Project Briefing

No 46 • September 2010

Aid and accountability in health: what can donors do differently?

Leni Wild and Pilar Domingo

Key points

- The health sector is seen as a 'tracer sector' for accountability in aid, in part because of the high levels of support it receives
- The failure of many donors to fulfil their commitments to mutual accountability in the health sector has contributed to one-way accountability – to donors rather than to citizens – in Uganda and Zambia
- Donors need greater interaction with domestic processes and accountability mechanisms

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

Aid to countries with high levels of poverty and poor governance can undermine already weakened domestic accountability systems. This may make recipient governments more accountable to donors than to their citizens, undermining the development of a tax-based citizen-state contract, and disrupting budget and policy processes (Hudson and GOVNET, 2009). Where this occurs, it further limits progress on poverty reduction and sustainable development.

Recognising some of these challenges, the Paris Declaration on Aid Effectiveness (2005) and the follow-up Accra Agenda for Action (2008) emphasise the need to enhance accountability to citizens and parliaments, as well as improve country ownership of aid and transparency. To this end, donors who signed the Paris Declaration have committed to increase the use of programme-based approaches and provide more aid on-budget and through country systems. The run-up to the fourth High-Level Forum in South Korea in 2011 is an opportune moment to reflect on progress in strengthening accountability, and assess how this might be further strengthened in future.

The health sector is increasingly seen as a 'tracer' sector for the agendas set in Paris and Accra. This is because of high levels of donor support, the fact that health underpins the Millennium Development Goals (MDGs), and because health aid often exemplifies many of the challenges around aid (including poor alignment and harmonisation, lack of ownership and weak mutual accountability) (OECD, 2009).

This Project Briefing draws on the findings of a recent study for World Vision UK which examined the impact of aid in health on domestic accountability, through case studies in Uganda and Zambia. It sets out some of the key lessons for donors. There are a wide range of donors in both countries and donor conduct varies considerably. This briefing draws some general conclusions from recurrent issues and, unless stated otherwise, refers generically to donor behaviour.

Mixed evidence for domestic accountability

Donors' use of programme-based aid approaches and donor support that works with national systems should help strengthen domestic accountability in recipient countries where they allow for greater oversight by domestic actors, including parliamentarians, Civil Society Organisations (CSOs) and, ultimately, citizens.

Research from Uganda and Zambia reveals that, to some extent, the use of Sector-Wide Approaches (SWAps) and aid modalities such as budget support have increased transparency and accountability in health. This is through the use of reporting frameworks such as the Annual Health Sector Performance Reports and, in the context of budget support, Joint Assistance Strategies.

These are seen as useful tools for scrutinising the performance of donors and recipient governments. They set specific indicators and provide annual appraisal processes for mutual, two-way performance scrutiny. In addition, Sector Working Groups (or Advisory Groups) allow a wider group of stakeholders, including parliamentarians and select CSOs, to participate in the planning, monitoring and review of health policies and implementation.

Despite these improvements, it was generally agreed that while these are useful in supporting domestic accountability in health 'on paper', they have not fundamentally altered the balance of power between actors. The failure of many donors to fulfil their commitments on mutual accountability has contributed to a continued prevalence of one-way accountabil-

ity, mainly from recipient countries to donors rather than to their own citizens.

Donors also need to consider how their aid approaches are likely to interact with existing and ongoing domestic processes. In both Uganda and Zambia, long-running decentralisation processes have had a significant impact on health, and understanding how aid modalities might interact with these domestic processes and accountability mechanisms is a 'missing link'.

In Uganda, for example, service delivery is increasingly implemented by local government. There is a growing focus on local accountability and monitoring of service delivery, some of which is funded by donors and International Non-Government Organisations (INGOs). At the same time, donors are engaged in processes of national policy dialogue regarding health. There is little evidence, however, of donors making meaningful links between these different levels of accountability.

Moreover, donors' own concerns at times still outweigh their commitments to building greater domestic accountability in health. In Zambia, for example, the recent corruption scandal highlighted flaws in the Ministry of Health's accounting system. When $2 million was embezzled by high-level Ministry officials, donors responded by freezing their funds to the health SWAp and seeking to recover lost funds. Recovery of donor funds is of course important. But donors were perceived to be much less concerned about the recovery of Zambian budget funds. This undermined their perceived commitment to supporting domestic systems in health during the crisis period.

The importance of politics

The agreements in Paris and Accra reflect growing recognition of the need to support domestic processes of development. But, in practice, in the context of health in Uganda and Zambia, donors still appear to lack an understanding of how different aid modalities and approaches interact with domestic power dynamics.

For example, donors do not appear to have fully realised the implications of aid modalities such as budget support and other programme-based approaches for power dynamics within governments. In Zambia, tensions appear to have arisen between the Ministry of Finance and the Ministry of Health regarding control of resources. Some within the Ministry of Health feel that their 'ownership' has been undermined by the shift away from basket funds and programme aid, in favour of budget support channelled through the Ministry of Finance. Distrust between the two ministries in part reflects distrust with respect to each other's accountability mechanisms as well as conflict over resources. The aid effectiveness agenda underlines a move towards programme-based approaches such as budget support. But there are important implications on the ground for how government structures and actors adapt to the resulting changes.

Donors should also consider wider political dynamics. There was a strong sense in both Uganda and Zambia that health is heavily politicised. In Uganda, some civil society respondents felt that the politicisation of the health sector meant any criticism or scrutiny of government policies and actions runs the risk of being labelled 'opposition'. In the run-up to elections in Uganda in 2011, this politicisation is likely to increase, potentially undermining the space for broader engagement and critique of government health policy.

Donors need to take better account of how far accountability for aid interacts with domestic power dynamics. For example, in both countries, domestic actors could identify some positive developments. In Uganda, the Social Services Parliamentary Committee felt that the health SWAp had increased their ability to hold government accountable over aid in health. In Zambia, both the Public Accounts Committee and the Auditor-General's Office were commended for their efforts in pointing to aid irregularities in health. But these institutions continue to be constrained by limitations over their formal competencies, resources and capacity, and the informal structures of executive-led politics.

It appears that some donors are beginning to respond to these concerns. In Uganda, for example, donor programmes such as the Deepening Democracy Programme seek to address some of these national level weaknesses (including in parliament, political parties, civil society and media). But few meaningful links seem to have been made between donors' support for broader governance and accountability reforms, and their sector support in health. In part, this reflects the fact that governance and sector specialists often work separately, which can lead to missed opportunities for greater collaboration.

Donors seem to have been slow to openly recognise the extent to which their decisions on aid approaches in health are shaped by their own domestic politics. For example, a perceived decline of public support for budget support in countries like the UK is seen as weakening the UK's commitment to this modality at country level. Moreover, donors continue to influence priorities in the health sector, as shown by the high levels of funding directed at well-publicised issues such as HIV and AIDS. This is to the detriment of more commonplace health problems and undermines country ownership of health priorities.

The proliferation of off-budget aid

A large proportion of aid to the health sector is still provided in the form of off-budget aid. This includes aid channelled 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 on AIDS Relief (PEPFAR). While it remains difficult to gauge the levels of off-budget project aid, a 2007 report on Uganda found that more aid was provided off-budget than on-budget in health (Christiansen et al., 2007). In Zambia, PEPFAR provided $269 million in 2008 and the GAVI Alliance is providing approximately $50 million from 2005 to 2015 (Pereira, 2009). Vertical funds have played key roles in servicing some of the health needs in countries such as Uganda and Zambia, which is important given the magnitude of the disease burden faced by these countries.

But the prevalence of off-budget aid in health, which generally uses mechanisms that work outside of budget processes and government systems, can be particularly challenging for domestic accountability. Requiring separate reporting structures and processes for aid projects creates significant hurdles to domestic oversight and scrutiny, as do reporting lines that flow from the implementing body to the donor agency (without wider information-sharing with domestic accountability actors). In countries such as Uganda, where service delivery is largely decentralised, this has led to a proliferation of donor-funded projects and organisations operating at district level and below. There are few incentives to work with and open up to district and national level accountability actors.

Some vertical funds, such as the Global Fund, have sought to work in ways that accommodate accountability for aid. They have tried to do more to support country systems (for example working through SWAp arrangements). But these funds commonly still require additional reporting and information, and disbursement has been slow and unpredictable. Moreover, the large scale on which off-budget aid operates further weakens country ownership of health policy design.

The International Health Partnership and Related Initiatives (IHP+) was launched in 2007 to respond to some of these challenges of the proliferation of actors and aid approaches in health. IHP+ brings together donors (bilateral, multilateral and vertical funds) and recipient governments in Global and Country Compacts to achieve the health MDGs.

IHP+ was seen as a translation of the Paris Declaration principles into practice. It was specifically aimed at tackling some of the challenges posed by the complexity of the health aid architecture and the proliferation of donors and aid approaches. In both Uganda and Zambia, however, there was little recognition of the added value of the Country Compacts. It appeared that the initiative was not particularly well understood by some domestic stakeholders and there was scepticism about its ability to have a meaningful impact. Some CSO representatives doubted its potential for greater empowerment of civil society in health policy-making.

What can donors do differently?

Be more transparent

In both Uganda and Zambia, it was emphasised that information and greater transparency lie at the heart of improvements to domestic and mutual accountability. Lack of donor transparency about aid commitments and disbursements in health (for both on-budget and off-budget aid), as well as blockages in information flows between citizens and the state, remain major barriers for accountability. Donors need, therefore, to significantly increase their levels of on-budget health aid and to improve transparency. Establishing Aid Management Policies (including 'platforms' where government and donors can share aid information) is key. Information should be provided in ways that are compatible with governments' planning, budgeting and accounting processes and should be publicly available (Moon and Williamson, 2010). This is in line with donor commitments to the International Aid Transparency Initiative (IATI) launched in 2008, with the aim of making information about aid spending easier to access, use and understand.

Explore support to domestic accountability systems

Evidence suggests that the aid effectiveness agenda in health, and the mechanisms for accountability it promotes, are not yet leading to meaningful shifts in domestic accountability arrangements. Many domestic actors appear to remain 'untouched' by (and at times unaware of) progress in this area. Moreover, if donors commit to providing more on-budget aid, there is a real need to strengthen domestic systems and accountability processes to provide effective scrutiny of health aid. Some donors have already committed to increasing their support to domestic accountability in light of this – for example, the UK's Department for International Development (DFID) White Paper in 2009 commits to allocate the equivalent of 5% of budget support funding to help build accountability. But it is not yet clear what this will mean in practice in countries like Uganda and Zambia.

To date, donor attention has focused on national level forums for dialogue with wider groups of stakeholders. Much less attention has been paid to linkages with issues of implementation, including accountability and incentives for front-line service providers, particularly in the context of decentralisation (Williamson and Dom, 2010). Donors need to seek to bridge the gaps between levels of engagement, and explore innovative ways of strengthening domestic accountability systems as a whole. The Deepening Democracy Programme in Uganda appears to be a promising start to working in a more holistic way, although it also focuses on national level reforms.

Shift donor incentives and behaviour

At present, donor choices regarding aid modalities in health are shaped as much by their own domestic politics as by analysis of the local context. There is still a need to improve donor capacity for understanding and analysing political context. Donors should include analysis of their own incentives and behaviour in these contexts. This should also be linked to efforts to better integrate sector and governance specialists, encouraging collaboration and formal linkages as well as more common, informal links.

Finally, donors need to be much more realistic about what can be achieved. Progress on domestic accountability is fundamentally a political process. It needs to be domestically led and is dependent on political will. Research in Uganda and Zambia reveals that donors could do more to analyse and respond to context and address their own internal incentives, in order to develop more realistic objectives for support – and accountability – in health.

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:

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. and Williamson, T. (2010) 'Greater Aid Transparency: Crucial for Aid Effectiveness'. ODI Project Briefing 35. London: ODI.

Organisation for Economic Cooperation and Development (2009) 'Aid to Better Health – What Are We Learning about What Works and What Do We Still Have to Do'. Interim Report from the Task Team on Health as a Tracer Sector, Working Party on Aid Effectiveness. Paris: OECD-DAC.

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

Williamson, T. and Dom, C. (2010) 'Sector Budget Support in Practice: Synthesis Report'. London: ODI/Mokoro

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.