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How Does International Aid Effect the Local Development of Recipient Countries?

The Impact of Italian External Intervention on Mozambique's Health System: The UR-Beira Project

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Riassunto

"Costruire un mondo più giusto e più sano per tutti, ovunque" (Giornata Mondiale della Salute 2021) e raggiungere una copertura sanitaria universale entro il 2030 costituiscono priorità fondamentali per la comunità internazionale. Infatti, l'Organizzazione Mondiale della Sanità (2007) afferma che sarà impossibile raggiungere obiettivi globali, inclusi gli Obiettivi di Sviluppo Sostenibile (SDG), se non verranno attuati investimenti efficaci e appropriati nei sistemi e nei servizi sanitari. Tuttavia, questi obiettivi ambiziosi non possono essere raggiunti senza prendere in considerazione e affrontare le gravi e persistenti disuguaglianze nell'accesso ai servizi sanitari paesi. A questo proposito, va sottolineato che, anche se molte sfide sanitarie sono condivise tra diversi sistemi sanitari e regioni, la maggior parte dei paesi in via di sviluppo è ancora afflitta da indicatori sanitari inaccettabilmente bassi. In effetti, problemi come l'invecchiamento della popolazione, le malattie non trasmissibili e l'attuale pandemia Covid-19 stanno colpendo tutti i paesi, nonostante il loro livello di sviluppo e ricchezza. Tuttavia, la differenza sta nel modo in cui le nazioni sono in grado di rispondere a queste sfide, rendendo fondamentale il ruolo del sistema sanitario e il suo legame con il contesto economico, sociale e politico, determinante per la natura e l'efficacia delle risposte (OMS , 2007).

Per ciò che concerne l'equo accesso ai servizi sanitari, le principali differenze tra paesi sviluppati e paesi in via di sviluppo sono date dalle molteplici barriere che i pazienti devono affrontare per accedere alle cure in termini di disponibilità, accessibilità economica e accessibilità geografica (Ragazzoni et al., 2021), mancanza di personale qualificato e scarsa qualità di servizi sia in termini di infrastrutture che di trasporti, insieme ad una scarsa consapevolezza dei cittadini. Inoltre, la situazione è ulteriormente aggravata dai conflitti armati e dai disastri naturali che continuano a mettere a dura prova i sistemi di erogazione delle cure di emergenza (Obermeyer et al., 2015). Tutti questi problemi portano a tassi di morbilità e mortalità più elevati nei paesi a basso reddito, e in particolare nelle comunità rurali (Caviglia et al., 2021).

A tal proposito, il contesto più critico è dato dai paesi dell'Africa subsahariana, caratterizzati dal più basso indice di copertura sanitaria universale (UHCI = 42) e dal più basso accesso ai servizi sanitari di base (25%) (Vera Cruz et al., 2021). Le ragioni principali della criticità caratterizzante questi indicatori sono date dalla carenza di operatori sanitari e dalla difficoltà di accesso ai servizi sanitari. Di conseguenza, la regione è afflitta da un elevato carico di malattie

e da un'elevata mortalità materna e neonatale, che restano una priorità sanitaria irrisolta nei paesi a basso reddito (Accorsi et al., 2017). In effetti, ci sono disparità allarmanti nella mortalità materna e infantile tra paesi e tra regioni urbane e rurali (Nazioni Unite, 2013). Questo è il motivo per cui la loro riduzione a livello mondiale è inclusa tra gli obiettivi di sviluppo sostenibile da raggiungere entro il 2030.

Nel tempo, e sempre di più a causa della pandemia, queste vulnerabilità che affliggono i paesi a basso e medio reddito hanno reso evidente l'importanza di rafforzare i sistemi sanitari e di ridurre le disuguaglianze esistenti a livello mondiale. Ecco perché, ora più che mai, i contributi di assistenza allo sviluppo diretti al rafforzamento dei sistemi sanitari rappresentano un investimento cruciale per la sicurezza sanitaria globale (Micah et al., 2021). Infatti, come afferma l'Organizzazione Mondiale della Sanità (2007), il ruolo dell'assistenza allo sviluppo per la salute è fondamentale al fine di garantire interventi sanitari e quindi migliori indicatori sanitari per le popolazioni più bisognose. Una forte collaborazione è quindi essenziale per affrontare le enormi sfide che affliggono soprattutto i paesi più poveri, e in particolare la regione dell'Africa subsahariana, caratterizzata da scarsi indicatori sanitari e risorse sanitarie.

A questo proposito, la pandemia potrebbe rappresentare un momento di svolta per gli investimenti nei servizi sanitari, sia a livello interno che internazionale. Tuttavia, il miglioramento della qualità degli aiuti dovrebbe venire prima dell'aumento della loro quantità (Chong et al. 2009), garantendo che gli aiuti siano efficaci per affrontare le attuali sfide allo sviluppo. Infatti, come affermano Bräutigam e Knack (2004), gli aiuti dovrebbero essere erogati in modo più selettivo e con lo scopo di rafforzare un circolo virtuoso di sviluppo, piuttosto che contribuire a un circolo vizioso di malgoverno e declino economico che affliggono la maggior parte dei paesi in via di sviluppo. Il sostegno dei donatori dovrebbe essere destinato tenendo in considerazione che ogni paese si è sviluppato in un contesto diverso. Gli aiuti dovrebbero quindi rispondere in primo luogo alle agende e alle priorità dei paesi. Considerando il caso specifico degli aiuti sanitari, ciò aiuterebbe i paesi riceventi a implementare il sostegno in modo efficiente e sostenibile nel lungo periodo e di conseguenza a gestirlo in modo indipendente.

Considerando il caso specifico italiano, la Legge 125/2014 definisce la Cooperazione allo sviluppo come parte integrante e qualificante della politica estera italiana. L'obiettivo è quello di promuovere uno sviluppo equilibrato nelle aree di intervento e una crescita economica equa, mediante azioni di rafforzamento delle autonome risorse umane e materiali (AICS, 2020).

L’azione dell’Italia nell’ambito della cooperazione allo sviluppo ha come destinatari le popolazioni, le organizzazioni e le associazioni civili, il settore privato, le istituzioni nazionali e le Amministrazioni locali dei Paesi partner, individuati in coerenza con i principi condivisi nell’ambito dell’Unione europea e delle organizzazioni internazionali di cui l’Italia è parte (ibid.).

Proprio in questo quadro di cooperazione italiana si colloca il progetto UR-Beira, che rappresenta un'importante iniziativa finanziata dall'Agenzia Italiana per la Cooperazione allo Sviluppo (AICS) nell'ambito del suo bando relativo alla “Promozione dei Partenariati Territoriali e implementazione territoriale dell'Agenda 2030”. Capofila e partner promotore è la Regione Veneto, che ha dato vita al partenariato formato da attori locali sia mozambicani che italiani: l'Ospedale Centrale di Beira, il Servizio Distrettuale per la Salute e l'Azione Sociale delle Donne (Serviço Distrital de Saúde, Mulher e Acção Social da cidade da Beira), il Servizio Medico di Emergenza in Mozambico (Serviço Medico de Emergencia em Moçambique), Medici con l'Africa Cuamm, la Croce Verde di Padova e l’Università Ca' Foscari di Venezia. Il progetto mira a potenziare i servizi di emergenza sanitaria gestiti dalle autorità locali nel distretto di Beira (Mozambico), con un particolare focus sulle emergenze ostetriche e pediatriche, al fine di contribuire alla riduzione della mortalità e morbilità legate alle emergenze mediche. In particolare, il progetto mira a promuovere un maggiore accesso ai servizi sanitari di emergenza offerti dall'Ospedale Centrale di Beira e dai centri sanitari ad esso collegati, attraverso l'adozione di un modello centralizzato di gestione dell'emergenza approvato dal distretto e dalle autorità nazionali.

L'attenzione è posta in particolare sull'assistenza alla maternità e all'infanzia perché, insieme ai servizi di assistenza ai pazienti affetti da HIV, rappresentano i settori più critici di un sistema sanitario, in particolare nel contesto della regione dell'Africa subsahariana. Infatti, la resilienza e l'efficacia di un sistema sanitario sono date principalmente dalla sua capacità di offrire servizi sanitari alle donne in gravidanza, ai bambini e ai pazienti affetti da HIV, gruppi più vulnerabili che contribuiscono ad un elevato carico di morbilità e mortalità nel Paese (Nyasulu et al., 2020).

Il progetto UR-Beira affronta un'altra criticità del Sistema Sanitario Nazionale del Mozambico, ovvero lo sviluppo di un sistema di pronto intervento. In effetti, una delle maggiori sfide in molti contesti rurali è rappresentata dalla scarsità di cure di emergenza e, ove presenti, dalla distanza e dal tempo per accedere a servizi appropriati (Kironji et al., 2018). Questi deficit

verranno superati grazie alla dotazione di un nucleo di ambulanze e attraverso l'installazione di un modello centralizzato di gestione dell'emergenza. L'obiettivo principale è quindi quello di consentire alle autorità regionali e locali di migliorare la governance e l'impatto sullo sviluppo e affrontare meglio le disparità all'interno del paese.

L'obiettivo di questa tesi è quello di analizzare l'impatto di questa iniziativa sul contesto locale, prendendo in considerazione sia i risultati attesi che quelli effettivi delle attività realizzate. Precedenti studi (Plsek et al., 2001; Denis et al. 2002; Coker et al. 2004; Atun et al. 2007) evidenziano come l'adozione e la diffusione di innovazioni nei sistemi sanitari siano influenzate dalla natura e dalla complessità dell'intervento e da come viene percepito dai paesi riceventi (Foy et al. 2002). Verranno quindi presi in considerazione tutti questi elementi per analizzare l'implementazione e gli effetti del progetto UR-Beira sulla comunità locale, tenendo presente che questi elementi si estendono al di là del sistema sanitario e sono strettamente legati al contesto di cui il sistema sanitario fa parte.

Il supporto dato dal progetto UR-Beira al sistema sanitario mozambicano è fondamentale. Infatti, l'iniziativa supporta le principali priorità strategiche del Mozambico relative alla salute, ovvero rafforzare il sistema sanitario garantendo un accesso equo crescente ai servizi sanitari e costruire una migliore capacità di gestione nel settore della salute pubblica (OMS, 2018). Il progetto UR-Beira affronta queste sfide fornendo il supporto per costruire un servizio di emergenza centralizzato, un nucleo di ambulanze, formazione per il personale sanitario e infine un'analisi costo-efficacia dell'implementazione di questi servizi. Tutte queste azioni saranno svolte tenendo presente che una volta terminato il programma, saranno le ASL e le autorità locali a gestire e mantenere il servizio. Ciò porterà a una capacità a lungo termine e sostenibile di fornire cure adeguate e tempestive ai pazienti e quindi ridurre sostanzialmente sia i tassi di mortalità che di morbilità.

Anche in un paese colpito da calamità naturali e conflitti protratti come il Mozambico è quindi possibile ottenere un'assistenza sanitaria di qualità a tutti i livelli. Si tratta ovviamente di un obiettivo complesso, in quanto per assicurare un aumento dello stato di salute dei mozambicani non basta un miglioramento del solo settore sanitario (Garrido, 2020). Essa, infatti, dovrebbe essere accompagnata dall'attuazione di politiche economiche e sociali volte a ridurre i livelli di povertà, nonché le disuguaglianze economiche e sociali.

Queste sfide sono affrontate dal progetto UR-Beira, che mira a rafforzare l'assistenza sanitaria in Mozambico, in particolare nel distretto di Beira. In questo caso, l'aiuto allo sviluppo per la salute avrà effetti significativi sulla salute della popolazione, in particolare per quanto riguarda i casi ostetrici e pediatrici. Tuttavia, i guadagni derivanti dal progetto beneficeranno non solo i settori sanitari, ma anche le strutture economiche e sociali del Paese. L'iniziativa, infatti, ha coinvolto fin da subito la comunità locale, valorizzandone le competenze tecniche e gestionali. Le attività di sensibilizzazione, inoltre, daranno a tutta la popolazione l'opportunità di entrare effettivamente a far parte del progetto, rafforzando ulteriormente il concetto di cooperazione, che potrebbe essere ulteriormente applicato ad altri settori che necessitano una riorganizzazione. Proprio per questo, le iniziative di aiuto internazionale come il progetto UR-Beira, se opportunamente attuate, sono fondamentali per affrontare le disuguaglianze e rendere i servizi sanitari più equi ovunque e per tutti, favorendo maggiore inclusione e la riduzione del divario tra paesi sviluppati e in via di sviluppo.

Abstract

The most stated goals of Official Development Aid (ODA) programmes are the eradication of poverty and the reduction of income disparities. Yet, after seventy years of foreign aid, most of the world still lives in chronic poverty and malnutrition. A direct link to this issue regards the fragile nature of developing countries' health systems. This, especially in Sub-Saharan Africa, further undermines the situation of the region, complicated by economic crisis, ethnic tensions, civil wars, and political instability. Therefore, Development Assistance for Health (DAH) has significantly increased over the last four decades, rendering development assistance an important source of health financing in many low-income countries. However, despite its noble declared intentions, the effectiveness and the role of ODA in reducing poverty and enhancing well-being remains controversial. The success of DAH is also questioned, as there are concerns that global health initiatives might affect health systems adversely. Thus, the intention of this thesis is to examine the effects of international aid on the local development of recipient countries. In particular, the focus will be on the impact of Italian external intervention on Mozambique's health system, using as case study the UR-Beira project, which aims at strengthening emergency health services managed by local authorities in the district of Beira (Mozambique).

Introduction

"To build a fairer, healthier world for everyone, everywhere" (World Health Day 2021) and achieve universal health coverage by 2030 constitute fundamental priorities for the international community. Indeed, the World Health Organization (2007) claims that it will be impossible to achieve global goals, including the Sustainable Development Goals (SDGs), unless effective and appropriate investments in health systems[1] and services are implemented. However, these ambitious objectives cannot be reached without taking into consideration and addressing the grave and persisting inequalities as far as access to health services across regions and countries. Under this regard, it is important to note that, even if many health challenges are shared across different health systems and regions, the majority of developing countries is still afflicted by unacceptably low health outcomes. Indeed, issues like aging populations, non-communicable diseases and the current Covid-19 Pandemic are affecting all countries, irrespective of their level of development and wealth. However, the difference lies in the way in which nations are able to respond to these challenges, rendering the role of the health system fundamental and its link with the economic, social and political context, determinant for the nature and effectiveness of the response (WHO, 2007).

The major differences between developed and developing countries regarding an equitable access to healthcare services are given by the multiple barriers that patients must overcome to access care in terms of availability, affordability, and geographical accessibility (Ragazzoni et al., 2021). Further obstacles include the lack of skilled medical staff and poor service quality both in terms of infrastructures and transportations, together with poor citizens' awareness. What is more, the situation is further worsened by armed conflicts and natural disasters that continue to strain systems when it comes to the provision of emergency care (Obermeyer et al., 2015). All of these issues lead to higher morbidity and mortality rates in low-income countries, and especially in rural communities (Caviglia et al., 2021).

[1] In todays' complex world, it is difficult to give an exact definition of what a health system is. However, the World Health Organization (2000) defines an health system as "all the activities whose primary purpose is to promote, restore or maintain health.

On this point, the most critical context can be seen in sub-Saharan African countries, which are characterized by the lowest Universal Health Coverage Index (UHCI = 42) and lowest access to basic health care services (25%) (Vera Cruz et al., 2021). The main reasons of these critical indicators are given by the shortage of health professionals and by the difficulty to access health services. Consequently, the region is tormented by a high burden of disease, substantially constituted by maternal and neonatal mortality, which remain an unsolved health priority in low-income countries (Accorsi et al., 2017). Indeed, there are alarming disparities in maternal and child deaths among countries, and between urban and rural regions (United Nations, 2013). This is the reason why reducing this phenomenon worldwide is included among the sustainable development goals to be reached by 2030.

Over time, and even more due to the pandemic, these vulnerabilities afflicting low- and middle-income countries have highlighted the importance of strengthening health systems and of narrowing the existing inequalities globally. Hence, now more than ever before, development assistance contributions directed towards the strengthening of health systems is a crucial investment for global health security overall (Micah et al., 2021). Indeed, as the World Health Organizations (2007) claims, the role of development assistance for health[2] is fundamental for ensuring health interventions and thus better health outcomes to populations in need. A strong collaboration is therefore essential to face the huge challenges afflicting especially the poorest countries, and particularly the Sub-Saharan African region, which is characterized by low health outcomes and health resources.

Considering the specific case of Italy, The Law 125/2014 defines Development Cooperation as an integral and qualifying segment of Italy's foreign affairs and has stated the potential goals and objectives, and they are: eradicate poverty and reduce disparities, improve the living conditions of the populations and promote sustainable development; safeguard and confirm human rights, the dignity of the individual, gender equality, equal opportunity for all and the principles of democracy and of the rule of law; prevent conflicts, support processes of peace, reconciliation, post-conflict stabilisation, consolidation and strengthening of the democratic institutions.

[2] Development assistance for health (DAH) refers to resources transferred from primary development channels to low-income and middle-income countries for the purpose of maintaining or improving health.

The aim, therefore, is to realise a more balanced global development plan that will promote an equal economic growth and a balanced development of the areas of intervention, through actions which would strengthen autonomous human resources and materials (AICS 2020). Italy's role in the context of development cooperation is to reach the populations, organisations and civil associations, the private sector, the national institutions and local administrations in the partner countries, which have been identified according to the shared principles outlined in the context of the European Union and of the international organisations Italy belongs to (ibid.).

Therefore, the UR-Beira project can be placed within this framework of Italian cooperation, as it represents an important initiative financed by the Italian Agency for Development Cooperation (Agenzia Italiana per la Cooperazione allo Sviluppo, AICS). It responds to the requirements of the call related to the promotion of territorial partnerships and of the territorial implementation of the 2030 Agenda ("Promozione dei Partenariati Territoriali e implementazione territoriale dell'Agenda 2030"). The Veneto Region is the leading and proponent partner, and it created the partnership consisting of both local Mozambican and Italian actors: the Central Hospital of Beira, the District Service for Women's Health and Social Action (*Serviço Distrital de Saúde, Mulher e Acção Social da cidade da Beira*), the *Serviço Medico de Emergência em Moçambique* (SEMMO), Doctors with Africa CUAMM, Padova Green Cross and Ca' Foscari University of Venice. The project aims at strengthening emergency health services managed by local authorities in the district of Beira (Mozambique), with a particular focus on obstetric and paediatric emergencies, contributing to the reduction of mortality and morbidity related to medical emergencies. Specifically, the project aims to promote greater access to quality emergency medical services offered by the Central Hospital of Beira and by health centres in its catchment area, through the adoption of a centralised emergency management model endorsed by the district and national authorities.

Above all, focus is placed on maternity care and child-care because, along with HIV services, they represent the most critical markers for the strength of a health system, particularly in the context of the Sub-Saharan African region (Nyasulu et al., 2020). Indeed, the resilience and effectiveness of a health system is mainly given by its ability to offer healthcare services to pregnant women, children and people with HIV, as they are more vulnerable groups who contribute to a high burden of morbidity and mortality in the country (ibid.).

The UR-Beira project addresses another critical issue in the Mozambican National Health System, that is to say the development of an emergency care system. In fact, one of the biggest challenges in many rural low resource settings is represented by "the scarcity of emergency care, and where present, the distance and time to access appropriate services" (Kironji et al., 2018). This obstacle will in fact be bypassed thanks to the provision of a nucleus of ambulances and through the provision of a centralised emergency management model. The main objective is thus to give regional and local authorities the opportunity to improve the governance and impact on development and to face and overcome the disparities within the countries in the best possible way.

The aim of this thesis is to analyse how this initiative is impacting the local context, taking into consideration both the expected and effective outcomes of the activities implemented. Previous studies (Plsek et al., 2001; Denis et al. 2002; Coker et al. 2004; Atun et al. 2007) highlight how the adoption and the diffusion of innovations in health systems are influenced by the nature and complexity of the intervention and by how it is perceived by the adopters (Foy et al. 2002). This last point is also considered in terms of the prevailing cultural norms, beliefs and values of the key actors and institutions within the adoption system (Atun et al. 2007). I will thus consider all these elements in order to analyse how the UR-Beira project has been implemented and has impacted the local community, bearing in mind that these elements extend beyond the health system and are intricately linked to the context within which the health system is embedded.

The main insight stemming from my analysis is that the UR-Beira project, thanks to its training activities and the involvement of local actors as main partners of the initiative, constitutes a good example in order to overcome two of the main issues deriving from the high flow of international aid: aid dependence and lack of the opportunity to learn. This will allow the local community to autonomously overcome the barriers related to availability, geographical accessibility and transportation infrastructure and thus to provide the population with an equitable access to healthcare services.

After this brief introduction, chapter 1 generally looks into the issue of Western development aid, with a particular focus on health aid. Chapter 2 deals with the description of the specific case of Italian foreign aid and Italian Official Development Assistance for Health. In section 3, I have provided contextual issues related to Mozambique's need for external intervention.

Finally, the description and effects' analysis of the UR-Beira project and of Italian Official Development Assistance for Health are explained in Chapter 4.

I would also like to mention that this thesis was supposed to be based upon an analysis of the UR-Beira project developed thanks to my presence in the city of Beira. However, due to the project timing, this was unfortunately not possible. Therefore, this dissertation stands as a discussion of the project based on its own design and goals, rather than on the actual situation on the ground. Nonetheless, I was able to consider the local community's positive feedback about the first stages of the project thanks to online meetings, which have resulted to be a very constructive exchange between all parties.

1. The Issue of Western Development Aid

For the aim of this thesis, it is first of all important to discuss the role of international aid in developing countries. To do so, after having considered its meaning and origins, the first chapter outlines the main driving forces of development aid. Under this regard, the key concept to keep in mind is that the allocation of aid is influenced both by donors' strategic interests and by recipients' needs and merits. The core purpose of this chapter is to explain the reasons behind the debate on aid effectiveness, originated as a consequence of the numerous issues stemming from the high flow of international aid, with the main one being dependence. It must be highlighted that, throughout the whole chapter, particular attention will be placed on Sub-Sahara Africa, as it is the region receiving the largest proportion of international aid. Finally, the focus will be shifted on health aid, considering the main donor institutions and programs and their impact on developing countries.

Development is a complex and variegated process. For this reason, Western development aid[3] has always played and continues to play a significant role in those developing countries lacking the knowledge and the resources to address challenges effectively (Helleiner, 2000). The most stated goals of donors' foreign aid programmes are the eradication of poverty and the reduction of income disparities. Yet, after seventy years of foreign aid, most of the world still lives in chronic poverty and malnutrition. In fact, according to a 2020 report by the U.N. Development Programme, 1.3 billion people in 107 developing countries are multidimensionally poor[4].

Commonly known as foreign aid, Official Development Assistance (ODA) is defined by the Organisation for Economic Co-operation and Development as government aid that promotes and specifically targets the economic development and welfare of developing countries. Foreign aid includes loans, grants and technical assistance on concessional financial terms with

[3] There is the tendency to refer to development aid as being strictly "Western". This is because the major official development assistance actors are Western international institutions, States, local authorities, development agencies and banks (e.g. the World Bank, the United Nations agencies, the European Union). However, at the regional level, regional development banks also play an important role (e.g. African Development Bank, Asian Development Bank and Inter-American development Bank).

[4] The Global Multidimensional Poverty Index (MPI) looks beyond income to understand how people experience poverty in multiple and simultaneous ways. It identifies how people are being left behind across three key dimensions: health, education and standard of living. People who experience deprivation in at least one third of these weighted indicators fall into the category of multidimensionally poor.

the objectives of reducing poverty and promoting economic development in developing countries (Younas, 2008).

Despite its noble declared intentions, the effectiveness and the role of aid for reducing poverty and enhancing well-being remains controversial and questioned. This is due to the fact that economists and political scientists over the years have explained that the allocative patterns of donor aid and their determining factors not only have been altruistic motives, but certainly also various strategic concerns have been shown to play a part in shaping donors allocative motives and decisions (Helleiner, 2000). Also significant past literature on aid allocation concludes that rather than development objectives, actually what play a dominant role in aid allocation decisions are the political, economic and strategic interests of donors (McKinlay and Little, 1977, 1979; Maizels and Nissanke, 1984; Dowling and Hiemenz, 1985; Svensson, 1999; Neumayer, 2003).

Under this regard, the following statement in the Human Development Report of the United Nations Development Program (2005) is worth noting: "International aid is one of the most powerful weapons in the war against poverty. Today that weapon is underused and badly targeted. There is too little aid and too much of what is provided is weakly linked to human development" (UNDP, 2005). Indeed, instead of preferring policies consistent with reducing poverty and inequality in developing countries, giving countries may instead prefer policies linked to considerations either of national security (the country may be a military partner) or of domestic politics (aid giving may be popular for voters without regard to its actual effectiveness) (Chong et al., 2009).

1.1 Brief History

The following section will outline the main phases and models of development aid throughout history, particularly between the 1950s and the 1990s (as introduced by table 1, page 13). The different stages of international aid are characterized by specific theories and instruments implemented by donor countries. In addition, the evolution of the development doctrine will be linked to a macro-economic analysis of the role and impact of international aid. Therefore, this section will provide the contribution given to the literature by Arthur Lewis and Walt Whitman Rostow.

Table 1: Historic overview of development aid

Time period	Phase	Actors	Instruments	Content
1950s	Post-WW II reconstruction in Europe	US and Europe	Marshall Plan	Transfer of resources to finance Europe's development
Late 1950s	Cold War	US + Third World	Modernization Theory	Industrialization as key factor for development
1960s	Cold War	Mainly US and USSR + developing countries	Aid programs in partnership	"Self-help"
1970s	Widespread poverty	Western donors + developing countries	Basic Needs Approach	Raising the standard of living of the poor
1980s	Debt crisis	IMF, WB + developing countries	Conditionality linked to programme lending	Aid in exchange for reforms in the direction of trade liberalisation, deregulation and privatisation
1990s	End of the Cold War	Western countries + developing countries	Aid towards social infrastructures and services	"Aid fatigue"

Foreign aid as an institution began in 1947 with the Marshall Plan, and almost immediately, concerns arose over the impact of large amounts of aid on the behaviour and attitudes of recipient governments (Bräutigam and Knack, 2004). The European Recovery Plan, promoted by the United States, had the aim of transferring resources to Europe in order to finance its reconstruction and development after the end of the Second World War. The growth of Europe as a market would also mean opportunities for the United States, as the country could gain a

chance to find a final market for its products. However, the main fear was that European countries were relying too much on external funding and not independently mobilizing resources for their recovery. According to the correspondence of a State Department official to the US team negotiating the terms of the plan in Paris, "too little attention is being paid by the participants to the elements of self-help".

In the 1960s foreign aid started to expand beyond Europe, towards developing countries. As aid programs grew in importance, the issue of "self-help" soon became the focus of practitioners, who began to emphasize that foreign aid must involve partnership instead of dependence (ibid.). As a matter of fact, in a 1966 article in Foreign Affairs, David Bell argued that "there "…" [was] a strong consensus that foreign aid in all its forms will produce maximum results only in so far as it is related to maximum self-help". In the 1970s, as a consequence of the deficiency of self-help affecting developing countries, scholars first coined the term "aid dependence" to a set of institutional problems that seemed to be affecting countries receiving large amounts of aid, as Bangladesh and Malawi. These researchers warned again that high levels of aid could lead to specific kinds of dependence problems.

Since the 1970s, aid flows have represented a relatively constant share of the growing GNP of the donor community and continued to grow in real terms until the early 1990s. However, international aid started to fall both absolutely and as a share of donor GNP after 1990 (Chong et al., 2009). This decline in aggregate aid flows can be attributed to a number of causes. As Helleiner claims, aid given on ideological grounds diminished as a result of the fall of communism. What is more, with the end of the cold war, while national security motives were still relevant in Israel, Egypt and parts of former Yugoslavia, aid to countries in Asia and Africa attracted less support. The traditional support of development aid by liberal groups has been eroded also by competition from other concerns, notably the environment. But the major issue was the so-called "aid fatigue", caused by the growing scepticism towards bilateral and multilateral aid agencies and by the widespread perception that aid has been ineffective in fostering growth (Helleiner, 2000).

It is also important to consider the conception of the role of aid under a macro-economic point of view, which evolved in parallel with the evolution of the development doctrine. In fact, in the 1950s, the role of aid was seen mainly as a source of capital to trigger economic growth through higher investment (ibid.). This was in line with the development approach conducted

by Arthur Lewis (1915-1991), who claimed that economic development is determined by the capacity of accumulating capital by a part of the population. Under this perspective, economic development could not take place if the capitalist class was not able to save enough to generate investment and growth. In the same period, also Walt Whitman Rostow (1916-2003) put economic growth at the centre of his theory of development. With his "Stages of Economic Growth" (1959), Rostow claimed that all developing countries were destined to have the same process of economic growth experienced by the first industrialising countries. For this reason, Rostow became the figure associated with the "modernization theory", according to which modernity and development were merely a consequence of industrialization. Consequently, the aim was to identify a universal recipe[5] that could be applied also to Third World countries with the aim of modernizing them. This theory was at the core of Western development aid for most of the cold war and continues to be very influential nowadays. But actually, poor nations have an incredible variety of institutions, cultures and histories. Thus, the idea of aggregating all this diversity into a developing world that will "take-off" with foreign aid is a "heroic simplification" (Chong et al., 2009).

During the 1960s the focus of foreign assistance was still on economic growth. In fact, the aim was that of removing a savings deficiency through an increased flow of foreign savings or of balancing the deficit in the current account of the balance-of-payments by providing the necessary foreign exchange (Helleiner, 2000). A major change in the role of international aid was reached in the 1970s, when the primary objective of foreign assistance became the one of raising the standard of living of the poor, especially through increased employment (ibid.). This new approach was moved by the evidence of widespread poverty, particularly in the third world. The main development theory following this line of thought was the Basic Needs Approach (BNA), which put emphasize on the need to distinguish the mere process of growth of GDP from the process of development, considered to be more closely connected with human needs.

[5] During the 1950s and 1960s, the British process of industrialization became a template for theories on development. This is because the United States needed an alternative theory to the Soviet vision of modernization, as the USSR moved itself from being a backward country to a superpower and industrialized country. In the US on the contrary, there was no central planning nor an ideology as solid as Marxism. Thus, between the 1950s and the 1960s, many universities set up centres of studies, mainly led by sociologists, focused on elaborating a recipe to modernize that could be offered to the third world. This is how the modernization theory originated.

In the 1980s, with the advent of the debt crisis[6], the role and conception of aid changed once again in a major way. The primary purposes of aid became both to act as a stop-gap measure to salvage the shaky international financial system and also to encourage the implementation of appropriate adjustment policies in third world countries through conditionality attached to programme lending (Helleiner, 2000). The World Bank and the International Monetary Fund started to condition lower income countries by lending money in exchange for structural adjustment programs. In exchange for loans, Western donor countries asked for specific reforms in the direction of trade liberalisation, deregulation and privatisation. What is more, in that decade characterised by pro-market rhetoric, there was strong sentiment to reduce aid drastically and substitute it with private capital flows. This pro-market rhetoric went in parallel with anti-government rhetoric, witnessed by government failure literature, which gained impetus particularly thanks to the work of Anne Krueger. She published the article "Government Failures in Development" (1990) suggesting that misleading focus was on the fact that developing countries did not have well-functioning markets and they therefore needed extensive government intervention to fix those failures. Her innovation was to claim that governments, just as markets, can fail; and indeed, the major troubles within developing countries were caused by government failures and not by market failures.

Finally, as previously mentioned, the decade of the 1990s was marked by a strong "aid fatigue" influenced by the rising fear that foreign assistance was generating aid dependency relationships in poor countries. The issue of the effectiveness of aid conditionality was also critically debated. For these reasons, in particular after 1992[7], there has been a marked switch toward more aid for social infrastructure and services (e.g. education, health, water supply and sanitation). In recent years, more than a quarter of ODA has been committed to the sector of human resource capabilities. Likewise, economic infrastructure and services (e.g. energy, transport and

[6] In the 1970s and early 1980s, the member countries of the Organization of the Petroleum Exporting Countries (a permanent and intergovernmental Organization created at the Baghdad Conference on September 10-14, 1960, by Iran, Iraq, Kuwait, Saudi Arabia and Venezuela) had become the monopolists of the sale of oil. Thus, these countries started to dictate conditions, significantly increasing the price of oil. This pushed numerous private companies and governments to invest in new explorations and extraction in places that would not have been profitable ten years before (like the North Sea, Alaska, Thailand, Mexico). Consequently, by the end of the 1970s, competition grew and prices began to decrease. As a result of this fall in oil prices, Mexico, Venezuela and other oil producers underwent huge foreign debt crises. Thus, the debt crisis of the 1980s can be considered as a Third World debt crisis and oil producers were among the most indebted countries.

[7] After the fall of the Soviet Union, donors could direct aid more selectively, reducing the flows of aid provided merely for strategic interests linked to the Cold War bipolarism.

communications) have received increased attention and flows, rising to more than 20% of commitments by 1991-7 (Helleiner, 2000).

It can be concluded that different phases of history and thus different geopolitical conditions lead to specific instruments and theories of development aid. However, despite many changes over the years, it can be said that there is one constant in the history of aid, namely the exploitation of development objectives in order to gain commercial and political advantages in recipient countries. An exception is provided by the kind of international aid provided in the 1960s and 1970s, which was based respectively on the issue of "self-help" in opposition to aid dependency and on the eradication of poverty.

1.2 Major Actors

Aid allocation is shaped both by the interests of the donor country and by the needs and merits of the recipient country. However, the direction of the flow of aid depends also on the specific characteristics of recipient countries. Berthélemy (2005) identifies two different categories of motives of aid. The first category comprises aid granted to the neediest countries, for the sake of poverty alleviation. While a second category takes into account the issue of aid efficiency. Thus, the focus is on the fact that the direction and effectiveness of international aid depends on the quality of economic policies and on the governance of the receiving countries. What is more, regarding the flow of international aid, there is a general agreement about what primarily matters for aid giving, namely poverty, strategic interests of donor countries, colonial history, trade and political institutions of the recipients (Alesina & Dollar, 2000). Hence, it can be said that both egoistic behaviours led by self-interest purposes and more altruistic development objectives related to the recipient needs and merits are combined in aid allocation decisions.

The self-interest argument may be linked to several objectives pursued by the donors (Berthélemy, 2005). For example, in addition to the geopolitical purpose, usually a donor will provide assistance to recipients who are like-minded or potential political allies. Lahiri and Raimonds-Møller (2000) link this political alliance factor to the colonial past of the donors. As a matter of fact, colonial ties continue to determine the major recipients of official development assistance from former colonial rulers. Most striking here is that an inefficient, economically closed, mismanaged and non-democratic former colony receives about twice as much foreign

aid than another country with a similar level of poverty, a superior policy stance, but without a past as a colony (Alesina & Dollar, 2000).

However, political factors and colonial links are not the exclusive explanation to the cross country differences that arise as far as international aid is concerned. In fact, when considering strategic interests, also commercial linkages play a significant role. Existing studies demonstrate that higher levels of imports from donor countries result in greater aid allocation in the importing country (Dudley and Montmarquette, 1976; Neumayer, 2003). As a result, given that Western donor nations are mainly producers and exporters of capital goods, a significantly larger amount of aid is provided to recipients who import capital goods, while imports by other category groups have no significant effects (Younas, 2008). As a consequence, it is clearly recognized that donor nations' motivations for providing aid also arise from their interest in acquiring a larger share of the recipient nations' imports and thus obtaining larger trade benefits. Regarding the economics of aid, financial motives are also worth mentioning. In fact, the debt crisis literature identifies the so-called "defensive lending argument". This could be explained as a "debt game", in which donors have to provide new resources to highly indebted countries to avoid that these debtors fall in arrear (Berthélemy, 2005).

Among the countries receiving more aid there are also countries that democratize. In fact, countries that have democratized tend to be rewarded with an average 50% increase in foreign aid immediately afterwards. However, donors pay more attention to strictly defined democratic institutions rather than to a broader approach towards civil rights or law enforcement (Alesina & Dollar, 2000). Also more efficient and less corrupt governments conduce to the reception of more foreign aid. This is because government corruption, lack of accountability and transparency, and bureaucratic incompetence all usually give rise to a wasteful allocation of aid. Thus, donors tend to privilege countries, which have undergone a recent public sector reform, as Elliot Berg (2000) demonstrates with his study on the experience with public sector reform initiatives since 1980.

Donors also appear to be more concerned about directing international aid towards developing countries with high levels of poverty. However, it is worth noting that a reduction in poverty in East Asia, Pacific Asia and in South Asia actually led to an increase in the allocation of aid from donor countries (Arvin & Barillas, 2002). This may be largely due to donors' self-interest purposes regarding commercial or political links. Another possible explanation could be that

more international aid is directed towards these countries as a reward for their effective policies that alleviated their poverty themselves. This increased credibility is due to the fact that, as already highlighted, good governance offers more fertile grounds for the effectiveness of aid.

To summarize, aid allocation is positively correlated with the bilateral trade intensity, with the tendency to democratize, with the level of poverty (except in East, Pacific and South Asia)[8] and with good governance. In fact, it has been found that, *ceteris paribus*, a country that is relatively open receives 20% more aid and a country that is relatively democratic receives 39% more aid (Alesina & Dollar, 2000). However, factors linked to strategic considerations and colonial past explain more of the distribution of aid than the political institutions or economic policy of recipients. In fact, a country that has a relatively long colonial past receives 87% more aid (ibid.). Thus, the direction of foreign aid is dictated both the by donors' political and strategic considerations, but also by the needs, merits and policy performance of the recipients (Berthélemy, 2005).

Despite these common traits, international aid varies considerably according to the developing countries' geographic and income characteristics (Arvin & Barillas, 2002). However, what can be said is that the sub-Saharan African region is of high priority, with 28.9% of total ODA in 2019 (Harcourt, 2021). This high percentage is due to the context of lingering economic problems that have afflicted many countries in this part of the world since at least the early 1980s, in combination with the dramatic situation of poverty afflicting this region. What is more, many African states today are still characterized by poor quality institutions, weak rule of law, an absence of accountability, tight controls over information and high levels of corruption (Bräutigam and Knack, 2004). The reasons behind sub-Saharan African poor governance are various, but among them colonialism has definitively caused the emergence of the major issues affecting the region still today. For instance, colonialism did little to develop strong, indigenously rooted institutions that could tackle the development demands of modern states (ibid.). Thus, after having gained independence, the new nations of Africa were not able to sustain self-governance and as a result economic crisis, ethnic tensions, civil wars, and political instability spread throughout the region.

[8] As abovementioned, the reduction of poverty in East Asia, Pacific Asia and in South Asia led to an increase in the flow of aid.

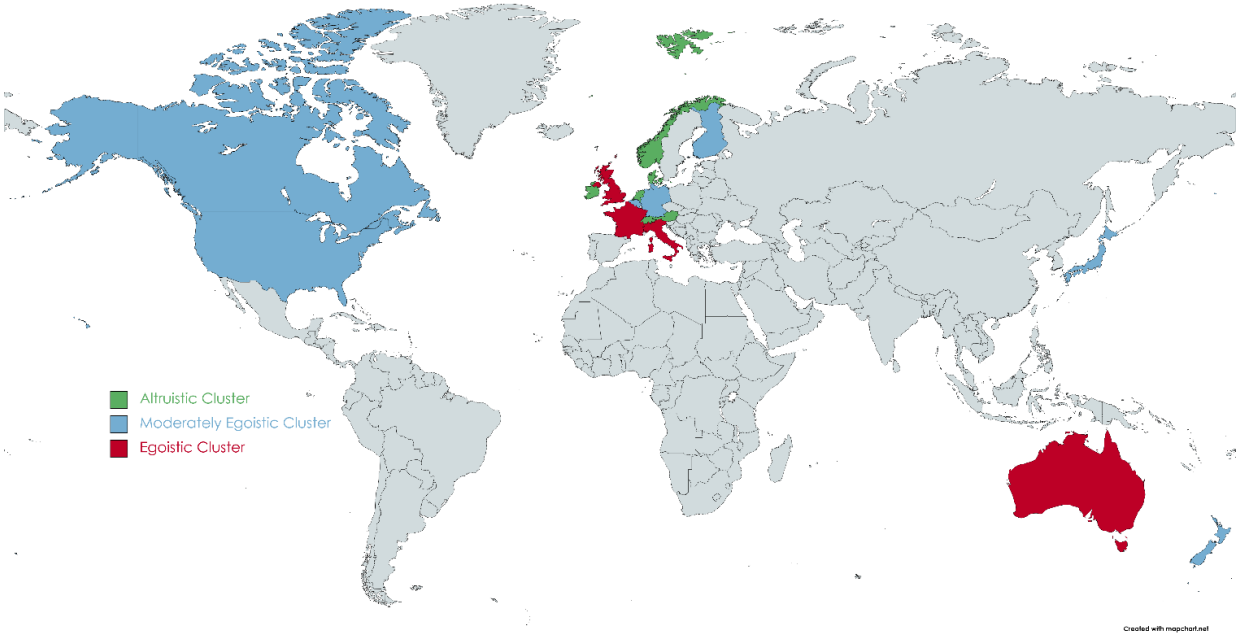
For these reasons, the amount of international aid directed towards sub-Sahara Africa continues to grow and to contribute to a very high percentage of receiving countries' government budgets. On the other hand, thanks to a higher level of economic development and a better access to alternative sources of finance, a number of other regions (e.g. North Africa, the Middle East and South and Central Asia), have seen their share of aid flows diminish markedly (Helleiner, 2000). Thus, while there is evidence of many examples of development successes, there is also a widening gap between the most and least successful processes of development; and the latter are mostly sub-Saharan African.

A high level of heterogeneity can be observed not only in receiving countries, but also in Western donor countries. In fact, donors implement different policies and have different objectives regarding international aid. When estimating allocations of individual donors, striking differences can be found. For instance, the total amount of aid reaches almost 2% of the GDP in Sweden and the Netherlands, but only 0,25% in the United States (World Bank Development Report, 2005). Accordingly, Berthélemy (2005) categorises Western donors in three clusters (as illustrated in figure 2, page 21), depending on how much they trade with developing countries. This means that the higher the trade intensity parameter, the higher the possibility that a donor is providing aid merely for commercial and thus strategic motives. The "altruistic cluster" has a significantly lower trade intensity parameter, and includes Austria, Denmark, Ireland, the Netherlands, Norway and Switzerland. Donors who have a trade intensity parameter not significantly different from other donors are Belgium, Canada, Finland, Germany, Japan, New Zealand and the United States, which are included in the "moderately egoistic" cluster. It must be said that the United States' purposes are relatively less commercial, but more influenced by political motives, as shown by the big bias of its aid to Egypt, and as suggested also by its significant assistance to conflict countries (ibid.). Finally, Australia, France, Italy and the United Kingdom are considered as being "egoistic clusters", as these countries have a trade intensity parameter significantly higher than other donors.

While certain donors, notably countries belonging to the "altruistic cluster", allocate aid on the basis of proper incentives, such as levels of poverty, democracy, openness and good institutions of the receiving countries; other countries relate more to former colonial and political ties. Such donors include France and Japan, with the former focusing on its former colonies and the latter on investments and trade relationships. Japan's aid is also highly correlated with UN voting

patterns: countries that vote in tandem with Japan receive more assistance (Alesina & Dollar, 2000).

Table 2. Donors by clusters identified by Berthélemy (2005)



1.3 The Effects on Local Structures

Even more than aid allocation, aid effects are a complex matter. This is because developing countries vary widely in their initial conditions, and this clearly affects their potential for development. Thus, the problem is multifaceted and location-specific, with deep roots in the social fabric and distribution of economic and political power (Helleiner, 2000). Also for this reason, the issue is not whether international aid works, but under which circumstances. Thus, the benefits of foreign aid have nearly always been under strict examination.

In this regard, an influential study by Burnside and Dollar (2000) focused on the interactions amongst choices of macroeconomic policies, aid and growth, claims that aid is beneficial only to those "countries with good fiscal, monetary, and trade policies but has little effect in the presence of poor policies". This statement supports the "Washington consensus" view, according to which more aid should go to countries with good policy environments (Helleiner, 2000). Burnside and Dollar (2000) also explain that foreign aid can be interpreted as an income transfer, which may or may not produce growth. They argue that the most efficient way to

implement a receipt of aid is to invest it[9]. On the other hand, if the aid received is consumed, the allocation of aid will be ineffective. This explains why aid is not promoting growth in the average recipient country.

However, the conclusion brought by Burnside and Dollar (2000) that aid can promote growth in good policy environments, has been questioned in more recent works. For instance, Easterly (2003) and Rajan and Subramanian (2008), claim that, even when institutional quality is high, there is no evidence of any effect of aid on growth; and Friedman (1958) argues that aid may even cause deterioration in the quality of democratic institutions[10].

What is more, there is a contradiction stemming from the deduction that international aid is more effective in receiving countries with good governance. This may be true, however, failed states or economic and political fragile states are precisely those actors which need aid the most, even if they are not able to implement it effectively. In fact, aid has to allow countries to overcome their vulnerability, to face external shocks, or at least to compensate for their effects. And actually, it must be said that, *ceteris paribus*, aid is more effective in more vulnerable countries (Guillaumont & Chauvet, 2001). In addition to the actual benefit that international aid can have on developing countries affected by external or environmental disasters, this effectiveness could also be found because the initial conditions of these countries are critical and thus relatively easier to adjust.

In addition to the problem of weak institutions, the literature identifies also more practical issues involved with the flow of international aid. Under this regard, Bräutigam and Knack (2004) claim that large amounts of aid may block governance improvements through the high transaction costs that accompany aid, the fragmentation that multiple donor projects and agendas promote and the obstruction of opportunities to learn. In fact, learning by doing could be a major benefit for staff in developing countries. The problem is that technical assistance is often provided autonomously by donors, without transferring skills to the recipient countries. Another matter concerning local staff is that in many developing countries, trained people are

[9] For example, aid can be invested in the improvement of transports, health systems and internet infrastructures. All of these initiatives may lower costs for local businesses and facilitate them in their growth.

[10] Friedman (1958) argues that, as most aid goes to governments, it tends "to strengthen the role of the government sector in general economic activity relative to the private sector." This is an important issue, as democracy and freedom are less likely to emerge and to survive where most economic activity is organized by the public sector (ibid.). What is more, Friedman underlines that high levels of foreign aid tend to reduce governments' necessity of tax revenues from citizens. Consequently, in recipient countries, there will be an increased influence of donor countries rather than tax-payers, thus limiting citizens' active political participation.

scarce. As a result, donors offer to capable staff higher salaries, removing them both from the private sector and from the government (ibid.). For instance, in Ghana which is one of the countries receiving the most aid in Africa, in 1993 senior officials each spent as much as 44 weeks a year facilitating or participating in donor supervision missions, time they were unable to devote to their ministries' own priorities (Sawyerr, 1997). Finally, aid may contribute to low revenues and fiscal deficits by reducing tax income for the government. This happens because expatriate personnel working for aid agencies are rarely required to pay local income taxes. What is more, aid projects import equipment such as vehicles and consumption goods without paying import duties. Thus, tax revenues are reduced (Bräutigam & Knack, 2004).

Another issue deriving from the large transfer of international aid is the one of aid dependence, defined by Roger Riddell (1996) as "that process by which the continued provision of aid appears to be making no significant contribution to the achievement of self-sustaining development". It can occur that, without foreign aid funding and expertise, a government becomes unable to perform on its own many of its main functions, such as the maintenance of existing infrastructures, the delivery of basic public services or the adjustment of prices. Unfortunately, this is the situation incurred in many countries in Africa today (Bräutigam & Knack, 2004).

As already mentioned, in sub-Saharan Africa, higher levels of aid are connected to the poor quality of governance. However, this causality can go in both directions. Meaning that large flows of aid allocation can cause the deterioration of governance; but also the other way round could be true, as donors may respond by delivering more aid to developing countries with poor governance. What is more, it is difficult to separate the impact of African instability due to civil wars from the impact of foreign aid. But actually, the evidence indicates that high levels of aid are the cause rather than the result of deteriorating governance. In fact, the high transaction costs of aid programs, "as well as the fragmentation, poaching, and other direct effects of a large number of donors" (ibid.) competing for the limited number of skilled workers, can weaken institutions that were not strong to begin with . However, the infusion of resources and technical assistance from donors can give an important boost to the efficiency and effectiveness of governance, as the issue of knowledge transfer remains critical in sub-Saharan Africa.

Yet, despite this possible benefit, large amounts of aid could also make it more difficult for good governance to develop due to the issue of the "African collective action problem" (ibid.).

The improvement of governance can be considered as a public good. Thus, as public goods benefit everyone, better governance also benefits the whole population, irrespective of who decides to provide it. This means that there is little incentive to sacrifice in order to provide good governance. Thus, the population continues to act as a free rider, exploiting others' achievements without acting concretely themselves.

In spite of these major issues, high levels of international aid may act as an incentive to improve the quality of governance. In fact, as Bräutigam and Knack (2004) highlight, flows of international aid towards governments with clear development agendas can be used to improve the quality of the civil service, strengthen policy and planning capacity, and establish strong central institutions. South Korea and Taiwan represent good Asian examples of this, while Botswana shows that the same processes can also work in sub-Saharan Africa (Carlsson et al. 1997). Also Bräutigam and Knack (2004) hypothesize that the negative impact of aid on the quality of governance might have weakened after 1990. This may be because of the increased focus on programs to reduce corruption, improve public expenditure management and tax administration systems. Considering a more strategic perspective, the end of the cold war also allowed the United States and other donors to target aid more selectively, rather than using it to strengthen corrupt but geopolitically useful autocracies (ibid.).

What is more, international aid can have the positive effect of promoting democracy. This can happen through the increase in the improvement of education, the support of free press and fair elections as well as the promotion of legislatorial and judicial checks on executive power (Bräutigam and Knack 2004). However, also the empirical evidence on the link between aid and democracy is rather mixed. While Knack (2000) claims that there is no evidence that aid can be conducive to democracy, Arvin et al. (2002) argue on the contrary that aid can spur democracy. Boone (1996) finds that more democratic regimes have on average 30% lower infant mortality rate and that democracy and higher incomes are linked. For these reasons, together with the eradication of poverty, one of the major goals of international aid must be that of promoting the spreading of democracy.

To recap, aid is more likely to directly benefit the growth of countries where governance and policies provide a solid foundation for development. On the other hand, international aid tends to be dissipated in the presence of poor policies, corruption, inefficiencies and bureaucratic failures. For this reason, Helleiner (2000) argues that it makes little economic sense to do

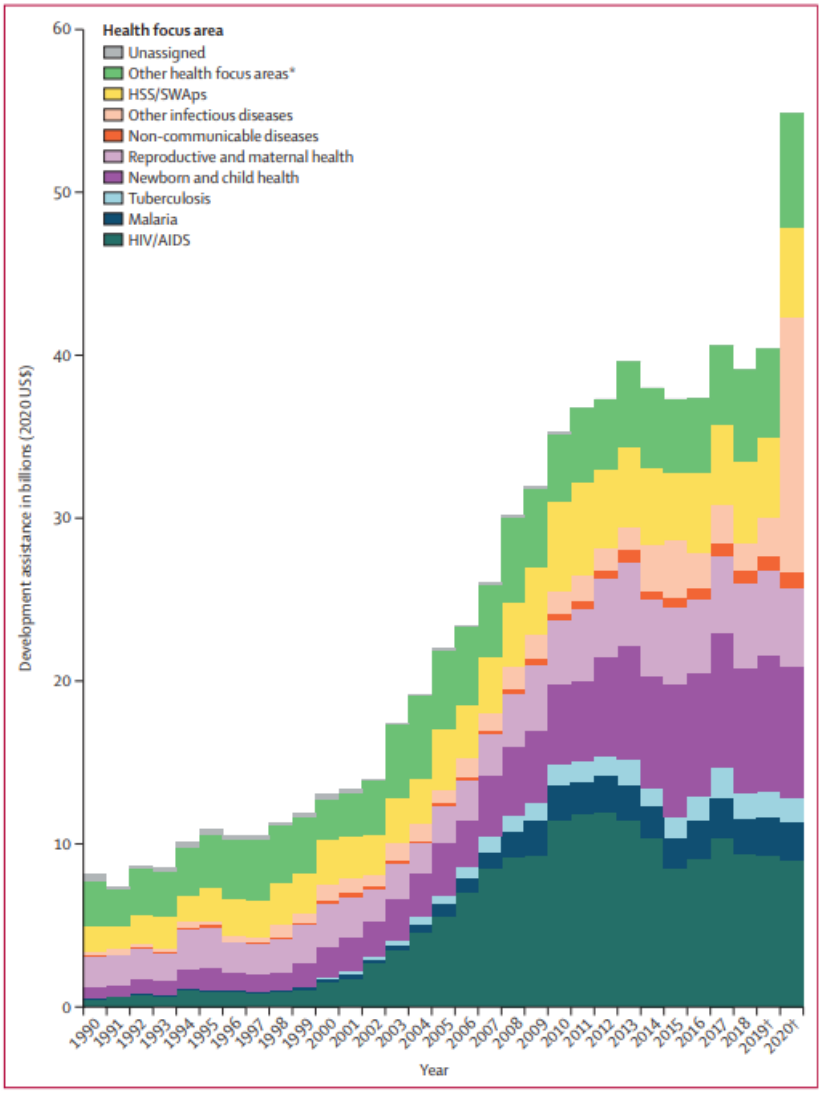
structural adjustment lending, when the macro policy environment is “bad” and there is little possibility for policy reform. What is more, it can be concluded that both Western donor countries and recipient countries are locked into a system that is unable to produce development consistently or predictably. Aid must thus be delivered more selectively and conditionally, taking into consideration the needs and merits of the receiving countries.

1.4 Health Aid

Making aid conditional on improvements in governance has been advocated not only for general economic aid, but also for health aid. In fact, both the volume and efficiency of international aid to finance health expenditure can be influenced by recipient countries’ governance (Fielding, 2011). Health aid or development assistance for health (DAH) refers to “the financial and non-financial resources that are disbursed through international development agencies to maintain or improve health in low-income and middle-income countries” (Micah et al., 2021). In the case of bilateral and multilateral donors, public-private partnerships and private foundations, health aid is delivered predominantly materially, in the form of financing. On the other hand, in the case of technical agencies, such as the World Health Organization, resources are primarily ideational, in the form of policy and technical guidance (Hafner & Shiffman, 2013). Thus, national health systems of developing countries are influenced and modified by these donors, which provide financing and policy ideas.

Considering that in developing countries health systems are often too weak to deliver quality services to those in need, development assistance for aid has significantly increased over the last four decades. Between 1990 and 2012, DAH more than quintupled in absolute terms from about 5 billion USD to 32 billion USD (WHO, 2013). However, as can be seen in Table 3 (page 26), the large majority of additional funding has gone to the fight against specific diseases or issues such as HIV/AIDS (Micah et al., 2021).

Table 3: Development Assistance for Health by health focus area, 1990-2020



Source: Micah et al., 2021

1.4.1 Health System Strengthening

After a period of proliferation of disease-specific initiatives, organizations involved in global health have paid increasing attention and resources to health systems strengthening (HSS), especially since the 2005 Paris Declaration on Aid Effectiveness[11] (Hafner & Shiffman, 2013). The critical factors causing this awareness include concern about the possible adverse effects of global health initiatives on recipient countries' health systems, the realization that weak

[11] The Paris Declaration was endorsed in 2005 by over 100 countries. The aim being to provide an action-oriented roadmap "to harmonize donor aid and to align aid with national government priorities" (Hafner and Shiffman, 2013). Thus, a monitoring system to assess progress and donors' and recipients' commitments was implemented.

health systems can cause organizational inefficiencies and fears among global health actors that health-system issues threatened the achievement of the health-related Millennium Development Goals (MDG) (Hafner and Shiffman, 2013).

The MDGs were a set of development objectives with a 2015 target date, unanimously approved in 2001 by 189 countries. Many organizations involved in global health soon became convinced that some of the MDGs could not be achieved without stronger health systems (ibid.). Of the eight goals[12], particularly three were health-related: to reduce child mortality, to improve maternal health, to combat HIV/AIDS, malaria, and other diseases (goals 4, 5 and 6 respectively).

The MDGs were derived from the United Nations Millennium Declaration, signed in September 2000, which committed world leaders to combatting "poverty, hunger, disease, illiteracy, environmental degradation, and discrimination against women" (WHO, 2018). This framework was agreed by all the world's countries and all the world's leading development institutions, with the aim of meeting the needs of the world's poorest. Indeed, the MDGs "helped to lift more than one billion people out of extreme poverty, to make inroads against hunger, and to enable more girls to attend school than ever before" (The Millennium Development Goals Report, 2015).

Thanks to the MDGs, major progress has been made also in the health sector. Indeed, the global HIV, tuberculosis and malaria epidemics have been turned around: HIV infections fell by approximately 40% between 2000 and 2013, from an estimated 3.5 million cases to 2.1 million; the malaria incidence rate has fallen by an estimated 37% and the mortality rate by 58%; the tuberculosis mortality rate fell by 45% between 1990 and 2013 (ibid.).What is more, child mortality and maternal mortality have greatly decreased, by 53% and more than 40% respectively since 1990 (WHO, 2015).

However, much remains to be done. For this reason, health issues are well placed also in the Sustainable Development Goals, heart of the 2030 Agenda for Sustainable Development,

[12] The eight Millennium Development Goals were: eradicate extreme poverty and hunger; achieve universal primary education; promote gender equality and empower women; reduce child mortality; improve maternal health; combat HIV/AIDS, malaria, and other diseases; ensure environmental sustainability; develop a global partnership for development.

adopted by all United Nations Member States in 2015. Following the Agenda, all countries and stakeholders, act in "collaborative partnership" (United Nations, 2015) in order to eradicate poverty, considered as the greatest global challenge and an indispensable requirement for sustainable development (ibid.). Unlike the MDGs, Sustainable Development Goals are more ambitious and wider in their scope, as the aim is to obtain sustainable development thanks to the link between environmental, economic, social and political goals. Thus, the 17 SDGs[13] have become the dominant global framework for development and have shaped national policy priorities.

Regarding sanitation, the health goal (SDG 3) is broad: "ensure healthy lives and promote well-being for all at all ages" (ibid.). The SDG declaration emphasizes that to achieve the overall health goal, "we must achieve universal health coverage and access to quality health care. No one must be left behind". What is more, the World Health Organization highlights the fundamental role of health aid, stating that "the Global Action Plan for Healthy Lives and Well-being for All has a simple premise: that stronger collaboration contributes to better health". This collaboration is essential due to the massive health challenges being faced by the world's poorest countries, particularly in Sub-Saharan Africa. For this reason, a series of high-profile global health initiatives have been implemented, including the Global Fund to Fight AIDS, TB and Malaria, Stop TB, Roll Back Malaria, The U.S. Presidential Emergency Plan for AIDS Relief, and the Global Alliance for Vaccines and Immunization. The importance of health system strengthening was already acknowledged in 1978, thanks to the WHO's Alma Ata Declaration on Primary Health Care. It aimed at reaching "health for all" by 2000 and stressed the importance of primary healthcare and HSS to reach this goal (WHO, 1978). As the approach was comprehensively focused on primary healthcare[14], the Alma Ata Declaration was immediately and commonly criticized as it was thought to be too broad (Steurs et al., 2018).

[13] The seventeen Sustainable Development Goals are: no poverty; zero hunger; good health and well-being; quality education; gender equality; clean water and sanitation; affordable and clean energy; decent work and economic growth; industry, innovation and infrastructure; reduced inequality; sustainable cities and communities; responsible consumption and production; climate action; life below water; life on land; peace, justice, and strong institutions; partnerships for the goals. The 17 SDGs are meant to be very broad and aspirational goals. For this reason, each of the seventeen SDGs also include 169 targets that are meant to be more specific and concrete. In addition, 232 indicators are used to measure progress toward the 169 targets and the overarching 17 SDGs. These indicators describe the data and statistics that experts gather to show whether progress is being made toward meeting the SDGs or the targets within the SDGs.

[14] Primary health care "addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services" (Declaration of Alma Ata, 1978). What is more, primary health care is fundamental for the overall social and economic development of the community (ibid.), as it represents the first element of a stable and effective health care system.

This is the reason why, as mentioned above, during the 1990s and especially the 2000s, the focus was shifted towards a more vertical approach based on funding to fight specific diseases rather than to HSS.

At the beginning of the 2000s, the proliferation of Global Health Initiatives, such as the Global Fund, redrew attention to the debate between vertical (disease-specific) and horizontal (overall strengthening of health systems) approaches (Mills, 2005). As Steurs (2018) explains, the vertical approach implies that funding is directed towards disease-specific interventions. This approach has the advantage of delivering quick, visible and measurable results. On the other hand, the horizontal approach focuses on strengthening basic health care needs and the wider health system. Hence, it is more sustainable in the long term, although results are less easy to measure. Regarding health care strengthening, another issue is that it involves managing complex relationships among multiple moving and inter-related elements (governance, finance, human resources and information management) and the solutions depend on context (Hafner & Shiffman, 2013). This is the reason why donors have different interpretations and use different strategies to implement HSS.

The fragmentation in the provision of aid caused by the implementation of the vertical approach led to the Paris Declaration of 2005. In this context, major bilateral and multilateral donors, UN agencies, national governments and other institutions decided to follow the holistic approach of the HSS agenda, focusing on the harmonization of donor aid and the alignment with national government priorities. What is more, in 2006, the World Health Organization circulated a framework, which considered the health system as being made up of six building blocks: policy, financing, human resources, supply systems, service management, information, and monitoring systems. HSS was defined as a ‘‘building capacity in critical components of health systems to achieve more equitable and sustained improvements across health services and health outcomes’’ (WHO, 2006).

1.4.2 HSS’s Actors: Donors and Recipient Countries

Despite these common grounds provided by the WHO, there is no shared understanding on what HSS exactly entails. Thus, actors embracing health systems strengthening have different interpretations and use different strategies to implement it, not constituting a cohesive policy community (Hafner & Shiffman, 2013). This is also due to the fact that several major actors,

very different among them, are involved in health aid. Thus, even if health systems strengthening is predominantly a national issue, the commitment of global actors is worth monitoring since they influence financing, national priority and policy approaches (Hafner & Shiffman, 2013). These global actors include the World Health Organization, UN Agencies (like UNICEF and UNFPA) the World Bank, the G8, private foundations and also Global Health Initiatives (GHIs). Among the major providers of health aid, also the European Union deserves to be mentioned. Indeed, the EU and its Member States provided 25.5% of all development assistance for health in the period 2002-2016 (IHME, 2018). This great attention to the issue of health aid was also emphasized during the conclusions of the Council of Ministers held in Brussels in 2010 regarding the EU's role in global health, in which it was stated that EU donors should "act together in all relevant internal and external policies and actions by prioritizing their support on strengthening comprehensive health systems in partner countries" (Council of the European Union, 2010).

However, heterogeneity is present also at the European level, as individual donors' approaches differ geographically and temporally. Indeed, Steurs (2019) classifies EU donors in three different categories. He identifies Belgium, Switzerland, Spain, Denmarkand the EU itself as "hardline health system strengtheners". These actors tend to apply HSS with a comprehensive focus and a high level of state involvement, regardless of the governance situation. The second category comprises the Netherlands, Sweden and the UK, which are considered to have a more targeted and less state-supportive approach. In addition, their involvement tends to change in light of the governance situation of the partner country. Therefore, they are referred to as "flexible". Lastly, Ireland's and Italy's approach can be placed between the above-mentioned. Indeed, they tend to be more state-supportive than the flexible group but they have a less profound approach than the hardliners. Furthermore, this category acts sometimes more issue-specifically (like the flexible group) and sometimes more comprehensively (like the hardliners).

Despite these differences at the specific level, there is a certain degree of unity among European donors at a more general level, which contrasts with other donors such as the US, confirming a transatlantic divide (Steurs, 2019). Under this regard, both approaches towards the Global Fund[15] can be considered. In fact, while the European donors tended to horizontalize the Global

[15] The Global Fund to Fight AIDS, Tuberculosis and Malaria was created in 2002 to manage resources to combat these harsh diseases. It is an international organization based on the partnership with governments, civil society, technical agencies and also the private sector.

Fund with a high level of state involvement, on the other hand, the US did not share the idea of broadening the approach of the Global Fund. What is more, in Ethiopia, Uganda and Mozambique, European donors were the earliest and most generous supporters of health aid, while the US did not take part in any of the pooled funding arrangements in these countries (ibid.). However, this transatlantic divide could be converging, as the US seems to be adopting a more comprehensive focus and a higher level of state involvement over the years. On the contrary, European donors seem to have become less profound supporters of HSS. What is more, several European donors are increasingly focusing on cost-effectiveness and direct results, traditionally more associated with the US and global health initiatives (ibid.).

As in the case of development aid, also the effectiveness of health aid depends on specific characteristics of both developing countries and the programme itself. Thus, regarding recipient countries, the efficacy of the adoption of health innovations depends on a number of contextual factors (Atun et al., 2010). Even more fundamental than adoption are assimilation and sustainability of these interventions into developing health systems. Despite their importance, these processes may not be linear. Indeed, the speed and extent of the integration varies according to the intervention nature and complexity, the health system characteristics and the context within which the intervention is introduced. What is more, also the adopters' perception of the innovation influences its diffusion in the health system. This perception is based on cultural norms, beliefs and values of the key actors and institutions within the adoption system (ibid.). While taking into account the significant determinants of health aid, the major indicators considered by donors are initial per capita GDP, initial infant mortality growth and initial growth in tuberculosis prevalence. Thus, part of the variation in health aid can be explained by variations in relative deprivation across countries. For instance, a 1% increase in infant mortality may lead to a 1.8% increase in health aid over the following five years (Fielding, 2011).

Again for what concerns beneficiaries of health aid, it is expected that their health systems will improve as a result of these massive flows. But actually, there is no consensus on the fact that increased Development Assistance for Health (DAH) has improved health outcomes in recipient countries, as disease burdens continue to be high (Gyimah-Brempong, 2015). In fact, while organizations involved in global health have augmented attention to HSS over the past decade, difficulties in the policy, problems and politics streams raise questions about the sustainability of their commitment (Hafner & Shiffman, 2013). This is because health systems

are national systems, and dynamics within countries are the most critical aspects of the issue. Thus, there is the appearance of adverse side effects on countries' health systems.

1.4.3 Issues and Positive Outcomes

Concerns that global health initiatives were affecting health systems adversely arose because it is claimed that these were contributing to the fragmentation of health systems, distorting national health priorities and placing undue reporting and co-ordination burdens on the governments of low-income countries (Msuya, 2004). In fact, already weak health systems may be further damaged as over-concentrated resources in specific programmes could leave many other areas under-resourced. In addition, interventions have often been implemented with little involvement of the recipient state, leading to the creation of so-called parallel systems (Steurs, 2019), which undermine local decision-making autonomy and thus lead to inefficiency. Another issue stemming from DAH regards recipient countries' health personnel. In fact, personnel could be both displaced internally, in order to assist health aid programmes, but also externally, in order to receive training abroad (Moullan, 2013). This would obviously have negative impacts on health outcomes, as developing countries may suffer from the emigration of skilled workers. For these reasons, critics warned that these initiatives were creating "islands of excellence in seas of under provision" (Buse and Waxman, 2001). This means that, without stronger health systems, health aid may not achieve its organizational objectives, as the existing local systems are not robust enough to capture massive resource flows. This issue of inefficiency is present particularly in Africa, where the low density of health care resources causes the lack of complementary inputs to render health inputs productive (Gyimah-Brempong, 2015). In other words, often, the receiving country is not equipped with the adequate resources necessary to implement efficiently and persistently the receipt of health aid.

Considering more practical outcomes, using several estimation methods and panel data, Wilson (2011) found no significant effect of DAH on infant and maternal mortality, nor on life expectancy. This is clearly a substantial issue, as health aid should be increasing as far as the indicators of morbidity and mortality are concerned. However, donors are not always sensitive to the health status of recipient countries. In fact, sometimes actors commit to the issue of global health initiatives for instrumental reasons (e.g. for achieving organizational objectives). Under this regard, it is also worth mentioning that, by the end of the 2000s, there was an increased focus on value-for-money and quick results that could be directly attributed to donor activities

and which could be easily communicated to the public (Koch et al. 2017). Thus, practices were often merely evaluated using quantitative indicators such as the amount of bed nets provided, the amount of people vaccinated, and, ultimately, "the amount of lives saved" (McCoy, 2013).

In contrast to studies that find a negative or no significant impact of health aid, several studies find a positive effect of DAH on health outcomes in recipient countries. For instance, Wolfe (2007) finds that aggregate aid improves public service delivery in health, education, water, and sanitation, thus improving health outcomes. Biesman et al (2009) concludes that health aid improves the health systems of recipient countries and consequently have a significant impact on infant and maternal mortality rates. In fact, the World Health Organization (WHO, 2013) reports that between 2000 and 2013, the child mortality rate decreased by about 4.2% per year in Africa. Similarly, an evaluation of the President's Emergency Plan for AIDS Relief for Africa indicates that mortality rates of AIDS patients as well as the rate of infections have declined dramatically (Bendavid and Bhattacharya, 2009). Thus, it can be said that health aid has significant effects on health outcomes also in African countries. Furthermore, Moullan (2013) claims that health aid, especially in the form of technical aid, decreases the emigration of doctors from aid recipient countries and thus may have positive consequences for health outcomes in these countries. This is a massive benefit particularly for Sub-Saharan Africa, as a report estimated that the region had only 3% of the world's health workers while carrying 25% of the world's disease burden (Joint Learning Initiative, 2004).

Moreover, donors sometimes use health aid to reward political reform. In fact, channelling health aid to countries with a good record of political reform may be an effective incentive to push others to engage in similar reform (Fielding, 2011). On the contrary, poor institutions make effective healthcare difficult and costly to deliver. This is why, as already mentioned, donors tend to direct health aid to recipients with strong institutions. In addition, health aid may allow policy makers in developing countries to shift domestic resources to other crucial sectors. DAH is also associated with increases in health expenditures in recipient countries (Gyimah-Brempong, 2015). In fact, as Fielding (2011) highlights, one extra dollar of health aid is likely to correspond to more or less one extra dollar of total health expenditure. This is likely to have a substantial impact on health outcomes and on the effectiveness of health aid itself. Thus, both better governance and higher domestic spending further increase the effectiveness of health aid.

1.5 Conclusions

To conclude, the fragile nature of developing countries' health systems makes it difficult to achieve and assimilate health aid innovations. Thus, there is increasing consensus that stronger health systems and institutional quality are key to achieving improved health outcomes. The agreement is more critical when considering how to strengthen them. This is because the efficiency of health aid depends on a variety of factors, including the nature of the problem being addressed, the adoption system, the health system characteristics and the broad context (Atun et al., 2010). If these attributes are not strongly linked together, and the recipient country lacks the necessary complementary inputs, DAH could also have a negative impact, leading for example to the mis-allocation of health resources.

An example of inefficient health aid can be provided by the massive implementation of disease-specific activities, which has been gradually substituted by a broader health system strengthening, which is a more horizontal and comprehensive approach. In fact, HSS in developing countries is now regarded as ''the first-order, immediate/medium-term goal to create the necessary enabling institutional and systemic environment to achieve and sustain higher order MDGs in the long run'' (Singh, 2006). However, in order to deliver health system strengthening efficiently, donors must reconsider the way in which health assistance is provided, especially in fragile governance contexts. What is more, given the fact that every country has developed in a different context, the development community advises Western countries to adopt a systemic approach to HSS that is contextual and that fits the countries' agendas first. This would help developing countries to implement health aid efficiently in the long run and to consequently manage it independently.

2. Italian Foreign Aid

In order to comprehensively analyse the case of the UR-Beira project, it is important to provide some fundamental insights into the developments and status of Italian foreign aid, with particular attention to Italian Official Development Assistance for Health (ODAH). This chapter also has the aim of filling a gap in the literature. Indeed, excluding institutional documents and domestic reviews (largely in Italian), few studies have investigated Italy's global engagement in the health sector to date (Missoni et al., 2009). Thus, this chapter begins by considering the main objectives of Italian foreign aid. It will then go on to provide an outline of the major historical landmarks and actors involved in Italian development assistance. The fourth section analyses how this system works in terms of budget and temporal processes. A brief section will also compare Italian Official Development Assistance (ODA) with other major Western donors' approaches and data. Finally, attention will be given to Italian Official Development Assistance for Health, mainly considering its strategies, policies and actors.

As Carbone (2007a) highlights, Italy is one of the major donors in terms of volume of aid. As a matter of fact, in 2020, Italy was the tenth-largest donor country among members of the Organisation for Economic Cooperation and Development's (OECD) Development Assistance Committee (DAC), spending US$4.2 billion on official development assistance (Donor Tracker). Despite this apparently encouraging data, Italy's ODA only represented "0.22% of the country's gross national income (GNI), putting it below the UN target of 0.7%[16] and the DAC average of 0.32%" (ibid.).

This low profile of development policy was and is currently due mainly to Italy's post Second World War economic conditions. In fact, as Tosone (2011) underlines, Italy received financial aid both from the Marshall Plan and the World Bank throughout the entire 1950s in order to recover from the war. This, in addition to inadequate institutional and public attention to issues of Third World development, complicated the Italian transition from being a receiving country to being a donor country (ibid.).

[16] The 0.7% ODA/GNI target was first identified by a UN resolution on 24 October 1970. It has then been recognized by the majority of DAC countries (with the exception of Switzerland and the Unites States). For instance in 2005, European Union member countries agreed to reach that target by 2015 (OECD, 2016).

Thus, Italian participation to issues of international development aid started in the 1960s, with a major involvement only since the 1980s. However, its flows already started to decrease in the following decade as a consequence of the 1992 political Tangentopoli crisis[17]. Some progressive changes seemed to occur only with the 2006 Prodi government, which however did not meet the prime minister's ambitious promises. The 2008 economic crisis also negatively influenced the flows of Italian aid, with a subsequent peak of US$5.9 billion in 2017 (Donor Tracker). Nevertheless, ODA fell by 31% in 2020 (ibid.).

Despite its irregular course, it is important to highlight that Italian development aid reached an important milestone in August 2014, with the parliament's approval of the law 125, which comprehensively reformed the development cooperation system, "from governance to stakeholder participation, from transparency to the role of the private sector" (OECD, 2021). This fundamental reform was the result of more than 20 years of political debate aimed at changing the previous and obsolete system in place since 1987 (Venturi, 2019).

2.1 The Objectives of Italian Development Aid

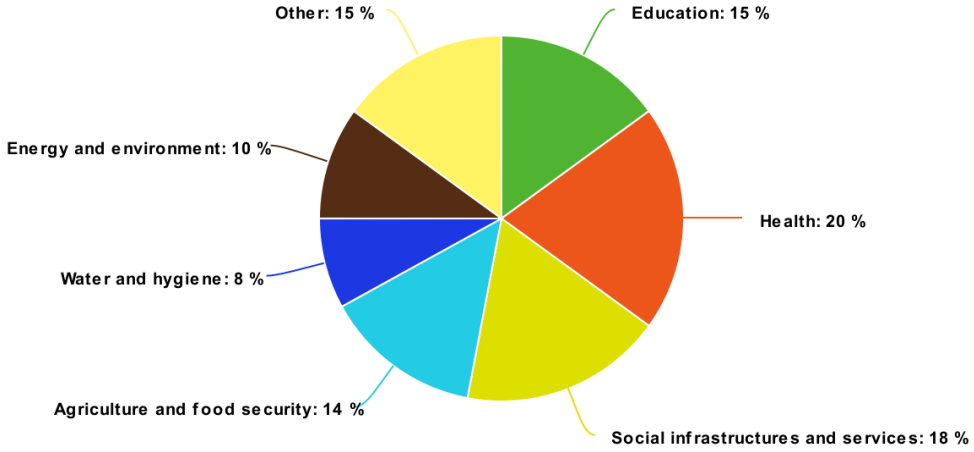
The primary fields of action of Italy's cooperation and aid systems are outlined by Law 125/2014, which identifies the eradication of poverty, the reduction of inequalities, the enhancement of sustainable development and of human rights, the prevention of conflict and peace-building as main objectives (OECD, 2021). In addition, the strategic priorities of development cooperation are also provided by the three-year Programming and Policy Planning Document (the current one being from 2021 to 2023), developed by the Ministry of Foreign Affairs and International Cooperation (MAECI). This section will thus, first of all, delineate the main purposes of Italian foreign aid, and it will then define to whom these flows are to be directed, with Africa being the main recipient continent.

The already mentioned Programming and Policy Planning Document for 2021-2023 highlights Italy's focus on the African continent and on mitigating the root causes of migration and displacement. Resources (distributed as indicated in table 4, page 37) are primarily directed

[17] The Tangentopoli or "Mani Pulite" crisis was characterized by inquiries and legal proceedings involving numerous politicians and entrepreneurs. These investigations focused on the widespread system of corruption and abuse of office common in Italy starting from 1992. This also brought an end to the so-called "First Republic".

towards issues regarding health, education, agriculture, food security and environmental protection (Documento triennale di programmazione e di indirizzo 2021-2023, 2021). Thus, the priority intervention areas are concentrated around the five strategic pillars of the 2030 Agenda: people, prosperity, planet, partnership and peace[18] (ibid.). It is worth mentioning that health, education, and agriculture are also defined as the key priority areas by the Italian Agency for Development Cooperation (AICS), on which attention will be focused later on in this chapter.

Table 4: Resources allocation for sectors of intervention



When discussing the main recipient sectors of Italy's Official Development Assistance, it is fundamental to highlight its prominent role in the implementation of health multilateral initiatives. For instance, in recent years, Italy has increased its contributions to health international organizations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, Gavi and the Coalition for Epidemic Preparedness Innovations[19] (Donor Tracker). In addition, Italy adopted a multilateral approach towards the Covid-19 pandemic and towards the related crisis. As a matter of fact, following the extraordinary G20 summit held in March 2020, Italy participated in the launch of the "Access to Covid-19 Tools Accelerator", a global collaboration that brings together governments, scientists, businesses, civil society and global health

[18] The so-called "5 Ps" are at the heart of the UN Agenda 2030. In fact, it can be said that effective and long-lasting sustainability sits at the core of these five dimensions: social inclusion, economic growth, environmental protection, partnership and peace (UNSSC).

[19] Gavi, the Vaccine Alliance is an international organization created in 2000 and based in Geneva, Switzerland. It brings together in partnership public and private sectors with the aim of improving access to new and underused vaccines for children living in the world's poorest countries (Gavi). Also the Coalition for Epidemic Preparedness Innovations (CEPI) deals with the development of vaccines and other biologic countermeasures against epidemic and pandemic threats in order to render them accessible to all people in need. This innovative global partnership between public, private, philanthropic, and civil society organisations was launched in Davos in 2017 (CEPI).

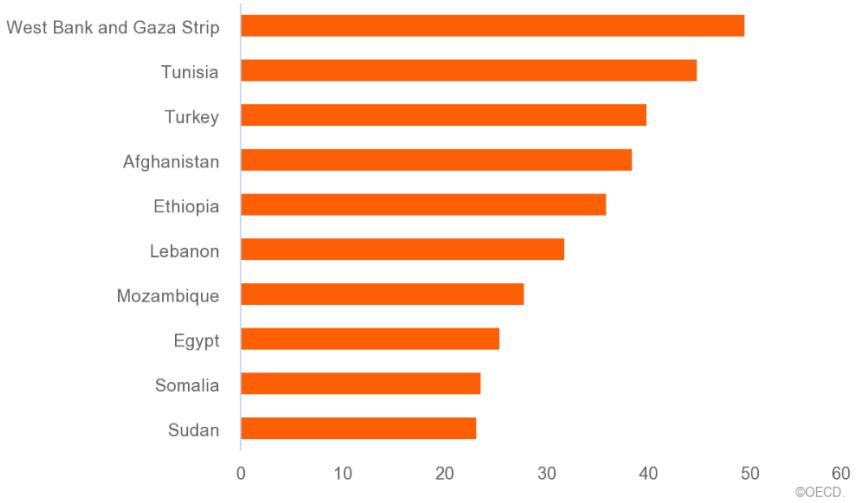
organizations with the aim of accelerating development, production, and equitable access to Covid-19 tests, treatments, and vaccines. Italy also took part in the Coronavirus Global Response Pledging Conference, held on the 4th of May 2020 and promoted by the European Union, together with its *global* partners (Documento triennale di programmazione e di indirizzo 2021-2023). The country further co-convened the Coronavirus Global Response Conference in May 2020, putting Global Health on top of its G20 agenda and it co-hosted the G20 Global Health Summit with the European Commission in May 2021 (Donor Tracker).

Another Italian priority is food security, which gained more importance due to the Covid-19 crisis and even more so with the Russian invasion of Ukraine. In fact, together with the Food and Agriculture Organization (FAO), Italy launched the Covid-19 Food Coalition and hosted the UN 2021 Food Systems Pre-Summit in July 2021. What is more, Italy is now putting increasing emphasis on the "One Health" approach, which highlights that human and animal health are interdependent and linked to the health of entire ecosystems (WHO). G20 members under the Italian presidency have also agreed to the establishment of a High-Level Independent Panel on financing the global commons for pandemic preparedness and response (Donor Tracker).

2.1.1 Italian Development Aid Recipients

Regarding recipient countries, as already mentioned, the primary regions receiving Italy's bilateral development aid are the sub-Saharan African and the Middle East and North Africa (MENA) regions (as highlighted by table 5, page 39), receiving respectively US$279 million and US$237 million in 2019 (ibid.). These resources represented 36% of Italy's bilateral Official Development Aid to Sub-Saharan Africa and 31% to the MENA region (ibid.), which are expected to remain Italy's primary focus also in the coming years.

Table 5: Italy's top 10 recipient countries in 2019 (gross disbursements, million USD, current prices)



Source: OECD, 2021

The direction of Italian development aid is largely due to its geopolitical position at the centre of the Mediterranean Sea. However, the flow of Italy's Official Development Aid is directed not only to physically nearby countries, but also to countries with which it has a political, economic and cultural relationship. For this reason, the 2021-2023 Programming and Policy Planning Document highlights that Italian engagement will be strengthened in the main crisis areas, such as the Balkan, the Middle East, Africa, Asia and Latin America. The identification of these priority geographical areas results, as already mentioned, from the existing historical and commercial relationships, but also from the need to intervene in low-income and least-developed countries in order to strengthen their governance and their socio-economic framework (Documento triennale di programmazione e di indirizzo 2021-2023). In these countries, Italian cooperation acts prevalently thanks to the Italian Agency for Development Cooperation (AICS) branches abroad. The current Programming and Policy Planning Document identified specifically 20 prioritised countries, 10 of which are classified as least developed countries: Burkina Faso, Mali, Senegal, Niger, Ethiopia, Somalia, Sudan, Mozambique, Afghanistan and Myanmar. (Documento triennale di programmazione e di indirizzo 2021-2023).

Even more than bilateral aid, Italy's contribution to ODA is focused on multilateral aid, which made up 68% of Italy's ODA in 2019, with the DAC average being 41% (Donor Tracker). More specifically, European Union Institutions received US$1.9 billion of Italy's ODA in 2019,

amounting to 63% of the country's total contributions to the multilateral system (ibid.). In 2019, other recipients of Italy's multilateral development aid flows in 2019 included the World Bank Group (US$423 million or 14% of multilateral ODA), regional development banks (US$271 million or 9%), and UN agencies (US$194 million or 7%) (ibid.).

To conclude, as the Policy Planning Document highlights, bilateral cooperation remains an indispensable tool and goes hand in hand with multilateral initiatives, making them more incisive and endorsed. Both these bilateral and multilateral initiatives allow Italy to actively contribute to global initiatives. However, at the same time, Italy exploits development aid in order to further strengthen its national political and business interests.

2.2 Legal and Institutional History of Official Development Assistance in Italy

In order to outline the history of Italian development assistance, it is first of all important to highlight that it has only been since the 1960s that the country got involved in issues related to less developed countries. Actually, Official Development Assistance started to find its role within the foreign policy of the country in the 1980s, as before it was not conceived as an useful foreign policy instrument and did not represent a tool through which Italy could build "mediation" between the North and the South of the world (Tosone, 2011, 130). Indeed, Italian development cooperation reached a systematic structure in 1979, when the increasing interventions both in qualitative and quantitative terms and in different geographical areas made it necessary to reorganize the subject in order to enhance development assistance as a fundamental aspect of the Italian foreign policy. So much so that in that same year, the passing of law n. 38 opened the most important phase of Italian development cooperation policy (ibid.). Thus, this section will analyse the different historical phases of Italian Official Development Assistance, starting from the 1960s until nowadays, with a particular focus on the legislation regarding this field of study.

The Founding Years: 1950-1960

As already mentioned, the 1950-1960 decade in Italy was characterized by massive economic problems due to post-war reconstruction. This, together with Italy's limited concern for Third World development issues, complicated the implementation of a foreign aid policy. In fact, it could be said that Italy, and particularly its South, was itself still a relatively poor and

underdeveloped country, and hence had neither the resources nor the public interest to engage in international development aid.

Thus, while other Western countries (especially the United States) started becoming involved in the development discourse, Italy was still not interested in becoming a donor country. As Tosone (2011) explains, Italian activities abroad in this period included only minor programs of technical assistance and an export credit program. What is more, financial assistance in grant form was given only in exceptional cases to countries with which Italy had strong historical ties, such as Somalia and Libya. Somalia, a former colony, represents a special case that will be discussed further on.

The Real Start to Official Development Assistance in Italy: 1960-1970

The Italian situation started to change in the 1960s, when, following the UN General Assembly resolution on the Development Decade (1961)[20] and international pressures particularly from the U.S., Italy started to pass a series of laws on technical assistance activities abroad[21] and to provide better conditions for credit on exports (Tosone, 2011). This happened also because of Italy's need to improve its image and position within the Atlantic Alliance. In fact, the Development Assistance Committee was constantly criticizing both the quantitative and qualitative limits of the Italian aid policy. In particular, the criticisms were directed towards the massive use of export credits (considered only as commercial advantages), the strict conditions of the loans and the private form in which aid was delivered.

However, for its part, Italy claimed that the international community had to take into consideration the fact that the Italian economy was much weaker than others. For example, in 1957, the Minister of Foreign Affairs Giuseppe Pella declared: "Although my country has achieved a considerable degree of economic development and industrialization […] it still has its own urgent development problems in the economically backward areas of the south". This

[20] The years between 1960 and 1970 are referred to as the "first development decade". In the 1960s, issues of development came to the attention of the international community through actions both within and outside of the United Nations. During this time, member states were required to intensify their efforts to mobilize support in order to accelerate progress toward self-sustaining economic growth and social advancement in the developing countries.

[21] For example, in 1961, the law 635 was passed. It extended the state guarantees to five years for the export of Italian goods and services. In 1962, law n. 1594 allowed bilateral technical cooperation with the Third World (the preceding laws dealt only with Somalia). In 1967, the law 13 regulated financial cooperation. In 1966, the law 1033 allowed to young men who wanted to serve as volunteers in Third World countries to delay or skip compulsory military service.

Italian attitude led Claire Sterling, a Herald Tribune journalist to refer to Italy as an "over-underdeveloped" country, as Italy considered itself "as the first of the least developed countries, and the last of the industrialized ones" (Tosone, 2011, 136). This position, as Tosone underlines, had the aim both to establish a sort of rhetoric friendship with the Third World and to remind of its domestic economic problems that did not allow that great resources be fed into foreign aid policy. However, this attitude started to lack credibility as Italy was gradually becoming more and more industrialized, to the extent that the country was admitted to the Group of the most industrialised countries, known thereafter as the G7.

In this period, as far as the geographical distribution of aid was concerned, Italian aid for development was concentrated in few countries with greater development and productive opportunities for Italy, located especially in the Mediterranean basin, Africa and to a lesser extent in Latin America. For example, in the period between 1965 and 1969, only ten countries[22] received 93% of Italian funds. It is worth mentioning that, of these ten countries, Yugoslavia, the United Arab Republic and Somalia absorbed 70% of the total bilateral fluxes (ibid.). Under this regard, the Somalian case deserves special attention, both for the historical relations and for the quality of aid that Italy channelled to the country. In fact, since the second half of the 1960s, thanks to the issue of decolonization, a few sectors of Italian public opinion started to gain interest in Third World underdevelopment and in international cooperation. For example, Catholic associations began their involvement in third world initiatives, and the Italian Communist Party supported some African national liberation movements (Borruso, 2009).

For these internal reasons and because of the constant international pressure, in 1966 the Minister of Foreign Affairs began the first real discussion on the Italian development cooperation policy. To this regard, the Foreign Affairs undersecretary Mario Zagari proposed an increase of multilateral contributions and a better coordination of the technical assistance activities through the reorganization of the institutional structures involved in development assistance. What is more, Zagari put emphasis on the fact that a more effective and credible foreign aid policy could benefit Italy with economic and commercial advantages (Tosone, 2011).

[22] With these countries being Yugoslavia, United Arab Republic, Somalia, Greece, Tunisia, Ethiopia, Nigeria, Brazil, Panama and Mexico.

Italy's Official Development Assistance Setback: 1970-1980

This debate led in 1971 to the passing of the law n. 1222, which unified all the preceding laws regarding technical assistance activities and innovated some points. However, the new law did neither deal with multilateral assistance nor with the soft-loans instrument (Tosone, 2011). This is one of the reasons why, as in the 1960s, also in the 1970s Italy did not improve its performance as a donor country. The other explanation of the Italian lack of initiative was the deep economic crisis of the 1970s, opened by the American President Nixon's decision in 1971 to end the conversion of the dollar into gold, and worsened by the consequences of the 1973 first oil shock. Thus, the law 1222 remained mainly unenforced and did not bring the expected results.

The scarcity of Italian development aid flows was also once again highlighted by the international community, which in 1972 criticized the too low percentage of Official Development Aid and the too severe conditions of the loans (ibid.). For this reason, and for the acknowledgment of the limits of the law 1222, a new parliamentary debate began in 1976 and culminated in 1979 with the passing of law n. 38, which can be considered as the basis of Italy's development cooperation policy. In fact, the law provided a more comprehensive political and economic framework through the regulation of both technical and financial cooperation. What is more, it reinforced the centrality of the Ministry of Foreign affairs, linking aid policy to the general foreign policy of the country and establishing a Department for Development Cooperation and coordination and planning committee (CIPES).

A Positive Change: 1980-1990

Thanks to the implementation of the law n.38, the years between 1979 and 1990 saw a remarkable growth in the amount of funds for cooperation, reaching an increase of 165% (ibid.). What is more, also the Italian composition of aid positively changed: more public funds were allocated replacing private ones, more loans were distributed at favourable conditions and technical assistance diminished. On this matter, it is worth mentioning that Italian activities were in countertrend with respect to donor countries' attitude in that same period. In fact, the 1980s are defined as the "lost decade" for development, as international resources for development drastically dropped in other countries, making Italy one of the major international donors.

During the 1980s, foreign aid was challenged not only internationally, but also internally to Italy. In fact, as Zucconi (2002) highlights, there was a "bipartisan consensus to boost foreign aid" at the party level. The Christian Democracy (*Democrazia Cristiana*) was supporting the more "development-oriented" allocations, the Italian Socialist Party (*Partito Socialista Italiano*) the more "economic-oriented", and finally the Italian Communist Party (*Partito Comunista Italiano*) the more "ideological-oriented" allocations. In addition, also a "left" and "right" differentiation can be considered. In fact, the centre-right coalition's foreign policy goals focused more on neo-Atlanticism and pragmatic bilateralism, while the centre-left was more inclined towards "neo-Europeanism[23] and effective multilateralism" (Carbone, 2007a, 903).

Despite this internal debate regarding the nature of foreign aid, the first Italian law regarding international cooperation was replaced in 1987 by the law n. 49. Under this normative framework, development policy was to become a central and integral instrument of the Italian foreign policy (law 26 February 1987, n. 49). However, despite being very detailed on implementation, the new law needed to implement a more long-term vision, so much so that its reform has been a constant theme in the public debate (ibid.).

The Tangentopoli Crisis and Other Political Issues: 1990-2000

Regarding the issue of Official Development Assistance, the rising profile that characterized Italy during the 1980s was replaced by a low profile until the beginning of the following decade. In fact, the tangentopoli political crisis of the early 1990s also affected the flows of international aid. More specifically, various cases of corruption in the public administration were found in 1992 and the discredit placed on the political sector caused a dramatic crisis also in the aid programme.

Both the centre-right and the centre-left attempted to raise the status of development policy in Italy. However, no significant progress was achieved. The only solution to Italy's crisis regarding its development policy was considered to be the reform of the law of 1987, which was proposed during Berlusconi's first cabinet in 1994. In fact, the Minister of Foreign Affairs of the time, Antonio Martino, proposed a sort of "privatisation" of foreign aid, through the creation of a private entity to implement projects outside the Ministry of Foreign Affairs. Yet,

[23] This strong support for the process of European integration was led by the Italian need to be included into Europe.

this proposal was never adopted (Fossati 1999). Nor did the centre-left coalition governing between 1996 and 2001 manage to raise the volume of international aid, which remained much below the EU average despite the expectation of development cooperation to become a priority with the advent of the centre-left government.

In general, it must be highlighted that the frequent changes at the political and the administrative level[24] and the fact that no under-secretary with exclusive competence for development policy was ever appointed, made it even more difficult for Italy to implement significant initiatives in the field of international development (Carbone, 2007a). However, despite these complications, by the end of the 1990s, Italian policy of cooperation was broadly in line with international parameters, both as far as objectives and methods were concerned (Tosone, 2011, 125).

The Need for a Legislative Reform: 2000-2010

The flows of Italian aid for development decreased again at the beginning of the new millennium. So much so that the European Commission, in its 2006 report assessing trends for 2005, decided to "name and shame" Member States, identifying Germany and Italy as being "behind schedule" in the agenda regarding foreign aid.

In that same year, however, the then elected Prodi government made grand promises during the electoral campaign, announcing that globally fighting poverty would be a central element of the programme and that a deputy minister would be appointed exclusively for development policy. This initial optimism rapidly vanished as the initial proposals "were far from marking the beginning of a new era in Italy's development policy" (Carbone, 2007a). In addition, the new deputy minister Patrizia Sentinelli stated that the new centre-left government would have reached the 0.33% target by 2006 and the 0.7% target by 2015, enhancing coordination among the various players in Italian development policy (ibid.). However, this ambitious programme was not implemented, nor were the pre-established targets met: Italy's ODA as a percent of GNI declined to 0.20% in 2006 and reached only 0,22% in 2015 (OECD, 2019). Thus, regarding the Italian program management and coordination, the Development Assistance Committee continued to highlight the need for a legislative reform that could allow a greater effectiveness of development policy (Tosone, 2011).

[24] Four different ministers changed over a five-year period, together with changes of the Director General for International Cooperation and the General Secretary of the Ministry.

2.2.1 Law 125/2014: General Law on International Development Cooperation

The Italian need for a new simplified and clearly-targeted legislative framework was met thanks to the law n.125, approved on 11 August 2014 and entered into force on 29 August 2014. This new general discipline on international development cooperation reflected the previous efforts to accord Italian legislation to the principles and issues related to development aid, which emerged in the international community during the last decades. In particular, the reform established the principal by which development cooperation, sustainable development, human rights and peace constitute the basis of Italy's foreign policy.

A further rationale for cooperation is introduced, the one to "promote mutually supportive and egalitarian relationships between peoples based on principles of interdependence and partnership" (Republic of Italy, 2014). Thus, the new law links Italian cooperation to the context of international partnership. In fact, it refers to the Charter of the United Nations and to the Charter of Fundamental Rights of the European Union, and obliges the government to indicate how Italy can meet its ODA commitments. In addition, collaboration with the European Union is underlined by the identification of multilateral cooperation as the first mode of cooperation (OECD, 2019).

What is more, in order to emphasize the greater role played by development cooperation in in Italian foreign policy, the reform changed the name of Italy's foreign affairs ministry, to the "Ministry of Foreign Affairs and International Cooperation" (MAECI). Law 125/2014 also established the Italian Agency for Development Cooperation (AICS), bringing Italy in line with other European countries, many of which had long since established similar specialised agencies (Venturi, 2019). The agency, which started its operations in January 2016, has enhanced transparency, improved projects' monitoring and evaluation and expanded the involvement of the private sector (ibid).

To conclude, law 125/2014 represents a fundamental progress in Italy's aid development history, replacing the unsuitability of the previous legislations on foreign aid, which, since the 1960s, had reflected a scarce commitment by the political establishment and also by domestic public opinion, and which found its limits in the economic problems of the country (Tosone, 2011).

To summarize, Italy can be considered as an ambiguous actor, especially because of its lack of commitment to global responsibility and its internally divisive political scene. What is more, the Italian path to Official Development Assistance has been mainly influenced by international pressure and thus state-driven, at least as far as the first stages are concerned.

2.3 The Actors

As emphasized by the law n.125 of 2014, development cooperation is an "integral and qualifying part" of Italian foreign policy and builds on an internal architecture that will be explained in this section. First of all, it must be said that Prime Minister Mario Draghi, the former head of the European Central Bank, who has been leading the Italian government since February of 2021, has been playing an important role in determining the focus of Italy's development cooperation. What is more, the Parliament is also active in the budget process, examining, amending, and voting on the draft budget developed by the government.

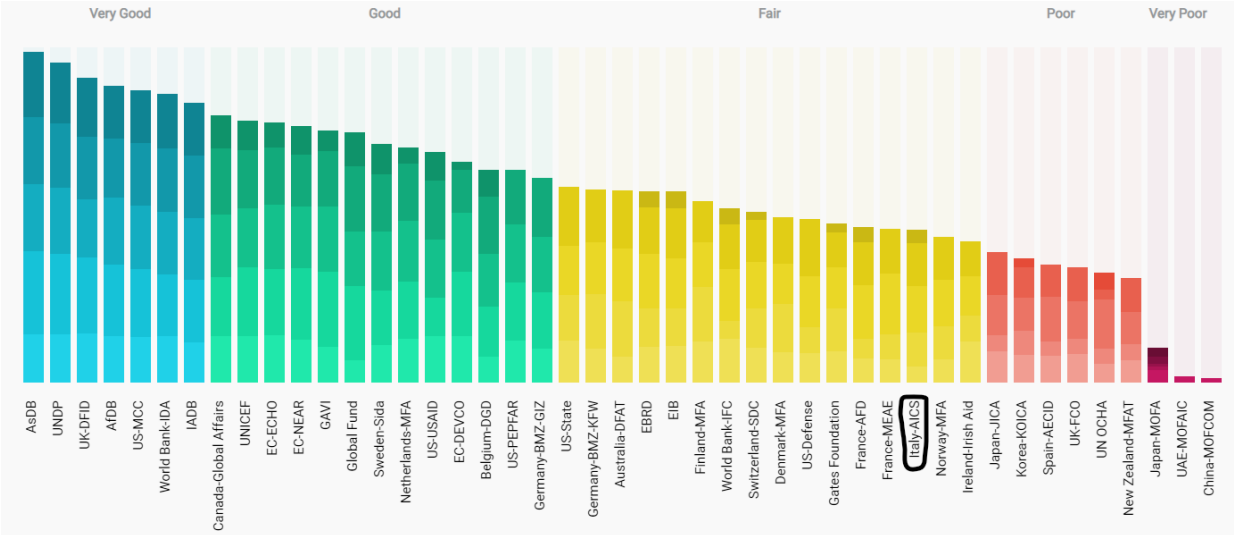
Regarding ministries, the Ministry of Foreign Affairs and International Cooperation, headed by Luigi Di Maio since September of 2019, defines the more specific strategic direction of Italy's development policy. Marina Sereni, the Vice Minister of Foreign Affairs and International Cooperation, is responsible for the cooperation portfolio, managing the ODA budget as well as the development of the already mentioned three-year Programming and Policy Planning Document, which defines the country's overarching development objectives and priorities. Another important role within the MAECI is the one played by the Directorate-General for Development Cooperation, Giorgio Marrapodi, who supports the Vice Minister in defining the strategic direction of development programs (Donor Tracker).

Moving on, the Ministry of Economy and Finance (MEF), led by Daniele Franco, collaborates with MAECI on the Official Development Assistance's budget. Considering its involvement in development-related initiatives, the MEF is also made up of The Directorate III on International Financial Relations, which consists of 10 specific offices that coordinate the partnership with MAECI as well as the organization of the G20's Development Ministry meeting, together with other informal government groups (ibid.).

Another committee which involves different ministries is the Interministerial Committee for Development Cooperation (CICS), chaired by the Prime Minister and of which the Minister and Deputy Minister of Foreign Affairs is the vice-president. The CICS usually meets twice a year to approve the three-year Programming Guidelines and has the task of managing all activities related to cooperation, ensuring the coherence of national policies with international initiatives of development cooperation (Documentazione Parlamentare, 2021). What is more, the development finance institution, Cassa Depositi e Prestiti (CDP) provides technical and financial support to MAECI and AICS, by signing agreements with the governments of partner countries or by managing Italian, European, international, and private sector funds. The CDP itself can also finance development projects, using its own resources or private and public blending instruments (Donor Tracker).

As already mentioned, a fundamental actor is the Italian Agency for Development Cooperation (AICS), which develops, supervises, and implements Italy's development programs. AICS acts in focusing on five thematic areas: economic development and opportunities; human development (including health and education, gender equality and disabilities); environment and use of natural resources; rural development and food security; and conflict-affected and fragile states (ibid.). It is also worth mentioning that AICS was classified as "fair" by the Aid Transparency Index 2018, a position that still places Italy behind many other donors (see Table 6, page 48), but definitively represents an improvement compared to the past (Venturi, 2019).

Table 6: The 2018 Aid Transparency Index



Source: Aid Transparency Index 2018

A further important aspect of the Italian system of development cooperation is that, as it is the case in all other countries, non-governmental organizations and the civil society are involved in the policy-making process. In fact, art.16 of law 125/2014 disciplines the functioning of the National Council for Development Cooperation (CNCS), which is a consultative body bringing together the main private-sector organizations, civil society organizations, and public authorities to provide feedback on the government's development policies (Documentazione Parlamentare, 2021). As far as the civil society is concerned, Italy's National Civil Protection department also participates in international relief operations, humanitarian aid, and post-emergency reconstruction projects. On the other hand, regarding non-governmental organizations, the most advanced actors in the field are Church-related initiatives, Caritas[25] being the leading one.

In addition to central authorities, Italian regions and autonomous provinces have also adopted laws to regulate decentralised international cooperation activities. For instance, five regions (Emilia Romagna, Lombardy, Tuscany, Umbria and Veneto) have introduced specific regulations for their health development aid and established dedicated offices within their Regional Health Departments (Missoni et al. 2014).

To this regard, it must be highlighted that, since the mid-1990s, Decentralized Cooperation has become a peculiar feature of the Italian cooperation system. The aim is that of promoting human development through the creation of "long-term cultural, technical and economic partnerships between local communities" (ibid.).

To conclude, the main actors involved in the Italian system of international cooperation and aid are national authorities, universities and public entities; regions, autonomous provinces and local actors; civil society and non-profit organizations; profit-organizations. They are all acting in accordance with the principles outlined by law 125/2014, with the commonly adopted standards regarding social responsibility and respecting human rights and the international community norms (Documentazione Parlamentare, 2021).

[25] The Italian Caritas was born in 1971 as "the helping hand of the Church". Its aim is that of helping the poor, vulnerable and excluded. Its direct connection with other national Caritas is fundamental, as is its link to Caritas Internationalis, which is a group of 162 Caritas organizations.

2.4 ODA's Budget

Taking into consideration the resources directed towards Official Development Assistance, the main ODA budget line is generally managed by the Ministry of Foreign Affairs and International Cooperation. However, it is worth mentioning that, during 2021, the largest part of Italy's ODA budget (45%) was actually managed by the Ministry of Economy and Finance, with a total amount of €2.4 billion (US$2.7 billion) (Donor Tracker). In that same year, the MAECI managed €1.2 billion (US$1.4, 23%) of the ODA budget (ibid.).

Regarding the allocation of resources, MAECI's budget is mainly directed towards the program regarding Development Cooperation, which comprises "chapters" of funding to Italy's development agency, AICS (€527 million or US$590 million in 2021), and contributions to the European Development Fund. It also includes several "chapters" of contributions to the UN and other International Organizations (ibid.).

In order to analyse the budget reserved for Official Development Assistance, it could be also interesting to outline the budget process in terms of timing and schedule. First of all, parliamentary budget discussions run from October to December, with overall ODA levels being set in March and April (Donor Tracker). From February to April, the government develops the Economic and Financial Document (DEF), which sets a three-year framework for economic and budgetary planning, including the budget directed to international aid. Key decision-makers in this process are the Prime Minister, the Minister of Finance, the Minister of Foreign Affairs and International Cooperation, and the Vice Minister of Foreign Affairs (ibid.). From July to September, the government develops the budget draft, which is presented to Parliament in mid-October. From October to December, the Parliament examines, amends, and votes on the budget draft, setting the final budget levels after having considered recommendations given by the Foreign Affairs committees of both houses (ibid.).

It is worth noting that, in addition to the regular budget process, at the end of December the government usually issues the so-called *Milleproroghe* ("one thousand extension decree"). This decree is adopted, among the other things, to finance additional measures in the next budget year, relating to any budgetary issue. This could provide an additional opportunity for interest groups to influence the ODA budget.

2.5 Different Approaches to Official Development Assistance

In order to understand the entire Italian system regarding Official Development Assistance and its characteristics, it will be useful to compare the Italian case with other countries' approaches to the issue. For instance, it is first of all important to underline that, as already mentioned, Italy does not have a long and consolidated tradition of development policy, contrary to the majority of the other Western countries.

As a matter of fact, as Tosone (2011) emphasized, Italy long held a significantly different foreign aid policy if compared to other Western countries, and especially with what the USA was trying to make them accept with regard to the volume and forms of aid. First of all, the volume of the resources that Italy transferred to least developed countries was always below the 1% GNP target established in 1964 at the first United Nations Conference on Trade and Development[26] (UNCTAD).

Another noteworthy difference is that, in opposition to other countries' ODA flows, Italian fluxes were never constant, but tended to rapidly increase or diminish, further highlighting the "episodic dimension" of Italian development cooperation policy (Tosone, 2011, 131). A further fundamental distinction concerns the form of Italian aid: while Italian private flows always exceeded public aid, the growth of ODA for other Development Assistance Committee countries was always higher than the growth of private flows (ibid.).

Despite these differences in the Italian case, other dissimilarities regarding the nature of foreign aid can be identified also considering other European countries. For instance, between the 1960s and the mid-1980s, the European Commission was divided on the issues of development aid. In fact, as Grilli (1993) explains, there was debate between regionalists and globalists. The former (France, Belgium and less openly Italy and other southern Member States) emphasised strategic links between Europe and its former colonies; while the latter (Germany, the

[26] In 1960, the UN General Assembly stated that "the flow of international assistance and capital should be increase substantially as to reach, as soon as possible, approximately 1% of the combined national incomes of the economically advanced countries" (Resolution n. 1522 (XV), 15 December 1960). In 1964, the UNCTAD accepted this target, recommending that it should apply to individual donor countries. It is worth noting that, although this target was confirmed in subsequent UNCTAD and DAC recommendations, actually none of the DAC countries has ever met it. It was, substantially, a moral and symbolic obligation rather than a legal one.

Netherlands, the northern Member States and the UK) placed more emphasis on poverty eradication.

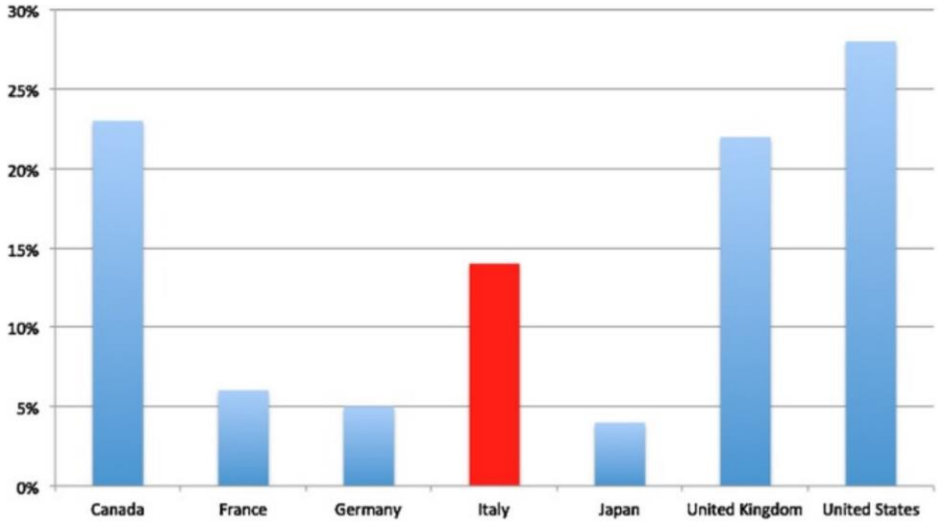
It can be said that this division in attitudes continued to persist almost unchanged over the years, as also nowadays there is high heterogeneity in donor behaviours. As a matter of fact, as already mentioned in Chapter 1 (page 20), Berthélemy (2005, 17) states that Austria, Denmark, Ireland, Netherlands, Norway and Switzerland can be identified as the "altruistic cluster", which allocate aid on the basis of proper incentives, such as levels of poverty, democracy, openness and good institutions of the receiving countries. On the other hand, the "egoistic cluster" is composed of Australia, France, Italy and United Kingdom. It should be noted that among the above-mentioned countries, only the United Kingdom radically changed its position from placing more emphasis on poverty eradication to being classified as an "egoistic" country. Instead, the other countries, generally maintained their attitude towards Official Development Assistance, directing more resources, either based on solidarity or strategic means.

2.6 Italian Official Development Assistance for Health

For the aim of this thesis, in addition to Italian Official Development Assistance main features, it is also important to focus on Italy's guidelines as far as health aid is concerned. Consequently, after having provided a brief introduction, this final section will outline the main approaches, actors and issues regarding Italian Official Development Assistance to Health (ODAH).

As previously mentioned, Italian cooperation with developing countries is governed by Law no. 125 of 11 August 2014, which aims at "uprooting poverty and narrowing inequalities, improving the living conditions of peoples and promoting sustainable development". With these objectives as a basis, Italian foreign aid's initiatives are developed with a particular focus on the health sector. According to the OECD's Creditor reporting System, Italy directed a total of US$ 1179 million between 2001 and 2012 to Official Development Assistance for Health. What is more, during the same period, Italy's ODAH as a percentage of total sector allocable aid was 14%, ranking fourth among the G7 countries (as illustrated in table 7, page 52), behind the United States, Canada and the United Kingdom (OECD's CRS).

Figure 7: G7 ODAH as percentage of total sector allocable ODA (aggregate values 2001-2012)



Source: Missoni's et al. (2014) elaboration on data extracted from OECD's Creditor Reporting System on 18.12.2013

More specifically, Italian development cooperation within the health sectors is guided by an emphasis on "prevention, community participation, appropriate technology, a cross-sectoral approach and the promotion of local self-sufficiency" (Missoni et al., 2008). With these objectives as main guidelines, Italy concentrated its health-related aid policies on the support of both national health systems and local health systems through decentralization processes. Indeed, the Italian approach to aid development for health is characterized by the involvement of civil society and coordination with all relevant local actors (Missoni et al. 2014).

For many years, another pillar of Italian health policy has been primary health care, with the aim of promoting equity in the distribution and access to health resources in its own national health system as well as in its development cooperation activities. Recently, however, Italian aid initiatives have been shifting their focus on fighting individual pandemics. For instance, even before the emergence of Covid-19, Italy contributed an overall total of 404 million euro to the Global Fund to Fight AIDS, Tuberculosis and Malaria, only between 2002 and 2005 (Missoni et al., 2008).

More in general, Italy's current health care key priorities are "promoting multilateral solutions to global health challenges, reducing inequality, and strengthening food security" (Donor Tracker). These objectives derive from a response to the current global health crisis, which led

the G20 presidency[27] to implement the 3Ps (people, planet, and prosperity) also in the strengthening of health systems and in the recovery from the Covid-19 crisis.

Italy's objective to strengthen health systems is also stated in its Programming and Policy Planning Document, which identifies health protection as a global public good and as a top priority in order to guarantee a universal health coverage. In particular, the focus is on a better prevention of pandemics and on sexual and reproductive health care, issues that especially affect developing countries. The specific aims of the triennium 2021-2023 are concentrated on ensuring equal access to health care services, on sustaining research, on producing and equally distributing medicines, health treatments and vaccines (Documento triennale di programmazione e di indirizzo).

Despite these virtuous premises, it must be admitted that the efficiency of Italy's ODAH is affected by the fragile structure, weak management and unstable funding that has characterized Italian's Official Development Assistance since the 1960s.

2.6.1 Paradigm Shift

As already stated, Italian cooperation in the health sector aims at "ensuring universal access to efficient and effective health services through suitable strategies and intervention in both national and local health plans". This traditional Italian attitude can be defined as a "horizontal"[28] and systemic approach to health.

Since the beginning of the new millennium, however, Italian attention has started to shift towards the promotion of single-issue and disease-oriented initiatives, sharply contrasting with its traditional comprehensive approach to health care. More specifically, Italy's main channel of development intervention concerning healthcare is the Global Fund for the fight against AIDS, Tuberculosis and Malaria (GFATM), with a total contribution of US$ 1008.3 million

[27] As part of the G20 presidency and in collaboration with the European Commission, Rome hosted the Global Health Summit on the 21th of May 2021, in response to the Covid-19 pandemic.

[28] A "horizontal" approach to health care aims to solve issues affecting the over-all health system implementing long-term solutions, for instance through the creation of permanent institutions. On the contrary, the vertical approach focuses on the eradication of specific diseases, with vaccination or disease-specific campaigns being its main instruments.

between 2001 and 2009, making the country the eighth largest donor with a seat in GFATM's board (Missoni et al. 2014).

To this respect, it is worth mentioning that, as a result of Italy's high contributions to the GFATM, launched at the Genoa G8 Summit in 2001, the donations of Italian ODAH tripled between 2001 and 2007 (Missoni et al., 2009). What is more, Italy increasingly started to engage in financing mechanisms, including the International Financial Facility for Immunisation and the Advance Market Commitment for vaccines initiatives, which aims to accelerate the development of new health related products by ensuring their subsequent purchase according to pre-arranged criteria with pharmaceutical companies. Italy contributed almost half of the financing for the first pilot project that aimed to accelerate the development of a new vaccine against pneumococcal disease (Missoni et al., 2008). Other global health multilateral initiatives that received Italian support include the Global Polio Eradication Initiative, the WHO's Roll Back Malaria programme, and the Stop TB initiative. It must also be emphasized that, in September 2007, together with other bilateral and multilateral donors, Italy undersigned an initiative put forward by the then British Prime Minister Gordon Brown to set up an International Partnership for Health, which aimed to supporting health systems and foster coordination among major donors (ibid.).

2.6.2 Italian Official Development Assistance Actors

This increasing involvement is also due to the engagement of many Italian actors in issues related to health aid initiatives. In addition I would like to highlight that the Italian Constitution states that "the Republic safeguards health as a fundamental right of the individual and as a collective interest, and guarantees free medical care to the indigent" (art.32). Thus, health being recognized as a "collective interest", not only the Italian National Health Service is increasingly engaged in Official Development Assistance for Health, but the civil society is also very active to this regard.

In addition to central authorities and Civil Society Organizations, Italian regions and municipalities have also adopted laws to regulate decentralised international cooperation activities. For instance, Emilia Romagna, Lombardy, Tuscany, Umbria and Veneto have introduced specific regulations for their health development aid and established dedicated offices within their Regional Health Departments (Missoni et al. 2014). Thus, regions' DAH

initiatives are implemented both directly through regional health services and indirectly through funding channelled by local and international NGOs. Italian regions also directly contribute to WHO programs and to research programs of the EU and other international organisations (ibid.).

Alongside these resources are those of private foundations, volunteer associations and academic institutions, which show growth in commitment to global health. In addition, it must be considered that the privileged connection with the health and social care network of the Catholic Church in developing countries is another important component of Italian ODAH. Regarding non-profit organizations, in 2014 there were 221,412 non-profit organizations in Italy, many of which were involved in international cooperation and solidarity activities, including health (ibid.). The role of non-profit organizations is fundamental also because they contribute to raising awareness, mobilizing sizeable resources from the private sector.

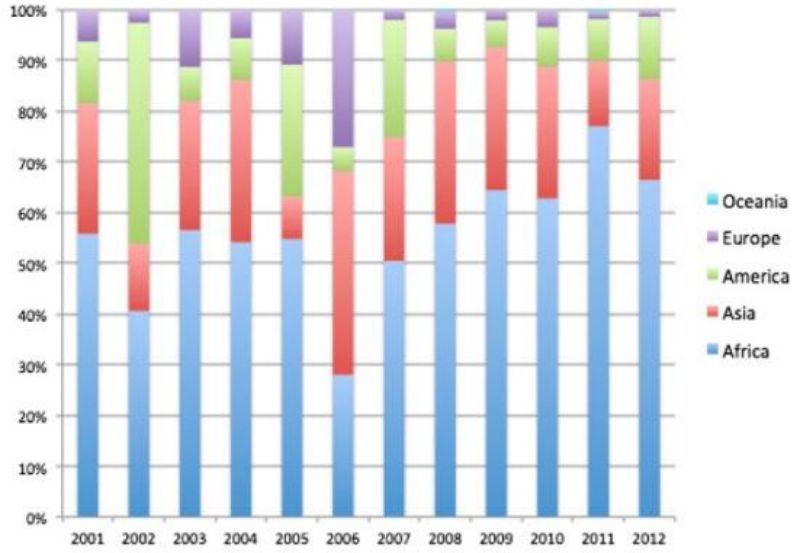
Indeed, large Italian corporate foundations and banking foundations have showed an increasing interest in global health issues. For instance, the Italian Oil Company ENI and Giorgio Armani have directly contributed to the GFATM. Additionally, in those countries where extraction activities are carried out (for example Azerbaijan, Congo, Libya, and Nigeria), ENI has been funding several health system development projects, as well as activities of international organizations such as UNICEF and WHO (ibid.).

Finally, the Italian Global Health Watch (*Osservatorio Italiano sulla Salute Globale*, OISG) has been raising public awareness about global health since 2002. Thanks to OISG, global health courses have been introduced not only in medical schools, but also in business schools, and faculties of social sciences, economics and management (Tediosi et al., 2013). The Medical Students Association (*Segretariato Italiano Studenti in Medicina*, SISM) and the Italian Society for Migrants Medicine (*Società Italiana di Medicina delle Migrazioni*, SIMM) are also significantly involved in organizing global health courses. What is more, in March 2010, an informal consortium[29] launched the Italian Network for Global Health Education, further contributing to the expansion of global health teaching and awareness in Italy.

[29] This informal consortium includes OISG (Osservatorio Italiano sulla Salute Globale), SISM (Segretariato Italiano Studenti in Medicina), SIMM (Società Italiana di Medicina delle Migrazioni), Doctors with Africa CUAMM, and a group of global health scholars. Their aim is that of exchanging ideas on issues of common interest and working on international health and the existing inequalities between and within countries. The main driving concept is to work towards introducing global health issues in Italy's general health system.

These actors implement their interventions worldwide, however, Sub-Saharan Africa remains the geographical priority for Italian ODA as well as for Official Development Assistance to Health. For instance, in 2011, Italian ODAH initiatives in Africa actually accounted for 70% of the total allocable funds for ODAH (Table 8, page 57) (Missoni et al. 2014).

Table 8: Geographically allocable ODAH. Distribution by Region. Years 2001-2012.



Source: Missoni's et al. (2014, 6) elaboration on data extracted from OECD's Creditor Reporting System on 18.12.2013

To conclude, Italy's Official Development Assistance in the health sector is implemented both bilaterally, through initiatives directly implemented in developing countries by NGOs, regions, local organizations, universities and public bodies, and multilaterally by working with the European Union and international organizations.

2.6.3 Issues of Official Development Assistance in Italy

Despite this great involvement, the limits of the Italian system for health aid must also be outlined. First of all, it must be said that these weaknesses are mainly due to the overall fragility of Italian development cooperation policies. However, Italy's approach to international health cooperation also suffered from specific limiting factors. For instance, the decision to follow the international tendency to implement narrowly targeted and "vertical" global initiatives, potentially undermined the effective delivery of integrated and universalistic health care, which was at the basis of Italy's DAH guidelines.

In addition, as Missioni et al. (2014) emphasize, Italy could better take advantage of the numerous energies of its country system already involved in global health, "including the experience of Italian institutions and civil society organizations in decentralized cooperation with homologous entities in partner countries".

To conclude, Italy's National Health System, which is founded on the principles of universal and equitable access to car, is also characterized by the distinctive feature of decentralized cooperation. This sees the involvement of a multiplicity of actors in the definition of health aid, from public institutions and private foundations, to the civil society and academic institutions. However, it must be said that the scope of success of Italian Development Assistance for Health is challenged by the current crisis due to the pandemic.

2.7 Conclusions

To summarize, since the emergence of Official Development Aid in the 1960s, Italy hardly recognized the need to become a donor country and was for long characterized by fragmentation of foreign aid programs. This was mainly due to economic limits and the very low concern of the Italian public opinion with regard to international aid.

Despite these initial difficulties, both the Italian government and the development community are now aware of the greater importance of issues related to underdevelopment and international aid. As a matter of fact, development cooperation is now recognised as an essential component of the Italian foreign policy. This shift has taken place mainly thanks to the implementation of law 125 of 2014, which tries to overcome the lack of transparency, accountability and effectiveness from which the sector has long suffered.

What is more, also Italian involvement in Official Development Assistance to health grew gradually over the last decades, placing the achievement of universal health care at the core of its policies and initiatives, carried out by a multiplicity of local bodies, institutions and associations acting in decentralized cooperation. However, as Venturi (2019, 1) underlines, Italy "still has a long way to go to bring development assistance more in tune with international standards and Italian interests". Under this perspective, Italian interests are mainly geopolitical,

as the Italian foreign policy under the Draghi government is shifting its priorities towards the European Union, the transatlantic relationship, and multilateralism more broadly, with a particular focus on health security, the climate, economic and infrastructure development (Coratella et al. 2021).

3. Historical Background: The State and the Health System of Mozambique

This chapter will take Mozambique's general context in consideration, with a focus on its National Health System. I will start by briefly considering its history, from colonization to independence, right up to more recent issues, like the Islamist insurgency afflicting the country. Subsequently, I will analyse the effects of perpetuated conflict on economic and human development, in order to then examine the challenges afflicting the health sector.

Mozambique's turbulent history has kept its people from developing a stable economy and has discouraged foreign investment. In fact, after having gained independence from Portuguese colonial rule in 1975, Mozambique experienced perpetuated internal conflict between the ruling Mozambique Liberation Front (Frelimo) and the Mozambique National Resistance (Renamo), due to the latter's intentions to weaken the government in order to change the Marxist political system, which Frelimo had established in the country. It was only in 1992 that the leaders of Frelimo and Renamo accepted a peace agreement. However, friction between the two groups still persists due to the enduring effects of the conflict. As a matter of fact, even if the country experienced great economic growth particularly after 2010 (Penvenne et al., 2020), more than half of the population remained mired in poverty creating imbalance and fear of political marginalization due to institutional weakness (Garrido, 2020).

Indeed, Mozambique, located in Southern Africa, is still one of the poorest and least developed countries in the world. The country ranks 181 out of 188 countries in the Human Development Index 2020, being classified as a low development country (dos Anjos Luis et al., 2016). Over half of its population, estimated at around 31,000,000 (The World Bank, 2020), lives below the poverty line (less than USD2 per person per day) (Gradín et al., 2019). In 2020, the country's Human Development Index was 0.456, ranking it among the 10 poorest nations in the world (UNDP 2020). What is more, the country's infant mortality rate is among the highest in the world, at 53 per 1000 live births (UNCEF, 2020). Average life expectancy is among the lowest in the world at 61 years (The World Bank, 2020), but comparable to that of other southern African countries (Penvenne et al., 2020).

3.1 Mozambique's Historical Background

In its early history, much of Mozambique was occupied by dispersed Bantu populations. Later, coastal areas started to be influenced by Arab traders and from the 16th century also by Portuguese settlers (de Tollenaere, 2006). These settlers gained control of the Island of Mozambique and the port city of Sofala and by the 1530s they had pushed their way into the interior. Between the 1890s and the 1930s, the Portuguese ruled Mozambique exploiting African people and resources (Penvenne et al., 2020). What is more, thousands of Portuguese settlers arrived in the 1950s and 1960s to take advantage of employment and business opportunities of which Africans were deprived (ibid.).

As Fitzpatrick (1981) explains, Mozambique's colonial economy was characterised by a high degree of economic dualism. This means that there were two economies in the country: one related to the peasant subsistence sector and the other one related to the commercial sector. It must be highlighted that the former largely involved the Mozambique's local population (about 90%), which was hardly included in the economic development initiated by the colonisers. On the contrary, the commercial market was mainly run by the colonizers, and more generally by Europeans and Asians, thus excluding the local community from any administrative and technical occupations.

This Portuguese colonial oppression led the African leadership, which had emerged in the late 1950s, to channel considerable discontent against colonial power. So much so that, in 1962, Mozambican representatives from exiled nationalist political groups met in Tanganyika (now Tanzania) and formed the socialist Mozambique Liberation Front (*Frente de Libertação de Moçambique*; Frelimo), with Eduardo Mondlane as its first president. In September 1964, Frelimo's guerrilla forces, trained and armed by African and Soviet-bloc supporters, attacked targets in northern Mozambique, launching the ten year long-war for independence (de Tollenaere, 2006). The conflict became violent, as colonial authorities resisted, responding with enormous military effort (Hanlon 2021). As the conflict continued, the Portuguese resulted militarily ineffectual against Frelimo's "small-scale guerrilla engagements" (Penvenne et al., 2020,). Thus, in 1974, the colonial regime fell and on 25 June 1975, Mozambique was declared an independent people's republic led by the single-party Mozambique Liberation Front (de Tollenaere, 2006), with its leader, Samora Machel serving as president.

3.1.1 1976-1992: The Civil War

Frelimo initially enjoyed widespread support because of its leadership during the independence struggle and because of its extensive investments in education, health care, and services (Manning et al., 2010). However, in 1977, the Frelimo government started to implement Marxist-Leninist policies through large-scale reforms and nationalisation projects, which were largely disruptive to Mozambique's society and economy. Indeed, the new approach characterized by the nationalization of properties and by a communal, cooperative, and state-run agriculture, irritated many Mozambican farmers (Penvenne et al., 2020). The government's agricultural and commercial policies thus fuelled a general economic collapse. These changes created noteworthy grievances among Mozambicans, especially in the rural areas (de Tollenaere, 2006), fuelling the upcoming civil conflict.

In fact, in 1977, the Mozambique National Resistance (*Resistência Nacional Moçambicana*; Renamo), an insurgency group supported by Rhodesia, South Africa, former Portuguese settlers, and Mozambicans opposed to Frelimo (Penvenne et at., 2020) launched its first attacks against the government. Renamo's main actions consisted in economic sabotage and destabilization of Frelimo's efforts to provide products and services to the population. For instance, as de Tollenaere (2006) outlines, this included the destruction of schools, hospitals and roads. Violence was also committed against people. The civil war between Renamo and Frelimo reached its peak in the period between 1984 and 1986 (de Tollenaere, 2006), when the official army started to use arbitrary violence against any civilians who were collaborating or were suspected of collaborating with Renamo (ibid).

The internal causes of the civil conflict were therefore related to the process of state formation in a complex context of ethnic pluralism, colonial legacy and post-independence policies (de Tollenaere, 2006). It is interesting to note that this was not unique to Mozambique, as wars for independence in Africa were often followed by civil conflict[30] (Bussotti, 2021). Indeed, despite the fact that all civil wars are different, similar patterns can be identified. For instance, every civil war can be considered as an intra-state conflict concerning the control over the government. The opponents are rooted in the same state and history, thus the battle takes place between neighbours, who are prepared to kill each other, often because they come to believe

[30] This was the case in Angola, South Sudan, the Democratic Republic of Congo and Zimbabwe

their neighbours want to kill them (Hanlon, 2021). What is more, initial conflict dynamics build on internal grievances, which can be measured by: ethnic grievances or religious hatreds, economic inequality, lack of political rights and government economic incompetence. In the specific case of the Mozambican civil war between Renamo and Frelimo, the main grievance among society members was given by the issues of economic and ethnic inequalities.

3.1.2 The 1992 General Peace Accord

Despite these difficulties given by the nature of the conflict, the sixteen-years long civil war ended thanks to the Mozambican General Peace Accord (GPA), signed in Rome in October 1992, hosted by the Italian government and other international mediators, including the U.S., Great Britain, Portugal and Germany (Manning et al., 2010). In addition, the peace process was overseen and supported by the UNOMOZ peacekeeping force (United Nations Observation Mission in Mozambique), which was central in supervising the ceasefire and the overarching formal framework for the implementation of the peace agreement (ibid.).

Formal negotiations between the two fractions began in July 1990, when the Catholic Community of Sant'Egidio was accepted by both parties as mediator. Peace talks were characterized by "a permanent tension between the desire for peace on the one hand and mutual distrust on the other" (de Tollenaere, 2006, 3). However, consensus was gradually reached, as Frelimo agreed to modify the constitution in order to open the political process to competing parties and end Mozambique's identity as a socialist country, in exchange for Renamo's promise to end the war.

The General Peace Accord mainly focused on the dismantling of Renamo troops, the integration of some of its armed forces in a new unified army, together with the preparation of the first multi-party elections (Manning et al., 2010). These missions were initially meant to be completed within one year, however, issues between the two parties were not totally resolved until 1994 (Penvenne et al., 2020). Indeed, the multiparty elections that took place in October 1994 are considered as the culmination of years of effort to reach peace between Frelimo and Renamo (de Tollenaere, 2006). The election campaign was supervised by the UN, while the European Union supplied election materials (Penvenne et al., 2020). It is also worth mentioning that the elections were considered free and fair by international observers, the population

participation was considerable, without notable clashes between the two parties. The losing party, Renamo, accepted the re-election of Frelimo's president Joaquim Chissano (ibid.).

3.1.3 2013: A Second Civil Conflict

Since the beginning of the 21st century, Mozambique experienced remarkable economic growth, mainly because of its rich resources like rubies, graphite and natural gas (Hanlon 2021). This economic growth, however, greatly increased inequality, leaving more than half of the population mired in poverty (Penvenne et al., 2020). Thus, marginalized groups, concentrated especially along the coast, argued that Frelimo leaders were not distributing wealth, in the same way the Portuguese colonialists had failed to do so before (Hanlon 2021).

This imbalance, fuelled also by political marginalization happening between the two parties, renewed the tensions between the Frelimo-led government and Renamo, which launched a low-level insurgency. The conflict culminated in October 2013, when Renamo decided to abrogate the 1992 General Peace Accord that had ended Mozambique's previous civil war. In August 2014 a new peace agreement between the two conflicting parties was reached. Despite this agreement, the climate of discontent continued, as a result the October 2014 presidential and legislative elections were contested (Penvenne et al., 2020). Indeed, after the victory of Frelimo's candidate Filipe Nyusi against Renamo's Afonso Dhlakama, tensions between the two parties persisted until 2016, when new peace talks began. Peace negotiations ended in August 2019, with Nyusi and Ossufo Momade (Dhlakama's successor) signing agreements with the aim of ending hostilities and fostering reconciliation (ibid.). Indeed, the following presidential and legislative elections held in October 2019 were characterized by a relatively peaceful climate, with few election-related incidents. Nyusi and Frelimo were again declared the winners: respectively with more than 73% of the presidential vote and with more than 71% of the legislative vote (ibid.).

3.1.4 The Islamist Insurgency

Together with political instability due to the recurrent tensions between Frelimo and Renamo, Mozambique is facing insurgencies involving Islamist militants concentrated in the northern Cabo Delgado Province since 2017. The roots of this conflict are multiple and complex, including historical, ethnical and religious issues. Local grievances are also driven by high

levels of poverty, growing inequality and disputes over access to land, the so-called "resource curse"[31] (Hanlon 2021). In fact, Cabo Delgado's strategic importance lies in the rich off-shore natural gas reserves being explored by the government in collaboration with multinational energy companies (Giles et al. 2021).

The complex context of the Cabo Delgado Province is given by the presence of Muslim local fundamentalists, who in 2010 started to argue that the economic problems in the Province were caused by a corrupt form of Islam. In addition, fundamentalists claimed that the Islamic Council of Mozambique (Cislamo) was dominated by Frelimo, who considered to have been helped by official Islamic leaders to steal the wealth deriving from Cabo Delgado's resources. Under this regard, as the independence war had been fought fifty years before with the aim of fostering equity, likewise, the Muslim fundamentalists argued that "sharia law[32] would bring equity and a fairer share of the province's wealth" (Hanlon 2021).

For these reasons, in 2017 the fundamentalists started a conflict against both the Islamic Council of Mozambique and the Mozambican government. The Islamist insurgency reached a critical point in 2020, the year in which attacks by militant groups sharply increased, causing more than 570 violent incidents in that year alone, including also violations of human rights as killings, beheadings and kidnappings (Giles et al. 2021). Another repercussion is that this instability forced massive number of people to leave their homes in areas where conflict erupted. Indeed, according to the UN Office for the Co-ordination of Humanitarian Affairs, nearly 670,000 people were internally displaced in the Cabo Delgado, Niassa and Nampula provinces by the end of 2020.

It is important to underline that the local fundamentalists and al-Shabab militia operating in the Northern area of the county are believed to have links with the wider Islamic state group (Penvenne et al., 2020). In fact, since 2020, both IS freelance jihadists have been providing support to the so-called "machababos", including training, arms, and financing (Hanlon 2021). While before 2020 the conflict had been considered as internal criminality, the IS involvement

[31] The resource curse generally occurs when global mining and gas companies share the surplus from resource extraction with a small local elite, and few resources reach the rest of the population.

[32] Sharia law is a religious law derived from the precepts of Islam, particularly the Koran and the Hadith. The fundamentalists who lead the insurgency follow a different version of Sharia law from that of other Cabo Delgado Muslims.

led the international community to refer to the war as international Islamic terrorism. This means that the Mozambican local civil war has taken a place in global geopolitics, attracting the interest of the United States and of the European Union, who see the Islamic State and Islamic fundamentalism as a global enemy (ibid.).

From their part, Frelimo and the government hope that by representing themselves as victims of Islamic terrorists, they will attract international aid and support. This could help to realize the Mozambican state plans to end the war within a few years. However, the country's track record suggests that, without dealing with the many local grievances, civil conflicts will continue to emerge (Hanlon 2021)

To summarize, after an eleven-year long liberation war, Mozambique gained independence from Portugal in 1975. However, independence did not imply the end of conflicts. Indeed, between the late 1970s and 1992, the country was afflicted by a civil war between the Liberation Front of Mozambique and the Mozambican National Resistance. The civil conflict formally ended in 1992, when the General Peace Accord was stipulated in Rome between the two conflicting parties. The peace agreement also marked the implementation of the first multiparty elections, held in 1994, characterized by the re-election of the previous ruling party, Frelimo.

However, despite the General Peace Agreement, stability in Mozambique remains weak, as demonstrated by the second civil war between the main parties in 2013 and the following Islamist insurgency started in 2017. The country thus remains in a double state of war: in the centre of the country because of military activity by Renamo, and in the North because of radical Islamist insurgents (Bussotti, 2021). It can be said that without resolving the local grievances related to economic and religious inequalities, civil wars and insurgencies will continue to arise.

3.2 The Effects of Latent Internal Conflicts: Short-Comings and Low State-Capacity

This section analyses how latent internal conflicts have had a negative effect on the county overall, leading to struggles for development and inequalities both in economic and political terms. In addition, in order to comprehend the effects of these conflicts on the local population, the concepts of "positive peace" and "negative peace" will be considered.

After gaining independence from Portuguese colonialism in 1975, the ruling Liberation Front of Mozambique widely invested in education, health care, and services (Penvenne et at., 2020). At first, this strategy was highly successful as it involved the majority of the population. However, a decade after independence, the civil conflict carried on by the anti-government forces of the Mozambique National Resistance started to produce social and economic upheaval, undermining the benefits gained in the previous years.

Indeed, the internal conflict hampering Mozambique had the consequence of displacing at least four million people, especially in the rural areas, and of causing one million deaths as a result of the violence, famine, and disease it produced (ibid.). Together with human losses, the tensions between Frelimo and Renamo negatively affected economic development, particularly under the regard of tourism and foreign investments.

Despite the formal end of the civil war thanks to the 1992 General Peace Accord, the country continued to be impacted by the effects of the conflict. In fact, the two opposition forces and the central government never definitively stopped their political rivalry, demonstrating how the peace agreement did not produce peace, failing to establish the conditions for preventing the emergence of new local conflicts and tensions. Thus, it can be said that the General Peace Accord was not able to create a climate for "positive peace" (Bussotti, 2021), creating instead a context of "negative peace", in which more subtle forms of conflict continue to evolve.

The opposite terms "positive peace" and "negative peace" were first used in 1964 by Johan Galtung, a Norwegian sociologist, who, in the editorial to the Journal of Peace Research, stated that "there are two aspects of peace as conceived of here: negative peace which is the absence of violence, absence of war; and positive peace which is the integration of human society" (Galtung, 1964, 2). In practice, it must be emphasized that peace is a multidimensional concept and that the mere absence of manifest violence in not an indicator for peace. In fact, in a context of positive peace, structural violence, intended as a subtle form of coercion that sustains relations of exploitation and oppression, is overcome as well.

Taking the Mozambican case into consideration, the peace process following the 1977 civil war, has thus failed to foster the expansion of the fundamental aspects defining the concept of positive peace, which can be considered as being "social equity, sustainable development and trust among the people" (Bussotti, 2021, 1). Such conditions of negative peace are confirmed

by the fact that, political instability between Remano and Frelimo re-emerged in Mozambique in 2013. In addition, since 2017, the Islamist Insurgency in the Cabo Delgado Province has been aggravating the situation in the country. These perduring episodes of political and military tensions continue to foster a "climate of marginalisation and exclusion of large sections of Mozambican society" (ibid.). Such a situation threatens safety and economic activities, negatively influencing the lives of the local people.

3.2.1 Economic Inequality

Sub-Saharan Africa is one of the most economically unequal regions in the world, this is because it is characterized by an imbalanced growth that disproportionally benefited the better-off causing increasing inequality (Gradín et al., 2019).

Considering the specific case of Mozambique, following the end of the civil war in 1992, the country was classified as the poorest country in the world, with a per capita GDP of current US$191.2 (The Word Bank Data) and widespread poverty. Recovery followed with rapid economic growth from the mid-1990s onwards, reaching a peak in GDP per capita of US$674 in 2014 (ibid.). Yet the country still ranks among the poorest in the world (Gradín et al. 2019). Regarding the colonial past of the country, the Mozambican colonial economy was characterized by "private monopolies, central planning, and state marketing of key products" (Penvenne et al., 2020), designed to promote capital accumulation by the state and Portuguese settlers, excluding most Africans from highly skilled and managerial positions.

After independence from Portuguese colonial rule in 1975, the country was challenged by issues of reconstruction and development (Arndt et al., 2012). Under this regard, the ruling party Frelimo adopted policies aimed at ending forced cultivation, forced labour, and ethnic discrimination. However, the government's initial strategy, characterized by socialist central planning, the nationalization of key properties and the administrative allocation of resources (ibid.) antagonized the local rural population. These counterproductive agricultural policies, together with the ongoing civil war and natural disasters further challenged Mozambican stability, causing the collapse of the agricultural production, commerce, and distribution system (Penvenne et al., 2020). Thus, only after a few years of independence, the country was hampered by huge economic crisis.

In 1984, in order to reorient and rebuild the economy, Mozambique joined the World Bank and the International Monetary Fund (IMF), announcing a significant change in its economic policy (de Tollenaere, 2006). The new economic plans influenced by the International Monetary Fund consisted in a structural-adjustment programme focused on privatization, decentralization and assistance to local rural populations (Penvenne et al., 2020) previously damaged by Frelimo's agricultural reforms. Finally, the government officially started to plan a post-war reconstruction rejecting its Marxist-Leninist approaches in 1989 (de Tollenaere, 2006), the year in which the Cold War's "proxy wars"[33] in developing countries also came to an end.

Mozambique's primary economic sector has always been agriculture. However, other economic activities play and have played an important role in the country's economy. Among these, the most important ones outlined by Penvenne (2020) are remittances from migrant labourers in South Africa, revenues from tourism and the country's port and railway sector, together with sources of foreign exchange. During the civil war, which started in the late 1970s, all these economic sectors deeply declined, regaining their importance only after the 1992 General Peace Accord. In the meantime, also the industry sector developed, especially as far as resource exploitation, aluminium smelting, and electricity production were concerned (ibid.). Sources of coal and natural gas also benefitted the country because they attired foreign investors. This, together with significant debt relief and economic reform endorsed by the government, led to an economic boom in the early 21st century.

However, this economic growth dramatically decreased in 2016, both because of a drop in commodity prices and because of an undeclared government debt worth about $2 billion, which led the International Monetary Fund, the World Bank and other donors to interrupt their aid to the country (ibid.), further worsening Mozambique's economic issues. While there used to be a relatively high level of trust between donors and the Mozambican government,, the situation deteriorated due to the occurrence of the debt scandal and due to the continuous corruption, which led donors to change their approaches (Steurs, 2019), limiting the flow of aid to the country.

The economic growth pattern which started occurring at the beginning of the 21st century had the positive effect of reducing poverty, but on the other hand, it had the negative effect of

[33] During the Cold War, the United States and the Soviet Union sponsored violent conflicts in developing countries in order to pursue their own ideological and strategical needs. These conflicts are referred to as "proxy wars".

substantially increasing social and economic inequality in Mozambique. This, as Gradín (2019) explains, is due to a disproportional increase in consumption among the better-off. This condition is worsened by the fact that it is taking place in a country with pronounced inequalities between urban and rural areas and between regions (North, Centre, and South) (Garrido, 2020). Thus, these situations of "growth without poverty reduction", common in all Sub-Saharan-Africa, raise concerns over the effectiveness of growth-oriented development strategies (Arndt et al., 2012).

To conclude, both colonialism and the civil war left a large imprint on the current Mozambican society (van der Berg et al., 2017). Indeed, in a country characterized by endemic poverty like Mozambique, inequality persists as wealth is concentrated in a relatively small part of the population. This issue, together with corruption and poverty, further fuels local discontent and grievances, making it even more difficult to create a stable and secure condition for this fragile country.

3.3 Focus on Mozambique's Health System

As dos Anjos Luis (2016) underlines, "universal health coverage has been considered a pillar of sustainable development and global security". Indeed, accessibility to healthcare[34] services plays a fundamental role in promoting health and a decent quality of life. For this reason, health related facilities should be universally available, accessible, acceptable, appropriate, and of good quality (AAAQ framework[35]).

Even though these are globally spread acknowledgments, many low-developed and low-income countries are not enjoying the benefits that a qualified health system should provide. Mozambique is not an exception. Indeed, despite the fact that the right of citizens to health care is provided by both the Constitution of the Republic (Articles 89 and 116) and the Charter of

[34] Accessibility to healthcare is the capability of a population to obtain a specified set of healthcare services.

[35] The Availability, Accessibility, Acceptability, Quality framework is a tool aimed at identifying potential barriers to accessing services in humanitarian settings. It was first developed with a focus on health services. However, it is now used to also evaluate other kinds of services.

Patient Rights and Responsibilities[36], the state of health of the majority of Mozambicans is precarious (Garrido, 2020).

The country's epidemiological situation is largely pre-transitional. This means that both communicable diseases (like malaria, HIV/AIDS, diarrhoeal diseases, acute respiratory infections and tuberculosis) and non-communicable diseases (cardiovascular diseases, injuries, cancers, etc.) are widely spread (dos Anjos Luis et al., 2016), so much so that Mozambique is one of the five countries in the world with the highest prevalence of tuberculosis and among the ten countries in the world with the highest prevalence of AIDS (Garrido, 2020).

In addition to diseases, chronic child malnutrition also poses a huge challenge to the general health of the country, increasing the morbidity and mortality rate in children aged under five and reducing their cognitive abilities. Indeed, the UNICEF Annual Report 2019 "The State of the World's Children 2019: Children, food and nutrition" states that Mozambique has one of the highest rates of child malnutrition in the world, with 43% of children under five suffering from chronic malnutrition and 8% from acute malnutrition (UNICEF 2019).

Regarding shortages the health care system, there is a chronic lack of skilled human resources, poor financial management and inappropriate planning. The referral system is weak and vulnerable, with the majority of the population having insufficient access to essential health care. Indeed, the coverage rate of basic public health services and the ratio of physician per 1000 inhabitants are among the lowest in the world (22 and 0.1%, respectively) (Vera Cruz & Dlamini, 2021). Consequently, Mozambique is among the countries with the highest gross mortality (8 per 1000 people in 2020) and low life expectancy at birth (60.9 years in 2020). Maternal mortality (289 per 100,000 live births in 2017) and infant mortality (54 per 1000 live births in 2020) are also very high (The World Bank Data, Mozambique).

Political and military instability, as well as the subsequent economic crisis further deteriorate Mozambique's health conditions, negatively impacting the lives of the people especially in towns and rural areas and negatively affecting activities in the health sector, leading to "stagnation or to setbacks in many health indicators" (Garrido, 2020).

[36] Approved by Resolution No. 73/2007 of the Council of Ministers, of 18 December 2007.

3.3.1 Issues Afflicting the Mozambican Health System

This section will consider the main challenges to which the Mozambican health system is exposed to, the main one being related to inequalities, poor accessibility conditions and a lack of skilled personnel. All these issues lead the national health system being weak and fragile.

The main causes of a weak health status and burden of disease in Mozambique are the country's high poverty levels, chronic malnutrition, poor access to clean water and poor sanitation, and insufficient geographical coverage of quality health services (dos Anjos Luis et al., 2016). Indeed, even after nearly fifty years of the proclamation of independence, the Mozambican National Health Service still is not able to respond to the basic needs of all its citizens. Garrido (2020) identifies three causes: the colonial legacy; the destruction of hundreds of health units during the first civil war; and the difficulty both in replacing the infrastructures destroyed and in building new infrastructures, due to the lack of human resources and chronic underfinancing.

Taking into consideration the issue of the inadequate accessibility to health care, there is a strict connection between the distance that patients need to travel in order to access health and the reduction of ill health in a country (AIHW, 2011). For this reason, the issues regarding the patients' distance from health care centres is constantly regarded as one of the main determinants of use of health services (Stock, 1983).

It is known that the tendency to use health facilities is greater if these are located close to patients (Mizen et al., 2015). This aspect affects third world countries in a negative way, as patients have to cover a significant distance in order to reach a health care facility. As a result, greater distances and therefore long time "influences the way people respond to the healthcare system in most African countries" (Soai, 2012), leading patients to avoid seeking medical care from qualified health facilities.

A study carried on by dos Anjos Luis et al. (2016) suggests that, in terms of population coverage, the problem of health accessibility is more acute in the walking scenario (in which the population reaches the health centre on foot), for which 90.2 % of Mozambique is considered an underserved area. The driving scenario is less problematic, with about 66.9 % of Mozambique being considered a served area. However, it must be highlighted that neither private vehicles nor public transportation are widely used, especially in the rural areas of the

country, characterized by a lack of infrastructure and motorized transport services (ibid.). In both walking and driving scenarios, the areas are classified as being underserved if it takes more than one hour to reach them. Thus, in terms of geographical accessibility, walking is the most problematic and worrying scenario in Mozambique because the majority of the population require 60 minutes or more to reach a health centre.

It must be noted that these results are totally the opposite of those of developed countries, where healthcare facilities are more accessible and the distance covered by patients is usually more favourable than in third world countries. For instance, in France, anybody can access hospital care in less than 45 minutes, and 75 % of the population can do so in less than 25 minutes (Coldefy et at., 2011).

In addition to the general poor accessibility conditions, also the attempts made to control the pandemic have had the collateral damage of limiting access and delivery of public and private health care services (Melo et al., 2020). Indeed, the public state of emergency declared in Mozambique at the end of March 2020 led to a fall in the number of people accessing health care facilities, due to the limitations on people's movements and reduced public services. What is more, the preventive measures have also led to diminished numbers of health care workers at primary care health centres and hospitals (Pires et al., 2021), further decreasing Mozambican health care quality.

Under this regard, the lack of human resources is the biggest weakness of the Mozambican National Health Service (Garrido, 2020). Indeed, Mozambique ranked 10th from the bottom on the WHO 2010 list of countries with the greatest health workforce deficits. This significant issue is worsened by the fact that embassies, NGOs, cooperation partner agents and the private for-profit sector pay higher salaries than the government to health workers, who are thus driven to leave the National Health Service to go to work for the abovementioned organizations (ibid.). Indeed, health personnel is stretched beyond its limit exactly in countries where it is needed most. Not surprisingly, regions with the highest burden of disease have the lowest proportion of health workers to deliver services (UN, SDG Overview). Least developed countries have fewer than 10 medical doctors per 10,000 people, and 98% have fewer than 40 nursing and midwifery personnel per 10,000 people. It is estimated that around 18 million additional health workers will be needed globally by 2030 to ensure healthy lives for all (ibid).

Another issue negatively affecting the Mozambican health system is its underfinancing and poor financial management. Garrido (2020) demonstrates this by considering the document "Macroeconomics and Health: Investing in Health for Economic Development", published in 2001 by the WHO. This document indicated that in order to be able to ensure the provision of basic health services, any country should spend a minimum amount of between USD30 and 40 per person for the health sector per year. However, in reality, since the year of independence in 1975, the amount of financing allocated to the National Health Service has never even reached a sum of USD25 per inhabitant per year. This means that Mozambique, together with inefficient planning and management, is facing a huge problem related to chronic underfinancing of the health sector.

Indeed, Mozambique's "archaic form" of management and administration not only contributes to a scarce quality of health care, but also to the corrupt practices engaged in by health workers (Garrido, 2020, 13). As a matter of fact, the inefficiencies of the country's health sector are largely due to the fact that the National Health System is considered to be one of the most corrupt sectors, along with public works, education, the police and justice bodies. It must be highlighted that, according to the Corruption Perceptions Index[37] published by Transparency International (2020), Mozambique was ranked 146th out of 180 countries in 2019, with an index of 26 (with 100 = very clean and 0 = highly corrupt). This classifies the country among the countries considered the most corrupt in the world, further diverting the goal of an efficient and equal health care for the entire population.

3.3.2 Structure of the Mozambican National Health System

The Mozambican health sector is structured in the following subsystems: a public subsystem run by the state and called the National Health Service and comprehending also socio-professional organizations such as the Doctors Association, the Nurses Association and the Medical Association of Mozambique; a private subsystem and a military and paramilitary health subsystem (Garrido, 2020). The country can count 1,596 health facilities, of which 96% deliver primary health care. These health facilities are spread over 11 provinces, 30 municipalities and 157 districts (WHO, 2018).

[37] The corruption Perception Index assesses the people's perception of corruption in the public sector.

Despite the organized structure of the National Health Service, the medical activity promoted by traditional medicine practitioners in terms of the coverage of primary health services nowadays still covers more than the public subsystem. Traditional medicine is the result of the knowledge and practices based on the indigenous theories and beliefs that developed in different countries. Traditional medicine, whether explicable and effective or not, is still used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness (WHO). Indeed, there are still people in Mozambique who are born, grow up and die using only traditional medicine for their health care (Garrido, 2020).

The deficits of the Mozambican Health Service are also given by the fact that the different Ministries work in isolation without cooperating with each other. This is a big concern since an inter-sector coordination between government sectors at all levels and between the central government and local governance authorities is fundamental for the development of an efficient health care policy and system. Indeed, a healthy community is not only strictly based on the provision of health assistance, but also on factors such as the availability of food, the supply of drinking water, environmental sanitation, quality housing, access to quality education and efficient public transport. These issues are under the responsibility of sectors other than the health sector, this is the reason why improving the state of health of a community depends largely on cooperation between the different institutions of the country (ibid.).

If on one hand internal cooperation and coordination are lacking, on the other Mozambique is beneficiary of huge help from the international community. Indeed, since the stipulation of the General Peace Agreement in 1992, the Government of Mozambique has not independently defined its public health policy. Under this regard, the Mozambican National Health System is financed through two main sources: domestic funds from the state budget and external funds (WHO, Mozambique). Indeed, the international community (made up of cooperation partners and donors) plays an enormous role in defining the country's health policy, as the largest financial contribution to the health budget is in fact provided by international donors. Support by international actors is delivered in terms of helping the Ministry of Health to optimize development and the utilization of its human resources for health, as well as in terms of medical products, vaccines, technology, knowledge management and sharing (WHO, Mozambique).

To conclude, the top strategic priorities for the country involve developing and implementing an effective and sustainable health system as well as expanding its coverage in order to provide

quality health care for the majority of its citizens. However, this cannot be achieved without a balance between political, economic and social development and without an efficient coordination and cooperation between the different local actors.

3.4 Conclusions

To sum up, Mozambique's historical trajectory has deprived its people of the possibility of developing stable institutions, and a diversified economy. Indeed, the country is characterized by weak institutions, particularly regarding the political sector, and huge economic inequalities. This is the demonstration that the 1992 General Peace Agreement failed to achieve the objective of bringing general peace in Mozambique, fuelling instead a climate of negative peace between the local communities and consequently creating the possibility of resurgence of conflicts. Indeed, the country remains in a state of war: in the centre of the country because of military activity by Renamo, and in the North because of radical Islamist insurgents. In addition to high levels of poverty and disputes over access to land, these internal conflicts have contributed to latent local grievances, dissonance and resentment.

The country's post-independence security problems also create an unfertile ground for the development of a strong health system. However, also in a country as destabilized and poor as Mozambique it is possible to advance progressively towards quality health care at all levels. Obviously, this is a long-term process, which can be achieved only through the will of the Mozambican state to prioritize the public health sector and through the cooperation between the different internal institutions. Lastly, another fundamental prerequisite is the implementation of a positive economic and social background capable of reducing poverty levels, as well as economic and social inequalities.

4. Mozambique as a Case Study for Italian Health Development Aid

UR-Beira is an International Cooperation Project financed by the Italian Agency for International Cooperation (AICS) and proposed by the Veneto Region. Its aim is to strengthen emergency medical services in the City of Beira, Mozambique, with a particular focus on maternal and child health, being the main Mozambican government priorities (Pires et al., 2021). As this localized and micro-international aid initiative addresses health-service issues, it will have an impact on Mozambique's healthcare. However, the intention of my thesis is to analyse the actual effects of micro-international aid on the recipient country. It is hoped that the outcome of this research will be positive, yet, it could also reveal that international aid has a useless or even negative impact on the societies in which it is implemented. Indeed, the efficiency of health aid depends on a variety of factors, including the nature of the problem being addressed, the adoption system, the health system characteristics and the broad context (Atun et al., 2010). If these attributes are not strongly linked together, and the recipient country lacks the necessary complementary inputs, DAH could also have a negative impact, leading for example to the mis-allocation of health resources. However, the UR-Beira project aims at overcoming these challenges. Indeed, it identified as its priorities the respect of Mozambique's strategic priorities related to health and the involvement of the local authorities, thus creating the conditions for a sustainable and long-term solution to emergencies.

This last chapter examines the UR-Beira project and analyse its objectives, together with the needs and solutions identified after having acknowledged the issues afflicting the Mozambican health system. The expected outcomes of the initiative will then be considered and finally the UR-Beira Project will be analysed within the Framework of Italian Official Development Assistance for Health in Mozambique.

4.1 Health Problems in Sub-Saharan Africa and Mozambique

I will first consider the main health-related issues afflicting the Sub-Saharan African region. This section aims at describing the UR-Beira project and its partnership, together with its objectives related to the strengthening emergency health services in the city of Beira.

It must be highlighted that there are disparities in maternal and child deaths both among countries and between urban and rural regions. Indeed, maternal and child deaths are concentrated in the poorest regions, and specifically in Sub-Saharan Africa and Southern Asia (UN, 2013). In particular, maternal deaths in Saharan Africa constitute more than a half of the world's maternal mortality[38] and the region has had the slowest annual reduction rate of maternal mortality since 1990 (Macunguzi et al., 2014). The World Health Organization (2018) argues that high maternal mortality ratios and neonatal mortality are mainly due to scarce quality of care, poor organization of service delivery and a weak health system.

In order to partially overcome these issues, the UR-Beira project aims at strengthening emergency health services managed by local authorities in the district of Beira, with a focus on obstetric and paediatric emergencies, therefore contributing to the reduction of mortality and morbidity related to medical emergencies. Specifically, the project aims to promote greater access to quality emergency medical services offered at the Central Hospital of Beira and at health centres in its catchment area. As dos Anjos Luis et al. (2016) highlight, an improvement of the Mozambican accessibility to health facilities could be achieved in three ways: through the creation of new Health Centres or the reallocation of some of them so as to maximize accessibility; through the optimization of the public transport network according to the population's needs and finally through the construction of new roads and the upgrading of existing ones. Thus, effective and reliable emergency transport services represent one of the most important determinants for reducing maternal and perinatal mortality in low-income countries (Macunguzi et al., 2014). This is why one of the UR-Beira project's main objectives is to provide the local community of Beira with a new nucleus of functioning ambulances.

The project aims to achieve the above-mentioned goals through the adoption of a centralised emergency management model[39] endorsed by the district of Beira and by national authorities. The initiative will also implement the realization of activities aimed at reinforcing the capacities of local health authorities in planning and coordinating medical emergency services at the Central Hospital of Beira and at health centres in its catchment area. Indeed, Mozambique is a

[38] The International Classification of Diseases (ICD-10) defines maternal mortality as "deaths from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy".

[39] A model that will allow the city of Beira and its district to properly address and respond to health-care emergencies.

country prone to disasters and outbreaks leading to situations of emergency. For instance, the country suffers from repeated cholera outbreaks and has been hit by cyclones and flooding (WHO, 2018). What is more, the national public health system, weakened by the Covid-19 emergency, is characterized by deep structural weaknesses and an by inefficient network of services on the territory, due to limited human, technical and financial resources that affect its development. Mozambique regularly faces epidemics (like cholera) which present a high risk of morbidity, mortality and widespread transmission among vulnerable groups and particularly those who are unable to access basic health care. In this context, the Mozambican health system thus needs to improve its limited capacity on Emergency Preparedness and Response, in particular regarding maternal and child health. This will be realised thanks to the valorisation of the exchange of good practices between the counterpart and local partners involved in the sector of the organization and management of emergencies.

Table 9: UR-Beira project's general information

Starting date	1st February 2022
Duration	36 months
Total budget	1.369.865,40 euros
AICS' financing	1.089.532,20 euros (79.54%)
Partners' co-financing	280.333,20 euros (20.46%)

The initiative started on 1st February 2022 and will last 36 months, with an overall budget of 1.369.865,40 euros, of which 1.089.532,20 euros (79.54%) financed through the AICS' statal contribution and the remaining 280.333,20 euros (20.46%) co-financed by the partnership (see table 9, page 79). The project will be implemented by the lead applicant, the Veneto Region, with the proactive cooperation of the District Service for Women's Health and Social Action (*Serviço Distrital de Saúde, Mulher e Acção Social da cidade da Beira*) in charge of planning, coordinating and delivering medical emergency services, and of the Central Hospital of Beira in quality of main referral facility for emergencies in the district of Beira and the Province of Sofala. In addition to the promotion of the accessibility of the entire population of Beira and of its 15 districts to the emergency services through the provision of three ambulances (photo 1, page 80), the project foresees the involvement of the *Serviço Medico de Emergência em*

Moçambique (SEMMO)[40] for the setting up of an integrated system for the management of emergencies at a national level.

Photo 1: The three ambulances provided to the Central Hospital of Mozambique by the UR-Beira project

To this regard, the Veneto Region, with the support of its health experts and partners Doctors with Africa CUAMM[41], Padova Green Cross[42] and Ca' Foscari University, aims to enhance the exchange of good practices with the counterparty and local partners in the field of emergency planning and management. On this matter, the objective of this initiative is to transfer knowledge and tools for the activation of emergency coordination mechanisms through the management of a centralized system responding primarily to obstetric and paediatric

[40] A public service for the management, coordination, direction, regulation, training, accreditation, monitoring and inspection of the activities tied to medical emergencies. The national headquarters is located in the city of Maputo and there are three regional branches in the provinces of Maputo, Nampula and Sofala.

[41] Founded in 1950, Doctors with Africa CUAMM was the first non-governmental organization focused on healthcare to be recognized by the Italian government. It is now the country's leading organization working on improving the wellbeing and health of vulnerable communities in Sub-Saharan Africa. Working with international and local partner teams, CUAMM provides medical aid and expertise in eight African countries: Angola, Central African Republic, Ethiopia, Mozambique, Sierra Leone, South Sudan, Tanzania and Uganda.

[42] Padua Green Cross is voluntary association and public body (IPAB public welfare and institution) founded 109 years ago. Since its creation it has been guaranteeing the transport of patients in emergency/urgent situations in the province of Padua thanks to a large number of ambulances and services (230 patient transport services a day) 60 ambulances, 1000 volunteers who offer their services night and day and 100 employees. It makes available its know-how for the organisation of a local emergency service.

emergencies. This will be enriched by a scientific based research carried out by the Ca' Foscari University in collaboration with the Catholic University of Mozambique and supported by the Veneto Region on the cost-effectiveness of the system set up in Beira. The purpose of the research is also to promote and spread the adoption of the developed emergency model at national level. The research is valuable for two reasons: it can be used in the short term in order to understand the actual effectiveness of the project over its course with respect to the cost and the sustainability of the action carried out; it can also become eligible for capitalisation thanks to the creation of an assessment, which can be used in other developing parts of the country or even in other nations of a similar context.

Finally, the Veneto Region, with its health experts and with the collaboration of the Central Hospital of Beira, Doctors with Africa CUAMM and the Green Cross, intends to contribute to transferring clinical skills and knowledge for the benefit of health personnel and the population. Under this regard, the Veneto Region will promote training activities for the healthcare personnel and an awareness-raising action for local communities on first aid and disaster preparedness. This will be implemented through the support of civil society subjects and local authorities operating in the Veneto region selected through re-granting, that is the creation of a call for assigning a part of the state project's contribution aimed specifically at conducting actions to inform and raise awareness among the local population. This training and formation initiative represents a fundamental element of the project, as it does not suffice to treat patients, but it is also necessary to treat them in an appropriate manner.

To sum up, the initiative's central activity will be the transfer of knowledge and instruments useful to Beira's local authorities and health workers for the activation of emergency coordination mechanisms. In this respect, the emergency transport network will be expanded through the already realised purchase of two new ambulances and the donation of a third one by the Croce Verde di Padova, which will be added to the already functioning and operational vehicle. In addition, the transfer of technical and logistical know-how regarding the management of the emergency centralised system represents a fundamental activity of the project, together with a specific action of training to guarantee the development of knowledge among the healthcare staff.

4.1.1 Needs Identified by the UR-Beira Project and Solutions to the Issues

This section outlines the main challenges faced by developing countries as far as health care is concerned, with a particular focus on emergencies related to maternal and paediatric care. The UR-Beira initiative will also be considered in relations to the Sustainable Development Goals which it aims to achieve. After having considered these issues, the solutions identified by the UR-Beira project will be analysed.

As demonstrated by the UR-Beira project, the development of emergency care systems is a growing focus in low- and middle-income countries. In fact, one of the biggest challenges in low resource settings is the scarcity of emergency care, and where emergency care is present, issues have arisen due to the distance and time necessary to access appropriate services (Kironji et al., 2018). This makes emergency care an important area of focus for international aid interventions aimed at reducing mortality in these settings. Together with emergency care issues, maternal and neonatal mortality remain a substantial but unfortunately unsolved health priority in low-income countries, and sub-Saharan Africa in particular (Accorsi et al., 2017). For this reason, the reduction in the number of these issues worldwide is included among the Sustainable Development Goals to be reached by 2030 (Caviglia et al., 2021).

Indeed, the actions implemented thanks to the UR-Beira international cooperation initiative aim at reducing mortality and morbidity of the Mozambican population, with a focus on obstetric and paediatric emergencies, thus pursuing the fulfilment of the 3rd, 10th and 16th Sustainable Development Goals of the 2030 Agenda for Sustainable Development, which refer respectively to the promotion of healthy lives and well-being for all at all ages; to the reduction of social, political and economic inequality within and among countries and to the promotion of just, peaceful and inclusive societies. In particular, the UR-Beira project aims at responding to the target 3.8, which deals with the achievement of "universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all". The SDG target 10.2 is directed towards the empowerment and promotion of the "the social, economic and political inclusion of all irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status". The initiative will thus cooperate in the country for the respect of the people's fundamental rights so as to leave no one behind and it requires that the rights of

communities/groups which are more significantly marginalised be one of the priorities of the action in each territory of intervention. Finally, the UR-Beira project deals with the target 16.b, which aims at promoting peaceful societies for sustainable development. In particular, the initiative aims at strengthening the governance of the regional/local authorities as far as the definition processes of the regional/local policies (health, disabilities etc.) are concerned.

Taking into consideration the Sustainable Development Goal number 3, "ensuring healthy lives and promoting well-being at all ages" is fundamental for achieving effective and sustainable development. The targets associated to this goal range from the reduction of the global maternal mortality ratio and of preventable deaths of new-borns and children to the reduction of the number of deaths and illnesses from hazardous chemicals and pollution (UN, SDG Overview). Indeed, as maternal and neonatal mortality constitute a substantial proportion of burden of disease in low-income countries, its reduction worldwide is included among the sustainable development goals to be reached by 2030.

It must be noted that big gains have been achieved for both targets, as significant global progresses have been made in increasing life expectancy and reducing child and maternal mortality. Indeed, the total number of under-5 deaths dropped from 9.8 million in 2000 to 5.4 million in 2017. However, despite remarkable improvements, the Covid-19 pandemic undermined many of these efforts, further challenging the achievement of health global targets. In fact, the proportion of child deaths remains unequally distributed, with four out of every five deaths of children under the age of five occurring in Sub-Saharan Africa and Southern Asia (UN, SDG Overview). What is more, children in the sub-Saharan African region "are more than 15 times more likely to die before the age of 5 than children in high income countries" (ibid.). Also regarding maternal health there is still a long way to go. In fact, in 2017, nearly 300,000 women died from complications relating to pregnancy and childbirth, of which over 90% lived in low- and middle-income countries and over 60% lived in sub-Saharan Africa (ibid.).

As Sub-Saharan Africa as a whole, also Mozambique still has highly critical health indicators. In the maternal and infant sector, high maternal mortality rates (289 deaths per 100,000 live births) and under-five mortality rates (73.2 per 1,000 live births) have been recorded (Human Development Reports). Focusing on the local context of the city of Beira, capital of the Sofala Province, it is the second most populous city of the country with 592,000 inhabitants and it is also the headquarters of the Central Hospital of Beira, reference for medical emergencies to

which 15 health centres are afferent. As a consequence of the impact of the Cyclone Idai (14-15 March 2019)[43], 90% of health care facilities were damaged and more than 600 deaths were registered. In particular, in the Central Hospital of Beira, the accesses to the emergency room increased significantly, with a 9% mortality rate (Relatorio Anual do HCB). It is also important to underline the high maternal mortality rate registered in the Central Hospital of Beira at 15.7% (6.8 up on the previous year) and a 10% mortality rate within 24 hours of the admitted paediatric cases.

These high maternal and infant mortality ratios are mainly linked to a scarce access or delayed and inappropriate access to the hospital and to a lack of quality of emergency services provided by the district of Beira. The high mortality ratios related to emergency situations are also due to the scarce quality of services delivered by the district health centres, from which derive 75% of the overall emergencies addressed by the Central Hospital of Beira. This insufficient quality of the emergency service is due to the fact that there is inadequate management and governance as far as the emergency system is concerned.

At the moment of the project proposal (2020), emergency services in Mozambique were managed at the national level by the *Departamento Central de Emergência Médicas de Moçambique* (DCEM), which deals with the coordination of medical emergencies. As a result of the decentralised structure of these services, the primary actors involved in managing emergencies in the Sofala province are the local health district authority (*Serviço Distrital de Saúde, Mulher e Acção Social da cidade da Beira*, SDSMAS) and the Beira Central Hospital, being the national and provincial structure of reference for the management of emergencies. It must be highlighted that these two actors supervise the urgencies and emergencies occurring in the city independently and without any cooperation. This lack of coordination is one of the reasons why the emergency transportation system of ambulances is disorganized and managed in an inorganic way.

In fact, it is noteworthy that, in most sub-Saharan settings, ambulances are available, but often poorly managed, badly maintained and breaking down frequently (Tayler-Smith et al. 2013).

[43] In March 2019 Mozambique was hit by Cyclone Idai, which killed about 600 people and devastated a significant part of the country. In particular, the port city of Beira was almost completely destroyed. In April another cyclone (Kenneth) hit the northern part of the country, killing more than 40 people. In all, more than 162,000 Mozambicans were estimated to have been displaced by the two storms (Penvenne et al., 2020).

Thus, the geographical distances to reach hospitals still pose a major barrier for timely access to care. What is more, the Beira Central Hospital's ambulances are not properly managed, as they are mainly used for the transport of HIV patients' blood tests, medication and materials, the transport of personnel, and hardly ever for emergency transportation. The Covid-19 pandemic further worsened the situation, as the Government restrictions had negative collateral effects on access to maternal and child healthcare services in Mozambique. However, even before the Covid-19 pandemic began, many women and children in the country faced barriers when they tried to access health services (Pires et al., 2021).

This poses a significant issue in the development of an effective health care system, as ambulance allocation across the country plays a major role in the emergency response (Ragazzoni et at., 2021). Indeed, the attention to the ambulance issue in the district of Beira emerged during the cyclone Idai emergency, during which the city of Beira was largely damaged and 50,000 inhabitants were lacking a functioning ambulance service. Thus, the foundations of the UR-Beira project were laid exactly in this period, thanks to CUAMM's donation of a first group of ambulances in order to respond to the catastrophic situation due to which was impossible to transport patients from the district health centres to the Central Hospital of Beira. The objective is thus that of creating a more modern and consolidated health system, founded on the main cornerstones of an emergency/urgency system; cornerstones that are not only related to the availability of an emergency transport service, but also to the presence of a communication system between the district health centres and the central hospital, together with the provision of effective protocols and guidelines.

The UR-Beira project identified an additional planning gap in terms of the disaster preparedness. As a matter of fact, during Cyclone Idai, both the hospital and the district lacked both an emergency management plan and an evacuation plan. Thus, a centralized communication system needs to be shaped in order to appropriately manage the emergencies. On this point, the role of three main actors is considered fundamental by the project: the Service for Medical Emergencies in Mozambique (*Serviço de Emergência Médica de Moçambique*, SEMMO) operating at the national and provincial level; the local health district authority (SDSMAS) and the Central Hospital of Beira operation at the district level. This will take place through the implementation of a control unit aimed at sorting the upcoming emergencies and through the utilization of transports equipped with GPS to monitor their usage and the time schedule. What is more, the Beira Central Hospital must be provided with an emergency

management plan and an evacuation plan based on the regulations given by the MISSAU (the Mozambican Ministry for Health). These plans must be developed in coordination with the local authorities in order to train the staff and create a team capable of managing catastrophes at the hospital as well as the district level.

Indeed, in the Sub-Saharan African area, there is a significant shortage of properly trained personnel in emergency medical care at all levels of the health workforce (Calvello et al., 2013). More specifically, in 2019, of the Beira district health centres' personnel (662 people in 2019, PES 2018/2019), only 78 people received training in the management of obstetric emergencies (CUAMM, 2020). It is thus necessary to upgrade the personnel working in health centres and in the Beira Central Hospital emergency department. What is more, the paramedical personnel must be trained with a focus on emergency identification and on the management and stabilisation during the transfer of patients.

After having identified these critical needs, the project aims at responding to the issues linked to the scarce quality and accessibility to emergency services managed by the Beira district local authorities. More specifically, the focus will be on the promotion of a greater access for the population to emergency/urgency services provided by the Central Hospital and by district health services, with a particular attention to pregnant women and children under-five. This will be implemented through an integrated and comprehensive health program based on the so-called "three delays" model, developed by the scientific literature (Thaddeus S. et al., 1994) for maternal mortality but replicable for all types of emergencies. The model is recommended to address the three delays hampering access to safe motherhood services: seeking appropriate medical care for an obstetric emergency; reaching an appropriate Emergency Obstetric and Newborn Care (EmONC) facility; and receiving adequate care when the facility is reached (WHO et al., 2009). On this matter, the broader effects of mortality reduction are obtained thanks to better availability, geographical distribution, usage and quality of emergency and basic health services, in particular regarding Emergency Obstetric and Newborn Care and Emergency Triage Assessment and Treatment (ETAT). In addition, strengthening the referral system and reducing economic barriers (for example by providing ambulance transport free of charge) must be considered as important areas to focus on in order to improve access to health facilities.

More concretely, the project will provide an emergency management model shared by the competent authorities both at local and national level. To this, the provision of three functioning ambulances equipped with trained staff will be added (before the implementation of the project, only two ambulances were available, one of which was unusable), as well as a training course for healthcare personnel regarding medical, obstetrical and neonatal emergencies and finally an awareness-raising action aimed at further informing the population on issues like first aid and catastrophes and epidemics risk management.

All these initiatives will involve a total of 12,000 direct beneficiaries, divided into 500 women who will receive emergency obstetric care, 3,000 children under-five who will receive emergency paediatric care and the rest of the patients who will receive emergency care thanks to the triage system implemented in the central hospital. What is more, 270 healthcare workers will be trained and an average time of 30 minutes will be established to be respected between the call and the arrival of the ambulance to the hospital. This will lead to an advancement of local institutions' capacity of planning, managing and coordinating emergency and urgency services in the city of Beira and thus to an improvement of the clinical organizational quality of the Beira Central Hospital and its district health centres.

4.2 Expected Outcomes of the UR-Beira Project

After having described the impact of the actions carried out by the initiative, the following section will analyse the five main areas of improvement identified by the UR-Beira project that will allow to demonstrate its concreteness.

Generally speaking, a comprehensive and effective emergency hospital and community based health program is recommended to reduce maternal and child mortality and morbidity in poor-resource settings (WHO, 2015). Indeed, the development of appropriate emergency medical services represents an important form of intervention in the African context, with the potential result of addressing and eliminating the geographical and transportation barriers that contribute to the delay in reaching care, thus reducing the avoidable burden of disease associated to emergencies (Caviglia et al., 2021).

Among those facilities aimed at achieving the goal of improving access to and quality of emergency care, the ambulance service plays an essential role, especially in remote settings, allowing the referral of urgent and complicated cases (Somigliana et al., 2011). In low-income countries, the realisation of a new system of emergency transport is often initially supported and implemented by donor programs. However, this service must be implemented taking into consideration that once the programs end, it will be the local health system that will deal with the maintenance of the service (ibid.). Thus, in order to deliver a supportive environment capable of enhancing accessibility to and the quality of emergency care in poor areas, a proper allocation of resources implies also the evaluation of local authorities and health professionals' capacities.

Indeed, to ensure the long-term maintenance and sustainability of the project, the UR-Beira partnership analysed and defined the standards and the context in which the emergency system would be developed. The fundamental principle is the creation of a scalable system, that is to say to create a system able to address and overcome current issues and emergencies (which at present mainly concern the inter-hospital transport) and at the same time to lay the foundation for subsequent and further developments applicable to a larger territorial and thematic scale.

Regarding the sensitization and awareness-raising activities at community level in the city of Beira, the contribution of the initiative will be fundamental in order to spread the knowledge about and the ability to recognize medical danger signs and address community-centred barriers to access. Indeed, patients are often not aware of when they should seek immediate care, generally preferring more widespread and familiar traditional approaches instead of newer emergency methods. Community education will be focused particularly on women in order to help to address gaps in care between men and women and to increase women authority to take ones' own decisions (Kironji et al., 2018). Awareness regarding health care will be fundamental for increasing trust in health services and thus lead to the increased utilization of medical services and reductions of delays.

As far as the specific impacts and outcomes are concerned, the UR-Beira project identifies five main areas of improvement in order to render concrete the single actions. The first gain for the local community of Beira is achieved thanks to the technical impact, to the improved quality of the health emergency service, in particular with respect to the clinical-organizational quality of the emergency/urgency services of the Central Hospital of Beira and of the related health

centres. The project also foresees a positive political and institutional impact as a consequence of the increased capacity of the local institutions to plan, manage and coordinate the emergency/urgency centralized service in the city of Beira as a result of the adoption of a centralized model to manage emergencies. The social impact is equally important, obtained through the expanded access of the community of Beira to the service and thus an enhanced recipients' satisfaction, with a particular focus on the most vulnerable categories like pregnant women and children under-five also in periods of catastrophes and epidemics. This progress will happen, among the other things, thanks to the training and awareness-raising activities (implemented through the financial re-granting). The economic impact must also be considered, as the developed centralized management emergency model will have a spill-over effect in economic and financial terms in the local health system. Finally, in terms of positive environmental effects, the UR-Beira project improves the responsiveness of the system and resistance in hypothetic extraordinary emergencies, such as catastrophes and epidemics.

To conclude, the UR-Beira project highlights how improving emergency health requires a comprehensive set of interventions in order to achieve worthwhile results and to bring about a reduction of morbidity and mortality. The expected outcome is thus a balance in the health system, reached thanks to integrated and various actions and thanks to a better coordination and capacity of the local parties involved.

4.3 The UR-Beira Project within the Context of Italian Development Aid

The following section will provide the framework in which the UR-Beira project has developed, with a particular focus on Italy's role in Mozambique and AICS' (Italian Agency for Development Cooperation) call for proposal regarding the "Promotion of the Territorial Partnerships and the territorial implementation of the 2030 Agenda", for which the UR-Beira initiative gained its financing.

Since the early 1990s, Mozambique has been one of the world's largest aid recipients (Arndt et al., 2012). This tendency started in 1987, five years prior to the end of the 1976 civil war between the ruling party Frelimo and Renamo. During this period, external aid to Mozambique was mainly directed towards emergency relief from the country's condition of drought and from the critical humanitarian conditions brought on by the war (Manning et al., 2010). Indeed,

between 1987 and 1992, Mozambique received US$1.6 billion in donor pledges for humanitarian assistance via the UN emergency appeals process (Manning et al., 2010)

Since its independence in 1992, Mozambique's aid dependency has led to the emergence of a varied and strongly invested donor community (Manning et al., 2010). However, interventions implemented by the donors do not always coincide with the strategies and programmes that were a real priority for the Government of Mozambique. This happened especially when it came to aid directed towards the health sector, which was particularly in need of aid from the international community in order to improve the provision of quality health care to Mozambique's citizens. Indeed, the majority of donors decided to channel large amounts of financial resources into vertical programmes for fighting disease, instead of supporting the National Health Service, which provides health care to over 90% of the population (Garrido, 2020). As already mentioned, these vertical programmes with bottom-up dynamics, dedicated to specific diseases and segments of the population, often further weaken the public health sector due to "the duplication of efforts, the distortion of national health plans" and the dislocation of scarce human resources (Garrido, 2020,15). Thus, international aid, if accompanied by external actors' lack of sufficient information about the local context, has the opposite effect to what is intended.

Undeniably, international donors often do not know enough about the nature and structure of power (political, economic, social, and repressive) of developing countries' contexts (Manning et al., 2010). However, it is important to note that long donor experience in a country fosters the formulation of effective cooperation actions and strategies. This is actually the case of Italy's aid directed towards Mozambique. In fact, Italy is particularly present in Mozambique for historical reasons, and it has led to the support and financing of a large number of cooperation projects, creating a deep and well conducted path for the flow of aid.

This involvement is a consequence of the important role that Italy has been playing in Mozambique's recent history, in particular since the 1992 General Peace Accord, which saw the Italians as important actors and protagonists of the long negotiations that took place after the end of Mozambican civil war. Actually, Italy was the earliest Western-based supporter of Frelimo (Howard, 2008), proving it with credits and trade since the mid-1980s. Thanks to the Rome-based Catholic lay community of Sant'Egidio, Italy would later host the peace talks in Rome (Bartoli, 1999). What is more, after adopting this role of a political nature and of

international intermediation, Mozambique has become a favourite destination for a wide range of coordinated projects stemming from Italian cooperation, where there are also direct interventions on the part of the NGOs and local administrations. In fact the UR-Beira can be counted among these, being funded by AICS, Agenzia Italiana per la Cooperazione allo Sviluppo (the Italian Agency for Development Cooperation).

AICS has also been long operating in Mozambique. In actual fact, since 2016 the Agency has allocated more than 422 million euros to various sectors of the county (health, rural development, and many other sectors that are in line with the goals of the 2030 Agenda) through the laying out of funds and human resources (civil society organisations, territorial bodies, businesses). The Italian Agency for Development Cooperation aims at facilitating the use of funds dedicated to international cooperation, but above all at combining profit and non-profit sectors, and those operating in the territories where the aid is destined. The idea is to start up a transfer and exchange of know-how with the beneficiaries of these projects ultimately to achieve a reciprocal exchange.

In particular, the UR-Beira project, which reflects one of the main and essential points of the cooperation based activities in the country, and that is health, the health system and the promotion of the health system, will be funded in a significant manner by AICS through its latest call for bids. This call falls into the context of the institution and of Law 125 of 2014, whose aim is to involve the territorial bodies in international cooperation. This innovative form of cooperation is given by the interaction among the partners, which represent a substantial added value for the project. Indeed, from the moment that the system is built, the partnership is not independent: each member has its own role, expertise, skills and above all the need to develop its competences over the course of 36 months. In addition, the consortium must learn teamwork, given that the intervention will be successful only thanks to internal and external cooperation.

Indeed, AICS's call itself, which will go on to finance the proposal put forward by the Veneto Region and by the developed partnership, aims at the "Promotion of the Territorial Partnerships and the territorial implementation of the 2030 Agenda". According to article 4 of Law no. 125/2014, the "initiatives of territorial partnerships" fall into the initiatives in which the "public cooperation for development" are included. Thanks to the territorial partnership, the legislation wanted to stress that the strengthening of structured dialogue among the members is at the core

of territorial cooperation at a national level and of the authorities and the civil society of the member countries. In fact, the territorial bodies carry out a fundamental role for achieving the Agenda 2030's Sustainable Development Goals (SDGs), as has been widely recognised, both on a European, as well as on a national level. Indeed, thanks to the territorial partnership, the priorities of the local partners are dealt with more efficiently, as are the needs of economic, environmental and social development of the territories. It is also easier to set up sustainable development programmes, which respond of these needs, by means of the active involvement of the local actors (institutions, universities, non-profit organisation, businesses, etc.) who operate at several levels.

Alongside traditional actors such as international and intergovernmental organizations, donors and partner countries, non-governmental organizations and, increasingly, sub-national actors play an important role, and in the Italian case Regions and Municipalities are also important. Under this regard, Doctors with Africa CUAMM, one of the major partners of the UR-Beira project, has been operating in Mozambique since 1978, when it began its intervention starting from the province of Sofala, engaging in the rehabilitation of the health network. Since then, CUAMM's intervention has expanded to six provinces in the country, providing support in 37 health facilities dedicated in particular to maternal-child health, sexual-reproductive health and chronic non-communicable diseases. In addition, in 2021 in Mozambique, like in the other seven countries in which CUAMM is present, it was necessary to work intensively to secure the hospitals and communities against Covid-19. This has been a great threat for Africa and there has been concern for the secondary effects it has generated. In fact, more and more people are still not going to hospital for fear of being infected, with the result that many women are risking their lives giving birth at home, and what is more many children are not being vaccinated against the most common diseases (Emilia Romagna Region, 2021).

Italian regions have also been engaged for several years in the field of international health cooperation, mobilizing their own guide lines and health systems alongside the decentralized and territorial cooperation of the regional structures that deal with international relations. This activism is mainly due to two factors: the increasing requests for health care especially following international emergencies, and the progressive decentralization of responsibilities from the central state to the regions. What is more, an important role is played by the push for international solidarity that comes from the civil society (CESPI).

The Italian system of development cooperation is thus based on the inclusion and dialogue between different actors. Among these (the organizations of the civil society, universities, the private sector...), the subjects of the territorial partnership, which are Regions, autonomous provinces, local authorities, not only contribute to pursuing the Sustainable Development Goals (adopted by the Italian Cooperation as guidelines), but they also play an important role of connection between the different territorial actors and the administrations of partner countries, exploiting the added value of decentralized cooperation. In order for this to happen, the involvement of Regions, autonomous provinces and local authorities in development cooperation activities cannot be limited to enhancing their internal skills, but must also include the resources and capabilities present in the territories, that the local public bodies are called to bring to the system (ibid.).

Hence, the proposals put forward by the territorial bodies will need to contribute to the development of the partner countries, acting as backup to the governance of the local institutions, of the reform processes that the institutions wish to launch, as well as a backup to the tasks of the institutions themselves in defining and implementing adequate policies for the requests of the communities in question. The strengthening and support provided by the institutional bodies of the partner countries also represents an essential condition for a concrete recognition and respect of human rights; for a concrete removal of those barriers blocking, at a territorial level, the sustainable development processes; for an equitable, responsible and transparent democratic and inclusive participation in the decision-making processes. Furthermore, the promotion and development of territorial, social-health, educational and professional training services are just as important, as they are the guarantee of inclusive access especially for women, children, young people, the elderly and people with disabilities (AICS, 2019).

In addition to achieving the 3rd, 10th and 16th Sustainable Development Goals, the UR-Beira project's development actions respond to the OECD (Organization for Economic Co-operation and Development) sectors and objectives[44], which are recognized and shared at an international level. Indeed, when it comes to a percentage value, the OECD sectors have been balanced in

[44] The OECD sectoral guidance establishes a common understanding among governments, business, civil society and workers in order to help identify and address risks to people, the environment and society.

percentage with regard to the project's interventions. That is to say, the health services account for the highest percentage (40%) and they respond to the need to create an infrastructure, which to date is non-existent in the country, like for example a central operations headquarters for dealing with medical and health related emergencies. To this is linked 30% regarding medical services and 20% basic health care, with the latter in fact creating an obstacle for reaching the main goals of the project, which are in particular to reduce maternal mortality and infant mortality. Finally, medical research represents a collateral activity for the project, accounting for 10% of the activities.

Regarding the OECD policy objectives, three of them in particular play important roles for the UR-Beira project: the Gender Equality Policy Marker, the Participatory Development and Good Governance Marker and finally the Disaster Risk Reduction Marker. Indeed, attention needs to be paid above all to women's needs, as women are particularly fragile in the country. In fact, a primary right, like that of essential services related to safe labour has never been well managed because there has always been a lack of an efficient medical transport service.

As far as governance is concerned, the project will develop and build the opportunity to supply a material-infrastructure based service (ambulances, equipment for the operations facility). Behind this lies the issue of the management of this emergency systems, which needs to be completed with training activities, aimed at rendering the service sustainable over the long-term. Indeed, if the donors supply real estate or material, without supplying the relative know-how and training on how to manage them, the intervention may prove to be totally useless. Therefore, training does not only provide information and dissemination, but it also makes the intervention recognisable, and creates awareness amongst the citizens about the availability of a new health service. This is of fundamental importance, because often, in developing countries, there is a lack of awareness due to the pyramid government structure, which prevents the more fragile and weaker members of the society to gain access to the most important information and to understand how to take advantage of certain services. The UR- Beira takes all of this into consideration, and in actual fact the action is not carried out in a top-down fashion, by intervening and ignoring the process of informing the local population, on the contrary, the process will be carried out from the bottom up, providing skills, information, training and awareness, with the aim of favouring the development of the local capabilities. The project in fact will have a considerable impact on the social fabric: if the project's initiatives do not make

the citizens aware of the development of the medical centre for emergencies/urgencies, the potential to have a real impact on the recipient country would be considerably reduced.

Finally, the significant objective related to the Disaster Risk Reduction (DRR) derives from the emergency situation created by Cyclone Idai. Indeed, the possibility to be able to act under emergency conditions following a natural disaster will increase significantly thanks to the fact that there is the aim to implement an emergency medical service, operations facility and ambulances which can provide their services to anyone in need.

This background analysis highlights that the project will be grafted into an existing situation, and the goals have been actually based on the analysis of the state of the art of the country itself. This goal must correspond directly with the needs of the area in question. However, other international cooperation projects have highlighted that there can be a gap between when the project is drafted and when it is implemented. But once the initiatives are implemented, a careful and detailed analysis of the needs on the ground is carried out, and therefore this gap will then be reduced. Thus, the first step is to carry out a detailed inspection in order to reduce the gap between the theory and the practice.

It is therefore evident that when dealing with international cooperation development projects, the analysis of the context, and identification of the needs and the choice of the solutions, must all be tied to a methodology related to the project itself. Under this regard, it is of fundamental importance to consider the real conditions of the country in question as a foundation to work on. This is on the grounds that the real conditions of the country in which aid is directed are distant and different to those of the donor counties, therefore there is the need for expertise and experience within the partnership, which must operate in direct contact in the field (in the specific case of the UR-Beira project, CUAMM is qualified for this). Indeed, Italian Cooperation considers communities' self-determination to be indispensable for health promotion, disease prevention and planning, use and quality verification of health services (CESPI).

When it comes to international cooperation projects, the phase dedicated to an in-depth research into the country's actual situation and a field analysis of its needs is therefore essential. On this matter, the desk review phase allows for the understanding, for example of the country's existing related guidelines and protocols. This is crucial because there may be administrative,

judicial or legal obstacles in the receiving country, and it is important to remember that the initiative needs to be framed within an administrative, institutional and political relations context together with the local and national authorities.

This context-based analysis is also vital because one of the potential outcomes of international cooperation projects in general is a package of initiatives that can be replicable and eligible for capitalisation. In the specific case of the UR-Beira project, the aim is that of creating a replicable model at the national level within Mozambique's health system, and that therefore it does not remain isolated and limited to the city of Beira. Indeed, any project needs to have a set of specific transferable characteristics, be it in terms of being able to correct any initiatives' shortcomings as well as in terms of replicating the feasible and productive actions. As a result, if the model proves to be truly efficient and sustainable, at the same time representing a best practice to be promoted and disseminated.

4.4 Conclusions

To conclude, Italian Cooperation recognizes health as a fundamental human right and promotes universal access to quality health services. The goal is thus the one of strengthening health systems from a universalistic perspective through the development of reforms oriented towards equity, solidarity and social inclusion (CESPI). Under this regard, the support that Italy can offer to the international community in terms of global health are important. Indeed, based on the consolidated experience of its universalistic national health service (Missoni et al. 2014) and thanks to the high engagement of its civil society, Italy could play a prominent international role sharing knowledge, experience and awareness with countries to which flows of international aid and health aid are directed.

On this point, Italy plays a fundamental role in Mozambique, which is a challenging operating environment. The country has a long historical context of poverty and conflict, and it is recovering from disasters, such as the sixteen-year long civil war that ended in 1992 and Cyclone Idai (14-15 March 2019), which hit in particular the city of Beira. Indeed, Mozambique is prone to emergencies stemming from natural disasters and mainly from floods, droughts and cyclones (WHO, Mozambique). Under this regard, the fragile nature of the National Health System and of its infrastructures, as well as the lack of human resources in the health sector, are conditions that further aggravate the public health system, therefore leading to emergencies,

increasing morbidity and mortality rates. Other barriers preventing an equitable access to healthcare services are to be considered in terms of availability, geographical accessibility (Ragazzoni et al., 2021) and transportation infrastructure. All of these challenges are thus addressed by the UR-Beira project thanks to the formalization of an emergency protocol and to the optimization of the ambulance system of transportation.

What is more, the initiative aims at reducing maternal and perinatal mortality, which disproportionately affect low-income countries. Indeed, sustained and effective investments in maternal health, especially in sub-Saharan Africa, are needed to meet the global targets set out by the Sustainable Development Goals (UN, SDG Overview). It is thus fundamental to provide citizens of underprivileged and neglected remote settings with emergency services, which are then properly integrated into the local community, in order to develop a prompt, safe, and effective access to the health care system.

On this matter, the UR-Beira project, which aims at strengthening emergency and urgency health services managed by the local authorities in the district of Beira, is considered to be an extremely important and valid initiative for achieving quality medical and health services. Undoubtedly, the local partners are enthusiastic as the project has a great value thanks to the support provided by the partnership, which is embracing the activities aimed at changing and improving the existing health services provided by the Central Hospital of Beira and its 15 districts. The project has in fact been considered as necessary and fundamental by the local authorities, as one of the main difficulties and concerns is represented by the referral and transport of patients. There is thus the desire to transfer patients in in apt manner in order to reduce the mortality rate.

In actual fact, the role played by the partnership is fundamental, as it aims at increasing the health system's capacity to properly address and respond to emergencies and necessities. The continuity of the project will further improve the conditions of the people living in the city of Beira and in its districts. It is true to say that, the possibility to contribute to the improvement of a context regarding obstetric and neonatal issues and the management of emergencies can really have a long-term and significant impact. The project thus represents a common benefit and progress, as the collaboration is fruitful not only for the partners but also for all the parties involved and interested.

Another fundamental point stands in the support to development that is in line with the country's context. Indeed, the local community was included and the local culture respected, developing the UR-Beira project evenly and homogenously with respect to the project. This will also make it possible to implement the project in other parts of Mozambique to guarantee better services and solutions to citizens' needs. Clearly, the logic of the intervention is precisely that of creating the conditions for its continuity and replication at the local and national level, developing a system that can be implemented by the Mozambican Health System. This will help the local and national authorities to ameliorate the country's governance and have a meaningful impact on its development, better facing and addressing the country's disparities.

Conclusions

In conclusion, both the international community and recipient countries "are locked into a system that is unable to produce development consistently or predictably" (Bräutigam & Knack, 2004). Indeed, even if there is the general belief and hope that aid can contribute to ameliorate the conditions of recipient countries, this is actually not always true. This discrepancy lies in the fact that the allocation of aid is motivated by both recipients' needs and humanitarian objectives, but also by donors' commercial, strategic and political interests and advantages.

What is more, high aid levels are generally associated with larger declines in the quality of governance (ibid.), as recipient states can become aid-dependent and excessively rely on donors' support without implementing their own policies. However, it can be argued that, especially as far as Sub-Saharan Africa is concerned, the level of governance is poor not because of the high flows of aid but because of its persistent instability. Indeed, colonialism, economic crises, civil wars and natural disasters afflicting the region have led to political instability and undermined its development. It is thus difficult to separate the impact of these issues from the impact of foreign aid, which is more often than not higher in those countries afflicted by these problems. To overcome these conflicting approaches, Official Development Assistance (ODA) needs to be provided in a more selective and cooperative way in order to support long-term and sustainable development rather than contributing to a vicious cycle of poor governance and economic decline.

These ambiguous issues are present not only in the general framework of international aid, but also in the more specific context of Development Assistance for Health (DAH). Indeed, there is no shared consensus on how aid affects health outcomes in recipient countries (Gyimah et al., 2015). For instance, international health programmes were generally directed towards the control and reduction of communicable diseases through the implementation of vertical programmes, which the Commission on Health Research for Development considered as "not fully integrated in the national health research picture and therefore do not contribute optimally to the development of a strong and self-reliant national health research system". This leads one to wonder whether recipient countries actually benefit in terms of outcomes from increased Development Assistance for Health. However, at the same time, there is evidence that donors' investments in health financing has contributed to progress toward global health goals,

particularly over the last two decades and especially in the Sub-Saharan African region, one of the largest recipients of aid.

Indeed, remarkable progress has been made in improving the health of millions of people, especially regarding child survival, as millions of children under five are more likely to survive today than in 2000 (UN, SDG Overview). What is more, effective interventions and increasing funds contributed to addressing priority health problems in low income countries and to the fall of prices related to health care. However, in order to reach the goal of universal health coverage for all and everywhere, progress will need to accelerate, especially in the most underprivileged and neglected remote settings. In fact, gross health inequalities continue to persist, with developing countries afflicted by fragile health systems unable to provide effective health services, especially in sub-Saharan Africa (Singh, 2006). This is because the region is characterized by limited resources, scarce personnel and lack of equipment, issues that further exacerbate the high burden of disease afflicting the area.

As the World Health Organization (2007) claims, it is only through the building and the strengthening health of systems that it will be possible to ensure better health outcomes. For this reason, donors' support given to low- and middle-income countries must be more selective and attentive to recipients' needs and agendas in order to maximize the effectiveness of health aid.

Under this regard, the support given by the UR-Beira project to the Mozambican Health system is fundamental, as it aims at strengthening emergency care in the Beira district by involving local authorities and properly including and integrating the local community. The UR-Beira project addresses these challenges by providing the support for building a centralized emergency service, a nucleus and ambulanced, formation and training for health personnel and finally a cost-effectiveness analysis of the implementation of these services.

All these actions will be carried out bearing in mind that once the programme ends, it will be the local health system and authorities that will manage and maintain the service. This will lead to a long-term and sustainable ability of emergency responders to give appropriate and timely care to patients and thus substantially reduce both mortality and morbidity rates. Indeed, an horizontal approach to global health initiatives, which can be considered to be comprehensively applied by the project, focuses on strengthening basic health care needs and the wider health

system. Hence, it is more sustainable in the long term. On the other hand, vertical and more specific programmes are claimed to contribute to the fragmentation of health systems, distorting national health priorities. In fact, already weak health systems may be further damaged as over-concentrated resources in specific programmes could leave many other areas under-resourced. In addition, interventions have often been implemented with little involvement of the recipient state, leading to the creation of so-called parallel systems. However, this is not the case of the UR-Beira project. Indeed, the initiative supports Mozambique's top strategic priorities related to health, which are strengthening the health system by ensuring increasing equitable access to health services and building management capacity in the public health sector, as well as expanding its coverage area for Mozambique (WHO, 2018).

This alignment between local priorities and the initiative's activities, allows the UR-Beira project to overcome another of the main issues related to large transfer of international aid, which is that technical assistance is often provided autonomously by donors, without transferring skills to the recipient countries. On the contrary, the UR-Beira project will provide opportunities to learn thanks to its training activities and the involvement of local authorities as main partners of the project. This will also be fundamental in order to avoid the issue of aid dependence, which afflict many recipient countries of Official Development Assistance in Africa today.

To conclude, the Covid-19 pandemic has further highlighted the critical need for preparedness. In this respect, the pandemic could prove to be a turning point for health emergency preparedness as well as for internal and international investment in health services. However, improving the quality of aid should come before increasing the quantity (Chong et al. 2009), ensuring that aid is effective in meeting current development challenges. Indeed, as Bräutigam and Knack (2004) claim, aid must be delivered "more selectively and in ways that reinforce a virtuous cycle of development rather than contributing to a vicious cycle of poor governance and economic decline", which is afflicting the majority of low- and middle-income countries. Donors' support should be allocated by taking into consideration that every country has developed in a different context, thus the support should, first and foremost, respond to the countries' agendas and priorities. Considering the specific case of health aid, this would help receiving countries to implement support efficiently and sustainably in the long run and to consequently manage it independently.

Even in a country afflicted by natural disasters and protracted conflicts like Mozambique, it is possible to progressively achieve quality health care at all levels. This is obviously a challenging objective, as in order to assure an increase in the state of health of Mozambicans, an improvement of the health sector alone is not sufficient (Garrido, 2020). Indeed, it needs to be accompanied by the implementation of economic and social policies aimed at reducing poverty levels, as well as economic and social inequalities.

It can be easily said that the UR-Beira project is addressing these challenges, and that thanks to the implementation of an emergency care system and an action of training and awareness-raising it also aims at strengthening health care in Mozambique, particularly in the district of Beira. In this case, Development Assistance for Health will have significant effects on health outcomes, especially regarding obstetric and paediatric indicators. However, the gains resulting from the project will benefit not only the health sectors, but also the economic and social structures of the country. Indeed, the initiative has immediately involved the local community, enhancing its technical and managerial skills, which may lead to an increase in the productivity of domestic resources. What is more, the awareness-raising activities will give the entire population the opportunity to effectively become a part of the project, further enhancing the concept of cooperation, that could be further applied to other sectors in need of reorganization. This is exactly why initiatives of international aid like the UR-Beira project, if appropriately implemented, play a fundamental role in addressing inequalities and making health services more equitable everywhere and for everyone, fostering the narrowing of the gap between developed and developing countries and leaving no one behind.

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