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After USAID

A Roadmap for the Future of American Development Cooperation with the Least Developed Countries



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Jonathan Glennie

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After USAID:

A Roadmap for the Future of U.S. Development Cooperation with the Least Developed Countries

Discussion Paper by Abbey Gardner and Jonathan Glennie
Global Cooperation Institute
September 2026

Based on primary research and analysis led by Abbey Gardner and Jéhane Sedky at the United Nations and the Science of Implementation Initiative

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Dedicated to Paul Farmer, MD, PhD
1959-2022

This report is dedicated to the memory of Dr. Paul Farmer, whose moral clarity, optimism, and relentless commitment to reducing poverty and improving global health inspire this work. It builds on more than fifteen years of primary research and analysis that began during Dr. Farmer's tenure at the United Nations and continued through the work of the Science of Implementation Initiative. The final phase of the research, an analysis of the global response to COVID-19, was initiated under his leadership and completed following his death in 2022.

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1. Introduction: The way aid is delivered is not neutral

This discussion paper is intended as a contribution to the current debate over the future of U.S. development assistance. At a moment when governments, foundations, think tanks, development institutions and others are undertaking important efforts to rethink what comes next, this paper makes the case for a model of development cooperation centered on national leadership, stronger public institutions, high-quality services, and the long-term capacity of countries to deliver for their own populations.

The ideas behind the roadmap outlined here are not new. Country ownership, alignment and stronger national systems were central to key international agreements including the Paris Declaration, the Accra Agenda for Action and the Busan Partnership. Harvard University's Dr. Paul Farmer and others pushed this thinking further, arguing that programs funded through development cooperation should not accept lower standards for people living in poorer settings simply because their countries had fewer resources. Instead, the ambition should be to accompany countries in building the institutions and systems capable of delivering high-quality services equitably, at scale and over time.

Over the past two decades, much of the development field has moved toward interventions that are targeted, measurable and capable of demonstrating attributable results over relatively short periods. Many have produced important gains. But this approach has also narrowed the way effectiveness is understood. An intervention may be highly cost-effective within the boundaries of a particular program while leaving unanswered a larger question: what does that investment do to the institutions, workforce and systems that countries need to deliver those results themselves?

Too often we measure success through the immediate results of individual programs rather than through the trajectory of the countries in which those programs operate. After decades of assistance and large-scale investment, many of the most aid-dependent countries remain unable to finance and reliably deliver essential services for their populations. There are many reasons for this, and it would be too simplistic to attribute that failure to aid alone. But decades of choices about how aid is financed and delivered have inevitably shaped the institutions and governments of the countries receiving it. Those effects have to be part of how we understand impact.

Today, some of the most important calls for a new way forward are coming from the countries and institutions that development assistance is intended to serve. African leaders and institutions are calling for greater sovereignty, stronger public systems, increased domestic financing and a different relationship with external partners. Initiatives such as Africa CDC's health sovereignty agenda and the Accra Reset are giving renewed urgency to questions that have been present in development for decades.

New technologies, therapeutics and private-sector innovation will be essential to the future of development. Artificial intelligence has the potential to transform health, education,

agriculture and other sectors, and countries that are unable to take advantage of it risk being left further behind. But innovation alone is not enough. Countries need the enabling environment (strong institutions, infrastructure, skilled workforces and appropriate governance) to evaluate new technologies, decide which innovations best serve their priorities, integrate them into national plans and systems, train people to use them effectively, and deliver them equitably and at scale. Accompanying countries to build that capacity should be part of development cooperation itself.

At the heart of this discussion is a simple but consequential point: the way donors deliver aid is not neutral. The choices donors make about how assistance is financed, designed and delivered shape institutions, incentives and capacity. When outside organizations offer better salaries and working conditions, capable people leave the public sector. When donors build parallel systems for procurement, data, service delivery and management, those capabilities are built outside rather than within national institutions. When priorities are established outside of countries where investments are taking place, national leaders have less opportunity to make choices, allocate resources and be accountable to their own populations. And when essential services depend year after year on outside organizations to finance and manage them, the public sector remains dependent on those organizations to provide them.

A program can produce excellent and measurable results while leaving a country no more capable of producing those results itself, and in many cases with a weaker public workforce, weaker institutions and less public trust than it had before.

This matters because there is ultimately no substitute for a functioning state. No country has sustainably reduced poverty, built broadly shared prosperity or reliably delivered health, education, infrastructure, security and other essential services without governments and public institutions capable of doing their jobs. International organizations, NGOs and other external partners can provide financing, expertise and accompaniment. They can help countries achieve things that would otherwise be beyond their current capacity. But they cannot permanently substitute for functioning public institutions.

The proposition explored in this paper is not that donors should choose long-term institution building over results today. They can and should do both. A health investment can treat patients today while building the workforce, infrastructure and systems that will treat patients tomorrow. International expertise can bring the best available evidence, technology and innovation into a national plan while leaving the country in charge of that plan and its implementation. External financing can meet immediate needs while building national capacity to finance and manage those services over time.

National plans are central to this approach. They provide a vehicle through which countries can set priorities and take responsibility for delivering them, while drawing on the best ideas, evidence and expertise available globally. Accompaniment is an overarching principle of this roadmap. It means working alongside countries as they build the institutions and

capabilities to lead their own development – bringing financing, technical expertise, evidence, innovation and experience to the table while leaving countries in charge of the choices they make and the plans they pursue. It is an active partnership: helping governments solve problems, build capacity, access expertise and new technologies, and adapt as circumstances and opportunities change. The aim is to support a country's journey toward self-reliance, with external assistance increasingly strengthening, rather than substituting for, the institutions that will ultimately carry the work forward.

This approach is demanding. It requires credible plans, capable and accountable partners, appropriate safeguards, serious technical accompaniment and different approaches in different contexts. It asks donors to tolerate less attribution and share more control. It requires a longer view of impact than a grant cycle or an intervention-level cost-effectiveness calculation can provide.

But it is far from impossible. There are strong examples, including in some of the world's most challenging environments, that show what this approach can look like in practice. This paper examines some of them because they demonstrate what is possible and begin to identify the conditions under which it works. We are continuing to identify and learn from a much broader range of experiences, including successes, failures and approaches that have evolved over time.
Ultimately, the distinction between short-term results and long-term systems strengthening is itself misleading. The short-term intervention is already affecting the long-term system. Donors should consider that effect as seriously as they consider the immediate results of the programs they fund. If an intervention produces excellent results today but leaves a country less capable of delivering them tomorrow, that is part of the impact too.

The goal cannot be a succession of successful projects in countries that remain unable to deliver for their own people. The goal has to be countries that work.

The evidence and case studies examined in this paper show that getting there does not require inventing a new model of development cooperation. It requires taking seriously principles that have been articulated for decades, learning from where they have worked and where they have fallen short, and applying them more deliberately to the choices donors make about how assistance is financed, designed, delivered and measured.

The roadmap we propose is built around four principles:

The Roadmap Forward

#	PRINCIPLE	IN BRIEF
1	Finance national plans and strengthen public institutions	Finance the implementation of nationally approved development plans while strengthening the public institutions responsible for leading their implementation.
2	Strengthen national and local economies	Ensure development investments strengthen national and local economies, including through local employment, procurement, workforce development, and institutional investment.
3	Invest in comprehensive, high-quality and innovative public services	Support nationally determined plans built around the highest evidence-based standards, incorporating new technologies, therapeutics and innovations as they emerge, and helping countries build the capacity to adopt and deliver them at scale.
4	Measure what matters	Evaluate development cooperation by whether it leaves countries more capable of leading, financing, and sustaining their own development, not only by outputs delivered while external funding was flowing.

The sections that follow examine the evidence behind these principles and examples of how they have worked in practice. Section VI returns to the roadmap in detail and considers how these principles could be implemented in future U.S. development cooperation.

2. Background: With USAID dismantled, what comes next?

Over the past decades, the United States has invested billions of dollars in development assistance to the world's poorest countries. The central question this report asks is: when that money is gone, what remains? Does development assistance leave those countries with stronger public institutions capable of delivering for their own citizens, or does it create dependency on outside actors? This report argues that the answer to that question is the ultimate measure of whether development assistance has succeeded.

This report is not intended to introduce a new philosophy of development cooperation. Rather, it seeks to echo and strengthen a reform agenda that has been advanced for more than two decades by leaders and institutions across the Global South including the g7+, the Accra Reset initiative, the Africa Centres for Disease Control and Prevention (Africa CDC), and successive international agreements starting from the 2005 Paris Declaration on Aid Effectiveness and the 2011 Busan Partnership for Effective Development Co-operation. Drawing on more than fifteen years of primary research, aid-financing analysis, and case studies conducted through the United Nations, the Science of Implementation Initiative, and now the Global Cooperation Institute, this report adds evidence to that conversation and helps answer the question: what model of development cooperation is most likely to reduce poverty, improve health and well-being, and strengthen countries over the long term?

An overdue question

When the Trump administration dismantled USAID in 2025, it did so without a public analysis and without the common understanding that should have preceded a decision of that scale. There was no public assessment of what was working and what was not, no accounting of which programs were delivering durable results and should have continued, which needed reform rather than elimination, and which needed time and a real transition plan to phase out rather than an abrupt end. That abrupt end had real costs, borne by the people USAID programs served.

But an honest accounting must ask a larger question: has the overall model of development cooperation helped the poorest countries achieve the kind of broad, sustained progress the international community has long sought? Undoubtedly, development assistance has delivered many important achievements. It has helped save millions of lives, dramatically expand access to HIV treatment, reduce child mortality, improve vaccination coverage, and support important gains in education and other areas. Yet those achievements should also be considered alongside broader measures of country-level progress.

Adopted by all UN Member States in 2015, the United Nations Sustainable Development Goals (SDGs) provide the international community's shared framework for assessing whether countries are making sustained progress toward reducing poverty, ending hunger, improving health and education, and advancing other fundamental development outcomes by 2030. The latest assessments indicate that among the 44 countries designated as the

LDCs by the United Nations, only three are currently progressing at the pace needed to reduce poverty, none are progressing at the pace needed to reduce hunger or improve health and well-being, and only one is progressing at the pace needed to improve education.[1] These findings raise an important question: could a different approach to development produce more durable, population-level progress?

For those who argue that aid itself is an outdated tool of development, and that only private economic growth can lift countries out of poverty, this report's answer is not a defense of aid as it has typically been delivered. This report also does not contend that, even in the best-case scenario, aid alone can lift a country out of poverty. It cannot substitute for a functioning tax base, a growing economy, accountable governance, or the political will of a country's own leadership. This report's argument is different: aid can be one essential tool in that greater effort, can provide support when countries need time to strengthen those other components, and when it is delivered well, the results can be transformative.

To be clear at the outset: this report argues against reviving USAID's old model for future cooperation with the LDCs. The argument here is different, and, this report contends, more useful to policymakers in either political party: development assistance can work, and has worked best, when it is built to strengthen the public institutions of the countries it serves rather than substitute for them – and the evidence for that claim, and a roadmap for acting on it, is what this report sets out to provide.

Our thesis: support national plans

The thesis of this report is that development assistance should finance the implementation of nationally approved development plans while strengthening the public institutions responsible for leading their implementation. In the LDCs, governments have already identified priorities through national and sector development plans, developed by ministries, civil servants, national experts, universities, and technical specialists, often with technical support and endorsement from organizations such as WHO, UNICEF, the World Bank, regional development banks, and other international partners. A key question this report poses is whether development assistance is financing nationally approved development plans and building in-country capacity—or financing something else.

There is a strong case that this approach would make development assistance more cost-effective. Financing and delivering more through national systems would reduce duplicative layers of administration, management, overhead, and parallel service delivery, allowing more of each development dollar to finance national priorities and build lasting capacity. Recent analysis by the Center for Global Development suggests that the potential savings from country-led service delivery could be substantial.[2]

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[1] Sustainable Development Solutions Network, *Sustainable Development Report 2026* (SDG Index and Dashboards), dashboards.sdgindex.org. Trend classifications ("On Track," "Improving," "Stagnating," "Decreasing") reflect the SDG Index's own methodology for assessing progress toward each Sustainable Development Goal by 2030.

[2] Rachel Bonnifield and Janeen Madan Keller "Tough Times, Tough Choices: Charting PEPFAR's Next Chapter While Safeguarding Its Legacy." Center for Global Development, November 14, 2025.

The public conversation since 2025 in the U.S. has included many who point to the lives saved by USAID's work. The lives saved are real. But those metrics do not tell us how many more lives could have been saved, or how much more durable those gains could have been, had the same resources been spent differently. A program can save lives in the short term while failing to build the public health system that would allow a country to sustain and expand those gains on its own. Much of the current debate over aid effectiveness still measures success through results achieved while aid dollars are flowing, rather than what remains after those investments end. That is a problem this report treats in detail, and one the roadmap we set out is built to correct.

The dismantling of USAID has prompted a broad reexamination of the future of U.S. development cooperation. Foundations, research institutions, and policy leaders are exploring what should come next. This report aims to contribute to that conversation by sharing primary research conducted by Abbey Gardner and Jéhane Sedky and their colleagues under the leadership of the late Dr. Paul Farmer, analyzing where U.S. and international development assistance went during three of the largest and most consequential humanitarian and development responses of the past two decades: the 2010 Haiti earthquake, the 2014 West Africa Ebola epidemic, and the global COVID-19 response from 2020 to 2022. Across all three – independent of which party held the White House or which agency administered the funds – the same pattern emerges: the overwhelming majority of U.S. assistance bypassed the public institutions of the countries it was intended to help.[3]

That data tracking has its own institutional lineage. It started at the United Nations Office of the Special Envoy for Haiti and the United Nations Office of the Secretary-General's Special Adviser on Community-Based Health and Aid Delivery, under the leadership of President Bill Clinton and the late Dr. Paul Farmer of Harvard University. It continued at the Science of Implementation Initiative, a think tank Dr. Farmer founded when his UN term ended in 2020.

What about "localization"?

In recent years, USAID placed increasing emphasis on an approach known as localization, which sought to direct more development funding to local organizations. In its final years, USAID also made the important decision to include partner-country governments within that framework, recognizing that public institutions themselves should receive greater support. Yet even in FY2024, only about 12 percent of USAID's funding was classified as going directly to local partners—and that figure is measured against acquisitions and assistance (A&A) and government-to-government (G2G) funding, a category that itself excludes large portions of USAID's total spending, such as funding routed through the UN and other multilateral

[3] Gardner A, Sedky J, with conclusion by Farmer P. *Changing Development with Data: Using a Scientific Approach to End Poverty and Disease*. Science of Implementation Initiative / United Nations Office of the Secretary-General's Special Adviser on Community-Based Health and Aid Delivery. March 2021.

channels.[4] Independent watchdogs have argued that measured against USAID's full funding envelope, the real share reaching local organizations is considerably lower.[5] Whichever denominator is used, the figure for partner-country governments specifically was starker still: in FY2024 less than 1 percent of the agency's total funding went directly to partner-country governments.[6]

Even the term "localization" is somewhat misleading. It suggests that development itself has become local when, in many cases, only the implementing organization has changed. Decisions about priorities, financing, program design, grant selection, performance measures, and accountability often continue to be made by external donors.

This report argues that localization as implemented by USAID addresses a different problem from the one confronting the LDCs. Shifting development funding from international organizations to local organizations does not address the chronic underinvestment in national development plans and the public institutions responsible for ensuring that they are carried out. Community organizations and NGOs are often important partners in development efforts, but they cannot substitute for the public institutions every country ultimately needs to deliver health care, education, infrastructure, public safety, and social protection to an entire population.

A cross-party analysis

This report is deliberately non-partisan. It draws on decades of evidence, internationally agreed principles, and years of partner-country leaders calling for a different model of development cooperation. Global South leaders have been making this case with increasing urgency. Recent examples include Ghana's 2025 Accra Reset initiative, which calls for a new model of development cooperation rooted in national ownership, and Africa CDC Director-General Dr. Jean Kaseya's assessment that 60 percent of traditional foreign health aid to Africa was effectively wasted. He and former Ethiopian Health Minister Dr. Lia Tadesse Gebremedhin argued that the problem was that too much of it was fragmented, poorly aligned with government priorities, and insufficiently invested in strengthening national systems.[7]

Policymakers in both political parties are considering what U.S. development cooperation should look like after USAID, and the actual architecture of that rebuild will likely take shape after the 2028 election, regardless of which party wins. That gives this report's central argument a useful kind of urgency: the decisions that will define U.S. development cooperation for a generation have not yet been made, and they are currently being shaped.

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[4] U.S. Agency for International Development, *Growing Momentum: USAID Localization Progress Report, FY 2024* (January 2025). The original USAID.gov hosting of this report is no longer live following the agency's 2025 restructuring; report figures confirmed via contemporaneous coverage, including DevelopmentAid, "USAID releases 2024 Localization Progress Report" (January 15, 2025).

[5] Publish What You Fund, "Metrics Matter II: USAID's Measurement Approach Is Undermining Progress on Localization" (June 2024); Oxfam America, Funding the Localization Agenda: Measuring Progress of United States Development and Humanitarian Assistance to Local Organizations (2023).

[6] See footnote 4.

[7] Sara Jerving, "Africa CDC chief: 60% of foreign health aid was effectively wasted," *Devex*, October 17, 2025.

This report attempts to inform that decision-making with primary research, analysis and case studies. Years of tracked aid flows, a consistent and well-documented reform agenda from the partner countries this assistance is meant to serve, and international agreements that donor countries (including the United States) have already signed all point in the same direction. The problem is not a lack of frameworks. Principles of country ownership, alignment and stronger national systems have been articulated and agreed upon for decades. The problem has been a lack of adherence: aid delivery has too often failed to follow them. What remains underdeveloped is the evidence base for measuring the long-term effectiveness of alternative approaches—and the will to put principles already agreed upon into practice.

It is important to acknowledge that elements of the Trump administration's emerging approach to global health assistance move in this direction. Its new global health strategy shifts U.S. health assistance toward multi-year bilateral agreements with partner governments, greater government-to-government support, increased domestic co-investment, and stronger national ownership. These agreements differ in important respects from the roadmap proposed here, but they reflect some of the same concerns about strengthening national systems and reducing dependence on aid that bypasses them.

Across very different crises and contexts, the same organizing principle emerges, even though this report did not invent it. The most durable examples of development assistance are built around financing nationally determined development plans and strengthening the institutions responsible for seeing that they are carried out. They begin by identifying who is nationally or locally accountable for a given problem long after the funding ends – typically a government ministry, a public institution, or a national workforce – and they define success according to nationally determined priorities rather than donor-defined objectives.

They are built, from the outset, around a planned transition to full local control, rather than around indefinite delivery by an outside actor. This report uses the concept that Dr. Paul Farmer and his colleagues referred to as "accompaniment" to describe the alternative approach: long-term partnerships that support national and local institutions in strengthening their own capacity rather than substituting for them.

The scope of this report is deliberately narrow. It concerns the 44 LDCs, not middle-income countries, whose development challenges, financing options, and relationship to foreign assistance are fundamentally different. In 2024, official development assistance (ODA) was the single largest source of external financing for LDCs—larger than foreign direct investment—making it one of the largest external inputs many of these countries receive.[8] In the poorest countries, where the consequences of institutional failure are most severe, the question of whether aid strengthens or substitutes for public institutions is not an

[8] UN Trade and Development, *World Investment Report 2025*, "Regional Trends: Least Developed Countries" (foreign direct investment to LDCs of $37 billion in 2024); OECD, "Final OECD Statistics on Official Development Assistance and Other Resource Flows to Developing Countries in 2024" (official development assistance to LDCs of $61.8 billion in real terms, 2024).

academic one. It is, this report argues, the central question, and one the United States, under either party, has the evidence and the opportunity to get right.

Done well, and applied consistently, this is not a marginal fix. A development strategy built on this approach to partnership, backed by the evidence and roadmap this report lays out, has the potential to produce transformational change over the long term and to generate more durable value from development spending by building capacity that continues to deliver after individual grants and programs end. It offers the United States a chance to set a credible course for other donor nations to follow at a moment when many are reconsidering their own approaches to development cooperation. And it serves America's own interests directly. Instability is rarely contained within national borders, and countries with stronger public institutions are better able to prevent and respond to epidemics, natural disasters, food insecurity, and conflict before they become far more costly humanitarian and security crises. Investing upfront to strengthen health systems, public infrastructure, and the national workforce needed to sustain them is often far less expensive (and far more effective) than repeatedly financing emergency responses after those systems have failed.

3. Our research: What we tracked and what we found

The evidence in this report comes from three of the largest humanitarian and development responses of the past twenty-five years: the Haiti earthquake of 2010, the West Africa Ebola epidemic of 2014, and the global COVID-19 response from 2020 to 2022.[9] Each of these cases involved an enormous, rapid mobilization of official development assistance. Each was tracked in close to real time by the primary researchers, Abbey Gardner and Jéhane Sedky and their colleagues. And each occurred in one or more LDCs, where the consequences of how aid is spent are most severe and most visible. Taken together, these three cases span natural disaster, epidemic, and global pandemic across multiple U.S. administrations. Yet each reveals the same underlying pattern.

Haiti, 2010

On January 12, 2010, a devastating earthquake struck Haiti. The earthquake caused catastrophic loss of life, displaced more than a million people, and devastated the country's already fragile public infrastructure, including government ministries, hospitals, and schools. The earthquake triggered a substantial international response. Bilateral and multilateral donors ultimately pledged $10.76 billion for Haiti's recovery and development, while international NGOs raised an additional estimated $3.06 billion in private funding for earthquake response and recovery—nearly $14 billion in external resources across these two funding streams.[10]

Yet our tracking revealed a striking disconnect between the scale of the response and the strengthening of Haitian institutions. Of the $6.43 billion in humanitarian and recovery assistance disbursed by bilateral and multilateral donors from 2010 through 2012, less than 10 percent was disbursed directly to the Government of Haiti using its own systems, and less than 0.6 percent reached Haitian organizations and businesses directly as program grants.[11]

During the emergency phase, the figure was less than 1 percent: just $22.1 million of $2.42 billion in humanitarian assistance went directly to the Haitian government. The UN flash appeal did not request funding for a single Haitian public-sector institution.[12] Total international assistance to Haiti over this period was more than four times the Haitian government's own internal revenue.[13]

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[9] Research and data referenced as "we" throughout this report were conducted by one of the authors, Abbey Gardner, in collaboration with Jéhane Sedky, and other colleagues noted in our acknowledgements, under the direction of Dr. Paul Farmer, during Ms. Gardner's and Ms. Sedky's work at the United Nations Office of the Special Envoy for Haiti, the United Nations Office of the Secretary-General's Special Adviser on Community Based Health and Aid Delivery, and the Science of Implementation Initiative.

[10] Office of the Special Envoy for Haiti, "Haiti 2010 Earthquake: Key Facts and Lessons Learned," January 2020 (Office of the Secretary-General's Special Adviser on Community Based Health and Aid Delivery); "Key Statistics," lessonsfromhaiti.org.

[11] Office of the Special Envoy for Haiti, "Haiti 2010 Earthquake: Key Facts and Lessons Learned," January 2020 (Office of the Secretary-General's Special Adviser on Community Based Health and Aid Delivery); "Key Statistics," lessonsfromhaiti.org.

[12] Office of the Special Envoy for Haiti, "Haiti 2010 Earthquake: Key Facts and Lessons Learned," January 2020 (Office of the Secretary-General's Special Adviser on Community Based Health and Aid Delivery); "Key Statistics," lessonsfromhaiti.org.

[13] Office of the Special Envoy for Haiti, Has Aid Changed? Channelling Assistance to Haiti Before and After the Earthquake, June 2011.

The lesson from our Haiti tracking was that substantial resources could be spent in a country without strengthening the institutions that would remain when the international response ended. Much of the response was implemented through international organizations, NGOs, contractors, and donor-country entities, while the Government of Haiti had limited visibility into resources being committed and spent. The result was a highly fragmented recovery effort that missed a historic opportunity to strengthen Haiti's public institutions and systems for the long term.[14]

The consequences extended beyond the loss of funding itself. When billions of dollars are spent in a country's name and its people see little visible improvement in the institutions meant to serve them, the most available explanation is not that the money bypassed the government, it is that the government failed. Haitians were largely left to draw that conclusion despite the government having little control over, or visibility into, most of the resources being spent in its name. As Dr. Paul Farmer, UN Deputy Special Envoy for Haiti at the time, explained: "The outpouring of goodwill that followed the 2010 earthquake... resulted in thousands of donors, philanthropists and international organizations coming to Haiti to offer services." Yet, he continued, those efforts did not contribute to strengthening Haiti's public health system, leaving the General Hospital to care for patients on a fraction of the operating resources available to some international providers.[15]

An illustration of this imbalance is that one international nonprofit raised $486 million in private donations following the earthquake (more than twenty times the $22.1 million that reached the Haitian government directly from all bilateral and multilateral donors combined during the emergency phase). That NGO committed just $3.8 million (less than 1 percent of the funds it raised) to salary support for the staff of Haiti's General Hospital, even as that hospital struggled to remain operational.[16]

The overall story of what happened to Haiti's General Hospital provides another example of what was (and was not) left behind. Rebuilding the country's principal public hospital in the capital was among the first major reconstruction projects approved after the earthquake. France, the United States, and the Haitian government committed tens of millions of dollars to construct a new 534-bed facility. Yet more than a decade later, the new hospital still had not opened. By 2023, the project was roughly ten years behind its original schedule and nearly $29 million over its initial joint budget. The reasons were multiple and complex (including technical and contracting problems, political instability, and eventually severe insecurity) but the outcome is difficult to ignore: amid nearly $14 billion in external resources

[14] Office of the Special Envoy for Haiti, "Haiti 2010 Earthquake: Key Facts and Lessons Learned," January 2020 (Office of the Secretary-General's Special Adviser on Community Based Health and Aid Delivery).
[15] Paul Farmer, "Accompaniment in Aid Delivery: A Concept Note by Paul Farmer," Office of Paul Farmer, Aid Delivery Support Initiative, New York, March 2012.
[16] American Red Cross, "International Disaster Response: Earthquake in Haiti" (Washington, D.C., 2012), as cited in Farmer, "Accompaniment in Aid Delivery," 2012.

pledged or raised for Haiti's earthquake response and recovery, one of the country's most important national public institutions remained unfinished.[17]

The experience demonstrated something that we would see over and over again: mobilizing substantial resources and delivering substantial assistance are not the same as building durable national capacity.

West Africa, 2014

When Ebola emerged in Guinea, Liberia, and Sierra Leone in early 2014, it spread into a public health vacuum. In one year we examined before the crisis, 2010, only 3.5 percent of Liberia's official development assistance flowed through its own national systems,[18] a version of the same pattern documented in Haiti, and a precondition for the workforce gap that followed. Liberia's Ministry of Health and Social Welfare, at the time of the outbreak, oversaw a public health workforce far too small to detect, trace, or contain an outbreak of Ebola's speed and lethality.

The outbreak also exposed a second problem: the standard of care offered to people in poor countries differed dramatically from the standard offered elsewhere. When Ebola treatment centers were established in West Africa, many were designed primarily to isolate the sick and contain the spread of disease, not to save the lives of those already infected, a standard of care far below what any wealthy country would have accepted for its own citizens. Case fatality rates in West African treatment settings ranged roughly from 40 to 70 percent over the course of the epidemic. Dr. Farmer, who treated Ebola patients in Sierra Leone during the outbreak, later wrote that with one exception, every American who fell ill with the strains circulating in West Africa survived, and so did most Europeans.[19] Patients evacuated for treatment in the United States and Europe received the same intensive supportive care (intravenous fluids, electrolyte replacement, blood pressure management) available in wealthier countries. That gap in trust and standard of care contributed to why the outbreak spread as far and lasted as long as it did.

COVID-19, 2020–2022

The global pandemic response repeated the pattern at greater scale, and represented another lost opportunity. The largest global health mobilization in a generation necessarily financed vaccines, tests, treatments, and other urgent commodities. But it was also an extraordinary opportunity to build lasting laboratory capacity, disease-surveillance systems, stronger health workforces, and public health infrastructure in the world's poorest countries. That opportunity was largely missed: the response relied heavily on debt

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[17] Jacqueline Charles, "Haiti's biggest hospital still not built 10 years after quake. That's not the worst of it," *Miami Herald*, January 12, 2020; Jacqueline Charles, "The U.S. allocated millions to help Haiti rebuild after 2010 earthquake. How was it spent?," *Miami Herald*, March 17, 2023; U.S. Government Accountability Office, *Haiti: USAID and State Should Improve Management and Assessment of Reconstruction Activities*, GAO-23-105211, March 16, 2023.

[18] Office of the Secretary-General's Special Adviser on Community Based Health and Aid Delivery, "Backgrounder for ECOSOC Special Session on Ebola," 2014, citing OECD (2010) data on Liberia's ODA channeled through national systems.

[19] Paul Farmer, Fevers, Feuds, and Diamonds: Ebola and the Ravages of History (New York: Farrar, Straus and Giroux, 2020).

financing and directed relatively little grant funding to the national public institutions responsible for delivering health services and preparing for the next pandemic.

Between 2020 and 2022, $207.9 billion in COVID-19 assistance was pledged globally, of which $170.9 billion was disbursed, 86.6 percent of it through the World Bank alone. Sixty percent of COVID-19 funding took the form of loans; just 8.9 percent reached partner governments as grants. Among bilateral donors, direct government support was scarcer still: of $19.7 billion disbursed bilaterally, only 7.6 percent went as grants to public sectors. Our analysis of OECD CRS data found that just 0.1 percent of U.S. bilateral COVID-19 disbursements ($3.2 million out of approximately $4.2 billion) was provided as grants to partner governments; 60 percent went to American and international NGOs or U.S. agencies.[20] The result was another enormous global health response that invested very little directly in the public institutions that will be responsible for confronting the next pandemic — despite the unprecedented scale of the global COVID-19 financing response.[21]

A consistent pattern

Across three crises, three different U.S. presidential administrations, and three very different diseases and disasters, the same structural pattern holds: assistance overwhelmingly bypassed the public institutions of the countries it was meant to help. The cost of that pattern goes well beyond any single failed pledge or underfunded ministry. It represents a repeated, compounding lost opportunity: to invest in durable public systems and local jobs instead of parallel, temporary delivery structures; to build lasting capacity instead of importing it, at high cost, in the form of foreign staff and overhead, for the duration of a crisis and no longer.

What was delivered through this architecture varied widely in quality and effectiveness, but it was repeatedly organized through temporary international structures rather than integrated into lasting national systems. In some cases, as the Ebola response made especially clear, the standard of care itself fell far below what would have been accepted in wealthier countries.

Taken as a whole, these responses did not produce the kind of durable, country-level institutional change that the scale of the investment might have made possible. This is not a partisan pattern, and it is not particular to any one donor, implementing agency, or type of crisis. It is a structural feature of how the dominant model of development assistance has operated for years, independent of who was in the White House or which party controlled the development budgets.

Testing the corruption assumption against the evidence

A common justification for routing aid around national governments is the fear that funds will be lost to corruption. In 2013, Paul Farmer's UN team conducted an analysis of data on

[20] Jéhane Sedky and Abbey Gardner, Tracking Donor Funding Toward the Global COVID-19 Response: An Analysis of Pledges, Commitments and Disbursements, Science of Implementation Initiative, July 22, 2025.
[21] Sedky J, Gardner A, Ivers LC. "Loans dominated COVID-19 funding: it's time to adjust." Lancet. 2025;406(10438):1946.

six major donors' documented losses to fraud and corruption (Australia, Belgium, Denmark, the European Commission, the United Kingdom, and the United States) and found losses ranging from roughly 0.015 to 0.163 percent of disbursed aid.[22] Nor does the corruption risk appear to differ meaningfully by delivery channel: the same six-donor dataset shows no clear relationship, in either direction, between how much aid a donor routed through national systems and how much it lost to fraud, which at minimum complicates the common assumption that bypassing national systems is what keeps aid safe from corruption.

These findings are based on an analysis of six donors over different reporting periods and should be read as suggestive rather than conclusive. They are, however, consistent with independent, audited figures: the UK's Foreign, Commonwealth and Development Office reported a detected fraud loss rate of 0.02 percent in 2020–21, closely in line with the UK figure in Dr. Farmer's UN team's six-donor dataset.[23] Separately, another analysis Dr. Farmer's UN office conducted found no meaningful correlation between a country's perceived corruption level and how much aid a donor channeled through its national systems,[24] suggesting that bypass decisions are not, in practice, closely calibrated to corruption risk in the first place. Taken together, these findings point to a need for far more rigorous, transaction-level research into where aid actually goes missing.

It is also worth being precise about what corruption data typically measures. The most widely cited corruption rankings, including Transparency International's Corruption Perceptions Index, are built from surveys of expert and business perception, not from measured incidence of actual corrupt acts. That distinction can be consequential. In one study across eight Sub-Saharan African countries, development-sector experts estimated that 52 percent of citizens would report having been affected by corruption in the previous year; when citizens themselves were surveyed, only 13 percent did.[25]

None of this means corruption risk should be ignored. Donors have well-established tools for managing it, including phased disbursement, independent financial audits, and technical accompaniment paired with direct investment, all of which mitigate risk without requiring wholesale bypass of the institutions aid is meant to strengthen.

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[22] Office of Dr. Paul Farmer, UN Deputy Special Envoy for Haiti, "Estimates of ODA Lost to Fraud From Six Donors," 2013 analysis, as published in Abbey Gardner and Jéhane Sedky, *Changing Development with Data: Using a Scientific Approach to End Poverty and Disease* (Science of Implementation Initiative, March 2021), Figure 11.
[23] ICAI, "Tackling Fraud in UK Aid: Country Case Studies," March 2024.
[24] Abbey Gardner and Jéhane Sedky, *Changing Development with Data: Using a Scientific Approach to End Poverty and Disease* (Science of Implementation Initiative, March 2021), Figure 12.
[25] Mireille Razafindrakoto and François Roubaud, "Are International Databases on Corruption Reliable? A Comparison of Expert Opinion Surveys and Household Surveys in Sub-Saharan Africa," *World Development* 38, no. 8 (2010): 1057–1069.

4. What a different model looks like

The argument for country-led development is sometimes treated as an aspiration that is too difficult to implement in the poorest and most fragile settings. The experience examined here suggests otherwise. This approach is not theoretical. There are examples in which governments have set ambitious national priorities, international partners have brought financing and world-class expertise behind them, and sustained investment has built public institutions capable of delivering services following high global standards.

These cases also demonstrate an important point made in the Introduction: countries do not have to choose between strong national ownership and access to the best ideas, technology and expertise in the world. Done well, international cooperation can provide both, while leaving behind institutions, people and capabilities that remain after external funding declines.

The examples that follow were selected because they clearly illustrate the principles proposed later in this report. Two – the Mirebalais University Hospital and the University of Global Health Equity – were developed by Partners In Health and its partners and are closely associated with the work of the researchers and their late colleague, Dr. Paul Farmer. We therefore do not present them as a representative sample or as independent validation of the framework, but as well-documented examples of how these principles can operate in practice. An important next step will be to identify and rigorously evaluate a broader range of development models—including those with no connection to the researchers or their institutions—using the same framework and measures of long-term effectiveness.

Rwanda: national leadership and long-term partnership

In the aftermath of the 1994 genocide, Rwanda faced one of the most difficult development challenges in modern history. Rather than allowing reconstruction priorities to be defined primarily by external actors, the Government of Rwanda articulated its own long-term national development strategy through a plan called *Vision 2020*. The strategy set ambitious national goals for reducing poverty, rebuilding public institutions, improving health and education, expanding economic opportunity, and transforming Rwanda into a middle-income country. Successive national health strategies became part of that broader vision, providing a framework around which development partners increasingly aligned their support.

Rwanda's progress reflected sustained partnerships in which the Government of Rwanda established national priorities while international partners supported implementation through financing, technical assistance, and long-term investments in public institutions. While different financing mechanisms were used, the common objective was to strengthen Rwanda's own capacity to lead, manage, and deliver health services rather than create permanent parallel systems.

One of the clearest examples was the *Human Resources for Health Program*, launched in 2012 under the leadership of Rwanda's Ministry of Health.[26] Rather than creating a separate service delivery program, the initiative partnered Rwandan teaching institutions with faculty from leading universities in the United States to strengthen Rwanda's own medical, nursing, public health, and health management education programs. The objective was not simply to provide care during the life of the program, but to leave Rwanda with the professional workforce and institutional capacity needed to sustain and continue improving its own health system for decades to come.

The results have been remarkable. Since the mid-1990s, Rwanda has achieved some of the fastest improvements in population health ever recorded in a low-income country. Life expectancy more than doubled, child and maternal mortality declined dramatically, vaccination coverage expanded, and access to health insurance became nearly universal.[27] At the same time, Rwanda steadily expanded the capacity of its own public institutions to train health professionals, manage health services, and lead future improvements. While many factors contributed to these outcomes, Rwanda demonstrates what can be achieved when development assistance aligns behind nationally determined priorities and makes sustained investments in the public institutions responsible for carrying them forward.

Rwanda also benefited from unusually strong national leadership and a government able to articulate and pursue a long-term development strategy with considerable consistency. That context matters. But the broader structural lesson does not depend on every country having the same political conditions. Development partners can still choose to organize their support around nationally defined plans, strengthen the public institutions responsible for carrying them out, and invest for the long term rather than build parallel systems. A better development architecture should make that approach the norm, rather than something that occurs only in exceptional cases.

Mirebalais, Haiti: building a national institution

If Rwanda illustrates what can happen when development partners align behind a country's long-term development strategy, Mirebalais University Hospital (or Hôpital Universitaire de Mirebalais, HUM) illustrates what that approach can look like at the level of a single public institution.

Following Haiti's devastating 2010 earthquake, the Haitian Ministry of Health asked the Boston based non-government organization Partners In Health and its Haitian sister organization, Zanmi Lasante, to expand plans for a small Sixty hospital into a 300-bed national teaching hospital that would become part of Haiti's public health system. Rather than creating a parallel institution outside government, the objective was to strengthen the country's own health system by expanding clinical care, medical education, and professional training within a public institution. The project was endorsed as part of Haiti's

[26] Binagwaho, Agnes, Peter Kyamanywa, Paul E. Farmer, et al. "The Human Resources for Health Program in Rwanda—A New Partnership." *New England Journal of Medicine* 369 (2013): 2054–59.
[27] Farmer, Paul E., et al. "Reduced Premature Mortality in Rwanda: Lessons from Success." *BMJ* 346 (2013): f65.

national reconstruction strategy and was designed from the outset as a partnership with the Ministry of Health rather than an NGO-operated facility.

From its inception, HUM was intended to do much more than provide clinical services. It was designed to strengthen Haiti's long-term capacity to train and retain its own health professionals. It was also designed to demonstrate that patients in one of the world's poorest countries deserved the same standard of care, dignity, and physical environment expected anywhere else. The hospital design incorporated natural light, open-air spaces, landscaped courtyards and gardens, and thoughtfully designed patient areas, reflecting the belief that the physical environment itself matters to healing and patient dignity.[28]

Working closely with the Ministry of Health and the State University of Haiti, the hospital established residency programs, expanded nursing education, created training opportunities for allied health professionals, and developed a new generation of Haitian clinicians, educators, and health system leaders. Education took place primarily within Haiti, with Haitian faculty working alongside visiting international colleagues in a model of accompaniment designed to transfer knowledge and leadership over time. HUM became a national center for education, training, and research.

HUM became Haiti's largest modern teaching hospital and, in 2019, became the first institution in the Americas to achieve the Accreditation Council for Graduate Medical Education's (ACGME) International institutional accreditation, demonstrating that a public teaching hospital in one of the world's poorest countries could meet the same rigorous graduate medical education standards as leading institutions in the U.S.[29]

By 2020, it had trained physicians across multiple specialties while achieving exceptionally high retention of graduates within Haiti.[30] The hospital also demonstrated that world-class clinical care and medical education could be delivered within one of the world's poorest countries while remaining fully integrated into the public sector. Researchers estimated that every dollar invested in the hospital generated approximately $1.82 in economic activity within Haiti, illustrating that investments in public institutions can strengthen both health systems and local economies.[31]

HUM ultimately faced challenges that no health institution could solve on its own. Escalating insecurity and gang violence forced the hospital to temporarily suspend operations in 2025, reflecting Haiti's broader political and security crisis.[32] During its years

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[28] See Anne DiNardo, "Take Five With Copley Wolff Design Group," *Healthcare Design*, October 30, 2013, describing HUM's courtyard gardens, breezeways, and outdoor spaces as integral to patient recovery, comfort, and infection control; see also Paul Farmer, quoted in True Mosaics Studio, "Mosaics for Mirebalais Hospital Project," 2011, describing the hospital as designed to be "as beautiful as it is functional" and to "confer dignity alongside the fruits of modern medicine."

[29] ACGME-International, institutional history, accessed August 14, 2026, https://www.acgme-i.org/about-us/history.

[30] Partners In Health, "University Hospital in Haiti Earns Global Accreditation as Teaching Institution," January 2020 (pih.org).

[31] Pantal, Michel-Ange, Peterson Faure, Jean-Gregory Jerome, Markus Von Wartburg, and Jean Claude Mugunga. "An Analysis of the Economic Impact of the Mirebalais University Teaching Hospital on the Haitian Economy: An Input-Output Approach." *Journal of Eastern Caribbean Studies* 40 (2015): 234–250.

[32] Partners In Health, "PIH Statement on Violence in Mirebalais," April 2025, pih.org.

of operation, however, HUM demonstrated what can be achieved when international partners invest not simply in delivering services, but in helping a country build and strengthen the public institutions responsible for training professionals, leading national systems, and sustaining progress over the long term.

University of Global Health Equity: investing in the next generation of public leaders

Strong public institutions ultimately depend on the people who lead and sustain them. The University of Global Health Equity (UGHE) in Butaro, Rwanda, illustrates this dimension of long-term capacity building: investing in the next generation of national and regional health leaders. UGHE was established through a partnership between Partners In Health and the Government of Rwanda, and grew out of a broader collaboration in the region that included Butaro District Hospital, where the government, Partners In Health, and MASS Design Group had demonstrated that a health institution serving a poor, rural population could combine world-class care with innovative architecture, beautiful surroundings, and an explicit commitment to patient dignity. UGHE extended that same ambition to education: creating a world-class university in rural Rwanda to train the people who would build, lead, and strengthen health institutions across Africa.[33],[34]

That ambition is reflected in the institution itself: a beautiful university campus, with striking architecture, state-of-the-art teaching and research facilities, and beautifully landscaped gardens and outdoor spaces, an environment designed to demonstrate that excellence in education and health care should not be determined by geography or national income.

UGHE was designed to close the gap between academic training and public service. Students study medicine, public health, implementation science, health systems management, and leadership while working directly within national health systems as part of their education. UGHE aims to prepare its graduates for leadership roles in ministries of health, universities, hospitals, research institutions, and public health systems across the continent.

Like the other examples presented in this report, UGHE reflects a long-term approach to development. Its primary outputs are not projects or short-term service delivery, but human capital, institutional leadership, and the capacity to strengthen public systems over generations. While the impact of such investments may take decades to fully measure, they represent one of the most durable forms of development assistance: preparing future leaders to guide their own countries' institutions long after external funding has ended.

Investments in innovative technologies in Rwanda (Gates Foundation and CHAI)

Recent investments by the Gates Foundation in Rwanda are an example of how development partners can support countries in adopting new technologies and innovations through nationally led systems. Several of these investments support the Government of

[33] University of Global Health Equity, "Our Story," ughe.org, accessed August 14, 2026.
[34] Lesley Stahl, “The MASS Model of Community-Focused Architecture,” 60 Minutes, CBS News, October 31, 2021, featuring Paul Farmer and MASS Design Group founder Michael Murphy.

Rwanda and Rwandan institutions directly, or finance technical partners to work alongside them.

- **Introducing innovations through the national health system.** In 2024, the Gates Foundation committed approximately $10 million directly to Rwanda's Ministry of Health to reduce maternal, stillbirth and neonatal mortality through the introduction of new innovations.
- **Building government capacity to use AI and health data.** The Clinton Health Access Initiative (CHAI) has worked in partnership with the Government of Rwanda for more than two decades, including helping the Ministry of Health build a national health-workforce training system that the government now manages itself. That long-term partnership is now extending into AI and advanced health data. With $4.3 million in support from the Gates Foundation, CHAI is working with the Ministry to institutionalize Rwanda's National Health Intelligence Center and operationalize a Health AI Lab for advanced analytics and primary health care.
- **Building the enabling environment to take AI to scale.** A $7.4 million Gates Foundation investment in Rwanda's AI Scaling Hub supports the expansion of AI applications in maternal health, agriculture and education, alongside the partnerships, governance and infrastructure needed to deploy them at scale.
- **Applying AI within existing public systems.** Other Gates-supported initiatives in Rwanda include using AI to strengthen procurement and forecasting, supporting health-worker decision-making and patient access, and validating AI-enabled ultrasound.

These investments illustrate an important dimension of the country-led development model. National ownership does not mean countries are expected to develop every new technology or capability themselves. External partners can bring financing, technology and specialized expertise. The important question is where the capacity is being built and who ultimately owns it. The objective should be to strengthen national institutions so that countries themselves become increasingly capable of evaluating, adopting and scaling innovations through their own systems.

5. Measuring what matters

If the way aid is delivered is not neutral, neither is the way its success is measured. What donors choose to measure helps determine what counts as success and, over time, what gets funded, studied and scaled. A system optimized to capture short-term project-level outputs will naturally favor interventions that produce those outputs. If institutional capacity, national leadership and long-term country progress are not measured with equal seriousness, they will continue to lose out in funding decisions.

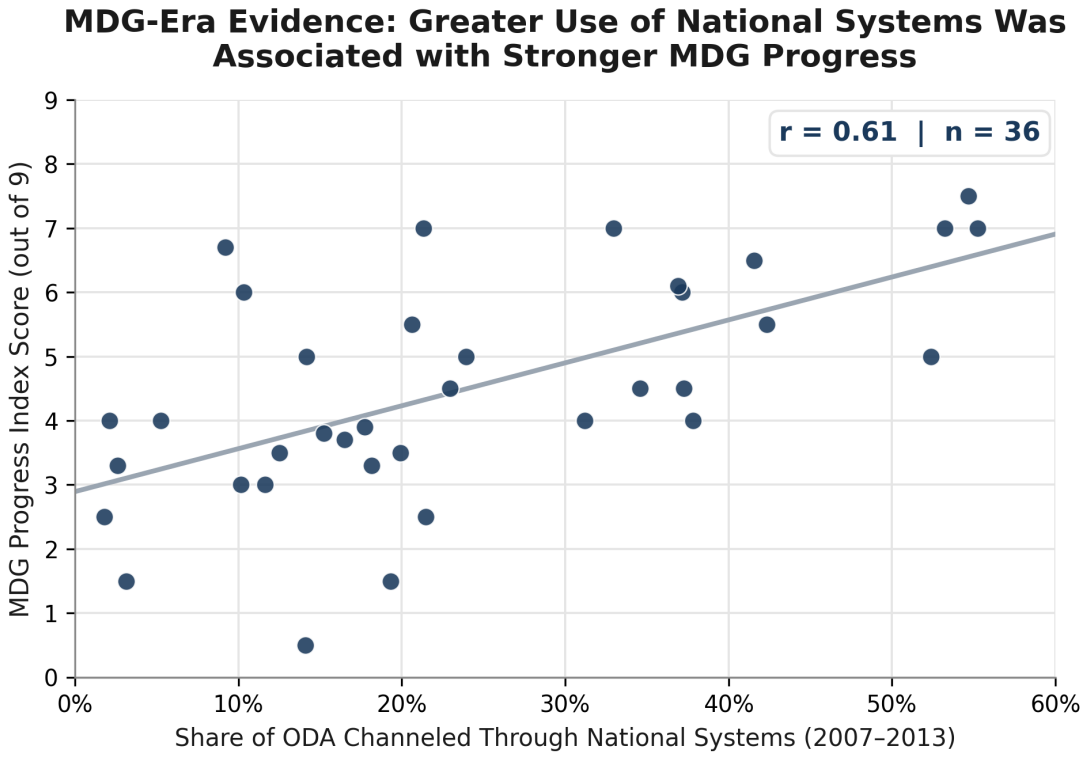
The first question, then, is whether there is evidence that strengthening national systems is associated with better country-level outcomes. The available evidence is still limited, and it does not establish causation. But two analyses conducted by Paul Farmer's team, a decade apart, using different measures of aid delivery and country progress, point in the same direction.

The evidence on country-level progress

An analysis of 36 Least Developed Countries during the MDG era found a substantial positive relationship between the share of aid channeled through national systems and country-level progress toward the Millennium Development Goals. Across the full sample, greater use of national systems was associated with higher scores on the 2015 MDG Progress Index ($r = 0.61$). The analysis does not establish that greater use of national systems caused better development outcomes. But it does show a substantial positive relationship: countries where a greater share of aid was channeled through national systems tended to have higher scores on the MDG Progress Index.[35]

[35] **Figure 1.** Analysis conducted by the Office of Dr. Paul Farmer at the United Nations, using OECD Paris Declaration Survey and OECD Creditor Reporting System data for 2007, 2010, and 2013, combined with UNDP Millennium Development Goal indicators. The national-systems measure estimates the share of total ODA received that was channeled through country public financial management systems. For each country, available national-systems amounts were summed across the three observations and divided by total ODA across those observations. MDG outcomes use the adjusted 2015 MDG Progress Index. Analysis includes 36 Least Developed Countries with available data. Originally presented in Abbey Gardner and Jéhane Sedky, with a conclusion by Paul Farmer, *Changing Development with Data: Using a Scientific Approach to End Poverty and Disease* (Science of Implementation Initiative, March 2021). Association, not causation.

Figure 1:

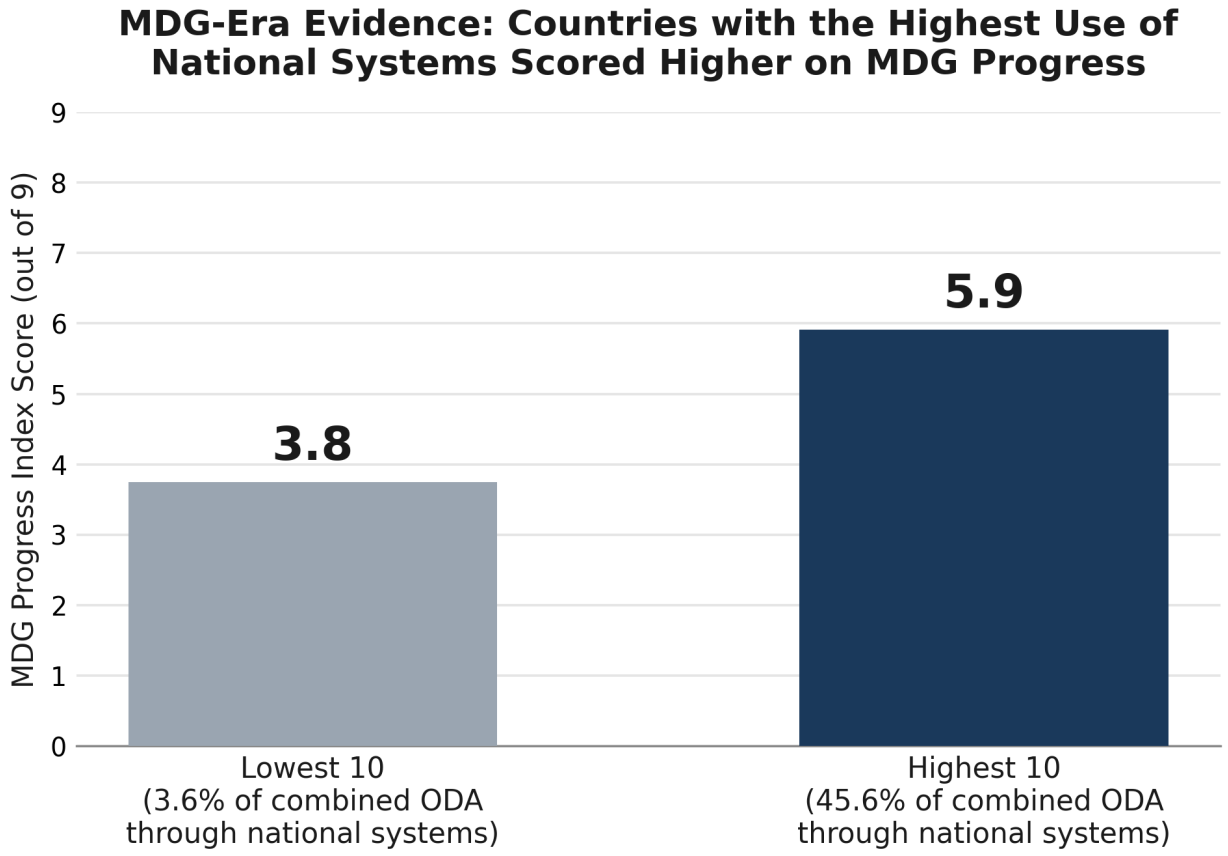


36 Least Developed Countries with available data. National-systems share based on 2007, 2010 and 2013 ODA data; MDG outcomes use the adjusted 2015 MDG Progress Index. Authors' reanalysis of estimates developed by the Office of Dr. Paul Farmer using OECD Paris Declaration Survey and OECD Creditor Reporting System data, combined with UNDP Millennium Development Goal indicators; originally presented in Gardner & Sedky, Changing Development with Data (SII, March 2021). Association, not causation.

The same data can be seen by comparing the countries at the two ends of the distribution. The ten countries with the highest shares of aid channeled through national systems scored an average of 5.9 out of 9 on the adjusted MDG Progress Index, compared with 3.8 among the ten countries with the lowest shares. Across the highest-use group, 45.6 percent of combined ODA was channeled through national systems, compared with just 3.6 percent in the lowest-use group.[36]

[36] **Figure 2.** Reanalysis of the same 36-country dataset developed by the Office of Dr. Paul Farmer at the United Nations and described in footnote 35. Countries were ranked using the same combined 2007–2013 national-systems measure used in Figure 1, calculated for each country as total ODA channeled through national systems across available observations divided by total ODA received across those observations. The highest- and lowest-use groups consist of the ten countries with the highest and lowest shares, respectively. MDG Progress Index values are simple country averages within each group. National-systems shares shown for each group are dollar-weighted, calculated as total ODA channeled through national systems divided by total ODA received across the countries in that group. Association, not causation.

Figure 2:

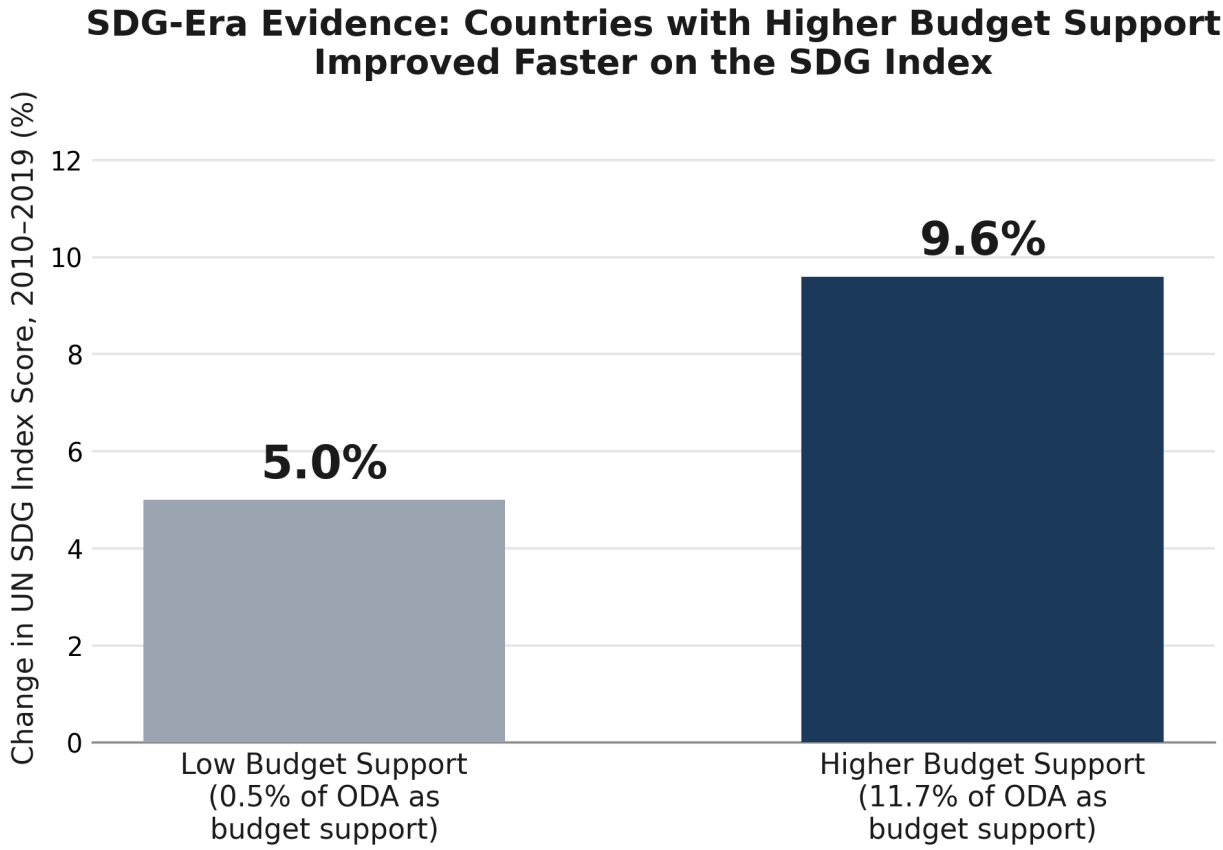


36 Least Developed Countries with available data. National-systems share based on 2007, 2010 and 2013 ODA data; MDG outcomes use the adjusted 2015 MDG Progress Index. Authors' reanalysis of estimates developed by the Office of Dr. Paul Farmer using OECD Paris Declaration Survey and OECD Creditor Reporting System data, combined with UNDP Millennium Development Goal indicators; originally presented in Gardner & Sedky, Changing Development with Data (SII, March 2021). Association, not causation. National-systems shares for the two groups are dollar-weighted: total ODA through national systems divided by total ODA received across each group.

A second analysis, using SDG-era data, points in the same direction using a different and narrower measure of aid delivery: budget support. Among 30 LDCs in Sub-Saharan Africa from 2010 to 2019, countries receiving a higher share of their ODA as budget support showed greater improvement on the UN SDG Index. Countries in the low-budget-support group, which received an average of 0.5 percent of ODA as budget support, improved by 5.0 percent on the SDG Index over the period. Countries in the higher-budget-support group, which received an average of 11.7 percent of ODA as budget support, improved by 9.6 percent.[37]

[37] **Figure 3.** Analysis conducted by the Science of Implementation Initiative using OECD Creditor Reporting System data and UN Sustainable Development Solutions Network SDG Index data for 30 Sub-Saharan African Least Developed Countries, 2010–2019. Aid delivery is measured as the share of total ODA provided as budget support, grants only, averaged over 2010–2019; the outcome is percentage change in UN SDG Index score over the same period. Association, not causation.

Figure 3:



30 Sub-Saharan African LDCs, 2010–2019. Measure is ODA to budget support as a share of total ODA (grants only), 2010–2019 average; outcome is change in UN SDG Index Score, 2010–2019. Authors' analysis of OECD Creditor Reporting System data. Association, not causation.

This finding should not be read as an argument that budget support is the only way to finance development assistance. Budget support is one particularly direct way of placing development resources under national control and using national public systems. Its relevance here is broader: the finding provides another indication that putting more resources through national institutions is compatible with stronger country-level development progress.

These analyses do not establish causation, and we do not present them as doing so. Countries that receive more aid through national systems or as budget support may differ in important ways from those that receive less, and more rigorous research is needed to understand those relationships. The two analyses also use different measures and should not be read as a continuous time series: the MDG-era analysis examines aid channeled through national systems broadly, while the SDG-era analysis examines the narrower category of budget support.

What is notable is that two analyses conducted across different periods, using different measures of aid delivery and different measures of country progress, point in the same

direction. At minimum, these findings challenge the assumption that greater reliance on national institutions necessarily comes at the expense of development results. More importantly, they provide empirical support for a proposition at the heart of this report: how aid is delivered may matter to a country's long-term development trajectory. They also strengthen the case for much more serious research into a relationship that has received too little attention.

Refocusing our measurement

If long-term institutional strengthening is not measured well, it will keep losing out to what is, regardless of which approach actually serves countries better. Donors have become highly effective at measuring immediate results — project delivery, organizational performance, lives saved this year — while remaining much less equipped to measure whether development investments are building the institutions and capabilities needed to sustain and expand those gains over time.

Existing accountability systems ask good, necessary questions: Were project objectives met? Were funds properly managed? Were outputs delivered on time and within budget? Were lives saved? These questions matter, and the tools and systems developed to answer them (including financial audits, project evaluations, donor transparency reporting) remain necessary.

But these measures do not adequately answer another essential question for the LDCs: are countries becoming more capable of leading, financing, and sustaining their own development?

Measures such as cost per disability-adjusted life year (DALY) averted or quality-adjusted life year (QALY) gained are valuable tools for comparing health interventions. But when they become the dominant lens for allocating development resources, important forms of value can disappear from the calculation: stronger institutions, skilled national workforces, resilient health systems, and the capacity of countries to sustain and expand health gains over time.

This is ultimately a question of effectiveness and value for money. An intervention that produces a large measurable benefit at low cost may be highly cost-effective on its own terms. But development cooperation also creates—or fails to create—long-term assets: trained workforces, functioning public institutions, stronger health systems, domestic economic activity, and the ability to respond to future crises without rebuilding external systems each time. If those benefits and costs are excluded from the analysis, we cannot know which development strategy actually produces the greatest return over time.

That requires measuring a broader set of outcomes and conditions — and, importantly, many are already possible to measure without waiting for a hypothetical future dataset. Examples include:

- **Use of national systems:** What share of ODA is channeled through or invested in

national institutions?

- **Alignment with national priorities:** Are national and sector plans being financed according to priorities and needs identified by partner governments?
- **National capability:** Are investments building and retaining skilled professionals and institutional capacity within the country?
- **Local economic value:** How much development spending remains in-country through local employment, procurement, businesses, and institutions?
- **Country leadership:** When donors support an evidence-based national plan, does the country have meaningful authority over how development resources are used to implement it — including when external partners are needed, what roles they should play, and how resources are allocated?
- **Quality and comprehensiveness:** Is development assistance supporting high-quality, evidence-based public services capable of addressing countries' actual burden of disease and development needs?
- **Long-term outcomes and fiscal capacity:** Are countries making sustained progress in health, education, poverty reduction and human well-being while increasing their capacity to finance and sustain those gains themselves?

The objective is not to replace existing measures, but to broaden the definition of effectiveness so that what development investments leave behind is measured alongside what they deliver.

Current measurement	Measures that should be added
Project performance	National capability
Organizational performance	Public institution strength
Donor accountability	Country leadership
Outputs delivered	Long-term capacity
Financial compliance	Use and strengthening of national systems
Lives saved	Capacity to sustain and expand health gains
Program expenditures	Economic value retained within partner countries

The same rigor should be applied to the concept of country ownership itself. A program should not be considered country-owned simply because it references a national plan, consults government officials, or is implemented by a local organization. Meaningful ownership requires examining who sets priorities, who controls development resources, who decides how they are used, and whether the investment strengthens the institutions that will remain responsible when external funding ends. Those are measurable questions, and they should become part of how development effectiveness is assessed.

None of this requires waiting for new global data infrastructure to be built. It requires the will and systems to track, publish, and act on data that already exists — and to build the missing pieces deliberately rather than treating their absence as a reason to defer.

6. The roadmap forward

The United States currently has an opportunity to reconsider what its development cooperation program for countries facing the highest levels of poverty and instability should finance, how those investments should be made, and how success should be judged.

The roadmap that follows builds on more than fifteen years of primary research and analysis undertaken under the leadership of Dr. Paul Farmer at the United Nations Office of the Special Envoy for Haiti, the United Nations Office of the Secretary-General's Special Adviser on Community-Based Health and Aid Delivery, and the Science of Implementation Initiative, as well as the principles established through the Paris Declaration, the Accra Agenda for Action, the Busan Partnership, and the New Deal for Engagement in Fragile States, and the evidence presented throughout this report.

Overarching philosophy of this roadmap: Grounded in the notion of accompaniment, development cooperation should support long-term partnerships in which donors and their implementing partners accompany national institutions in pursuing nationally identified priorities, rather than substituting for them.

The first three principles describe what development assistance should finance. The fourth describes how we would know it worked.

PRINCIPLE 1: Finance national plans and strengthen public institutions

Development assistance should finance the implementation of nationally approved plans while strengthening the public institutions responsible for leading their implementation.

Why this matters

Nearly every partner country has already identified its own priorities through national and sector development plans prepared by ministries, public institutions, universities, researchers, and technical experts, often with support from organizations such as WHO, UNDP, UNICEF, the World Bank, and other international partners.

Yet these plans remain chronically underfinanced, while billions of dollars continue to support projects planned and managed outside them.

Financing national plans should also mean country leadership over their implementation. When donors agree to support a credible, evidence-based national plan, public institutions should have meaningful authority over how those resources are used—including when external partners are needed, which partners to engage, what roles they should play, and how resources are allocated.

There may be circumstances in which direct financing through public institutions is not feasible or appropriate. In those settings, development partners should manage risk while remaining aligned with national plans and, wherever possible, work through locally trusted national and local institutions or relevant regional bodies. Alternative arrangements should be designed to preserve and strengthen public capacity over time, rather than allowing temporary workarounds to become permanent parallel systems.

This is distinct from the rare case in which the international community, through a recognized collective process, such as comprehensive multilateral sanctions or the absence of international recognition, has determined that no legitimate national government exists to align with. Those cases are the exception precisely because they rest on broad, structured, multilateral judgment, not a single donor's unilateral political preference.

What this looks like

- Begin with nationally approved development plans.
- Finance the public institutions responsible for carrying them out.
- Invest in the people, systems, infrastructure, equipment, and operating capacity needed for long-term success, not only short-term project activities.
- National institutions determine where NGOs, universities, private firms, and international experts can add value.
- Use financing arrangements that strengthen public institutions over time.

How would we know this principle is being met?

- ✓ National and sector development plans are increasingly financed.
- ✓ Public institutions lead implementation.
- ✓ External partners support nationally identified priorities and nationally led implementation.
- ✓ Institutional capacity strengthens over time.
- ✓ Parallel implementation structures decline.
- ✓ Countries increasingly deliver services through their own public institutions.

PRINCIPLE 2: Strengthen national and local economies

Development assistance should be designed so that investments in health, education, infrastructure, and other national priorities also strengthen national and local economies.

Why this matters

Development assistance is also an economic investment. The same resources used to finance health care, education, infrastructure, and other national priorities can do double duty: delivering essential services while creating jobs, strengthening public institutions, developing professional expertise, supporting national and local businesses, and expanding domestic productive capacity. When more development spending remains within partner countries, its benefits extend beyond the immediate program and contribute to stronger economies and a broader foundation for long-term development.

Not every good or service can or should be sourced locally today. But development investment can help build the infrastructure, workforce, supply chains, and productive capacity that allow countries and regions to provide more of what they need themselves over time.

What this looks like

- Hire nationally and locally whenever possible.
- Procure goods and services within the country whenever feasible.
- Invest in workforce development, universities, and professional training.
- Invest in the infrastructure, supply chains, and productive capacity needed to expand national and regional production over time.
- Measure how much development spending remains in-country through salaries, procurement, institutions, businesses, and other national and local investment.
- Complement development assistance with efforts to expand countries' fiscal space, including through concessional finance and debt relief.

How would we know this principle is being met?

- ✓ A greater share of development spending remains within partner countries and contributes to national and local economic activity.
- ✓ Stable, skilled employment increases.
- ✓ Domestic and regional procurement and productive capacity expand over time.
- ✓ Universities and training institutions produce professionals who can build careers at home.
- ✓ Development investments leave stronger institutions and local economies.
- ✓ Debt service consumes less fiscal space.

PRINCIPLE 3: Invest in comprehensive, high-quality and innovative public services

Development assistance should encourage partner countries to develop comprehensive national plans built on the highest evidence-based standards, not plans constrained by assumptions about what poorer countries can afford.

Why this matters

Development assistance has often favored interventions that are inexpensive, easily measured, and capable of producing rapid results. Many of these investments have produced important results. But they should not define the standard to which partner countries are encouraged to plan. Donors should instead encourage national plans built around the highest evidence-based standards including technological innovations, and support countries in progressively achieving that vision over time.

High-quality public services must evolve as knowledge and technology advance. National systems should be capable of evaluating and incorporating the best available therapeutics, technologies and innovations (including artificial intelligence) rather than leaving people in poorer countries waiting years or decades to benefit from advances available elsewhere. Development partners should actively share new technologies, therapeutics, evidence and innovations with governments, support their incorporation into national plans, and fund their adoption and delivery. That funding should include access to the external technical and private-sector expertise countries may need to evaluate, adapt and implement complex new technologies and therapeutics. The promise of these innovations will only be realized if countries have the capacity to integrate and deploy them at scale. Doing that requires the enabling environment (including what Paul Farmer often described as the "staff, stuff, space, systems and social support") needed to make new approaches part of national systems and ensure their benefits reach populations broadly and equitably.

This changes the question donors should ask about sustainability. Too often, ambitious services in poor countries are dismissed as "unsustainable" because governments cannot finance or deliver them immediately on their own. The better question is not whether high-quality and innovative services are sustainable today, but what investments, institutions, financing and time are required to make them sustainable. Poverty should not affect the standard countries are expected to achieve.

Achieving comprehensive public services does not require a single donor to finance every component. Different partners can support different elements of the same nationally led vision over time.

What this looks like

- Establish evidence-based service standards.
- Incorporate new technologies, therapeutics, and clinical innovations as part of the evidence-based standard — not something reserved for wealthy-country patients.
- Draw on outside technology and technical expertise where the standard requires it —

directed by national institutions, not imposed by donors.

- Invest in the workforce, facilities, technology, and systems needed to achieve them.
- Strengthen quality improvement and accountability.
- Support teaching institutions and research capacity.
- Expand access to specialized as well as primary services.

How would we know this principle is being met?

- ✓ Service quality improves across public systems.
- ✓ Professional capacity expands.
- ✓ Public institutions provide increasingly complex services.
- ✓ Quality gaps between richer and poorer settings narrow.
- ✓ Public confidence in national services grows.

PRINCIPLE 4: Measure what matters

Development cooperation should be evaluated by whether it leaves countries more capable of leading, financing, and sustaining their own development — not only by outputs delivered while external funding was flowing.

Why this matters

What gets measured comes to define what counts as success and that, in turn, shapes what gets funded, studied, and scaled. Donors have become highly effective at measuring immediate results (such as project delivery, organizational performance, lives saved this year) while remaining much less equipped to measure whether development investments are building the institutions and capabilities needed to sustain and expand those gains over time. If long-term institutional strengthening is not measured well, it will continue to lose out to what is.

What this looks like

- **Use of national systems:** Track what share of ODA is channeled through or invested in national systems and public institutions.
- **Alignment and financing:** Measure whether national and sector development plans are adequately financed according to the priorities and needs identified by partner countries.
- **National capability:** Track whether development investments build and retain skilled professionals and institutional capacity within the country.
- **Local economic value:** Measure how much development spending remains in-country through local employment, procurement, businesses, institutions, and investment.
- **Country leadership:** When donors support an evidence-based national plan, measure whether the country has meaningful authority over how development resources are used to implement it — including when external partners are needed, which partners to engage, what roles they should play, and how resources are allocated.
- **Quality and comprehensiveness:** Measure whether development assistance supports high-quality, evidence-based public services capable of addressing countries' actual health and development needs.
- **Long-term outcomes and fiscal capacity:** Track sustained progress in health, education, poverty reduction, and human well-being, alongside countries' growing capacity to finance and sustain those gains themselves.

How would we know this principle is being met?

- ✓ Development investments are evaluated for what they leave behind as well as what they deliver.
- ✓ National plan financing and funding gaps are visible and reported.
- ✓ Institutional capability and public-sector strength become standard measures of development effectiveness.

- ✓ The economic value retained within partner countries is tracked and reported.
- ✓ Country leadership and authority over implementation are measured, not simply assumed from donor alignment.
- ✓ Long-term country outcomes are evaluated alongside project-level results.
- ✓ Long-term institutional strengthening competes on equal footing with short-term delivery metrics in funding decisions.

Many of these measures can be developed from data that already exist; others will require new indicators, partner-country data, and deliberate investment in better measurement.

7. Conclusion: from aid to accompaniment

The dismantling of USAID has created an extraordinary opportunity to reconsider the design of U.S. development cooperation. The question before us is what have recent decades of experience taught us about how development assistance can achieve greater and more lasting impact?

Across Haiti, the West African Ebola response and COVID-19, our research found that enormous amounts of international assistance were delivered while remarkably little was invested directly in the national institutions and economies of the countries the assistance was intended to help. The cases examined here also show that another model is possible: one that combines national leadership with international financing and world-class expertise, while building institutions, workforces and capabilities that remain long after an individual program or grant has ended.

At the heart of the argument is a simple point: the way donors deliver aid is not neutral. Development assistance does more than produce the outputs of the program being funded. It also shapes institutions, workforces, economies, incentives and the capacity of countries to deliver for their own populations.

This matters for how we think about effectiveness. A targeted intervention may deliver impressive results quickly and at low cost. But it does not, by itself, tell us whether it was the best use of development resources. The intervention is not the only unit of analysis. We also need to ask what that investment did to the country's capacity to sustain and expand those gains; what institutions, infrastructure and human capabilities it helped build; what economic value remained in the country; and what a different use of the same resources might have made possible over time.

This is why the distinction between achieving results today and strengthening systems for tomorrow is ultimately a false one. The short-term intervention is already affecting the long-term system. A development investment can meet an urgent need today while also building the workforce, infrastructure, institutions and systems that will meet that need tomorrow. Development cooperation should be designed to do both, and its effectiveness should be measured accordingly.

The same logic should shape how development cooperation responds to scarcity. Resources are finite, and governments and donors will always have to make difficult choices about priorities and sequencing. But scarcity should not become the organizing principle of what poorer countries are expected to achieve. The ambition should be to help countries build toward comprehensive, high-quality services based on the best available evidence, technology and expertise, recognizing that getting there will take time and that no single donor can or should finance everything.

National plans provide a practical way to organize that effort. They allow countries to establish priorities, make choices and take responsibility for delivering them, while drawing on the best ideas and expertise available globally. They also provide donors with a clear framework for deciding what they will fund and for measuring progress against agreed goals. Country ownership does not mean countries should be left to manage alone. International partners will continue to have essential roles providing financing, technical expertise, innovation, accountability and long-term accompaniment. The question is whether those resources are organized around strengthening a country's ability to lead and deliver, or around structures that continually substitute for it.

This approach is not naïve about the challenges. Governments differ enormously in capacity, governance and political will. National plans vary in quality. Some settings will require more safeguards, more technical assistance and more gradual transitions than others. But the existence of difficult cases cannot justify an architecture built around bypass as the default. The appropriate response to weak institutions is to manage risk while helping strengthen them, because ultimately there is no sustainable alternative to capable national institutions.

In the language of the human rights-based approach to development, states are the primary "duty-bearers" to their populations, the actors with the formal, structural obligation to progressively realize the rights and services their citizens are owed. No government fulfills that obligation perfectly, and public institutions in the poorest countries too often do not have the resources, staff, and systems they need to meet it. But governments remain the only actors in the system carrying that duty at all, however imperfectly it is discharged in practice. International NGOs, philanthropies, and donor governments can bring real expertise and genuine commitment to the populations they serve. But good intentions are not a substitute for accountability, and a system of development cooperation cannot be built on the former in place of the latter.

Organizing development investments around this roadmap could also significantly reduce the cost of delivering aid. If development assistance primarily went toward financing nationally approved plans and strengthening the public institutions responsible for carrying them out, much of the parallel apparatus that currently exists to decide what should be funded and how could be substantially reduced. Donors would still play key roles in evaluation, technical assistance, accountability and accompaniment. But the assessments, strategy papers, planning processes, and program design structures that effectively duplicate decisions already made through national processes would become far less necessary. The Center for Global Development recently examined how moving more service delivery into national systems within PEPFAR might reduce costs and estimated potential overall savings of approximately 40 percent, based on efficiencies across administration, management, service delivery, and other program costs.[38]

[38] Rachel Bonnifield and Janeen Madan Keller, "Tough Times, Tough Choices: Charting PEPFAR's Next Chapter While Safeguarding Its Legacy," Center for Global Development, November 14, 2025.

Recent changes in U.S. global health policy may provide an important opportunity to test elements of this approach in practice. Under the 2025 America First Global Health Strategy, the United States has begun entering into five-year bilateral health cooperation agreements with partner-country governments that seek to increase country ownership, domestic co-investment, and responsibility for delivering health services over time. This represents a significant shift from previous U.S. practice toward greater government-to-government partnership and national responsibility. The agreements are still new and differ in important respects from the broader approach proposed in this report, but their increased emphasis on government-to-government partnership and national responsibility is consistent with important elements of the principles outlined here. Their implementation and results will be important to assess and track over time.[39],[40]

Supporting nationally led development means that donors will have to share more control, accepting less attribution and taking a longer view of impact. It may mean investing in institutions whose success cannot be captured within a single grant cycle. It should also mean reducing the parallel structures created to assess needs, design programs, hire staff, procure goods and manage services outside the institutions ultimately responsible for doing those things.

This is the idea behind accompaniment. It describes a partnership in which international resources and expertise help countries pursue ambitious, nationally determined goals while progressively building the institutions and capabilities to carry them forward. It recognizes that development is ultimately a long-term process of building societies and institutions capable of improving the lives of their own people.

As the United States reconsiders its approach to development cooperation, the opportunity is larger than deciding which programs or institutions from the old architecture should be preserved or rebuilt. It is an opportunity to ask a more fundamental question about what development assistance is ultimately trying to accomplish.

If its purpose is development, then success cannot be measured only by what outside assistance delivers while it is there. It must also be measured by what countries are increasingly able to deliver when it is not.

[39] U.S. Department of State, “America First Global Health Strategy,” September 2025.
[40] KFF, “KFF Tracker: America First MOU Bilateral Global Health Agreements,” updated July 1, 2026.

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Abbey Gardner's work spans development finance, global health and institution-building in low-income and fragile states. For more than fifteen years, she has led research tracking how international development assistance is financed and delivered, with a particular focus on whether those investments strengthen the public institutions and economies of the countries they are intended to support.

She served as a Senior Policy Adviser in Dr. Paul Farmer's United Nations office as well as in the United Nations Office of the Special Envoy for Haiti under President William J. Clinton. While at the UN, she and her colleagues tracked international financing following the 2010 Haiti earthquake, cholera outbreak, and the West African Ebola epidemic, producing datasets and analyses used by the United Nations, policymakers and international media to understand where development resources were actually going. She later served as Executive Director of the Science of Implementation Initiative, founded by Dr. Farmer, and co-authored research on global COVID-19 financing published in The Lancet in 2025. She was also co-editor of Dr. Farmer's *Haiti After the Earthquake*.

Earlier in her career, Gardner served as Regional Director for Russia at the Open Society Foundations, where she oversaw development and public health initiatives across Russia and the former Soviet Union, including work that contributed to the reform of World Health Organization treatment guidelines for multidrug-resistant tuberculosis and expanded access to treatment. She was also the founding Executive Director of the Baltic-American Partnership Fund, a public-private partnership of the Open Society Institute and USAID created to strengthen civil society and democratic institutions in the post-Soviet Baltic states.

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Jonathan Glennie is Founder and Director of the Global Cooperation Institute and an internationally recognized expert on development cooperation and development finance. His work focuses on the changing role of international cooperation, including new approaches to development finance, global public investment, and the relationships among governments, international institutions, civil society, and the private sector.

He previously served as a Research Fellow at the Overseas Development Institute (ODI), where he led research and policy advice on the future of development cooperation, and was a regular columnist for *The Guardian*'s Global Development section. He advises governments and international organizations on development strategy and policy and is the author of *The Future of Aid: Global Public Investment* (2021) and *The Trouble with Aid: Why Less Could Mean More for Africa* (2008).