

# Will Money Solve Africa's Development Problems?

## No.

By now we should have learned. Donor nations have spent billions of dollars for development schemes in post-colonial Africa, yet there is little to show for this beyond dependency and corruption. Yet current policy and sentiment seem to advocate more of the same. Pop music and movie stars join celebrity academics in trying to shame wealthy nations into committing ever-expanding funds to address African poverty and ill health. This grand scheme mentality has remained immune



from the feedback that failed programs ought to have provided. As for the intended beneficiaries, we find a psychological colonialism that has brainwashed the poor into believing the solutions to their problems are to be found in the technical know-how and largesse of wealthy countries.

A recent book, *The White Man's Burden*, by William Easterly, challenges “utopian social engineering” by international development experts he calls *planners*, for whom poverty is an engineering problem with technical solutions only they can concoct. Needed instead are *searchers*, who go to Africa with humility, open minds, and ability, to learn and discern what works and what doesn't in different cultural settings.

Public health is one of the few areas of development that has achieved some genuine, sustained results. Yet we need only examine the Western response to AIDS, one of Africa's worst problems, to see replication of every mistake made by planners over the past half-century. Evidence is mounting that the Western biomedical model of AIDS prevention — condoms, antibiotics for sexually transmitted infections, and testing people for HIV infection — has been largely ineffective in Africa. More recently, billions of dollars has gone into treating AIDS with expensive antiretroviral drugs, an unprecedented public health intervention with as-yet unknown effects on the future of the pandemic. Availability of these drugs has not reduced the rate of new HIV infections in the U.S.

African AIDS is driven primarily by those men and women who have multiple, concurrent sexual partners. The global prevention model focuses on medical devices and does not actively promote partner reduction, or even address multipartner sex — dismissing this inaccurately as an abstinence-only scheme. Yet, largely before Western technical advisors showed up, Uganda developed its own response to AIDS based on common sense, sound public health principles, and cultural/religious compatibility. Its emphasis on partner reduction (*zero grazing*) was appropriate to the type of generalized epidemic Uganda faced. HIV prevalence fell by an unprecedented two-thirds between 1992–2004. The cost? During the early years of major behavior change, \$0.23 per person, per year. Meanwhile, the AIDS prevention investment per capita in South Africa and Botswana, where Western-favored approaches are funded, is hundreds of times higher. Yet these countries have among the highest HIV prevalence anywhere and it has been difficult to demonstrate the impact of these expensive programs on HIV infection rates, where it counts. Alas, most Western donors seem to have learned nothing from all this. Until the reasons for this are examined openly and objectively, the wealthy nations are likely to continue repeating the mistakes of the past.

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