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Accountability and Aid in the Health Sector

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List of acronyms

AAB	Annual Activity Budget (Zambia)
ABC	Abstain, Be Faithful, Use Condoms
AfDB	African Development Bank
AG	Auditor General
AGH	Action for Global Health
AGHA	Action Group for Health, Human Rights and HIV/AIDS (Uganda)
APRM	African Peer Review Mechanism
AIDS	Acquired Immunodeficiency Syndrome
CABRI	Collaborative Africa Budget Reform Initiative
CBO	Community-Based Organisation
CBoH	Central Board of Health (Zambia)
CCM	Country Coordination Mechanism (Global Fund)
CHOGM	Commonwealth Heads of Government Meeting
CIVICUS	World Alliance for Citizen Participation
CSO	Civil Society Organisation
CSPR	Civil Society for Poverty Reduction (Zambia)
CVA	Citizen Voice and Action
DAC	Development Assistance Committee (OECD)
Danida	Danish International Development Agency
DATF	District AIDS Task Force
DFID	UK Department for International Development
DP	Development Partner
EC	European Commission
EU	European Union
FinMAP	Financial Management and Accountability Programme (Uganda)
FNDP	Fifth National Development Plan (Zambia)
GAVI	Global Alliance for Vaccines and Immunisation
GBS	General Budget Support

GDP	Gross Domestic Product
GRZ	Government of the Republic of Zambia
GoU	Government of Uganda
HDP	Health Development Partner
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
HMIS	Health Management and Information System
HPAC	Health Policy Advisory Committee (Uganda)
HSSP	Health Sector Strategic Plan (Uganda)
IATI	International Aid Transparency Initiative
ICT	Information and Communication Technology
IHP	International Health Partnership
IHP+	IHP and Related Initiatives
INGO	International NGO
JAF	Joint Assessment Framework (Uganda)
JAR	Joint Annual Review (Zambia)
JASZ	Joint Assistance Strategy for Zambia
JCTR	Jesuit Centre for Theological Reflection (Zambia)
MDG	Millennium Development Goal
MMD	Movement for Multi-Party Democracy (Zambia)
MoFPED	Ministry of Finance Planning and Economic Development (Uganda)
MoFNP	Ministry of Finance and National Planning (Zambia)
MoH	Ministry of Health
MoU	Memorandum of Understanding
MP	Member of Parliament
MTEF	Medium-Term Expenditure Framework
NGO	Non-Governmental Organisation
NHSP	National Health Strategic Plan (Zambia)
NRM	National Resistance Movement (Uganda)
ODA	Official Development Assistance
ODI	Overseas Development Institute
OECD	Organisation for Economic Co-operation and Development
PAC	Public Accounts Committee
PAF	Performance Assessment Framework
PEAP	Poverty Eradication Action Plan (Uganda)
PEMFA	Public Expenditure Management and Financial Accountability (Zambia)
PEPFAR	President's Emergency Plan for AIDS Relief
PF	Patriotic Front (Zambia)
PFM	Public Financial Management
PHthC	Parliamentary Health Committee (Zambia)
PIU	Project Implementation Unit
PRSP	Poverty Reduction Strategy Paper
SAG	Sector Advisory Group
SBS	Sector Budget Support
Sida	Swedish International Development Cooperation Agency
SWAp	Sector Wide Approach
SWG	Sector Working Group
TIZ	Transparency International Zambia
TNDP	Transitional National Development Plan (Zambia)
UJAS	Uganda Joint Assistance Strategy
UK	United Kingdom
UPDF	Uganda People’s Defence Forces
UPND	United Party for National Development (Zambia)
WHIP	Wider Harmonisation in Practice (Zambia)
ZGF	Zambian Governance Foundation

Executive summary

Despite considerable progress, poverty reduction and sustainable development remain a major challenge for many countries. Aid remains one important component in contributing to progress, but in recent years increasing attention has been paid to some of the challenges for aid effectiveness. Linked to this, there has been growing recognition of the ways that aid can impact on and be affected by accountability, governance and politics in donor and recipient countries. However, a real gap in understanding remains with regard to the relationship between aid effectiveness and accountability, and whether and how the two can reinforce each other. This report, commissioned by World Vision UK, looks at these issues in the case of Uganda and Zambia, using the health sector as a lens.

Accountability relates to the relationship between decision makers and those affected by decisions. As such, it is about politics and power and involves answerability (the extent to which demands can be made for decision makers to justify their actions) and enforceability (the sanctions that can be used if decision makers fail to fulfil their commitments). Accountability also requires transparency, in terms of access to information on the commitments of decision makers and whether these have been met. Key elements of domestic accountability include oversight activities of parliaments, political parties, audit institutions, civil society and the media. Accountability should also involve marginalized groups of citizens, including vulnerable children. Mutual accountability for aid concerns the two-way relationship between donors and recipients and entails setting and monitoring progress towards, and meeting reciprocal commitments on, delivery and use of aid.

Aid to developing countries with poor governance has the potential to further weaken domestic accountability, making governments more accountable to donors than citizens and undermining the development of a more legitimate citizen–state social contract. How much this occurs depends in part on the extent to which recipient governments can control and manage aid, and the extent to which other domestic actors can play roles in scrutinising the use of this aid. In this context, there is growing debate on the interaction between aid effectiveness and accountability, including on the impacts of different aid modalities and approaches.

The Paris Declaration recognises some of these challenges, and emphasises the need to enhance donor and recipient government accountability to their citizens and parliaments; the importance of timely and transparent information on aid flows; and the need to advance mutual accountability. The follow-up Accra Agenda for Action identifies the importance of greater parliamentary and civil society engagement. As part of this agenda, donors have committed to providing aid in ways that strengthen national ownership and accountability and support national systems.

Health is increasingly being seen as a ‘tracer’ sector for this agenda, partly because of increased donor interest and funding, and partly because health is also seen as underpinning all the Millennium Development Goals (MDGs) (OECD, 2009). Moreover, aid to health seems to exemplify many of the challenges for aid effectiveness, because of the complexity of the aid architecture, the common lack of alignment with country priorities and the dominance of donor preferences and of actors that tend to work outside of the aid effectiveness framework (Ibid.).

This report seeks to answer the following questions with regard to aid and accountability in the health sector, drawing on interviews and background research conducted during fieldwork visits to Uganda and Zambia: Who are the key actors and how do they relate to each other? What mechanisms are in place for managing aid in the health sector and ensuring accountability for aid, and how well do they work? What information is available and to whom? To what extent is the configuration of these factors contributing to greater accountability for aid in the health sector?

Overall, there is a limit to what donor aid can achieve through aid effectiveness in terms of contributing to strengthening domestic accountability, which is complex, dynamic and driven by internal historical, political, social and economic factors. Nevertheless, some forms of donor aid can make a difference, both in terms of ensuring that they 'do no harm' to existing domestic accountability systems and in potentially strengthening these systems. Moreover, a number of underlying themes and challenges exist around power dynamics and political contexts, from which some core arguments can be drawn.

Aid modalities and the aid effectiveness agenda interact in differing ways and have different impacts on domestic accountability structures, according to the context. In Zambia, donors in general seem to exercise more influence on aid accountability; in Uganda, there are signs of greater capacity for national decision making and accountability for aid, but also some serious concerns regarding the strength of the domestic accountability system. In both, the dominant donor mechanisms and approaches are similar (including sector-wide approaches (SWAps) and trends towards budget support) but at times there is a lack of attention paid to how these interact with domestic power and accountability relationships and a lack of understanding of how national systems can be supported alongside the strengthening of domestic accountability systems.

Information and greater transparency sit at the heart of improvements to domestic and mutual accountability. Where aid is not provided on budget, or where information on aid is poor, governments make budgetary decisions based on partial or inaccurate information. In these cases, domestic actors are limited in their ability to scrutinise these decisions and review how resources are used. In both countries, the lack of transparency regarding aid commitments and disbursements as well as blockages in information flows between citizens and the state are major barriers to improving accountability.

The biggest challenge in this respect seems to be off-budget aid, including aid from some vertical funds in health. Working outside domestic systems at best does not support them and at worst further undermines them. In Uganda, high levels of off-budget project aid 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. This contributes to a vicious circle, whereby weak accountability and poor governance lead donors to prioritise project aid, further weakening accountability and governance.

Proposals for Aid Management Policies (and information management systems) should be given serious consideration in light of some of these weaknesses, with information provided in ways that are compatible with government planning, budgeting and accounting processes. Furthermore, the current focus on community-level monitoring and dissemination of information should seek to link with national-level processes. For example, civil society organisations (CSOs), parliamentarians and others could work together to push donors and governments to make reporting more publicly available, then use this information at local levels to inform and engage citizens.

The evidence is mixed on the impact of aid and the aid effectiveness agenda on domestic accountability in health. Some positive changes are noted. For example, the Social Services Committee of the Parliament of Uganda felt that the health SWAp and forums like the National Health Assembly allow them greater engagement in planning, budgeting and monitoring on health issues. In Zambia, CSO participation in the Sector Advisory Group (SAG) has been welcomed and is supposed to enable their input into planning and monitoring for health. However, these changes have not yet led to meaningful shifts in domestic accountability arrangements. Domestic accountability institutions and actors generally seem to remain untouched by the aid effectiveness agenda; and where donors are supporting broader governance reforms these do not seem to be meaningfully linked to their sector support in health.

In both Uganda and Zambia, the majority of donor attention remains focused on the national level, with forums for policy dialogue. Much less attention is paid to how these link to issues of service delivery, including accountability and incentives for frontline service providers, particularly in the context of decentralisation.

Meanwhile, moments of crisis can provide both challenges and opportunities for strengthening accountability for aid and aid effectiveness. The recent corruption scandal in Zambia posed significant challenges, but at the same time it was recognised as significant that relevant domestic accountability mechanisms were able to detect and act on the identified irregularities, leading to a number of improvements in aid accountability systems.

In order to address accountability weaknesses, there is a strong need for donors to provide more aid on budget. Putting more aid through the budget could increase the incentives for domestic actors to play a fuller role in accountability and oversight for decisions and implementation in the budget process. At present, in both Zambia and Uganda, budget processes for health appear relatively unchallenged. Increasing the level of resources provided on budget could help push relevant actors to engage more actively – although this should be accompanied by appropriate capacity development and support.

There are concrete signs of improvement in Uganda and Zambia in terms of reporting and there is evidence of some progress on monitoring aid and increasing predictability and reliability. The International Health Partnership and Related Initiatives (IHP+) represents an attempt to take progress further, in terms of increasing donor alignment and harmonisation (and including vertical funds within this). However, progress remains patchy, and the IHP+ does not yet constitute a meaningful framework to shape donor interventions, and donor accountability, in either country. Moreover, where mutual accountability is weak, it is likely to be more challenging for recipient governments to hold donors themselves to account for their aid commitments.

Donors need to reflect on behaviour and incentives for aid effectiveness and accountability with regard to their own aid relationships and in their own agencies. At present, donor choices regarding aid modalities continue to be shaped as much by their own domestic politics or concerns as by context. In Uganda, this has led to some questioning of budget support, given a perceived lack of domestic support in donors' own countries. In both Uganda and Zambia, it has led to a strong prioritisation of those health issues (such as HIV and AIDS) that have garnered high levels of international coverage and support, to the detriment of more commonplace health problems. There remains a real need to improve capacity to understand political context (and donors own incentives and behaviour within these contexts). This should be linked to efforts to better integrate sector specialists with governance specialists, encouraging more institutional linkages alongside existing reliance on good personal links between colleagues. Addressing the barriers on both sides of the aid relationship should encourage donors to better 'live up to their commitments on aid effectiveness and to the Paris Declaration.

Ultimately, any assessment of the impact on domestic accountability of the aid effectiveness agenda, and the shift towards corresponding aid modalities and new forms of donor/recipient country relations, must work with realistic expectations about what can be achieved. Domestic accountability refers to no less than the governance structures – including mechanisms and actors – that shape state–society relations. Progress on domestic accountability is therefore fundamentally a political process and one which must be domestically led, dependent on political will and power dynamics. Donors can help support this, through prioritisation of support to strengthen domestic accountability actors and systems, but they will also need to recognise the limitations of their actions, and commit above all else to 'do no harm'.

1. Introduction

Despite considerable progress, poverty reduction and sustainable development remain a major challenge for many countries. Aid is a key component in tackling poverty and contributing to poverty reduction (along with a wide number of other factors and resources). And there has been a growing focus on the challenges surrounding aid, in terms of its lack of effectiveness in some contexts and, linked to this, the ways that aid can impact on (and be affected by) accountability, governance and politics in donor and recipient countries. The Paris Declaration on Aid Effectiveness and the follow-up Accra Agenda for Action recognise some of these challenges and stress the link between accountability and aid effectiveness. But there remains a real gap in understanding the relationship between aid effectiveness and accountability, and whether and how the two can reinforce each other. This report, commissioned by World Vision UK, seeks to contribute to filling that gap, with a focus on aid effectiveness and accountability at the sectoral level.

Accountability relates to the relationship between decision makers and those affected by decisions. As such, it is fundamentally about politics and power and involves answerability (the extent to which demands can be made for decision makers to justify their actions) and enforceability (the sanctions that can be used if decision makers do not meet certain standards or fail to fulfil their commitments). Accountability also requires transparency, in terms of access to information about the commitments of decision makers and about whether these commitments have been met.

This report focuses on accountability for aid, including domestic and mutual accountability. Domestic accountability for aid concerns the relationship between governments that manage and use aid and domestic constituencies on whose behalf aid is managed. Key elements of this include oversight activities of parliaments and political parties, audit institutions, civil society organisations (CSOs) and the media. Mutual accountability for aid concerns the two-way relationship between donors and aid recipients and entails setting and monitoring progress towards, and meeting reciprocal commitments on, the delivery and use of aid.

The Development Assistance Committee of the Organisation for Economic Co-operation and Development (OECD DAC) has led the way in developing an agenda to enhance aid effectiveness, including through a focus on ownership and greater accountability for aid. A High-Level Forum in Paris led to the Paris Declaration on Aid Effectiveness, which enshrines a number of key principles that all have relevance to accountability for aid to varying degrees (Box 1).

Box 1: Key principles in the Paris Declaration

1. **Ownership:** Partner countries exercise effective leadership over their development policies and strategies and coordinate development actions
2. **Alignment:** Donors base their overall support on partner countries' national development strategies, institutions and procedures
3. **Harmonisation:** Donors' actions are more harmonised, 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

Source: OECD (2008a).

In particular, the Paris Declaration emphasises the need to enhance donors' and recipient governments' respective accountability to their citizens and parliaments; the importance of timely and transparent information on aid flows; and the need to advance mutual accountability. A follow-up forum in Accra led to the Accra Agenda for Action (OECD, 2008a), which seeks to give greater prominence to accountability and states that: 'We recognise that greater transparency and accountability for the use of development resources – domestic as well as external – are powerful drivers of progress' (Para 22). It also identifies the importance of greater parliamentary and civil society engagement. As part of this agenda, donors have committed to providing aid in ways that

strengthen national ownership and accountability as well as supporting national systems. Some donors have also made specific commitments in terms of accountability. For example, in its recent White Paper, the UK Department for International Development (DFID) specifically agreed to allocate an amount equivalent to 5% of budget support funding to help build accountability (DFID, 2009).

Aid can contribute to domestic accountability in two key ways. First, it can impact on capacity for domestic accountability (for example through donor support to civil society, parliamentarians and other key domestic actors). Second, and most importantly for this study, aid can impact on the scope for domestic accountability (Hudson and GOVNET, 2009). There has been increasing criticism of the extent to which aid to low-income countries with poor governance (particularly in parts of Africa) can further weaken domestic accountability (Bräutigam and Knack, 2004). It can skew accountability, creating incentives so that governments are more accountable to donors than to their citizens; it can undermine the development of a more legitimate tax-based social contract between citizens and the state; and, where there is a lack of transparency, it can undermine budget processes and policy processes, for example by reducing the ability of parliaments, audit institutions and civil society to hold the government to account where they do not know how much aid has been received and how it has been used (Hudson and GOVNET, 2009).

The extent to which these negative impacts occur depends, in part, on the extent to which recipient governments can control and manage the aid they receive (including incorporating it into their budget and policy processes) (Hudson and GOVNET, 2009). Different aid modalities allow for varying degrees of government control and should have differing impacts on domestic accountability.

In this context, there is growing debate on the interaction between aid effectiveness and accountability, including a focus on the impacts of different aid modalities and approaches (see Booth and Fritz, 2008; Williamson and Dom, 2010). This report seeks to contribute some sector-specific, country-grounded findings to this debate, with a particular focus on how these issues interact at the sector level. For the purposes of this study we focused on the impact of aid in health on the scope for domestic accountability, to determine whether different forms of aid support or can undermine domestic accountability.

Using health as the entry point is particularly relevant, as health is increasingly seen as a ‘tracer’ sector for aid effectiveness (OECD, 2009). In part, this is because there has been increasing donor interest and funding in health in developing countries: in the past 20 years, official development assistance (ODA) for heath has risen six-fold and health now has a greater share of overall ODA (Dodd and Hill, 2007). Moreover, health is seen as important not just in its own right but also to the extent that it underpins, and is vital to the achievement of, all of the Millennium Development Goals (MDGs) (OECD, 2009). At the same time, aid to health seems to exemplify many of the challenges for aid effectiveness, because of the complexity of the aid architecture, the lack of alignment with country priorities and the dominance of donor preferences (and of actors that tend to work outside of the aid effectiveness framework, such as vertical funds).

In light of these complexities, this report is structured around a framework that focuses on: the *actors*, including those holding to account and those being held to account for aid; the *mechanisms* or the relationships and processes through which various actors come together around aid; and the *information* on aid that – through the workings of particular mechanisms – flows between and among various actors.

The key questions that it addresses include: Who are the key actors and how do they relate to each other? What mechanisms are in place for managing aid in the health sector and ensuring accountability for aid, and how well do they work? What information is available and to whom? To what extent is the configuration (of actors/mechanisms/information) contributing to greater accountability for aid in the health sector?

The report draws on interviews and background research conducted during short fieldwork visits to Uganda and Zambia (with support from World Vision national offices). This fieldwork allowed us to make progress in mapping the actors, mechanisms and information around different aid modalities in health, and provided an informative view of some of these issues. It does not provide the basis for a full evaluation or assessment of the impacts for accountability. Box 2 sets out a summary of key terms for the research.

Box 2: Key terms for the research

- **Aid modality:** The range of ways in which donors choose to deliver aid
- **Basket funding:** Joint funding by several donors for a set of activities through a common account, with the basket resources kept separate from other resources intended for the same purpose
- **Direct budget support:** A form of programme-based funding involving funds channelled directly to recipient governments using their own allocation, procurement and accounting systems and not linked to specific project activities, comprising general budget support (GBS) or sector budget support (SBS), depending on the nature of the dialogue (Handley et al., 2010)
- **On-budget aid:** Aid that uses country budget systems (CABRI, 2009)
- **Programme-based approaches:** Aid that is 'based on the principles of coordinated support for a locally owned initiative, such as a national development strategy, a sector programme, a thematic programme or a project of a specific organisation' (OECD, 2009)
- **Project aid:** An individual development intervention 'designed to achieve specific objectives within specific resources' (Handley et al., 2010)
- **Sector-wide approach (SWAp):** In a SWAp, '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)
- **Vertical funds:** Focus 'vertically' on specific issues or themes, in contrast with the 'horizontal' approach of the country-based model of aid. For this report, we focus only on vertical funds in health, such as the President's Emergency Plan for AIDS Relief (PEPFAR), the Global Fund to Fight AIDS, Tuberculosis and Malaria and the Global Alliance for Vaccines and Immunisation (GAVI Alliance).

The report proceeds as follows. Section 2 draws on the Ugandan fieldwork and examines the context for aid and accountability in the health sector and the implications for different actors, different mechanisms and the role of information in accountability. Section 3 looks at these issues in the context of the health sector in Zambia, again with a focus on the context for aid and accountability and the implications for actors, mechanisms and information. Section 4 synthesises these findings, setting out some of key themes and policy recommendations for the future.

2. The view from Uganda

2.1 The context for aid to health in Uganda

2.1.1 Understanding the political context

The National Resistance Movement (NRM), led by Yoweri Museveni, assumed power after more than two decades of political turmoil and civil war following independence in 1962, a period characterised by dictatorship (including under Idi Amin), conflict and civil war. President Museveni's immediate agenda focused on building legitimacy and raised expectations of increasing public participation, government accountability and improved development outcomes (Moncrieffe, 2004). His regime attracted high levels of donor support in the 1990s and was praised for securing relative stability across Uganda and for its achievements in economic development (the economy grew at an average growth rate of 6% in the 1990s) (ibid).

The NRM initially promoted 'no-party democracy', with elections held but not contested by political parties. This, it was argued, was necessary to prevent the formation of divisive political parties based on ethnicity or religion (Kasfir and Twebaze, 2005). In 2005 a national referendum led to the re-establishment of a multiparty system of governance, allowing political parties to compete in elections. Crucially, this was linked to the abolishment of the constitutionally defined maximum of two terms of office for a president, allowing Museveni to stand for (and win) a third term.

Despite the recent shift to multi-partyism, political parties remain weak and the NRM continues to dominate the political space. As a result, Parliament is viewed as weak in its oversight and scrutiny functions, although there has been increasing activism on the part of some committees, including the Public Accounts Committee (PAC) (which is chaired by an opposition party member) (APRM, 2009). There are some independent media (including the Daily Monitor newspaper and Independent magazine), a large number of CSOs (although most of these are focused on service delivery) and a number of state accountability institutions (such as the Auditor General, the Inspector General of Government and the Ministry of Ethics and Integrity). But there is also a growing perception of the 'slipping back' of democratic and political gains, and according to a recent report, the "political culture of the no-party movement lingers on" (APRM, 2009: xxxix).

Part of the explanation for growing concern about the political context in Uganda is the dominance of the President who, under the 1995 Constitution, is Head of State, Head of Government and Commander-in-Chief of the Uganda People's Defence Forces (UPDF). Commenting on this dominance, Booth and Golooba-Mutebi (2009) argue that: 'It endows the President with significant scope to override opposition and impose his views when he considers it important to do so ... In other words, there are no actors, within the executive or legislative branches of government or elsewhere within the state (e.g. the army or judiciary), with the power to veto a presidential policy decision.'

Moreover, corruption appears to be prevalent in Uganda, and the Government of Uganda (GoU) has undertaken several measures to tackle this in recent years, with mixed results (APRM, 2009). According to Transparency International in 2009, Ugandans perceive corruption to be more rampant than it was five years ago (TI 2009; TI 2004).

Decentralisation has been a key feature since 1993, with administrative and elected positions, budgeting capacity and some revenue collection at district level. Service delivery is increasingly implemented through local government, including large primary and later secondary education and primary health care programmes. The political and administrative system runs from village (LC1) up to parish (LC2), sub-county (LC3), county (LC4) and district (LC5). In principle, all levels participate in planning and budget processes (feeding into District Development Plans). Health

financing is mainly through central government grants (Primary Health Care Conditional Grants and Non-Governmental Organisation (NGO) Grants) and donor project funds (Moncrieffe, 2004).

2.1.2 The aid environment

Uganda is highly aid dependent. On-budget donor aid averaged 9.6% of gross domestic product (GDP) between 1999/00 and 2008/09; during the same period, on-budget donor aid as a percentage of total government expenditure averaged about 45.4% (Handley et al., 2010).

Uganda has received some of the highest sustained flows of direct budget support (both general and sector) of any developing country (Ibid.). In 2007, a number of donors came together to agree on a common framework for budget support, in accordance with the Paris Principles, leading to the Joint Budget Support Framework and, in October 2009, the Joint Assessment Framework (JAF). Donors providing budget support include the World Bank, the European Commission (EC), the African Development Bank (AfDB) and the governments of the UK, Germany, Ireland, Sweden, Norway, Denmark and the Netherlands. The JAF is the formal instrument for measuring performance of GoU and donors.

Project aid also remains a major source of funding and has increased as a proportion of aid in recent years (Handley et al., 2010). Some of this is provided on budget and using country systems, but a significant proportion is off budget. Paris Declaration surveys have found that the proportion of aid to GoU using country systems declined from 60% in 2005 to 57% in 2007; that using national procurement systems declined from 54% to 37% (ibid). In contrast, the overall quality of GoU public financial management (PFM) systems broadly improved in the same period (ibid). Table 1 summarises some of the key findings of the 2008 Paris Monitoring Survey.

Table 1: Paris Monitoring Survey indicators for Uganda 2008 (data from 2007)

Overall ranking	**Uganda**	**2010 target**
Ownership	High	-
Harmonisation	Moderate	
Alignment	Moderate	
Managing for results	Moderate	
Mutual accountability	Moderate	
Key indicators	**Uganda**	**2010 target**
Indicator 3: Aid flows are aligned to national priorities	98%	90%
Indicator 5a: Use of country PFM systems	57%	73%
Indicator 5b: Use of country procurement systems	37%	Not applicable
Indicator 6: Strengthen capacity by avoiding PIUs (no. of PIUs)	55	18
Indicator 7: Aid is more predictable	74%	92%
Indicator 8: Aid is untied	85%	More than 81%
Indicator 9: Use of common arrangements or procedures	66%	66%
Indicator 12: Do countries have reviews of mutual accountability?	No	Yes

Note: PIU = project implementation unit.
Source: OECD (2008b).

The Poverty Eradication Action Plan (PEAP), first drafted in 1997, is the GoU's national planning framework and was the country's first poverty reduction strategy paper (PRSP) under the Heavily Indebted Poor Country (HIPC) Initiative. Its purpose is to provide an overarching framework to guide public action to eradicate poverty. It is underpinned by the Medium-Term Expenditure Framework (MTEF), which is an annual, rolling three-year plan that sets out expenditure priorities, budget constraints and spending ceilings against which sector and district plans can be developed and refined. The Uganda Joint Assistance Strategy (UJAS) was designed by seven development partners (DPs) (AfDB, Germany, the Netherlands, Norway, Sweden, the UK and the World Bank) and aims to articulate a harmonised development financing response to the PEAP.

There is growing speculation regarding Uganda's likely transition (over the next few years) from an aid-dependent country to one largely reliant on oil-generated revenues. For some, this heightens the need to strengthen accountability before the so-called 'resource curse' takes hold (see Collier, 2003).

2.1.3 Aid in the health sector

One of the key challenges for the health sector in Uganda is the proliferation and complexity of aid modalities and aid flows to health. In 2008/09, total GoU funding to the health sector was UGX628.46 billion (approximately $312 million), of which UGX375.38 billion (approximately $186.5 million) was GoU funding and UGX253.08 billion (approximately $116.8 million) was donor project funding (MoH Uganda, 2009).

It is difficult to gauge the level of off-budget donor funds to health in Uganda. A 2007 report found that, within the health sector, more off-budget than on-budget aid was provided (Christiansen et al., 2007). In part, this is due to the growing presence of a number of vertical funds.

The Health Sector Strategic Plan (HSSP) is developed within the framework of the PEAP and the National Health Policy. Taken together, these govern the health sector in Uganda. Policy implementation is supported by a health SWAp, which is applied to planning, management, resource mobilisation and allocation in the sector. HSSP 1, from 2000/01-2004/05, prioritised primary health care and greater decentralisation. HSSP 2, 2005/06-2009/10, also prioritised decentralisation, including the operationalisation of health sub-districts.

A summary of the main aid modalities in health is as follows:

- **Budget support** disbursed through the Ministry of Finance Planning and Economic Development (MoFPED) either as GBS or SBS. World Bank and DFID currently provide GBS; the Swedish International Development Cooperation Agency (Sida) provides SBS.
- **On-budget project aid** which may be disbursed through government systems and should be in accordance with HSSP and SWAp arrangements.
- **Off-budget or off-system project aid** including through vertical funds such as PEPFAR and through donor project funds. The total amount of this aid remains difficult to quantify.

2.2 Aid modalities, actors and accountability

This section focuses on the challenges and opportunities that different aid modalities seem to provide for a range of key actors which play roles in accountability and aid in Uganda, including the Government of Uganda, the Parliament (including the Public Accounts Committee and the Social Services Committee), the Auditor General and a range of CSO, NGOs and INGOs.

Looking first at the **Government of Uganda**, budget support and providing aid on budget remains the strong preference of the government, as this allows for the inclusion of aid into budget and policy processes, in theory aligning it to nationally defined priorities. A number of steps have been taken to improve country systems and state capacity to manage and account for the use of funds, including through the Financial Management and Accountability Programme (FinMAP),[1] which includes the MTEF and output budgeting software (and its rollout to local government).

Overall, a key concern appears to be the distinction between aid provided on budget and aid that is provided outside of the budget. On-budget aid is seen as supporting the capacity of government systems and opening up opportunities for greater domestic scrutiny and oversight, but as Box 3

[1] For more information on FinMAP, see www.finance.go.ug/docs/FINMAP%20Terms%20of%20Reference%20-%20Financial%20Management%20Specialists.pdf.

sets out there are in practice a wide number of dimensions of 'on-budget' aid. This study was not able to explore these issues in more detail, but further research is needed to better understand how these different dimensions might impact on accountability – and which may be most beneficial to strengthening accountability.

Box 3: Defining on-budget aid

On-budget aid is used in this study to refer generally to aid that uses country budget systems. The Collaborative Africa Budget Reform Initiative (CABRI) has undertaken a more systematic analysis of the parameters of on-budget aid, which outlines seven different dimensions, as set out below:

- On plan: Programme and project spending is integrated into spending agency planning documentation
- On budget: Programme and project aid (and its intended use) 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.

Source: CABRI (2009).

Despite some of these institutional reforms, concerns remain regarding the government's ability to effectively manage resources, prevent instances of corruption and ensure accountability to donors and to citizens. Some respondents, including donors and civil society representatives, cited barriers including a lack of strong answerability and enforceability mechanisms, such as effective sanctions for poor performance (e.g. legal sanctions for accounting officers who misuse funds). There is also evidence that aid modalities such as budget support may have affected the balance of power between ministries, by privileging MoFPED and undermining the role and leadership of the Ministry of Health (MoH). Politicisation of health policy and delivery is seen as likely to increase in the run-up to elections in 2011. Moreover, service delivery in health is increasingly implemented through local government, and challenges remain where there are tensions between central and local government (see 2.3 for more details).

Turning to domestic accountability actors, in the context of aid provided on-budget, the **Parliament of Uganda** should be a key actor in the oversight and use of that aid, including through parliamentary scrutiny of the budget process. However, at present the Parliament is not viewed as a particularly effective watchdog and it is seen as marginal in decision making about government activities. It is also seen as playing little role in the formulation of the PEAP (Buse and Booth, 2008). At sector level, parliamentarians, including those who are part of the Social Services Committee, feel that the SWAp and the use of budget support have increased their ability to hold government to account over the use of aid and other resources (see Box 4 for a recent example of the Committee's work in health). Parliamentarians also echoed government concerns that direct project funding to NGOs and international NGOs (INGOs) makes it difficult to scrutinise and have oversight of a significant proportion of spending in health, and that this further complicates relationships with citizens. Others argued that, while the Social Services Committee has been active in pushing for resources to be directed to specific regions and issues, it has been less effective in looking comprehensively at health programmes and agendas. Some respondents suggested that the interventions of individual parliamentarians, with limited evidence or in pursuit of individual concerns, could in fact contribute towards skewing health funding away from areas of most need.

Box 4: Report on field visits by the Sessional Commission on Social Services, May 2009

In 2009, the Social Services Committee visited 16 districts to document critical information on the performance of the health sector, and in order to demonstrate to GoU why the health sector should be a priority in 2009/10. Visits focused on planning and financial management, management of drugs, supplies, medical equipment, personnel and infrastructure, reproductive health services, transport and accessibility, monitoring and supervision. The report found that: 'Decentralisation alone is no guarantee for a more

effective responsive Government. Unless there is community participation in making decisions and managing development, decentralisation may be less responsive to community needs and desires than centralised authority.' The report is submitted to Parliament and published (although it was printed in January 2010, suggesting that it may be poorly timed to influence decision making in 2009/10).

The **PAC** scrutinises government accounts, produces reports (which are then debated in Parliament) and can question ministers and officials. It relies on the findings of the Auditor General and can also receive public complaints. Chaired by an opposition MP, the PAC is broadly seen as proactive on issues regarding the misuse of resources. It has recently been involved in high-level investigations, including into the use of funds received for the Commonwealth Heads of Government Meeting (CHOGM) in 2007. Challenges are said to include capacity inadequacies, including institutional technical capacities, which undermine its ability to provide adequate oversight of fiscal operations, and an inability to be current in scrutiny of annual accounts, leading to backlogs (APRM, 2009). Despite the activism of the PAC, there was a perception that there remains a lack of parliamentary analysis of budget decisions in health (for example, with a lack of value-for-money or cost-effectiveness analyses) and few examples were given of linkages being made between parliamentarians and other domestic accountability actors (such as CSOs) on health issues.

The Auditor General provides independent oversight of government operations through financial, performance and other management audits. The Auditor General was established by the 1995 Constitution and is appointed by the President with the approval of Parliament. The main functions include auditing public accounts and conducting financial and value-for-money audits of any project that involves public funds. The Auditor General also plays a key role in ensuring that Parliament is involved in the monitoring and management of public finances and has been current in delivering expenditure annual reports to the PAC (APRM, 2009). The **Inspector General of Government** – also established by the 1995 Constitution – acts as a corruption watchdog, reporting directly to Parliament. These institutions are seen as poorly resourced, which is likely to hinder their effectiveness and the Auditor General has been viewed as lacking independence (APRM, 2009).

A range of **CSOs, NGOs and INGOs** operate in the health sector. Many of these are engaged in service delivery and receive funds from central government and donors. Advocacy is seen as a relatively new concept (CIVICUS, 2006). INGOs often seem to be the most influential, and some felt that their access to external funds means that in practice they have a 'green light' for their activities. Organisations working around specific diseases, such as HIV and AIDS, are more able to readily access donor funds and engage in advocacy around these issues (Buse and Booth, 2008).

Some INGOs appear to be working in the 'spirit of Paris', for example by aligning with government guidelines and policies, but there is no clear sense of how these organisations are themselves accountable for their programmes, particularly where they are able to set their own agendas and where there are few political consequences if their programmes fail. Some INGOs appear to be using informal networks in Uganda to their own advantage, employing lobbyists who are ex-government to influence the government on their behalf.

The political constraints to work in health were often raised, in terms of both the power of the Executive (and the President) as well as the power of some donors (particularly those directly funding civil society). This limited the space for advocacy – for example, HIV and AIDS organisations are some of the most influential but struggle to address the needs of some of the most vulnerable (including sex workers or gay men), as their issues are not politically palatable in Uganda (and may not be politically palatable for some donors). To mitigate these constraints, some organisations focus on community- and district-level advocacy and accountability issues, which may be seen as a 'softer approach'. For others, working through networks and coalitions is seen as a way of shielding individual organisations from criticism. Others felt that 'public

campaigns do not work' in health in Uganda and instead worked behind the scenes to push accountability issues.

In some **specific health areas, such as HIV and AIDS**, there have been moves towards greater government coordination of GoU, donors and NGO activity. For example, the National AIDS Commission (separate to MoH), set up in 1992, leads on national planning and monitoring for HIV and AIDS. In light of the proliferation of actors involved, the Commission initiated the formation of the Uganda HIV and AIDS Partnership and the Annual Partnership Forum to serve as broad-based representative coordination mechanisms bringing together key partners (DFID, 2005). The National AIDS Commission also houses the Civil Society Fund, set up in 2007 to improve and better harmonise civil society provision of HIV and AIDS-related services in support of the National Strategic Plan. This could improve coordination in civil society and relations with the state; broadening it beyond HIV and AIDS services could also strengthen its impact. This study was not able to determine the extent to which coordination of planning and monitoring in this area is being carried out effectively. However, a number of criticisms have been made of these bodies, for example for their tokenistic involvement of non-public sector stakeholders and in practice, coordination around HIV and AIDS is often seen as weak (HLSP, 2006). Overall, the power imbalances between the government and other domestic actors in Uganda suggest that the domestic accountability system around health remains weak.

In general, **donors** appear to focus on their relationship with the government with few instances cited of their engagement with domestic accountability actors in health (e.g. parliamentarians). Decisions on aid modalities and approaches in health seem to be influenced as much by donor domestic politics than by an analysis of local context and accountability issues. For example, there is a perception that weakening support for budget support in the UK will affect DFID's approach in Uganda, demonstrating the extent to which donors' own political dynamics continue to impact programming at country level.

The relationship between donors' own politics and politics in Uganda has been brought to the fore by recent concerns regarding the closing of political space, changing of term Presidential limits and, most recently, concerns regarding the proposed 'Anti-Homosexuality Bill'[2]. If passed, the latter may affect some donor support (with knock-on impacts in health). In part as a response to some of these concerns, donors are currently providing support to a range of governance and accountability initiatives in Uganda. The UK's DFID, for example, is contributing to the Deepening Democracy Programme (a multi-donor basket fund), and developing new accountability and anti-corruption initiatives, some of which include a sector focus (see Box 5).

Box 5: DFID support to governance and accountability

DFID support to governance and accountability in Uganda includes:

- Deepening Democracy Programme: multi-donor basket fund with components for Parliament, political parties, CSOs, media, and Electoral Commission.
- Joint response to corruption: DFID and other Development Partners are currently working towards a more joined up response to corruption, through developing a stronger evidence base and clearer processes for responding to corruption. Test cases are being piloted, including in drug management.
- Accountability Programme: DFID is currently developing a new five year accountability programme, which may include continued support to FinMAP, and support for local accountability initiatives including CSO oversight of service delivery.

[2] A proposed Anti-Homosexuality Bill would, if enacted, broaden the criminalisation of homosexuality by introducing the death penalty for those with previous convictions, who are HIV-positive, or who engage in same sex acts with a minor or disabled person. Homosexual acts are already illegal in Uganda and punishable by up to 14 years in prison; the proposed Bill would increase that penalty to life in prison. There has been international pressure to modify the Bill.

These governance programmes have potentially important implications for aid and accountability in health, but there is a lack of evidence of strong linkages between donor sectoral programmes and governance work which, for most agencies, is overseen by separate staff. In part, this reflects the way that many agencies are themselves structured. For example, DFID is organised around professional cadres. This has been positive in that DFID now has a large presence of governance advisors in-country, but can also mean that governance and sector programming are treated separately, with effective collaboration or joint programming reliant on personal relationships rather than institutionalised linkages (Foresti and Wild, 2009). Moreover, DFID Uganda no longer has a dedicated health advisor. This role is now covered by a MDG results advisor, who deals with a number of sectors and cross-cutting issues.

2.3 Aid modalities and accountability mechanisms

This section examines some of the specific mechanisms that bring the above actors together around different aid modalities. It focuses primarily on those associated with programme-based approaches, as advocated in the Paris Declaration, which work through government systems and are on budget, and accompanying frameworks such as the health SWAp. Providing aid in this way should help strengthen government systems for the management of resources and should, in theory, strengthen domestic accountability, where it allows for greater oversight by domestic mechanisms, such as state institutions but also parliamentarians, CSOs and ultimately citizens.

2.3.1 On-budget aid: Implications for accountability

A Memorandum of Understanding (MoU) between GoU and health development partners (HDPs) (AfDB, World Bank, EC, Germany, Netherlands, UK, France, Ireland and Italy) forms the basis of the health SWAp. The SWAp provides for a number of key mechanisms and processes (Box 6).

Box 6: Key mechanisms in the health SWAp

- **Health Policy Advisory Committee (HPAC):** Provides overall policy guidance to the sector (comprised of representatives from GoU and HDPs).
- **Health Sector Working Group:** Focused on the budget cycle; manages approval and alignment of project inputs to the sector and oversees management of the annual health sector budget process. (Housed in MoFPED, with representatives from government, HDPs and civil society).
- **Joint Review Missions:** Provide annual joint monitoring of sector performance; review Annual Health Sector Performance Reports and contribute to priorities for the following year (strategic priorities and broad budget allocations) (GoU and HDPs).
- **National Health Assembly:** An annual forum for engagement with wider stakeholders (including central and local government, civil society, parliamentarians, HDPs) to review sector policy, plans and performance. MoH provides the Secretariat.
- **HDPs Group:** Responsible for coordinating donor responses to government and information sharing. Reviews Annual Health Sector Performance Reports and mid-term reviews of the HSSP. Lead agency rotated annually (Sweden was lead at time of writing).

To some extent, the strength of the SWAp and the use of budget support and on-budget aid appear to have strengthened accountability between GoU and donors, by allowing for improved reporting processes, government systems and opportunities for domestic scrutiny. While much of this appears to run from GoU to donors, some donors also seem to be aligning more with country systems and processes.

Frameworks such as the JAF and the Annual Health Sector Performance Report are increasingly seen as useful tools to scrutinise performance in the health sector. They set specific indicators for both GoU and donors, and annual appraisal processes are seen as a useful opportunity to mutually appraise behaviour. (However, according to some donors, it remains necessary to commission external monitoring reports due to a lack of trust in the consistency and accuracy of government reporting).

Moreover, **the Sector Working Group (SWG) and annual joint sector reviews are active forums** with participation from key stakeholders. Respondents also viewed the National Health Assembly as a useful forum for allowing a wider group of stakeholders to participate in oversight and decision making for health. The Assembly, for example, meets annually to review progress and set priorities for the coming year, and includes participants from central and local government, donors, parliamentarians and major NGOs and INGOs. According to members of the parliamentary Social Services Committee, mechanisms such as this have improved accountability, not least because 'all stakeholders now know what is being done and who is doing what' (also suggesting the important role that information plays in accountability). Overall, donor demands for greater accountability appear to be increasingly aligned with government processes, so the SWAp approach seems to have provided more space for domestic accountability (see also Wilhelm and Krause, 2008).

Despite these successes, there was consensus that, while 'on paper' there have been useful attempts to increase domestic accountability and some opening of space, **these mechanisms have not yet fundamentality altered the balance of power or accountability relationships**. According to one respondent, there remains a 'big gap between what the documents say in black and white and what actually happens'.

As set out earlier, **several features of the political context in Uganda may contribute to holding back greater accountability for aid**. The dominance of the Executive and of the President, constrains domestic actors' ability to scrutinise and critique government decisions. This led to the recent claim that 'Uganda is in danger of slipping back into a period of neo-patrimonial rule' (APRM, 2009).

Programme-based aid and the mechanisms associated with it are not provided in a vacuum; rather, they interact with political contexts and power dynamics. This means that introducing mechanisms to strengthen accountability for aid without paying proper attention to the underlying power and political dynamics is unlikely to shape behaviour significantly, and this appears to be the case in Uganda. For example, a number of civil society representatives commented on the level of politicisation within the health sector, highlighting that criticising government policy and actions in health entails the risk of being labelled 'anti-government'.

To some extent, donors appear to be responding to governance concerns in Uganda, as manifested in the sense of **growing donor disillusionment with the SWAp framework** and with budget support (Örtendahl, 2007). However, as others have pointed out, a return to project aid that works outside of government systems is not alone likely to adequately address the challenges discussed here (Buse and Booth, 2008) and where governance reforms are not linked to sector programming, there may also be gaps between different donor agendas. This disillusionment may be reflected in the sense that the HDP Group within the SWAp is not seen as particularly effective, in part due to the impacts of staff turnover and the reported loss of particularly active individuals.

Moreover, **existing SWAp mechanisms and the budget support framework have not been able to make much progress in ensuring greater mutual accountability**, even though the Paris Monitoring Survey indicator ranks progress as 'moderate'. Cited challenges include delays in donor disbursements, late provision of figures for projects (disrupting the budget process), the use of onerous special audits and the general sense of a 'one-way relationship' for accountability, suggesting that donors still tend to dominate accountability relationships. It is reportedly difficult for the Ugandan government to raise disillusionment with donor behaviour in existing formal forums.

Interaction between aid for health and domestic political processes and relationships is shown in the practice of decentralisation, which is a particularly significant feature of state structures in Uganda. Providing aid on budget and through government systems should allow for greater transparency and accountability at local levels, including in health, in that it contributes to central government resources, some of which will be directed at districts (as long as those systems

are themselves transparent). There is evidence of mechanisms at district level to ensure greater transparency over the use of resources: information on District Development Plans is displayed in public spaces and forums such as budget conferences exist, involving NGOs, religious and community leaders and district officials. The establishment of Village Health Teams also provides an important link between the state and local communities. Moreover, there are a number of civil society initiatives which seek to monitor service delivery at local levels (including those supported by INGOs or donors).

At the same time, **significant challenges were identified, including a perceived lack of oversight or link between national and local level processes**. For example, a common concern was the issue of stock-outs of essential medicines in districts and hospitals, in part because of mismanagement of supplies or deficiencies in the procurement process (see AGHA, 2009). Mechanisms of accountability at district levels do not seem well equipped to deal with these challenges and National Medical Stores are in the process of being recentralised. These challenges may be highlighted during the joint sector review process but this study could not determine the effectiveness of follow-up.

Significantly, **aid modalities such as budget support remain concentrated on upstream policy issues and dialogue (with mechanisms introduced at national level) but appear to have had little impact downstream** on the issues discussed here and on incentives and behaviour for district-level implementation (see Williamson and Dom, 2010). While there appears to be an increasing focus on local level monitoring and accountability (particularly by CSOs), there is a lack of attention paid to how this might intersect with domestic accountability at the national level. Bridging the 'gaps' between accountability at different levels seems crucial going forward.

2.3.2 The rise of off-budget projects in health

Vertical funds and off-budget project funds have provided much-needed resources for health in Uganda. For example, PEPFAR is estimated to have contributed around 70% to total AIDS spending in 2006/07 (Lake and Mwijuka, 2006). But the prevalence of **off-budget project aid, including in the form of vertical funds such as PEPFAR, which generally use mechanisms that work outside of budget processes and government systems, is seen as particularly challenging for accountability**. These initiatives use mechanisms that involve separate reporting structures and processes, and reporting lines usually flow from the implementing agency back to the donor only. Despite the stated commitment of some initiatives to work within Paris Declaration principles, there is a general perception of a lack of 'culture of accountability' to domestic stakeholders for these funds.

Linked to this, few mechanisms exist for greater coordination and alignment. Moreover, some vertical funds appear to work in ways that do not support national priorities and plans. For example, the government has adopted the ABC approach to HIV prevention in Uganda (Abstain, Be faithful, use Condoms) but PEPFAR reportedly funded only the 'abstain' and 'be faithful' components in 2007/08, contributing to condom shortages across the country (Zikusooka et al., 2009). It should be noted that government policy is also perceived by some as having shifted away from the ABC approach in this period – highlighting the importance of changing politics, both domestically and for donors.

These challenges have implications at district level too. For example, **districts are able to solicit their own funds** directly from donors, and both districts and donors do not always report to central government on these funding streams, making planning and oversight highly disjointed. Moreover, respondents cited challenges in directing aid activities towards actual needs when these conflict with donor priorities. For example, preferences to support projects close to transport links make it difficult to respond to the most vulnerable in rural areas.

The **prevalence of NGOs and INGOs operating using donor project funds is also seen as challenging for local accountability**. Officials reportedly struggle to identify all donor-funded

projects within a district, as this information is not consistently shared. Recent GoU policy requires NGOs to register with districts, and to be monitored by them, but some are seen as avoiding this oversight. NGOs have countered this, arguing that district officials themselves can use their position of power to influence the work and funds of NGOs.

In recent years, **some vertical funds have sought to work in ways that accommodate the aid effectiveness agenda and support country systems**. For example, Global Fund resources have been channelled to the government, and are generally on budget and captured as part of sector ceilings. The Global Fund is seen as 'generally following SWAp procedures' and mechanisms, but has additional reporting and information requirements, and disbursements of funds have been slow and unpredictable (in part because of the lingering effects of a corruption scandal in 2005 which led to funds being suspended temporarily) (Zikusooka et al., 2009). Therefore, there remains room for improvement even among those funds that appear to be more open to this agenda.

2.3.3 The International Health Partnership

In the Ugandan context, moves to establish a **Country Compact for the International Health Partnership and Related Initiatives (IHP+)** are not seen as particularly meaningful. Launched in 2007, the IHP+ was seen as the translation of the Paris Declaration principles into practice for health, specifically aimed at tackling some of challenges posed by the complexity of the health aid architecture and the proliferation of vertical funds (see Box 7).

Box 7: The International Health Partnership

The IHP+ brings together donors (bilateral, multilateral, global health initiatives) with recipient country governments in a Global Compact and Country Compacts to achieve the health MDGs. Among other commitments, donors agree to use national health plans and be accountable for their aid. Recipient governments agree to improve their accountability to domestic actors.

Source: IHP (2007).

While the IHP+ appears to correctly diagnose some of the accountability challenges for aid in health, in Uganda there was little recognition of the added value of the proposed Country Compact. For some, there were questions as to how this initiative will be able to achieve behaviour change in terms of accountability: How can its principles (generally recognised to be the right ones) be turned into action? Linked to this was the view that it is a 'flash in the pan' in Uganda, and that it does not have enough political leadership (particularly from donors) to be followed through. Moreover, it seemed that the IHP+ is not always well understood, and that disillusionment with some vertical funds has led to scepticism with regard to its usefulness. Finally, it was not clear what the IHP+ will add to the SWAp framework – and there was a sense that the SWAp itself should be evaluated for lessons learnt before a new framework is taken up.

2.4 Aid modalities and information flows

Challenges of access to information and transparency were common concerns in interviews. Greater transparency cuts across many of the principles of aid effectiveness – recipient governments need information so that they can prepare realistic budgets, donors benefit from information sharing, so that they can better coordinate their efforts, and citizens require information to effectively hold decision makers to account.

However, across the board, **donors do not provide enough information** on their aid commitments and disbursements (for both on and off budget modalities). Some thought that GoU could be more proactive regarding obtaining this information, but many agreed that, as standard practice, donors should be providing better (more complete, more timely and more accurate) information on aid. The JAF commits budget support donors to disclose this information, but at present only the Danish International Development Agency (Danida) is seen as providing comprehensive information on aid disbursements. The JAF also commits donors to establishing an

Aid Management Platform (not yet implemented). This is a web-based application where government and donors can share aid information – from planning through implementation – analysed by donor, sector, status, region, timing and other attributes. This would help strengthen transparency and accountability – although a range of donors (not just budget support) should be involved.

According to one respondent, lack of information limits the ability of the GoU – and by implication of parliamentarians, citizens and others – to know how much is actually received for health in Uganda. A significant proportion of donor resources are thought to be off budget in health and even where aid is provided as budget support or as on-budget project aid, donors are remiss in providing accurate information on fund disbursements. In practice, this undermines the budget process, as the lack of accurate information on the total level of resources available contributes to a context where ministries (health and finance) and the related domestic accountability system are structured around a standard government budget but where the reality is far from this model.

Citizens are generally unaware of aid and funding allocations in health, and information (where provided) is often not very accessible. For example, District Development Plans and Annual Health Sector Performance Reports, although available, are seen as difficult for citizens to process and not particularly relevant to their day-to-day experiences of the health sector. Moreover, where information is available, citizens still need to know where to look. CSOs highlighted that this is even more challenging when monitoring donor projects that operate outside of government systems, for which it is very difficult to identify the 'key duty-bearers' for a given health issue.

Alongside these access challenges, there appear to be a **number of blockages to information flows between citizens and central government**, although there are many CSO- or NGO-led community monitoring and information dissemination initiatives (Box 8 gives an example). These seem to work well in disseminating information to sub-district levels and identifying gaps and challenges for health service provision at local levels.

Box 8: World Vision's Citizen's Voice and Action tool

The Citizen's Voice and Action tool seeks to empower communities to hold service providers to account in the delivery of various services such as health and education.
In the context of health, this involves the following:

- Community leaders are given information regarding basic standards for health centres and citizen's entitlements in health.
- These leaders are then trained to act as monitors, assessing standards in health centres and disseminating information within their communities.
- World Vision Uganda facilitates dialogue between communities and key local stakeholders (health workers, district officials) regarding any challenges identified. These have included a lack of drugs that should be available and the prevalence of expired drugs.
- This dialogue commonly leads to the production of an action plan to improve the delivery of services.

However, there was little evidence that this contributes to meaningful information flows up to central government or that it links to more meaningful accountability for health at national levels. For example, district councillors were not seen as responsive to these initiatives and there was little evidence of these initiatives being used to present accountability concerns at the national level. As such, it is unclear how they improve the overall accountability or responsiveness of state structures. Moreover, their lack of attention to donor projects that are outside of government systems seems a potentially significant weakness.

Despite these challenges, there were some examples of good practice, including through the work of the **Budget Monitoring and Accountability Unit**, housed in MoFPED (see Box 9). Set up in 2008, this produces monitoring reports on donor- and government-supported projects, including in

health. To date, these reports have been shared with the MoFPED Permanent Secretary, circulated to the PAC, the Inspector General of Government and the Auditor General and presented in summary to the President.

According to one respondent, districts are now aware that 'someone is watching', helping to strengthen accountability in the long term. It was reported that the results of the unit's monitoring are already shaping budgeting – for example, the unit has recommended establishing cost guides for districts, to ensure greater consistency in spending across districts, and this is now being implemented. The unit was also reported to have identified the presence of so-called 'ghost health centres', and it was felt that it is contributing to improved district reporting in the long run. The unit also liaises with civil society, including conducting monitoring training for communities, but its reports have not yet been made publicly available. Doing so would mean that they could become a valuable tool for wider accountability.

Box 9: Budget Monitoring and Accountability Unit

The Budget Monitoring and Accountability Unit was established in MoFPED in August 2008. It employs eight technical officers, three research assistants and eight graduate trainees, covering a range of sectors/issues, including health, agriculture, energy, information and communication technology (ICT), water, education, roads and PFM. The unit produces quarterly reports on spending of the budget and monitors donor and government projects, for example for primary health care grants, capital development, construction, recurrent expenditure, drugs and procurement. This is done by identifying a representative sample across all regions, conducting monitoring visits and producing reports that are then circulated across government.

2.5 Preliminary conclusions

Examining the actors, mechanisms and information flows around different aid modalities in the context of the Ugandan health sector allows us to identify a number of key trends. Donors and recipient governments remain the dominant actors across aid modalities, but there are some (albeit limited) signs of greater activism from other domestic actors, such as parliamentary committees, in light of the SWAp framework and new aid modalities. Similarly, there have been some promising changes for accountability in mechanisms around the SWAp and programme-based aid approaches, but these have not yet shifted into substantial changes in terms of the behaviour and incentives of key actors. Transparency of information flows, particularly where aid is off budget, remains a key barrier to achieving greater accountability for aid.

Overall, the evolution and dynamics of accountability systems around aid (i.e. the configurations of actors, mechanisms and information) still depend on the underlying power dynamics and political contexts in a given country. In Uganda, donors and the aid they provide must take account of the dominance of the ruling party and the President, and the distribution of power that results from these factors. Where on-budget aid or budget support is provided, it therefore needs to be done in ways that can also support the strengthening of domestic accountability actors and mechanisms (including the activism of the PAC and the Auditor General, or of wider CSO and media scrutiny). Donors appear to be struggling to bring together these different aspects of support. At the same time, off-budget project aid that works outside of government systems and also outside of any domestic accountability system has the potential to reinforce existing power imbalances and further weaken the relationship between citizens and the state. Within the health sector, the dominance of off-budget project aid appears to be a key stumbling block in attempts to strengthen domestic capacity to account for and manage resources.

Donors do not yet seem to fully recognise and address these underlying dynamics. In part, this may reflect – for some donors – a lack of robust analysis of context. But this study also found that many donors have a sophisticated understanding of the contextual challenges faced in Uganda and are aware of the importance of improving governance structures to enhance domestic accountability. Yet they remain held back by their own political considerations and incentives, and

by the lack of evidence base for how to effectively support domestic accountability. Addressing these issues will be crucial if donors are to play more a constructive role in domestic accountability in the future.

3. The view from Zambia

3.1 The context for aid to health in Zambia

3.1.1 Understanding the political context

Zambia has formally been a multiparty electoral democracy since 1991, when the Movement for Multi-Party Democracy (MMD) won a general election under Frederick Chiluba, following the government of Kenneth Kaunda of the United National Independence Party. Chiluba served for two terms of office. Levy Patrick Mwanawasa, of the same party, was elected in 2001 and re-elected in 2006; Rupiah Banda, of the same party, was elected in 2008 after the death of Levy Mwanawasa. Elections are due in 2011 and, despite divisions in the MMD, the incumbent is likely to win.

The constitutional and legislative framework puts in place formal structures of domestic accountability in line with the spirit of democratic governance (Burnell, 2001). These include parliamentary oversight powers and mechanisms (including the PAC); the Auditor General's Office; an independent judiciary; and an Anti-Corruption Commission. On the non-state side, there is a degree of independent media (notably through The Post newspaper) and CSOs have gained some ground with regard to more presence and voice on aid. In reality, however, domestic accountability systems are weak. The logic of dominant party rule has contributed towards harbouring political practices of clientelism, patronage and widespread corruption (Duncan et al., 2003; Venter, 2003).

Zambia's political history of effectively dominant party rule has implications for the nature and quality of accountability relations. The Executive branch makes most political decisions (albeit heavily influenced by donors) and opposition parties do not act as an effective political counterweight to the incumbent, despite a recent move by two of the parties to come together under a common electoral alliance (the Patriotic Front (PF) and the United Party for National Development (UPND)). Overall, political parties are vehicles for personalist politics rather than programmatic views of development. The Zambian political system has some authoritarian tendencies in practice and Freedom House places it in the 'partly free' category (Simon 2007).

Two current political processes of note, which may have an impact on accountability mechanisms, including for aid, include an ongoing process of constitutional reform[3] and the NGO Bill (Tiwana, 2009). The latter is seen as a measure by the government to restrict CSO activities and to give greater regulatory powers to the Executive over the activities of CSOs in ways that may undermine domestic accountability. Some argue that this measure is likely to intimidate CSOs into inaction, for instance with regard to exercising oversight over the Executive branch.

3.1.2 The aid environment

Since the 1970s, Zambia has received large amounts of aid in proportion to GDP. In 2007, aid amounted to 4.9% of GDP (OECD, 2008c). Until 2005, Zambia's dependency on aid was especially high, with donor funding amounting to approximately 40% of the total national budget. This decreased to about 25% in 2008, related in part to Zambia reaching completion point under the HIPC Initiative (CSPR, 2008). At the same time, it has been at the forefront of experimenting with new aid modalities and frameworks, particularly since the 1990s, and the health sector has been no exception.

[3] The three central issues are: the electoral system for electing the Executive and whether to replace the simple majority with 50% rule for the presidency; the powers of the Executive branch; and the Bill of Rights (Henriot, 2010).

A PRSP was put in place for 2002-2004 within the broader Transitional National Development Plan (TNDP). This has been followed by the Fifth National Development Plan (FNDP) 2006-2010, which currently constitutes the national framework for reducing poverty and promoting development.

Aid has traditionally been important for health, representing over 60% of the sector's budget. In 2000, on-budget donor support amounted to 84% of ODA. With the increase of vertical funds, by 2004 this figure had dropped to 59% of on-budget support, and 41% of donor funding was off-budget project aid (Bartholomew, 2009).

In connection with this, and in line with the aid effectiveness agenda, Zambia has moved ahead with putting in place a number of frameworks to enhance donor coordination and alignment with country systems, and in support of country ownership and better accountability for aid. Table 3 sets out current progress against the Paris Monitoring Survey indicators. In 2007, the Joint Assistance Strategy for Zambia (JASZ) set out a roadmap for good practice. This medium-term framework aims to manage relations between the Government of the Republic of Zambia (GRZ) and partners in development cooperation in ways that are aligned to the FNDP. It is intended to support country ownership of development in line with Paris Declaration principles. The harmonisation process is outlined in the Wider Harmonisation in Practice (WHIP) MoU between GRZ and the DPs, a key component of which is the establishment of a division of labour between DPs which specifies the sectors in which they will operate. The JASZ also outlines the arrangements and procedures for SWAps, joint financing and a coordinated approach to financing.

As part of the aid effectiveness trend towards programme-based approaches, and on-system and on-budget support, GRZ has made important progress in the reform of public financial systems through the Public Expenditure Management and Financial Accountability (PEMFA) programme. This is a donor-funded programme aimed at supporting GRZ to improve capacity to mobilise and use public resources as well as its financial and reporting mechanisms (Bartholomew, 2009). In relation to evaluating progress against the development plan in the Ministry of Finance and National Planning (MoFNP), reporting and review take place through a Performance Assessment Framework (PAF). The MTEF is a three-year rolling framework which, along with the Annual Activity Budget (AAB), informs resource allocation to the sector level from MoFNP.

Table 2: Paris Monitoring Survey indicators for Zambia 2008 (data from 2007)

Overall ranking	**Zambia**	**2010 target**
Ownership	Moderate	-
Harmonisation	Moderate	
Alignment	Moderate-High	
Managing for results	Moderate	
Mutual accountability	Low	
Key indicators	**Zambia**	**2010 target**
Indicator 3: Aid flows are aligned to national priorities	74%	85%
Indicator 5a: Use of country PFM systems	59%	No target
Indicator 5b: Use of country procurement systems	71%	Not applicable
Indicator 6: Strengthen capacity by avoiding PIUs (no. of PIUs)	34	8
Indicator 7: Aid is more predictable	85%	75%
Indicator 8: Aid is untied	100%	More than 99%
Indicator 9: Use of common arrangements or procedures	47%	66%
Indicator 12: Do countries have reviews of mutual accountability?	No	Yes

Source: OECD (2008b).

3.1.3 Aid and the health sector

Coordination and planning in the health sector takes place within the context of the SWAp, which began in 1993 as a framework to manage relations between GRZ and DPs. A MoU was signed in

1999, and then again in 2006, setting the terms and procedures by which donors can support and align with the National Health Strategic Plan (NHSP).

The main aid modalities in the health sector can be summarised as follows (see Boxes 2 and 3 for definitions of aid modalities):

- **Budget support** disbursed through MoFNP either as GBS or SBS. The latter tends to be earmarked. DFID and the European Union (EU) are leaders in budget support modalities (Bartholomew, 2009).
- **On-budget project aid**, such as pooled funds in the form of basket funds at various government and service delivery levels. Funding is disbursed into MoH and continues to provide the main financial framework for the sector. The key DPs in the SWAp are the Netherlands, Sweden and Canada.
- **Off-budget or off-system project aid** through vertical funds, which constitutes a large proportion of funding to the health sector in Zambia. PEPFAR (with $269 million in 2008), the Global Fund ($69 million in 2007) and the GAVI Alliance (approximately $50 million in 2005-2015) are the biggest funders (Pereira, 2009).

However, any optimism on progress with respect to the aid effectiveness agenda was dampened with the eruption of a major corruption scandal in the health sector in May 2009, which has deeply affected the relationship between government and donors (see Box 10).

Box 10: Health corruption scandal 2009

In May 2009, the Anti-Corruption Commission, on information provided by a whistleblower, made public that $2 million had been embezzled by high-level officials in MoH. It is alleged that officials paid a consultancy firm for workshops that never took place. This led to a suspension of funding by the governments of Sweden and the Netherlands and to delays in funding by the GAVI Alliance, the Global Fund and the EC. An Action Plan for Strengthening Accountability and Controls was put in place after talks between MoH and DPs, intended to restore trust and improve accountability and fiduciary mechanisms within MoH. A number of officials are undergoing judicial investigation. The freeze of donor funds led to a 25% reduction in funding in MoH. Of the embezzled funds, it is estimated that 60% came from the national budget. Notably, donors have had more weight in negotiating the Action Plan than have domestic accountability actors.

Source: Pereira (2009); Nugulube (2009).

3.2 Aid modalities, actors and accountability

This section examines the role of the different actors involved in accountability in the health sector around different aid modalities, including the government, the Parliament (and the PAC), the Auditor General, the Anti-Corruption Commission and CSOs. The media and the judiciary are also relevant and donors play a number of roles.

Progress towards improved accountability for aid requires changes in political structures and in the balance of power between different actors. Looking first at the **government**, a number of steps have been taken to strengthen financial management systems and the government maintains a preference for aid which is on budget (including budget support). This institutional change, which includes that promoted in the aid effectiveness agenda, and the focus on results for aid, reporting on performance and working with local accountability structures, can contribute to reshaping power dynamics on the ground. However, a number of weaknesses in the domestic accountability system limit the extent to which real behaviour change has been achieved.

In the health sector, **Parliament** is perceived as inadequate with regard to its role of scrutinising budgetary processes and the actions of MoH, and it is seen as a body that rubberstamps government decisions. This reflects a combination of weak political will and capacity and institutional limitations. For instance, in budget planning, the legislative branch is generally given little time to scrutinise the budget, and operates with limited information on decision making and

how priorities are set (Chiwele, 2009). Of note is the fact that MPs are entirely absent from the joint review process (Wohlegemuth and Saasa, 2008). Finally, the dominance of the ruling party weakens Parliament's ability to question Executive actions, including decisions on resource allocation and setting health priorities. This contributes to the sense that Parliament is not an effective deliberative or legislative body. Moreover, to the extent that mutual accountability reinforces the relationship between GRZ and donors, Parliament can be crowded out. Thus, mutual accountability mechanisms, while not responsible for the political accountability failings of Parliament, may reinforce habits of inaction on policy debates within Parliament.

In contrast, the **PAC** is seen to take seriously its role of oversight as it takes on the Auditor General's yearly report. The PAC comes into action upon receiving the report from the Auditor General's Office (AG). The AG and the Accountant General are permanent witnesses before the PAC. The PAC can call ministry officials for questioning and does so as a matter of course – to the level that officials can feel sufficiently intimidated by the experience. In part, this activism may reflect the fact that the PAC is chaired by a member of an opposition party. However, there are institutional constraints on the effectiveness of its oversight role, for example its recommendations are merely 'noted' by the ministry under question and rarely followed up on (Chiwele, 2009; TIZ, 2007). The Parliamentary Health Committee has the mandate to oversee the activities of the Ministry of Health. One role it has played is to lobby for progress towards the commitment that the GRZ meet its commitment for health to constitute 15% of the national budget, in line with the Abuja Agreement.[4] In the 2009 budget there is an allocation of 11.9% to health (Bartholomew, 2009)

The **Auditor General's Office** is viewed overall as competent but limited by institutional and financial constraints. Its role is central in terms of drawing attention to irregularities in the use of funds and its reports suggest diligent efforts to exercise an oversight role, but it has limited power to ensure that its findings and recommendations are followed up. Like the PAC, the limited powers of enforcement are a major weakness of the accountability system. In addition, a number of informants noted that the report works with a two year time lag. To this is added the difficulties of tracking which of its recommendations are acted on, so that it is very easy to sweep things under the carpet (TIZ, 2007). The **Anti-Corruption Commission** has a poorer reputation, but it works with limited resources and powers. Among its limitations is the fact that CSOs cannot take cases to the Commission.

There is consensus among different stakeholders in the health sector that accountability for aid could be improved through more and better participation of **CSOs** in decision making and monitoring of implementation and performance in service delivery. But CSOs are highly diverse and there are important power imbalances between them. For instance, INGOs have more voice and are able to create space, but they also tend to fill this space, leaving smaller or community-based organisations (CBOs) out. Thus, where NGOs and CSOs are positioned within aid structures will help determine their scope for voice and accountability. The nature of their relationships with donors, GRZ and each other is inevitably embedded in power dynamics, which can affect their inclination to take on an activist oversight role from the bottom up.

In some cases, the scale of funding that NGOs command means that they develop the logic of local donors with respect to smaller CBOs. Some are seen as being too close to the source of funding, making it difficult for them to act as effective accountability actors. Capacity issues are also a key factor in shaping CSOs' role in accountability. Additional challenges at the district and community level include issues of distance in relation to the centre of policy decision making.

In recent years, there have been increasing opportunities for CSO involvement in the budget process, and improved capacity and advocacy strategies for a number of CSOs. CSOs can make submissions to the budget process in the health sector and are able to comment on the budget

[4] The health summit in Abuja in 2001 for member governments of the Organization of African Unity set a target of 15% of annual budgets to be allocated to health.

once it is presented. However, there is little indication that their voice has any impact in shaping allocation decisions (Chiwele 2009). With respect to vertical funds, CSOs can be trapped in a relationship of dependency, in which it is difficult for them to hold donors to account, given the substantial funding they receive from them.

A range of CSOs have acquired presence in public expenditure matters. The work of Transparency International Zambia (TIZ), Civil Society for Poverty Reduction (CSPR), the Jesuit Centre for Theological Reflection (JCTR) and the Zambian Governance Foundation (ZGF) has become particularly relevant. CSPR has been important in providing information, through assessments of the evolution of governance and aid processes, and in engaging in advocacy work to ensure better societal voice in dialogue forums and policy formulation process. The ZGF has also been involved in awareness raising and capacity development for building demand-side voice on local and community needs (including on policy directions and oversight strategies for public expenditure processes). CSO action can contribute to bridging the gap between top-down policy decisions and local needs on service delivery at the community level, and enabling upstream practices and habits of accountability through capacity development, awareness raising and advocacy.

While CSO involvement is generally seen as desirable, the move towards budget support, in line with moves to improve aid effectiveness, raises important questions about the nature of the role of CSOs in formal accountability mechanisms on budgetary processes. Democratic governance relies on robust oversight through parliamentary action and other horizontal accountability mechanisms. The need for CSO oversight is justified precisely because ineffective accountability through these systems characterises current governance structures. However, in the long term, it may be desirable to build up formal accountability mechanisms.

There is evidence of progress in the role and behaviour of **donors** with respect to the aid effectiveness agenda, but some areas remain problematic. Harmonisation and coordination among donors is limited in part because donors prioritise responding to their own domestic political pressures (including the perceived needs of taxpayers). Problems of harmonisation become more visible in times of crisis, such as during the corruption scandal. In part, the range of modalities in health and challenges for harmonisation reflect differing approaches among donors about where their priorities lie and where they feel they will get more ‘bang for their buck’. For example, the Dutch and Swedish governments, even in the wake of the corruption scandal, continue to prefer basket funds within the health SWAp, as in theory they retain greater say over monies at the sectoral level.[5] This also reflects concerns over the domestic accountability capability of the Zambian state. By contrast, DFID and the EU have made a strong bid for supporting budget support. DFID’s strategy is focused on improving country-level accountability mechanisms and building the PFM capacity of GRZ. Moreover, DFID argues that, through GBS, the enhanced role of MoFNP will encourage it to become more sensitised towards and knowledgeable of sectoral needs (including MoH), and that in the long run this should result in better communication between the ministries (see AGH, 2008).

Donors also face capacity issues in terms of their own ability to analyse local context and adapt decisions on funding and aid modalities accordingly. High staff turnover contributes to limited institutional memory and insufficient country knowledge. This diminishes donor capacity to fully understand the contexts in which they operate. Moreover, given the inevitable power asymmetries in aid for accountability relationships, donors continue to crowd out CSOs and other domestic actors in decision making and oversight in relation to donor funds. At the same time, donors share the view that accountability for aid ultimately requires more robust domestic structures through better governance. Therefore, there has been some donor engagement in governance support to strengthen Parliament, PFM structures, the Anti-Corruption Commission and CSOs.

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[5] By the same token, both governments are involved in support to CSOs across a range of initiatives.

3.3 Aid modalities and accountability mechanisms

This section addresses some of the main mechanisms and processes around different aid modalities, and their implications for accountability. A key finding is that aid to Zambia's health sector, and the accompanying mechanisms around aid, have become increasingly fragmented, in large measure by the expansion of vertical funds in health. This seems to impact accountability structures in a number of ways.

3.3.1 On-budget aid: Implications for accountability

GRZ and many donors have maintained a long-term commitment to move towards budget support (either general or sector), channelled through MoFNP. This is in line with the rationale of making better use of country systems and supporting improvements in domestic accounting and monitoring structures in public accounts. At the same time, funding channelled directly through MoH (in the form of basket funds or on-budget project funds) continues to play an important role in addressing the needs of the health sector in Zambia.

On both fronts, **the range of mechanisms and frameworks put in place, on paper at least, speak of progress in terms of improved accountability** and review mechanisms in relation to financial accountability. These include mechanisms around the JASZ and the health SWAp (Box 11). Moreover, there has been a clear move towards enhancing CSO participation.

Box 11: Key mechanisms and processes in the health SWAp

- **Annual Consultative Meeting:** A forum for joint policy dialogue and the body that approves the NHSP, the sector MTEF and the Annual Action Plan and Budget (includes GRZ, DPs and INGOS and relevant private sector service providers).
- **The Sector Advisory Group (SAG):** Meets biannually to oversee implementation of the sector's activities as established in the NHSP and to review progress on performance indicators and approve disbursements from the common basket (also includes participation of CSOs).
- **The monthly Consultative Meeting:** Between DPs and MoH, discussing policy issues and strategic and technical recommendations from sub-committees and working groups.
- **The sector Joint Annual Review (JAR):** The key reporting mechanism to review performance against the NHSP. A participatory process involving MoH, other line ministries, DPs, NGOs and CSOs, as well as district- and provincial-level staff.

Dialogue forums within the SWAp provide some space for non-state actors to participate in review processes, but with limitations. For instance, SAG meetings are well attended and seek to enhance dialogue in the sector. However, decision making and accountability generally seem to be restricted to the relationship between donors and GRZ: other participants see the meetings as token gestures, with no meaningful decision making occurring. There is also a view that donors continue in practice, including within MoFNP, to micromanage decision making at the ministerial level. Meanwhile, donors and government officials suggested that CSOs frequently do not make the most of the opportunities for participation and oversight afforded by the dialogue forums. Some respondents pointed to these efforts at mutual accountability as excessively time consuming and bureaucratic, with the point being merely to pay lip service to commitments. This is potentially problematic for domestic accountability and for the political process of domestic actors defining policy priorities and resource allocation through the channels of representative government.

Therefore, the mechanisms introduced 'on paper' do not seem to have translated into concrete changes in behaviour or shifts in accountability. A number of crosscutting challenges may help examine this. First, these mechanisms do not operate in an institutional vacuum. Rather, their impact is constrained by existing power structures and interests. For example, **tensions seem to have arisen between MoFNP and MoH** in Zambia regarding control of resources and use of different aid modalities. Some within MoH feel that their 'ownership' over health is being undermined by what is perceived as a shift away from basket funds and MoH programme aid modalities towards budget support channelled through MoFNP. There is a strong sense of distrust

and a feeling of loss in MoH regarding what it sees as its increased dependency on MoFNP allocation processes and disbursement rates.

Even in the case of SBS mechanisms, which are in principle earmarked for the sector, tensions between MoH and MoFNP have not been managed adequately (Bartholomew, 2009). On the principle of additionality in MoFNP allocations, MoH staff feel that there is insufficient clarity regarding how this affects total amounts of budget support allocated to MoH from GBS (ibid). MoFNP voices insist that the figures show otherwise. Distrust between the two ministries reflects distrust with respect to each other's accountability mechanisms and capacity for good governance, as well as conflict over resources as these are reallocated as a consequence of shifting donor preferences. The aid effectiveness agenda emphasises moving towards programme-based approaches such as budget support but there are implications on the ground for how government structures and actors need to adapt to resulting changes.

Second, although some mechanisms bring in a wider group of stakeholders and although there is a stated intention for more two-way accountability, there is a prevailing view that the **emphasis in accountability systems remains one way and upwards to donors**. In reality, there seem to be limited mechanisms by which local stakeholders can hold donors to account, despite commitments to the spirit of mutual accountability.[6] The evolving PAF in MoFNP has improved reporting mechanisms on donor performance regarding the proportion of ODA disbursed through budget support, the predictability of funds and reliability in relation to donor commitments (MoFNP, 2008; 2009). However, this has not translated into wider accountability with other stakeholders or shaped the behaviour of non-budget support donors. Overall, good intentions in the trend towards greater budget support are somewhat lost because of the political and power dynamics in the ways in which different actors in the sector interact and perceive their role and interests to be affected.

The recent **corruption scandal in the health sector** also appears to have had a significant impact on donor–government relations and mechanisms. The scandal highlighted flaws in MoH accounting systems but also signalled a degree of institutional capacity in the Auditor General and the Anti-Corruption Commission to identify problems, expose them and activate the necessary investigative process through the courts. The media also played an important role in maintaining a degree of public scrutiny of the process. Interestingly, CSOs were noticeably silent.

With regard to donors' reaction to the scandal, a number of issues are of note. First, donor funding in the SWAp was immediately frozen (which was not without short-term consequences for service delivery needs in the health sector) and donors set about trying to recover funds. Second, there was concern among local stakeholders regarding what was perceived to be an uncoordinated response among donors in the short term, as they showed themselves to be concerned primarily with their own funds and not with the Zambian budget funds which had also gone missing. Donors seemed to have responded to their own domestic political pressures ahead of their commitments to the principle of harmonisation and building country systems. Third, the Action Plan for Strengthening Accountability and Controls in MoH, put in place in July 2009, did not involve domestic accountability actors such as Parliament and CSOs, and instead was drawn up by donors and GRZ/MoH. The Action Plan aimed to restore trust between donors and MoH and to improve accountability and fiduciary mechanisms within the ministry. By December 2009, the Netherlands, Sweden and the EU had resumed funding of the health sector in view of the perceived successful implementation of the Action Plan.

Throughout the study, **structural problems of power imbalances were seen to be recurrent across the range of aid modalities and their mechanisms** in the health sector. This suggests that working to improve prospects for accountability in health requires a deep understanding of context and a mapping of relevant stakeholders and of the nature of the relationships between

[6] In addition, donors are not sanctioned for late disbursement, poor levels of transparency or predictability in funding (Bartholomew, 2009). See also Gerster and Chikwekwe (2007).

them. Therefore, again, the aid effectiveness agenda does not evolve in a vacuum but rather interacts with existing systems, institutions and actors. Insufficient attention tends to be paid to how aid initiatives interact with – and impact on – these existing processes and mechanisms, in some cases with unintended and negative consequences for country systems.

For example, since the 1990s, and in tandem with changes in aid structures, the health sector in Zambia has undergone a number of institutional changes, which have interacted with the evolution of aid modalities in complex and unforeseen ways. This has included processes of **decentralisation**, particularly with regard to the Central Board of Health (CBoH) (Box 12).

Box 12: The Central Board of Health

The National Health Service Act of 1995 led to the creation of the CBoH, which was intended as an autonomous body charged with managing and overseeing service delivery through district-level health service delivery structures. MoH was to have no direct health service delivery functions and was intended to become primarily a policymaking and regulatory institution. The process of decentralisation also intended for more local participation in priority setting and decision making by diverse stakeholders at different levels of the health system. These included health centres and neighbourhood committees.

The CBoH was merged into MoH in 2006 on the basis that it established parallel and duplicate systems, and in an effort to streamline the organisational structures of the health sector. Many saw this as a positive measure, some suggested that it had been too closely micromanaged by donors and that it incorporated uneven wage structures that drew personnel away from MoH. Some civil society representatives and district-level stakeholders involved in service delivery, however, also indicated that the CBoH had better systems in place for both accountability and voice from below, which have not been adequately compensated for in the merger. For example, it appears that neighbourhood health committees have collapsed with the removal of the CBoH, and this has left some stakeholders feeling that their ownership of health policy processes has been undermined (Chakwe, 2009). District officials and other stakeholders felt that the merger has led to effective recentralisation of policy decision making, which is now less attuned to local service delivery needs.

For this study, the merits or perils of the decision to close down the CBoH have not been found to be clear, either during the fieldwork phase or in the secondary literature. Decentralisation remains on the agenda and is undergoing a reorganisation around different structures, in what is seen to be a highly politicised process, where the objective of empowering local communities in their ability to drive demands and pursue accountability of central government remain distant (Chikulo, 2009). The key point here is that choices around aid modalities are likely to interact with domestic processes in ways that may have unforeseen consequences. In the case of the CBoH, it seems that expectations about directions of institutional change may have been poorly managed, creating tensions between stakeholders rather than the desired changes in behaviour and capacities (Bartholomew, 2009). This can have a negative impact on *perceptions* about voice and accountability among relevant stakeholders.

Donors and local actors across the board acknowledge that aid effectiveness ultimately relies on the capacity and credibility of domestic accountability mechanisms and systems. But there is also widespread consensus that **mechanisms and actors are currently limited in their capacity to exercise oversight over aid in health policies**. In part, this reflects embedded structures and practices of patronage and clientelism. But it is also the product of weaknesses, inconsistencies and ambiguities in the Zambian legal and constitutional framework (Chiwele, 2009).

3.3.2 The rise of off-budget project aid in health

A large proportion of funding to the health sector is provided in the form of **off-budget project aid**, including through health vertical funds. This has increased considerably in recent years, and has contributed to the fragmentation of health sector funding. Vertical funds play a key role in servicing some of the health needs of Zambia, which is particularly important given the magnitude of the

disease burden. They are also more targeted, which may result in more effective addressing of specific disease needs, and can meet funding gaps in service delivery in more remote areas.

But vertical funds in health are problematic for a number of reasons: they create high transaction costs for MoH, as they use parallel systems; they draw qualified staff away from the government health system, causing staffing retention problems; they create administrative burdens for recipient service provider organisations, as their reporting systems and application procedures are not harmonised and take up resources; they undermine the prospects for country ownership and development of country systems; and there are issues to do with levels of predictability and reliability of funds (Pereira, 2009; 2008; Bartholomew, 2009).

Local stakeholders interviewed further noted the following drawbacks: vertical funds have limited in-built flexibility to adapt to changing needs on the ground; they are frequently not sufficiently attuned to CBO absorption capacity; and application procedures, reporting and review mechanisms are bureaucratic, time consuming and not coordinated, creating operational problems that are exacerbated by limitations on use of funding for administrative purposes.

However, the scale of funding is such that their size was seen by some to compensate for their failings. There are also some signs of changes in approach, with some funds increasingly committing to using country systems more effectively and in alignment with country priorities. The Global Fund, for instance, has introduced the Country Coordination Mechanisms (CCM) aimed at improving donor coordination, it provides aid to MoH and MoFNP (on budget) and it attends SAG meetings in MoH (Pereira, 2009). This could be built on so that other vertical funds also provide aid in ways that allow it to be captured on budget. The Global Fund also recommends an internal review process prior to submitting an application, to examine how the application supports budget allocations and priorities. At present this process does not seem to be functioning effectively in Zambia (or in Uganda), highlighting the challenges a reliance on the relevant actors (e.g. the Ministry of Health or other applicant organisation) themselves ensuring that their applications support domestic processes, but without safeguards build in to identify where this does not occur.

3.3.3 The International Health Partnership

For GRZ, the IHP+ signified an opportunity to strengthen mutual accountability commitments by donors to improve their performance with regard to predictability of funding and disbursement in alignment with the NHSP. Prior to the corruption scandal, Zambia was on the verge of embarking on the IHP+ Compact, due to be signed in June 2009. This was interrupted, and further discussion on the IHP+ has been put on hold pending the outcome of investigations. Although funding for health has resumed, the mood among donors is now one of much greater scepticism with regard to the IHP+. Moreover, many CSOs are dubious with regard to the empowerment potential of the IHP+, in part because they were not very involved in the drafting of the MoU Addendum. Some expressed that they expect better voice through GBS mechanisms than through the IHP+.

3.4 Aid modalities and information flows

A central issue in determining the scope and quality of accountability for aid in the health sector relates to the quality and availability of information on aid and disbursement processes. High levels of fragmentation in funding structures make transparency around funding flows much more challenging.

Some actors felt that there has been **important progress in improving the quality and accessibility of information.** At government level, MoH and MoFNP officials pointed to important

improvements through mechanisms such as the JAR and the PAF. For instance, the budget can now be accessed by anyone through the official government printers. However, even if data are more readily available, their presentation tends not be user friendly, with the budget largely an impenetrable document of numbers and charts that are minimally referenced or explained. Some have called on MoFNP to simplify the way the budget is presented and to make it more accessible to stakeholders: it is key not only to know where to look for information but also for that information to be accessible. Within the MoH, the development of the Health Management and Information System (HMIS) is intended to provide information on indicators and targets within the health sector to inform planning, activities and monitoring of results on health and service delivery (Bartholomew, 2009; MoH Zambia, 2008). This was created in 1994 in line with the SWAp. Recent EU funding for capacity development has aimed to strengthen the HMIS and contribute towards streamlining information collection both for the SWAp and for SBS (ibid).

At the district level, health sector officials signalled **progress in the reporting systems of community- and district-level activities upwards** towards MoH and MoFNP. They also indicated improved levels of transparency for local CBOs. At the same time, however, District AIDS Task Force (DATF) members, made up of members of the community, felt unequivocally that information on funding flows was neither available nor transparent.

Although there was a widespread belief that donors are still not sufficiently transparent with regard to funding flows within the SWAp and on-budget aid in MoFNP, the **frameworks that are evolving in the spirit of supporting the aid effectiveness agenda have led to greater transparency** over the timeliness and reliability of donor funding. For instance, in the JAR there is information regarding specific delays in donor funding that have consequences for performance (MoH, 2008).

However, **challenges in accessing donor information are particularly evident in relation to vertical funds** in health. In part, this owes to the limited presence on the ground of these organisations and the logic in how global funding bodies operate. At the same time, these funds are less advanced in aligning with country systems or coordinating their reporting and review mechanisms.

Poor information flows undermine effective participation in dialogue forums. Potential for CSO participation, for example, is hampered by the fact that invitations and information on meetings such as the SAG are sent with only a few days' notice, and the necessary documents are often not available beforehand. At the same time, donors and ministry officials point to CSOs' own capacity limitations as a factor explaining both poor levels of engagement in oversight and participation in budget processes and decision making, as well as limited technical knowledge of how to use information. It is also worth pointing out that this is a moving picture in which CSOs capabilities are changing through on-the-job learning, as well as a cumulative process of awareness and advocacy campaigns. Moreover, there is an acknowledgement of the need to go beyond Lusaka and work at the district and community level to enhance capacities for voice. Ultimately, however, increased voice from below needs to be matched by changing institutional frameworks and modes of conduct among other actors in the aid equation.

3.5 Preliminary conclusions

An analysis of the actors, mechanisms and information flows around different aid modalities for health in Zambia identifies a number of themes similar to those in Uganda. Donors and recipient governments again seem to be the dominant actors, although new patterns of increased CSO activism (and the role of INGOs) are also highlighted. Mechanisms around the SWAp framework and associated with programme-based aid approaches also seem 'on paper' to present a number of positive opportunities for greater accountability, but in practice meaningful shifts in accountability

for aid in the health sector have yet to be realised. Challenges were also cited with regard to the transparency of information. Off-budget aid was perceived to be especially problematic.

Progress is evident on information for on-budget aid, but the user friendliness of this information was identified as a significant challenge. Overall, accountability in aid relationships continues to be skewed towards donors, with very limited opportunities for downstream accountability. Moreover, the aid dependent nature of Zambia contributes to privileging donor concerns over citizens' voice.

However, the Zambia case study reveals the interesting finding that the recent corruption scandal has both contributed to a rowing back of commitments in aid effectiveness and accountability (with the IHP put on hold and off-budget project funds increasing) and provided opportunities for domestic actors to play their roles in oversight and scrutiny and for accountability reforms to occur.

As in the case of Uganda, the Zambia study showed that the evolution and dynamics of accountability systems around aid (i.e. the configurations of actors, mechanisms and information) must be viewed against the wider context of the underlying power dynamics and political structures of the country. Zambia continues to be an Executive-dominated polity, with a limited role for the formal domestic accountability institutions of the political system, namely Parliament and watchdog bodies such as the AG. On-budget aid, including budget support, should therefore involve strategies that can also contribute to strengthening domestic accountability actors and mechanisms. At the same time, off budget project aid that works outside of government systems and also outside of any domestic accountability system needs to be critically assessed in terms of its potentially negative impact in reinforcing power imbalances that weaken the relationship between citizens and the state.

In Zambia, donors are aware of the importance of improving governance structures that enhance domestic accountability within the political system. However, at the same time there continues to be a mismatch between this awareness and the overriding approach to aid effectiveness. As in the Uganda case, this may reflect uneven understanding and knowledge of context. But it is also a consequence of the reality that country level donor staff need to balance Zambian needs with answering to the political constraints and considerations of their own countries and electorates.

4. The way forward: Key themes and recommendations

Our analysis highlights that there is a limit to what donor aid overall can achieve through aid effectiveness in terms of contributing to strengthening domestic accountability. Domestic accountability systems are complex, dynamic and driven by internal historical, political, social and economic factors. Bearing this in mind, however, the preceding analysis also shows that some forms of donor aid can make a difference, both in terms of ensuring that they 'do no harm' to existing domestic accountability systems and in potentially strengthening these systems. Moreover, analysing the actors, mechanisms and information flows around different aid modalities in health has allowed us to better explore the relationship between aid effectiveness and accountability. In doing so, it has revealed a number of underlying themes and challenges around power dynamics and political contexts. In this respect, some core arguments can be drawn from the above.

4.1 The importance of context

Aid modalities and the aid effectiveness agenda interact in differing ways, according to the context. For the same reason, they will have differential impacts on domestic accountability structures. In Zambia, where the ratio of aid to GDP is greater, donors appear to exercise more influence over aid accountability, whereas in Uganda the picture seems more complex, with some signs of greater (Executive-led) capacity for decision making and accountability for aid but also some serious weaknesses in the domestic accountability system. In both, mechanisms and approaches of donors are similar (for example, working within a SWAp framework and trends towards budget support) but there is evidence of a lack of attention paid to how these mechanisms and approaches interact with domestic power and accountability relationships. Moving ahead with this agenda requires greater understanding of these implications, in order to manage changes in relationships and expectations, and to ensure that domestic accountability systems are strengthened and supported alongside national systems and processes.

4.2 The importance of information and transparency

The extent to which information and greater transparency sit at the heart of improvements to domestic and mutual accountability was emphasised consistently in both countries. Where aid is not provided on budget, or where information on aid is poor, governments are forced to make budgetary decisions based on partial or inaccurate information and domestic actors are limited in their ability to scrutinise how decisions about aid are reached and how resources are used. In both countries, the lack of donor transparency regarding aid commitments and disbursements (across a range of aid modalities) in health, and blockages in information flows between citizens and the state regarding health, were seen as a major barrier to improving accountability.

The biggest challenge in this respect seems to be off budget aid, including aid from some vertical funds in health, which appear to significantly undermine progress at the interface between aid effectiveness and accountability. Although existing systems and channels of domestic accountability appear to have significant weaknesses, findings from Uganda and Zambia support the view that working outside of these systems at best does not support them and at worst further undermines them. This has important implications for information and budgeting processes. For example, in Uganda it was reported that the high levels of funds received as off-budget project aid 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. This is related to what others have referred to as the 'vicious circle', whereby weak accountability and poor governance lead donors to prioritise project aid (and

the use of project management units), in turn further weakening accountability and governance (Williamson and Kizibash Agha, 2008).

Proposals for Aid Management Policies and information management systems should be given serious consideration in light of some of these weaknesses, and aid information systems should ensure that information is provided in ways that are compatible with government planning, budgeting and accounting processes (Moon and Williamson, 2009). This information should also be publicly available, even where budget processes are weak. Sixteen donors have so far signed up to the International Aid Transparency Initiative (IATI) (including the UK, the World Bank and the GAVI Alliance). Implementing an Aid Management Platform in Uganda, for example, would help to support the IATI's commitment to greater transparency in aid.

Furthermore, the current focus on community-level monitoring and dissemination of information should seek to link with national-level processes. For example, civil society, parliamentarians and others could work together to push donors and government to make their reporting more publicly available (such as appraisals of the JAF and the Budget Monitoring and Accountability Unit in the MoFPED in Uganda, or the JAR and the PAF in Zambia), and then use this information at local levels to inform and engage citizens. Moreover, in both Uganda and Zambia, the information challenge is also a presentational one. Access to information is hindered by the 'quality' of the information, in other words, how information is organised and how user friendly it is to relevant stakeholders across the health sector – including citizens.

4.3 Impact of aid in health on domestic accountability

There is **mixed evidence of the impact of aid on domestic accountability**. Some positive changes for domestic accountability have resulted from the aid effectiveness agenda and from changes in aid modalities and approaches. For example, the Social Services Committee of the Parliament of Uganda felt that the health SWAp and forums like the National Health Assembly allow them greater engagement in planning, budgeting and monitoring for health issues. In Zambia, CSOs participating in the SAG should in theory be able to input into planning and monitoring for health.

At the same time, **these changes have not yet led to meaningful shifts in domestic accountability arrangements**. Domestic accountability institutions and actors, such as the Auditor General or Parliament generally seem to remain untouched by progress on the aid effectiveness agenda. Moreover, there is little evidence in either country that governance reforms have been mainstreamed into how donors are approaching the aid effectiveness agenda specifically in the health sector.

In both Uganda and Zambia, donor attention is very focused on the national level, with forums for policy dialogue that involve a wider number of stakeholders. **Much less attention is paid to the linkages with 'downstream' issues of implementation, including issues of accountability and incentives** for frontline service providers, particularly in the context of decentralisation. Analysing SBS specifically, Williamson and Dom (2010) term this the 'missing middle' in service delivery, which overlooks 'the process for management of frontline service providers, the actual delivery of services, human resources management, and the accountability for service provision'.

Interestingly, our research in Zambia highlighted that **moments of crisis can provide both challenges and opportunities for strengthening accountability for aid**. The recent corruption scandal in Zambia posed significant challenges, with donors freezing funds and questioning the reliability of country systems, but at the same time it was recognised as significant that relevant domestic accountability mechanisms were able to detect and act on the irregularities that were brought to light. The scandal appears to be leading to a number of improvements in the

accountability system for aid, particularly as reporting and review mechanisms create more opportunities for greater transparency and access to information.

4.4 Shifting the balance in aid

In order to address these challenges, this research has identified the **need to provide more aid on-budget**. Doing so would increase the likelihood of an enabling environment for ministries, agencies and wider stakeholders to more actively participate in the budget process and focus the attention of various actors on 'turning the budget into an effective instrument for mobilising, allocating and monitoring the use of public resources' (Booth and Fritz, 2008).

At present, budget processes in both countries appear to have been weakened by the lack of substantive engagement of a range of domestic accountability actors (including parliamentarians) and the high levels of aid provided off-budget. Putting more aid through the budget could **increase the incentives for domestic actors to play a fuller role in accountability and oversight** for decisions and implementation in the budget process. At present, in both Zambia and Uganda, the budget process for health appears to remain relatively unchallenged, with a lack of scrutiny of budget allocations and issues of efficiency and responsiveness to health needs (by a range of domestic actors, from parliamentarians to wider civil society). Increasing the level of resources provided on-budget (including through budget support) could also help push these actors to engage more actively – but this should be accompanied by capacity development and support to strengthen domestic accountability actors and systems.

DFID's White Paper commitment to allocate an amount equivalent to 5% of budget support funding to help build accountability (DFID, 2009) is an interesting one in this respect, though it is not yet clear what this means in practice in contexts such as Uganda and Zambia, and this commitment would not be appropriate to all donors. Moreover, there remains a lack of evidence for how domestic accountability and better governance can best be supported – but there are some potentially innovative initiatives emerging, including the Deepening Democracy Programme in Uganda, which warrant further exploration and research.

4.5 Shifting donor behaviour

Emerging mechanisms of mutual accountability in both Uganda and Zambia point, on paper, to some positive developments, and there were concrete signs of improvement in terms of reporting (both for donors and recipient governments) and some progress on monitoring aid and increasing predictability and reliability in mechanisms such as the JAF or through SWAp mechanisms. The IHP+ initiative represents an attempt to take progress further, in terms of increasing donor alignment and harmonisation (and including vertical funds within this). In reality, though, progress remains patchy, and the IHP+ does not yet constitute a meaningful framework to shape donor interventions, and donor accountability, in either country. Moreover, where mutual accountability is weak, it is likely to be harder for recipient governments to hold donors to account for their aid commitments in recipient countries.

In order to better support the shift to more substantive changes for accountability for aid, a **greater focus is needed on behaviour and incentives** for aid effectiveness and accountability, rather than the narrow concentration on specific mechanisms and aid modalities adopted to date. For donors, this requires more sophisticated and intelligent engagement, underpinned by strong understanding of context. For example, both Zambia and Uganda have political systems that are shaped by long-term *de facto* one-party dominance, but this affects power relationships and dynamics for health in differing ways. Understanding how these factors in practice influence sector-level governance and accountability is an important first step.

This will require donors to reflect on behaviour and incentives within their aid relationships and in their own agencies. At present, donors' choices regarding aid modalities appear to continue to be shaped as much by their own domestic politics as analysis of context. In Uganda, this has led to some questioning of budget support, given a perceived lack of domestic support in donors' own countries (for example, in the UK). In both Uganda and Zambia, this has led to a strong prioritisation of some health issues (such as HIV and AIDS) that have garnered high levels of international coverage and support, to the detriment of more commonplace health problems.

This supports the notion that donors need to recognise 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, emphasis added). Underlying this remains a real need to improve donor capacity to understand political context (and their own incentives and behaviour within those contexts). This should be linked to efforts to better integrate sector specialists with governance specialists, encouraging more institutional links alongside the existing reliance on good personal links between colleagues.

Addressing the barriers on both sides of the aid relationship should help to encourage donors to **better fulfil their commitments in terms of aid effectiveness** and under the Paris Declaration principles. Particularly in Zambia, the direction of accountability systems across all aid modalities continues to be focused primarily upwards to donors. Under this logic, downwards accountability towards users of health services, or to the Zambian taxpayer, can be undermined. This weakens the prospects for strengthening domestic accountability systems in ways that support more effective aid delivery.

Any assessment of the impact on domestic accountability of the aid effectiveness agenda, and the shift towards corresponding aid modalities and new forms of donor/recipient country relations, must work with realistic expectations about what can be achieved. Domestic accountability refers to no less than the governance structures – including the mechanisms and actors – that shape state–society relations. Progress on domestic accountability is therefore fundamentally a political process. Ultimately, it must be domestically led, and it will be dependent on political will and power dynamics. Donors can help support this, through prioritising support that can strengthen domestic accountability actors and systems, but they need to recognise the limitations of their actions, and commit above all else to 'do no harm'.

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Annex 1: List of interviews

Uganda

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