Keeping a tight grip on the reins: donor control over aid coordination and management in Bangladesh

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A long-standing consensus that aid coordination should be owned by recipient authorities has been eclipsed by accord on the desirability of recipient management of aid along-side domestic resources. Nonetheless, in many low and lower-middle income countries, donors remain remarkably uncoordinated; where attempts at coordination are made, they are often donor-driven, and only a small proportion of aid is directly managed by recipients.

This paper draws on evidence from an in-depth review of aid to the health sector in Bangladesh to analyze the systems by which external resources are managed. Based on interviews with key stakeholders, a questionnaire survey and analysis of documentary sources, the factors constraining the government from assuming a more active role in aid management are explored. The results suggest that donor perceptions of weak government capacity, inadequate accountability and compromised integrity only partially account for the propensity for donor leadership. Equally important is the consideration that aid coordination has a markedly political dimension. Stakeholders are well aware of the power, influence and leverage which aid coordination confers, an awareness which colour the desire of some stakeholders to lead aid coordination processes, and conditions the extent and manner by which others wish to be involved. It is argued that recipient management of external aid is dependent on major changes in the attitudes and behaviours of recipients and donors alike.

Introduction

Global consensus, as articulated on the one hand by the OECD, IMF and World Bank, and by the United Nations on the other, holds that aid coordination should be driven and owned by recipient governments. More recently, the health sector aid community agreed that mechanisms for aid delivery and monitoring should support and strengthen existing government systems and administrative procedures instead of circumventing these to accommodate short-term donor concerns for accountability, disbursement or impact.

An examination of the aid regime in the health sector in Bangladesh reveals that, although lip service is paid to the over-used notion of ‘putting the recipient in the driver’s seat’ a conspiracy of interests, suspicion, development practices and inertia prevents this. All too often, the government is not even in the car until the destination has been chosen and the route mapped out. Most donors perceive this to be because the government is unwilling and/or unable to take a leading role in this demanding task.

This paper seeks to determine the factors which constrain the Government of Bangladesh (GOB) from assuming a more prominent position in aid coordination and management. It begins by describing the context within which aid is deployed. The government’s institutional arrangements and processes established for aid coordination are outlined, with emphasis placed on their perceived inadequacies. Attention is briefly turned to the mechanisms which the donors have institutionalized for inter-agency coordination. The central focus of the paper revolves around an examination of why external management of aid resources persists and, given the shift to a sector-wide approach, what the prospects are for getting the government more squarely into the saddle.

Methods

This paper is based on findings from an in-depth, historical case study of health sector aid coordination in Bangladesh (1973–1997) which was carried out in 1996 and 1997 as a component of a doctoral study. Three research methods were employed: (1) a review of documents including government policy, planning and project papers, minutes of meetings, correspondence between the primary stakeholders, internal memoranda from the principal organizations, aide-memoires from project-related missions, and donor project documents; (2) discussions with serving and retired personnel from government and donor agencies in Dhaka and donor capitals (87 officials); and (3) administration of a semi-structured questionnaire under the auspices of a government-led task force. The latter involved posting questionnaires to officials in 19 donor headquarters and 21 Dhaka-based offices for self-completion, as well as administering a slightly modified questionnaire to government officials in four departments in an interview setting.
A horse that needs taming: Bangladeshi politics, governance, accountability and administration

Before turning to the question of health sector aid coordination, it is useful to consider the socio-political context in which it takes place. This context influences donor thinking as to the management of ‘their’ resources and thereby yields insights into the prospects and determinants of effective aid coordination.

Politics

A review of the political history of Bangladesh suggests that the principles of representative democracy have been severely debased. It has been argued that politics in Bangladesh revolves around personalities, not ideas or institutions. Prolonged military rule (accounting for 15 of the country’s 26 years), eight years of martial law, and the recourse to force for the resolution of political conflict has compromised democratic institution building. Although ‘democracy’ was restored in 1990, the fact that two of the three leading political parties have a military pedigree raises concerns over their democratic legitimacy.

The manner in which non-military regimes assume and retain power is problematic. One commentator reflected that ‘incumbent government parties have tended to misuse public resources in order to remain in power. As a result, most parliamentary and presidential elections have been orchestrated by the party in power with serious violations of campaign finance rules and questionable use of government functionaries and facilities, often including coercion, fraud and resulting in political violence.’ Consequently, prior to the June 1996 election, no sitting government had lost an election. The voter registration process has been described as ‘highly suspect’ and the violation of election laws as ‘common’ by those in power.

Divisive partisan politics have become the norm in democratic Bangladesh at a great cost to social stability. In 1989, there were 247 hartals (closing of offices, shops and blacking of streets due to political agitation) called by a spectrum of social and political groups. In 1996, 54 working days were lost due to hartals – approximately one quarter of the working year. According to Rashiduzzaman, the hartal, with its ‘uncompromising politics’, represents the ‘hollowness of conventional party politics in Bangladesh’ and undermines the constitutional process. In so far as ‘it is an open secret in Bangladesh that paid mercenaries, demonstrators and armed activists, hired by both the opposition and pro-government groups, make up the street mobs [hartals],’ few observers view them as a ‘healthy’ democratic response of a blossoming civil society.

Whatever the causes of the political culture of Bangladesh, donor governments have questioned the legitimacy of successive administrations. These questions have presumably coloured donor views with respect to: (1) the nature of accountability within government; (2) the relationship between the state and its citizenry; and (3) the conviction and vision applied by the government to economic and social development. In particular, the perceived lack of legitimacy may account for the low levels of trust and confidence placed by donors in the government, and predisposed external agencies to exercise great caution in the aid relationship.

Accountability and transparency

Inadequate accountability pervades government life in Bangladesh. Although democracy has in recent years provided a potentially important framework for enhancing accountability, in practice parliamentary accountability does not yet work very well. One of the problems relates to the concentration of power vested in the executive, while others arise from the non-observance of parliamentary norms and procedures, practical problems due to poor facilities, as well as those arising from political corruption.

Central to effective accountability is a robust system of financial control. In Bangladesh, financial monitoring of government activities rests with the Comptroller and Auditor General (CAG), whose office verifies all expenditure, including those externally financed, ex-post. The CAG is criticized as being unsatisfactory for a number of reasons: (1) inadequate skills (i.e. no chartered accountants on staff); (2) outmoded practices and foci (e.g. focus on compliance with GOB expenditure rules and procedures as opposed to value-for-money, or performance, audits); (3) dual responsibility for accounting and auditing which compromises the integrity of the office; and (4) long delays in issuing reports and following up on audit observations.

Donors, who require timely audited financial statements, were extremely critical of this aspect of government capacity, as delays beyond the covenanted agreements were common. For example, with respect to the First Population Project of the World Bank and its cofinanciers (1975–1982), the annual project accounts were reported as ‘always being late’ and financial statements had not been audited two years after the project closed. According to a World Bank report, the follow-on project fared no better: ‘GOB compliance with audit requirements are seriously lagging,’ and in 1987, audits for 1983/84 had still to be completed. Of greater long-term significance to donor confidence in GOB financial accountability was the fact that serious material audit objections were the norm. During the course of the World Bank/co-financer Third Population and Family Health Project (1986–92), a total of 907 observations were raised by the auditors, of which 97 were of a ‘serious material nature.’ These observations could take years to resolve. For example, although the Third Project closed in June 1992, by 1997 only 75 of the serious irregularities had been resolved. Once resolved, disciplinary action became impractical as the responsible officers had usually been transferred, which naturally further undermined donor confidence.

Completed questionnaires, fourteen from donors and eight from government, were analyzed.

Validation of the findings involved triangulation of sources and peer-checking. So as to ensure factual accuracy and to probe for biases and alternative interpretations, preliminary results were shared with stakeholders in the form of two draft reports.

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One of the criticisms of the CAG’s work is that it fails to undertake performance audits. Yet, this is not possible in Bangladesh because ministries and departments (other than the ministry of finance) do not specify key objectives, performance targets and prior year achievements which would allow for performance-based auditing. According to one study, when attempts are made, ‘the goals and objectives as set out in government documents are not clearly spelled out. Some items are so broadly or vaguely listed that it is not possible for anyone to discern what it is supposed to mean.’

Performance-based auditing is further constrained by weaknesses and peculiarities in the planning and budgeting processes which do not facilitate the link between objectives and expenditures.

Accountability is further eroded by the lack of transparency within government. Officials are bound by oath to rules that make it a criminal offence to disclose various types of information. One set of regulations forbids civil servants, unless authorized, ‘to disclose directly or indirectly to government servants belonging to sister organisations… the contents of any official document, or communicate any information which has come into his possession in the course of his official duties.’ Civil servants are further inhibited from information-sharing because: (1) they lack confidence in their decision-making capacities and thus operate according to a maximum safety rule; (2) they are unsure of their responsibilities and jurisdiction; and (3) information is viewed as an asset which may have a significant market value. As a result, the label ‘confidential’ or ‘restricted’ is applied to the most mundane of documents. Limited access to public documents by civil servants, donors and the general public, renders mundane of documents. Limited access to public documents by civil servants, donors and the general public, renders documentation of aid resources.

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Capacity

In the absence of effective and representative government, the civil service has entrenched itself as the nerve centre of the government. Studies of the bureaucracy’s capacity to make decisions, however, have criticized its processes as too slow, too unpredictable, too centralized, too secretive and too prone to rent-seeking. Such studies have provided empirical basis to the criticism, noting, for example, the excessively long time that is required to hire a consultant, procure a service, complete tendering processes, etc. Slippage is generally attributed to the proclivity of government officers to avoid decision-taking by passing matters ever upwards in the hierarchy. Poor decision-making has implications for the aid relationship, which include: (1) increased transaction costs; (2) delays in government project approvals; and (3) slippage in project execution and fund disbursement.

While government officials are maligned for their sloth and inefficiency, part of the problem rests with the system of human resource management in the public sector. Bureaucrats often lack knowledge and skills relevant to their substantive area of work, are unclear of their duties and responsibilities, and lack knowledge of the rules and procedures. Moreover, the service appears to offer few rewards for success and few penalties for failure. Pay in the civil service is low and has diminished substantially in real terms since independence. For example, in 1994 the basic salaries of Secretaries and Joint-Secretaries (the top-ranking civil servants) were US$250 and US$195 per month, respectively. Remuneration at the Secretary level has declined by 87% in real terms during the past 25 years. It is reasonable to expect that low and eroding salaries can at least in part account for low efficiency, low morale, absenteeism, rent-seeking and the deteriorating quality of new entrants into the systems. However, other aspects of human resource management are also likely to be at play.

Position descriptions do not exist and serious constraints are associated with performance evaluation and promotion. Although merit-based personnel rules do exist, they are routinely circumvented and ‘more often than not, certain individuals either with political connections or because of their closeness to the chief executive have been favoured, while those with proven competence were ignored when it came to deciding promotions.’ Another problem with human resource management concerns the area of specialist training. A random survey of personal data sheets concluded that training is not effectively employed. One of the cases of mis-utilization of training cited an officer who had received three graduate degrees in health service administration from different countries but his postings with 11 different departments had never included any that were health-related. Frequent transfers of senior officials between ministries and departments further impair the performance and accountability of the bureaucracy. One study found that only 10% of Deputy-, Joint- and Additional Secretaries complete two years in the same post, and that 80% of these officials stayed in the same post for a year or less. In the Ministry of Health and Family Welfare (MOHFW), the ‘permanent’ secretary was changed four times between 1992 and 1996.

Patronage and clientelism, the failure to apply criteria fairly in the appointment and promotion of civil servants, and the absence of esprit de corps have adversely affected the morale and efficiency of public servants, thereby eroding the performance of the public sector. Donors frequently blame weak personnel management for problems in project implementation and respond to this risk by establishing project implementation units with expatriate staff as well as locals who are not liable to work through normal channels of bureaucratic control.

Rent-seeking

Donor confidence in government is further undermined by their perception of corruption. According to Transparency International, ‘corruption is widespread in Bangladesh’ and ‘corrupt practices have become institutionalised’ in public office. Some of the findings of a national study of 620 households conducted by the national branch of the organization
provide an indication of the scale of corruption in Bangladesh. For example, 68% of complainants reported having made a payment to the police to file a complaint; 96% of respondents expressed the view that it was ‘almost impossible to get help from the police without money or influence’; more than three-fifths of those households involved in a court case reported bribing court officials, more than a quarter did so through their lawyer; almost 90% of respondents expressed the view that ‘it was almost impossible to get quick and fair judgement from the judiciary without money or influence’. Respondents also reported paying a variety of informal fees to get public services or to exempt themselves from paying the state sanctioned prices. For example, in the health sector, 20% of households who had frequented an out-patient department during the preceding year reported making extra-payment for services, while approximately one-third of those seeking in-patient treatment did so through some extra-normal process. Such figures were confirmed by a study carried out by the Ministry of Health, which found that some patients were paying ‘informal fees’ at a rate of 11 times the official cost in some facilities.35

There is a perception among some donor officials, who wished to remain anonymous, that the government is not only unable to provide effective leadership to aid coordination, but may also be unwilling to do so. It is argued that effective coordination, and the transparency it behoves, would reduce the room for political manoeuvring and, thereby, limit opportunities among civil servants for rent-seeking.

In summary, negative perceptions of government capacity and integrity provide the pretext for: (1) aid programmes which routinely circumvent government administration; (2) the establishment of parallel administrative and organizational structures within government to manage external resources; and (3) aid coordination arrangements which are externally-driven. Paradoxically, the dim view held by most donors of successive political and bureaucratic administrations within Bangladesh has not tempered their proclivity to internally-driven. Paradoxically, the dim view held by most donors of successive political and bureaucratic administrations within Bangladesh has not tempered their proclivity to externally-driven. Paradoxically, the dim view held by most donors of successive political and bureaucratic administrations within Bangladesh has not tempered their proclivity to externally-driven.

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Government’s machinery for aid coordination

The government has concluded that ‘in the absence of a well planned and systematic aid negotiation and coordination arrangement for the health and population sector, piecemeal aid allocation and donor pressure for assistance in particular areas have resulted in duplication of efforts in some areas and inadequate attention to other areas. ‘36 Problems with government-led coordination can be traced to weaknesses in policy and planning processes, and inadequacies in the institutional arrangements established to coordinate aid.

Policy frameworks may ideally provide a number of avenues through which aid can be better coordinated. Policies may be developed through consultative processes whereby consensus among stakeholders on priorities and goals emerge. They may be linked to decisions regarding aid allocation, and they may set out the instruments and institutional arrangements which governments and donors alike will employ to achieve the broad policy objectives. These ideals have not obtained in the health sector in Bangladesh. Despite numerous attempts, a well-articulated health policy has never been adopted. The absence of an over-arching health sector policy and, until very recently, an agreed strategic plan for the sector (1998–2003), provided donors and interested domestic parties with a virtual tabula rasa for project investment.

Where broad policies have been endorsed by the government, such as the population policy of 1976 and the recently introduced health and population sector strategy (HPSS), these have been largely driven by parties within the donor community. Consequently, shallow government commitment and ownership of these policies has limited the extent to which the government, and donors not party to the policy dialogue, are willing to deploy their resources with reference to these frameworks.

The planning process can, and should, provide the government with a powerful instrument through which to harness external resources in support of its policy objectives. In Bangladesh, the absence of a health sector policy elevates the potential role of the planning machinery in aid coordination even more. The government’s Planning Commission prepares the country’s development plans and, based on these, allocates resources among sectors and assesses aid requirements in consultation with the ERD and the line ministries. In addition, the Commission reviews all externally aided project proposals formulated by the line ministries, recommends allocation of funds to projects within each sector, and prepares a list of ‘aid worthy’ projects for presentation to the donor community.

A consensus appears to have emerged between donors and the Ministry of Health and Family Welfare that the Commission has yet to produce a sufficiently clear planning and expenditure framework to guide external investment in response to nationally defined priorities. Government officials expressed the unanimous view that the Commission was either irrelevant or inadequate in aid coordination in the health sector, a conviction shared by all but one donor. Part of the problem rests with the plans themselves, whose health sector chapters typically provide a generalized overview of sector issues, make references to the government’s commitment to the goal of ‘Health for All’ and then enumerate a lengthy ‘wish list’ of disparate and unlinked projects. The weakness of these plans stems partly from the limited capacity of the increasingly emasculated Commission and partly from its relative marginalization from developments at the sector level. Equally important is the distraction created by the excessive emphasis placed on project formulation and approval.

Donors also bear some responsibility for the absence of coherent, comprehensive and credible plans for the sector. It is apparent that, where donors have taken an interest in plan development, they have supported the MOHFW in playing a more prominent (although not necessarily substantive) role. However, this has been limited to planning donor-driven initiatives as opposed to making a greater contribution to the
government’s long-established planning instruments. While this recently included the health and population sector strategy, which attempted to encompass all the activities under the purview of the MOHFW, the tendency has been to use scarce ministry capacity to formulate individually aided projects. For example, the proposed health and family welfare programme for the fourth Five-Year Plan (1990–1995) consisted of 211 distinct projects. These investments have been made in an ad hoc manner in accordance with interested party priorities, not necessarily with reference to any agreed overall set of priorities nor appraised in relation to other actual or anticipated spending plans.

In general, the government-led planning machinery has not proven effective at coordinating and managing aid because: (1) it places excessive emphasis on project formulation and approval to the detriment of sector planning; (2) there exists an inability, or unwillingness, on the part of high-level decision-makers to delegate lower-level decisions to lower-level managers, which results in the former being preoccupied with routine tasks at the expense of strategic planning; (3) at the sector level, planning skills are in short supply, inadequately developed, and overwhelmed by the exigencies of project processing and administrative demands (the latter often reinforced by the incessant demands of donors for expediting the implementation of their projects or disbursement of their funds). In addition, there is reason to believe that strong donor involvement in micro-planning (e.g. relying on expatriate technical assistance to design projects in response to donor perceived needs) may have weakened the credibility of plans within government circles. GOB officials view planning as an exercise undertaken for donors rather than for developmental purposes.

The inadequacies of the government’s processes for aid coordination are mirrored in the weaknesses of the national institutions. Again, some donors’ working practices often reinforce these limitations. The department with formal responsibility for aid coordination is the Economic Relations Division (ERD) of the Ministry of Finance. Its responsibilities involve liaising, mobilizing and negotiating aid flows with donors so as to ensure that these are provided on terms that are in the best interests of the economy. The extent to which the ERD is involved in sector-level aid coordination is, however, minimal. In the study’s survey, the ERD was thought to perform an adequate function with respect to health sector aid coordination by only two of the nine donor respondents and none of the government officials. This was the case, it was argued, for two reasons. First, in that its organizational structure corresponds to the source of external funds, as opposed to line ministry functions, knowledge of sector needs and priorities within the Division is poor. The limited understanding and oversight of the sector constrains the ERD’s ability to assist the MOHFW in harnessing aid in support of a sectoral strategy. Second, ERD’s aim of maximizing aid flows has predisposed it to supporting all external investment regardless of whether or not it might be duplicative of other assistance.

Wide-spread support is extended publicly by both donors and government officials to the establishment of a government-led, government-donor, apex body for aid coordination in the health sector. Attempts were made during 1997 to merge three high-level bodies in the health sector into an over-arching consultative committee. However, progress was not recorded because, according to Bank staff, other higher order priorities prevailed. It is perhaps more accurate to suggest that the parties with the influence to merge the committees (i.e. the Bank and the GOB) lacked the interest to do so.

Some culpability for the relative absence of GOB leadership, and the weakness of its institutions, in aid management rests with donors themselves. As noted by a Swedish evaluation of its aid to Bangladesh, including the World Bank/cofinancier FPHP: ‘With programmes of this size, it is rather self-evident that the government’s coordinating role falls victim to interests of efficiency. The nature of the programmes as gigantic by-pass operations, set to avoid the negative influence of the bureaucracy, tends to be perpetuated.’ The situation is exacerbated by the practices of the aid agencies. For example, donors have a proclivity to operate behind closed doors, to inundate government officials with foreign visitors and other demands, to induce confusion through a constant barrage of contradictory policy prescriptions, and perhaps most importantly, to orient the development agenda towards external priorities, thereby weakening domestic ownership and support of it.

Green pastures for development cowboys: health needs and donor interests

‘The problem is one of too many lollies. The government behaves like a child. We, the donors, act like aunts and uncles. Its hands are full; yet we compete to push more of our own lollies, and it keeps trying to grasp them.’ (Senior representative of a multilateral agency)

In 1972, shortly after Bangladesh gained its independence through a bloody war of succession, Henry Kissinger was falsely attributed with referring to the country as an ‘international basket case’. Nevertheless, despite such sentiments, others felt that the case for humanitarian assistance was overwhelming. As a result, ‘Bangladesh was treated with unparalleled generosity’ and by March 1973, when the initial UN relief operation wound up, more than US$ 1300 million worth of external assistance had been mobilized (in 1973 prices). By the 1990s, the case for developmental assistance remained just as convincing. The scale of the country’s poverty, inequality, low educational attainment, malnutrition, ill health and natural disasters is public knowledge. Consequently, Bangladesh remains a priority recipient of aid. During the 1990s, annual aid commitments fluctuated between US$ 1.5 and 2.4 billion, disbursements between US$ 1.2 and 2.1 billion, and the pipeline has always contained more than US$ 5 billion.

Total expenditure in the health and population sector was estimated at US$ 855 million (fiscal year 1994/95) or approximately US$ 7.1 per capita (not including food and commodity aid contributions). Of this amount, approximately 47% was accounted for by household out-of-pocket expenditure, while the national treasury contributed 27%, and donors the
remaining 26%. The country’s budget is separated into development and recurrent expenditure, with the former heavily dependent on external finance. In 1993/94, 69% and 52% of development expenditure in the population and health budgets respectively was supported by aid.44

**Donor involvement in the health sector**

Donors took an early and intense interest in the country’s population sector. In fact, they were so worried about the consequences of population growth that in early 1974 UNFPA wrote ‘there are so many external organisations involved in the family planning programme in Bangladesh that it is almost impossible to give a complete picture of external assistance available to the government in this sector over the next three to four years.’45 At about the same time, the World Bank noted the significant level of funds available for population in Bangladesh which were ‘far in excess of specific projects,’46 as did a German mission.47 Even the government, which was facing a balance of payments crisis in 1973, asked that certain donors, which were interested in investing in the population programme, refrain from doing so.48 So keen were the donors to address the population issue that repeated promises were made by high-level World Bank officials to the GOB that its population programme would never be short of external funding.49 By the 1980s, most donors had broadened their interest in the sector to encompass health-related activities, particularly MCH (maternal and child health) and child survival interventions, although their motivations to do so often lay in demographic goals.50 By the early 1990s, the portfolio of donor involvement in the health sector reflected global concern with health sector reform and, therefore, included human resource planning, institutional reorganization, resource allocation according to evidenced-based analysis and financing mechanisms.51

The sector is today crowded with donor agencies; with at least 13 multilateral and 18 bilateral organizations committing funds to the Ministry of Health and Family Welfare (MOHFW) between 1992–1996 for operational activities in the sector (these are listed in Table 1). It is estimated that there are also over 400 NGOs active in the health sector. As noted above, aid is deployed through a proliferation of projects – the appraisal, disbursement, procurement, reporting, accounting and auditing of which is often undertaken through dedicated bilateral arrangements between the donor and the ministry. This permits donors to maintain some degree of control over the uses to which aid is put but does not facilitate the harmonization of donors’ procedures nor their use of common management arrangements embedded in the administrative machinery of government. Moreover, for most of these projects, donors establish project implementation units which are headed by Directors appointed for the duration of the project, generally from outside of the ministry, thus blurring lines of accountability, authority and coordination within the ministry.

Some efforts have been made to coordinate activities around government programmes. However, due to the project approach to aid, these coordination arrangements can themselves be competitive and duplicative. For example, in the early 1990s there was an MCH coordination cell in the MOHFW, an MCH Working Group set up by the National Steering Committee on Future Challenges (a USAID driven

**Aid coordination and the World Bank-led donor consortium: an adequate corral?**

Despite the number of donors and the significant share of aid in the health budget, there are relatively few formal

| Table 1. Donors having committed or disbursed funds to the MOHFW between 1992–96 (in alphabetical order) |
| Donor countries/ Bilateral agencies | Multilateral agencies |
| 1. Australia’s AusAid | 1. ADB |
| 2. Belgium’s BADC | 2. EEC |
| 3. Canada’s CIDA | 3. IDA |
| 4. China | 4. IDB |
| 5. Denmark’s DANIDA | 5. ILO |
| 6. Netherlands’s DGIS | 6. OPEC |
| 7. France | 7. UNAIDS |
| 8. Germany’s GTZ | 8. UNCDF |
| 9. Italy | 9. UNDP |
| 10. Japan’s JICA | 10. UNESCO |
| 11. Germany’s KfW | 11. UNFPA |
| 12. Norway’s NORAD | 12. UNICEF |
| 13. United Kingdom’s ODA/DFID | 13. WHO |
| 14. Saudi Fund | |
| 15. Switzerland’s SDC | |
| 16. Sweden’s Sida/SIDA | |
| 17. South Korea | |
| 18. USA’s USAID | |

| Table 2. Approximate annual commitments of major donors to the MOHFW (1992–96) |
| Donor | US$ commitment per annum |
| World Bank and cofinanciers of FPHP | 78 million |
| USAID | 30 million |
| UNICEF | 14 million |
| ADB | 10 million |
| UNFPA | 6 million |
| WHO | 5 million |
group), an MCH Coordination Group set up by UNICEF, and an MCH Forum organized by UNFPA. These were not only overlapping in function, but many comprised a similar membership.

During the 1990s, a number of global initiatives of the UN to promote enhanced coordination of its organs at the country-level have been introduced in Bangladesh under the aegis of the Resident Coordinator System. While these tools provide, to varying degrees, a measure of increased consultation and concertation amongst the UN organizations, they remain constrained by a host of factors. These can be traced to the fact that the Resident Coordinator lacks adequate authority in a resource-starved system in which participation remains essentially voluntary. Notwithstanding the general weaknesses of the system, its instruments were not designed, nor do they appear to have been adapted, to facilitate coordination of activities at the sector level: they focus on macro- and inter-sectoral issues and are therefore too blunt. The UN agencies involved in the health sector have not pursued coordination through adaptations of the system’s tools, primarily, it would appear, because of competition among them for leadership, resources and visibility.

The most prominent donor coordination arrangement in the sector is the World Bank-led Health and Population Consortium, which evolved out of the First Population Project of the Bank in 1975. The recently concluded Fourth Population and Health Project involved the collective financial resources of nine bilateral agencies, the World Bank and the government; estimated at US$ 781 million over a six-year period (1992–98). This represented approximately 35% of aid in the sector. An impressive project support unit, run by the Bank (consisting of 11 professional staff in 1997) but supported by all consortium donors, was established to coordinate and monitor the projects. Responsibilities entrusted to the unit included leading regular meetings and missions of consortium members, representing the collective views of the consortium to government, and providing services such as fund disbursement and expenditure reporting.

Despite criticisms, the consortium has been successful in achieving the tasks set out for it and has provided a significant measure of coordination to a proportion of aid provided by a subset of actors in the sector. This includes some use of harmonized procedures (i.e. joint project appraisal and monitoring) and the use of some common management systems established or pre-existing in government (i.e. project finance cell and audit office). The consortium, however, does not and can not provide comprehensive aid coordination for the sector; this is not its brief. A significant failing has been the extent to which it has usurped, rather than reinforced, many aid coordination and management functions of the government, and that it has not included government in its regular meetings. Moreover many donors, although invited to join the consortium, have refrained from doing so. They provided a range of reasons (see Box 1) for their hesitation, but the major underlying and unstated reason is arguably that coordination is seen to be used as a covert means to exercise dominance over other actors and over the development agenda. Consequently, the resources of major donors, including USAID, ADB, UNICEF, WHO and UNFPA, were not harnessed by this coordination tool.

Prospects for government leadership under a sector-wide approach

In 1995, the World Bank wrote to its consortium partners ‘wondering if it would make sense to consider more a program approach’ in any follow-on project. Despite the nomenclature, what was envisioned was essentially a sector-wide approach (SWAp):

‘Under such an approach, we would reach agreement with government on the whole program of the MOHFW – broad priorities and strategies, annual operational plans and policies, and annual expenditure programs and financing. This agreement would provide a framework within which donors would offer assistance according to their interests. This assistance could take the form of focused projects or of time-slice (or program) finance, to help cover whatever the focused projects do not, in a flexible manner.’ The Bank became the leading advocate of a SWAp. It began pressing the MOHFW to develop the aforementioned health

<table>
<thead>
<tr>
<th>Box 1.</th>
<th>Reasons advanced by donors for not joining the donor consortium</th>
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<tbody>
<tr>
<td>1.</td>
<td>Membership would reduce agency’s visibility.</td>
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<td>2.</td>
<td>Membership would reduce agency’s autonomy in decision-making.</td>
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<td>3.</td>
<td>Agency’s resources too insignificant to influence decisions in the consortium.</td>
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<td>4.</td>
<td>Membership would reduce agency’s access to senior government officials.</td>
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<td>5.</td>
<td>Agency dissatisfied with decision-making style in the consortium.</td>
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<td>6.</td>
<td>Agency dissatisfied with policy decisions taken by the consortium.</td>
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<td>7.</td>
<td>Agency concerned that World Bank uses leadership to advance its corporate agenda.</td>
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<td>8.</td>
<td>Concern that membership would reduce plurality of views in the sector.</td>
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<td>9.</td>
<td>Concern that the consortium devotes inadequate attention to NGO and private sectors.</td>
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<td>10.</td>
<td>Agency unable to fund and execute favoured project sub-components.</td>
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<td>11.</td>
<td>Agency sufficiently influential to effect policy agenda without need to join consortium.</td>
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<td>12.</td>
<td>Due to proclivities of agency staff.</td>
</tr>
<tr>
<td>13.</td>
<td>Due to legal, administrative and/or accountability reasons.</td>
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<tr>
<td>14.</td>
<td>Agency dissuaded from joining due to potential impact on dynamics within consortium.</td>
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<tr>
<td>15.</td>
<td>For reasons not associated with functioning of the consortium (i.e. change of government).</td>
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</table>
and population sector strategy (HPSS) and later a Programme Implementation Plan (PIP) covering all expenditures in the sector under the purview of the ministry for a five-year period. It made the adoption of the HPSS a condition for pre-appraisal, and the PIP for negotiations of the follow-on project of the consortium. Although limited, the participatory nature of the preparation of these two documents provided a valuable process through which government and donor priorities and strategies were made explicit and a level of agreement on these was reached. While marking a feat in the context of Bangladesh, the achievement was tempered by the fact that numerous donor agencies, as well as government officials, were concerned that they may not agree with the strategic framework and did not have enough say in its development. Moreover, the government was concerned that unprecedented levels of donor coordination may result in undue leverage exerted by donors over policy direction and resource allocation.

The PIP includes expenditure plans which provide an umbrella framework to guide all external investment in the sector under the purview of the MOHFW. However, many donors indicated that they wish to retain the right to operate outside of this framework and would do so in practice. The government also indicated its preference for a flexible approach to working outside of the agreed public expenditure plans so as to accommodate ‘political’ projects.

The SWAp in Bangladesh makes provisions for, and aspires to, the use of common management arrangements for resource deployment. While government, and to a lesser extent aid, officials described this as desirable, many donors indicate that they will continue to rely on separate management arrangements. They will do so because they are concerned about attribution, accountability and government capacity to manage these systems.

It would, therefore, appear that while the SWAp has benefited the cause of health sector aid coordination by bringing attention to certain failings and possibilities with respect to prevailing arrangements, over the short-term, it may not fulfill its potential. This is the case because too few stakeholders wish to be bound by its instruments, either because they are concerned that the government lacks the capacity to manage the SWAp adequately or because the SWAp is seen to divest the agencies of their autonomy.

Conclusions

Donor perceptions of successive administrations as weak, illegitimate and corrupt have influenced their thinking in relation to the desirability and feasibility of relinquishing leadership in the management and coordination of aid to government. In the same vein, these factors provide a pretext for some donors to continue to contravene their stated commitment to ensuring that the government takes a leading role in this area. Donor ambivalence towards coordination may not be solely attributable to duplicity, but may in part stem from the manner in which coordination is rightly viewed; namely as a powerful tool with which to exercise leverage over the development process. This consideration fuels the desire of stakeholders to lead the coordination process and conditions the extent to, and manner by, which they wish to be involved (or not) in various coordination arrangements.

Donor concerns regarding inadequate accountability and capacity are justifiable and the characteristic response, to set up parallel administrative systems, is understandable. Circumventing government addresses the immediate problem and also presents two beneficial spin-offs: home country consultants and staff can be hired to meet tied-aid requirements; and it facilitates the attribution of specific achievements to donor expenditures. Parallel, bilateral modes of interaction between the donors and their project counterparts have, however, become entrenched at the expense of sustainable, coordinated, collective action under the aegis of the government.

The solution appears to lie in the time-consuming process of augmenting the capacity and systems of government until they are sufficiently robust that they not only enjoy donor confidence, but also fail to provide an excuse for their circumvention. In this regard, partial progress is in hand. As noted above, under the Fourth Population and Health Project, donors have begun to strengthen and make greater use of some governmental systems. The SWAp has built upon this precedent, particularly in the area of joint donor–government planning (albeit not through the Planning Commission) as well as the commitment to provide some aid in the form of budget support and to make greater use of the ministry’s administrative and managerial machinery.

Experience with the design of the SWAp, however, points to a number of challenges that remain. For one, where the government is not seen to be truly in the lead on articulating activity and financing plans, it and other external financiers will justifiably continue to operate outside of these donor-inspired frameworks. Clearly, greater emphasis must be placed on developing more consultative processes through which all stakeholders can participate in framing policies and plans for the sector. If this can be achieved, novel approaches to ensuring that external resources are deployed within these frameworks must be sought, including consideration of incentives and sanctions. In light of government and donor practices over the past quarter century, ‘loosening the reins’ will require a very different approach by both parties to development cooperation.

Endnotes

1 This paper is based on findings from a study of health sector aid coordination in Bangladesh (1973–1997) carried out in 1996 and 1997, thus all statements refer to this period.
2 The study focused on multilateral and bilateral agencies to the exclusion of non-governmental organizations.
3 These are indicative figures derived by dividing the amount of the agency’s approximate programme commitment by the number of years of the programme period.
4 The Fourth Population and Health Project cofinanciers were AusAID, CIDA, DOIS, EEC, GTZ, KfW, NORAD, ODA and Sida.
5 The Ford Foundation, the Population Council, the Government of New Zealand, SDC, UNFPA, UNICEF and USAID.
6 These include ADB, BAD, DANIDA, FINNIDA, the Ford Foundation, the Population Council, the Government of New Zealand, SDC, UNFPA, UNICEF and USAID.
vi Time-slice finance is synonymous with direct re-imbursable budget-support.

References

38 Interview with multilateral agency chief of mission in Dhaka who wished to remain anonymous. Dhaka, 1996.
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Biography

Kent Buse is an independent consultant, trained in political economy, policy analysis, epidemiology and health planning and financing. His current research interests lie in the health policy process. In particular, he has been exploring the role of international organizations in the health policy process in countries and low- and lower-middle income as well as aid coordination and management and its integration into policy processes at the national level. He has published on child rights, health financing, the World Bank, aid coordination, and globalization.

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