



## Aid and accountability in health: key themes and recommendations

Leni Wild and Pilar Domingo

### Key points

- The aid effectiveness agenda has had a mixed impact on domestic accountability in health so far
- Information and greater transparency should sit at the heart of improvements to both domestic and mutual accountability in health
- Donors need to consider their own behaviour and incentives for aid accountability in health, in their aid relationships and within their agencies

### 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](http://www.odi.org.uk)

**D**espite considerable progress, poverty reduction and sustainable development remain major challenges for many countries. Aid is an important component in progress but, in recent years, attention has been paid to some of the challenges to its effectiveness. There has also been a growing recognition of how aid can impact on, and be affected by, accountability, governance and politics in donor and recipient countries. But there is still a real gap in understanding about accountability for aid. This paper draws out the key themes and recommendations of a recent study for World Vision UK that examined aid and accountability through case studies in Uganda and Zambia, using the health sector as a lens.

### Opportunities for aid and accountability in health

Aid to low-income countries with poor governance may further weaken domestic accountability, making governments more accountable to donors than their citizens and undermining the development of a more legitimate citizen-state social contract (Bräutigam and Knack, 2004; Hudson and GOVNET, 2009).

This depends partly on the extent to which recipient governments are able to control and manage aid, and partly on the role of other domestic actors in scrutinising its use. In this context, there is a growing debate on aid accountability and the impacts of different aid modalities and approaches.

The commitments made under the Paris Declaration on Aid Effectiveness (2005) emphasise the need for donor and recipient governments to enhance accountability to their citizens and parliaments, timely and transparent information on aid flows, and mutual accountability. The follow-up Accra Agenda for Action

(2008) identifies the importance of greater parliamentary and civil society engagement. As a consequence, donors have committed to providing aid in ways that strengthen national ownership and accountability and support national systems.

Health is increasingly seen as a 'tracer' sector for the aid effectiveness agenda. This is partly because of increased donor interest and funding, and partly because health is seen to underpin all of the Millennium Development Goals (MDGs) (OECD, 2009). Moreover, health aid appears to exemplify many of the challenges for aid effectiveness, including: the complexity of the aid architecture, common lack of alignment with country priorities, dominance of donor preferences, and the presence of actors that tend to work outside the aid effectiveness framework.

While there is a limit to what donor aid can achieve in terms of strengthening domestic accountability, some forms of aid can make a difference, from 'doing no harm' to actually strengthening existing domestic accountability systems.

With this in mind, the research into health aid for Uganda and Zambia identified a number of important themes and challenges related to underlying power dynamics and political contexts, which are set out below.

### The importance of context

In health, the impact of aid modalities on domestic accountability structures differs according to context. In Zambia, donors seem to exercise more influence on accountability for aid. In Uganda, there are signs of greater capacity for national decision-making and accountability for aid in health, although there are also serious concerns about the strength of the domestic accountability system.

In both countries, donor mechanisms and approaches in health are similar and include the use of Sector-Wide Approaches (SWAs), and trends towards budget support. However, there is insufficient attention given to how these aid modalities and approaches interact with domestic power and accountability relationships and a lack of understanding of how national systems can be supported while at the same time strengthening domestic accountability systems.

## The impact on domestic accountability

Evidence of the impact of aid on domestic accountability in health is mixed. There are some positive examples of this agenda helping to strengthen domestic accountability in health. For example, the Social Services Committee of the Parliament of Uganda reported that the health SWAp and forums like the National Health Assembly allowed them greater engagement in planning, budgeting and monitoring on health issues. In Zambia, the participation of Civil Society Organisations (CSOs) in the Sector Advisory Group was welcomed and should increase their input into planning and monitoring for health.

However, these changes have not yet led to meaningful shifts in domestic accountability arrangements in health. In both Uganda and Zambia, accountability institutions and actors such as parliaments and Auditor-Generals remain largely untouched by the push for accountability for aid for the health sector. In part, this is because they are constrained by overall weaknesses in domestic accountability as well as limitations in their own formal competencies, resources and capacity, and in the informal structures of executive-led politics.

However, donors may also be contributing to the lack of a meaningful shift where they fail to fulfil their commitments to greater mutual accountability in health, and work outside domestic accountability systems.

In both Uganda and Zambia, accountability for aid mechanisms in health have not always taken account of ongoing domestic processes. For example, the health focus of donors in both countries is at the national level. This is true of health SWAp forums for policy dialogue, which involve a wider number of stakeholders. Much less attention is given to linkages with 'downstream' issues of implementation, for example, accountability and incentives of front-line service providers – particularly in the context of decentralisation (Williamson and Dom, 2010).

The evidence shows that in both countries, long-running decentralisation processes have had a significant impact on health, and there remains a missing link to understanding how aid modalities might interact with these domestic processes.

In Zambia in 2006, for example, the decision to merge the Central Board of Health into the Ministry

of Health was presented as a reform to better streamline the organisational structures of the health sector. It was, however, seen by some to have removed systems for accountability and 'voice' from below. District officials and other stakeholders felt that the merger led to the effective 'recentralisation' of policy decision-making, where once it was seen as more attuned to local service delivery needs. Donors and their aid approaches do not always respond appropriately to these concerns.

Meanwhile, moments of crisis may present challenges, but they also present opportunities to strengthen accountability for aid. The recent corruption scandal in Zambia highlighted flaws in the Ministry of Health's accounting system (with \$2 million embezzled by high-level Ministry officials). This led donors to freeze their funds and seek to recover lost funding.

However, this crisis also signalled a degree of institutional capacity in the Auditor-General and the Anti-Corruption Commission. They were able to identify and expose the corruption, and activate the necessary investigative and judicial procedures.

Donors were rightly worried about their own funds, but it is also important to recognise growing domestic capacity to detect and act on irregularities.

## The importance of transparency

Information and greater transparency should sit at the heart of improvements to domestic and mutual accountability in health. Where aid is not provided on-budget or aid information is poor, governments make budgetary decisions based on a partial or inaccurate picture, and domestic actors are limited in their ability to scrutinise these decisions and how resources are used.

In Uganda and Zambia, lack of donor transparency regarding health aid commitments and disbursements, as well as blockages in information flows between citizens and the state, have proved to be major barriers to improving accountability.

In light of these weaknesses, proposals for Aid Management Policies (including 'platforms' where government and donors can share aid information) should be given serious consideration. Information should be provided and made publicly available in ways that are compatible with government planning, budgeting and accounting processes (Moon and Williamson, 2010).

Furthermore, the current focus on community-level monitoring and dissemination of information in health should seek to link with national-level processes.

For example, CSOs, parliamentarians and others could work together to push donors and government to make health reporting more publicly available and then use this information at local levels to better inform and engage citizens on health issues.

## Shifting the balance

One of the biggest challenges for strengthening domestic accountability in health is the prevalence of off-budget aid, including aid from some vertical funds. A 2007 report on Uganda found that more aid was provided off-budget than on-budget in health (Christiansen et al., 2007). In Zambia, the US President's Fund on AIDS Relief (PEPFAR) provided \$269 million in 2008 and the Global Alliance for Vaccines and Immunisation is providing approximately \$50 million from 2005-2015 (Pereira, 2009).

At best, working outside domestic systems does not support them. At worst, it further undermines them. In Uganda, high levels of off-budget project aid in health seem to undermine the existing budget process, as it cannot capture substantial resources directed to health. In Zambia, the range of parallel systems created around vertical funds obscures rather than facilitates information on aid flows.

The International Health Partnership and Related Initiatives (IHP+) represents an attempt to address some of these issues, by further strengthening donor alignment and harmonisation (and including vertical funds within this). Launched in 2007, IHP+ sought to bring together donors (bilateral, multilateral and vertical funds) and recipient governments in Global and Country Compacts to achieve the health MDGs. This is presented as the translation of the Paris Declaration principles into practice for health, and it aims to tackle some of the challenges posed by the complexity of the health aid architecture and the proliferation of donors and aid approaches. However, progress in the IHP+ in Uganda and Zambia, including in establishing Country Compacts, remains patchy, and the IHP+ does not yet constitute a meaningful framework to shape donor interventions or accountability around health in either country.

In light of these challenges, there is a strong need for donors to provide more on-budget aid in health. This would increase the likelihood of an enabling environment for a range of domestic actors to participate more fully in health budget and policy processes.

At present, health budget processes in both Uganda and Zambia appear to be relatively unchallenged, with a lack of scrutiny of budget allocations and issues of efficiency and responsiveness to health needs. Increasing the level of aid provided on-budget in health could push domestic actors (including parliamentarians and CSOs) to engage more actively in health budget processes – although this would need to be accompanied by capacity-building and additional support to these actors.

The 2009 White Paper from the UK Department for International Development (DFID) commits to allocate an amount equivalent to 5% of budget support funding to help recipient countries build accountability. This is interesting, though it is not yet clear what it means in practice in countries such

as Uganda and Zambia, and this commitment would not be appropriate to all donors.

Moreover, there remains a lack of evidence of how domestic accountability and better governance can best be supported, including in the health sector. Some emerging and potentially innovative initiatives, such as the Deepening Democracy Programme in Uganda, warrant further exploration and research.

## Donor behaviour and incentives

Donors need to reflect on their own behaviour and incentives for accountability for aid in the health sector, both in their aid relationships and within their agencies. At present, donor choices regarding aid modalities in health are shaped as much by their own domestic politics as by context.

In Uganda, this has led to some questioning of budget support, particularly given a perceived waning of donor domestic support, for example in the UK. In both Uganda and Zambia, donor incentives have led to a strong prioritisation of health issues (such as HIV and AIDS) that have high levels of international coverage and support, to the detriment of more commonplace health problems.

There is a real need to improve donor capacity to understand the political context of aid (and donors' own incentives and behaviour within these contexts). This should be linked to efforts to better integrate sector specialists (including in health) with governance specialists, encouraging more institutional linkages as well as the existing reliance on good personal links between colleagues. Addressing the barriers on both sides of the aid relationship should further encourage donors to better 'practice what they preach' in terms of aid accountability and commitments to the Paris Declaration.

Ultimately, any assessment of the impact of the aid effectiveness agenda on domestic accountability must be realistic. Domestic accountability refers to the structures, mechanisms and actors that shape state-society relations. Progress on domestic accountability is fundamentally a political process and it must be domestically led, dependent on political will and on power dynamics.

In line with the 'do no harm' principle, donors should ensure that weaknesses in domestic accountability are not aggravated, and that the strengths are at least not undermined and, preferably, supported.

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

## References and project information

### References:

- Bräutigam, D. and Knack, S. (2004) 'Foreign Aid, Institutions and Governance in Sub-Saharan Africa', *Economic Development and Cultural Change* 52 (2): 255-285.
- 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 for 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](http://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.



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](mailto:publications@odi.org.uk)

Readers are encouraged to quote or reproduce material from ODI Project Briefings for their own publications, as long as they are not being sold commercially. As copyright holder, ODI requests due acknowledgement and a copy of the publication.

The views presented in this paper are those of the author(s) and do not necessarily represent the views of ODI or World Vision.

© Overseas Development  
Institute 2010  
ISSN 1756-7602