



Why politics matter: Aid effectiveness and domestic accountability in the health sector

A comparative study of Uganda and Zambia

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Executive summary

Tackling underdevelopment, addressing poverty and delivering basic services remain key challenges in many developing countries, despite some considerable progress. Aid remains an important component in addressing these challenges and, in recent years, there has been increasing emphasis on improving aid effectiveness and accountability for aid. There has also been a growing recognition of the extent to which a country's domestic politics and governance arrangements can shape the use of aid and its effectiveness. However, there is still limited understanding about the types of accountability relationships which should be prioritized and the directions of accountability. With these issues in mind, this paper examines how aid to the health sector, and different aid modalities affect the opportunities for and constraints on domestic accountability in two case study countries: Uganda and Zambia. It draws heavily on a research project funded by World Vision UK.

The Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD-DAC) has led the way in developing the current aid effectiveness agenda, which was enshrined in the Paris Declaration on Aid Effectiveness and which includes key principles of building greater country ownership, ensuring greater transparency and working towards mutual accountability. The follow-up Forum in Accra sought to place greater emphasis on domestic accountability and on the roles of specific actors, such as parliamentarians and civil society.

In parallel with these debates, a growing body of research and evidence explores the ways in which aid itself impacts on domestic accountability. In part, this is about aid which is focused on building the capacity of domestic actors, such as parliamentarians, which this paper does not address, but it is also about understanding how aid can affect the scope for domestic accountability (Hudson and GOVNET 2009). This includes examining how aid can affect the incentives for recipient governments, potentially encouraging them to be more accountable to donors than to citizens, and how aid can affect policy and budget processes. Differing approaches to aid – including different aid modalities – are likely to have differing impacts on domestic accountability, depending on levels of government control of resources and on the existing system for domestic accountability (Ibid.).

Looking at these issues through the lens of the health sector is useful because health is increasingly seen as a 'tracer sector' for aid effectiveness (OECD 2009). This is in part because of the high levels of donor support to health because health is seen as a crucial underlying factor for many other development indicators, including across the Millennium Development Goals. It has also been a sector in which aid effectiveness has been particularly challenging – not least due to the proliferation of donors and aid approaches, and the complexity of the aid architecture.

Both Uganda and Zambia offer interesting cases to focus on in terms of the health sector. Both countries are formally multiparty systems but both have faced major challenges in domestic accountability. For example, both have experienced long periods of one-party rule.

In Uganda, this was for a time in the guise of the ‘no-party’ system. In Zambia, there is a history of dominant party rule. This has in turn exacerbated the dynamics of executive dominance over decision-making, weakening institutions of accountability – such as parliament or opposition parties – which are the checks and balances within electoral democracies.

This paper examines how aid and mechanisms around aid have interacted with domestic accountability relationships, as well as with information flows between donors and governments and outwards to citizens. In particular, it compares and contrasts experiences of aid that is on budget with that which is off budget in both countries, and the implications across a range of actors and interests.

The authors recognize the extent to which domestic accountability in both Uganda and Zambia is itself complex, dynamic and driven by historical, political, social and economic factors. This makes it important to recognize the limits of what aid can achieve in contributing to strengthening domestic accountability. Nonetheless, some forms of aid can make a difference, in terms of ensuring that they ‘do no harm’ to existing domestic accountability systems and in potentially helping to strengthen those systems in the long run. With this in mind, this paper draws a number of conclusions in respect of aid and accountability in health in both countries.

There is a genuine need to take better account of context and of existing systems of domestic accountability – and their weaknesses – when designing aid interventions. In both Uganda and Zambia, there was some evidence of a lack of attention to how different mechanisms around aid (from aspects of the Sector Wide Approach framework such as Sector Working Groups to the functioning of vertical funds such as the Global Fund) take account of and interact with domestic accountability dynamics and actors. Some of these mechanisms, such as Sector Working/Advisory Groups or National Health Assemblies, have not contributed significantly to achieving shifts in domestic accountability, even where they engage with a wider range of domestic actors. This is because existing wider incentives and power dynamics continue to shape the policy space in which these mechanisms operate.

Interestingly, moments of crisis can provide opportunities as well as additional challenges for domestic accountability. For example, a scandal over the misuse of both government and donor resources in the health sector in Zambia in 2009 pushed some donors to revert back to securing their own interests and working in more fragmented ways, but it also allowed for greater recognition of the capabilities of some domestic actors, including the Anti-Corruption Commission and the Auditor-General, which were able to detect and act on irregularities.

While aid approaches which are seen as on budget, and which use country systems, do not always address existing domestic accountability weaknesses, aid which is provided off budget and outside of government planning and policy processes can reinforce existing weaknesses, and provide few incentives for strengthening domestic accountability systems. At present, for example, in both Uganda and Zambia the health budget process is still relatively unchallenged, with a lack of wider scrutiny of budget allocations and implementation, although there are some positive signs, for example, in terms of the role of the Auditor General.

Transparency and access to information remain cross-cutting issues for accountability, and potentially key areas of linkage between domestic and mutual accountability debates. In both

countries, the lack of donor transparency as well as blockages in information flows between citizens and recipient governments remain key stumbling blocks to achieving greater accountability.

Finally, donors' own incentives and motivations need to be recognized as an important part of the picture. This study highlights some positive examples of changing donor behaviour in health, including improvements in reporting, some donors shifting to work in more 'on budget' ways and some improvements in predictability. There remains a strong sense, however, particularly in Zambia, that accountability runs primarily upwards to donors and that there are few incentives to encourage donors to make good on their commitments under the Paris Principles in each country.

As we approach the next High Level Forum to be held in South Korea in 2011, it is important that these issues of domestic politics and of donors' own incentives are reflected on further, not least because greater progress in making aid truly more effective is unlikely to be made if they are not better taken into account.

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1. Introduction

This paper focuses on the role of international aid in shaping opportunities for and constraints on domestic accountability. The question of the impact of different forms of aid on domestic accountability is of particular relevance in the run-up to the next High Level Forum on Aid Effectiveness, to be held in South Korea in 2011.

To date, the aid effectiveness agenda, derived from the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action, has been premised on the assumption that accountability for aid combined with country ownership over development agendas will, in part, lead to better development results. There remains, however, limited understanding of the types of accountability relations that should be prioritized, and the directions of accountability. Moreover, this agenda has been increasingly challenged for its often technical approach, which has not always taken full account of domestic politics and accountability relationships.

In this paper, we address the impact of different modalities of international aid on domestic accountability through the lens of the health sectors in Uganda and Zambia, with a particular focus on answerability for aid resources. Domestic accountability for aid concerns the relationship between governments that manage or use aid and the domestic constituencies on whose behalf aid is managed. Crucially, however, this is shaped, among other factors, by the nature of the aid relationships through which resources are disbursed, managed and used.

Unpacking the impact of aid on domestic accountability is of relevance in the current context as the aid effectiveness agenda has placed great emphasis on the accountable use of aid resources. The OECD-DAC has led the way in developing this agenda, which was enshrined at a High Level Forum in Paris in 2005 and the resulting Paris Declaration, the key principles of which are set out in Box 1.

Box 1. Key principles of the Paris Declaration (OECD 2008)

1. **Ownership:** Partner countries exercise effective leadership over their development policies and strategies, and coordinate development actors
2. **Alignment:** Donors base their overall support on partner countries' national development strategies, institutions and procedures
3. **Harmonization:** Donors' actions are more harmonized, transparent and collectively effective
4. **Managing for results:** Managing resources and improving decision-making for results
5. **Mutual accountability:** Donors and partners are accountable for development results

The Paris Declaration emphasizes the need to strengthen both donors' and recipient country governments' accountability to their citizens and parliaments, as well as the importance of timely and transparent information on aid flows. The follow-up High Level Forum in Accra sought to place greater emphasis on domestic accountability and on the roles of specific actors, such as parliamentarians and civil society, which were seen as left out of the original

discussions. Thus, donors committed to provide aid in ways which strengthen national ownership and accountability, as well as support to national systems (OECD 2008).

Until recently, the predominant concern within much of the donor community was with the accountability relationship between donor and recipient governments. Thus, the notion of ‘mutual accountability’ has emerged to characterize a two-way relationship between donors and aid recipients for setting and monitoring progress towards, and meeting reciprocal commitments on, the delivery and use of aid. In reality, there are still too many examples of an emphasis on holding recipient governments answerable to donors rather than on the two-way relationship of answerability. Regardless of how ‘mutual’ aid relationships have become, however, the impact of aid on domestic accountability has, until recently, remained understudied and poorly conceptualized in a policy world that is concerned with aid effectiveness. Concerns over domestic accountability were relegated to debates about, and programming on, governance, but not sufficiently connected to how donors’ actions in areas such as health might be relevant.

At the same time, some have pushed for the issue of country ownership of development priorities and strategies, which featured in the Paris Declaration, to be extended to mean ownership not only by the government but also by other levels of the polity and society (Meyer and Shulz 2008). Through the notion of ownership beyond the government, there has been growing acknowledgement that relations of accountability should focus not only on answerability between donors and recipient governments, but also on how they then answer to their respective constituencies (taxpayers or citizens in aid recipient countries) through different mechanisms of accountability.

Aid can have an impact on domestic accountability in different ways. First, it can affect the capacity of domestic accountability actors, for example, through donor support to civil society or to parliamentarians. This aspect of impact is not focused on in this study. It can also affect the scope for domestic accountability, which is a key focus of this research (see Hudson and GOVNET 2009). There has been increasing analysis of the extent to which aid to poor countries with weak governance can further weaken domestic accountability (Bräutigam and Knack 2004). In these contexts, it can create incentives for governments to be more accountable to donors than to their citizens, it can undermine the development of a social contract between citizens and the state, and it can undermine budget and policy processes particularly where there is a lack of transparency about aid flows (Hudson and GOVNET 2009).

There is increasing recognition that the extent to which some of these negative impacts occur will depend in part on whether recipient governments can control and manage the aid that they receive (Ibid.). Therefore, different aid modalities will allow for differing levels of government control and will have varying impacts on the domestic accountability system in question, depending on context. This paper looks at these issues of aid and accountability in the context of the health sector. Health is seen as a tracer sector for aid effectiveness (OECD 2009). This is because of the high levels of donor support for and interest in health in recent years (official development assistance for health has risen six-fold in the past 20 years) and

because of the extent to which health is seen as underpinning many other areas of development (Dodd and Hill 2007). At the same time, however, the health sector illustrates many of the known challenges for aid effectiveness, due to the complexity and lack of coordination within the aid architecture and the proliferation of actors, including newer actors which work outside the aid effectiveness framework. Understanding how these issues interact at sector level and in terms of the wider political context can be seen as addressing an important gap in knowledge and thinking to date.

Defining domestic accountability

This paper sees accountability at its core as the relationship between decision makers and those affected by decisions. As such, it involves concepts of: oversight, whether accountability mechanisms have the competences and capability to monitor the behaviour of decision makers; answerability, whether decision makers can be made to justify their actions in line with the prevailing rules of the game; and enforceability, whether sanctions can be used if decision makers do not meet certain standards. Transparency in decision-making and about implementation processes is crucial to all this, as information is required about commitments made and whether they have been met. Thus, the quality and availability of information are key components of accountability relationships.

The elements of the domestic accountability system on which this paper focuses include those mechanisms and actors that are relevant to exercising oversight over the use of aid resources, and to ensuring answerability for decisions and actions on the use of aid resources. This includes both horizontal accountability mechanisms of political, financial and legal oversight and answerability (parliaments, and the range of public audit and oversight institutions within the state bureaucracy that should have a say in how aid resources are managed), and vertical accountability actors including opposition parties, civil society and the media (Schedler et al. 1999, Peruzzotti and Smulovitz 2006). In addition, measures such as legislation on freedom of information and transparency can have an impact on the effectiveness of domestic accountability mechanisms. It is also important to stress that how accountability relationships develop depends on the formal institutional framework, but perhaps even more so on the informal rules of the game.

Ultimately, the quality of domestic accountability is connected to the quality of governance processes, and it is deeply political. On the one hand, it is a reflection of the state's institutional capacity to ensure probity in the exercise of power and enforce law-abiding conduct. More importantly, however, it reflects the degree to which governing elites are willing to be bound by the logic of answerability for their actions. In part, this responds to the balance of power; in part, it is a consequence of embedded attitudes and conduct towards public resources – and often reflects the logics of patronage and clientelism.

This paper therefore examines the ways in which different aid modalities in the health sector either undermine or support the development of domestic accountability mechanisms and the participation of actors in accountability for how aid resources are used. The report is structured around a framework that focuses on: the actors, including those holding to

account and those being held to account; the mechanisms, the relationships and processes through which actors come together around aid; and the information flows between and among various actors.

It is based on a research project supported by World Vision UK, as part of its Partnership Programme Agreement with the British Department for International Development, and it borrows heavily from the synthesis report from that study. The authors are particularly grateful for World Vision UK's support for this work.¹ The project involved qualitative case studies, through fieldwork in Kampala, in January 2010, and Lusaka, in November 2009, as well as interviews with a range of stakeholders, including donors, civil society organizations, parliamentarians, government officials and representatives from the media, and a limited review of the available literature.

Section 2 analyses the political contexts in Uganda and Zambia. Section 3 examines the impact of aid modalities and mechanisms on domestic accountability in both countries, with a focus on on budget and off budget aid, and on information flows. Section 4 sets out some of the key conclusions that emerge from this analysis.

¹ More information about the project and its outputs can be accessed at
<<http://www.odi.org.uk/work/projects/details.asp?id=1968&title=aid-accountability-health>>

2. Understanding the political context in Uganda and Zambia

This paper focuses on understanding the impact of the aid effectiveness agenda, and the aid modalities and approaches it recommends, on domestic accountability in Uganda and Zambia. Both countries are formally multiparty democracies but face a number of major challenges in their domestic accountability systems. Both countries have experienced long periods of one-party (Uganda) or dominant party (Zambia) rule. This, in turn, has contributed to exacerbating the dynamics of executive dominance over decision-making, and weakening those institutions of horizontal accountability, such as parliament, that constitute the logic of checks and balances in electoral democracies.

In Uganda, the National Resistance Movement (NRM), led by Yoweri Museveni, came to power in 1986 after more than two decades of civil war and political instability. The NRM initially promoted a form of ‘no-party democracy’ in which elections were held but not contested by political parties, something which was seen as necessary in the light of Uganda’s history of civil war and internal divisions over ethnicity and religion. To begin with, this was welcomed by the international community, which praised the NRM for ensuring relative stability across most of Uganda and for its significant achievements in economic growth and development (Moncrieffe 2004).

In 2002, under growing pressure from the international community and from domestic actors, political parties were effectively allowed to re-establish themselves. In 2005, a national referendum was held which led to the re-establishment of a multiparty system. However, this was linked to the abolition of term limits for the office of the President, and thus seen as a political tactic on the part of Museveni rather than a genuine commitment to democratic reform. This has led some to highlight a worrying trend of the dominance of the president, and the view that ‘...there are no actors, within the executive or legislative branches of government or elsewhere within the state with the power to veto a presidential policy decision’ (Booth and Golooba-Mutebi 2009: 29).

Opposition parties remain weak, although there are growing signs of their organization (see Wild and Golooba-Mutebi 2010), and Museveni’s ruling party continues to dominate the political sphere. Parliament is generally viewed as weak in its oversight and scrutiny functions, despite some activism in committees such as the Public Accounts Committee, which is chaired by an opposition party member. There are some independent media organizations, but there are also reports of increasing crackdowns, including through proposed new legislation. Although there are a large number of civil society organizations, many focus on service delivery and remain relatively immature in their roles as accountability actors (CIVICUS 2006). There are a number of state accountability institutions, such as the Auditor General, the Inspector General of Government and the Ministry of Ethics, but these institutions are seen as poorly resourced which undermines their effectiveness and some – such as the Auditor General – are seen as lacking independence (APRM 2009).

Zambia has formally been a multiparty democracy since 1991, although since then the Movement for Multi-Party Democracy (MMD) has won successive elections and there has

been no alternation in power. The logic of dominant party rule has contributed to perpetuating political practices of clientelism, patronage and widespread corruption, often making domestic accountability institutions ineffective (Duncan et al. 2003, Venter 2003).

Opposition parties are weak, personality based and unable to act as a political counterweight to the ruling party, despite a recent merger of two parties in a common electoral alliance (the Patriotic Front and the United Party for National Development). Parliament is perceived as largely inadequate in its oversight roles and as a body which largely rubber stamps government decisions. This reflects a combination of weak political will and weak capacity as well as institutional limitations. For instance, in budget planning, the legislative branch is generally given little time to scrutinize the budget and operates with limited information on decision-making and how priorities are set (Chiwele 2009, Wohlegemuth and Saasa 2008).

The dominance of the ruling party is an important factor in undermining parliament's ability to question executive actions, including decisions on resource allocation and setting policy priorities for aid resources. The Public Accounts Committee has, as in Uganda, been increasingly active, particularly in scrutinizing the Auditor General's annual report and questioning members of the executive branch. Part of this activism may lie in it being chaired by a member of an opposition party. There are, however, institutional constraints on the Committee. Its recommendations are merely noted by the ministry in question and rarely followed up (Chiwele 2009, TIZ 2007).

The Auditor General's Office is viewed as competent but is also limited by institutional and financial constraints. It has limited powers to ensure that the findings and recommendations of its annual reports are followed up. This is exacerbated by the fact that reports work on a two-year time lag. The Anti-Corruption Commission in Zambia has a poor reputation: civil society cannot bring cases to the Commission and its resources are limited.

Again, there is a range of civil society organizations present in Zambia, with a large number engaged in service delivery, but there is also a wide diversity within civil society in the health sector. For example, international NGOs are seen as having more voice on accountability issues and smaller, domestic or more community-based organizations are seen as having been pushed out. In instances where civil society organizations are heavily reliant on government or donor funding, this is seen as undermining their ability to operate as effective accountability actors.

In sum, some significant weaknesses in accountability were identified in both Uganda and Zambia. This is in part a function of the history of one-party and executive dominance in both countries, which contributes to some of the institutional weaknesses of those organizations which should be a check on government power. Both countries face elections in 2011, which could place additional stresses on both horizontal and vertical accountability actors – which may further weaken their ability to play oversight roles, particularly if the dominant party becomes less tolerant of dissent. In Zambia, there is a general consensus that the MMD will be relatively unchallenged and will be re-elected. In Uganda, however, although the NRM looks likely to be re-elected, opposition parties have been growing in

their capacity and level of institutionalization, leading some to suggest that this election will be much more competitive than previous elections – which could increase the pressure on domestic accountability actors as issues such as health become much more politicized.

Both countries are categorized as highly aid dependent. Uganda has attracted high levels of donor support since the 1990s. This has been in the form of project aid, that is, aid to specific donor projects, and in recent years Uganda has also received some of the highest and most sustained flows of direct budget support. Zambia has received large amounts of aid since the 1970s and, until 2005, donor funding amounted to approximately 40 per cent of the total national budget, decreasing to 25 per cent by 2008 (CSPR 2008).

In the health sector, both countries have experienced a proliferation of aid donors and modalities. Although it remains difficult to quantify total levels of aid, three main aid modalities can be identified. The first is general or sector budget support, disbursed through the Ministry of Finance; the second is on budget project aid or donor project aid, which should be in accordance with sector strategies and may be disbursed through government systems (see Box 2); and the third is off budget project aid, which includes some of the so-called vertical funds in health, such as the President’s Emergency Plan for AIDS Relief (PEPFAR) or the Global Fund to Fight AIDS, Tuberculosis and Malaria, which works in ways separate to those of the respective governments of Uganda and Zambia. The implications of these different aid approaches for domestic accountability are addressed in section 3.

Box 2. Defining on budget aid

The term ‘on budget aid’ has been used to refer to a variety of practices. In this study, the term is used to refer generally to aid that uses country budget systems. As a recent study by the Collaborative Africa Budget Reform Initiative (CABRI) points out, this can refer to a variety of different processes. These are likely to have differing impacts on domestic accountability. Unfortunately, this study was not able to dig deeper into this analysis but it notes the seven different dimensions highlighted by CABRI for on budget aid (CABRI 2009):

- On plan: programme and project spending is integrated into agency spending planning documentation
- On budget: programme and project aid and its intended uses are reported in budget documentation
- On parliament: aid is included in the revenue and appropriations approved by parliament
- On Treasury: aid is disbursed into the main revenue funds of government, and managed through government systems
- On accounting: aid is recorded and accounted for in the government’s accounting system
- On audit: aid is audited by the government’s audit system
- On reporting: aid is included in ex-post reports by government.

3 The impact of aid modalities and mechanisms on domestic accountability

3.1 On budget aid and SWAp frameworks in Uganda and Zambia

The aid effectiveness agenda sets out some key principles and recommended approaches for improving both the effectiveness of aid and accountability for it – for both donor and recipient governments (see Box 1). While the Paris Declaration emphasized the need to strengthen both donors' and recipient country governments' accountability, the follow-up forum in Accra placed greater emphasis on domestic accountability and on the roles of specific actors, such as parliamentarians and civil society, which were seen as left out from the original discussions. To what extent are there signs that some of the approaches recommended at Paris and Accra, from programme-based aid to greater transparency, have had a positive impact on domestic accountability?

In both Uganda and Zambia, a Sector Wide Approach (SWAp) has been adopted to the health sector. In theory, this means that 'all significant funding for the sector supports a single sector policy and expenditure programme, under Government leadership, adopting common approaches across the sector, and progressing towards relying on Government procedures to disburse and account for all funds' (Brown et al. 2001: 7). The SWAp framework provides a framework for coordinating aid which is on budget. It involves a number of mechanisms, including Sector Working or Advisory Groups. In theory, the SWAp framework and the mechanisms it establishes should provide increased opportunities for domestic scrutiny of aid in the health sector by a wider range of actors.

In Uganda, the Sector Working Group manages the approval and alignment of project inputs to the sector and oversees the management of the annual health sector budget process. It includes representatives of the government, donors and some civil society organizations, and it involves the participation of some key stakeholders, although the participation of domestic accountability actors is limited to these organizations. In addition, the National Health Assembly is an annual forum for engagement with a wider range of stakeholders, including central and local government, civil society, parliamentarians and donors, which meets to review sector policy, plans and performance, and to agree policy priorities for the coming year. According to members of the parliamentary Social Services Committee, mechanisms such as this assembly have improved accountability, not least because 'all stakeholders now know what is being done and who is doing what'.

Similarly, the range of mechanisms in place in the health sector in Zambia seems to speak of progress in terms of improved accountability and review mechanisms. These include the Annual Consultative Meeting, which is a forum for joint policy dialogue that includes the government, donors, international NGOs and relevant private sector service providers. The Sector Advisory Group meets twice each year to oversee the implementation of the sector strategy and to review progress against performance indicators. This includes participation by civil society organizations alongside the government and donors.

A number of these mechanisms, including the Sector Working/Advisory Groups, in theory play roles in developing policy and programming within the health sector, in line with sector and national level frameworks. In the context of SWAps, health sector strategy is drawn primarily from the National Development Plans or Poverty Reduction Strategy Papers, with specific plans discussed in forums such as the Sector Working/Advisory Groups and at annual meetings such as the National Health Assembly or the Annual Consultative Meeting.

Despite some of these improvements, there was a general consensus that while ‘on paper’ there had been useful attempts to increase domestic accountability and some opening up of space for a wider range of actors in both Uganda and Zambia, this had not fundamentally altered the balance of power or accountability relationships in either country. According to one respondent in Uganda, ‘there remains a big gap between what the documents say in black and white and what actually happens’.

In Uganda, for example, the dominance of the executive and the president constrains the ability of domestic actors to influence, scrutinize or criticize government decisions. This highlights the reality that programme-based aid approaches and frameworks such as SWAps do not occur in a vacuum, and therefore that introducing mechanisms without paying proper attention to underlying power and political dynamics is not likely to substantively change behaviour. In the run-up to the elections in 2011, some civil society representatives interviewed noted that health was an increasingly politicized issue in Uganda, and that any position seen as critical of the government runs the risk of being labelled anti-government or ‘opposition’.

Box 3. The health corruption scandal, 2009

In May 2009, the Anti-Corruption Commission went public with information that USD 2 million had been embezzled by high-level officials in the Ministry of Health, by paying a consultancy firm for workshops which never took place. The governments of Sweden and the Netherlands suspended their funding as a result and there were delays in funding from the GAVI Alliance, the Global Fund and the European Union. An Action Plan for Strengthening Accountability and Controls was developed by the Ministry of Health, with inputs from donors, and a number of officials are still the subject of judicial investigation. It is estimated that 60 per cent of the embezzled funds came from the national budget (Pereira 2009).

In Zambia, although dialogue forums provide some space for accountability actors to participate in policy processes, including policymaking and processes of oversight, a number of limitations have been identified. For instance, the Sector Advisory Group meetings are well attended but decision-making and accountability relationships seem to be restricted to donors and the Zambia Government, with only token participation by other actors.

Moreover, there are limits to the extent to which these groups have real decision-making power. For example, anecdotally there was some sense in interviews that priorities in health were still heavily influenced by donor priorities, reflected in the high levels of funding in areas such as malaria and HIV/AIDs and the relative neglect of more commonplace health

problems and issues of health systems strengthening. Civil society organizations and other domestic actors may also reinforce this, particularly where they ‘follow the funds’ available and focus on health issues with a greater profile for donors, although these issues may have a higher profile in domestic politics too.

In the Zambian context, and reflecting the high levels of aid dependency, there is still a prevailing view that accountability in terms of oversight remains one way – upwards to donors – in that there are, in reality, limited mechanisms for local stakeholders to hold donors to account. A corruption scandal in the health sector in May 2009 provided useful insights into these issues (see Box 3).

While this episode highlighted serious corruption within the Ministry of Health, it also highlighted a degree of institutional capacity in that the Auditor General and the Anti-Corruption Commission were able to identify a problem and expose it, and then activate the necessary investigative and judicial procedures. The media also played an important role in exposing this scandal and maintaining public scrutiny of the issue.

Donors responded to the scandal by immediately freezing their funding to the health sector and setting about trying to recover funds. Domestic stakeholders strongly perceived that donors were more concerned about recovering their own funds than the Zambian funds which had been misused. Moreover, the Action Plan developed as a result reportedly did not involve domestic accountability actors such as parliamentarians and civil society representatives, as it was developed by the Ministry of Health and donors. This plan is primarily seen as aiming to restore trust between the government and donors rather than the government and its citizens.

In both countries, there was little sense that meaningful mutual accountability had been achieved. Officials in Uganda felt that it remained difficult to raise disillusionment with donor behaviour in existing formal forums. Moreover, donors were frequently criticized for delays in disbursements, late provision of figures for projects, undermining the budgeting process, and the use of onerous reporting procedures in addition to country system processes, including the use of ‘special audits’. This added to the perception that accountability was often one way, towards donors, rather than genuinely between donors and recipient governments and then extended to citizens.

There was also evidence of a disjuncture between domestic political processes, including around decentralization, and aid modalities and approaches. In Uganda, decentralization is a particularly significant feature of the state. In theory, providing aid on budget and through government systems should allow for improvements in accountability at the local level, including in health, as central government resources are disbursed at the local level.

There is some evidence of improved mechanisms for ensuring greater transparency and accountability for resources at the local level in Uganda, for example, through the establishment of Village Health Teams and through processes around the development of District Development Plans, which cover health and other core services. However, a number of challenges are also evident, particularly where there is a lack of oversight and scrutiny

between national and local level processes. Aid modalities which are on budget, including budget support, still seem to be focused on national level policy dialogue issues, but have been less concerned with implementation and issues around the incentives for and the accountability of front line service providers (see Williamson and Dom 2010). The lack of attention paid to some of these gaps in accountability remains a serious impediment to improving accountability in the health sector.

Similarly, in Zambia since the 1990s the health sector has undergone a series of institutional changes, which have interacted with aid in a number of ways. This has included some processes of decentralization in regard to the Central Board of Health. The Central Board of Health, established in 1995, was intended to be an autonomous body to manage and oversee service delivery through district-level health service delivery structures (with the Ministry of Health primarily playing policymaking and regulatory roles). The Central Board was subsequently merged back into the Ministry of Health in 2006, a decision justified by the Ministry and other actors as a move to streamline organizational structures in the health sector.

Some of those interviewed felt that this process had been too closely managed by donors, and they perceived that the Central Board may have had better systems in place for ensuring accountability at the local level (Chakwe 2009). Regardless of the potential merits of the process, there was a sense that it had been decided after limited consultation and had been poorly communicated, fuelling the perception of diminished accountability at the local level. The way donors behave and how they direct aid therefore can affect, and be affected by, these domestic changes, making it important to recognize the accountability implications of reform efforts.

3.2 The prevalence of off budget aid in health

As is noted above, on budget aid and the mechanisms which have been developed in the health sector and through the SWAps remain reliant on the capacity and credibility of domestic accountability systems within Uganda and Zambia. Where these are weak, this limits the ability of a variety of actors to hold decision makers on health to account, including both the government and donors.

Alongside these challenges, the health sector in both Zambia and Uganda has experienced a proliferation of off budget project funding, primarily through ‘vertical’ funds, which focus vertically on specific health issues or themes in contrast to the more ‘horizontal’ approaches of country-based aid. The total size of these funds is hard to quantify but it is thought to have increased significantly in recent years. In Zambia, prominent vertical funds include PEPFAR (USD 269 million in 2008), the Global Fund (USD 69 million in 2007) and the GAVI Alliance (approximately USD 50 million in 2005–2015) (Pereira 2009). In Uganda, PEPFAR is estimated to have contributed around 70 per cent of total AIDS spending in 2006–2007 (Lake and Mwijuka 2006). It remains difficult to gauge total levels of off budget project funding, but a 2007 report on Uganda found that more off budget than on budget aid was provided in the health sector (Christiansen et al. 2007).

To some extent, this funding has helped to provide much needed resources for health in Uganda and Zambia. However, the prevalence of off budget aid, which works outside of budget processes and government systems, is seen as particularly challenging for domestic accountability in both countries. Vertical funds use separate reporting structures and processes, and reporting lines flow from the implementing organization to the donor, excluding any domestic accountability or scrutiny. In both Uganda and Zambia, funds which operate in this way are seen as undermining ownership of health policy and implementation.

In Zambia, local stakeholders felt that vertical funding lacked the flexibility to respond to changing needs on the ground, and was frequently not attuned to local organizations' absorption capacity. In Uganda, the prevalence of off budget project aid disbursed at district levels was identified as a particular challenge. For example, districts have been able to solicit funds directly from donors and this has not always been reported to central government, undermining planning and oversight by national level domestic accountability actors such as parliamentarians. Some of those interviewed felt that donors' priorities still took priority over actual needs, for example leading to higher numbers of projects funded which were close to transport links rather than in the most vulnerable rural areas.

The number of international and domestic NGOs operating using donor project funds is also seen as a particular challenge for accountability. For example, officials and parliamentarians reported that they struggled to identify all donor-funded projects within a given district, as this information was not consistently shared. However, civil society organizations also have tensions and fears over government control. Recent government policy requires all NGOs to register with districts and to be monitored, but this is seen, in some instances, as a tool to leverage funds for the district (or the individual involved) rather than a commitment to accountability. Understanding these complexities and the extent to which aid exacerbates existing weaknesses remains a problem for donors.

In recent years, some vertical funds such as the Global Fund have sought to work in ways which accommodate aspects of the aid effectiveness agenda and which support domestic systems and processes. In Uganda, Global Fund resources have been channelled to the government in recent years, and are generally captured in the health budget and within sector ceilings. As a donor, the Global Fund is generally seen as 'following SWAp procedures', although it retains some additional reporting requirements (Zikusooka et al. 2009).

The International Health Partnership (IHP) was introduced in 2007 to bring together a range of donors, including bilateral, multilateral and vertical funds, with recipient country governments in both Global and Country Compacts to achieve the health Millennium Development Goals. Commitments under the IHP include donors agreeing to use national health plans and to be accountable for aid, and recipient country governments committing to improve their accountability to domestic actors (IHP 2007).

Our study suggests that progress with realizing these commitments remains slow in both Uganda and Zambia. In Uganda, there was little recognition of what an IHP Country Compact might add or change, because of the lack of political will or leadership which were

seen as key impediments to addressing these challenges. In Zambia, there was greater optimism about what the IHP might offer. For the Zambian Government, the IHP was seen as an opportunity to encourage donors to meet their mutual accountability commitments, for example, in terms of predictability and disbursement. Zambia was due to sign a Country Compact in June 2009, but this was suspended in the light of the corruption scandal which came to light in May 2009, and since then there has been a perception of much greater scepticism regarding the IHP – particularly on the part of donors.

3.3 Information flows and transparency

Issues of information and transparency are seen as cross-cutting challenges in both Uganda and Zambia and as key stumbling blocks to realizing greater accountability. Greater transparency should also be a core part of the aid effectiveness agenda, as donors can ensure greater coordination where they share information, and recipient governments can ensure more effective budgeting and policy processes where they have information on the resources available. Citizens and intermediary groups such as parliamentarians and civil society can also struggle to hold decision makers to account where they do not have sufficient information on the decisions taken. Greater transparency is also potentially a key area of linkage between domestic and mutual accountability, in that, where donors and governments provide better information to each other, it should be easier to share this with domestic actors.

In both Uganda and Zambia there was some evidence that improved reporting processes between donors and the recipient government had contributed to greater transparency. In Uganda, the annual Health Sector Performance Report and other reporting frameworks were seen as useful tools for assessing and scrutinizing performance in the health sector. Budget support frameworks such as the Joint Assessment Framework set out specific indicators for the government and for donors to allow them to mutually appraise behaviour. In Zambia, some of those interviewed felt that there had been important progress in improving the quality and accessibility of information. For example, the budget can now be accessed by citizens through the government printers – although the data do not tend to be very user friendly, with minimal explanation of the figures and charts presented. Moreover, information is now made available on specific delays in donor funding, which was seen as a positive step forward (MoH 2008). In Zambia, the development of a Health Management and Information System in 1994 was intended to provide information on indicators and targets within the health sector in order to inform the planning, implementation and monitoring of health service delivery (Bartholomew 2009), and there have been more recent attempts to streamline information collection.

At the same time, there is a recognition that donors across the board do not provide enough information on their aid commitments and disbursements for both on and off budget aid modalities. There is common agreement in both countries that donors should provide more complete, timely and accurate information. Budget support frameworks commit donors to disclose this information, but many fail to do so in its entirety. This has important implications for decision-making, including around budget processes. For example, in Uganda the government – and by implication those with oversight roles such as parliamentarians – are restricted in their ability to know exactly what level of resources has

been committed to the health sector, what is actually disbursed and what this is spent on. This seems to be a particularly pressing issue because such a high proportion of the aid is off budget. Existing models of accountability do not seem equipped to address this; for example, the domestic accountability system around the budget process works on the assumption that all resources are channelled through the budget. Few additional mechanisms exist to encourage domestic scrutiny of the resources which fall outside the budget.

Moreover, poor information flows seem to be limiting the effectiveness of a number of dialogue forums. For example, in Zambia, civil society participation in the Sector Advisory Group is undermined by the fact that information on meetings is sent out with only a few days notice, and key resources are often not available in advance. At the same time, donors and ministry officials highlight civil society's own capacity gaps, as they are viewed as lacking in the technical skills and resources to interpret complex budget information and decision-making. There is some evidence that this may have been changing over time, as civil society representatives 'learn on the job', but also a sense that some capacity building as well as frameworks or codes of conduct would be helpful.

A number of civil society initiatives at the community level in Uganda focus on disseminating information to the sub-district level and identifying gaps and challenges for health service providers at the local level. In the main, these are focused on services provided by the government. To date they have not linked up with national level decision-making and reviews, and they are not being used to present accountability concerns at the national level.

However, parts of the media have become increasingly active in spotlighting key health concerns and pushing for a greater response at the national level. For example, in Uganda a number of national newspapers have given high levels of coverage to issues of 'ghost health centres', which exist in government records but not in reality, as well as issues related to drug stocks. In the case of the latter, some civil society campaigns have increasingly worked with the media to raise the profile of the lack of access to basic medicines, suggesting the potential importance of making links between domestic actors on accountability issues.

Uganda has also developed an interesting model in the form of the Budget Monitoring and Accountability Unit, which is housed in the Ministry of Finance, Planning and Economic Development. This unit was set up in 2008 to monitor government-funded and donor-supported projects in a number of sectors, including health. The unit's reports are then shared with the ministry's Permanent Secretary, the Public Accounts Committee, the Inspector General of Government and the Auditor General, and presented in summary form to the president. According to one interviewee, districts are now aware that 'someone is watching', and this is helping to strengthen accountability at the local level and to link it up to the national level too. The unit also liaises with civil society and has conducted monitoring training for communities, although its reports have not yet been made public.

4 Conclusions

This study highlights the implications of aid in the health sector for domestic accountability systems and dynamics. It focuses on whether the mechanisms and principles put forward under the aid effectiveness agenda have contributed to meaningful shifts in domestic accountability, and whether they are supportive of the existing domestic accountability system. It also addresses whether efforts to achieve greater mutual accountability between donors and recipient governments can link to or support greater domestic accountability. A number of conclusions and recommendations can be drawn from the above analysis when thinking through these issues and tensions.

Adapt programming to context

First, this study emphasizes the key need to take better account of context and existing systems of domestic accountability, looking at both the weaknesses and strengths within those systems, when designing aid interventions, including in the health sector. In both Uganda and Zambia there was evidence of a lack of attention paid to how the SWAp frameworks and accompanying mechanisms such as Sector Working or Advisory Groups interacted with existing domestic accountability dynamics, for example, in terms of the capacity and strengths of parliamentarians or of civil society. There was also evidence of a lack attention to how aid modalities interact with existing domestic political processes, such as processes of decentralization and recentralization.

In line with the do no harm principle, the international community should ensure that weaknesses in domestic accountability are not exacerbated through their actions, and that the strengths are at best supported and at worst at least not undermined. This requires more conscientious coordination across donor programmes, including ensuring that governance objectives – in which domestic accountability principles are more explicitly embedded – are more effectively mainstreamed into sectoral work, such as in health.

Mixed evidence on domestic accountability

Second, this study found that some of the mechanisms supported by the aid effectiveness agenda are not yet leading to meaningful shifts in the dynamics of domestic accountability. There are some positive examples. The Social Services Committee in Uganda felt that the health SWAp and forums such as the National Health Assembly have provided greater engagement in policy discussions on health issues. In Zambia, the Sector Advisory Group in theory gave some civil society organizations greater participation in planning and monitoring for health. These changes, however, have not yet contributed in meaningful ways to supporting more effective domestic accountability. In part this is because the overall power and political dynamics which shape the policy space have not been particularly altered by these mechanisms – including in relation to the role of donors. For instance, in both countries, the dependency on aid introduces the risk of the potentially distorting role of donors in interfering with domestic political decision-making processes.

In addition, it is important to understand the different roles played by a range of accountability actors around policy and budget processes at the sectoral level. For example,

in both Uganda and Zambia there appear to be greater opportunities for some domestic actors – particularly civil society organizations – to play roles in monitoring and oversight, but fewer opportunities to play roles in the formulation of strategy and budgets. Unpacking the nature of the domestic accountability system around these cycles, and understanding where significant blockages exist and why, remain underexplored.

Related to this, our study has focused on a relatively conventional set of actors (national civil society organizations and NGOs, INGOs, parliaments, and state institutions such as the Auditor General). Within the constraints of the available time and resources we were not able to dig deeper into the entry points for a wider range of actors, including political parties, particularly those in opposition; aspects of the media and non-traditional aspects of civil society, including social movements, users groups and professional associations; or the judiciary. In part, this reflects the fact that some of these actors in practice play a limited role in domestic accountability within these countries – particularly professional associations and user groups. Some, however, such as opposition political parties, are increasingly active and should be included in analyses of domestic accountability systems and aid going forward. In both countries, the run-up to elections in 2011, which look to be more closely contested than in previous years, even if the incumbents remain in power, may lead to greater challenges and opportunities for actors such as political parties on issues around health.

The analysis also reveals that moments of crisis can provide both challenges and opportunities for strengthening accountability, including around aid. The corruption scandal in Zambia in 2009 posed challenges in that donors responded by freezing funds and reverting back to their own self-interest, but it also led to recognition of the capabilities of some domestic actors, including the Anti-Corruption Commission and the Auditor General, which were able to identify a problem and ensure steps were taken to address it.

The key point here is that how domestic accountability systems evolve is essentially a reflection of the nature of the political system, the balance of power between different interests, and the quality and density of the institutions and processes – both formal and informal – that work to either support or undermine the prospects for the oversight and answerability of decision makers and holders of power.

Transparency and access to information

Third, this study reinforces the view that transparency should sit at the heart of both domestic and mutual accountability. Where information on aid flows is poor, governments are forced to make budgetary decisions based on partial or inaccurate information, and domestic actors are limited in their ability to scrutinize decisions and implementation in the health sector. In both countries, the lack of donor transparency as well as blockages in information flows between citizens and recipient governments have been identified as key challenges for accountability. The presence of a large number of vertical funds in the health sector in both countries poses particular challenges, as these types of fund often work within their own reporting mechanisms, which are not shared with the range of domestic actors. In Uganda, for example, an interviewee suggested that the high level of funds received off

budget in the health sector seriously undermined the budget process as it did not capture some of the substantial resources being directed towards health.

Donors' own priorities and incentives

Finally, a greater focus is needed on donors' own behaviour and their incentives for achieving greater aid effectiveness. This study highlights some concrete improvements by donors in terms of their reporting and some progress in predictability and reliability, including through SWAp mechanisms. There was still a strong sense, however, particularly in Zambia, that accountability runs primarily upwards to donors and that there are few incentives to encourage donors to make good on their commitments under the Paris Principles and in each country.

How might progress be made in this area? On the one hand, donors still need more sophisticated and intelligent engagement with domestic politics in the countries in which they operate, underpinned by a stronger understanding of context. For example, Zambia and Uganda have had their political systems shaped by long term de facto one party rule, but this manifests itself in different ways and has different implications for donors' development strategies.

On the other hand, there is a need for donors to reflect on their own incentives within their aid relationships and within their own agencies. Donors' choices regarding aid approaches can still be shaped by their own political considerations, which often trump consideration of the political context in the countries in which they operate. This is also reflected in the strong prioritization of donor funding in some health areas, such as HIV/AIDS, over more commonplace health problems. Thus, donors need to recognize that they are in a 'relationship business' and that 'the outcomes that matter – signalled by the Millennium Development Goals – will not be achieved in low-income Africa without addressing the key *institutional* barriers that exist on both sides of the aid relationship' (Booth and Fritz 2008: ix).

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