Norway, Poland, Portugal, Slovak Republic, Slovenia, Spain, Sweden, Switzerland, the United Kingdom and the United States (OECD-DAC 2015).

Measuring Aid Flows

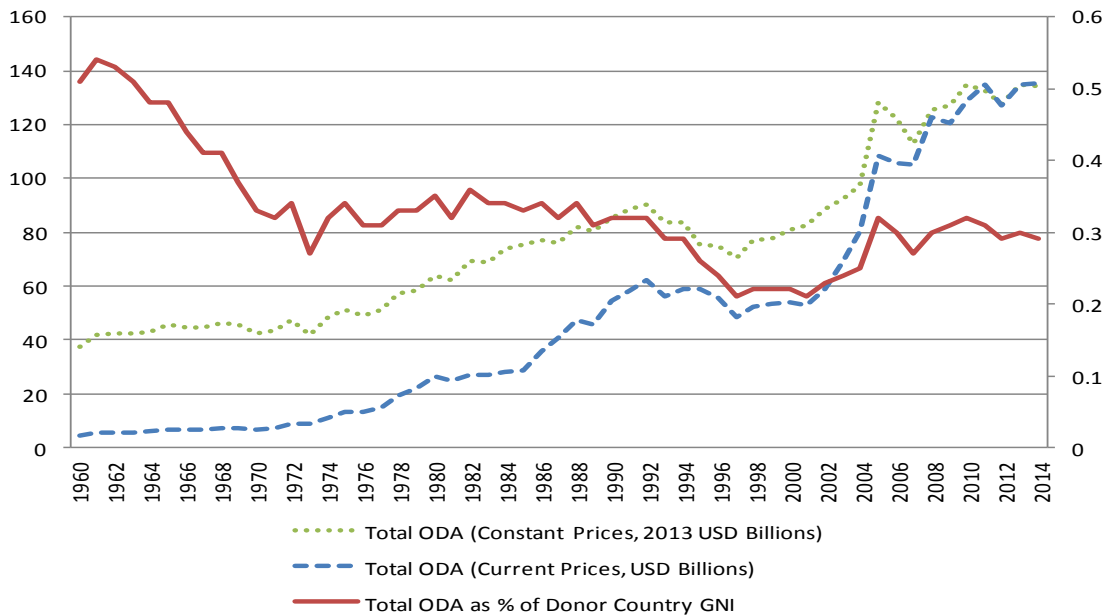
Aid is usually measured by one or more of the following indicators: net ODA, net ODA as a percentage of donor country's gross national income (GNI), net ODA per capita of recipient country, or net ODA as a percentage of recipient country's GNI (Radelet 2006). Each indicator may be measured in either current dollars (nominal prices) or in constant dollars adjusted for inflation and fluctuations in exchange rates between U.S. dollars and the donor country's currency for a given period of time.

Figure 11 illustrates total ODA from DAC countries from 1960 to 2014. It shows that total ODA disbursement from DAC members rose steadily in absolute terms from 1960 all the way to early 1990, following which it dipped to US\$48.7 billion in 1997 in the wake of the economic recession of the 1990s. ODA levels did not rebound until the turn of the millennium, with a rapid growth partly driven by the post-9/11 flows to Afghanistan and Iraq. The year 2014 has been the historic peak of ODA at a staggering US\$135 billion. Although some European countries are slashing their aid budgets, it is hard to imagine that aid levels will decline beyond 2014 in light of the humanitarian crises due to the rise of the Islamic State, the Ebola outbreak and the continuing high demand for aid in some of the largest aid recipient countries like Iraq, Afghanistan, Pakistan, Nigeria, Egypt, and Palestinian territories.

By contrast, total ODA as a percentage of donor country GNI has been declining, especially during the 1960s and 1990s. Following a dip in 1973 after the oil price shocks, aid as a percentage of GNI hovered between 0.3% and 0.4% during the 1970s and 1980s, until it dropped again to its historic low level of 0.21% in the years 1997 and 2001.

Although the steep rise in absolute levels of aid in 2000s managed to pick up aid in relative terms, it continues to linger around an average of 0.3%, far below the United Nations (UN) target of 0.7%.¹²

Figure 11 Total ODA disbursed by OECD countries



Source: OECD-DAC Statistics (2014)

It is important to note, however, that data analysis and interpretation are highly sensitive to the choice of variables and indicators. To illustrate the point, consider Figure 11, which reports total ODA disbursed by DAC countries on the left-hand-side vertical axis and ODA as a percentage of donor country GNI on the right hand side vertical axis.

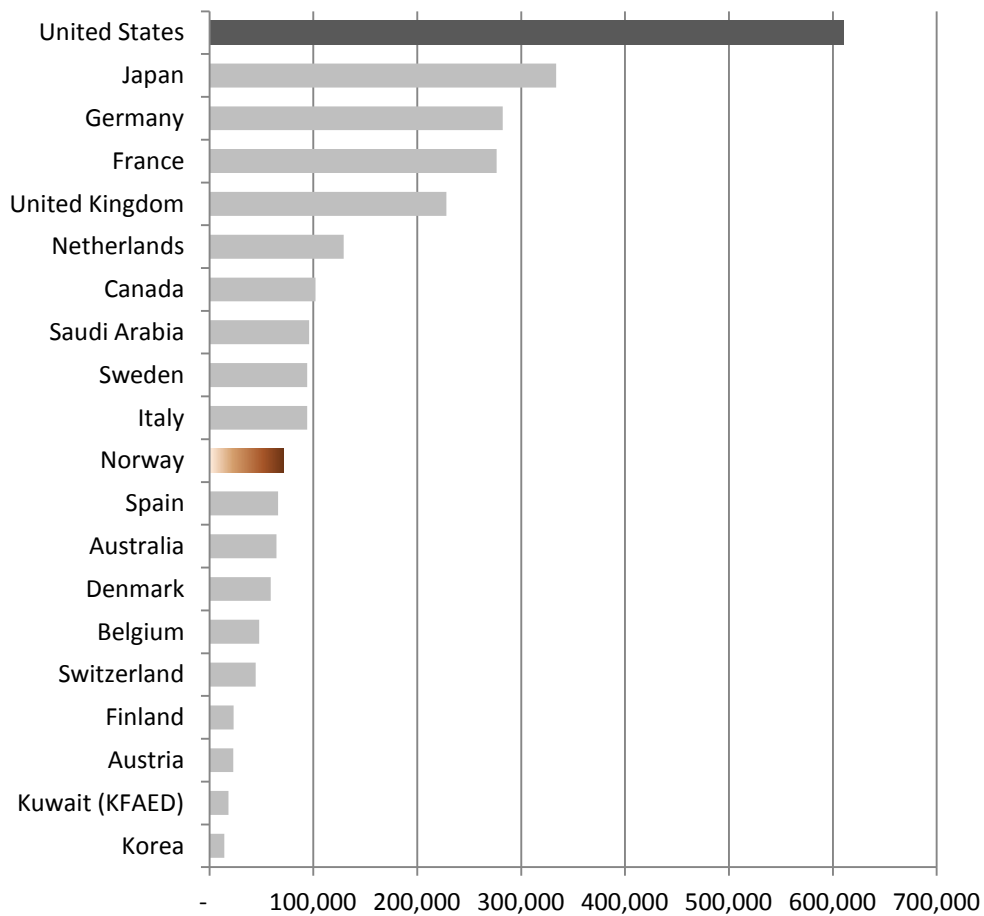
¹² This target dates back to the year 1958 when the World Council of Churches proposed the idea of one percent target to all United Nations Delegations (Führer 1994). Later in 1970, the United Nations adopted the 0.7% target as follows: “Each economically advanced country will progressively increase its official development assistance to the developing countries and will exert its best efforts to reach a minimum net amount of 0.7 percent of its gross national product at market prices by the middle of the decade” (UN General Assembly Resolution 2626 (24 October 1970) in OECD 2010, 1).

If one were to consider the left-hand-side axis, one would conclude that overall, aid levels in 2013 constant prices have almost quadrupled from about US\$37 billion in 1960 to nearly US\$135 billion in 2014. The slope of the line, depicting the rate of increase in ODA disbursements, increases when disbursements are measured in current prices as compared to constant prices. On the other hand, if one were to consider the right-hand-side axis, one would conclude that overall, donors have become less generous with aid disbursements, because relative to their incomes, they are contributing 0.2 percentage points less aid (as a percentage of their GNI) than the levels they used to contribute in the early 1960s. Although DAC countries are giving more aid in absolute terms (even after adjustments for inflation), it is increasingly a smaller percentage of their income, because they are getting richer at a rate faster than the rate at which they are increasing their ODA.

The choice of measurement indicator also affects the ranking of countries, both the recipient as well as the donor countries. For example, in absolute terms, the United States has been the largest donor by far, followed by Japan, Germany, France and the United Kingdom (see Figure 12). When measured as a percentage of donor country's GNI, however, donor rankings change dramatically (see Figure 13). For example, the top two donor countries in absolute terms, i.e. the United States and Japan, are ranked 17th and 18th respectively in their aid disbursements relative to the sizes of their domestic economies. On the other hand, Scandinavian countries, such as Norway and Sweden are catapulted as the number one and number three most generous donor countries respectively, measured by their aid disbursement relative to the sizes of their domestic

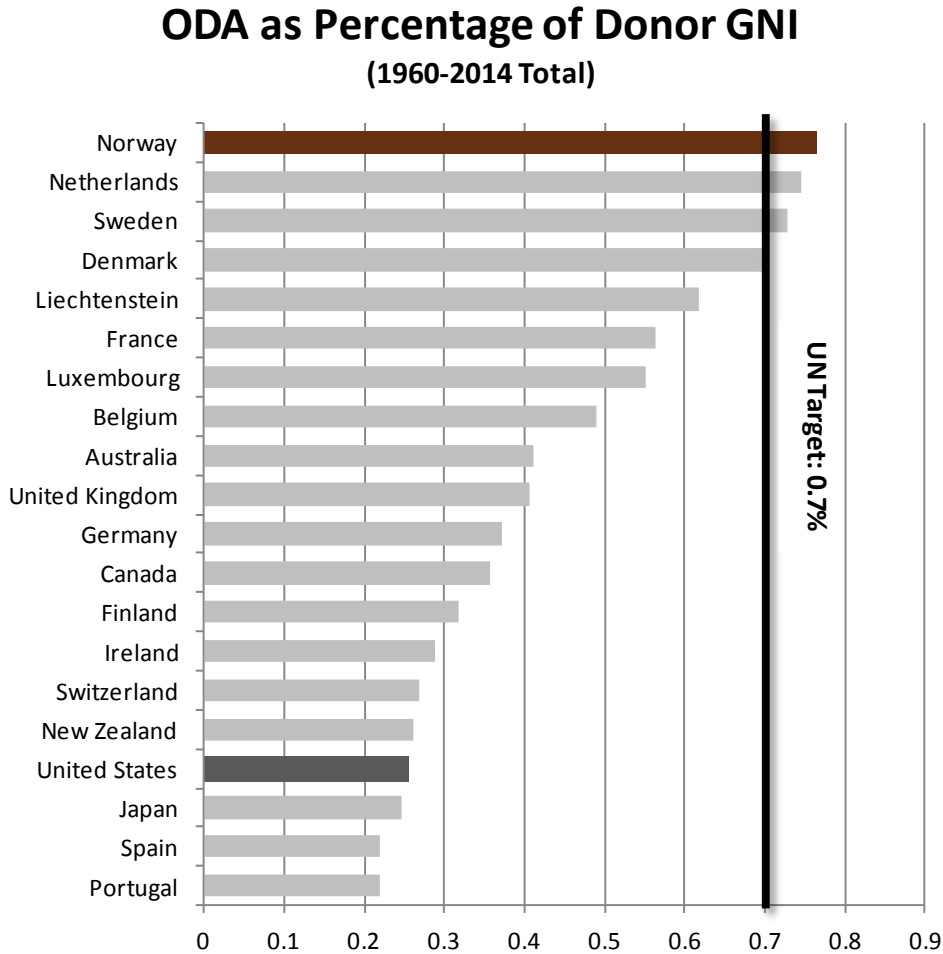
economies. In fact, only Norway, Netherlands and Sweden exceed the United Nations target of giving at least 0.7% of donor GNI in aid. As illustrated in Figure 13, the 2014 numbers put the following four countries ahead of the UN target: Sweden (1.1%), Luxemburg (1.07%), Norway (0.99%), Denmark (0.85%) and UK (0.71%).

Figure 12 Top 20 largest donor countries, total ODA disbursed 1960-2014 (Current Prices, US\$ Millions)



Source: OECD DAC Aid Statistics (2014)

Figure 13 Top 20 most generous donor countries in history



Source: OECD-DAC Aid Statistics (2014)

History of Foreign Aid

Foreign aid, in one form or another, has existed for centuries. In fact, the transfer of resources, including gold, has been used as an important foreign policy tool to secure peace or form new alliances since even before the invention of the nation-state concept. Some of the earliest signs of foreign aid, defined here broadly as resource flows from the rich to the poor, can be observed since at least the 18th century in the form of missionary

schools, and the Colonial Budget Offices. Edwards (2015, 298) calls the British Colonial Development Act of 1929 “the first legal statute dealing expressly with official aid.” However, the modern structure of development assistance took shape after the Second World War through the creation of the Bretton Woods Institutions.

For example, at a commencement speech to the graduating class of Harvard University in 1947, General George Marshall, the then U.S. Secretary of State appointed by President Truman, emphasized the importance of providing aid abroad for achieving security at home:

it is logical that the United States should do whatever it is able to do to assist in the return of normal economic health to the world, without which there can be no political stability and no assured peace. Our policy is not directed against any country, but against hunger, poverty, desperation and chaos. (Marshall 1947)

Gradually, Marshall’s call for aid to fight hunger, poverty, desperation, and chaos has become the cornerstone of American foreign aid policy. For the United States, the world’s largest donor in absolute terms, the foundations of foreign aid were laid by President Truman. In his Inaugural Address at the Capitol on January 20, 1949, President Truman (1949) famously said:

We must embark on a bold new program for making the benefits of our scientific advances and industrial progress available for the improvement and growth of underdeveloped areas. More than half the people of the world are living in conditions approaching misery. Their food is inadequate. They are victims of disease. Their economic life is primitive and stagnant. Their poverty is a handicap and a threat both to them and to more prosperous areas. For the first time in history, humanity possesses the knowledge and skill to relieve the suffering of these people.... Only by helping the least fortunate of its members to help themselves can the human family achieve the decent, satisfying life that is the right of all people.

President Truman's legacy has continued to the present through various administrations. For example, the establishment of the U.S. Agency for International Development (USAID) by President Kennedy following the Foreign Assistance Act of 1961 further solidified United States' commitment to international development. Outside the US, the establishment of the Development Assistance Committee (DAC) under the OECD in 1960 marked the earliest efforts to coordinate aid from developed countries to the developing world. This period was critical because of an upward trend in the flow of aid from DAC and non-DAC donor countries alike, against the backdrop of the Cold War rivalries.

The Aid Narrative

Much of the intellectual history of foreign aid dates back to the post-WWII period. For example, Walt Rostow's (1960) *Stages of Economic Growth* popularized the idea of "take-off" as a step towards achieving economic development and arriving at the promised age of mass consumption after a successful drive to maturity. In his article on the "Problems of Industrialization of Eastern and South-eastern Europe," Paul Rosentein-Rodan (1943) is credited with developing the idea of the "Big Push" – although he did not use this specific term in his paper – as a model of economic development. He basically argued in favor of large-scale investments in industrialization to absorb the unemployed masses in developing countries in order to escape a low level equilibrium trap and embark on a trajectory of economic growth.

At the heart of the earlier big push narrative lies the belief that what is holding back the developing countries from embarking on economic growth is insufficient initial

investments, especially in large infrastructure projects. Here, foreign aid comes to the rescue by filling this investment gap, which will jump start the economy and lead to a take-off, thus creating a virtuous cycle of more growth and higher returns to investment. This narrative was formalized in a “two-gap” model, also known as financing gap model, or “aid-financed investment approach to development” (Dollar and Easterly 1999, 548), developed by Chenery and Bruno (1962) and Chenery and Strout (1966), in which the first gap is related to savings and the second gap is related to trade in order to generate foreign exchange¹³. The two-gap model is in large part an extension of the Harrod-Domer model, which despite having been originally developed to explain business cycle and growth, has had significant influence on development theory over time. Hirschman's (1958) emphasis on investing in industries with strong forward and backward linkages completed the narrative, which according to critics is still the only major narrative guiding development effort despite its many theoretical flaws and lack of empirical support. For example, Easterly (2003, 34) posits that “the idea that ‘aid buys growth’ is an integral part of the founding myth and ongoing mission of the aid bureaucracies.”

Since then, the big push model has found traction in many circles. For example, building on this model, Jeffrey Sachs and others have reinvigorated the idea of ending extreme poverty through the fusion of large sums of foreign aid dollars into poor countries. As Easterly (2006) argues, the turn of the century brought about a “big push Déjà Vu” despite the scarcity of evidence, in his view, to support such classic narrative of aid-driven economic development.

¹³ Since then, there has been an explosion of other-gap models including three-gap model developed by (Bacha 1990) and others related to technology-, food-, gender- and environment-gaps (Hansen and Tarp 2000).

These early intellectual developments formed the cornerstone of foreign aid infrastructure both domestically in the US and abroad. For example, as Wiarda (1999, 49) argues:

for a long time (and often continuing to today), these ideals of the causative relationships between economic and social change *and* democratization represented the ideological foundation of the U.S. foreign aid program directed at the developing countries.

He also points to the key role that Rostow played as an architect of U.S. foreign aid program in the early 1960s, which gave rise to programs such as Peace Corps, the Alliance for Peace, and aid to various sectors and groups including the peasants, trade unions, political parties, education, mass communication, and community development. More recently, the development of the Millennium Development Goals (MDGs) (and now the Sustainable Development Goals or SDGs) may also be considered a brainchild of this renewed commitment to fighting poverty with the tools of foreign aid.

Debates to Date on Aid Effectiveness

As the volume of aid has grown, more than quadrupling its volume in 1960 in constant dollars,¹⁴ so has the literature on aid effectiveness, with ardent supporters and critical opponents contesting both the legacy and the future relevance of foreign aid. The vast literature on foreign aid effectiveness is an interesting case of polarized views, some considering it a panacea and others a complete failure. For example, in line with the view that aid works, the entrance of the World Bank headquarters in Washington, DC, is

¹⁴ In 2013 constant prices, total ODA has nearly quadruples from US\$38 million in 1960 to US\$135 million in 2014. In current prices, however, the increase is almost 29 times as much, from US\$4.7 million in 1960 to US\$135 million in 2014.

inscribed with the slogan “our dream is a world free of poverty.” In opposition to the effectiveness of aid, one of the greatest development economists, Peter Bauer (1975 in Shleifer 2009, 379–380) has famously criticized aid for being “a transfer of resources from the *taxpayer* of donor country to the *government* of a recipient country.”

Some of the main proponents of foreign aid include Jeffrey Sachs (2006), Joseph Stiglitz (2006; 2002), Nicholas Stern (1974) and others, who have lately been joined by celebrities such as Bono and Angelina Jolie. The proponents of foreign aid attribute the reduction of global poverty and other achievements in health, education and well-being in developing world to foreign aid. For example, they point to the economic success of large aid recipients such as Botswana, Indonesia, South Korea, Tanzania, and Mozambique as evidence in support of foreign aid. Even in the cases of apparent failure of foreign aid to achieve results, they argue that aid has prevented conditions from further deterioration. They therefore constantly call for an increase in the volume of aid to the 0.7% of donor countries’ GNI target in order for aid to be more effective in its fight against poverty.

Some of the most noted critics, on the other hand, include Milton Friedman (1958), Peter Bauer (1972), Paul Mosley (2015) , Peter Boone (1996), William Easterly (2005), and Dambisa Moyo (2009). They argue that the majority of aid recipient countries, such as Democratic Republic of Congo, Somalia, Haiti, and Papua New Guinea, have failed to show results despite the inflow of billions of foreign aid dollars for more than five decades. For example, in her provocatively titled book, *Dead Aid*, Dambisa Moyo (2009, xix) argues that “aid has helped make the poor poorer, and growth

slower.” Other critics charge that aid has worsened weak governments, helped the elite, distorted local economies or has simply been wasted.

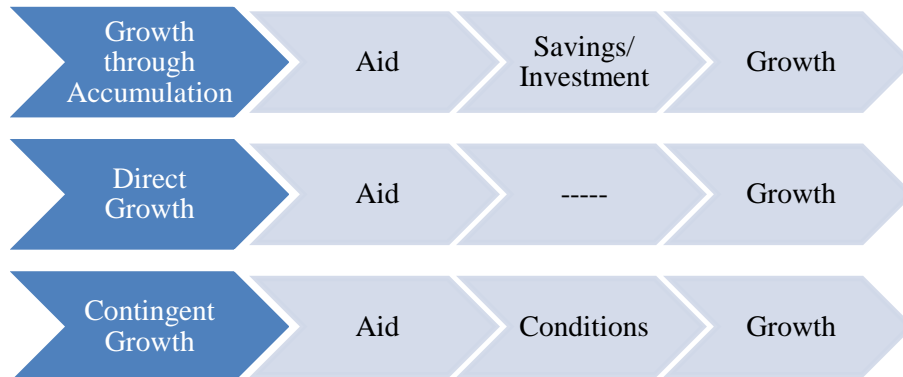
One recent shift in thinking about and in the practice of defining aid effectiveness by the development community is in defining it not at the level of impact, outcome or output, but implicitly defining aid effectiveness at the level of input, namely through the volume of aid disbursed. This practice essentially equates every dollar of aid input to comparable units of outcome and impact, an assumption that cannot be further from the truth. This shift in thinking is summarized by Judith Tandler (1975 in Easterly 2003, 34) as follows:

A donor organization’s sense of mission, then, relates not necessarily to economic development but to the commitment of resources, the moving of money. . . . The estimates of total capital needs for development assistance in relation to supply seem to have been the implicit standard by which donor organizations have guided their behavior and judged their performance . . . the quantitative measure has gained its supremacy by default. Other definitions of success and failure of development assistance efforts have been hard to come by.

Keeping in mind the diversity of opinions regarding the right measure of aid effectiveness, for the remainder of this chapter, I choose to focus on economic growth of recipient countries as the outcome variable of interest, which is the most common measure of aid effectiveness in the literature. Establishing the causal mechanism between aid disbursements on the one hand and growth on the other helps us categorize the voluminous literature on aid effectiveness into a few distinct groups. In fact, as depicted in Figure 14, the aid effectiveness literature is divided into three broad categories based on the hypothesized causal mechanism between aid and growth (Doucouliagos and Paldam 2009; Radelet 2006; Hansen and Tarp 2000). While the first and second

categories estimate the causal relationship between aid and economic growth without specifying any conditions, the third category argues that aid will be effective only under certain conditions.

Figure 14 Three waves of literature on aid effectiveness



Source: Adapted from Doucouliagos and Paldam (2009, 441)

The first wave of literature, which relied on growth theories focusing on factor accumulation, failed to show support for the aid effectiveness narrative. For example, Boone (1996) found that aid was going primarily to public consumption instead of investment, thus simply enlarging the government and not necessarily contributing to growth even if the theory was sound. Some also found evidence to the contrary, namely that aid actually decreased saving (Griffin and Enos 1970; Weisskopf 1972). Doucouliagos and Paldam (2009) also find that only 25% of aid goes to accumulation, while the remaining 75% goes to public consumption, which is shown to negatively affect growth (Barro and Sala-i-Martin 2003).

In a related line of argument, some scholars have studied the impact of aid on recipient country fiscal behavior, including taxation, public investment and government

expenditure, because “aid funds pass through a policy maker’s hand prior to reaching their destination” (Khan 2003, 351). More recently, Mosley (2015, 106) links fiscal behavior directly with aid effectiveness by arguing that:

tax effort and the ability of the state to diversify its taxation structure, we find, are significantly linked to growth and poverty indicators. The key message for policy is that a broadening of the tax structure in low-income countries is crucial in order to enable those countries to escape from the ‘weak-state–low-tax trap,’ and to make aid effective.

Similarly, the second wave of literature, which argues that aid has a direct relationship to growth, finds little support in literature. For example, Doucouliagos and Paldam (2009) find that although this model has been tested with nearly 400 control variables, there is still scant evidence to support the claim of the model. Bauer (1972) actually found a zero or negative relationship between aid and growth.

The third wave, however, seems to have stood the test of time and replication better than the preceding two waves, thus deserving a deeper look inside. This wave of literature, which I call the contingent growth category, posits that aid may or may not lead to growth depending on a number of conditions. The specific conditions under which aid may be more effective is large and growing. Radelet (2006), for example, further classifies the third wave into three sub-groups, arguing that the conditions under which aid could be more effective fall into one of three sub-categories.¹⁵ My proposed hypothesis, i.e. that relative effectiveness of aid is conditional upon local capacity, falls best under the first sub-category discussed below.

¹⁵ It is worth noting again that my proposed hypothesis on the centrality of local capacity for aid effectiveness falls best under the first sub-category.

1. Recipient country characteristics: an entire sub-group of literature deals with the effectiveness of aid conditional on certain key characteristics of the recipient country. For example, Isham, Kaufmann, and Pritchett (1995) argued that aid would be more successful in countries with stronger civil liberties. Boone (1996) found that short-term aid targeted to support new liberal regimes *may* be a more successful means of reducing poverty than other programs. Burnside and Dollar's (2000) argument that aid works in a “good policy environment” defined as the weighted sum of budget surplus, inflation rate and trade openness, also falls in this category. Since the Burnside and Dollar paper, many papers have reacted to their results, some supporting while others refuting it in a state that Easterly (2003, 23) has called a “political football.” For example, Rajan and Subramanian (2005) find no evidence that aid works better in better policy or geographical environments. Similarly, Easterly, Levine, and Roodman (2003) use the exact same specification as Burnside and Dollar, but simply added more data. Here, they show that the “good policy environment” argument in fact could not be replicated. Hansen and Tarp (2000) also find that aid in all likelihood increases the growth rate, and this result is not conditional on good policy. Dollar and Easterly (1999) salvage the good policy argument by finding that aid, if offered in a good policy environment, paves the way for attracting private investment, which would otherwise be crowded out.
2. Donor practices: Another strand of literature shows that aid may be more effective if a) aid is channeled multilaterally and not bilaterally, b) more aid is provided as

untied, c) aid is provided with better coordination among various donor agencies (Bigsten and Tengstam 2015), c) donors reduce fragmentation and instead concentrate on a few countries (Brown and Swiss 2013), and d) aid is coupled with greater ownership and participation of recipient countries. For instance, Winters (2010, 218) finds that “foreign aid functions better—both at the macro-level of aid flows and at the micro-level of individual aid projects—when there is more government and implementing agency accountability” measured by participation.

3. Aid typology: The last sub-strand of literature shows that different kinds of aid are aimed at different outcomes and treating them all under one variable may be misleading. For example, Clemens et al. (2012) study three types of aid, including aid given for humanitarian purposes, aid channeled to health and education sectors, and aid spent on infrastructure, and they find that only the third type is correlated with growth.

Does the Evidence Support the Aid Narrative?

Considering all, the preponderance of evidence, especially those coming from cross country regressions relating aid to growth, suggest that aid does not work, with the exception of certain cases within the third wave of literature, namely conditional effectiveness of aid. Hristos Doucouliagos and Martin Paldam (2009; 2011) support this position through combining the results of decades of studies in meta-regression analysis. For example in a paper titled appropriately “The Aid Effectiveness Literature: The Sad Results of 40 Years of Research,” they show that the results of 97 econometric studies as

of 2004 show that aid has not been effective, primarily because of Dutch disease (Doucouliagos and Paldam 2009). They updated their list in 2011 and correspondingly changed the title of their paper to “The *Ineffectiveness* of Development Aid on Growth” [emphasis added] and show that the net effect of aid on growth, through 105 papers and 1217 estimates, is positive, but of no statistical or economic significance (Doucouliagos and Paldam 2011).

The litany of hypothesized reasons that make aid ineffective is long and expanding, and are sometimes at odds with each other. They include the following: too little money; too much money; overreliance on non-government organization (NGOs), which are not designed to promote growth; too much recipient government involvement and allegations of corruption; bypassing local governments; low absorption capacity; multiple layers of sub-contracting; misaligned incentive structures among the many principals and agents (Martens et al. 2008).

If the preponderance of evidence is against the effectiveness of foreign aid, why does aid continue to not only survive but also thrive? Before attempting to answer this question, however, this section briefly addresses the question of why donor countries provide aid to developing countries, regardless of the evidence on aid effectiveness, or the lack thereof. Despite much overlap, these are two distinct questions, as clarified below.

Donor Motivations

Why do the governments of rich countries provide aid to poorer countries? Unlike the literature on aid effectiveness, the question of donor motivation reverses the model by

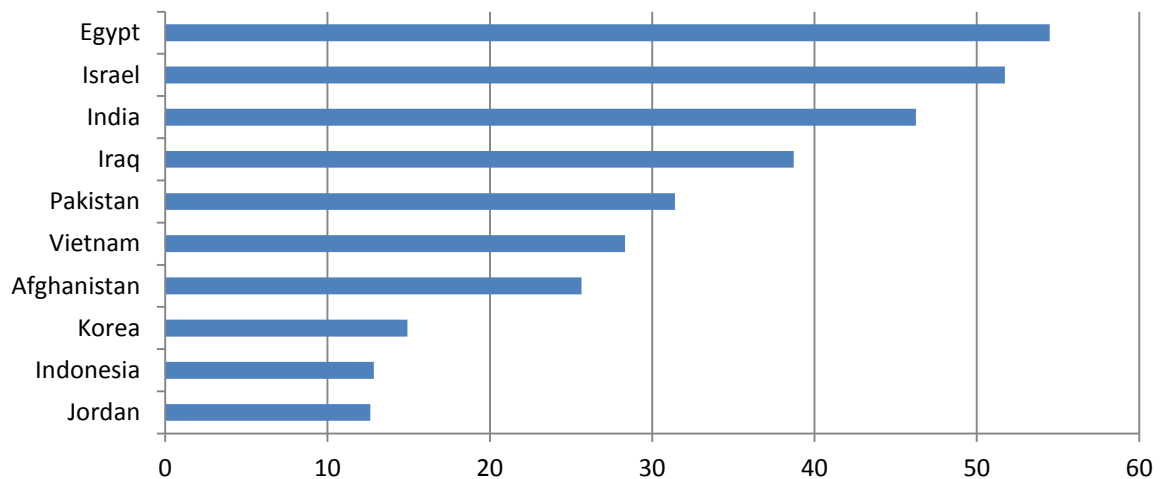
treating aid flows as the dependent variable and various potential donor motivations for aid-giving as explanatory or independent variables.

At the theoretical level, the donor country motivations for providing aid may best be illustrated on a continuum from altruism on the one hand and self-interest on the other. Those closer to the altruistic or idealist camp posit that aid is and should be given on the basis of recipient countries' *needs* with less or no regard to all other considerations. Much of the "humanitarian assistance," especially those channeled through smaller NGOs and provided by individual donors falls closer to this category. On the other end of the spectrum lies the Marxist and Neo-Marxist view, which is concerned with how aid may be used as a tool at the hands of the rich countries to subjugate the poor or at least maintain global power relations. In between these polarized positions lies the majority view that see aid as serving both the needs of the poor as well as meeting the strategic interests of the donor countries.

The reality of the motivations on the ground is an empirical question that may be tested with data. For example, if altruism was the main force driving aid flows, at least three conditions must be satisfied. First, aid must flow to those regions of the world with greatest need, e.g. measured by the levels of poverty in recipient countries. Second, aid flows must stop once the need is satisfied in comparison to other regions of the world. Third, in order to take away the incentive from the recipient country governments to become perpetually aid dependent, certain conditions must be imposed, monitored and enforced. In reality, however, it is not hard to find evidence that shows how the three conditions are violated: i) on all measures of aid, some relatively richer countries receive

more aid than many poorer countries; ii) the discontinuation of aid flows is determined by factors other than the reduction in levels of need; and iii) conditions are not always imposed, and when they are, they are rarely followed through.

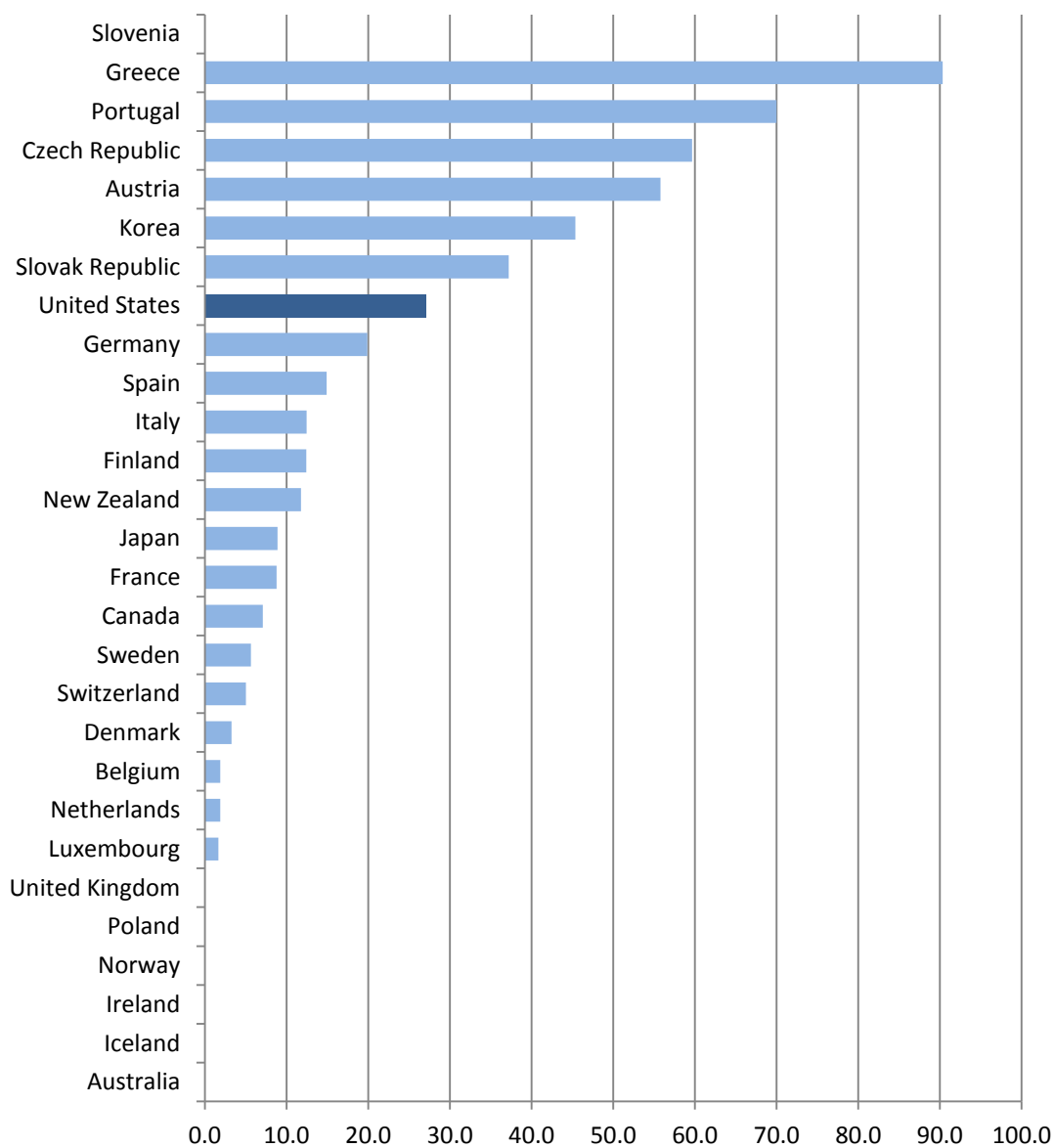
Figure 15 Top ten recipients of American ODA from 1960 to 2013 (Constant Dollars, 2013 US\$ Billions)



Source: OECD-DAC Aid Statistics (2014)

Furthermore, aid is not always given to the poor, best demonstrated by the list of top ten recipients of American aid in Figure 15. In fact, between 1975 and 1996, Egypt and Israel accounted for more than 45% of total American aid of US\$195 billion disbursed to more than 100 recipients. Finally, need-driven aid should not be tied, but the reality as depicted in Figure 16 paints a different picture for many of the donor countries. Similarly, Ellmers (2011, 4) finds that “more than 50% of total official development assistance, is spent on procuring goods and services for development projects from external providers.”

Figure 16 Percentage of official tied aid for DAC members in 2013



Source: OECD-DAC Aid Statistics, table 23 (2014).

Note that Slovenia did not report tying status for 2013.

The extreme Neo-Marxist view, i.e. that aid is given to subjugate the poor and maintain global power relations, also fails logical and empirical tests. The fluctuations in the flow of aid over time, without corresponding changes in the donor countries' incentive structure, cannot be explained by this view. While such a polarized and dichotomous representation of aid motives may be criticized for it "underestimates the complex interplay of hard-nosed realism and human ideals," I believe that the concept of a continuum helps the reader see the entire landscape and situate particular viewpoints relative to others in an ordinal fashion (Breuning 1994, 358).

The view of aid motivations between these two extremes, i.e. altruism and self-interest, best explains aid flows both over time and across countries. Proponents of this view – embraced by almost all scholars, yet still lying across a continuum separated by their belief in the relative proportion of aid being motivated by altruism vs. self-interest – believe that aid serves both the needs of the poor and the strategic interests of the donor countries. An example that best illustrates this point is the U.S. aid provided to "friendly" nations during the Cold War, which was given with the explicit purpose of curtailing the Soviet "encroachment" *in addition to* promoting development.¹⁶ As Qian (2014) points out, the top recipients of foreign aid, especially of American aid, are countries that are politically important to the top donor countries, such as Vietnam during the 1970s, China during the reform era of the 1980s and 1990s, and Iraq and Afghanistan since the event of 9/11. Yet it is also true that the largest donor for many least developed countries, in absolute terms, is the United States. Therefore, as De Haan (2009, 3) points out, "its [aid's] principles always reflect a combination of motives, and aid practices tend to create

¹⁶ For example, read on the Mutual Security Act of 1951 and its amendment in 1959.

their own dynamics, as do all policies, through the institutions responsible for their implementation.”

In a much cited article, Alesina and Dollar (2000, 33) find that “the direction of foreign aid is dictated as much by political and strategic considerations, as by the economic needs and policy performance of the recipients.” Examples of strategic interests may include compensation for colonial practices, efforts to expand the market for one’s goods; to increase one’s influence and soft power in the region; to make new political allies or continue to please old allies; to signal diplomatic approval of a new regime in power; to reward good behavior such as the reduction of barriers to free flow of goods, financial resources, people or ideas; and to improve infrastructure to facilitate the expansion of extractive industries. Riddell et al. (2008) argues that aid-giving behavior by donor countries is best explained by a combination of factors and objectives bundled together, including humanitarian, economic, political, strategic, cultural, historical, and moral imperatives. The real debate, therefore, is just about the degree to which aid may be given for altruistic and self-serving reasons, not either-or. The recently increasing pattern of South-South aid flows lends further credibility to a complex interplay of motivations influencing aid policy.

The Aid Continuation Puzzle

In the preceding section, we asked why the donor countries deliver aid in the first place. We mapped donor motivations on a continuum from altruism to self-interest, and showed that there is almost universal agreement that donor countries’ aid policies are informed by a combination of both altruism and self-interest, the degree of which is up

for debate. This section asks a different question, albeit with overlapping responses. In particular, I show that the preponderance of evidence is stacked against the effectiveness of foreign aid, yet aid volumes continue to expand even in real terms. This section, therefore, asks why governments of rich countries continue to provide aid despite a lack of evidence to show that it works. Elaborating on this question forms the main subjects of discussion in this section.

There are many reasons for the continued thriving of foreign aid despite the lack of sufficient evidence to support that it works. The most obvious answer, stemming from the discussion in the previous section, is that aid continues to grow because it at least serves the strategic self-interests of the donor countries. This, however, is only a partial response. In order to summarize, I group potential responses to this question into five major categories, namely the strategic, humanitarian, theoretical, methodological, and ideological case for aid.

A. The Strategic Motive

Aid may also continue to exist and expand because even if it does not achieve growth, it still serves the other strategic interests of the donor countries. In line with the view that the primary motivations of donor countries are political and strategic, and by extension development outcomes are secondary, aid will continue to exist for as long as the primary interests of the donor countries are safeguarded. In addition to the political interests, tied aid, also known as “boomerang aid,” may in fact benefit the donor countries economic interests. In addition to economic interests, foreign aid may also buy

donor countries soft power by influencing public opinion (Goldsmith, Horiuchi, and Wood 2014). Lastly, the aid infrastructure – including multilateral and bilateral aid agencies, private contractors, foundations, and international and local NGOs – has grown so large and ubiquitous that path dependence and institutional stickiness come in the way of any major reform. For these reasons and more, proponents of this view see little reason for aid to subside, especially when it comes at an average cost of about 0.3% of donor country income.

B. The Humanitarian Case

One of the reasons that foreign aid continues to thrive despite the lack of evidence to support the aid narrative is the moral or humanitarian case (e.g., Lumsdaine 1993). Even after acknowledging the failure of foreign aid to deliver on its promises, the people and governments of rich countries will continue the effort to deliver aid to those less fortunate than them, driven by their values and ideals. For example, Stern (1974), considers aid a “moral obligation” on the part of the rich in the developed world to help those in the developing world, where even the rich experience a lower standard of living than the poor in developed countries. This argument resonates more in today’s globalized world where despite the increased interconnectedness, the gap between the winners and losers of globalization is widening.

C. The Theoretical Defense

At a theoretical level, some critics of aid have challenged the aid narrative, but continue to stand behind aid on the grounds that even if aid cannot buy growth, it can at least improve people's lives in other ways, albeit relatively much less ambitious, such as providing short term employment, temporary relief, and other band aid solutions. Mosley's (1986) "micro-macro paradox" is a testament to the fact that aid, at least at the micro level, achieves certain objectives, thus benefiting the poor. He observed that much of the macro-level evidence, i.e. the cross country regression analyses that failed to prove a robust relationship between aid and GDP growth, point towards aid ineffectiveness. On the other hand, much of the micro-level evidence, i.e. ex post project level studies conducted by the World Bank that showed "success" measured by more than ten percent rates of return, point towards aid effectiveness. Therefore, it could be argued that even if aid fails to achieve growth, it helps achieve other smaller goals. As Easterly (2005, 11) argues, expecting the existing foreign aid infrastructure to achieve economic growth is like expecting a cow to win the Kentucky Derby. In essence, the theoretical case for aid questions the somewhat narrowly-framed definition of aid effectiveness in terms of GDP growth.

Others argue that the aid ineffectiveness literature is understandable because aid goes to countries and regions that need it the most, and not those that have the highest potential to attain sustained growth. For example, summarizing key findings of the DAC Chairman's Annual Report of 1985, Führer (1994, 39) argued that:

Aid is not only concentrated in countries with the most difficult and intractable development problems; substantial amounts of it must be used to cope with emergency situations arising from natural calamities, refugee influxes or strife. It is not at all surprising, therefore, that many of the major aid recipients are not among the fast-growing countries. Almost all have been helped significantly by aid to accelerate social development and to lay at least some of the foundations for rapid economic progress.

While this may have been true in the early years and for certain kinds of aid, such as humanitarian assistance, this view that aid goes to the poorest countries is not supported by evidence. In fact, Qian (2014, 13) shows, using more recent data, that “countries that are richer in total and in per capita terms receive much more aid, while factors such as poor economic growth or the occurrence of natural disasters has very little influence.” She further shows that only about 1.69% to 5.25% of total aid is given to the poorest twenty percent of countries in any given year.

Führer (1994, 40) further argues that “aid has to be more concerned with creating the fundamental conditions for its effectiveness.” This view, however, is also refuted by Deaton (2013, 273), who in his recent book *The Great Escape: Health, Wealth, and the Origins of Inequality*, shows that “when the ‘conditions for development’ are present, aid is not required. When local conditions are hostile to development, aid is not useful, and it will do harm if it perpetuates those conditions.”

D. The Methodological Challenges

One reason that aid continues to thrive despite lack of evidence is that the evidence is not considered to be convincing enough. Proponents of this view continue to hold on to the aid narrative by respecting the theory and casting doubt on the empirics. In fact, much of the earlier literature refuting the aid narrative is often dismissed for its lack

of methodological rigor to account for endogeneity. The endogeneity problem likens the aid-growth nexus to a chicken-and-egg problem where it may be difficult to establish the direction of causality.

The advancement in modern quantitative theory and techniques renewed hopes in determining for a fact the fate of the long standing debate on aid effectiveness literature. The quantitative advancements, however, have not only failed in reducing the debate but it has in fact added to it because of the sensitivity of the statistical models to the choice of estimator and the set of control variables (Hansen and Tarp 2000). Cross country analyses are also taken with a grain of salt because sometimes the effect is so small relative to noise that the two become indistinguishable (Roodman 2007).

The strong conviction to show evidence in support of the aid narrative has led some to engage in creative ways including obfuscation, data mining, and spin control. For instance, Doucouliagos and Paldam (2009, 444) show that “the development aid data have been so thoroughly mined that it is highly likely that some type I errors [acceptance of false aid-effect] have been published and that many ‘significant’ aid effects are not in fact statistically significant or practically relevant.” In a more sobering statement, Doucouliagos and Paldam (2015, 26) conclude from the often contradictory findings that “Let us face it: Economists are human!” Echoing similar reactions, Arndt, Jones, and Tarp (2010, 4) state that “if the profession has experienced serious difficulties estimating the causal effect of schooling on earnings in developed countries, then it should not be surprising that estimating the impact of aid on growth in developing countries is contentious.”

The diversity of opinion on the strength of evidence is understandable because much of the existing literature indeed treats all kinds of aid as one homogenous unit, which it is not because one can arguably expect aid to have a different impact depending on whether it is bilateral or multilateral, tied or untied, humanitarian or non-humanitarian, cash or in-kind transfer, spent in the donor or the recipient country, spent on one sector or another, etc. In addition to the kind of aid, Bourguignon and Sundberg (2007) discuss the causal mechanism “black box” that needs to be deconstructed and unpacked.

Yet others argue that the real challenge emanates from both theoretical and methodological origins. For example, Bjørnskov (2013, 4) argues that foreign aid must be viewed as a “multidimensional international transfer” in which different types of aid can have different kinds of impact along the economic, social, reconstruction and other dimensions. Therefore, estimating the effects of aid given for social purposes on economic indicators, for example, is a theoretical mistake. For this reason, many focus on estimating the effects of aid on specific sectors, such as education or health, rather than on aggregate economic indicators (Michaelowa and Weber 2007; Dreher, Nunnenkamp, and Thiele 2008; Mishra and Newhouse 2009).

Kilby and Dreher (2010) attempt to separate aid inflows depending on the motives of different donors, suggesting that aid given with political motives is less likely to contribute to development. Collodel and Kotze (2014, 197) similarly argue that “if after more than 50 years of research, we still do not have a conclusive answer to the question of whether aid is effective, then we should examine whether the methodology currently used to measure the effect of foreign aid is the most appropriate.”

E. Ideological Reasons

Even when some analysts invoke empirical evidence and theoretical explanations, their identification and selection of facts is grounded in deep seated ideological convictions. The proponents of this view will defend the sanctity of the aid narrative with unrelenting effort, and instead point to other potential flaws in the aid giving process, including the volume of aid as either too much or too little. For example, some argue that one of the main reasons aid is not working is because it has fallen much short of its 0.7% of donor country GDP target, thus unable to generate enough momentum for a big push (Sachs 2006). Others argue that aid has not been spent on the actual drivers of growth, although Easterly (2003) argues we do not really know what those actual drivers of growth are and what we do know changes over time.

A whole body of literature on aid conditionality has been developed on the premise that the real culprit is recipient country governments that do not exercise fiscal prudence. But even aid conditionality suffers from several challenges, such as lack of agreement on what conditions to impose,¹⁷ the number of conditions and the sectors on which to impose conditions, and enforcing conditions and pulling the plug when conditions are violated. Bearce and Tirone (2010) find that aid is actually more effective at boosting growth when strategic benefits of donors are small, such as the post- cold war

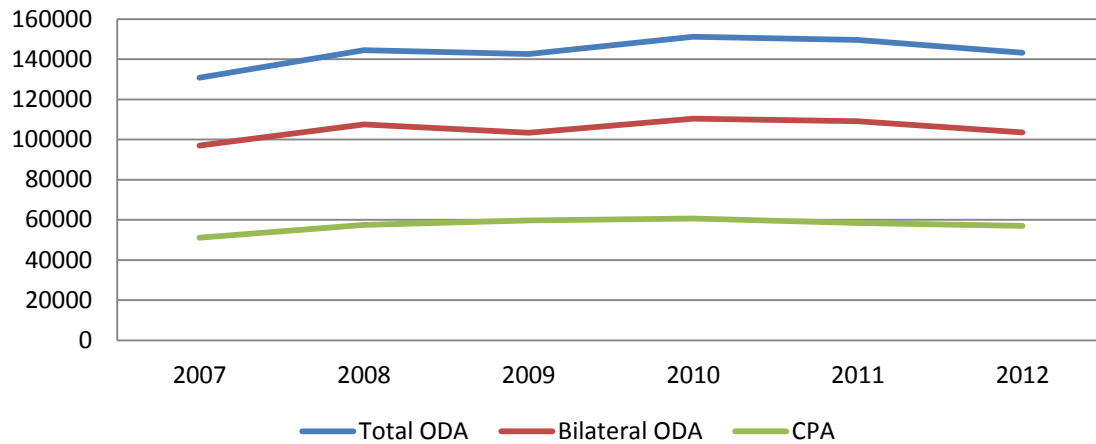
¹⁷ Washington Consensus and Post-Washington Consensus are just to name a few examples. For a more detailed analysis of this point, refer to (Easterly 2012) “Was Development Assistance a Mistake?” or refer to (Edwards 2015) for a discussion of the evolution of the thinking behind development, from the “planning approach “ of the 1950s to neo-classical models of the 1960s, and a current focus on “small” projects. Similarly, in contrast to neoliberal’s small-state, market-centered approach to development and building on Chalmers (Johnson 1982) influential work on developmental state, (Joshi 2012) illustrates three non-Western pathways to achieving development, as measured by the MDGs, namely human-, natural- and social-capital developmental state paths.

period of the 1990s, because donors can more credibly threaten to curtail aid if economic reform conditions are not met by recipient countries.

Another effort to salvage the aid narrative is the introduction of Effective Development Assistance (EDA) instead of ODA, to account for the non-grant component of ODA (Chang, Fernandez-Arias, and Serven 1998). But even this did not help, because recipient governments behave as if all of ODA was EDA given their short time horizons. Similarly, Hynes and Scott (2013, 2) propose measuring Official Development Effort (ODE), instead of ODA, in order to “exclude domestic expenditures on in-donor refugees, overseas students, and ‘development awareness’ programmes.”

Recognizing the limitations of ODA as a measure of aid, OECD-DAC developed the concept of Country Programmable Aid (CPA), an idea first discussed at the DAC Workshop on Scaling up for Results and Aid Allocations in February 2007. OECD (2014, 420) defines CPA as the proportion of ODA “over which host countries have, or could have, significant say.” Although DAC has retroactively made CPA data available from 2000 onwards, the data after 2007 is relatively more robust. As illustrated in Figure 17, on average, only about half of all aid disbursement by DAC members count as CPA, thus explaining, at least partially, the lack of evidence in support of the aid narrative.

Figure 17 Country Programmable Aid (CPA) relative to ODA (Constant 2011 Prices, US\$ Millions)



Source: OECD-DAC Aid Statistics (2014)

Others argue that aid itself is a mixed bag of positive and negative effects and the negative effects cancel out the positive. Examples of the negative side effects include the Dutch Disease undermining competitiveness and export of manufacturing (Bjerg, Bjørnskov, and Holm 2011), the distortionary effects of changing relative prices (Rajan and Subramanian 2009), aid spent on short run political gains as opposed to long run growth, and the fungibility of aid. In the absence of a proven better alternative to, therefore, aid may be viewed as a “regrettable necessity” to help some of the people some of the time in some places (Basu 1999). In summary, a deeper etiological assessment of the aid continuation puzzle, despite lack of evidence to show that it leads to growth, must be founded on a myriad of interrelated strategic, humanitarian, methodological, theoretical, and ideological factors.

How to Make Aid Work?

To make aid work, various solutions have been proposed. For example, a World Bank study by (Baker 2000, vi) argued in favor of conducting more evaluations because “despite the billions of dollars spent on development assistance each year, there is still very little known about the actual impact of projects on the poor.” Similarly, in his book, *Making Aid Work*, Abhijit Banerjee (2007) makes a strong case for why donors should fund only those programs that have been proven to work through Randomized Control Trials (RCTs) which are “the simplest and best way of assessing the impact of a program” (Banerjee 2007, 10). Easterly (2006) argues against unrealistic and grandiose plans to end poverty through the existing foreign aid machinery, because aid agencies can do incremental good, but they cannot end world poverty. Development agencies, especially the World Bank and the OECD through multiple declarations and fora on aid, have called for aid conditionality, improved coordination, increased transparency and accountability, and local ownership as possible ways to improve aid effectiveness.¹⁸

Hubbard and Duggan (2009, 3) in their book, *The Aid Trap*, devised a plan, in light of the Marshall Plan, to use aid to end poverty through supporting the business sector because “switching aid to the local business sector in order to cultivate a middle class is the oldest, surest, and only way to eliminate poverty in poor countries.” Easterly

¹⁸ For example the 2002 Monterrey conference focused on financing development. The 2003 High Level Forum on Harmonization and the 2005 Paris Declaration on Aid Effectiveness emphasized ownership, alignment, harmonization, managing for results, and mutual accountability. The 2008, 3rd High Level Forum in Accra, Ghana emphasized strengthening country ownership over development, building more effective and inclusive partnerships for development, and focusing on development results. Finally, the 2011 fourth High Level Forum in Busan, South Korea focused on local ownership, alignment of development programs around a country’s development strategy, harmonization of practices to reduce transaction costs, avoidance of fragmented efforts and the creation of results frameworks.

(2005) argues that the aid bureaucracy is not working and the solution will come from relying on decentralized markets to match those who want to help the poor with the poor themselves freely expressing their needs and aspirations. Gulrajani (2014) is among the few who focus on the organizational challenges of managing aid and therefore sees solutions in improving aid effectiveness in unpacking and improving on the organizational procedures within aid agencies. She examines empirical evidence from donor dynamics in Norway, the UK and Canada to push for a new and important lens through which to view and improve aid functioning.

Despite these dismal results, there is hope for optimism. For instance, Doucouliagos and Paldam (2015) show that there is a recent rise in the size of the estimates of aid effectiveness, based on the new literature from 2007 onwards, although they caution that the improvement could be simply an artifact. Studying 141 papers with 1,777 estimates produced over 43 years since 1960, they show that the average effect of aid on growth is +0.03 with a standard deviation of 0.01, thus making the estimator statistically significant, but still economically negligible. This result of “positive but small” relationship between aid and growth has also been confirmed by others (Rajan and Subramanian 2005; Hansen and Tarp 2000; Arndt, Jones, and Tarp 2010). Similarly, Arndt, Jones, and Tarp (2010) ask if we have come full circle in our studies of aid effectiveness. They show, using Program Evaluation literature, which aid does in fact lead to growth, but only in the long run. Addison, Mavrotas, and McGillivra (2005), for example, show that growth would have been lower and poverty higher in the absence of aid and that all criticisms of aid at the macroeconomic level were not supported by the

bulk of research. More recently, Galiani, Knack, and Xu (2014) found aid increased growth by focusing on 35 poor countries using improved identification strategies, similar to a regression discontinuity design.

Birdsall and Savedoff's (2011) promising new model of *Cash on Delivery (COD)* has yet to be tested and provide evidence of its effectiveness. However, at least in theory, the cash on delivery model has a number of advantages over older models of aid. In particular, it proposes paying for specific outcomes, which will address three main challenges with the existing aid model. These include a) focusing on results rather than disbursements, b) encouraging innovation, and c) strengthening government accountability to their citizens.

Alternative Measures of Aid Effectiveness

Given the dominant role that development economists, especially those with reductionist tendencies, have played in the earlier intellectual and institutional developments of foreign aid infrastructure, including the Bretton Woods Institutions, much of the literature has defined aid effectiveness in economic terms. In particular, the ultimate outcome variable of interest has been defined as GDP growth rate. In the immediate aftermath of World War Two, “an obsession grew with economic growth models and national income accounts,” notes Mahbub ul Haq (1995, 24), one of the founding fathers of Human Development Reports,¹⁹ “people as the agents of change and beneficiaries of development were often forgotten...the delinking of ends and means

¹⁹ According to Mahbub ul Haq himself (1995, 25), he was the first to propose the idea of developing an annual report on human development to William Draper III, the UNDP Administrator, in the spring of 1989, and just a year later in May of 1990, the first Human Development Report was produced.

began, with economic science often obsessed with means.” In fact, sometimes this obsession ran so deep that the means-ends distinction was starting to look fuzzy, with growth having replaced human development as the ends. For example, even when some studies assessed the effectiveness of foreign aid against more immediate outcomes, such as life expectancy or educational achievements, the implicit assumption was that these outcomes are valuable *because* they will ultimately contribute to increased growth at the national level.

An exclusive focus on growth may be criticized for the measure’s failing to account for real wellbeing of the people as the ultimate intended beneficiaries of aid and growth. This is not to claim that growth is intrinsically an unfit indicator of wellbeing, rather it is the kind of growth that matters as a means, and not the end in itself, to human wellbeing. For example, much of the critique currently raised against growth as the outcome variable would be weakened had growth always been more inclusive and equitable. Even though growth is often uneven, it still benefits the country as a whole.

No society has in the long run been able to sustain the welfare of its people without continuous injections of economic growth. But growth on its own is not sufficient – it has to be translated into improvements in people's lives. Economic growth is not the *end* of human development. It is one important *means*. (UNDP 1992, 12)

This view on the superiority of growth as the outcome variable started to change as more and more critiques were made. For example, a key turning point was when a Nobel laureate in economics, Theodore W. Schultz (1981), argued that improvements in people’s education and health should be viewed as important investments that would in turn promote economic development. In particular, he demonstrated that investing in

people's acquired abilities – through education, work experience, and good health – will make people more productive and thus valuable contributors to growth (Schultz 1981). At first sight, even this seems to be premised on the instrumental value of health and education as means to growth, not on their intrinsic value. However, this was still an important pronouncement at a time when previously health and education were mostly considered consumption goods, to be afforded only after more essential needs had been met, thus always taking a secondary status especially vis-à-vis growth promotion. When these ideas were later directly reflected in the Human Development Reports, a two-way relationship between investments in human development and growth was also explicitly stated, for example, as follows: “people contribute to growth, and growth contributes to human well-being” (UNDP 1992, 12).

The first Human Development Report (UNDP 1990, 1) has human development as its theme and clearly states that:

This report is about people – and about how development enlarges their choices... human development is a process of enlarging people's choices. The most critical of these wide-ranging choices are to live a long and healthy life, to be educated and to have access to resources needed for a decent standard of living.

The last three concepts, namely life expectancy, literacy, and per capita GDP, constituted the three key components of what makes the Human Development Index (HDI). The HDI, and human development theory more broadly, is inspired in part by the works of another Nobel laureate economist, Amartya Sen (e.g., in *Development as Freedom*, 1999), and especially his works on the capability approach, developed in partial refutation of the classical utilitarian approach that “reduces all qualities into quanta of utilities” (Khan 2014, 107).

More recent literature, as those discussed under aid motivations, suggest that the real motivations behind aid-giving are not primarily or exclusively the economic growth of the recipient countries. Therefore, it is argued that the literature on aid effectiveness must also reflect that diversity in the literature's dependant variable (Collodel and Kotze 2014). It is therefore not surprising that the use of growth as the dependent variable does not constitute agreement on the definition of aid effectiveness. For example, Radelet (2006, 7) argues that the main objective of foreign aid has been one of the following four:

- to stimulate economic growth through building infrastructure, supporting productive sectors such as agriculture, or generating new ideas and technologies,
- to strengthen education, health, environmental, or political systems,
- to support subsistence consumption of food and other commodities, especially during relief operations or humanitarian crises, or
- to help stabilize an economy following economic shocks.

According to Helmut Führer (1994), OECD-DAC member countries adopted a statement as early as in 1977 that emphasized the idea of “basic human needs” as not just a substitute for but also a key component of economic growth. As a result, recognizing that development is ultimately about meeting basic human needs, several alternatives to economic growth have been proposed, including HDI, poverty reduction, and the Millennium Development Goals (MDGs), now the Sustainable Development Goals (SDGs). To take this debate one step further, the 2014 Human Development Report

(UNDP 2014, 1) focuses on *sustainability* of impact as an added dimension to the measure of development by arguing the following:

Real progress on human development, then, is not only a matter of enlarging people's critical choices and their ability to be educated, be healthy, have a reasonable standard of living and feel safe. It is also a matter of how secure these achievements are and whether conditions are sufficient for sustained human development.

Aid in Conflict Affected Countries

Conflicts can take fully functioning states to the status of fragile, failing, or failed state depending on the conflict's impact on the state's core functions of authority, legitimacy, and capacity.²⁰

A failed state is characterised by: (a) breakdown of law and order where state institutions lose their monopoly on the legitimate use of force and are unable to protect their citizens, or those institutions are used to oppress and terrorise citizens; (b) weak or disintegrated capacity to respond to citizens' needs and desires, provide basic public services, assure citizens' welfare or support normal economic activity; (c) at the international level, lack of a credible entity that represents the state beyond its borders. (Derick W. Brinkerhoff 2005, 4)

An entirely separate body of literature, from the one discussed earlier on aid effectiveness, deals with the role of development assistance in fragile states and conflict affected countries, including the "securitization" of foreign aid (Brown and Grävingholt 2015). For instance, the *Journal of Conflict, Security and Development* deals almost exclusively with this subject area. Similarly, a number of studies under the Empirical

²⁰ For a more thorough treatment of failed and fragile states, see Robert Rotberg's classic edited book on "When States Fail: Causes and Consequences" which also provides a sharp and clearly-delineated definition of various cases of strong, weak, failed, and failing state typologies along the dimensions of political goods that states can or cannot produce (Rotberg 2003).

Studies of Conflict (ESOC) project investigate the relationship between aid and its ability to promote peace in conflict affected regions, and they find that only certain specific types of aid, such as targeted and low-profile conditional transfers to needy families, can reduce conflict (Berman, Felter, and Shapiro 2015).

In the context of Afghanistan, it has been identified that development actors face critical dilemmas when balancing the need between short term security gains and long term development goals, which have led some to propose peace conditionality, i.e. tying the flow of aid to steps taken towards reducing local conflict and working towards peace (Boyce 2008; Fishstein and Wilder 2012). Others argue for an almost delinking of security and development, especially when assessing the overall impact of international community's engagement in conflict affected countries. For example, studying the relationship between aid and security in Afghanistan, Fishstein and Wilder (2012, 6) remind the readers that setback in the security sector should not undermine gains on the development front:

Including decreases in infant and maternal mortality, dramatic increases in school enrollment rates for boys and girls, a media revolution, major improvements in roads and infrastructure, and greater connectivity through telecommunication networks.

Simultaneous to the growth of literature dealing with aid in conflict affected regions, a new set of institutions have been set up since the turn of the 21st century in recognition of the need to respond to conflict-affected countries differently from other low-income countries (Baranyi and Desrosiers 2012). For example, OECD-DAC's International Network on Conflict Affected and Fragile States (INCAF) has facilitated the development of new body of literature on aid in fragile states since 2008, in addition

to developing the “New Deal for Engagement in Fragile States,” which “proposes key peacebuilding and statebuilding goals, focuses on new ways of engaging, and identifies commitments to build mutual trust and achieve better results in fragile states” (International Dialogue on Peacebuilding and Statebuilding 2009, 1). The New Deal has been hailed for its inclusive and participatory process, which has included significant participation from 19 conflict affected countries and civil society organizations, while the key criticism against it has been the rather long time horizon required for these principles to be consolidated (Nussbaum, Zorbas, and Koros 2012).

In 2007, OECD-DAC’s Fragile States Group (FSG) adopted a list of Fragile States Principles (FSPs), designed in particular “to complement the partnership commitments set out in the Paris Declaration on Aid Effectiveness” (OECD-DAC 2007, 1). In addition to these, Baranyi and Desrosiers (2012) mention the following three: a) the establishment of the Low-Income Countries Under Stress (LICUS) Taskforce in 2002 by the World Bank, 2) the USAID’s taking on the language of ‘fragile states’ as the first donor in 2004, and recognizing the need to develop new approaches accordingly, and 3) the UK’s hosting a Senior Level Forum on Development Effectiveness in Fragile States in 2005, which led to a Section on Fragile States in the Paris Declaration.

The Paris Declaration of Aid Effectiveness was one in a series of high-level fora and conferences held to discuss new ways of making aid more effective. Some of these conferences include the Monterrey Consensus in 2002 with a focus on various domestic and international financing mechanisms, the Rome Conference of 2003, which with its focus on harmonization and alignment paved the way for the Paris Declaration in 2005,

the Accra conference of 2008, and the Busan conference of 2011. Among them, the Paris Declaration has been the most influential, with its particular focus on the following five overarching principles (OECD 2012).

1. Ownership: Recipient countries setting their own strategies for poverty reduction
2. Alignment: Donor countries aligning their interventions behind recipient country priorities
3. Harmonization: Donor countries coordinating their activities to avoid duplication of efforts
4. Results: Recipient and donor countries focusing on measurable development results
5. Mutual accountability: All concerned partners are accountable for development results

Although calls for similar principles have often been made in the past, it is the first time that the Paris Declaration has made these principles the cornerstone of aid effectiveness debate. Strict adherence to these principles, however, has been elusive, in part due to the institutional stickiness of large donor agencies, varied expectations among donor countries, and lack of credible incentive mechanisms on the part of developing country governments. It is for these and other reasons that assessments of aid practices, based on the principles of Paris Declaration, have almost always fallen short. For example, a 2011 review of progress towards implementing these principles found that:

At the global level, only one out of the 13 targets established for 2010 – coordinated technical co-operation (a measure of the extent to which donors coordinate their efforts to support countries’ capacity development objectives) – has been met, albeit by a narrow margin. (OECD 2012, 15)

Booth (Booth 2012, 538) attributes these failures to the over-stretching of the principles far beyond just “country ownership” making the end result an “over-decorated Christmas tree.”

In the context of Afghanistan, the principles do not seem to have fared very favorably either (Roberts 2010). In particular, Roberts argues that true ownership is weakened given the disproportionately high influence that foreigners carry in domestic policy decisions and the large gap between the people and the central government; alignment is irrelevant when the Afghan government lacks the capacity to determine their own priorities in the first place; harmonization is nearly impossible given the bloated and overly complicated international presence; managing for results is not the number one priority when diverse actors bring divergent agendas; and finally lack of ownership undermines the prospects of mutual accountability.

While these and similar observations are shared by many analysts studying or working in Afghanistan, I argue that such broad generalizations, although valid at the country level, obscures the far more important variations across various departments and sectors within the Afghan government. For example, as I will show in later chapters, while it is true that foreign expertise, called international Externally Funded Staff (EFS), dominate certain ministries, such as the Ministry of Finance given the extreme shortage of local human capacities in this area, other ministries, such as the Ministry of Public Health, has always prided itself on relying more on local expertise than on EFSs. A

deeper look at the functioning of aid management practices across sectors will, therefore, yield a different image on the performance of Afghanistan against the principles laid out in the Paris Declaration on Aid Effectiveness.

In dealing with conflict affected countries more broadly, development assistance becomes an integral tool and instrument for meaningful engagement with developing country governments. This is a welcome move at a time when greater calls are made for bringing the state back in (Evans, Rueschemeyer, and Skocpol 1985). In fact, in their book on *The Dilemmas of Statebuilding*, Paris and Sisk (2009, 1) note an important shift in peacebuilding strategy in the late 1990s and early 2000s, namely a shift from traditional peacebuilding operations (typically involving UN forces to monitor ceasefire or patrol neutral zones) to statebuilding or the “strengthening of legitimate governmental institutions” in post conflict societies. They further construe this new statebuilding strategy as a particular approach to peacebuilding, except that statebuilding, by definition, rests on the belief that building sustainable peace requires functioning government institutions, which in turn requires longer term commitment by the international community to work alongside the host country governments to develop the latter’s capacities as was the case in Timor Leste.

However, the increased engagement in conflict-affected countries, despite the development of new set of institutions to guide their operations, has met a number of challenges. In particular, a number of dilemmas and contradictions have been identified in the process of engaging with conflict affected countries (Paris and Sisk 2009; Derick W. Brinkerhoff 2010; Boyce 2008; Baranyi and Desrosiers 2012; Smillie 2001). For

example, Boyce (2008) discusses the inherent dilemma between short term peacebuilding goals and longer term development objectives, which are often at odds with one another, the pursuit of one undermining the prospects of the other. Similarly, Paris and Sisk (2009) identify five critical contradictions in working in conflict affected countries, including 1) outside intervention vs. fostering local-government, 2) international control being required to establish local ownership, 3) universal values promoted as remedies for local problems, 4) statebuilding requiring both a distance as well as a reaffirmation of the history, and 5) short-term imperatives being at odds with longer-term objectives.

These dilemmas are real and pose serious challenges to the international community's engagement in these countries. For example, it is well-documented that civil wars and violent conflicts not only kill and maim people (Ghobarah, Huth, and Russett 2003), they also have enormous economic consequences, including the destruction of human and physical capital, disruption of social order, diversion of public spending, dis-saving and ensuring reduction in capital stock, and portfolio substitution out of the country (Collier 1999).

It is, therefore, the right role for post-conflict reconstruction to focus on (re)building state institutions, alleviate poverty and horizontal inequalities, and bring about political and economic stability (Fearon and Laitin 2004). But the real question concerns "how" statebuilding must be carried out. For instance, in the case of Afghanistan, Suhrke (2009) has carefully crafted her chapter's title as "the dangers of a tight embrace: externally assisted statebuilding in Afghanistan." In this chapter, she discusses some of the negative consequences of the heavy dose of development

assistance for Afghanistan, which has, among other things, created dependency, neo-colonialism and trusteeship, and undermined the state's ability to generate domestic revenues through taxes. This is a real challenge, especially when the state's revenue-generating capacity through tax collection is considered an important component of state capacity (Joshi 2011; Derick W. Brinkerhoff and Morgan 2010).

Aid Effectiveness and Local Capacity

Statebuilding, loosely defined around the restoration of recipient nation state's authority, legitimacy, and capacity, is invariably closely tied to the existing levels of state capacity at various levels. Without any existing capacities, external statebuilding is sure to face all the dilemmas discussed earlier. For example, how can the host country regain its legitimacy in the eyes of its stakeholders when they don't have even the absorption capacity to spend the resources provided to them by their international counterparts, let alone the capacity to generate their own revenues to finance reconstruction and development? How can they take ownership of the process when they lack the capacity to steer the direction of development and set their own priorities should they be placed in the driver's seat?

As it is becoming evident, however, the term capacity can have multiple connotations, dimensions, and applications, and thus become a malleable concept. To begin, a definition of the term is in order, followed by a discussion of its various typologies. Fortunately, this task has already been undertaken by many others interested in the interplay of this concept in development practice. Capacity may be defined as "the

aptitudes, resources, relationships and facilitating conditions necessary to act effectively to achieve some intended purpose” (Derick W. Brinkerhoff 2010, 66). This definition has put more emphasis on the means (such as aptitudes, resources, relationships and facilitating conditions) used to achieve open-ended “intended” objectives. Peter Morgan (in Smillie 2001, 16), on the other hand, defines capacity as “the ability of individuals, groups, institutions, organizations and societies to identify and meet development challenges over time.” This definition, focusing on different levels, from individuals to societies, defines capacity more specifically in the context of development. Both definitions, however, see capacity as the means to achieve certain ends. A third definition emphasizes the empowerment element by arguing that the main purpose of capacity building is “to empower and strengthen institutions and the ability of people to take control of activities that affect their lives” (Juma 2002, 166).

A typology of different kinds of capacity will be helpful in clarifying the concept further. Brinkerhoff and Morgan (2010) discuss five core capabilities, a term used interchangeably with capacities. First is the capability to commit and engage, referring to the actors’ ability to mobilize financial, human, and organizational resources; create space for action; and actually engage collectively to achieve various intended ends through the exercise of all their other capabilities.

Second is the capability to carry out various tasks, including technical, service delivery, and logistical tasks. Given the requirement of sector-specific technical expertise, such as experienced doctors, engineers, lawyers, and educators, this area of capability may have been affected the most through conflict’s impact on brain drain.

Actors must exhibit the ability to transform inputs into meaningful outputs and outcomes and go beyond the call of duty to add value for the end users of their services. This is the key capability area that I will show lies at the heart of variations in aid effectiveness across sectors in Afghanistan, where technical skills in certain areas, such as medicine and engineering, are relatively more abundant than in other areas. In the area of health governance, it is particularly important that the state has the ability “to manage the policy-making process effectively, to plan and design programmatic interventions, and to enforce and implement health policy decisions made” (D. W. Brinkerhoff and Bossert 2014, 688–689). I will show that those in the leadership positions at Afghanistan’s Ministry of Public Health (MoPH) have exhibited this ability to a large extent, which has contributed to their outperforming other sectors. It is important to highlight, however, that effective management capacity has been in short supply and unevenly distributed across the country. This will be an important consideration because my analysis will reveal that significant gains have been achieved *in spite of* a lack of effective management capacity all across the health sector, which has put more pressure on technical and service delivery capacities alone.

The third typology of capability is the ability to attract support, including financial and otherwise. This capability refers to the actors’ ability to establish and manage diverse alliances and partnerships; build legitimacy; and handle competition and politics. In my observation, this is one area where most recipient country leaders are well-endowed with, except the ability to generate domestic revenues through taxation. The problem of inadequate attention to domestic revenue generation is likely to stay for as

long as the inflow of development assistance is divorced from the recipient state's ability to take concrete steps towards achieving financial self-sufficiency. President Ashraf Ghani's roadmap, also presented at the 2014 London Conference, sets out to do exactly that, at least on paper (Islamic Republic of Afghanistan 2014).

More broadly, the incentive structure of local elites and political leaders must be carefully monitored, and when possible, nudged to align them with development priorities. For example, Booth (2012) argues that unlike the implicit assumption of the Paris Declaration, developing country leaders are not necessarily development-oriented, and therefore, donor countries can take a more proactive role in nudging them to make development more attractive than their other short term goals and priorities. Similarly, Zurcher (2012) finds that one of the main reasons development assistance has not been very effective in Afghanistan is the mis-aligned incentives of local elites who lack the political will to implement changes fearing that they might threaten their existing power relations. This could change, however, if the elites realize that the continuation of aid dollars hinges on their willingness to implement difficult changes.

The fourth capability refers to the actors' ability to adapt and self-renew in light progress and changing internal and external contexts. The fifth and final capability is to balance diversity and coherence, a tall order that has proven hard to materialize in Afghanistan with the exception of few sectors. This type of capability refers in particular to the actors' ability to develop a shared vision despite seemingly disparate interventions; to balance the need to control with the ability to allow flexibility; to coordinate and

harmonize plans in highly complex environments; and to effectively manage stability and change.

The typology discussed above by Brinkerhoff and Morgan (2010) may be characterized as different competencies organized by functions or activities, such as the ability to engage, to carry out certain tasks, to attract support, to adapt, and to balance. This, however, is only one dimension along which to classify various types of capacities. Smillie (2001, 11) presents a three-by-three matrix of different types of capacities along two dimensions, namely by level (organization, sector, institutions) and by means-process-ends dimension.

The specific kind of capacity that this research is particularly interested in lies at the intersection of societal level and the ability to carry out various technical and service delivery tasks (Brinkerhoff and Morgan's second typology discussed above). Managerial capacity seems to matter only in as much as it complements technical and service delivery capacity. Effective managerial capacity would have been crucial in increasing the efficiency with which resources were used. In fact, one interviewee with significant experience in the area of development, both in Afghanistan and internationally, put managerial capacity at the core of success in achieving development outcomes. In particular, he was critical of the lack of managerial capacity at all levels of the government. In his view, Afghanistan's existing gains in health care service delivery, despite this lack of managerial capacity, is all the more impressive. He argues, however, that success would have been much more visible had more attention been paid to building

and developing adequate managerial capacity of the health sector personnel. The following statement summarizes his thoughts:

I consider lack of adequate capacity in management to be a critical aspect of why the billions of dollars spent on healthcare systems have not yielded the type of results that it could potentially have yielded. In the presence of adequate management capacity in healthcare service delivery, the indicators, which are great right now, would have been significantly better and it would have already put Afghanistan on par with other more advanced developing countries. The child and maternal mortality rates would have been lower, the access to healthcare for all would have been more widespread, cost effectiveness of expansion and service delivery would have been more favorable, quality of service delivery would have been higher, capacity development of health workers would have been more effective, and reliability of Afghans on Pakistan, India, the Gulf and other countries for specialized healthcare would have been significantly lower.

The fact that local human capacity matters for development is not novel. What I consider the key contribution of this study, however, is the causal role it can play in making the difference between less and more effective aid, holding everything else constant. In other words, local capacity as a conditional variable in the aid effectiveness literature seems to have not received significant attention. This research may be the starting point of the recognition of the role of local human capacity in making aid work.

Situating my Research within the Literature

The extreme polarization of the debates is a sign that the truth must lie somewhere in between, or as Bates (1997, 166) said “when arguments become polarized, it often signals that divisions are falsely drawn.” In the same way, I believe one of the main reasons for the diversity of opinion regarding the effectiveness of foreign aid, as sketched above, lies in the fact that aid effectiveness has often been defined rather too narrowly in

terms of GDP growth alone. Expanding this definition to include sector-specific development outcomes, such as drops in mortality rates and school enrollment rates, would broaden the debate and allow for identifying variations in aid effectiveness across sectors, the analysis of which could yield policy informing contingent generalizations.

In addition, all forms of development assistance have often been viewed as a one-dimensional tool, encompassing the grassroots activities, the utopian “big push” plans and everything in between. As Easterly (2003, 40) stated, “the idea of aggregating all this diversity into a ‘developing world’ that will ‘take off’ with foreign aid is a heroic simplification.” The debate could, therefore, benefit from a more nuanced assessment of the various kinds of aid under different circumstances. In my analysis, I will develop and test the hypothesis that aid is more effective in sectors with greater levels of local human capacity to transform aid dollars into meaningful outputs and outcomes. My proposed hypothesis about the centrality of local capacity in making aid work is especially in line with the argument that “in order to be genuinely effective, foreign aid must have the right FACE,” where FACE is defined as the Foreign Aid Complementary Elements, such as private investment, human capital, and governance structures (Khan 2003, 347). This research fits squarely within the *contingent school* of literature on aid effectiveness, because it specifies the conditions under which aid is more effective.

CHAPTER FOUR: THE MACRO LEVEL EVIDENCE

The previous chapter provided an extensive review of literature on aid effectiveness, with a particular focus on the definition of aid effectiveness at the macro level, measured as the GDP growth rate. This chapter is an attempt to empirically test the relationship between volumes of aid and macro level economic indicators in Afghanistan. To provide some background, this chapter discusses trends in aid flows globally, focusing on Afghanistan as historically being one of the top recipients of aid. Following that, I will provide a macro level view of major achievements and setbacks of the last decade along the economic, political, and social dimensions. Finally, I will present key findings from three models, using Ordinary Least Squares (OLS), Two-Stage Least Squares (2SLS) regressions, and finally Three-State Least Squares (3SLS) aimed at uncovering relationships between volumes of aid and various measures of economic development. This chapter will show that if aid effectiveness is narrowly defined in terms of GDP growth rates, the results may be both too sensitive to the choice of variables and measurement and might also be less likely to generate contingent generalizations that could be used to inform policy on improving aid effectiveness.

Global Aid Flows

Aid flows have risen significantly in the last fifty years in both current and constant prices, peaking around 1992 at the end of the Cold War and rebounding at the

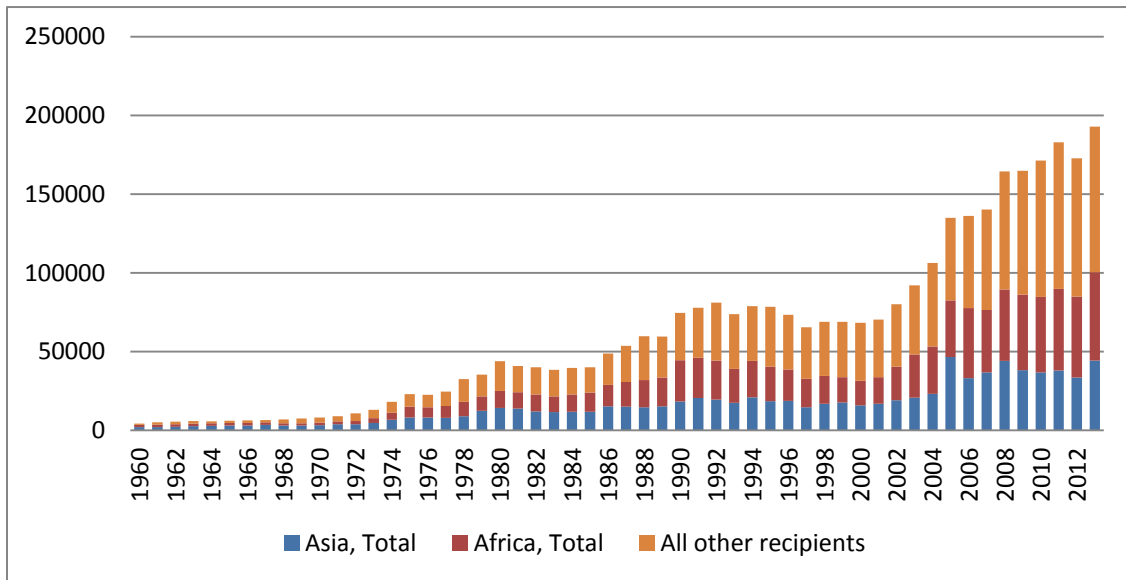
turn of the millennium, following the event of 9/11. As discussed in the earlier chapters, much of the bilateral aid goes to those recipient countries where the donor countries see some political and strategic interests, including previous colonial ties, potential market for the donor's exports, buying of political allegiance, and an interest in expanding one's soft power in the region. A view of the total aid flows, including bilateral and multilateral, dilutes this clear relationship between donors and recipients. In fact, simply disaggregating total aid flows by regions reveals that much of the flows of aid may in fact be dictated by economic needs of the recipient countries, in addition to serving the foreign policy interests of donor countries (Riddell et al. 2008).

Figure 18 illustrates that regionally, Africa has been the largest recipient of foreign aid, having received nearly US\$1 trillion out of the total US\$3.4 trillion dollars in ODA from 1960 to 2013. Africa is followed by Asia that received US\$863 billion or 26% of total ODA during the same period (OECD-DAC 2014). This macro level perspective supports the view that much of the aid in fact flows to regions with the largest numbers of people below the poverty line.

Over the 1960-2013 period, Afghanistan was the fifth largest recipient of official aid, preceded by India, Egypt, Iraq, and Pakistan respectively (OECD-DAC 2014). In the post-2001 world, however, both the total volume as well as the pattern of aid flows changed. In terms of volume of aid, the amount of official aid in real terms disbursed since 2001 is almost equal to the amount of official aid disbursed through the entire period from 1960 to 2001. For example, in the 2003-2016 decade, Afghanistan received a

total of US\$51 billion in official aid, making it the world's second largest recipient of aid in absolute terms, preceded by Iraq that received US\$67 billion (OECD-DAC 2014).

Figure 18 Global ODA flows from 1960 to 2014 (Current US\$ Millions)



Source: OECD-DAC Aid Statistics (2014)

The Macro Level Analysis

What has been the impact of aid on Afghanistan? The question of aid effectiveness in the context of Afghanistan has received significant attention, especially during the last five years as the international community was hoping to prepare the country for transition to self-sustainability beyond 2014, the year when the majority of U.S. troops were scheduled to return home. Most of these studies have taken one of three forms.

One group of studies comes primarily from the Afghan government sources, often with the technical and financial support of a donor agency. Examples include reports to

evaluate the performance of the country against the eight Millennium Development Goals (MDGs), with the fourth and final report on this topic published by the Ministry of Economy in December of 2013 (Islamic Republic of Afghanistan 2005; Islamic Republic of Afghanistan 2008a; Islamic Republic of Afghanistan, Ministry of Finance 2010; Islamic Republic of Afghanistan, Ministry of Economy 2013).

The second group of studies comprises external assessments of a particular segment of the Afghan society. For instance, since its establishment by the U.S. Congress in 2007, the Special Inspector General for Afghanistan Reconstruction (SIGAR) has conducted dozens of studies of specific reconstruction efforts in Afghanistan. Since the primary objective of these investigations is to “detect and prevent waste, fraud, and abuse,” most SIGAR reports focus on the mismanagement of aid dollars and are therefore critical of the reconstruction efforts (SIGAR 2015b, 1). Recent examples of these include the following: 1) *DoD’s Compressed Natural Gas Filling Station in Afghanistan: An Ill-Conceived \$43 Million Project* (SIGAR 2015b), and 2) *Power Grid Project at the Counter Narcotics Strip Mall in Kabul: Construction Met Contract Requirements but Electrical System Was Not Deemed Operable Until More Than 18 Months After Project Completion* (SIGAR 2015a).

Finally, the third group of studies includes project and program evaluations commissioned by various development agencies and conducted by contracted third-party organizations. Most of these reports and assessments are used internally by program implementers to improve future programming, and are often not made available to the public.

This study, however, will be different from the above studies on the basis of its more systematic and deeper analysis of the effectiveness of foreign aid in Afghanistan in a way that will derive meaningful contingent generalizations to inform future policy and practice. Since the end of the Taliban era, progress in Afghanistan has been mixed. Some of the key political, economic, and social achievements include rapid economic growth with relatively controlled levels of inflation (with large fluctuations); the introduction of new currency in 2002 that reset the Afghani-US\$ exchange rate from 48,000:1 to 50:1; improved public sector administration and financial management; gains in health and education; a historical transfer of power through relatively peaceful and democratic elections in 2014; improved women's participation in public life, including a nomination of the first female in the Supreme Court in 2015 (but was turned down by the Parliament); an explosive growth of media, including newspapers, radio and television; and nearly full mobile phone coverage across the country.

Economically, with an average growth rate nearing double digits, Afghanistan's economy has put up an impressive growth performance since the 2002 American intervention in the country (World Bank 2014).²¹ GDP per capita, in purchasing power parity, has more than doubled from about US\$700 in 2002 to nearly US\$1,600 in 2013. The level of GDP has gone up from US\$2.4 billion in 2002 (or US\$3.7 billion in 1979, the highest in pre-2002 era) to more than US\$20 billion in 2013 (World Bank 2014). While the rising levels of GDP reflect the increasing injections of foreign aid dollars and

²¹ Despite the continuing inflow of significant aid dollars, however, the drawdown of the international military forces from the country since 2014 has had a noticeable downward effect on growth rates. For example, GDP growth rates in 2014 and 2015 were down to 3.7% and 1.3% respectively (Islamic Republic of Afghanistan, Ministry of Finance 2016, 2).

military expenditure, the growth rate is driven by a variety of factors, including productivity in the agricultural and service sectors in the country.

In the security sector, Afghanistan's National Army, National Police and National Security forces are now more than 350,000 strong (excluding the nearly 30,000 Afghan Local Police), which enabled the country to take over the security of the country from the International Security Assistance Forces (ISAF) in 2014 (Schroden et al. 2014).

International forces are down from their 2010 peak of nearly 100,000 troops to about 10,000 in 2014 (Belasco 2014). Significant challenges remain in terms of corruption permeating the entire country, but from the perspective of governance and rule of law, Afghanistan has functioning legal institutions. This proved through Afghanistan's three rounds of relatively successful and moderately peaceful presidential and local elections.

Indicators of social development are not any less impressive. For instance, the number of schools has more than doubled from its 2001 levels, from 6,000 to more than 14,000 in 2014 (UNDP 2013). Not surprisingly, parallel to the explosive increase in number of schools, primary and secondary school enrollment has grown more than eight times from its 2001 levels, from 1.1 million students to more than 8 million students in 2014, almost 40% of which are girls. The country's higher education has also experienced significant growth, with the number of private institutions of higher education mushrooming from nearly zero to more than 150.

Health indicators illustrate the progress made since the overthrow of Taliban in 2002. The number of health facilities has more than quadrupled from 496 in 2002 to more than 2,300 in 2014, which has seen health outcomes dramatically improved. For example,

maternal mortality rates dropped by almost 80% from 1,600 per 100,000 live births in 2002 to 327 per 100,000 live births in 2014. Infant mortality rates were more than halved from 165 per 1,000 live births in 2002 to 68 per 1,000 live births in 2014. Mortality rates among children under 5 years of age declined from 257 per 1,000 live births in 2002 to 94 per 1,000 live births in 2014.

The National Solidarity Program (NSP), a flagship program under the Ministry of Rural Rehabilitation and Development (MRRD), has delivered basic infrastructure to rural areas around the country through elected Community Development Councils (CDCs). This program relies on basic engineering capacities, and is considered one of the most successful projects in Afghanistan (Briggs, Atkins, & Gilmour, 2012).

Afghanistan enjoys a dramatically improved network of roads connecting cities and populations across the country compared to the pre-2002 era, thus significantly reducing travel times. This has helped the developments in media to be explosive, with the number of private television stations around the country reaching nearly 100. Similarly, Afghanistan has made significant strides in athletics. Examples include winning the country's first ever Olympic medal in Taekwondo, significant growth in Cricket and tremendous achievements in football, including the first South Asian championship in 2014. These advancements, combined with better electricity and mobile phone coverage, have contributed to an overall improvement in Afghan society and quality of life in the country.

Despite these achievements, significant challenges remain. For example, Afghanistan continues to lag behind as one of the world's least developed countries with

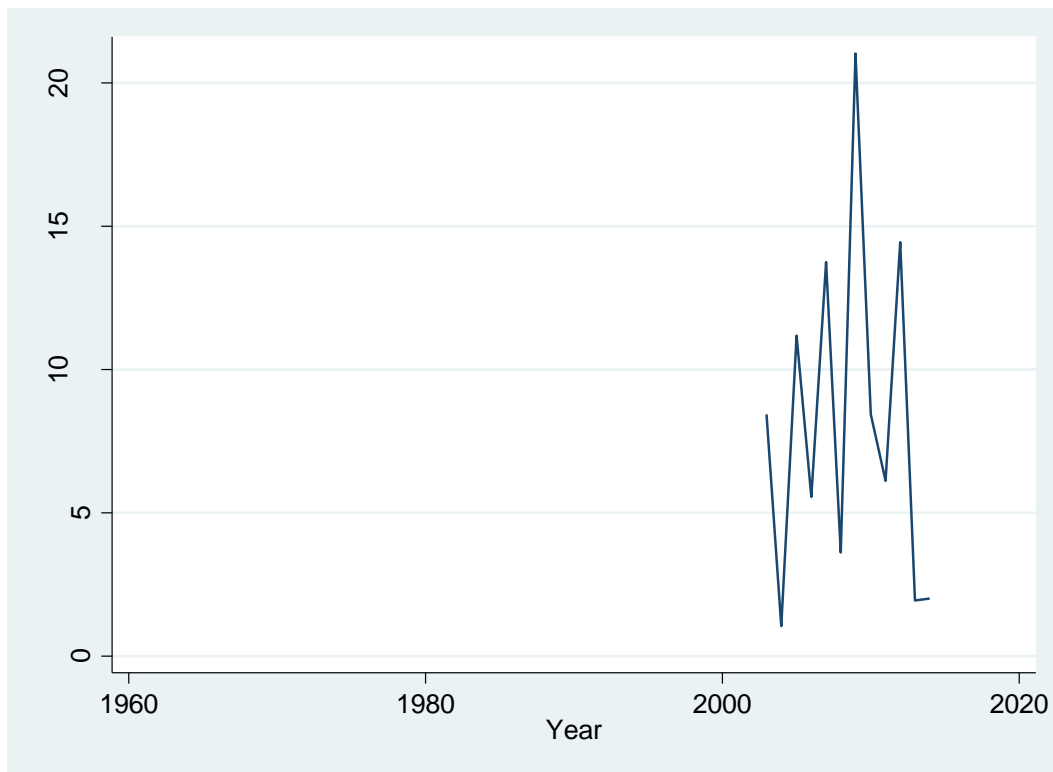
a per capita income of less than US\$1,000, and ranked amongst the bottom 20 countries according to Human Development Index (HDI) score. More than a third of the population continues to live below the official poverty line, three-quarters are illiterate and unemployment rate is about 35%. Above all, much of the country's progress is heavily dependent on foreign aid and all the gains are vulnerable to threats of insecurity, corruption and illicit economic activities, including the production and trade of narcotics. It is for these and other reasons that "despite mutual efforts by the government of Afghanistan and the international community toward accepted principles of the aid effectiveness, it is still evaluated as unsatisfactory" (Islamic Republic of Afghanistan, Ministry of Economy 2014, 8).

While a listing of key achievements made since the overthrow of the Taliban is important, it does not answer the more important questions about aid effectiveness. In particular, it does not clearly lay out the relationship between volumes of aid and outcomes achieved. It does not answer the counterfactual question, nor does it answer how the situation in Afghanistan would have been if there had been no foreign aid. It also does not answer the question of efficiency, i.e. could the country have achieved even higher levels of improvement with the given resources. And lastly, it does not lend to producing lessons learned that can inform future policy and practice. For these reasons, in this chapter and the next, I assess more systematically the links between volume of official aid and outcomes achieved.

Data, Variables and Key Findings

In order to study the impact of aid on macro level indicators in Afghanistan, I extract data from mainly two sources: the World Development Indicators (WDI) (World Bank 2014) and the OECD-DAC Database of Aid Statistics (OECD-DAC 2014).

Figure 19 GDP growth rates for Afghanistan in WDI database



Source: World Development Indicators (2014)

As discussed in chapter three, one of the most common ways of assessing the impact of aid on recipient countries is by exploring the relationship between the volume of aid and recipient country's GDP growth rate. In the context of Afghanistan, however,

this is not an easy task because of data unavailability. In fact, excluding the last decade, even data on economic growth is missing (see Figure 19). The paucity of reliable data is well documented. Unavailability of data for the case of Afghanistan is especially acute, as illustrated in this quote (World Bank 2012b, v):

it is well known that collecting reliable data on Afghanistan is extremely difficult. Moreover, much of the information that is available is subject to large margins of uncertainty, as well as often problems of incompleteness, incomparability, etc. Data are frequently changed and updated. Collecting and triangulating data on issues such as jobs, aid inflows, and security costs has posed a major challenge...

Although data on ODA is available for Afghanistan from 1960, the unavailability of other important indicators pose at least three limitations (see Table 2). First, the paucity of data limits our ability to apply more sophisticated quantitative analyses, such as the use of disaggregated time series data to investigate causality. The unavailability of data for most indicators from 1960 to the present forces us to focus only on the last decade. Incidentally, figures clearly indicate that in the last ten years, official aid in Afghanistan has begun to occupy a much larger part of the picture. Second, in order to account for fluctuations in inflation and exchange rates, constant prices would have been preferred to current prices. However, the only key variable available in constant prices is net ODA levels, which are available in both current prices as well as in 2012 constant prices. Given the unavailability of data on inflation, whether measured through consumer price index or as GDP deflator, we cannot convert the remaining variables from current to constant prices. As a result, we have to limit our analysis to variables in current dollars, except otherwise noted. Third, the most common macro level indicator of interest in assessing the impact of aid at the national and international levels is GDP growth rates.

However, the unavailability of data on economic growth (except for the last ten years) forces us to analyze the relationship between *levels* of GDP and official aid.

Table 2 Data availability on Afghanistan

Category	Variable Name	Variable Description	Data Available for
Foreign Aid	Aid Current	Net ODA, Current US\$	1960-2014
	Aid Constant	Net ODA, 2012 Constant Prices	1960-2014
	Aid/GDP	Net ODA as a Percentage of Recipient's GDP	1960-1981, 2001-2014
	Aid PC	Net ODA per capita, Current US\$	1960-2014
GDP	GDP Current	GDP, Current US\$	1960-1981, 2001-2014
	GDP Growth	GDP Growth Rate, annual %	2003-2014
Economy	Inflation, CPI	Inflation, Consumer Price Index, annual %	2005-2014
	Inflation, GDP Deflator	Inflation, GDP Deflator, annual %	2003-2014

Source: Author's compilation

Based on the available data, we can develop and test a simple time series model, correlating official aid with GDP figures. In line with the theoretical argument, we would expect a positive relationship between official aid and GDP. Before running regressions, it is worth testing this relationship by looking at the extent of correlation between the available indicators. In particular, we focus on GDP levels as our dependent or outcome variable, and we focus on four measures of aid as the independent or explanatory variables. These include total official aid to Afghanistan in nominal variables, total

official aid in 2012 constant prices, official aid as a percentage of Afghanistan’s GDP, and official aid per capita.

Table 3 Correlation between GDP and ODA levels

	GDP	AidCurr\$	AidConst\$	Aid/GDP	Aid pc
GDP	1.0000				
Aid Current	0.9473	1.0000			
Aid Constant	0.9352	0.9980	1.0000		
Aid/GDP	0.6973	0.8497	0.8772	1.0000	
Aid per cap	0.9276	0.9974	0.9992	0.8834	1.0000

As illustrated in Table 3, this simple test of correlation reveals that the levels of net ODA and GDP display almost perfect correlation. The degree of correlation between levels of GDP and nominal aid is strongest at 0.9473, while the weakest relationship is between levels of GDP and aid per as a percentage of GDP, which can be explained by the fluctuating figures of the latter. In the post-2001 era, the overall strong correlation between measures of GDP and aid is not surprising since when foreign aid has played a central role in the reconstruction of the country following three decades of war.

Beyond the simple correlation, we can run simple ordinary least squares (OLS) regressions to analyze the direction and statistical significance of the relationship between the outcome and explanatory variables. Given the available data, we manage to run five different regression models, utilizing three measures of economic wellbeing, namely GDP growth rates, levels of GDP in current dollars and GDP per capita, and three measures of official aid, namely net ODA as a percentage of Afghanistan’s GDP, net

ODA in current dollars and net ODA per capita. Overall, we would expect a positive relationship between measures of economic development and levels of foreign aid.

Discussion of Regression Results

Key results of the five regression models are presented in Table 4 below. The coefficients on all the regressions are positive, which suggests a direct correlation between measures of economic development and aid, thus confirming the findings of Table 2 on the measure of correlation. The magnitude and statistical significance of each regression, however, deserves closer scrutiny.

The first row in Table 4 shows the relationship between the natural logarithm of GDP growth rates and net ODA as a percentage of Afghanistan's GDP. Given that the data for GDP growth rates are only available since 2003, I restricted the first regression to the period from 2003 to 2014. The results indicate that a one percent increase in net ODA as a percentage of GDP is associated with a 0.035 percentage points increase in GDP growth rates. Although the sign of the coefficient is positive as predicted, the relationship is not statistically significant, suggesting that the observed increase in GDP growth rates could have been due to factors other than the injection of official aid in the economy. In fact, this is also supported by a small R-squared value of 0.09 (not displayed in Table 4), which suggests that the given model only explains about 9% of variations in GDP growth rates. This finding should not come as a surprise when researchers fail to find a statistically significant positive relationship between economic growth and aid in forty years of research (Doucouliagos and Paldam 2009).

Table 4 OLS regression results

No. Dependent Variable	Independent Variable	Constant	Coefficient (SE)	p-value ²²	Data Range
1) GDP Growth (ln)	Net ODA as % of GDP	.0412	0.035 (.037)	0.37	2003-2014
2) GDP Current \$	Net ODA Current	1.58e+09	2.283 (.205)	0.00	1960-2014*
3) GDP Current \$	Net ODA Current	2.05e+08	2.544 (.361)	0.00	2001-2014
4) GDP per capita	Net ODA per capita	139.17	1.811 (.201)	0.00	1960-2014*
5) GDP per capita	Net ODA per capita	38.04	2.361 (.370)	0.00	2001-2014

*Includes missing values for the period 1982-2000

One of the key shortcomings of the first model was the small number of data points. The unavailability of data on GDP growth rates means the model was restricted to the last thirteen years. In models two and three, I overcome this challenge by including data from 1960 through 2014, but I unavoidably introduce two new challenges. First, I have to replace GDP growth rates, a better indicator of economic development, with levels of GDP in current dollars. Second, although data for aid is available for the entire period from 1960 through 2014, data for GDP levels are unavailable for the period from 1982 through 2000. For this reason, we run this regression in two forms, one for the entire period and another for the period from 2001 to 2014. The second and the third models are, therefore, the same except that the latter restricts the analysis to the last 13 years for which we have complete data on both key indicators.

²² The p-value may be interpreted as follows: if the null hypothesis was right, i.e. there was no relationship between ODA as a percentage of Afghanistan's GDP and GDP growth rate (the null hypothesis states that the GDP growth coefficient is zero), the probability of finding a relationship of 0.035 magnitude is 0.37. Since this probability is much higher than the conventionally accepted threshold of 0.05, we fail to reject the null hypothesis. In other words, the observed magnitude of 0.035 is so close to the prediction of the null hypothesis that we cannot plausibly reject the null hypothesis. With a standard error of 0.037, the observed magnitude of 0.035 is only about one standard deviation away from zero, thus too close to warrant a rejection of the null hypothesis.

What I find is that there is not only a strong correlation between measures levels of GDP and foreign aid, but the relationship is statistically significant at a five percent level. The regression result may be interpreted as follows: each dollar of foreign aid infused in the country is associated with a \$2.28 increase in levels of GDP. Restricting this model to the last 13 years alone when complete data is available on both indicators increases the magnitude of the relationship, such that each additional dollar of aid is associated with a \$2.54 increase in level of GDP. Again, these findings are not surprising in a country where foreign aid constitutes between one-half and two-thirds of GDP.

Finally, I tested this relationship at a per capita level. Rows four and five of Table 4 present our findings from regressing GDP per capita against levels of official aid per capita. Like the case of rows two and three, data for GDP per capita are unavailable for the period from 1982 through 2000. For this reason, the key distinction between rows four and five is that the latter limits the analysis to the period 2001-2014 for which we have complete data for both variables.

As expected, the coefficients for both models four and five have a positive sign, indicating a positive relationship between the two variables, and both are statistically significant at 5% level. The results may be interpreted as follows: considering the entire period from 1960 to 2014, each dollar of foreign aid per capita is associated with a \$1.81 increase in GDP per capita. Limiting our attention to the period from 2001 to 2014, the magnitude of this relationship increases in a way that each dollar of foreign aid per capita is associated with a \$2.36 increase in GDP per capita.

The Endogeneity Problem

The discussion above is based on the following theoretical model:

$$Growth_t = \beta_0 + \beta_1 Aid_t + \varepsilon_t$$

This model suggest that GDP growth rate (or GDP levels in regressions 2-5) is an increasing function of *Aid* measured by ODA as a percentage of GDP, net ODA and net ODA per capita. This model, however, may be criticized for paying inadequate attention to the issues of reverse causality and endogeneity of *Aid*. This critique is grounded on the assumption that aid may in fact be determined by the low levels of economic growth, not the other way around. The problem of endogeneity poses serious threats to the estimators because “an explanatory variable that is determined simultaneously with the dependent variable is generally correlated with the error term, which leads to bias and inconsistency in OLS” (Wooldridge 2009, 550). In addition, there may be other omitted variables that are correlated with the error term (ε) and thus biasing these results.

One solution to the endogeneity problem is to use an instrument variable that meets the “exclusion restriction” criteria, i.e. a variable that is not correlated with the error term (ε) but is correlated with the outcome variable only through its effect on the independent variable. A specific form of the use of instrument variable is the two-stage least squares (2SLS) method when we have another exogenous variable that can be used as an instrument. In such circumstances, the 2SLS estimator may be said to be consistent and unbiased.

While *Aid* may be endogenous (because both *Aid* and *Growth* may co-vary due to the same factors, and also *Aid* may be correlated with the error term), $Aid_{(t-1)}$ is assumed

to be exogenous. This is based on the principle that “since a time trend is exogenous, it can always serve as its own instrumental variable” (Wooldridge 2009, 532). Therefore, in this case, I use the lagged variable of *Aid* as the exogenous instrument variable. In time series analysis, it is usually the case that lagged variables are correlated with the original variable, but not correlated with the error term at time t precisely because the lagged variable, by definition, was generated at an earlier time, such as $t-1$. One serious threat to the assumed exogeneity of the lagged variable, however, comes from the autocorrelation of error terms. For this reason, I run the Breusch–Godfrey test for autocorrelation using the “estat bgodfrey” command in STATA. If this test reveals that the first lag also suffers from autocorrelation problem, second or third level lags may be used instead to mitigate this challenge.

After running an OLS regression between natural log of GDP growth rate and net ODA as a percentage of GDP, the p-value for the first lag on the Breusch–Godfrey test is greater than 0.05, and therefore I see no need to apply more distant lags. The results are presented in Table 5 below.

Table 5 STATA output for the Breusch–Godfrey test for autocorrelation

```

estat bgodfrey, lags (1 2 3 4)
-----
Breusch-Godfrey LM test for autocorrelation
-----

```

lags (p)	chi2	df	Prob > chi2
1	3.082	1	0.0792
2	3.100	2	0.2123
3	3.319	3	0.3450
4	3.524	4	0.4742

```

-----
H0: no serial correlation

```

I run similar models of 2SLS to reproduce the same five regression results as those discussed in Table 4, the difference being that these results are from 2SLS as opposed to OLS. These results are presented in Table 6.

Table 6 Regression results, using two-stage least squares (2SLS) method

No. Dependent Variable	Independent Variable	Constant	Coefficient (SE)	p-value	Data Range
1) GDP Growth (ln)	Net ODA as % of GDP	-.977	0.069 (.060)	0.27	2003-2014
2) GDP Current \$	Net ODA Current	1.4e+09	2.406 (.142)	0.00	1960-2014*
3) GDP Current \$	Net ODA Current	-3.5e+09	3.313 (.594)	0.00	2001-2014
4) GDP per capita	Net ODA per capita	376.03	6.115 (1.178)	0.00	1960-2014*
5) GDP per capita	Net ODA per capita	258.83	6.726 (1.504)	0.00	2001-2014

*Includes missing values for the period 1982-2000

These results may be interpreted as follows. The first row suggests that a one percent increase in net ODA as a percentage of GDP is associated with a 0.069 percentage points increase in GDP growth rates, as opposed to 0.035 in Table 4 using OLS. Similar to the OLS regression, this relationship is not statistically significant. Rows two and three explore the relationship between net ODA and GDP levels. It shows that each dollar of foreign aid infused in the country is associated with a \$2.40 increase in levels of GDP, as opposed to \$2.28 in the case of OLS. Restricting this model to the last 13 years, this magnitude increases to \$3.31. Finally, rows four and five explore the relationship between net ODA per capita and GDP per capita. Row four suggests that each dollar of foreign aid per capita is associated with a \$6.11 increase in GDP per capita for the entire period from 1960 to 2014. Limiting our attention to the period from 2001 to

2014, however, the magnitude of this relationship increases slightly to \$6.72. Except for the first row, all estimated relationships are statistically significant.

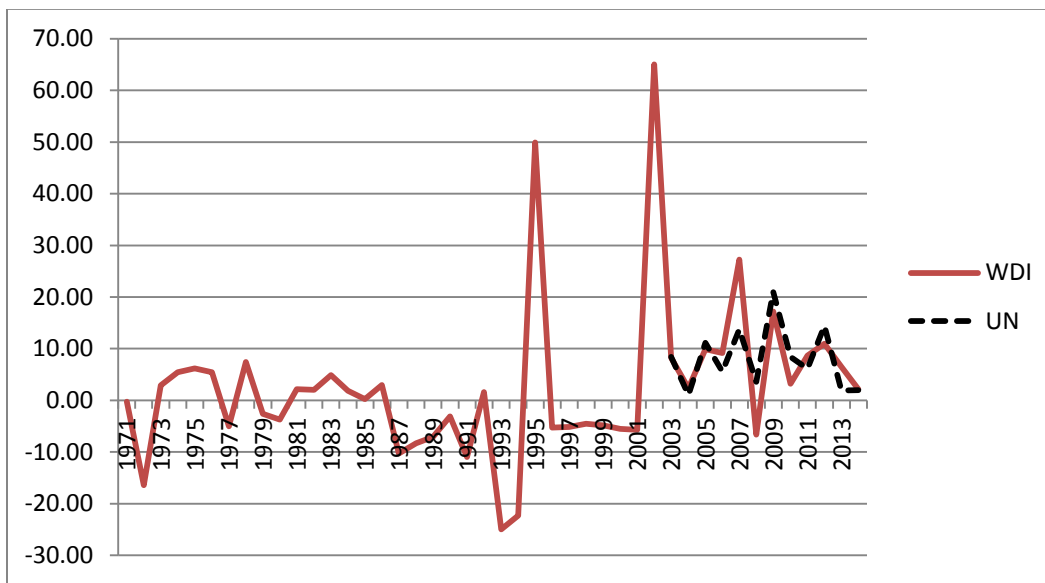
In order to determine if the 2SLS is an improvement over the OLS method, the Hausman test may be applied, which compares the difference between the two estimates. With a P-value of greater than 0.05, the results do not support the case for 2SLS. One reason for this might be the rather insignificant number of data points. For the first regression between GDP growth and ODA as a percentage of GDP, this model had to be limited to the most recent 11 years because of missing data for GDP growth rates before 2002.

Another important weakness of 2SLS, although a significant improvement over OLS, is that although 2SLS produce unbiased estimates, they may not be the most efficient. One way to make up for this shortcoming is by using three-stage least squares (3SLS), which is a particular form of Simultaneous Equations Modeling (SEM). In particular, “system estimation methods are generally more efficient than estimating each equation by 2SLS. The most common system estimation method in the context of SEMs is three stage least squares” (Wooldridge 2009, 560). If applied correctly, with maximum likelihood estimation, 3SLS can reach the Cramer-Rao lower bound, thus producing more efficient estimates than 2SLS, if not always the most efficient estimate. One of the reasons that 3SLS may not be perfectly applied with the given data is the limited number of data points – the same challenge that undermined the 2SLS estimates.

In order to overcome this challenge, I combine GDP growth rate data from a difference source, namely from the United Nations’ (United Nations 2015). One of the

main advantages of this database is that it complements the other two main databases I am using, namely the World Bank’s World Development Indicators (World Bank 2014) and the OECD-DAC Database of Aid Statistics (OECD-DAC 2014), by providing data on GDP growth rates for Afghanistan for the entire period from 1970 through 2014. An important drawback of this database is that the data from the two sources do not match perfectly. In fact, the degree of correlation between GDP growth rates from the two sources for the period of overlap from 2003 to 2014 is only 0.7.

Figure 20 Comparing data from UN and WDI



Source: United Nations (2015) and World Development Indicators (2014)

With these caveats in mind, I run 3SLS on the following basic model:

$$\text{reg3} (\ln Gr \text{ unODAperY lagAidperY}) (\text{unODAperY} \ln Gr PR)$$

where,

- *lnGr* is the natural logarithm of GDP growth rate
- *unODAperY* is net ODA as a percentage of Afghanistan's GDP
- *lagAidperY* is the first lagged variable for net ODA as a percentage of Afghanistan's GDP
- *PR* is political rights, derived from the Freedom in the World Country Ratings database (Freedom House 2016)

In this model, the basic assumption is that aid and growth variables are simultaneously determined, one affecting the other. In order to estimate the relationship between these two variables, 3SLS needs at least two predetermined or exogenous variables, one in each of the two simultaneous equations. In the first equation, I have treated the first lagged variable of net ODA as a percentage of Afghanistan's GDP as the exogenous variable. In the second equation, I have treated the political rights variable as the exogenous variable. In such scenarios, "we typically call a lagged endogenous variable in an SEM a predetermined variable. Lags of exogenous variables are also predetermined" (Wooldridge 2009, 562).

Table 7 Regression results, using three-stage least squares (3SLS) method

Three-stage least-squares regression

Equation	Obs	Parms	RMSE	"R-sq"	chi2	P
lnGr	25	2	.977121	0.221	3.72	0.1560
unODAperY	25	2	645.375	-1169.942	0.02	0.9900

	Coef.	Std. Err.	z	P> z	[95% Conf. Interval]
lnGr					
unODAperY	.0545498	.0521598	1.05	0.296	-.0476816 .1567811
lagAidperY	-.0356962	.0515215	-0.69	0.488	-.1366766 .0652841
_cons	1.309729	.2861933	4.58	0.000	.7488004 1.870657
unODAperY					
lnGr	621.216	11283.87	0.06	0.956	-21494.76 22737.19
PR	276.118	5408.543	0.05	0.959	-10324.43 10876.67
_cons	-2766.277	53081.47	-0.05	0.958	-106804 101271.5

Endogenous variables: lnGr unODAperY
 Exogenous variables: lagAidperY PR

Regression results are presented in Table 7. The highlighted row shows that a one percent increase in net ODA as a percentage of GDP is associated with a 0.054 percentage points increase in GDP growth rates. This relationship, however, is not statistically significant given a p-value of 0.296. When compared to OLS and 2SLS regression results discussed earlier (see Tables 4 and 6), this value of 0.054 lies between the OLS estimate of 0.035 and 2SLS estimate of 0.069, thus indicating potential understatement by OLS estimator and overstatement by 2SLS.

Concluding Remarks

Despite the paucity of credible data, this chapter was an attempt to investigate the relationships between the flows of development assistance and macroeconomic indicators, in particular GDP growth rates. The analysis in this chapter revealed that

while there are positive and statistically significant relationships between aid and levels of GDP, there was little evidence to show that aid promoted growth, the key indicator often used to measure aid effectiveness.

Whereas much of the gains of the last decade, such as those in health and education, provide real evidence for the impact of aid on the Afghan society, the regression results should be interpreted with caution for a number of reasons. First, missing data for many indicators and many years significantly limit the scope and strength of statistical analysis. For example, as mentioned previously, data for the most basic and important variable, i.e. GDP growth rate, is unavailable in the WDI database for the entire period, except for the last decade. Data for most variables, including levels of GDP, are missing for a twenty-year period between 1982 and 2002, coinciding with the Soviet invasion of the country and the ensuing conflicts until the American intervention in 2001. Furthermore, in order to account for inflation and exchange rate variations, the use of variables in constant dollars would have been preferred to the use of variables in current dollars. The unavailability of data in constant terms (except for net ODA) rules out analysis in constant dollars.

Second, one has to acknowledge the methodological limitations so as not to erroneously equate correlation with causation. Conditions for establishing causality could not be strictly satisfied in this rudimentary analysis, even after attempting to use instrumental variables in a two-stage least squares model and three-stage least squares. One should, therefore, exercise caution before attributing all the gains to the flow of official development assistance alone. For example, it is not unreasonable to imagine that

these improvements could have been, at least partially, due to factors other than ODA flows, such as the nearly one trillion dollar dollars spent on war. Lastly, although the regression results found consistently positive relationship between aid and growth, the relationship was not statistically significant given the p-values of large than 0.05.

While these findings are both interesting and informative, they are not conclusive about the question of aid effectiveness, thus pointing to the misleadingly narrow conception of aid effectiveness if defined primarily in terms of GDP growth. In addition, without a deeper understanding of the causal mechanisms, this kind of analysis alone does not lend itself to informing policy and drawing lessons learned on how to make aid more effective in the future. One way to arrive at contingent generalizations is to identify variations in aid effectiveness within the country. Aid effectiveness must be defined in terms of development outcomes across sectors. The next step would involve singling out instances where aid has been relatively more successful. Next, the causal mechanisms must be mapped out and finally one could arrive at the conditions under which aid is more effective. In the following chapters, I set out to do exactly this.

CHAPTER FIVE: THE MICRO LEVEL EVIDENCE I

In the previous chapter, I showed that aid-growth relationship in Afghanistan is spurious, and despite the use of various estimations (including two-stage and three-stage least squares) a statistically significant relationship between aid and GDP growth rate could not be established. While an investigation of the aid-growth nexus is important, it can be misleading because the impact of aid on a country cannot be well-represented by narrowly focusing on growth alone. It can undermine valuable gains in the area of human development, including both health and education. In addition, a preoccupation with growth alone obscures the far more important question of variations in aid effectiveness within the country and across sectors. I find that at a cross-sectoral level, development progress in Afghanistan when measured in sector-specific development outcomes presents significant variations that can be exploited to find out where was aid most effective and why. Although the country has made significant strides since 2001 in basic health, education, and rural development sectors, it has fared less well in other areas such as social protection, mining, and urban development.

This chapter will discuss the selection of the sectors and present a ranking of aid effectiveness in each sector. After setting up the problem statement (i.e. the variations in aid effectiveness across sectors that are operating under essentially the same overall conditions), I discuss process tracing which is the methodology of choice and best fit for

this study. I also discuss the strengths and weaknesses of case study approach and in particular process tracing vis-à-vis large-N statistical analysis, and show that given the theory-confirming nature of this study, case study approach is better suited for this study. This chapter ends with a description of the steps involved in conducting process tracing and thus sets the stage for a more in-depth process tracing of the health sector in particular, as the most successful sector in Afghanistan in the following chapter.

The Sectors: an Overview

The sectors chosen for this study are outlined in the Afghanistan National Development Strategy (ANDS) (2008-2013), a document produced by the Government of Afghanistan that serves as the country's first and only Poverty Reduction Strategy Paper (PRSP). The ANDS took a stock of conditions that existed in 2006, set priorities and objectives and clarified programs and projects needed to achieve those set targets and goals, with commitment from the international community to support the development process.

The ANDS was in fact a written commitment by the Afghan government and its international counterparts to achieve the objectives and implement the plans laid out in the Afghanistan Compact. The Compact is a political agreement that documented the obligations and roles of the international community and the Afghan Government after the 2006 London Conference. This important conference was chaired by British Prime Minister Tony Blair, Afghanistan's President Hamid Karzai, and UN Secretary-General, Kofi Annan, and was attended by representatives from 66 states and 15 international organizations. It is, therefore, not surprising that there are similarities between the

priority areas and targets identified in the two documents. In fact, ANDS puts the benchmarks in these two documents and the MDGs on par by saying that “the effectiveness of aid can be measured against attainment of MDG, Compact and ANDS poverty reduction targets” (Islamic Republic of Afghanistan 2008, 155).

Table 8 ANDS overall structure

Main Pillars (3)	Pillar 1: Security	Pillar 2: Governance	Pillar 3: Economic and Social Development					
	Sub-Pillars (8)	Security	Good Governance and Rule of Law	Infrastructure and Natural Resources	Education and Culture	Health	Agriculture and Rural Development	Social Protection
Sectors (17)	Security	Governance, Public Administrative Reform, and Human Rights	Energy	Education	Health and Nutrition	Agriculture and Rural Development	Social Protection	Private Sector Development and Trade
		Justice and Rule of Law	Urban Development	Culture, Media and Youth		Refugees, Returnees and IDPs		
		Religious Affairs	Transportation					
			Mining					
			Information and Communication Technology					
			Water Resource Management					
Cross-Cutting Issues		Regional Cooperation	Counter Narcotics	Anti-Corruption	Gender Equity	Capacity Building	Environment	

Source: Adapted from Afghanistan National Development Strategy (ANDS) document (Islamic Republic of Afghanistan 2008c, 5)

As illustrated in Table 8, the ANDS sets the stage by organizing Afghanistan's key priority areas into three main pillars: 1) Security, 2) Governance, and 3) Economic and Social Development. It further expands the three main pillars into eight sub-pillars: 1) Security, 2) Good Governance and Rule of Law, 3) Infrastructure and Natural Resources, 4) Education and Culture, 5) Health and Nutrition, 6) Agriculture Rural Development, 7) Social Protection and 8) Economic Governance. From these eight sub-pillars emerge 17 sectors, 13 of which are grouped under the third main pillar, namely Economic and Social Development. Finally, these 17 sectors are complemented with six cross-cutting focus areas, including 1) Regional Cooperation, 2) Counter Narcotics, 3) Anti-Corruption, 4) Gender Equity, 5) Capacity Building, and 6) Environment.

The ANDS is the culmination of several years of work by the Afghan government and the international community, in particular the International Monetary Fund (IMF) and the World Bank. From the Afghan government, the process was handled under the leadership of the Higher Oversight Committee, including the Ministries of Foreign Affairs, Finance, Economy, Justice, Education, Commerce and Industry and the National Security Advisor. The ANDS was drafted in a participatory process, involving several rounds of consultation with around 17,000 stakeholders, almost half of which were women. After the document's approval by the Afghan Cabinet in April 2008, it was presented at the Paris Conference in June of that year. According to an evaluation of the ANDS in 2014, the ANDS was implemented over a five-year period with a budget of nearly US\$15.6 billion, compared to the budgeted amount of US\$35.9 billion, estimated

at the time of drafting the ANDS (Islamic Republic of Afghanistan, Ministry of Economy 2014).

The ANDS was supposed to undergo a thorough review process, with the first progress report scheduled for March of 2009 followed by annual reviews, and revisions to the document to be incorporated September of 2010. Confusion about the ownership of the ANDS review process within the Afghan government seems to have contributed to inadequate attention given to the quality of the review process. The main source of confusion seems to be between the Afghan government's Ministry of Finance and Ministry of Economy. The division of responsibility between these two ministries regarding the coordination of ANDS and monitoring its results is hampering coordination and progress. The line ministries have raised this issue at both ministerial and international donors' meetings. If measures are not taken to amend this separation of responsibility, appropriate planning, budgeting and reporting on progress toward sector results cannot be guaranteed.

One of the interviewees – a senior level international development expert with significant experience in Afghanistan, including at the time of initial developments of ANDS – was particularly critical of the international community and by extension, the Afghan government, for their failure to follow through the ANDS. In fact, she argued the ANDS was written on paper but never implemented in practice. Instead, she continues, the international community jumped from one strategy document governing development in Afghanistan to another strategy document. Having mentioned these challenges with ANDS, it remains a key authoritative document that this research relies on for providing

a ranking of the various sectors in achieving their objectives in Afghanistan at the national level.

While these variations in performance are important, they are not very useful at answering the question, i.e. where was aid most effective and why, because success in achieving better health outcomes is not readily comparable to the failure in countering corruption or insecurity. In fact, corruption, insecurity and narcotics are cross-cutting issues that affect almost uniformly all other sectors. Therefore, a more useful comparative analysis would involve assessing the impact of aid across relatively more comparable sectors, such as health, education, rural development, agriculture and mining. If significant variations emerge in the performance of these sectors, a good research question will identify the potential factors that explain variations in aid effectiveness across sectors. In particular, in line with Mill's method of similarity and difference, factors that are present in more successful cases and absent in less successful ones, may be identified as the key causal variables that explain aid effectiveness.

According to the country's first Afghanistan Mortality Survey (APHI/MoPH et al. 2011), the health sector has improved greatly with the Maternal Mortality Rate (MMR) declining significantly from 1600 (per 100,000 live births) in 2002 to 327 in 2010. Over the same period, Infant Mortality Rate (IMR) has declined from 165 (per 1,000 live births) to 77, and mortality rate among children less than 5 years of age has declined from 257 (per 1,000 live births) to 97 (APHI/MoPH et al. 2011). In the education sector, the number of active schools has more than doubled from nearly six thousand in 2001 to nearly 14 thousand in 2011 (UNDP 2013). Over the same period of time, primary and

secondary school enrollment has multiplied from 1.1 million to 7.2 million, half of which are girls (UNDP 2013).

In the area of rural development, through the Ministry of Rural Rehabilitation and Development's (MRRD) flagship National Solidarity Program (NSP), the country has improved local governance, promoted rural reconstruction and contributed towards poverty reduction through the creation of Community Development Councils (CDCs).

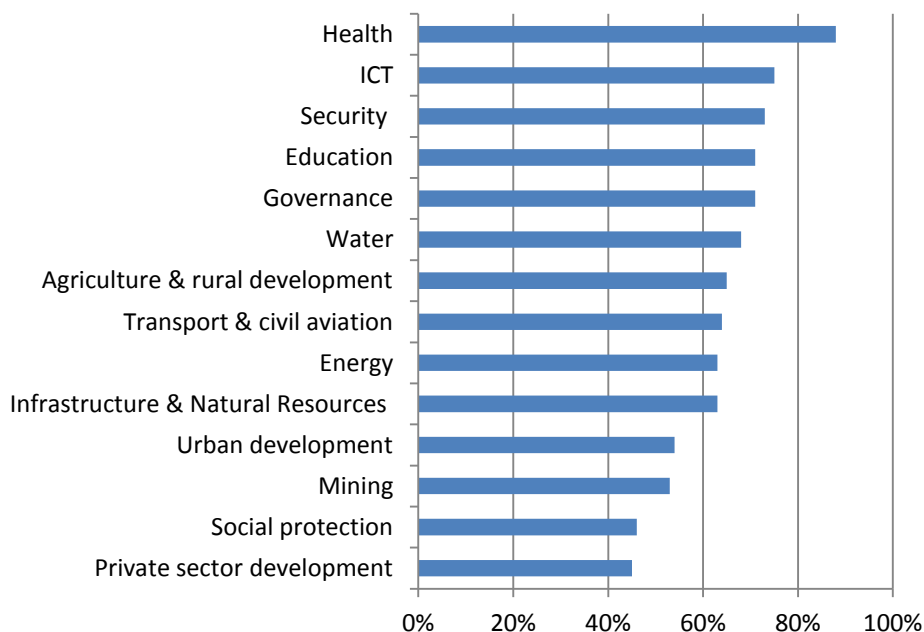
In the area of agriculture, Afghanistan continues to rely on imported agricultural products despite the fact that Afghanistan is primarily an agrarian economy with nearly 80% of the labor force working in agriculture (World Bank 2012). In fact, the latest figures indicate that Afghanistan spends nearly US\$3 billion a year to import agricultural products (World Bank 2014). To put this figure into perspective, it is nearly 15% of total GDP of US\$20 billion, or almost equivalent to the entire export value of the country. Conversely, only 24% of the GDP originates in agriculture, the remaining coming from the industry and service sectors.

Figure 22 establishes the health sector as the best performing sector, with an overall achievement rate of 88%. The sector that performed least well is the private sector development with an achievement rate of only 44%. Therefore, the ANDS calls the health sector "the most successful sector" compared to all other sectors identified in the document (Islamic Republic of Afghanistan, Ministry of Economy 2014, 18).

Although a thorough assessment of the process used to arrive at these achievement rates lies beyond the scope of this research, a closer look at the outcomes and indicators used to assess the health sector's performance in particular will be a useful

exercise.²³ As Table 9 shows, the performance of the health sector was assessed against three overarching outcomes and twelve specific indicators.²⁴ The three outcomes include “increased quality of health care services” with a focus on quantity and quality of healthcare infrastructure, “increased access to health care service” with a focus on citizens’ access to well-equipped health facilities and communicable disease detection and treatment rates, and “effective reproductive and child health system” with a focus on mortality rates among mothers, children and infants, and immunization coverage.

Figure 21 Ranking of sectors by their performance



Source: Afghanistan National Development Strategy (Islamic Republic of Afghanistan, Ministry of Economy 2014)

²³ For a more thorough reading of the process, see ANDS 2008-2013 document (Islamic Republic of Afghanistan 2008).

²⁴ It is important to note that in the actual ANDS evaluation, there are thirteen indicators. Upon closer look, I found that the second indicator under the third outcome, i.e. % of children under one year having received measles antigen, is repeated in the first indicator. The reason for this repetition is probably due to the fact that measles antigen rate has a different baseline than other vaccinations. For details, refer to Appendix A.

Table 9 The health sector’s outcomes and indicators according to ANDS

Expected Outcomes	Indicators
1. Increased quality of health care services	<ul style="list-style-type: none"> • Number of functional public and private hospitals set up • Number of provinces where organized structure is in place • Index on the progress of putting in place quality health care services • Overall score on Balanced Scorecard
2. Increased access to health care service	<ul style="list-style-type: none"> • % of population within two hours walking distance from PHC services • Number of health facilities, district, provincial and regional hospitals equipped with standard package of defined clinical and diagnostic services • % of TB cases detected and treated • % of Malaria cases detected and using preventive treatment
3. Effective Reproductive and Child health system	<ul style="list-style-type: none"> • % of children under 1 year having received measles antigen, DPT & hepatitis dosage and polio drops • Maternal mortality ratio • Under 5 mortality rate in the country (%) • Infant mortality rate (IMR) in the country (%)

Source: Adapted from the Afghanistan National Development Strategy (Islamic Republic of Afghanistan 2008, p.255-256)

Among the three outcome areas, Afghanistan’s health sector outperformed its targets in dropping mortality rates and improving immunization coverage. The ANDS evaluation notes that 100% of targets under the third outcome were met. While the health sector’s performance under the second outcome was also near perfect, where it underperformed was in improving the quality of health care services with its four indicators focusing on the number of functional hospitals, the number of provinces with organized structures in place, the index on quality health care services, and overall score on Balanced Scorecard, a measure developed to assess overall performance of the sector across the country.

This is not surprising given the difficulty in ensuring both access and quality of care, especially in remote districts and areas of active conflict. This aspect of the challenge was in fact confirmed by my own experiences on the ground. For example, in 2015, I led a team of researchers in Afghanistan in conducting a Public Expenditure Tracking Survey (PETS) of the health sector, which required the surveying of a carefully selected sample of 140 health facilities across eight provinces distributed across the country's seven regions (Dost 2015). One of the main challenges in this study was to ensure that the sample of health facilities was representative of the entire population because any systematic exclusion of health facilities would bias our findings. This, however, proved a formidable challenge as we had to constantly drop a large number of health facilities from the sample due to security threats in certain parts of the country. In fact, the final list of health facilities surveyed had 35 facilities dropped from the originally envisaged 140 sample size. This single example puts the situation into perspective by illustrating that if a small survey team cannot be easily deployed for a short visit to all the regions, ensuring adequate access to quality health care across the country is an unfathomable challenge.

This discussion brings us to the topic of the absolute and relative performance of the health sector in Afghanistan. When this study refers to the health sector as “the most successful” sector in the country, it is not the same as saying that Afghanistan's health care challenges have been resolved. Rather, this must be understood in relation to other sectors in the country. In fact, at the international level, even when compared to neighboring countries or other countries with similar income levels, health indicators in

Afghanistan, including mortality rates, are among the worst in the world. In addition, these relative gains have been achieved at the expense of highly inflated costs, mostly due to the security challenges associated with delivering services to remote and conflict-ridden regions around the country. The following figures from the 2015 national survey of the Afghan people, conducted by the Asia Foundation, shows the achievements of the health sector as perceived by ordinary citizens into perspective (Warren and Hopkins 2015, 9):

Overall, 49.1% of respondents say they are somewhat or very satisfied with their access to clinics and hospitals, and 42.4% report satisfaction with their access to medicine. Among rural Afghans, just 44.3% of respondents are satisfied with clinics and hospitals in their area, while 38.3% are satisfied with access to medicine. In contrast, a majority of urban Afghans are satisfied with clinics and hospitals (63.5%) and availability of medicine (54.6%).

This study is designed to provide a contextually meaningful explanation for why the health sector has achieved 88% of its stated targets, while all other sectors lag behind. In particular, it explores answers to the question of how the health sector made it from being in a state of “near total disrepair” in 2002 to “the most successful sector” in 2014 (Waldman and Hanif 2002, i; Islamic Republic of Afghanistan, Ministry of Economy 2014, 18). How did the health sector develop a relatively well-functioning health service system “out of almost nothing in post-2001 Afghanistan” (Michael, Pavignani, and Hill 2013, 322)? To answer these questions, we need to go deeper into the health sector and trace the process of its reconstruction in the post-Taliban era.

Methodological Framework

The way I have set this study up, this research design combines Mill's method of agreement and differences in what he called, Concomitant Variation (Mill 1925).

According to the method of difference (or most similar design), cases differ only in their dependent or outcome variables, while the majority of the independent variables appear to be the same. As a result, the variation in dependent variable may be attributed to the variations in one or more independent variables. An application of this design in my study involves the comparison of one or more "relatively successful" sectors with one or more of the "relatively less successful" sectors. Given that all the sectors operate under essentially the same environment, any variations identified in the two groups of cases may in fact be the causal variable that makes the difference between more and less success. More specifically, we would expect the more successful sectors to enjoy higher levels of local capacity than the less successful sectors, holding everything else constant.

Likewise, according to the method of agreement (or most different design), cases differ in most of their independent or explanatory variables, while they all share the same dependent or outcome variable. As a result, the one common independent variable that is shared among all the cases may be identified as the causal variable. An application of this design in my study involves the comparison of several "successful" sectors among themselves. As a result, "success" may be attributed to the one common independent variable that is present in all cases. More specifically, we would expect all the successful cases to have a relatively higher level of local capacity in common.

The combined method of agreement and different (Concomitant Variation) requires a comparison of a few successful cases with a few less successful cases. In line with the expectations of this design, I expect that we will find higher levels of local capacity in the more successful cases and lower levels of local capacity in the less successful cases. I provide further evidence in support of the local capacity argument by studying the health sector in further detail and looking for the causal mechanism and signs of other predictions of the local capacity hypothesis. One of the key advantages of this method of comparison is that it controls for all external confounding variables, such as type of aid, and donor commitment because all sectors operate under the same environment. The focus, therefore, remains on the internal or local factors within the aid recipient country, which I believe has received little attention in the study of aid effectiveness as an explanatory variable.

However, it is well documented that complete adherence to Mill's methods is not feasible in most studies in the social sciences, because the method essentially requires that the units of comparison be identical or different in all but one aspect. In other words, Mill's method works under three very strict conditions. First, the causal relations must be deterministic regularities involving conditions that are either necessary or sufficient for a specified outcome. Second, all causally-relevant variables must be identified prior to the analysis. And third, there must be available for study cases that represent the full range of all logically and socially possible causal paths (George and McKeown 1985). In fact, Mill himself considers this as "completely out of the question" due to the issue of equifinality or the possibility of different causal paths leading to the same outcome (Mill

1925, 3). While agreeing with such objections, although “founded on a too exacting scientific standard,” Lijphart’s solution is less exacting than Mill’s, and states “this standard should be approximated as closely as possible” (Lijphart 1971, 688), which is the intention of my study.

In response to these challenges regarding complete adherence to Mill’s methods, several solutions have been proposed. One key solution is to combine Mill’s method with the method of process tracing to compensate for the limitations in the application of Mill’s methods, although it cannot completely eliminate the challenges (Levy 2002). The method of process tracing is defined as “a procedure for identifying steps in a causal process leading to the outcome of a given dependent variable of a particular case in a particular historical context” (George and Bennett 2005, 176).

The method of process tracing can be used to effectively identify not only key causal variables, but also the causal paths to the outcome and check for spuriousness, even in a single case. The main reason for this is that the method of process tracing is an empirically strong method that compares observations with hypothesized intervening variables and events based on prior theories. There is an element of “progressive theorizing” to explain not only existing variations, but also new puzzles and anomalies (Lakatos 1970; George and Bennett 2005).

One of the main requirements for carrying out an effective process tracing is “a case-based methodology that can be applied successfully only with *good knowledge of* individual cases [emphasis added]” (Mahoney 2010, 131). I have developed a deep understanding of the development context in Afghanistan in general, and the health sector

in particular, through several years of studying and working in the country, predominantly in the post-2001 era. My knowledge of the region's culture and history, coupled with my on-the-ground experiences in the areas of health, education, peacebuilding, and capacity development, have provided me with a unique perspective on investigating complex development challenges in the country. For example, in the health sector, I have contributed to some major studies and evaluations with significant policy implications, such as the costing of the revised Basic Package of Health Services (BPHS) in 2011, the evaluation of Health System Strengthening in 2013, and a Public Expenditure Tracking Survey (PETS) of the health sector in 2015 (Dost 2015).²⁵

In addition to my personal experiences, this study relies heavily on both primary and secondary qualitative and quantitative data gathered through desk review, consultations with senior executives at the Afghan government and donor agencies, in-depth interviews conducted with various stakeholders including NGO and health facility leaders, and field observations, including focus group discussions with health staff and patients at the point of service delivery. The recruitment of interviewees took place on the basis of their relevance and expertise on the subject matter.

Before the instruments, including interview and focus group guides, could be developed, it was important to review relevant documents pertaining to Afghanistan's development at the national level, including health policy and strategy documents. It is important to note that the data collection instruments were customized to respondent type. For example, the questionnaires used in a health facility manager was significantly

²⁵ These documents are not referenced there because of their unavailability to the public. However, they may be made available by the MoPH upon formal request.

different from one used to interview a senior level official at the MoPH. The data from all sources, however, were used to triangulate the findings. Where significant differences emerged, further probes were conducted to identify the reasons for variations across the different sources. One of the key advantages of mixed methods, as was carried out in this study, is that the qualitative data can help fill the gaps identified through the quantitative component of the study. Once all the data from fieldwork were gathered, the data analysis stage began, with an aim to glean common emerging themes that provided answers to the specific research questions.

All ethical guidelines and codes of conduct were strictly adhered to throughout the fieldwork, including those set by the University of Denver's Institutional Review Board. For example, an implicit consent was elicited at the time of recruiting interviewees. However, before an interview was conducted, a written consent form was provided to all the study participants, where they were given ample information on what their participation meant, what kind of questions would be asked, that their participation was completely voluntary with no risks to them, that they had the option to refuse to answer any question at any point in time, and that they had the right to end the interview at any point in time.²⁶

The Method of Process Tracing

According to Peter Hall (2013), the origins of process tracing may be traced to George (1979) or Campbell (1975). Since then, it has had its own trajectory and growth. For example, when first popularized, this method was primarily used in the science of

²⁶ For more details, see the information sheet in Appendix B.

decision making in organizations (George and McKeown 1985). More recently, the method has been used by a large number of political scientists to trace any causal relationship between independent and outcome variables. As such, the method of process tracing has had a wide area of application in different fields (Checkel 2008).

The method of process tracing is essentially a particular methodology within the case study approach and as such it may offer certain advantages over large-N statistical methods. Despite the advances in the tools and techniques employed in cross-country regression analysis, the case study approach may be better suited to explore certain questions in social sciences. The study of foreign aid effectiveness is one such topic where the depth of analysis offered by case study approach may provide more meaningful insights into the conditions under which aid is more effective. For example, writing about the failure of cross-country regression analysis in measuring aid effectiveness, Hansen and Tarp (2000) stress the need for more theoretical work to inform policy and practice, thus providing support for this kind of theory-confirming case study.

There are a number of other advantages as well associated with the case study approach, defined as “the detailed examination of an aspect of a historical episode to develop or test historical explanations that may be generalizable to other events” (George and Bennett 2005, 5). For example, unlike the cross-country regression analysis that averages out differences among units of study, the case study approach allows the flexibility to choose to focus on both the average and the outliers. Unlike the cross-country regression analysis that treats all countries, all donors and all types of aid as

homogenous, the case study approach allows the flexibility to single out particular countries, particular donors, and particular types of aid, yet exploit some form of variations within the country to tease out key lessons learned. Unlike the cross-country regression analysis that assumes all aid is given to promote growth in the recipient country, the case study approach allows the flexibility to relax this assumption and consider other outcomes as well. This also ties closely with the definition of a case itself as “a phenomenon, or an event, chosen, conceptualized and analyzed empirically as a manifestation of a broader class of phenomena or events” (Della Porta & Keating, 2008, p. 226). The broader phenomenon in this study is the role of local human capacity in making aid work. To use Lijphart’s (1971) language, this is a theory-confirming case to show the critical role local human capacity plays in explaining the success of the health sector.

Although Easterly has not advocated the use of case study approach as a better alternative to cross-country regression analysis in measuring aid effectiveness, he has objected repeatedly to the widely held assumption that aid will promote growth. Instead, he pushes for the acknowledgment that aid cannot buy growth and that instead aid should be allocated “where it can do good” (Easterly 2003, 36). This sentiment has been echoed by several others. For example, cross-country regression analyses may be criticized because “aid is used to serve a donor agenda and therefore cannot and should not be measured against growth in recipient countries” (Collodel and Kotze 2014, 213).

Edwards (2015, 279) makes one of the strongest cases for case study approach, in a way that I am approaching the study of aid effectiveness.

There is little hope of making significant progress in these debates if the economics profession continues to rely heavily on cross section and panel regressions. In order to move forward and find out under what conditions aid is helpful and when it fails, these works need to be supplemented by in depth case studies that follow a country's history for many decades, focus on specific details of policy, understand the way in which the authorities relate to aid officials, concentrate on the political economy of reforms, and scrutinize the beliefs of politicians, policy makers and other key players. Only then will the profession be able to understand the intricacies of foreign assistance and its level of effectiveness.

Although some have criticized the method of process tracing for not yielding sufficient external validity, others argue that it can in fact yield external validity in the form of what Campbell once called "portable truths" (Campbell 1975 in Hall 2013, 22). Partly because of this debate, Hall (2003; 2006; 2013) cuts a specific niche within this debate and calls it "systematic process tracing" to differentiate it from one that may lack external validity. In particular, Hall (2013, 24) argues that he sees systematic process tracing "as a relatively positivist mode of enquiry, focused on hypothesis testing that uses systematic empirical observations to accept or reject propositions drawn from an overarching theory."

In a review article on qualitative research methodology, Mahoney (2010) contrasts the highly influential and equally controversial work of King, Keohane and Verba (1994), hereinafter referred to as KKV, with what he calls "the new methodology" in the post-KKV era (in particular, five books under review, namely Brady and Collier 2004; George and Bennett 2005; Gerring 2007; Goertz 2006; Ragin 2008). He joins others in critiquing KKV for overstating the strengths of quantitative research and undervaluing the unique characteristics of qualitative research. He further discusses the "tacit assumption" in KKV's writings about how qualitative researchers could benefit

from the superior principles of quantitative research, such as regression analysis, while never considering the possibility of the reverse being true.

Partly in response to the KKV claims about the superiority of quantitative research, Mahoney argues, an increased sense of “methodological self-consciousness” has emerged, thus giving rise to this “new methodology” as represented by the five books under review, which “encompasses KKV ’s helpful insights while avoiding their most obvious missteps” (Mahoney 2010, 122). Relating to the debate on the superiority of one approach over the other, Mahoney argues against such dogmatic views, arguing that the two approaches may be seen as complementary to one another given that each is designed to achieve distinctively different ends. In his view, while case studies focus on the “why” question about causal analyses, quantitative methods aim at estimating average effects of particular explanatory variables on outcomes of interest.

The Reductionist and Anti-reductionist Debate

The debate over reductionism (or essentialism) and anti-reductionism (or anti-essentialism) has dominated research in social sciences for a long time. Rather than advocating for the adoption of one or the other, I argue that each approach on its own is limited in its ability to produce useful findings given their particular strengths and weaknesses. Although there are instances where one approach may be a better choice than the other, a combined application of both will yield better outcomes rather than an exclusive reliance on one or the other. For instance, the boiling down of economic wellbeing to purely income based measures by reductionists (as was demonstrated in Chapter IV) ignores wellbeing in many other non-income domains. Similarly, the Human

Development Index, although not purely anti-reductionist, would not have been an improvement over income based measures had it not relied on per capita output as one of its three key components.

In order to make sense of the objects in the world around us, we have to employ a methodology of identifying and selecting the objects and theorizing about the relationships among them. The different approaches that one can use in theorizing lie in a continuum between *reductionism* on the one end and *anti-reductionism* on the other. Other terms often used interchangeably with (anti)reductionism are (anti)essentialism and (anti)determinism. For simplicity, I will stick with reductionism and anti-reductionism in this paper.

As the name suggests, the reductionist approach refers to the presumption made that the cause of any event can be *reduced* to a few “essential” variables, often referred to as the key determinants. The basic approach of a reductionist methodology follows the following three steps (Wolff and Resnick 1987, 15). First, when we observe the occurrence of an event, such as changing GDP growth rates, we also know that an infinite number of other events are happening simultaneously just as another infinite number of events have happened in the past. Second, the theorist selects few variables or “essences” among these infinite potential variables, to be used as the causal, essential or determinant variables that are believed to be the driving force behind the observed effect. An example of such select variables in our study could be the changes in aid volumes or variations in local capacity. Finally, the theorist builds models where the identified causal variables *explain* the changes in the observed effect, by dividing them into dependent and

independent variables, and separating essential from non-essential potential causes. Much of the neoclassical economic theory seems to fit perfectly the profile of reductionist approach to social problems. The empirical works presented in Chapter IV that investigated the relationship between volumes of aid and GDP growth rates is another example of the reductionist approach.

Anti-reductionism, on the other hand, refuses to elevate any variables to the privileged or *essential* status over other variables. The presumption is that there are infinite changes in other variables happening at any time, thus making it both impossible and obsolete to attribute a change to few causal variables. For any event, instead of being *determined* by a few causal variables, the event is said to be *over-determined* through the interplay of an infinite number of changes in variables. It does not make sense, therefore, to single out a few select variables as the *causal factors* or *essences*, especially since any variable is presumed to be both a cause and an effect at the same time. It can also be inferred that an anti-reductionist account of a cause-and-effect relationships cannot be modeled through a dependent-independent variable mode, which is most common among neoclassical economists in their statistical models.

Although the prefix “anti” in the term “anti-reductionism” suggests that the latter is anything that reductionism is not, there are more similarities between the two approaches than what first meet the eyes. For practical reasons, even the most religious followers of anti-reductionism will inevitably be forced to drop many of the variables that are believed to contribute to an event, and narrow the list down to a manageable set. No phenomenon can be explained by referring to an infinite number of causes, each of which

could have been caused by an infinite number of other causes, and so on it goes. The difference, however, is in how these dropped and retained variables are treated. While reductionists may treat the former as contingent or secondary, and the latter as essences, anti-reductionists refuse to do so. Instead, they may drop some variables *temporarily* for practical reasons and view the selected variables as merely “entry points” into analysis, not the final set of essences.

This brings us to the *dynamic* progress, a key distinguishing feature of the two approaches. Reductionist approaches have an intrinsic tendency to reinforce strongly held ideologies. So much faith is placed on the model that it may blind the theorist to alternative truths. In fact, at one extreme, the model may be idolized so much that it may not match the reality on the ground, except in the internal workings of the model. Progress over time would be aimed at *proving* that the initial specification of the model is right, rather than a willingness to thrust aside the model or even make significant changes to the initial specification to match the reality. While this stickiness may bring about clarity, precision and consistency, it also renders the approach too rigid.

The anti-reductionist approach, on the other hand, offers a lot more flexibility and frees the researcher from the confines of the accepted norms and structures. Adherents of this approach are in fact more than willing to not only update their models but to even discard what they previously held to be true. To an outside observer, these tendencies make anti-reductionist approach seem messy, disorganized, inconsistent and at times chaotic. Gleaning such subtle differences can only come from a sustained examination of the researchers’ works over a long period of time.

Finally, the most subtle and perhaps the most important distinguishing feature of the two approaches lies in the intent and the underlying ground that supports the researchers' claims about the world. A superficial examination of a claim may not tell us much about the deeper ideological and normative commitments of the researcher. Determining the right intent and the underlying ground may not be as simple as it sounds. One way around this issue is provided by Wolff & Resnick (1987, 20), who argue that an anti-reductionist may choose to focus on a select few variables as long as the researcher is "aware of and explicit about" the partial and incomplete nature of the analysis. Some researchers, however, may be aware of but do not make explicit the partiality of their analysis. Other researchers may exhibit all signs of reductionism by making claims that resemble those of reductionists, yet s/he may have arrived at those claims through an anti-reductionist logic or vice versa.

It is important to note that the choice of the theory is extremely important in reflecting the theorist's normative commitments, because "what we see is shaped by how we think just as much as how we think is shaped by what we see" (Wolff and Resnick 1987, 18). The choice of the approach is consequential in terms of the research findings and policy outcomes emanating from the research. Two researchers, analyzing the same subject, may very well end up with quite different or even diametrically opposed policy conclusions depending on the approach they choose. It is for this reason that I have undertaken the investigation of aid effectiveness in Afghanistan through both lenses.

In conclusion, both reductionism and anti-reductionism have a number of desirable features. Reductionism, for instance, allows its adherents to analyze issues with

remarkable parsimony, clarity, precision, call to action and universalist tendencies. Anti-reductionism allows its adherents the flexibility to analyze complex issues with a sense of humility that removes the anxiety and obsession of getting it all correct in one attempt. It acknowledges messiness and complexity and sees policy formation as requiring a process of continued trial and error.

Taken to their limits, however, both extreme reductionism and extreme anti-reductionism are exposed to some serious challenges. Extreme reductionism, for instance, can lead to rigidity, blindness to alternatives, and worst of all leave you dealing with enormous consequences from getting it fundamentally wrong. Similarly, extreme anti-reductionism can lead to complete inaction. If everything is caused by everything else at the same time, there is no way one can detangle the mess without resorting to some degree of reductionism.

I argue that the world of foreign aid and development is too complex to be addressed through either one or the other approach, thus needing a balanced use of both to get a much more enriched analysis. The two approaches are more complements than substitutes for one another, although they may be seen the other way around by some unyielding believers in each camp. To the extent possible, we should exercise intellectual honesty, and state our conceptions and methodological tendencies explicitly. The right question, therefore, is not which approach is better but rather which approach is more likely to produce better results in which contexts.

After considering this tangent, we now turn to Mahoney's discussion of process tracing. The most relevant aspect of Mahoney's article for this study relates to the way

process tracing may be operationalized in not just generating new theories but also *testing* them. In particular, he discusses the slightly different understanding of the method of process tracing by KKV vis-à-vis the other five books under review. Mahoney argues that KKV understand process tracing merely as the search for intervening variables that link an independent variable with a dependent variable. When viewed in this light, process tracing will clearly seem ill-suited at causal inference because there is no way of choosing between a large number of intervening causal steps that may be identified along the way from an independent variable leading to the outcome variable of interest. Given these limitations of the process tracing methodology, they consider it “unlikely to yield strong causal inference” because it can only “promote descriptive generalizations and prepare the way for causal inference” (KKV 1994, in Mahoney 2010, 123).

Similar critiques of not just the method of process tracing but all qualitative methodologies have emerged in the past. For example, it is well documented that while case study approach offers some improvements over cross country regression analysis, it suffers from other shortcomings, in particular, the much debated problem of too many variables with too few cases. The typical strategies to ameliorate this limitation include increasing the number of cases temporally and spatially, reduce the number of variables by collapsing conceptual categories, building more parsimonious theories by focusing on smaller number of variables, and adding more comparable cases that have similar dependent variables (Lijphart 1971).

Another common critique is that unlike large-N statistical analyses, the case study approach cannot produce probabilistic theories. This, however, may not be such a serious

challenge because qualitative researches, like the one that I am conducting, do not stop at finding a probabilistic statement, even if they were to arrive at one. They instead focus on the “why” and “how” questions and keep refining and reworking their theory to improve its ability to explain observation.

A final critique of case study approach is its inability to yield the kind of precision about the magnitude and significance of identified relationships that statistical approaches can. The closest that case study approach gets to ascertaining the strength of hypothesized relationships is that they can identify those explanatory variables whose presence or absence could make a noticeable difference in the identified cases. In other words, while the overall significance of identified relationships can be determined, arriving at percentage of confidence is not possible. This may not be such a real challenge because case study approach tackles those kinds of issues that are hard to quantify and measure in the first place.

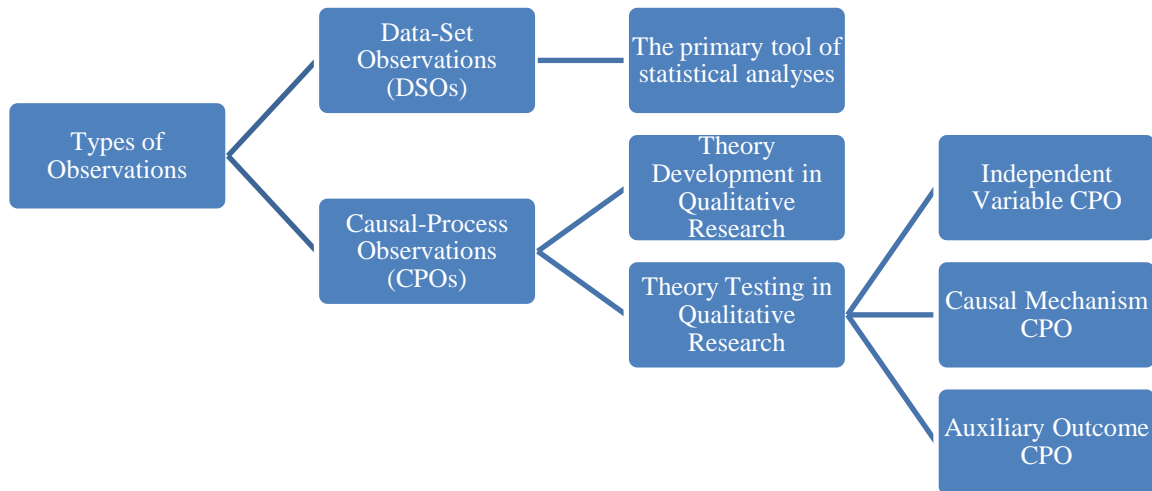
Taken together, these critiques question the ability of qualitative comparative cases to produce both internally- as well as externally-valid claims about causal processes. Mahoney and others, however, argue that these critiques do not pose a serious threat to qualitative research, precisely because they emerge as a result of a conscious effort to compare qualitative approaches to regression analysis as the gold standard. Qualitative methods, in particular the method of process tracing, should therefore be seen as a distinctive approach by itself, while making efforts to take into the critiques when they are meaningful threats to inferential validity. Mahoney (2010, 124) argues that the new methodology pushes back strongly on this notion because it “links process tracing

not to regression norms but to a distinctive qualitative approach to causal analysis.” For example, George and Bennett (2005, 13) argue that “process tracing is fundamentally different from statistical analysis because it focuses on sequential processes within a particular historical case, not on correlations of data across cases.”

To clarify how process tracing relies on a completely distinct frame of thought, Mahoney highlights Collier, Brady, and Seawright’s distinction between data-set observation (DSO) and causal-process observation (CPO). While DSO refers to a general observation as understood in qualitative approaches, CPO refers to a “smoking gun” type of evidence that only comes to light with an in-depth knowledge of the particular case and its context, thus, if properly identified, carrying significantly more weight than a DSO. The reliance of the method of process tracing on CPOs, vis-à-vis the reliance of regression analysis on DSOs, therefore, should make the distinction between the two clearer.

Contrary to the popular belief that large-N studies are best suited for theory testing and case studies are best at theory generating, Mahoney argues that the new methodology, in particular process tracing, is in fact quite well-suited for theory testing. Building in particular on the works of Brady and Collier (2004) and George and Bennett (2005), Mahoney identifies three specific types of CPOs used in theory testing (See Figure 22). Even though Mahoney shows through examples that even the application of one type of CPO may be sufficient to establish and test causal inference, I attempt to show all three types in this research for added confidence in my findings.

Figure 22 Types of observation employed in qualitative and quantitative approaches



Source: Adapted from Mahoney (2010, 126)

The first type of CPO is called Independent Variable CPO because it focuses exclusively on identifying the existence of a causally critical independent variable in the cases under investigation. While this may look trivial at first sight, we have to remember that this independent variable of interest is identified a priori from previous theory development case(s) and this merely tests the external validity of that theory in one more context. Secondly, it is not just the mere existence of the independent variable that lends greater credibility to the pre-existing theory, but the manner in which this independent variable is present, the timing and sequence of its occurrence, and the nature of causal path it travels through to the outcome variable. One example that illustrates Mahoney's point is Nina Tannenwald's search for the existence of a "nuclear taboo" in explaining the non-use of nuclear weapons by the United States since World War Two. In her study,

it is not the number of historical episodes (a DSO) but the existence of a norm or value (a CPO) that matters for validating her claim.

In the case of my study, the generated hypothesis posits that sufficient local capacity is a key determinant of effective aid utilization. While this theory is generated based on my observations of the health sector in particular, a good test of the theory would reveal that local capacity is indeed present in all sectors in varying degrees of success. Furthermore, the absence of local capacity in the least successful sectors would lend further credence to the proposed hypothesis about the conditions under which aid may be more effective. Both these conditions are satisfied in this study, in that some of the most successful sectors, such as health, education and rural development also enjoyed more abundant levels of local capacity in providing basic health, primary education, and building basic engineering structures. Some of the least successful sectors, such as mining and private sector development also suffer from the lowest levels of local capacity.

The second type of CPO is called Mechanism CPO because it highlights the significance of an “intervening event” that is considered critical in the causal chain and that is posited a priori by the theory. This follows Bayesian logic where the original theory says if X is right, then we should expect to Y to happen, thus emphasizing the importance of theoretical priors and ex-ante expectation of events. Depending on the conformity of prior expectations with new observations, the new evidence might either support or undermine the strength of existing theory. This type of CPO is best illustrated by Theda Skocpol’s (1979) study of the relationship between ideologically motivated

vanguard movements and social revolutions. Although she finds vanguard movements present in all instances of social revolutions (thus satisfying the first type of CPO or independent variable CPO), the absence of Mechanism CPOs casts doubt on the theory. In particular, the theory's prior expectations were that these vanguard movements trigger lower-class revolts. But this is not corroborated with evidence if vanguard movements show up *after* revolts. As a result, it reveals that the sequence of events matter for drawing conclusions.

Levy (2002, 443) argues that process tracing is an especially useful methodology because it “follows a different logic and tries to uncover the intervening causal mechanisms between conditions and outcomes through an intensive analysis of the evolution of a sequence of events within a case.” In his view, process tracing is a strong methodological choice because it allows for the identification of the causal mechanism, which is a key advantage over large-N statistical analysis. It is also good at opening the black box of what goes inside the processes between inputs and outcomes. Finally, it is good at studying nonlinear relationships with key inflection points and path-dependence where timing and sequencing matter.

In my study, I show that local capacity is present in the pre-aid era, developed through the decades of war delivering basic services to Afghans in Afghanistan and in Pakistan, and that when aid dollars are delivered to the country, these Afghan health experts and ex-NGO employees are able to exercise local ownership by being in the driver's seat in managing aid and delivering results. Therefore, it is not just the existence of local capacity that matter, but the way in which these Afghan health experts get

organized, embrace leadership roles, and display their ability to achieve results that matter the most for effective utilization of foreign aid.

The third and last type of CPO is called Auxiliary Outcome CPO because it is aimed at identifying other “traces” or “markers” left behind by the causal explanatory variable. Mahoney (2010, 129) defines this type of CPO as “particular occurrences that should occur alongside (or perhaps as a result of) the main outcome of interest if in fact that outcome were caused in the way stipulated by the theory under investigation.” This is different from both the first and second type of CPO in that it is neither about the existence of the cause, nor is it an intervening or process variable. Instead, it adds the requirement to show evidence of other outcome variables, in addition to the main outcome variable of interest. While the existence of these auxiliary outcomes, although closely related to the main outcome variable, is not sufficient evidence by themselves, their simultaneous existence with the main outcome variable adds credence to the posited theory. To illustrate the point, Mahoney uses Gregory Luebbert’s work on red-green alliance in explaining the rise of social democracy in interwar Europe. In order to convince the readers that red-green alliance indeed was the cause, Luebbert had to show evidence of other traces left behind by this alliance, which include “a reluctance of socialists to challenge the distribution of wealth in the countryside; high levels of worker and union autonomy; and an inability of socialists to rely on the middle peasantry as viable electoral base” (Mahoney 2010, 130).

In this study, I show that one observable implications of the local capacity hypothesis is the reproduction of local knowledge and expertise through conferences and

peer-reviewed papers written predominantly by Afghans in international journals. In other words, I investigate that if local capacity was indeed the key causal factor contributing to the health sector's remarkable success in effective utilization of foreign aid, then this local capacity should have left behind other traces and markers, such as conferences and papers led by Afghan health professionals. In addition, while it is true that the probability of finding more local capacity in relatively more successful sectors is not that low, the probability of finding both local capacity as well as such other visible traces is so low that it cannot be due to chance alone.

I find that Afghan health experts have indeed displayed their abilities in reproducing knowledge by the following actions: authoring peer-reviewed journal articles on rebuilding health systems, facilitated numerous conferences at the local and international levels, advised other developing and post-conflict country governments, and have actively promoted the BPHS and contracting-out mechanism as a proven and successful model of health care service delivery in post-conflict environments. For example, the journal of Global Public Health includes numerous publications authored by Afghan experts affiliated with the MoPH. In particular, this journal's Special Issue in 2014 (Vol.9, Supp.1) reflected many articles by noted Afghan scholars-practitioners, including the current minister, Dr. Feroz, and the previous minister Dr. Dalil.

Another visible trace of the abundance of Afghan capacity in health is manifested through the presence of medically-trained doctors in sectors other than medicine. Some interviewees pointed out to the presence of medical doctors in key leadership positions in other ministries and organizations, while the reverse (i.e. the presence of other experts in

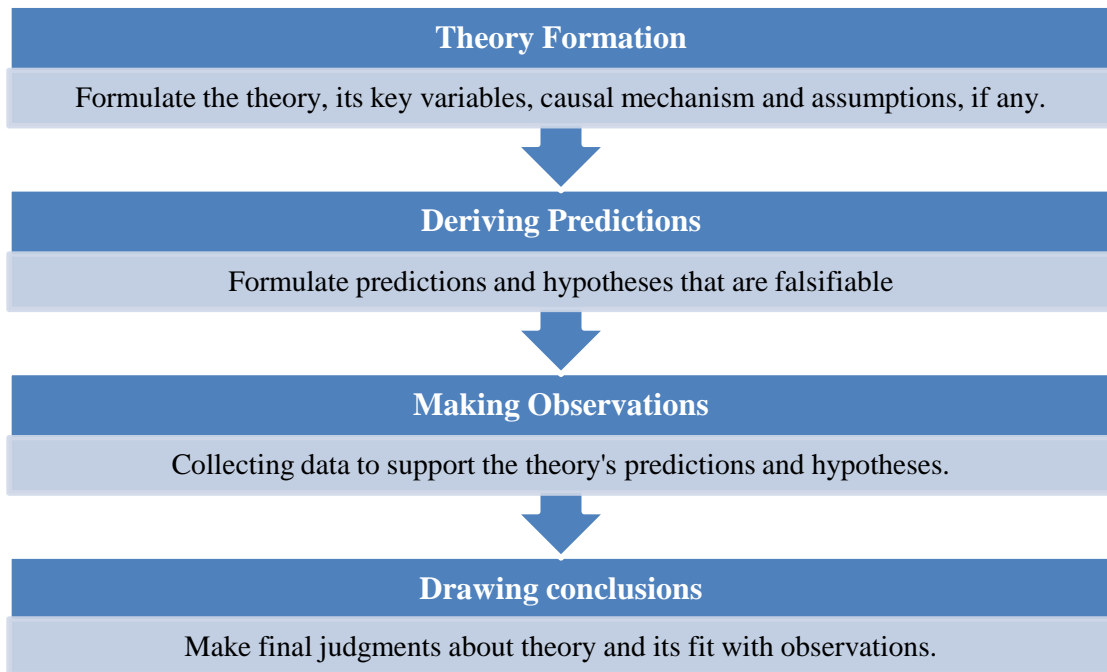
leadership positions in MoPH or other health-focused organization) would not hold true. In other words, while MoPH and other health-focused organizations are almost exclusively run by medical professionals, this is not true in all other sectors. For example, the ministries of economy, finance or trade have only a handful of professionally trained economists, finance or trade specialists. Interviewees note that it is not uncommon, however, to see medical staff in these other fields. Although this is a reflection of their superior leadership and managerial skills more than their capacity in health, it nonetheless shows the overall competence and the relative abundance of Afghan health experts. For example, some interviewees were quick to point out that if it hadn't been for Dr. Nasrin Oryakhil's outstanding performance in her medical field, she would not have been nominated for the position of minister at the Ministry of Labor, Social Affairs, Martyrs & Disabled.

As a result, the combination of all the above three types of CPOs in my study should convince the readers that local capacity in fact holds the secret to the health sector's remarkable performance. This is not just because a) I show the existence of local capacity in relatively more successful sectors, or b) I show the sequence of intervening variables in the causal chain between local capacity and success across sectors, or c) I show the presence of other outcomes corroborating my local capacity hypothesis, but because I illustrate that all the above three conditions are satisfied in the same study.

According to Hall (2006), the method of process tracing involves four steps, as illustrated in Figure 23. A complete application of these steps will be presented in the

upcoming chapters. This section presents a brief introduction to key elements in each step.

Figure 23 The four steps of applying process tracing



Source: Adapted from Peter Hall (2006)

1. Theory formation: This main contribution of this theory confirming case study is that in line with the contingency school of aid effectiveness literature, aid is likely to be more effective conditional upon the presence of local capacity in the recipient countries. The key causal mechanism is that local experts are there for the long run, have a deeper appreciation of the local complexities, and in most cases, have a greater sense of motivation and incentives to play important roles in

the reconstruction of their societies, thus allowing for the exercise of “local ownership” as emphasized by the Paris Declaration (Roberts 2010).

2. Deriving predictions: exploiting cross-sectoral variation in aid effectiveness in Afghanistan, this study predicts that sectors with relatively greater levels of local capacity should be relatively more effective in their utilization of foreign aid resources. Operationalizing this model is all the more challenging given the paucity of data in Afghanistan. The outcome variable, i.e. aid effectiveness in each sector, is derived from the percentage of targets achieved as outlined in the Afghanistan National Development Strategy document (Islamic Republic of Afghanistan, Ministry of Economy 2014). A ranking of various sectors according to this measure was presented in Figure 21 in the previous chapter. As for the main explanatory variable, a measure of local capacity is developed from mainly three sources. First, data from university entrance examinations, number of graduates and dropout rates provide a basic overview of potential existing capacity in different sectors. Second, data on Afghan and international Externally Funded Staff (EFS) in each sector provide further evidence of local capacity vis-à-vis reliance on borrowed capacity from abroad. Third, expert opinion has been sought through key informant interviews and discussions to complement the other two sources of data on local capacity.
3. Making observations: in accordance with the proposed hypothesis in step one, the next step is to make relevant observations on expected events, their sequence, actions by key actors, and evidence on the causal chain (Hall 2006). If my

proposed hypothesis about the centrality of local capacity in effective utilization of aid is correct, one would expect a gradual, but early transfer of authority and responsibility to local experts as they earn the trust and confidence of their international counterparts in managing resources effectively and delivering results. The local experts should simultaneously display their skills, abilities, motivations, and ambitions to exercise true local ownership and accountability.

4. Drawing conclusions: making a definitive judgment about the extent of congruence between theory predictions and observations requires careful assessment in light of the available data and methodology. As I will show in the coming chapters, not all the observations match the theory's predictions perfectly. However, there is significant evidence to support the argument that local capacity is indeed a, if not *the*, central variable that determines the effective utilization of foreign aid dollars, as exemplified in the success of the health sector in Afghanistan. In addition, the success of the top three most successful sectors is strongly correlated with their relatively higher levels of local capacity. With more data, future research could test the strength of this hypothesis in explaining variations in aid effectiveness across sectors in other countries around the world.

The next chapter conducts in-depth process tracing of the health sector as the most successful sector in the effective use of foreign aid dollars in comparisons to other sectors. Special attention is also paid to rival hypotheses that could be argued to explain the health sector's remarkable success.

CHAPTER SIX: MICRO LEVEL EVIDENCE II

The previous chapter set the stage by presenting the selection and ranking of the sectors and identifying the method of process tracing as the method of choice for this study. In this chapter, endeavor to explain why the health sector has been such a remarkable success, when all sectors were operating under the same set of conditions. With an aim to uncover the conditions under which aid can be more effective, this chapter will first conduct an in-depth process tracing of the health sector with a focus on the early 2000s, starting with the international community's first key meeting in Islamabad in November 2001. In addition, this chapter will consider four key alternative hypotheses in explaining the health sector's success, thus providing further evidence to support the local capacity hypothesis.

Health as the Most Successful Sector

The success of the health sector has attracted much attention among both academics and policymakers. For example, the previous minister of Public Health, Dr. Suraya Dalil, and her co-authors explain the success of the health sector by focusing on six key factors: i) country ownership through a real stewardship role for the MoPH, ii) strong “donor coordination and collaboration,” iii) “participatory decision-making” processes involving the MoPH and donors, iv) evidence-based programming with a focus on achieving results, v) strong donor commitment evidenced by “reliable aid flows,” and

vi) “a critical mass of individuals” who worked hard to makes all these achievements possible (Dalil et al. 2014, S124). Their logic, however, becomes circular when they build their premise on the five principles of the Paris Declaration on Aid Effectiveness, which are ownership, alignment, harmonization, managing for results and mutual accountability and argue that aid was effective in the health sectors *because* of these factors.

Other factors identified to explain the success of the health sector include the careful design and rollout of the BPHS, effective engagement by the international community with the fragile states, community-based health care delivery and the decision to adopt a contracting-out modal of service delivery(Dalil et al. 2014; Newbrander, Waldman, and Shepherd-Banigan 2011).

The approach that I adopt in studying the success of the health sector differs from the above-mentioned studies in at least two fundamental ways. First, just as I consider the success of the aid sector relative to other sectors in the country, I also try to identify potential factors that could explain the success of the health sector in comparison to the presence or absence of those factors in other sectors. For example, the argument made in favor of contracting-out model of service delivery as a key factor in explaining the success of the health sector can be strengthened if we find that this practice is present in other more successful sectors and is absent in less successful sectors. Second, my analysis does not end with the identification of potential factors that could explain the success of the health sector. Instead, I delve deeper by inquiring about the potentially causal mechanism through which the identified factors affect health outcomes.

One of the key advantages of this approach is that many potentially confounding factors, with the exception of sector-specific factors, are automatically controlled for by virtue of the units of comparison operating under the same environment. In other words, the principle of *ceteris paribus*, or holding everything else constant, is satisfied to a large extent because many of the potential explanatory variables are expected to have an essentially uniform impact on the effective utilization of foreign aid dollars in all sectors under comparison.

Reviving the Health Care System after 2001

In the pre-war years of 1960s and 1970s, the government was directly in charge of delivering much of the health services, albeit this resulted in much of the rural areas across the country being ignored. Starting in the mid-1980s, with the number of Afghan refugees in Pakistan exponentially increasing, and donor funding following suit, the NGO sector emerged to fill the gap in Pakistan and engage in some cross-border operations as well. This trend continued until the Taliban take-over of the country in the mid-1990s, during which time the MoPH capacity was at its record low, thus NGOs were left as the sole providers of health services. By this time, many of the NGOs had developed their capacities and built standard procedures for health care delivery in some of the hardest regions through their experiences in the previous decades both inside Afghanistan and for Afghan refugees in Pakistan. During this time, the Afghan Ministry of Public Health (MoPH) played little role in coordinating health services, thus leaving the health care service delivery to be fragmented and unequally distributed across the country.

The decades of conflict and the Taliban ban on female education significantly impeded the development of female health care providers to keep pace with their male counterparts, a challenge that continues to haunt the country to this day. In fact, lack of female health care professionals in all health facilities is one of the key challenges in effective service delivery, especially in rural areas (Hill, Mansoor, and Claudio 2010). Ironically, the Taliban requirement for female patients to be seen by female care givers only provided opportunities for a few female health practitioners to continue practicing medicine during the Taliban reign. It is not surprising then that “since the fall of the Taliban regime in 2002, gender inequalities in health have improved” (Samar et al. 2014, S76).

Starting in late 2002, however, the health sector experienced a massive overhaul, in particular, with the establishment of the BPHS, and an overall better coordinated health system with carefully developed national policies, strategies and priorities. One of the key policy choices made during these critical months included the complete transfer of health care service delivery role to NGOs through a system of “contracting-out” mechanism, while limiting the role of the MoPH to stewardship and oversight.

After the fall of the Taliban, the health system that the new transitional government inherited seemed broken beyond repair, with none of the ingredients of a functioning health system in sight. The situation was best described as follows:

Afghanistan's health system is in a state of near total disrepair. Standard health indices, including the infant mortality rate, the childhood mortality rate and the maternal mortality ratio, are among the worst in the world. As the new interim government re-establishes and slowly strengthens social services, it finds itself facing a multitude of technical, managerial and operational problems that need to be clarified before they can be solved (Waldman and Hanif 2002, i).

In the year 2014, an evaluation of all sectors under the Afghanistan National Development Strategy (ANDS) finds that the health sector is “the most successful sector” in the country (Islamic Republic of Afghanistan, Ministry of Economy 2014, 18). How did the health sector make it from being in a state of “near total disrepair” in 2002 to “the most successful sector” a decade later (Waldman and Hanif 2002, i; Islamic Republic of Afghanistan, Ministry of Economy 2014, 18)? What is the secret behind the health sectors unmatched performance in creating a well-functioning public health delivery system with a stellar record “out of almost nothing in post-2001 Afghanistan” (Michael, Pavignani, and Hill 2013, 322)? However, a focus on the health sectors is warranted not just because of its stellar record, but also because service delivery in the health sector restores government legitimacy and is a “bridge for peace” in post-conflict environments (Vaux and Visman 2005, 3).

Alternative Hypotheses

In developing new hypothesis, considering alternative hypotheses adds further credibility to theory (Kuhn 1970). Furthermore, the idea of a “three-cornered fight” between observation, existing theory and alternative hypotheses was popularized by Lakatos (1970). In this section, I present four key alternative hypotheses that may be presented to explain the health sector’s success. As Khan (2008, 15) argues, “much dogmatism in social sciences can be avoided if rival theorists were to make explicit the causal mechanisms and the grounds for what would comprise a fair causal comparison among rival theories.”

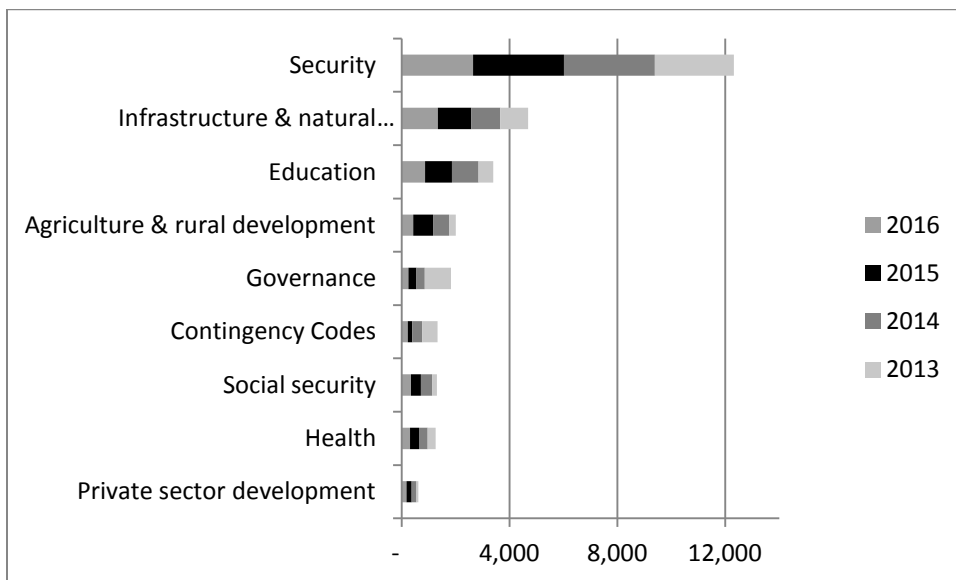
At least four reasons may be presented as the potential explanation for the success of the health sector. In the following section, I consider each of these arguments and refute them as key rival hypotheses in favor of the fifth hypothesis, i.e. the local capacity hypothesis (LCH), that I argue best explains the success of the health sector compared to the other sectors in Afghanistan.

The first rival hypothesis may be called the Financial Support Hypothesis (FSH), referring to the massive financial contribution of the donor community to the health sector in Afghanistan. On the surface, this is the most powerful rival hypothesis to refute. In fact, no one can deny the fact that the centrality of the donor moneys in rebuilding the broken health system of the country cannot be overstated. If it were not for the international community's financial support, even the very first Conference on Preparation for Reconstruction in Islamabad in November 2001 would not have been held. As Dr. Hussein Gezairy, the then WHO Regional Director for the Eastern Mediterranean said, "significant financial and technical resources are required more than ever before" (WHO 2001, 1).

While the significance of donor support in reconstructing the health system in Afghanistan cannot be denied, it should be noted that the question raised is about the relative success of aid in the health sector. When viewed from this perspective, the amount of aid spent on the health sector should be compared to that of the other sectors. If the amount of aid was the only determinant of success, we could reasonably expect that the sector with the highest budget be the most successful sector. Such a comparison reveals that the reason for the extraordinary performance of the health sector does not lie

in the amount of foreign aid spent on the sector (see Figure 24 and Appendix B for more details). In fact, sectors with higher budgets are outperformed by the health sector, just as some less successful sectors enjoy higher budgets than that of the health sector. From this analysis, it is clear that the financial support hypothesis does not stand up to this simple logical test.

Figure 24 The distribution of government core budget across ANDS sectors



Source: National Budget Document, 2013-2016 (Islamic Republic of Afghanistan, Ministry of Finance 2016; Islamic Republic of Afghanistan, Ministry of Finance 2014; Islamic Republic of Afghanistan, Ministry of Finance 2013; Islamic Republic of Afghanistan, Ministry of Finance 2012)

I call the second rival hypothesis the Easy Indicator Hypothesis (EIH). Under this hypothesis, the critics argue that the reason more was achieved in the health sector with relatively less financial support is because the chosen indicators of success for the health sector were easier to achieve than those for the other sectors. An assessment of the process of selecting indicators and targets for ANDS allowed the line ministries significant control, and leaves the possibility to such a bias. In fact, the unchecked

influence of the line ministries throughout the process gave them an incentive to select softer and easier to achieve targets and indicators.

While a thorough evaluation of the process of ANDS development and an objective comparative analysis of the targets and indicators across sectors are beyond the scope of this research, two arguments may be presented to refute the easy indicator hypothesis. First, since the process presented all the line ministries with the same opportunity to develop their targets and indicators, we have no reasons to believe that the health sector was either in a more privileged status or that they behaved differently from the rest of the group by setting their targets at proportionately easier levels than their counterparts. Second, even a cursory look at the set of indicators in the ANDS reveals that the indicators selected for the health sector are far from easy. One of the key critiques that may be charged against the ANDS Monitoring Matrix is the apparent confusion and inconsistency in the framing of outcomes, indicators and targets. More specifically, the document does not seem to clearly differentiate between output and outcome, with the former being a direct product of activities, while the latter is achieved as a result of achieved output(s). By this definition, a sector that sets its targets at the output-level may be deemed to have selected easier indicators for assessing its success.

In the case of the health sector, while it is true that some output-level indicators - such as “number of functional public and private hospitals set up” or “90% of population within two hours walking distance” of health care services by 2010 – have crept into the health sector, this sector also includes some critical and hard-to-achieve outcome – and even impact-level indicators too (impact refers to highest level objectives). Examples of

the latter category include 50% reduction in maternal and child mortality rates, and 30% reduction in infant mortality rates, all by 2013 (Islamic Republic of Afghanistan 2008c, 255–256). Almost all the other sectors, however, suffer from an abundance of relatively easier-to-achieve output-level indicators where they should have had outcome-level indicators. For example, in the energy sector, some targets include 25% of rural households and 65% of urban households electrified by 2011 (Islamic Republic of Afghanistan 2008c). Almost all targets and indicators for the Information Communication Technology sector are about increased coverage of various technologies. In the mines and natural resources sector, almost all objectives, such as the approval of various regulations, “survey of 5% area of country's natural resources,” are specified at the output level (Islamic Republic of Afghanistan 2008c, 252). Lastly, many of the indicators for the agriculture and rural development sectors are focused on the number of Community Development Councils (CDCs) established and the province-wide coverage of the National Solidarity Program (NSP), both of which are clearly output-level indicators.

The easy indicator hypothesis, however, does have some explanatory power in explaining the differences in the relative performance of education, and social protection sectors. In the case of the education sector, many of the indicators, such as those focused on enrollment rates and the number of new school buildings with amenities for both boys and girls are set at the output level. The closest it gets to outcome indicators, such as learning outcomes, is designing “competency tests” for students, teachers and principals, yet still not even discussing improved test scores on these competency tests (Islamic

Republic of Afghanistan 2008c). The social protection sector is ranked as the second least successful sector, mainly because of the difficulty in achieving its poverty and vulnerability reduction targets. Examples include a 3% reduction per year of people living on less than \$1 a day, or a 20% reduction in the chronically poor female headed households (Islamic Republic of Afghanistan 2008c).

The third rival hypothesis to explain the health sector's unmatched performance may be called Low Baseline Hypothesis (LBH). Under this hypothesis, one may argue that the main reason that the health sector is displaying a spectacular performance is that all the indicators were at such low levels in 2002 that any minor push could result in significant gains. From this hypothesis, two sub-hypotheses can emerge. First, the baseline indicators were deceptively low because of unreliable data. With the passage of time and more reliable data, subsequent surveys reveal the actual levels of health status across the country. These figures were mistakenly interpreted as improvement in health outcomes due to the interventions introduced after 2002. The second sub-hypothesis may posit that even if the baseline data was reliable, the indicators were artificially and temporarily kept low because of the impact of war. By extension, it could be argued that the improvements noticed in the post-2002 surveys simply reflect the settling of the dust in the post-conflict Afghan society. In line with the theory of diminishing marginal returns, it could be argued that, each additional dollar of foreign aid invested in the health sector will result in successively smaller gains in health outcomes.

Theoretically, the first sub-hypothesis (unreliable data) is hard to rule out because measurement and sampling errors are not only common but even expected in such

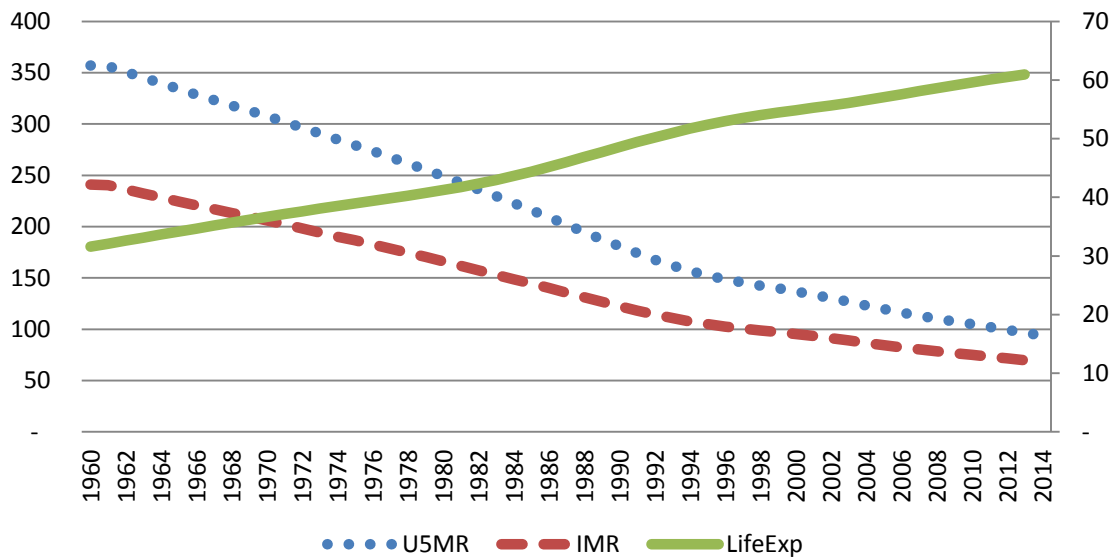
difficult and insecure environments. In addition to errors, even willful manipulation of data may be understandable given the incentive structures and the pressure to produce results. Similarly, the second sub-hypothesis (the temporary war impact) cannot be rejected given the war's direct impact on the quality and utilization of health care services and other complementary factors, such as good nutrition.

As Waldman and Newbrander (2014, S3) have noted, some exaggeration of achievements and underestimation of failures by donor agencies may be understandable “given the quest to legitimise the fledgling Afghan Government, the magnitude of their investments, and the risks that accompanied those investments because of the highly politicized atmosphere in which the reconstruction of Afghanistan is taking place.” Controversy about reported success was at its highest when the 2010 Afghan Mortality Survey (AMS) results were out, which indicated the following examples: average life expectancy at birth had jumped from 42 years in 2002 to 62 years in 2010; maternal mortality rates had dropped from 1,600 women per 100,000 live births in 2002 to 327 in 2010 (APHI/MoPH et al. 2011). In a seminar at the Center for Global Development, featuring Dr. Kenneth Hill of Harvard School of Public Health, the seminar title asked if the gains in Afghan health were “too good to be true” (Center for Global Development 2012). The magnitude of the change was so inexplicably high that it casts doubt not only on the 2010 survey but also the baseline survey that has been used as the benchmark for comparison of all health statistics since 2002. For example, it was argued that “believing the new numbers are accurate probably means accepting that the old numbers were way

off, which makes it impossible to say exactly how much health has really improved” (National Public Radio 2012).

Two tests may be applied to assess the strength of low baseline hypothesis. First, if the low baseline hypothesis were correct, we would expect to observe a dip in mortality rates in late 1990s and early 2000s. Fortunately, the World Bank’s World Development Indicators database has historical data on average life expectancy, infant and child mortality rates continuously from 1960 to 2014 (World Bank 2014). This data is presented in Figure 25 below. The vertical axis on the right hand side corresponds to the solid line for average life expectancy, while the vertical axis on the left hand side corresponds to the dotted lines for infant and under five mortality rates.

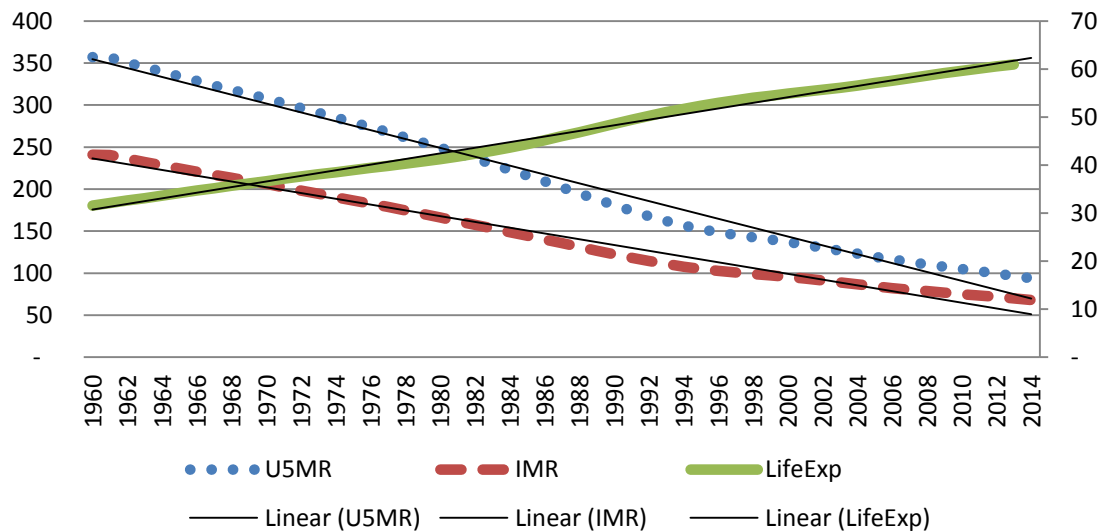
Figure 25 Historical trend of health outcomes, 1960-2014



Source: World Development Indicators

In order to detect any anomalies in the data, I have added simple linear trend lines for each of the indicators in Figure 26. This simple test reveals that for the most part, the super-imposed linear trend line follows the actual data almost in tandem. Contrary to the predictions of the low baseline hypothesis, we detect no anomalies in the data round late 1990s and early 2000s. The largest deviations between the actual and predicted data for mortality rates appear in mid 1990s and 2014.

Figure 26 Historical trend of health outcomes with linear trend lines, 1960-2014



Source: World Development Indicators

The evidence presented through this simple test may be used to dispel, or at least weaken, the doubts raised by low baseline hypothesis. Two caveats, however, must be noted about the evidence presented. First, the data from the World Development Indicators do not match perfectly the data from the Afghan Mortality Survey (AMS) for the years that the AMS were conducted. In fact, the results of various surveys in the last

decade – such as Multiple Indicator Cluster Surveys (MICS), Afghanistan Health Survey (AHS), National Risk and Vulnerability Assessment (NRVA), Afghanistan Mortality Survey (AMS), and Reproductive Age Mortality Survey (RAMOS) – fail data triangulation tests by source of data. This, however, is not surprising not simply because of expected sampling variability but also because of the challenges in conducting valid and reliable surveys in post-conflict societies. Second, this data is presented for life expectancy, infant and under five mortality rates, and leaves out the measure of maternal mortality rates that are equally, if not a more critical measure. The reason for this omission is that continuous annual data on maternal mortality rates are not available. The World Development Indicators database reports sporadic figures for MMR for only six years out of the 54 year period from 1960 to 2014. Specifically, it reports an MMR of 1200 for 1990 and 1995, 1100 for the year 2000, 730 for the year 2005, and 500 for the year 2010 (World Bank 2014). The Afghan Mortality Survey (AMS), however, shows a sudden drop from 1600 in 2002 to 327 in 2010 (APHI/MoPH et al. 2011). This anomaly is harder to explain than the improvements in other health indicators such as infant and under five mortality rates.

A second test to assess the strength of the low baseline hypothesis, and in particular, the doubts surrounding the validity of survey data involves the assessment of other indicators complementary of health. In other words, if the gains of the health sector in reducing mortality rates were in fact too good to be true, one would expect zero or insignificant gains in other factors thought to be key determinants of mortality rates. In fact, much has been written and debated in response to the doubts raised about the 2010

AMS results. One article is written in particular to carry out a test that I have posed here. In particular, one article sets out to ask if the gains in the health sectors, as measured through the various mortality rates, are in fact consistent with the trend in other health indicators. They find support for the reported gains by showing that “decreases in these mortality rates are consistent with changes in key determinants of mortality, including an increasing age at marriage, higher contraceptive use, lower fertility, better immunization coverage, improvements in the percentage of women delivering in health facilities and receiving antenatal and postnatal care, involvement of community health workers and increasing access to the Basic Package of Health Services” (Rasooly et al. 2014, S29). In addition, these gains should not surprise us given the complementary nature of gains in all other measures, including improved nutrition, better access to clean drinking water, improved hygiene, higher per capita incomes, gains in education, better access to and utilization of health services due to improved roads and wider coverage of communication technologies, etc.

In conclusion, while the low baseline hypothesis does raise interesting questions, it is not supported by sufficient evidence. Furthermore, even if we accept some of the doubts raised by this hypothesis – such as the war impact – it cannot be reasonably argued that they do not apply to the other sectors that the health sector is being compared to. Therefore, we can refute the low baseline rival hypothesis in explaining the health sectors relatively more successful performance in Afghanistan. Furthermore, the validity of the theory of diminishing marginal returns does not necessitate acceptance of the low baseline hypothesis. In other words, we could continue to expect successively smaller

gains in health outcomes with additional investments in the health sector, whether or not the health sector had started with low baseline data.

Finally, the fourth rival hypothesis may be called the Foreign Capacity Hypothesis (FCH). Local capacity deficit in all post-conflict societies, including Afghanistan, has been well documented. In fact, almost no report or article on Afghanistan fails to bemoan the dearth of local capacity, and by extension praise the critical role that foreign experts have played in the Afghanistan reconstruction process. The drumbeats on capacity building programs by all local and international agencies have been in response to this blatant truth. The channeling of more than 15% of all official aid to “technical cooperation grants” is further testament to this hypothesis (World Bank 2014). In addition, in order to fill the capacity gaps in the country, foreign experts (including foreign-trained Afghans) have been planted in key technical support positions in Afghan ministries as Externally Funded Staff (EFS) through programs such as Civilian Technical Assistance Program (CTAP). A World Bank survey of eight ministries and one agency in 2011 found that there were nearly 5,000 EFS in these entities, brought in at an estimated cost of nearly US\$125 million a year (World Bank 2012a, 13). Although the majority of EFS are Afghans (only 200 of the mentioned 5,000 EFS were non-Afghans) they are often better trained than the civil servants and therefore paid much higher than those under the government payroll.

Although the local capacity deficit and the significance of foreign technical support cannot be denied, they fail to explain the variation in aid effectiveness across sectors in Afghanistan. If the foreign capacity hypothesis were to succeed in explaining

the cross-sector variations in aid effectiveness, the sectors with greatest foreign technical support would be expected to outperform other sectors. What I find, however, points in the opposite direction. Some of the sectors with the greatest concentration of foreign experts rank among the least successful sectors, and vice versa. For example, Table 10 shows that the top most successful sectors have the lowest ratios of international to national EFS.

Table 10 Distribution of Externally Funded Staff (EFS) across sectors in 2011

Sector	Number of Civil Servants	EFS		International/National EFS
		National	International	
Rural Development	2,110	1,879	21	1%
Education	41,464	1,353	16	1%
Governance	19,971	253	4	2%
Health	17,750	374	13	3%
Agriculture	9,156	339	36	11%
Mining	2,709	66	9	14%
Public works	2,278	67	11	16%
Energy	2,806	129	24	19%
Finance	7,036	237	60	25%
Total	105,280	4,697	194	4%

Source: World Bank Report (2012a) and author's calculations

Table 11 further reinforces the point about the significance of local capacity in the health sector in particular by showing that the MoPH has not needed to rely on more than 3% international EFS as a percentage of national EFS. This evidence points to the direction of refuting the alternative foreign capacity hypothesis and supporting the local capacity hypothesis, which I argue is the best predictor of cross-sector variation in aid effectiveness. The rest of this chapter will explicate this argument in more details.

Table 11 Externally Funded Staff (EFS) in the health sector

Year	Number of Civil Servants	EFS		International/National EFS
		National	International	
2010	17,000	458	12	3%
2011	17,750	443	12	3%
2012	17,750	411	9	2%
2013	18,000	415	10	2%
2014	18,000	410	9	2%
2015	18,000	290	10	3%

Source: Discussion with MoPH staff and author's calculations

The Role of Local Capacity in Explaining Gains in the Health Sector

The role of local capacity in the reconstruction of the broken health system in Afghanistan after the Taliban era cannot be overestimated. Using the method of process tracing, I will use this section to show that the driving force behind the success of the present-day health sector in Afghanistan lies in the decades of the 1970s, 1980s, and 1990s. During that time, today's policy makers and health practitioners received their medical training and invaluable professional experiences inside Afghanistan and abroad, especially in Pakistan while delivering basic health care services to Afghan refugees.

In fact, the traces of Afghan capacities in medicine built during these decades of war can be found in present-day Afghanistan when medical professionals have not only dominated the field of medicine, but are also visibly present in all other prominent positions ranging from the country's chief executive, Dr. Abdullah Abdullah, to the cabinet, members of parliament, the private sector and the thriving non-profit sector. As it will be illustrated in more details below, tracing the process of rebuilding the health system in general and BPHS in particular in the post-2001 Afghanistan is especially

instructive at demonstrating the significance of local capacity leading to the exemplary success of the health sector as compared to other aid-financed sectors.

After the fall of the Taliban and the return of Afghan refugees from abroad, the Afghans with the financial and technical support of the international community got together in late 2001 to devise a plan and put together a strategy to revamp the health sector. Even before the formation of a national interim administration and the signing of the Bonn Agreement, the donors and NGO community held an important three-day conference in Islamabad to prepare for the reconstruction of Afghanistan's health system. One of the first decisions made during this and other deliberations was to conduct a national needs assessment, which formed the basis of the country's national health policy, first drafted in March 2002. Two of the key policy choices outlined in this document include a) a deliberate focus on primary health care and b) a decentralized MoPH structure, centered around providing stewardship, management and regulation, rather than on providing health care service directly.

For improved coordination and collaboration, it was decided that the major donor agencies interested in rebuilding the health system would hold joint meetings. In order to appreciate the policy development and decision making processes in these critical months, special attention has to be paid to the three Joint Donor Missions, because "it was during these times that policy options were placed on the agenda, debated, and concrete steps were taken to ensure that discussion was transformed into action" (Strong, Wali, and Sondorp 2005, 16). During these early discussions, the indispensable role of the pre-existing NGO sector could not be ignored.

Contracting-out of Service Delivery to NGOs

The already demonstrated strength of the NGO sector in delivering basic health care services was a key impetus for one of the boldest decisions made at the national policy level, the decision to “contract out” health care service delivery to NGOs. It was during the first Joint Donor Meeting, held in April 2002 and co-chaired by WHO and the World Bank, that the contracting-out policy was reiterated using the World Bank’s favored mechanism of Performance-based Partnership Agreements (PPA) (Strong, Wali, and Sondorp 2005). In PPA, service providing NGOs would go through a competitive bidding process and be paid on an estimated per capita cost basis, given their predetermined particular catchment areas, and their performance would be evaluated based on the findings of third party evaluations.²⁷

PPA and contracting-out in Afghanistan was chosen on the basis of two experiments in Haiti and Cambodia, which according to Ridde (2005) were not strong enough evidence to prove its superiority. In particular, the Haitian example was not very helpful because there was no comparison between the NGO and public-sector service delivery, nor was there a comparison between NGOs with and without PPA contracts. For these reasons, Ridde (2005, 12) concludes that the World Bank proposal on the use of PPA “lacks a strong scientific basis.”

In the Cambodian case, districts were randomly assigned to one of the following three funding modalities, in order to assess the relative effectiveness and impact of each (Bhushan, Keller, and Schwartz 2002). First, under a “contracting-out” mechanism, such

²⁷ For more thorough discussion of the interconnections between the public, private and nonprofit sectors, particularly in the delivery of health services, see (J. M. Brinkerhoff & Brinkerhoff, 2002)

as that employed for the majority of provinces in Afghanistan, the contractors were paid directly for their work operating the health facilities and the contractors were in charge of the entire operations, including service delivery, human resource management, procurement of supplies, equipment and drugs, and every day management of health facilities.

By contract, in a “contracting-in” modality, the Ministry continued to remain in charge of human resource management, procurement decisions, and every day management. The contractors, however, helped strengthen the ministry’s existing structure by providing management support to civil servants in return for budget supplement for staff incentives and operating expenses.

The third modality of funding applied was the complete provision of services by the government. Functioning as a control group in these districts, the Government District Health Management Team (DHMT) was in charge of everything from day-to-day management to procurement, human resource management and service delivery.

The results of a before-and-after survey indicate that “contracted districts consistently outperformed the control districts with respect to the predefined coverage indicators. The contract-out model performed better than the contract-in model” (Bhushan, Keller, and Schwartz 2002, p.2). The same study also shows that contracted districts had the added advantage of efficiency gains and achieved more equitable access, including households of lower socioeconomic status.

On an experimental basis in Afghanistan, it was decided to employ the “contracting-in” modality in three of the country’s 34 provinces, namely Parwan, Kapisa

and Panjshir provinces. This modality of funding, supported by the World Bank is called the MoPH Strengthening Mechanism (SM). Both mechanisms, however, are based on the proven model of PPA, a transparent and competitive model of funding that had been borrowed from Cambodia and piloted by the Asian Development Bank (Bhushan, Keller, and Schwartz 2002). According to Afghanistan's Strategic Plan for 2011-2015, "contracting has proven to be enormously successful in expanding service coverage and improving quality of care" (Government of the Islamic Republic of Afghanistan 2011, 9). It is important to note, however, that although Afghanistan's SM model is based on the contracting-in model of funding, it has been slightly modified for the context of Afghanistan. In particular, the Afghanistan SM model involves "the use of national consultants to assist with planning and implementation of SM activities, and salaries are generally linked to the National Salary Policy that is applied by NGOs" (Blaakman, Salehi, and Boitard 2014, S111).

In 2003, the MoPH adopted a strategy of contracting-out the delivery of basic health care services to NGOs, who had a pre-existing strong presence in some of the country's most remote regions during the preceding decades of conflict, so that the MoPH could concentrate fully on its stewardship role. Currently, 31 of the country's 34 provinces are under the coverage of this contracting out mechanism, but there are some differences across provinces depending on whether the province is covered by the WB, USAID, or the EC. In the remaining three provinces (Parwan, Kapisa and Panjshir), the MoPH is engaging in direct delivery of health services through a process called the "Strengthening Mechanism." The management of the 31 provinces' contractual

obligations was awarded to a newly established Grants and Contracts Management Unit (GCMU) within the MoPH in 2003.

After an appraisal mission was conducted by the World Bank in February 2003, two important policy decisions were made. First, it was decided that the country's 34 provinces would be divided among the three major donors, the World Bank, USAID and the European Commission (EC). This allowed for improved accountability and clearer division of responsibilities among the donors, thus avoiding a diffusion of responsibility and duplication of effort, which are common in many other contexts. The second major decision was to establish an independent unit within the MoPH called the Grants and Contracts Management Unit (GCMU). This unit would be responsible for liaising between the donor agencies, the contracted NGOs and the MoPH.

The establishment of GCMU was a smart way to bypass the bureaucratic delays typical of civil administration, which is why it has been called a “ministry within a ministry” (Michael, Pavignani, and Hill 2013, 328) given its function as an independent unit, with significant access and control over donor financial assistance and contracts.

National Health Strategy

At first, the MoPH developed an interim National Health Policy (NHP) and National Health Strategy (NHS) from 2002 to 2004 and in the post-2005 years, a National Health Policy was developed. Following this, the next step for the MoPH was to transform the policy into a national strategy because “effective aid is dependent on building a structure of good policies and institutions” (Michael, Pavignani, and Hill 2013, 338). The MoPH initiated the process of developing the interim health strategy in August

2002 and completed it in February 2003, through a number of seminars funded by the UK's Department for International Development (DFID). Some of the key components of this strategy document included capacity building within MoPH, revised organogram of MoPH, and a firm commitment to implementing the BPHS for the next five years.

The MoPH developed its latest Strategic Plan for 2011-2015, which laid the foundation for moving towards a Sector Wide Approach (SWAp) in the health sector. This document identified ten strategic directions which focused on nutrition, human resource development, equity in access to health, health financing, evidence-based decision making, regulation of the private sector, community empowerment, promotion of healthy environments and creating an enabling environment for quality pharmaceuticals (Government of the Islamic Republic of Afghanistan 2011). Prior to this, the health sectors strategic direction was outlined in the Health and Nutrition Sector Strategy (HNSS) developed in 2008. This document promoted the adoption of eighteen specific strategies, ten aimed at reducing morbidity and mortality rates and eight aimed at institutional development (Islamic Republic of Afghanistan 2008b).

Since the development of the first national health policy in 2003, successful implementation of the BPHS has always received a deliberate focus. For this reason, every year close to 50% of total government's core health budget goes to BPHS, which explains the centrality of the BPHS in the success of the health sector (World Bank 2012b). For these reasons, I now turn to a discussion of the process involved in developing the concept of BPHS from idea to fruition. The process of developing the BPHS is also instructive at identifying factors that led to its success.

The Process of Developing BPHS and EPHS

Once the World Bank managed to garner enough donor and MoPH support for the idea of delivering health services through a PPA approach, the next obvious question was what those services would constitute. As a result, an advisory committee was appointed by the Health Coordination Taskforce (HCTF) to devise the package of services. This advisory committee was headed by a WHO consultant, Dr. Xavier Modol, and the committee comprised of representatives from MoPH, WHO, UNICEF, USAID, UNFPA and MSH (Transitional Islamic Government of Afghanistan, Ministry of Health 2003).

From there onwards, the process seems to have picked considerable pace. In fact, within just a month of work, a final draft of BPHS was presented for feedback and discussion, and by April 2003, MoPH was in the driver's seat and the BPHS wheels came in motion (Islamic Republic of Afghanistan, Ministry of Public Health 2005b). The BPHS soon became the official policy of the government on health and the move was made from discussion and planning to actual implementation and service delivery. As the first BPHS document notes:

The cornerstone of the emergence of a new Afghan health system is the Basic Package of Health Services, because it addresses the most common health problem at all levels and focuses on priority interventions for reducing mortality and morbidity. (Transitional Islamic Government of Afghanistan, Ministry of Health 2003, 44)

These developments were quite impressive given that the “first point that delivering a basic package was articulated as a strategy to improve health” was just in November 2001 during the three-day Islamabad Conference (Strong, Wali, and Sondorp 2005, 15).

The idea of a “package” of health services is not new. In fact, Essential Health Packages (EHPs) “took centre-stage in the debate when the 1993 World Development Report posed a practical question – how should governments in low-income countries spend their very limited health budgets?” The response was that they should spend their limited health budgets “on a minimum package of essential public health and clinical services,” which have been known by different names in different countries (WHO 2008, 3). For example, while this package is known as BPHS and EPHS in the case of Afghanistan, Uganda piloted a Minimum Health Care Package or MHCP in the 1990s. The common thread in all these EHPs is that they are the “guaranteed minimum” health services and that they provide the “best value for money” for resource-poor countries (WHO 2008, 1). Other countries that have adopted such packages include Liberia (Petit et al. 2013), Cambodia, Rwanda, South Sudan, Somalia and more. These examples reveal that, more recently, such EHPs have become a natural part of health system reconstruction, especially in post-conflict or fragile state environments.

The early draft of the BPHS was criticized for not representing the views of key stakeholders on the ground, including the MoPH, and thus not reflective of the realities of Afghanistan (Newbrander et al. 2014). As a result, a Health Coordination Taskforce (HCTF) was formed to ensure broader participation in the development of the BPHS and to customize it to the realities of the country. In order to get a better sense of these realities, the Afghanistan National Health Resources Assessment (ANHRA) was conducted, which helped inform the contents of the BPHS, including a stronger focus on mother and child initiatives (The Communication Initiative 2003).

On a practical level, clarity and focus were two of the most important achievements in the development of the BPHS. The BPHS brought about considerable clarity to the field through its adoption of a standard set of nomenclature that replaced all previously confusing naming arrangements. Beyond the taxonomy, the BPHS provided clear answers to all logistical questions, such as what services will be provided, where to go for specific types of care, who will deliver the services and how the services will be delivered. Each health facility type, such as Basic Health Center (BHC) and Comprehensive Health Center (CHC), is defined by the following: its catchment area, type of services offered, staffing patterns, and the recommended list of equipment and essential drugs. Furthermore, a costing exercise was carried out, which found that the services listed under BPHS could be provided at an annual per capita cost of US\$4.55 (Newbrander, Yoder, and Debevoise 2007). The second most important contribution of the BPHS to the health sector is the kind of focus it brought on specific health related interventions and target outcomes. The division of provinces among a small set of three major donors simplified coordination mechanisms and prevented fragmentation of health care services.

To complement the services offered by the BPHS, the MoPH and its international development partners turned their attention to the development of a similar package at higher levels of health facilities than the District Hospital. As a result, the Essential Package of Hospital Services (EPHS) was born in 2005, in order:

- (1) to identify a standardized package of hospital services at each level of hospital, (2) to provide a guide for the MoPH, private sector, nongovernmental organizations (NGOs), and donors on how the hospital sector should be staffed, equipped, and provide materials and drugs, and (3) to promote a health referral

system that integrates the BPHS with hospitals. (Islamic Republic of Afghanistan, Ministry of Public Health 2005a, 2).

Despite the seemingly natural unfolding of these processes in hindsight, they were far from seamless. In fact, the process was fraught with challenges as a result of intense debates, disagreements, and differences of opinion on how best to move forward. I will illustrate this through the following three examples.

Firstly, there was some opposition to the entire BPHS initiative for its prioritizing of rural areas and for its disproportional focus on preventive measures. For example, the Afghan cabinet wanted to see greater emphasis on curative health by supporting and expanding the national hospitals, as had been historically the case in the pre-war decades (Newbrander et al. 2014). Whereas some international NGOs were keen to support a more vertical programming, which was also a practice that they used during the last two decades of conflict in Afghanistan (Newbrander et al. 2014).

Secondly, there was some opposition to the concept of contracting-out because the government considered service delivery as a part of its mandate, and that the public perception of health services being delivered by anyone other than the state would threaten the government's authority and legitimacy. In early 2000s, the NGOs also had their reservations about the contracting-out of services because they saw their independence under threat.

Thirdly, some interviewees working for the MoPH conceded that although the donors recognized the government's lack of capacity for direct service delivery, they also sympathized with the government's reservations to adopt a contracting out mechanism.

At the same time, the donors were unable to unanimously decide what the right solution would look like. The first major hurdle was coming to common terms about the World Bank's proposed PPA approach. Then, the three major donors insisted on making their mark on the system by modifying elements of the PPA approach, which actually led to three divergent paths to the contracting mechanism. These paths only converged to a common platform in 2014, over ten years since its conception (Strong, Wali, and Sondorp 2005). In particular, some Afghan employees at the Bank admitted that the World Bank wanted to see contracts between the MoF and NGOs, with the latter holding full control and flexibility over the contract amounts. On the other hand, USAID and EC both wanted to see a direct relationship between the donors and the NGOs.

All of these examples indicate the challenges of various actors working together towards a common goal. Although less important, the three donors could not even adopt a common terminology in their operations. For instance, the World Bank would issue "request for proposals," while the USAID would put out "request for application," and EC would issue "call for proposals." At first, these variations caused some confusion for the NGOs and the Afghan government. Similarly, it appears that GCMU could have had one less letter in its acronym if it were not for the World Bank's insistence on "contracts" and USAID and EC's insistence on "grants" to be included in the name. This is just one example pointed out by some interviewees that show the extent of disconnect among the three donors.

Revisiting the Role of Local Human Capacity in Health Sector

The foregoing analysis reveals a number of critical points about the role of local human capacity as a key determinant of success in the health sector and the causal mechanism associated with it. The turn of the century was a critical juncture for both Afghanistan and the international community. While the Bonn Conference was in session in December of 2001, demand for change in how aid is delivered was gaining momentum. It was being increasingly acknowledged that while aid was a necessary condition for development, it is not sufficient. Following the Monterrey Consensus in 2002, the subsequent high level fora paved the way for the Paris Declaration on Aid Effectiveness in 2005, which pushed for much greater attention to how the donors and the recipient country governments would behave.

In fact, it was argued that the Paris Declaration was “all about changing behavior” of donors and recipient countries, and that more aid alone was “unlikely to make a serious dent into global poverty if donors do not change the way they go about providing aid and developing countries do not enhance the way they currently manage it” (OECD 2006, 54). But optimism was on the rise earlier when “the year 2005 was billed in advance the ‘year of development’” (OECD 2006, 14).

It was against this backdrop that the international community came together to lay the groundwork for rebuilding Afghanistan. With the exception of a few sectors, Afghanistan failed to utilize aid in its most effective manner in line with the five principles of the Paris Declaration, namely ownership, alignment, harmonization, managing for results and mutual accountability (Roberts 2010). One interviewee

attributes Afghanistan's failure to achieve more effective use of development assistance to the lack of a specific kind of capacity, namely managerial capacity, defined as the ability to set strategic vision and harness the available resources in an efficient manner towards the achievement of that vision.

The health sector, however, managed to take maximum advantage of the readiness of the international community to allow for MoPH to claim greater ownership on the process and achieve greater alignment and harmonization of efforts. A critical factor that contributed to the success of building a strong health system included the early assumption of leadership roles by Afghan health experts in the MoPH and the NGO community. For example, the "Program Secretariat" was abolished in 2002 "for having too many expatriates involved and not enough Afghan leadership" and instead, a Consultative Group for Health and Nutrition (CGHN) was adopted with MoPH leadership (Strong, Wali, and Sondorp 2005, 29). The CGHN was composed of members from the MoPH, donor agencies, UN agencies, the International Security Force (ISAF) and other line ministries, and held weekly meetings to discuss technical issues and deliberate on key decisions. As Afghans proved their capabilities, donor agencies receded more control over time. For example, Newbrander et al., (2011, 653) states that:

An indicator that the management, monitoring and financial systems had become sufficiently developed manifested itself in 2008 when the US Administration signed an agreement with the Government of Afghanistan that committed US\$218 million for the funding of basic health services for 13 provinces for five years through direct budgetary support to the MOPH through the Ministry of Finance. This arrangement represents the first time that USAID has directly provided funding of this amount to a host nation.

According to the former minister of public health, Dr. Suraya Dalil, the success of the health sector is attributed to “a critical mass of individuals with the right experience and expertise being deployed at the right time and able to look beyond agency mandates and priorities to support sector reform and results” (Dalil et al. 2014, S124). This critical factor is identified by others as well. For example, the majority of interviewees noted the key role of ex-NGO employees in the post-Taliban reconstruction of Afghanistan’s health system. Following the fall of the Taliban, the MoPH “emerged with a relatively new team of leaders, many of whom came from UN agencies and NGOs with valuable exposure to the realities of the field” (Strong, Wali, and Sondorp 2005, 9). Beyond the case of Afghanistan, the World Health Organization also identifies “well-performing health workforce” as one of the six building blocks of a health system (WHO 2007, 3). Although some observers (Bower 2002; Waldman and Hanif 2002) have noted a lackluster presence of the NGO opinion in these early debates, the observers attribute the absence of NGOs to their lack of experience in policy formulation, as opposed to their field experience in programmatic areas.

In programmatic and service delivery areas, however, some 80% of health facilities across the country were operated by NGOs and it was argued that “if the public health system in Afghanistan runs at all, it runs because of what NGOs have managed to do” (UNICEF Officer, in Bower 2002, 18). This point was also identified in a World Bank report which found that more than 70% of these NGOs were in fact local Afghan NGOs. The World Bank called it “external capacity built during the 1990s” (World Bank 2012b, 90). This capacity built during the war period filled important positions both in

the service delivery sector (operated by the NGOs) as well as in the stewardship role (by the MoPH). For example, Newbrander et al. (2014, S10) identify the important role they played in the formation and operation of the GCMU within MoPH to manage the planning and implementation of BPHS “which included recruitment of knowledgeable former NGO staff.” Afghan health experts were in the driver’s seat even in the early stages of developing the BPHS as part of the Health Coordination Task Force (HCTF).

In fact, one of the main reasons that the MoPH (and Ministry of Rural Rahabilitation and Development, MRRD) adopted a contracting-out strategy is precisely because of the capacities built by the NGOs during the decades of war. The critical role that people, in particular trained and experience professionals, play in the working of the state cannot be overstated. For example, “the state must attract, train, and retain a sufficient number of talented and honest people to run its programs effectively” (Joshi, 2011, p. 349). For the case of the health sector in early 2000s, this critical factor was already there with training and experiences that had prepared them in the pre-aid era of 1970s through 1990s. In short, the preponderance of evidence points in the direction of local human capacity having played the key deciding role in the success of the health secor and other successful sectors, like education and rural development.

This finding is not surprising in the context of Afghanistan where certain occupations, such as medical doctors, engineers and educators are highly sought after due to the social prestige they carry. This cultural preference acts as a self-screening tool, through which parents prepare their best and brightest children to pursue a career in these fields. In fact, as several of the interviewees pointed out, it is common knoweldge in

Afghanistan that social pride comes with the occupation you hold in society. Among the various occupations, becoming a doctor or an engineer is the top two aspirations anyone carries for themselves or for their loved ones. For instance, parents expend a great deal of energy in ensuring that their children, especially if they exhibit signs of greater competence, pursue their education in either medicine or engineering. Interviewees pointed out that one would rarely encounter a parent who would dream of their child growing up to become an artist, a farmer, an economist or even a successful entrepreneur, but doctors and engineers are on the tip of every tongue.

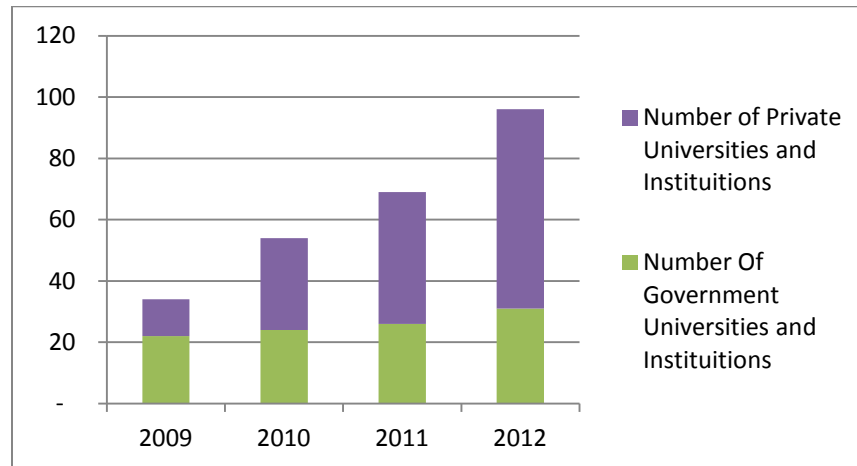
Although Afghanistan offers free (publicly funded) education, including at the post-secondary level, Afghans have exhibited their willingness to pay for an education even in the worst economic circumstances. For example, as some interviewees noted, during the late 1980s and early 1990s when the number of Afghan refugees in Pakistan was soaring, one of their top aspirations was to provide opportunities for higher education for the youth. Afghans, numbering in several million, were not allowed to attend public Pakistani colleges and universities, and they could not afford the private institutions. As a result, they started establishing their own private institutions of higher education, which were merged into the Afghan University in Peshawar in 1999 (UNHCR 2000). Some of the interviewees, who are graduates of that university and are currently in leadership positions at the MoPH, emphasize that the top two departments within the Afghan University were the departments of medicine and engineering.

The higher education system in Afghanistan further reinforces these cultural preferences for certain fields of study. It has to be noted that before 2002, the only

suppliers of higher education in Afghanistan were the public universities and specialized institutes of higher education. Admission to public universities was granted based on a competitive entrance examination, called *Kankor* (from the French Concours). The minimum score threshold set for admission into medical and engineering programs are set higher than those for any other program of study, thus further picking the best minds into these programs. The students in these sought-after fields undergo relatively more rigorous training as evidenced by much higher dropout rates than in any other field.

The government's disproportionate attention to these fields of study is also illustrated by the number and type of programs offered in each field. For example, out of a total of 29 programs offered, only two are related to less successful sectors like finance and private sector development, namely the faculty of economics, and faculty of management and trade. Conversely, the field of medicine offers a wide variety of specialized programs including faculty of pharmacy, faculty of general medicine, faculty of medical treatment, faculty of stomatology, and faculty of nursing. Similarly, the field of engineering (which explains the success of the rural development sector) offers a variety of programs including faculty of general engineering, faculty of construction, and faculty of electromechanical engineering (CountrySTAT 2015). With the increasing popularity of private institutions of higher education (especially in Kabul) this scenario might change over the coming decades. As Figure 27 illustrates, private institutions of higher education have outnumbered public institutions.

Figure 27 Private universities and institutes of higher education in Afghanistan



Source: CountrySTAT, Afghanistan (2015)

The popularity of the medical doctor's profession, however, has not yet resulted in an oversupply of medical professionals. In fact, with an average ratio of 0.4 doctors per 1,000 people in the early 2000s, the overall number of doctors was still lower than the average of 1.1 doctors per 1,000 in all developing countries (Strong, Wali, and Sondorp 2005). The total number of health care personnel, including doctors, nurses and midwives, in Afghanistan is just a little over 6 per 10,000 population, which is still lower than the 23 per 10,000, which is recommended by the WHO (World Bank 2012a).²⁸ However, these figures still put the health sector ahead of other less successful sectors, such as finance, mining and private sector development because comparatively health experts are still better trained, more experienced and higher in numbers, which supports the local capacity hypothesis for the health sector (CountrySTAT 2015, also supported by some interviewees from the Ministry of Higher Education).

²⁸ This number of health personnel per 10,000 population is based on a conservative estimate of a total of 18,000 civil servants working for the MoPH, divided by Afghanistan's total population of approximately 29 million people. Others estimate this figure at 7.2.

In addition, it is not just the number of physicians per population that matter for Afghanistan. In the context of Afghanistan over two-thirds of the population lives in rural areas. Therefore, there needs to be a focus on simple and preventative care, community midwives and community health workers (CHWs). These are practitioners that can make a real dent in national statistics on mortality and disease prevalence, because “even non-literate CHWs, male and female, in remote communities can treat childhood health problems and communicable diseases such as malaria” (Newbrander et al. 2014, S10). The official endorsement and expansion of community midwifery program in Afghanistan in 2005 will exponentially increase the number of community midwives in the coming years and decades and thus continue to make significant positive impact on health outcomes.

In short, the causal chain from local capacity to the success of the health sector in achieving 88% of its stated objectives as defined by Afghanistan National Development Strategy, is best described by the narrative below. Some interviewees who were present during the early discussions on rebuilding the Afghan health system in early 2002 said they knew what mattered the most for the international community was the trend of key indicators, especially infant and maternal mortality rates. As a result, the MoPH, with support from their international counterparts, carried out a number of exercises, baseline surveys, and studies to determine key determinants of mortality and bottlenecks in the Afghan health system to achieve significant reductions in mortality rates. The results of these studies informed all policy level decisions and strategies.

For example, it was identified that at the heart of the disproportionately high infant mortality rates lay high rates of malnutrition, spread of infectious disease, acute respiratory illnesses, diarrheal related illnesses, and other vaccine-preventable disease. Taken together, these findings informed the MoPH's concerted efforts on developing solid programs in the areas of nutrition, control of infectious diseases and the rapid growth of expanded program on immunization (EPI) across the country.

Similarly, it was identified that maternal mortality rates were driven primarily by pregnancy related complications that were easy to treat but could prove fatal if left undetected. The key strategies to address these root causes included an expansion of training with community nursing, community midwives and community health workers (CHW), which significantly increased the rates of Skilled Birth Attendance (SBA) and consequently dropped maternal mortality rates. The official endorsement of the National Midwife Education and Accreditation in 2005 boosted the expansion of midwifery across the country. This is an especially welcomed move given that the lack of female health workers in health facilities was identified as a critical challenge in health service delivery in rural Afghanistan.

The depth with which health posts (HPs) staffed with CHWs covered even remote regions and built a strong early detection and referral system prevented pregnancy related complications from escalation. The increasing rates of ante-natal care (ANC) and post-natal care (PNC) over time support this claim. The expansion of BPHS in supporting these initiatives, coupled with systematic training of midwives, nurses and CHWs, was highly consequential for the gains achieved since 2002.

Although local human capacity played a significant role in the health sector's success, other factors that also contributed to their success should not be ignored. For example, rather than choosing the path of least resistance to invest in tertiary curative care and large hospitals in urban centers (which had enormous political support by Afghan politicians), the international community and the experienced Afghan health experts based their entire policy and strategy on the realities on the ground that came to light through national surveys, such as the Afghanistan National Health Resource Assessment (ANHRA) in September 2002. This was an important policy choice which prevented the sacrificing of the long-term development for short term political gains.

It was the ANHRA that paved the way for developing the BPHS, which by itself is a key factor contributing to the health sector's overall success. In fact, Newbrander et al. (2014, S7) call the development and implementation of BPHS "one major factor" that contributed to the relative success of the health sector in Afghanistan. One of the key criteria of the BPHS was to enable the Afghan government and the international community to get the biggest bang for the buck, by addressing the most critical needs on a priority basis. The BPHS development was slow at the beginning and did not produce any visible results during the first few years, but it helped build strong foundations, and thus struck a good balance between the short run need to show results and the long run strategic objectives of the sector. The lesson learned from this is that effective aid will balance the elements of relief, rehabilitation and development all at once. More specifically, "Stakeholders should aim not only to save lives and protect health but also to

bolster nations' ability to deliver good-quality services in the long run" (Newbrander, Waldman, and Shepherd-Banigan 2011, 639).

Finally, it is important to acknowledge the fact that many other factors have important implications for the success (or lack of it) of effective aid utilization. In the context of Afghanistan, key variables include the degree of corruption, the role of informal economy, informal institutions, and political dynamics. The reason these factors have not been dealt with in this study is that they are not believed to have had differentiated impact across sectors. In other words, I find little evidence to believe that corruption or lack of it is more or less pertinent to the health sector vis-à-vis the education sector. Differences in local human capacity, however, was identified as the key factor determining the variations in aid effectiveness across sectors.

Ensuring the financial sustainability of the health sector, however, is the last remaining key challenge facing the MoPH. In 2014, about 74% of national health budget, and 69% of overall national budget comes from foreign aid (Islamic Republic of Afghanistan, Ministry of Finance 2014). Raising domestic sources of revenue would therefore lead the path towards financial self sufficiency.

In conclusion, this chapter presented strong evidence in support of local capacity hypothesis in explaining the variations in effective utilization of aid across sectors, and in particular in explaining the remarkable success of the health sector. The next and final chapter of this study will discuss the policy implications of the local capacity hypothesis for Afghanistan before presenting concluding remarks in further testing this hypothesis and setting the stage for further research in this area.

CHAPTER SEVEN: CONCLUSIONS AND DISCUSSION

This study investigated the question of aid effectiveness in Afghanistan, with a particular attention to the post-Taliban era from 2002 to 2014. During this time, Afghanistan was the second largest recipient of official development assistance second only to Iraq, thus making it a critical case study. The literature defines aid effectiveness in one of two ways: first, aid effectiveness is assessed against rise in recipient country's GDP growth rates; second aid effectiveness may be defined as the achievement of other development outcomes in areas such as health and education. In line with the first definition, I investigated the relationship between ODA levels and GDP growth rates using data from OECD-DAC Aid Statistics database, the World Bank's World Development Indicators and the United Nations' National Accounts Main Aggregates database. Despite applying three statistical models – namely ordinary least squares (OLS), two-stage least squares (2SLS) and three-stage least squares (3SLS) – the regression results were inconclusive mainly for their failure to arrive at statistically significant relationship between levels of ODA and GDP growth rates.

I want to show that Afghanistan's lackluster performance in macroeconomic indicators (such as the aid-growth link) is not necessarily indicative of the failure of aid in Afghanistan. In fact, while the macro-level indicators are important, they obscure the achievements of development outcomes at the micro levels. I also show that these

variations of success at the micro-level can be illuminating of the factors that lead to success under certain conditions, thus locating my research with the contingency school in the aid effectiveness literature.

As a result, I turned my attention to applying an alternative definition of aid effectiveness based on its achievement of development outcomes across sectors. Fortunately, most of the background work in this area has already been carried out by the Afghan government and the international community. In particular, the country's first and only poverty reduction strategy paper (PRSP) called the Afghanistan National Development Strategy (ANDS) clearly lays out the various priority sectors, along with their structures, goals, and targets (Islamic Republic of Afghanistan 2008). As presented in Table 8, ANDS identifies 17 sectors, grouped under three main pillars of Security, Governance, and Economic and Social Development, and six cross-cutting focus areas, such as environment, counter narcotics and anti-corruption efforts. Furthermore, an extensive evaluation of all sectors was carried out in 2014, which identified a ranking of the sectors based on the percentage of targets each sector had achieved (Figure 20). Based on this evaluation, the health sector topped the list with a cumulative achievement of 88% of its targets, while the lowest performer, i.e. private sector development, achieved only 44% of its targets (Islamic Republic of Afghanistan, Ministry of Economy 2014).

This questions why there were such extreme variations in the effectiveness of aid across sectors even though all sectors were operating under essentially the same set of conditions, including the same donors and the same environment. Methodologically,

although a one-country case study, I exploit the within country variations to make some meaningful comparison of the performance of aid in different sectors. The end goal of this study was to identify conditions under which aid is more likely to be effective by employing Mill's method of concomitant variation coupled with the method of process tracing, informed by significant desk review and key informant interviews.

In particular, I choose to focus on the health sector and defend the argument that pre-aid levels of local human capacity, built during the decades of conflict from 1970s through 1990s, best explains the health sector's success at not only rebuilding the health system after it was almost devastated by the end of the Taliban era. It was also achieving remarkable reductions in infant, under five, and material mortality rates among other health indicators.

There are a number of reasons why the health sector in particular enjoys greater levels of local human capacity compared to other less successful sectors. First, in the cultural context of Afghanistan, certain professions carry greater social prestige than others. For example, as most of the interviewees reiterated, the greatest aspiration that Afghan parents can have for their children is for them to grow up to become either doctors or engineers or educators. This attitude shapes the children's desires and aspirations as they grow up. A good example of this preference for certain professions was illustrated in the 1990s, when the Afghan refugees in Pakistan were not allowed to attend Pakistani institutions of higher education, but they established their own private university, called Afghan University, whose two primary departments were medicine and engineering (UNHCR 2000).

Second, partly in response to the society's preferences, Afghanistan's higher education system is built around tightening the grip on who gets into and out of these highly sought-after departments by raising the admission requirements through the annual national university entrance examinations, called *Kankor*. In addition to attracting the best and the brightest minds to these departments, the higher education system pays special attention to the quality of these departments given their privileged status. Higher dropout rates ensure yet another layer of screening process to retain the most capable individuals in the program.

Third and most importantly, during the decades of conflict from the 1970s through 1990s, in response to the rising numbers of conflict affected IDPs in Afghanistan and Afghan refugees in Pakistan, there was an outpouring of humanitarian and development assistance from the international community. Given the gap in service delivery created by the near collapse of the state (and the absence of it for Afghan refugees in Pakistan), NGOs rushed to fill the vacuum and deliver the needed services. Here as well, interviewees who used to work for these NGOs emphasize the greater attention paid to delivering basic health, and primary education, including literacy training. This process ended up building and developing the capacity of Afghans in the practical aspects of service delivery as an unintended consequence of delivering aid and humanitarian assistance to conflicted Afghans in Afghanistan and Afghan refugees in Pakistan.

Taken together, the above-mentioned three factors explain the differentiated extent of local human capacity, particularly in medicine, engineering, and education.

While the local capacities in medicine and education manifest themselves in the success of health and education sectors, engineering skills are best put to use in MRRD's flagship program called the National Solidarity Project (NSP), which delivers basic infrastructure projects to rural Afghanistan through bloc grants administered by elected Community Development Councils (CDCs). The traces of Afghan expertise in health can be found in at least two ways. First, Afghan health experts have taken an active role in producing and disseminating knowledge and best practices locally and internationally, e.g. by writing papers in the journal of Global Public Health, and promoting the concept of BPHS internationally. Second, the presence of Afghan health experts has expanded beyond just the MoPH to other sector, including in key leadership positions.

I consider four alternative hypotheses to explain the health sector's performance relative to other sectors, but refute them in defense of the local capacity hypothesis. The Financial Support Hypothesis (FSH) that attributes the gains in the health sector to the international community's financial support. This hypothesis is refuted because the health has one of the lowest budgets when compared to the other sectors. The Easy Indicator Hypothesis (EIH) attributes the gains in the health sector to the ease of achieving the stated targets. This hypothesis is refuted on the grounds that the target setting exercise was conducted under the same conditions for all sectors. In fact, the targets in the health sector (such as a drop in the mortality rate) are far from easy. The Low Baseline Hypothesis (LBH) attributes the gains in the health sector to the condition of health outcomes in the post-Taliban era. This hypothesis too is refuted on the grounds that significant gains are also achieved in other health indicators, including those considered

to be key determinants of mortality (such as immunization coverage and rates of skilled birth attendance). Finally, Foreign Capacity Hypothesis (FCH) attributes the gains in the health sector to borrowed capacity. This hypothesis is also refuted on the grounds that the health sector has one of the lowest proportions of international externally-funded staff (EFS) compared to other sectors.

The causal path linking local capacity to significant gains in the health sector, especially in achieving significant reductions in mortality rates, is best illustrated through a number of deliberate policy decisions at the MoPH in the early periods of post-2001 reconstruction. One key decision was to go systematically about identifying and addressing key determinants of mortality rates among infants, children, and mothers. In fact, it was found in 2014 that the drops in mortality rates went hand in hand with corresponding changes to:

key determinants of mortality, including an increasing age at marriage, higher contraceptive use, lower fertility, better immunization coverage, improvements in the percentage of women delivering in health facilities and receiving antenatal and postnatal care, involvement of community health workers and increasing access to the Basic Package of Health Services. (Rasooly et al. 2014, S29)

Having discussed the evidence in support of local capacity hypothesis to explain the health sector's relatively more successful performance, I now turn to the implications of this study for the field of development. The findings of this study have important implications that will inform both policy and practice for an intelligent allocation of foreign aid both for the case of Afghanistan and beyond. For the particular case of Afghanistan, this study revealed that Afghanistan is a complex case study with deep

historical, social, and political roots that are salient in the study of development process. For example, it asserts that without an appropriate strategy to handle Afghanistan's relationships with Pakistan, achieving peace and security will always elude us.

At the theoretical level, a focus on local capacity in determining aid effectiveness takes the debate away from supply-side factors such as volume of development assistance (Sachs 2006), or demand-side factors such as good policy environment (Burnside and Dollar 2000). Furthermore, it showed that a narrow conception of aid effectiveness, defined exclusively in terms of GDP growth rates, may be misleading primarily because growth is a function of a myriad of factors and foreign aid is but one such factor. As illustrated in the case of Afghanistan, valuable development gains may be overlooked on the basis of not finding statistically significant relationship between levels of ODA and growth. More importantly, variations in aid effectiveness within a country (as defined by development gains across sectors) may be helpful in arriving at contingent generalizations, thus informing policy and practice. Such a broad view of aid effectiveness, coupled with the case-based methodology of process tracing, can be more illuminating than aid-growth regression analysis. This study is also a partial response to the micro-macro paradox, in that it shows that gains at the micro level can coexist with lack of evidence to show that aid works at the macro level precisely because aid may be able to achieve one and not the other (Mosley 1986).

Methodologically, this study revealed the superiority of combining elements of reductionism and anti-reductionism to relying on any one approach. While the former brings parsimony, clarity and precision, the latter allows for greater flexibility in dealing

with complexity. This may be why widespread agreement on the advantages that the case study approach (in particular the method of process tracing) offers has not gone hand in hand with a consensus on what the method of process tracing precisely is as different aspects of process tracing have been emphasized by different experts (e.g. King, Keohane, and Verba 1994; Mahoney 2010; Hall 2013; George and Bennett 2005; Checkel 2008).

The most important contribution of this study, however, is the emphasis on local capacity as an explanatory variable to variations in aid effectiveness across sectors. Therefore, at a practical level, a few policy implications are pertinent. First, aid allocation across sectors should be based on and informed by a thorough assessment of existing local capacities, which will determine both the absorption capacity as well as the probability of success in achieving key development outcomes. Second, channeling aid to capacity-rich sectors could yield predictably higher results. Furthermore, policy makers could pursue a capacity enhancing strategy by channeling more aid to those sectors with relatively higher levels of local capacity. Third, policy makers could pursue a capacity equalizing strategy by focusing aid efforts on those sectors with relatively lower levels of local capacity by engaging in capacity improvement before disbursing more aid. This strategy will provide a more level playing field and increase the potential of all sectors to benefit from future investments and support. Such an approach will also increase the overall absorption capacity of the recipient country. This is in line with previous calls for focusing on the human aspect of development (e.g. Sen 1999; M. ul Haq 1995; K. Haq and Kirdar 1986; Schultz 1981).

It is worth noting, however, that one of the most important policy messages of the human development agenda is that “the link between economic growth and human progress is not automatic” (UNDP 1990, 3). Although this quote referred to aspiring towards a more balanced growth, I argue that more than just balanced growth, we need a more focused and deliberate strategy on promoting human development as was the case, for example, in producing a cadre of trained community midwives in mid-2000s in Afghanistan.

Developing human capacity, however, should not be assessed on the basis of its instrumental value alone, i.e. in so far as they are shown to contribute to growth. In particular:

We should avoid restricting the definition of human resource development to sectors contributing to the short-term satisfaction of basic needs. If health, nutrition and basic education are important in the perspective of a minimum level of self-sustained development, other sectors, such as agriculture, energy and transportation - even telecommunications - could constitute the turning point in adapting to change. (Jean-Guy St-Martin in K. Haq and Kirdar 1986, 33)

Although Bennett and Elman (2006, pp. 94–95) argue that “causation is not established through small-n comparison alone but through uncovering traces of a hypothesized causal mechanism within the context of a historical case or cases,” I found that a solid application of this methodology is an iterative process that cannot be established at once. In particular, I believe this study can be further strengthened to include additional tests, both over time and across different cases to lend further credence to its claims. For example, future research could include a longitudinal design that investigates whether aid effectiveness changes over time as local capacity increases. This

could be done within the same sector or across sectors over time. For example, as Afghanistan's private institutions that flourished since early 2000s produce their future leaders in various fields, it would be interesting to observe if a corresponding increase in achieving outcomes in those particular fields come to the fore. Similarly, one could ask if aid effectiveness changes in other sectors with varying levels of domestic capacity. Finally, this hypothesis could be tested for its application outside these sectors and outside Afghanistan.

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APPENDIX A: HEALTH SECTOR'S OUTCOMES, INDICATORS, AND TARGETS

Expected Outcomes	Indicators	Baseline	Targets
Increased quality of health care services	<ul style="list-style-type: none"> • Number of functional public and private hospitals set up 	Under Assessment	Functional regulatory framework for quality health services in place by 2013
	<ul style="list-style-type: none"> • Number of provinces where organized structure is in place 	Under Assessment	Functional regulatory framework for quality health services in place by 2013
	<ul style="list-style-type: none"> • Index on the progress of putting in place quality health care services 	Under Assessment	Increased quality of health care services will be available throughout Afghanistan by 2013
	<ul style="list-style-type: none"> • Overall score on Balanced Scorecard 	TBD	TBD
Increased access to health care service	<ul style="list-style-type: none"> • % of population within two hours walking distance from PHC services 	66% of population with nearby access to PHCs (2006)	90% of population with access to PHC services (2010)
	<ul style="list-style-type: none"> • Number of health facilities, district, provincial and regional hospitals equipped with standard package of defined clinical and diagnostic services 	Under Assessment	Comprehensive referral system integrated with BPHS & EPHS in place by 2013
	<ul style="list-style-type: none"> • % of TB cases detected and treated 	68% (2006)	Increase of 12% from the baseline
	<ul style="list-style-type: none"> • % of Malaria cases detected and using preventive treatment 	To be assessed	Reduction by 60% from baseline
Effective Reproductive and Child health system	<ul style="list-style-type: none"> • % of children under 1 year having received measles antigen, DPT & hepatitis dosage and polio drops 	77% (2006)	Achieve and sustain above 90% national coverage (2013).
	<ul style="list-style-type: none"> • % of children under 1 year received measles antigen. 	35% (2000)	Achieve above 90% coverage by 2010.
	<ul style="list-style-type: none"> • Maternal mortality ratio 	1600 deaths /100,000 live births (2000)	Reduce by 50% between 2002 and 2013
	<ul style="list-style-type: none"> • Under 5 mortality rate in the country (%) 	257 deaths/1000 live births (2000)	Reduce by 50% between 2003 and 2013
	<ul style="list-style-type: none"> • Infant mortality rate (IMR) in the country (%) 	165 deaths per 1000 live births(2000)	Reduce infant mortality rate by 30% by 2013 from the baseline of 2000

Source: Afghanistan National Development Strategy (Islamic Republic of Afghanistan 2008, p.255-256)

APPENDIX B: INFORMED CONSENT SHEET

University of Denver Information Sheet for Exempt Research

Project Title: Explaining Sectoral Variations in Aid Effectiveness: The Case of Afghanistan

Principal Investigator: Ahmad Najim Dost

DU IRB Protocol #: 734862-1

Exempt Issued: 05/07/2015

Faculty Sponsor: Prof. Devin Joshi

You are being asked to be in a research study. This form provides you with information about the study. The PI will describe this study to you and answer all of your questions. Please read the information below and ask questions about anything you don't understand before deciding whether or not to take part.

Invitation to participate in a research study: You are invited to participate in a research study about the effectiveness of foreign aid in Afghanistan. This study is not funded and will lead to my dissertation for my PhD at the University of Denver, in Denver, Colorado, USA. You are being asked to be in this research study because you are considered a key informant on this topic.

Description of subject involvement: If you agree to be part of the research study, you will be asked to answer a few questions about the effectiveness of foreign aid in Afghanistan. This will take about one hour. I will be interviewing up to 100 individuals for this study.

Possible risks and discomforts: There are no risks associated with this study because I will not be asking you for any sensitive information. Even then, you have the option of choosing to remain completely anonymous, i.e. no identifiable information about you will be published.

Possible benefits of the study: If you agree to take part in this study, there will be no direct benefits to you. However, information gathered in this study may help all of us gain further insights into the conditions under which aid may be more effective in the context of Afghanistan.

Study cost & compensation: I do not anticipate that you will incur any costs as a result of participating in this study. And you will not receive any payment for being in the study.

Confidentiality, Storage and future use of data: You can choose one of the following three options relating to the level of privacy you wish to maintain. Please read all three and then make your selection by initialing on the space provided. Please note that regardless of the level of privacy chosen, the data will not be made available to other researchers for other studies following the completion of this research study.

_____ 1. You can remain completely anonymous, in which case no identifiable data will be published about you in any research products. And your responses will remain anonymous too. When referencing information provided by you, a study number will be used instead of your name.

_____ 2. You can choose for your name, tile and organizational affiliation to appear at the end of the final research products in recognition to your contributions to the research. In this case your responses will remain anonymous, but your participation will not. When referencing information provided by you, a study number will be used instead of your name.

_____ 3. You can choose to be not only identified but also quoted in the final research products. In this case, neither your participation nor your responses will remain anonymous. Furthermore, you will be given a chance to sign off on the materials that may be quoted before publishing your quotes.

I may use a voice recorder to record our conversation. The recording will only be used for accurate transcription purposes only. During this time, the recording will be kept safely in a password protected computer and will be destroyed when they are transcribed. Please initial here _____ if you give me the permission to audio record our conversation.

Voluntary Nature of the Study: Participating in this study is completely voluntary. Even if you decide to participate now, you may change your mind and stop at any time. If you decide to withdraw early, the information or data you provided will be destroyed.

Contact Information: The researcher carrying out this study is Ahmad Najim Dost. You may ask any questions you have now. If you have questions later, you may call Ahmad Najim Dost at +93.799.038356 or +1.226.600.8555 or via email at adost@du.edu.

If the researcher cannot be reached, or if you would like to talk to someone other than the researcher about; (1) questions, concerns or complaints regarding this study, (2) research participant rights, (3) research-related injuries, or (4) other human subjects issues, you may contact the Chair of the Institutional Review Board for the Protection of Human Subjects, at 303-871-4015 or by emailing IRBChair@du.edu, or you may contact the Office for Research Compliance by emailing IRBAdmin@du.edu, calling 303-871-4050 or in writing (University of Denver, Office of Research and Sponsored Programs, 2199 S. University Blvd., Denver, CO 80208-2121).

Agreement to be in this study: I have read this paper about the study or it was read to me. I understand the possible risks and benefits of this study. I know that being in this study is voluntary. I choose to be in this study: I will get a copy of this consent form.

Please provide a valid email address if you would like the results of this study to be sent to you.
_____@_____

Signature: _____ Date: _____

Print Name: _____

Do you have any questions before we proceed? Yes _____ No _____

APPENDIX C: LIST OF RESEARCH PARTICIPANTS

No.	Last Name	First Name	Title	Organization
1	Ahmad	Javid	Program Coordinator	German Marshal Fund, Kabul, Afghanistan
2	Ahmadi	Prof. Jawida	Deputy Dean	Kabul University, Journalism Department
3	Amin	Prof. Hamidullah	Chancellor	Kabul University (KU)
4	Amin	Mohammad	Chairman	Art and Culture Foundation in Ghazni, Afghanistan
5	Anwari	Hamidullah	Country Director	University of Nebraska Omaha, Projects for Afghanistan
6	Balakarzai	Abdul Tawab	Vice Chancellor	Kandahar University, Afghanistan
7	Banerjee	Nipa	Professor	University of Ottawa, Ottawa, ON, Canada
8	Bashardost	Dr. Ramazan	MP, Former Presidential Candidate	Afghan Parliament, Kabul, Afghanistan
9	Dad	Khuda	Community Leader	Local Community, Kabul, Afghanistan
10	Eichstaedt	Peter	Program Coordinator	Institute for War & Peace Reporting (IWPR), Kabul, Afghanistan
11	Erfany	Sohaila	Dean of Department	Herat University, Journalism Department, Afghanistan
12	Farid	Andeisha	Founder & Executive Director	Afghan Children Education & Care Organization (AFCECO), Afghanistan
13	Fayez	Dr. Sharif	Founding President	American University of Afghanistan (AUoA), Kabul, Afghanistan
14	Feroz	Dr. Ferozuddin	Minister	Ministry of Public Health (MoPH), Kabul, Afghanistan
15	Grassi	Ricardo	Director Media Development	Development & Humanitarian Services Afghanistan, Afghanistan
16	Hamid	Ezatullah	Chancellor	Polytechnic University, Kabul, Afghanistan
17	Hamidi	Farid	Commissioner	Afghan Independent Human Rights Commission (AIHRC), Afghanistan
18	Hunter	Katherine S.	Senior Deputy Country Representative	Asia Foundation, Kabul, Afghanistan
19	Hussaini	Mr. Ghulam Bariz	Chancellor	Herat University, Afghanistan
20	Ishaqzai	Taimor Shah	Deputy Minister, Youth Affairs	Ministry of Information & Culture (MoIC), Afghanistan
21	Jamili	Dr. Anwar	Country Director	Equal Access, Kabul, Afghanistan
22	Kakar	Rafiq	President	Opinion Research Center of Afghanistan (ORCA), Afghanistan
23	Kakar	Khaled Ahmad	Chancellor	Karavan University, Kabul, Afghanistan
24	Khan	Juma	Community Member	Kabul, Afghanistan
25	Ludin	Rafaat B.	President & CEO	International Home Finance & Development (IHFD), Denver, CO, USA
26	Miakhel	Saboor	Independent	Independent

No.	Last Name	First Name	Title	Organization
27	Nawabi	Mariam	Founding Member	Afghanistan Advocacy Group, Kabul, Afghanistan
28	Niayesh	Dr. Hasibullah	PhD Candidate, Public Health	Walden University, USA
29	Parwiz	Dr. Sardar Mohammad	Manager	Extended Program on Immunization (EPI), MoPH, Afghanistan
30	Pazhwak	Barmak	Senior Program Officer	U.S. Institute of Peace (USIP), Washington, D.C.
31	Polocka	Magda	Director	Center for Intercultural Edu & Devt, Georgetown University, USA
32	Qayoumi	Dr. Mohammad	President	San Jose University, USA
33	Rahmani	Ahmad Idrees	Afghanistan Political Analyst	Independent
34	Rasool	Mohammad	Local community member	Local community elder, Kabul, Afghanistan
35	Roberson	David	VP for University Relations	American University of Afghanistan, Kabul, Afghanistan
36	Saay	M. Salim	IT Director	Ministry of Higher Education, Kabul, Afghanistan
37	Sabawoon	Dr. Ajmal	Senior Researcher	Governance Institute of Afghanistan (GIA), Kabul, Afghanistan
38	Saber	Dr. Mohammad	Chancellor	Nanagarhar University, Nangarhar, Afghanistan
39	Sadaat	Dr. S.	Former Director of Foreign Relations, Professor at KU	MoHE, Kabul University, Kabul, Afghanistan
40	Safi	Najibullah	Director General, Preventive Medicines	MoPH Afghanistan, Kabul, Afghanistan
41	Sahil	Ahmad	Independent Consultant	Independent, Kabul, Afghanistan
42	Sufizada	Mohammad Hanif	Graduate Student	Cornell University, USA
43	Undisclosed	Undisclosed	Undisclosed	Undisclosed
44	Undisclosed	Undisclosed	Undisclosed	Undisclosed
45	Undisclosed	Undisclosed	Undisclosed	Undisclosed
46	Zaman	Wendy	Staff	US Embassy in Kabul, Afghanistan
47	Zamir	Assad	Minister	Ministry of Agriculture, Irrigation, and Livestock (MAIL), Afghanistan
48	Zia	Ehsan	Former Minister	Ministry of Rural Rehabilitation and Development (MRRD), Afghanistan
49	Eight-member focus group discussion held in Kabul among outpatients near Malalai Maternity hospital.			
50	Nine-member focus group discussion held among ordinary citizens in Bagh-e-Babur, a national park in Kabul.			
51	Eight-member focus group discussion held among internally-displaced community representatives in a makeshift camp in Kabul City.			

APPENDIX D: NATIONAL BUDGET ALLOCATION BY ANDS SECTORS

Sectors	2016		2015		2014		2013	
	US\$ Mill	% of Total	US\$ Mill	% of Total	US\$ Mill	% of Total	US\$ Mill	% of Total
Private sector development	179	3%	197	3%	174	2%	66	1%
Health	317	5%	325	4%	328	4%	289	4%
Social security	345	5%	370	5%	418	5%	175	3%
Contingency Codes	233	4%	162	2%	374	5%	560	8%
Governance	258	4%	286	4%	320	4%	963	14%
Agriculture & rural development	436	7%	729	10%	590	8%	252	4%
Education	874	13%	987	13%	987	13%	543	8%
Infrastructure & natural resources	1,350	20%	1,226	16%	1,083	14%	1,028	15%
Security	2,644	40%	3,371	44%	3,376	44%	2,929	43%
Total	6,636		7,652		7,650		6,805	