Project Briefing

No 45 • September 2010

Aid and accountability in health: country findings

Leni Wild and Pilar Domingo

Key points

- There are limits to the impact of donor aid on strengthening accountability in recipient countries, which is complex, dynamic and largely driven by internal processes
- Some forms of donor aid can, however, make a difference, either by 'doing no harm' or by strengthening domestic accountability systems
- Evidence from the health sectors in Uganda and Zambia reveals too little mutual accountability between governments and donors

Overseas Development Institute

ODI is the UK's leading independent think tank on international development and humanitarian issues.

ODI Project Briefings provide a focused and specialised summary of a project, a country study or regional analysis.

This and other ODI Project Briefings are available from www.odi.org.uk

The Paris Declaration on Aid Effectiveness (2005) commits donor and recipient governments to enhance accountability to their citizens and parliaments for development policies, strategies and performance. It emphasises the importance of two-way or 'mutual' accountability between donors and recipient governments. The follow-up Accra Agenda for Action (2008) reinforces the importance of greater transparency and accountability for development results.

In part, these commitments reflect growing recognition of the impact that aid can have on accountability. For example, aid to developing countries with poor governance can further weaken domestic accountability by skewing incentives so that governments are more accountable to donors than to their citizens. Where there is a lack of transparency, it can reduce the capacity of domestic actors (such as parliamentarians and civil society organisations) to hold the government to account for its use of aid (Hudson and GOVNET, 2009). In the long-run, this can undermine overall accountability for aid.

The run-up to the fourth High-Level Forum in South Korea in 2011 presents an opportunity to improve our understanding of the linkages and tensions between domestic and mutual accountability for aid and to think through how aid can be delivered in ways that strengthen accountability overall. To contribute to this debate, this Project Briefing takes a closer look at aid and accountability in the health sector in Uganda and Zambia. It is based on a research project funded by World Vision UK and sets out some of the key findings for each country.

The political context

Uganda and Zambia face a number of significant weaknesses in their domestic accountability systems. Both have experienced long periods of de facto one-party rule, contributing to 'executive dominance' in decision-making, weak political parties, and weak parliamentary oversight.

In Uganda, the National Resistance Movement came to power in 1986, following more than two decades of civil war and instability and was praised for securing relative stability and achieving higher levels of economic development. However, despite a recent shift to multi-party politics in 2005, the ruling party, led by President Yoweri Museveni, has retained considerable influence, prompting fears of a 'slipping back' of democratic and political gains (APRM, 2009).

Zambia established multi-party rule in 1991, but the ruling party, the Movement for Multi-Party Democracy, has retained power ever since, and there are growing fears of a weakening of domestic accountability. This is reflected, for instance, in the recent introduction of an NGO Bill, seen as a measure to restrict the activities of Civil Society Organisations (CSOs) and increase the power of the Executive over their activities.

In these contexts of weak domestic accountability and strong executive power, there is increased scope for aid to further weaken the ability of actors to hold decision-makers to account. Both countries are highly aid-dependent, and both have been at the forefront of experimenting with new aid modalities such as budget support and frameworks like Sector Wide Approaches (SWAps). At the same time, both countries receive significant levels of aid in health in the form of project aid, which generally is provided 'off-budget' and outside of national systems.

Aid modalities, actors and accountability

In Uganda, the key domestic actors in accountability and aid include the government, parliament (including the Public Accounts Committee

and the Social Services Committee), the Auditor-General and a range of CSOs, Non-Governmental Organisations (NGOs) and International NGOs (INGOs). The government has maintained a strong preference for budget support and providing aid on-budget in health. This allows for the inclusion of aid into budget and policy processes, in theory aligning it to nationally defined priorities. A number of improvements to country systems and state capacity to manage resources have been undertaken, including through the Financial Management and Accountability Programme (which seeks to deepen and consolidate reforms around public financial management).

But some concerns remain regarding the government's ability to effectively manage resources, prevent instances of corruption and ensure accountability to donors and citizens. Moreover, service delivery in health is increasingly implemented through local government, but challenges remain where there are tensions between local and central government.

In the context of aid that is provided on-budget, parliament should be a key actor in exercising oversight of that aid, through parliamentary scrutiny of the budget and policy processes. However, the parliament in Uganda is not viewed as an effective watchdog, due to the dominance of the ruling party, although some parliamentary committees have become increasingly active. The Social Services Committee has been active in pushing for resources in health to be directed to specific issues and regions, but it is not perceived to look comprehensively at health programmes and agendas. The Auditor-General and the Inspector-General of Government (a corruption watchdog) should also be key state institutions for the oversight of government operations. However, they are poorly resourced.

A wide range of CSOs operate in the health sector and the majority are engaged in service delivery (and funded by the government and/or by donors). In practice, advocacy for greater accountability in health is seen as a relatively new concept, although some have been more active on these issues, particularly in relation to diseases such as HIV and AIDS.

In Zambia, the government has also taken steps to strengthen country systems, including its public financial management systems and, like Uganda, it has a preference for aid which is on-budget, including budget support.

The key domestic actors for accountability in health in Zambia include the parliament (the Public Accounts Committee and the Health Committee), the Auditor-General, the Anti-Corruption Commission and CSOs. While parliament should be a key player, it is perceived as inadequate with regard to its role in scrutinising executive action. The Public Accounts Committee has exercised oversight of budget processes, on the findings of the Auditor-General's report, but it lacks the power to follow up effectively on recommendations. Moreover, the Auditor-General's Office is generally viewed as competent but remains limited by institutional and financial constraints. Similarly the Anti-Corruption Commission has limited resources and power.

The CSOs that are active in health in Zambia are highly diverse, and there are important power imbalances between them. For example, INGOs and Lusaka-based NGOs have access to higher levels of funding and command greater voice and influence than others. But more 'voice' has not always translated into effective oversight. In recent years there have been increasing opportunities for CSO involvement in the budget process, and improved capacity and advocacy strategies for a number of CSOs. But there is still little indication that they have had a significant impact on shaping resource allocation in health.

Overall, the power imbalances between the government and other domestic actors suggest that the domestic accountability system in health remains fragile in both countries. Donors have been limited in their attempts to support greater domestic accountability in health, despite parallel donor engagement in governance support. The multi-donor Deepening Democracy Programme in Uganda indicates some useful progress towards more holistic accountability support, but it remains separate from support to the health sector. In Zambia, donors have been involved in supporting a number of governance support efforts, but these are also in ways that are detached from donor aid to health.

In general, donors appear to focus more on their relationship with the government, with little evidence of engagement with domestic accountability actors in health. And domestic accountability actors – including parliamentarians and CSOs – do not seem to have capitalised on the commitments made at Paris and Accra. To date, these actors have been weak in using these commitments to campaign for greater accountability and transparency in the use of aid in health.

Aid modalities and accountability mechanisms

Under the Paris Declaration, donors committed to increase their use of programme-based aid approaches that work through government systems and are on-budget. This, in theory, strengthens domestic accountability and contributes to mutual accountability. Both Uganda and Zambia were at the forefront of the use of programme-based aid approaches, including budget support and SWAp frameworks in health.

To some extent, health SWAps appear to have strengthened accountability, particularly between the government and donors in both countries. In Uganda, for example, reporting processes such as those linked to the National Health Assembly and the Annual Health Sector Performance Report, are seen as useful tools for a range of stakeholders to scrutinise performance in the health sector. Moreover, the health SWAp Sector Working (or Advisory) Groups in

both countries are active forums with participation from some domestic accountability actors, including parliamentarians and select CSOs.

However, these mechanisms do not seem to have translated into concrete changes in behaviour or shifts in accountability. In part, this can be explained by the broader challenges for accountability and governance in both countries. Where there are structural power imbalances, formal mechanisms such as Sector Working Groups alone are unlikely to guarantee greater participation in decision-making from a wider group of stakeholders.

In Zambia, a recent corruption scandal in health highlighted significant weaknesses in Ministry of Health accounting systems but also signalled a greater degree of capacity for domestic accountability systems. In May 2009, the Anti-Corruption Commission exposed the $2 million embezzlement by Ministry of Health officials. This led donors to freeze their funding and seek to recover lost funds, but it also signalled increased institutional capacity of the Auditor-General and the Anti-Corruption Commission to identify irregularities.

Aid approaches that should support country systems and processes do not seem to be contributing substantively to greater domestic accountability for health. But aid that is delivered outside these systems appears to further weaken domestic accountability in health.

A large proportion of aid to the health sector in both countries is provided off-budget, including through vertical funds such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Global Alliance for Vaccines and Immunisation (GAVI Alliance) and the US President's Emergency Fund for AIDS Relief (PEPFAR). It is difficult to gauge the levels of off-budget project aid, but a 2007 report on Uganda found that more aid was provided off-budget than on-budget in the health sector (Christiansen et al., 2007). In Zambia, PEPFAR provided $269 million in 2008 and the GAVI Alliance is providing approximately $50 million from 2005-2015 (Pereira, 2009).

This aid has helped service some of the health needs in Uganda and Zambia, which is important given the magnitude of the disease burden these countries face. However, it generally uses mechanisms that work outside budget processes and government systems and reporting lines flow from the implementing body to the donor agency, creating significant hurdles to domestic oversight and scrutiny.

In recent years, some funds have sought to work in ways that promote accountability. In both Uganda and Zambia, the Global Fund, for example, has sought to follow SWAp procedures. But challenges remain where additional reporting measures are still required and funds are delayed.

The International Health Partnership and Related Initiatives (IHP+) was established in 2007, in part to respond to some of the challenges posed by the proliferation of donors and complexity of the aid architecture in health. IHP+ brings together donors and recipient country governments in a Global Compact and Country Compacts to achieve the health Millennium Development Goals (MDGs). However, in both Uganda and Zambia this partnership is not seen as particularly meaningful in terms of the added value of a Country Compact (neither country has yet fully established such a Compact).

Information flows

Challenges of access to information and transparency in health were common in both Uganda and Zambia. Greater transparency cuts across many of the principles of aid effectiveness outlined in the Paris Declaration: recipient governments need information to prepare realistic budgets, donors benefit from information-sharing to improve coordination, and citizens require information to effectively hold decision-makers to account.

While progress in terms of SWAp arrangements has improved transparency, donors do not provide enough information on their aid commitments and disbursements in Uganda and Zambia. The provision of more complete, more timely and more accurate information remains a significant stumbling block to greater accountability in health. Provision of this information would support the strengthening of both domestic and mutual accountability, especially where it is compatible with government planning, budgeting and accounting processes (Moon and Williamson, 2010). Moreover, challenges in accessing donor information are particularly evident in relation to vertical funds in health.

There is also evidence of poor information flows with wider groups of stakeholders participating in accountability mechanisms in the health sector. In Zambia, for example, CSO participation in the Sector Advisory Group was seen as hampered by poor circulation of advance information. There have been some attempts to improve information flows, with the Ugandan Ministry of Finance, Planning and Economic Development establishing a Budget Monitoring and Accountability Unit to monitor government and donor supported projects in a number of sectors, including health. Reports are circulated to government, parliamentarians, the Auditor-General and the Inspector-General of Government.

Despite some improvements, information flows between citizens and government (and donors) remain weak in both Uganda and Zambia. While information is increasingly available at district levels, for example in the form of District Development Plans in Uganda, these are difficult for citizens to process and not particularly relevant to their day-to-day experiences of the health sector. Much of the information available is not very accessible, emphasising the importance of both access to, and the quality of, information.

A number of CSO- or NGO-led monitoring initiatives seek to address some of these challenges, including World Vision's Citizen's Voice and

Action tool. These seem to work well in disseminating information to sub-district levels and identifying gaps in provision. They do not, however, systematically link to national-level processes and central government.

Conclusions

Our analysis highlights that there are limits to what donor aid can achieve in terms of strengthening accountability in recipient countries. Domestic accountability is complex, dynamic and largely driven by internal processes. Bearing this in mind, the preceding analysis also shows that some forms of donor aid can make a difference, both in terms of ensuring that they 'do no harm' to existing domestic accountability systems and in potentially strengthening these systems, particularly where linkages can be identified between mutual and domestic accountability.

Greater transparency is a key area of potential linkage, but it remains weak in important ways in both Uganda and Zambia. Moreover, donors' own incentive structures do not always support the strengthening of greater domestic and mutual accountability, and domestic actors themselves have not always capitalised on some of the opportunities offered by the aid effectiveness agenda, which emphasises greater accountability to citizens and parliaments.

In the run-up to the next High Level Forum, there is a need for careful consideration of how support to domestic and mutual accountability can be mutually reinforcing, leading to the overall strengthening of accountability, in the health sector and beyond.

Written by Leni Wild, ODI Research Officer and Pilar Domingo, ODI Research Fellow. For more information, please contact l.wild@odi.org.uk.

Overseas Development Institute

111 Westminster Bridge Road, London SE1 7JD

Tel +44 (0)20 7922 0300

Fax +44 (0)20 7922 0399

Email publications@odi.org.uk

ISSN 1756-7602

References and project information

References:

African Peer Review Mechanism (2009) 'Republic of Uganda, Country Review Report 7'. Pretoria: APRM.

Christiansen, K.; McLeod, D.; Williamson, T.; Clarke, A.; Mugerwa, C.; Juuko, S. and Oling, V. (2007) 'Interim Report of the Uganda Donor Division of Labour Exercise'. London: ODI.

Hudson, A. and GOVNET (2009) 'Background Paper for the Launch of the Workstream on Aid and Domestic Accountability'. OECD-DAC GOVNET. Paris: OECD.

Moon, S., Williamson, T. (2010) 'Greater aid transparency: crucial for aid effectiveness'. ODI Project Briefing 35. London: ODI.

Pereira, J. (2009) 'Zambia, Aid Effectiveness in the Health Sector: a case study'. Case study report, Brussels: Action for Global Health.

Project information:

Accountability for aid has emerged as a key concern for aid effectiveness. There is, however, a knowledge gap on the relationship between aid effectiveness and accountability, and whether and how the two can reinforce each other.

This study was supported by World Vision UK (www.worldvision.org.uk) as part of their Partnership Programme Agreement with the UK Department for International Development (DFID), and in particular by Besinati Mpepo, Senior Economic Justice Policy Adviser, and Kate Eardley, Health Policy Adviser.

With this funding, ODI completed a six-month study (October 2009 to April 2010) on these issues in the health sector, based on case studies from Uganda and Zambia. The Zambia case study, led by ODI Research Fellow Pilar Domingo, was carried out in November and December 2009. The Uganda case study, led by ODI Research Officers Leni Wild and Daniel Harris, was carried out in January 2010. Case studies involved interviews and a literature review. A synthesis report is available online.