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POWER OR EMPOWERMENT? AN EXPLORATORY STUDY OF THE FUNDING OF ZAMBIA HEALTH SECTOR

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ABSTRACT

The purpose of this paper is to explore the influence of donor funding practices on the design of health programmes and health service delivery within Zambia's health sector. Drawing on Bourdieu's theory of capital and Freeman's stakeholder theory, the study explores power structures surrounding the design, funding and implementation of health programmes in an attempt to better understand the role of donor organisations on health service delivery. Guided by a qualitative research approach through semi-structured interviews and content analysis, the study provides important insights regarding the impact of donor influence on Zambia's health sector performance. The paradoxical nature of these findings suggests that despite the good intentions exhibited by donor organisations to empower health service delivery through funding activities, the exercise of power and influence in terms of resource allocation structures may require some balancing to ensure that the needs of other stakeholders are equally fulfilled.

Keywords: Healthcare, Bourdieu's theory, Freeman's stakeholder theory Stakeholders, Zambia.

1. INTRODUCTION

Donor funding structures and practices have often been questioned in a number of least developed countries (LDCs) as to whether they are aimed at empowering local masses or are meant to be instruments of power intended to elevate the interests of economically elite at the expense of the social needs of the less privileged (Annisette, 2004; Jayasinghe and Wickramasinghe, 2011). Consistent with the experiences of many LDCs, healthcare financing has been Zambia's core challenge for improving the performance of the health sector. Almost entirely dependent on internal income in form of tax revenues, government health funding remains considerably below the 15 per cent of the national budget as recommended by the Abuja and Maputo Declarations (OAU, 2001) – with only 9.9 per cent allocated to health in the 2014 national budget (Ministry of Finance, 2013).

In an effort to address this funding challenge, government has had to turn to donors for a helping hand over a long period now. To date, donors contribute over 40 per cent towards total healthcare expenditure. However, most donor funding has been channelled into vertical

projects that often exclude the involvement of government agencies. This practice is believed to arise from concerns by the donor community with weaknesses in local accounting and accountability systems (Ministry of Health and World Bank, 2010. Instances of alleged abuse of donor resources have led to the suspension of donor funding in the recent past pending assurances from government to enhance accounting and control systems (Usher, 2010). The practice of vertical funding is also defended on the rationale that it provides guarantees of funding to important sectors and disease areas in times of economic and budgetary fluctuations as politicians may try to divert pooled resources to politically important areas (Adugna, 2009). A considerable amount of such projects have often bypassed government structures and implemented directly through Non-Governmental Organisations (NGOs).

Conversely, concern has been raised by governments in developing economies over the lack of flexibility, reliability and predictability of donor funding and the integration of vertical programmes into the mainstream health system (Powell-Jackson and Mills, 2007; Ministry of Health, 2012). Conditions attached to most donor funds are also considered to create uncertainties in the delivery of health services. Further, this programme fragmentation often means that busy government officials may not have sufficient time to deal with the planning, monitoring, accounting and evaluation of such projects. The proliferation of programmes is considered by some as compromising the very institutional capacity donor aid purports to build (Cassels and Janovsky, 1998). Attempts have been made on international arenas to address this trend through introducing the concept of Sector Wide Approach to funding (SWAp) in line with guidance provided by the Paris Declaration on Aid Effectiveness (OECD, 2005a). While SWAp seems to provide a remedy to the problem of parallel projects, bilateral and multilateral donors appear to favour project funding that they consider politically safe since such projects provide a better accountability platform for tracking resources. Although Cassels and Janovsky (1998) consider that donor health projects are by no means unsuccessful, others believe that vertical funding approaches reflect donor preferences, power and influence (Shiffman, 2006; MacKellar, 2005) and consequently fail to address the priority health needs of local populations.

However, this position has received little attention in the development literature in terms of theoretical constructions of power and influence on government activities in less developed economies. It is the intention of this paper to investigate this phenomenon by exploring the role of donor funding on health service delivery within Zambia's health sector. The study further seeks to explore how the funding of vertical projects, as a reflection of donor power and influence, may compromise the needs of other stakeholders and how potential contradictions may affect healthcare performance. The rest of the paper proceeds as follows: A review of the literature is presented in the next section before the framework for analysis is discussed. Section 4 presents an overview of Zambia's healthcare policy while the research method is presented in section 5. Findings are presented in section 6 and the paper concludes with a discussion and conclusion.

2. AN OVERVIEW OF SELECTED HEALTH SERVICES LITERATURE

A growing body of literature suggests that most donor health funding in LDCs comes in form of projects/programmes (Cassels and Janovsky, 1998) and is usually aimed at addressing specific diseases or disease groups (World Health Organisation [WHO], 2007) that are considered as top priorities by particular donors (Adugna, 2009). This position is in conformity with recent trends that have become particularly pronounced with the advent of the United Nations' Millennium Declaration in its pursuit of Millennium Development Goals (MDGs) (United Nations, 2000). More often than not, such health initiatives have been implemented based on the priorities set by donor organisations that may not be in harmony with the goals of local policy makers (OECD, 2005a; Shiffman, 2006). While this goal incongruence is no longer a secret among policy makers, it is believed that governments in

developing countries accept such aid on the premise that donors subsidise the cost of running such programmes (Waddington, 2004).

Data from both the Organisation for Economic Cooperation and Development (OECD) and International Development Association sources indicate that earmarked foreign aid has been on the increase from the late 1990s to the late 2000s (OECD, 2005b). Despite the diversity of potential explanations for this trend, Shiffman (2006) has proposed three motives that attempt to explain donor funding practices as a reflection of their power and influence: a *recipient need* motive, a *provider interest* motive, and a *global policy* motive. A recipient need donor motive emerges from the desire to address health problems with the most adverse effects on local populations. This motive may be based on the burden of the disease, its speed of spread or the level of threat it poses. The motive may explain the huge investment that has gone and continues to go towards HIV/AIDS programmes (Waddington, 2004; Adugna, 2009) to reflect donor choices.

A provider interest donor motive is driven by the paramount interests and priorities of resource owners in developed countries who may wish to create visibility of such projects for continued funding (Cassels and Janovsky, 1998; Adugna, 2009). Donors are often coerced into making certain priorities because political elites consider those diseases to be a threat to their own countries. For instance, the potential spread of HIV/AIDS from poor countries to rich countries may likely have influenced developed economies to prioritise programmes targeting the control of HIV/AIDS. The approach is deemed to be politically appealing since donors attach their flagship to the initiative and get associated with subsequent successes. Diseases may also be prioritised if they represent a profit potential for pharmaceutical companies from donor countries dealing with that disease (Shiffman, 2006).

On the other hand, a global policy motive assumes that donor funding is influenced by the orientation of powerful global organisations like the UN, WHO, World Bank and other philanthropists. While not reflecting national priorities of home countries, donors are inclined to harmonise their funding structures with the perspectives of global leaders in order not to be seen as left behind. For instance, the UN's Millennium Declaration and its MDGs entail that donors have had to focus on the identified key areas of child and maternal health, particularly through addressing the spread of HIV/AIDS and malaria (Cassels and Janovsky, 1998; Shiffman, 2006). Public accountability has also emerged as an alternative explanation towards vertical projects. The rationale becomes increasingly pronounced in view of escalating reports of misappropriation of donor funds in a number of developing countries (Usher, 2010). The need to accelerate the attainment of MDGs is believed to have aggravated the pressure on financial accountability as donors seek to justify the outcomes of their funding (Powell-Jackson and Mills, 2007). In order to explore these dimensions, the conceptual framework is presented below and will be drawn upon in later sections for discussing findings from the field.

3. THEORETICAL FRAMEWORK

This study draws on Bourdieu's (1986) theory of capital and Freeman's (1984) stakeholder theory as suitable analytical lenses to inform a conceptual framework for understanding the role of donor organisations and their practices within Zambia's health sector. Bourdieu's (1986) theory perceives capital as any resource effective in a given social setting that enables one to appropriate specific benefits and participation and to acquire positions in society. For Bourdieu, capital manifests in three principal forms: economic capital as reflected by material and financial assets, cultural capital as exhibited by scarce symbolic goods, skills and titles, and social capital that is manifested by resources accrued as a result of membership in a group. Regarding social capital, the association with the group provides members with the backing of the collectively-owned capital. The network of connections within the group is perceived to be a product of investment aimed at establishing or reproducing social relationships that are directly usable in the long or short term (Friedland,

2009). The notion of capital helps to render institutional analyses more sensitive to the structuring of power relations and how the identities of actors in organisational fields take shape. The concepts of capital and organisational fields are also useful in delineating the macro-level processes involved in structuring power relations and evolving practices (e.g. Lounsbury, 2008; Modell, 2015).

However, Bourdieu (1986) suggests a fourth type of capital which he terms 'symbolic capital' to designate the effects of any form of capital when people don't perceive them as such. An example of symbolic capital is when society attributes lofty moral qualities to members of the upper class as a result of their donation of time and financial resources to charity within their habitus. While the other forms of capital are equally relevant, symbolic capital forms the basis of this study's conceptual framework to inform the analysis in subsequent sections in terms of how donor resources produce symbolic images of power and influence. Symbolic capital is also regarded in terms of the prestige and renown attached to donor organisations that can be readily converted back into economic capital for exercising domination, power and influence (Bourdieu and Wacquant, 1992). Public institutional fields are increasingly perceived as evolving networks of social relations in which struggles for power and domination are played out by specific actors of influence (Dobbin, 2008; Emirbayer and Johnson, 2008). Accordingly, it is considered that agents who are in a position to command and appropriate material and symbolic resources are able to dispense with strategies aimed expressly and directly at the domination of individuals, organisations, institutions and society at large.

In order to have a more coherent framework, the study blends Bourdieu's theory with stakeholder theory. Stakeholder theory contends that institutional and organisational actors have a moral obligation to consider and appropriately balance the interests of all stakeholders' present within a certain habitus (Freeman, 1984). While stakeholder theory provides a dominant paradigm within corporate organisations, perspectives within public services suggest that the effective application of power and influence needs not only satisfy taxpayers and fund providers (Gomes, 2006) but also take into account the needs of diverse stakeholder groups including employees, communities, suppliers and consumers of goods and services (Heath and Norman, 2004). In situations where stakeholder interests conflict, the demands and interests of all stakeholders need to be moderated or sacrificed in order to fulfil basic obligations to other stakeholders. This is particularly true within donor-funded economies where donor demands and priorities may not necessarily be in harmony with the needs of local populations. This study draws on the descriptive perspective of stakeholder theory (Jawahar and McLaughlin, 2001; Orij, 2010) in order to explicate how actors within the health sector require not only conformance to donor power and influence but are also expected to respond to the health needs of local masses.

4. METHODS AND MATERIALS

This study adopted an interpretive research approach that helped to understand the multi-faceted and subjective nature of social phenomena under study. The research design places emphasis on perspectives that different stakeholders attach to social phenomena and entails a highly contextualised and time specific analysis of how actors understand phenomena within particular settings (Ahrens, 2008). Such an interpretive approach possesses not only the ability to generate subjectivist and emic understandings of different actors' meanings of concepts but also the sequence of events in local settings in order to understand relationships between phenomena (Lukka and Modell, 2010). A qualitative approach that is consistent with interpretive research was adopted to provide for a deeper understanding of practice in terms of how these are socially constructed by individual and collective human actors (Vaivio, 2008; Ahrens and Chapman, 2006). In an effort to unravel the dynamics involved in the funding and implementation of health programmes, a purposive sampling approach was adopted that

helped to ensure that respondents with relevant experience were consulted. Accordingly, empirical data was collected through semi-structured interviews with respondents that included five (5) legislators (members of the Parliamentary Committee on Health), six (6) policy makers from the Ministry of Health (MoH) headquarters, six (6) health service regulators, eight (8) healthcare professionals and eight (8) healthcare managers. These respondents were chosen based on their suitability with the research questions being explored since they form part of the health service supply chain (Modell, 2001) in the course of designing, implementing and managing donor-funded projects.

Legislators and policy makers interact with donor organisations during funding negotiations, policy formulation and health programme design. Legislators also provide an oversight role on the activities of the MoH to ensure that their activities conform to public expectations of health service delivery. On the other hand, healthcare professionals and managers are involved in design processes and management of healthcare services. Regulators monitor the performance of healthcare professionals to determine their compliance with healthcare standards in meeting the health needs of the population. Therefore, all selected respondents have substantial experience in dealing with processes surrounding the design, implementation and monitoring of donor-funded projects (Modell, 2003) and how these affect the performance of the health sector. Conducted between January and October 2013, most of these interviews lasted an average of one hour. All interviews were conducted in English and guided by a semi-structured questionnaire containing questions dealing with the context, content and the process of designing, implementing and managing donor-funded health programmes. Audio recordings were later transcribed and read through several times to validate the transcript content. Primary interview accounts were complimented by documental evidence based on policy, planning, monitoring and review reports sourced from the MoH Headquarters. Included among these documents are the *National Health Strategic Plan* (MoH, 2011), the *National Health Policy* (MoH, 2013), the *2010 Country Health Status Report* (MoH and World Bank, 2010), the *Sixth National Development Plan* and the *Vision 2030* (Republic of Zambia, 2006, 2011). These documents contain information on Zambia's healthcare funding and performance frameworks, the definition of health policy, plans and goals together with programme design, review and monitoring mechanisms. Thus, these documents offered a useful source of archival data that was used to triangulate primary accounts emerging from interviews with respondents.

Interview transcripts were subsequently subjected to content analysis. This entailed coding the data based on recurring themes that were deemed to address the study's research questions. Data analysis was conducted based on stakeholder perspectives in order to compare and contrast the experiences of different stakeholders in their interactions with donor agencies. Such an inductive approach also enabled the researcher to identify patterns of experiences, similarities and differences, and linkages between these patterns. This analytical process was equally useful in the effort of triangulating interview accounts with archival evidence.

5. RESULTS AND DISCUSSIONS

5.1 Overview of Zambia's Health Policy

The overarching aim of Zambia's health policy is "to reduce the burden of disease, maternal and infant mortality and increase life expectancy through the provision of a continuum of quality cost effective healthcare services as close to the family as possible in a competent, clean and caring manner" (MoH, 2013, p. 23). To achieve this aim, the performance of the health sector is determined and monitored mainly at two levels – the national level and health facility level. Performance at the national level carries a macro perspective based purely on quantitative key performance indicators intended to reflect the health impact, outcomes, outputs and inputs (MoH, 2011). However, performance at the facility level remains a hazy

area but embraces a mix of indicators with an emphasis on health service delivery. On the one hand, performance in the NHSP 2011 – 2015 is said to be analysed using the health system approach based on the WHO's health system building blocks. On the other hand, quantitative facility level performance is routinely reported on a quarterly basis using the health management information system (HMIS) which contains largely qualitative measures for reporting health service delivery.

A variety of plans and frameworks have been adopted and developed to strategically guide and support the performance of Zambia's health sector. Notable among these are local frameworks that include the overall V2030, the SNDP and the NHSP. The UN's Millennium Declaration that embraces MDGs, the Abuja Declaration and the Paris Declaration on Aid Effectiveness are the main international frameworks influencing healthcare performance in Zambia. While the purpose of the V2030 is to transform Zambia into a thriving middle-income economy by the year 2030, the SNDP is aimed at achieving sustained economic growth and poverty reduction (Republic of Zambia, 2006, 2011). The NHSP 2011 – 2015, developed within the context of the national development agenda and forming part of the SNDP, has been crafted with the vision oriented towards the attainment of health-related MDGs and other health priorities in a clean, caring and competent environment (MoH, 2011). As a UN initiative, the Millennium Declaration has the main objective of reducing poverty and fostering development and health improvement among LDCs (UN, 2000).

Whereas the Abuja Declaration was intended to address the exceptional challenges of HIV/AIDS and malaria and increase healthcare funding (OAU, 2001), the Paris Declaration on Aid Effectiveness aims at promoting the effectiveness of donor aid (OECD, 2005b). However, the NHSP 2011 – 2015 and the Millennium Declaration are the main frameworks that provide guidelines and impetus on health programmes and performance targets at the national level.

5.2 Research Results

This section presents results regarding the role and effect of donor funding on health service delivery in Zambia together with potential explanations for this trend from the perspectives of local healthcare stakeholders. These findings highlight contentions surrounding the design and implementation of vertical donor programmes and how these practices affect the performance and impact of health programmes. The ensuing findings are presented based on two broad themes that have emerged from the data.

(a) Contradictory Use of Power and Influence by Donor Organisations

Interview accounts demonstrate that goal incongruence has emerged due to the power and influence of donors, also called cooperating partners (CPs) who fund most health programmes based on their own identified priorities. A legislator who is also a former Minister of Health who interacted closely with CPs had an elaborate picture concerning programme fragmentation and the mismatch in priorities between government and donors. He reflected on instances where CPs even bypassed government structures and worked directly with NGOs in the course of implementing health programmes.

> "Many times in developing countries these guys [CPs] have come to say, 'We've got a pot of money for HIV and AIDS', the other one [says] 'Malaria', the other says, 'Oh, I'm concerned with diarrhoeal diseases so money for water and sanitation'. And they say, 'We are accountable to our governments for these donor funds, here is how the programme should be done'…And worse still when these projects ended they had

> not been integrated into the main health system, so the results ended being in reversal…"

These sentiments were echoed by a Principal Planner in charge of budgeting who reiterated that despite efforts by government to encourage budgetary support and pooled funding, some donors had continued with parallel funding.

> Programmatic funding or vertical programmes or parallel programmes is the situation where money is given through certain programmes – it could be earmarked for T.B., HIV/AIDS or malaria. Alternatively, it could be given and it goes directly to the NGO and this NGO takes it to the province, district or directly to the health facility. That's not the way it should be encouraged…But there are certain partners who prefer to fund like that due to their own different reasons.

The disease-specific approach favoured by donors is understood to have compromised health performance at the national level. The multiplicity of initiatives has fragmented the financing of health services, making the impact and progress of such programmes increasingly blurred. These are projects that start without government's full endorsement and ultimately fail to deliver expected results for the sector. A Medical Officer with extensive experience working with international donors in designing health programmes elaborated how donors go to the extent of bypassing government structures and work directly with NGOs - leading to resource wastage resulting from the proliferation of uncoordinated programmes.

> Unfortunately, you find that in some instances there have been some Cooperating Partners who have their own interest. They will ask you to go along a certain path specifically from their own perspective…So you find that some health programmes have been designed outside the country and we are supposed to follow them. You find that in a way those health programmes fail because they are not developed by the community inside the country; they are not developed by the Ministry of Health…There was a time when donors would bypass the Ministry of Health and fund NGOs directly. There was so much duplication of programmes; so much wastage of funds…That was the problem especially for the AIDS programmes.

The parallel funding approach brings the risk that earmarked projects may divert attention and resources away from joint planning, implementation and accountability. A legislator explained how the focus on HIV/AIDS funding by donors has promoted symbolic and resource-seeking behaviour among healthcare providers:

> It is the issue of money which is determining these strategies. If you compare the issue of cancer and sugar disease [diabetes] against HIV, you will find that cancer and diabetes have been with us for such a long time as compared to HIV. But just because there isn't so much money put in to combat cancer and diabetes, you find that not a lot of people, even collaborating partners, are in these two diseases. Emphasis has been on HIV because people are making money under the HIV programmes...

The perceived bias towards HIV/AIDS programmes is also acknowledged by a fellow legislator who considers that other disease areas like non-communicable diseases have not

received appropriate attention and funding and have, therefore, been ignored despite their known negative impact on national health. HIV/AIDS programmes have become attractive to health providers at the expense of more devastating emerging disease areas.

> There were projects specifically for HIV/AIDS until recently when we said, 'Look, we are not making as much progress as we might have by this isolation approach. Why don't we integrate HIV/AIDS into sexual and reproductive health'? So much damage was done because the other diseases were really not attractive to go there. They didn't have money, they didn't have resources, they didn't have vehicles. Money was in HIV/AIDS.

A Monitoring and Evaluation Specialist in charge of HIV/AIDS programmes at the national level explained how donor coercion causes local stakeholders to adopt projects in a fashion that diminishes local value:

> It [donor aid] is conditional on how you respond to a request or a proposal. They would stipulate exactly how they would want you to do things; if you do not follow that which they want then you will not be funded…

The above accounts depict variations and controversies among stakeholders concerning the focus and priorities for the health sector. These incongruent goals and implementation approaches may have a huge bearing on the perceived impact of these programmes as others may believe that efforts and resources are being diverted to non-priority areas.

(b) Collaborative Application of Power and Influence

It is believed that donors' external design and parallel funding of programmes could have its own justifications. While international donors are willing to fund health programmes, they also remain accountable to their governments for the prudent utilisation of resources entrusted to them. Due to perceived deficiencies in the local accounting systems, CPs have often considered that their role should embrace not only the funding but also the design of programmes and accounting systems for purposes of transparency and accountability in the application of those funds. A member of the Health Committee explained:

> I would like to be very fair. I think the donor community see the needs and genuinely they want to help. But I would like to believe that they probably don't trust us and, therefore, they would rather persuade us to have a specific project where there could be proper accounting and tracking of the money to report back to their capitals. I think they do ask, 'But you have a gap here; a gap there; yes, can we help'? Various donors would rather support this Ministry in, say, water and sanitation because they put money there and they want to follow that money...

This account reinforces the view that weaknesses embedded in the local accounting and accountability systems persuade CPs to resort to parallel funding of programmes. In support of donor funding, another legislator argued that donors were the very heartbeat behind the fight against HIV/AIDS and malaria. The legislator believes that donors have a genuine concern for the health development of the country as demonstrated by the suspension of aid in 2009 when suspicions of financial misapplication emerged at the Ministry of Health.

> I think the support financially has been so strong; Zambia has been the best case in the world in terms of the fight against malaria - in Africa at least. So in that sense the donors played a very critical role in terms of financial support. We have seen also in the fight against HIV/AIDS, the ARVs; the financing is very much donor-driven. And I think their influence has been so much that even when there was a hint of corruption problems at the Ministry of Health, you saw clearly how strong the donors came in threatening...in fact financing was suspended for a while.

While some stakeholders consider that programmes designed abroad fail to address local health needs, others dismiss this view on the belief that foreign initiatives are tried and proved before their migration to Africa. An example of foreign initiatives that are perceived to have been implemented with successful results is the Prevention of Mother to Child Transmission (PMTCT) of HIV. A Health Programmes Manager working in a donor-funded facility explained how PMTCT was adopted based on lived experiences from the WHO.

> For instance, the prevention of mother to child transmission of HIV; that's a proven strategy that Zambia adopted…They [donors] do a lot of studies; they test strategies to see how effective they are and share with countries and organisations to see if they can buy in and roll it out and see how it is going to help in improving the healthcare in the country. WHO, for instance, comes up with a lot of strategies, they influence countries to say, 'This is a proven initiative and it can help improve the status of the health service in the country'.

Although designed and implemented in an apparently imposed fashion, such programmes are also accepted on the rationale that they are adapted to suit local needs. A Deputy Director of Monitoring and Evaluation argued that external programmes are adapted based on local descriptions, thereby making them appropriate for meeting local needs:

> Most of the programmes that the sector implements draw the mandate from internationally recognised institutions like the WHO. If they are undertaking a particular programme of you have to use the agreed description of those programmes. But at the end of the day, these programmes, even if they are coming from outside the country, have to be adapted to suit the country's situation. That has been the case but at times there have been challenges where partner influence on how certain activities are undertaken kind of...[causes] country ministries really not [to] focus on that which they are supposed to do…

The compromised position in which government agencies find themselves is evident here. While fully aware of national health priorities that need to be addressed, they also require some tolerance with donor influence and pressure. Although it is claimed that these imported programmes are adapted for local effectiveness, the disruptive nature of the influence from CPs is also acknowledged to the extent that ministries are diverted from their national priorities due to adopting and implementing coerced programmes. These controversies may derail the direction of projects to the extent that local health needs fail to be realised.

6. CONCLUSION

This section integrates the views emerging from field accounts with archival evidence in order to shed further light on donor funding practices and how these may enhance and contradict the performance of the health sector. By so doing, the paper contributes towards the literature on resource power in terms of how the practice of donor funding simultaneously promotes and hinders the performance of the health sector in Zambia. Firstly, donor organisations appear to have predetermined goals and targets as to where to invest their resources. This is demonstrated by their inclination towards particular health programmes. The sustained focus on HIV/AIDS programmes as demonstrated by interview accounts provides evidence towards all the motives identified in the literature.

The *recipient need* motive is reinforced by the fact that during the late 1990s and early 2000s, HIV/AIDS threatened to wipe out certain nation states in the absence of aggressive action. By this time, the HIV prevalence rate in certain parts of Sub-Sahara Africa had gone beyond 20 per cent and was still rising. This motivated developed countries and other philanthropic organisations to dedicate huge streams of funds specifically for this cause. For instance, the United States government introduced the PEPFAR initiative to save the lives of people suffering from HIV/AIDS worldwide. PEPFAR is reported to be the largest initiative by any nation to combat a single disease internationally (UN, 2000). The focus of PEPFAR remains on maternal and child health in terms of improving the health of women, new-borns and children. Embedded within donor motives for vertical projects is the call for accountability (Usher, 2010). Several concerns have been expressed about perceived weaknesses inherent in recipient countries' accounting and accountability systems.

While the Paris Declaration (OECD, 2005a) encourages donors to tie less and less of their funding to conditions and promote budgetary support, adverse experiences have done little to move donors in this direction. As revealed by interview accounts and documentary evidence, donors prefer to put their money in projects where they can track the application of the funds to their intended purpose. The tendency for vertical projects becomes more pronounced as donors also need to report the usage of resources to their capitals in order to ensure a sustainable funding flow. As observed by one legislator, donors appear to be sceptic of local systems of accounting and accountability. The suspension of funding by the Global Fund to Zambia's Ministry of Health in 2009 epitomises this donor motive. Usher (2010) reports that up to $137 million in Global Fund grants to Zambia was suspended in August 2009 as donors sought assurances from the government on accountability concerns emerging over a period of time. This case did little to encourage donors to provide budgetary support and pooled funding. Events unfolding at the time indicate the Global Fund's intention to approach a UN agency to act as a recipient for channelling such donor aid in order to safeguard the application of such resources.

Conversely, local stakeholders are of the view that vertical projects fail to address priority health needs since they are designed abroad and implemented in areas not prioritised by government. The insistence by donors on using imported methodologies is believed to adversely compromise the impact of such programmes in remote areas where traditional health providers would be more effective. The dominance of donor perspectives in the design of such projects fails to integrate local ideas and prescriptions that may enhance the performance of these projects. As noted by the Deputy Director of Monitoring and Evaluation, such donor pressure coerces government officials to implement projects that do not reflect government priorities. It has been repeatedly stated that untying donor funding increases aid effectiveness and produces better value for money due to better goal alignment by recipient countries (OECD, 2005a). Bypassing government structures and implementing projects directly through NGOs is considered to be outside the remits of government goals as reflected in development and strategic plans. The focus on HIV/AIDS has reached a point where some stakeholders

consider that it has come at the expense of other emerging diseases like diabetes, hypertension and cancer.

In conclusion, this paper has unravelled tensions and contradictions embedded in the design and implementation of donor-funded projects in Zambia's health sector. By so doing, the paper contributes towards health development literature by providing further insights on the theory of capital and stakeholder theory in terms of how power, interests, tensions and contradictions among stakeholders may enable and impede healthcare performance. These contradictions mainly emerge from inconsistencies between government and donor goals and priorities. While donors may favour vertical projects based on their vested interest and to safeguard their resources from potential abuse, the study reiterates the notion that initiatives designed at a distance may end up producing contradictory outcomes despite their good intentions. Moving forward would require all stakeholders to identify workable mechanisms that may help to close this expectation gap in terms of funding and accountability structures and how these mechanisms can fulfil the health needs of local populations.

REFERENCES

Adugna, A. (2009). *How Much of official development assistance is earmarked?* CFP Working Paper Series No. 2, New York, World Bank.

Ahrens, T. (2008). Overcoming the subjective–objective divide in interpretive management accounting research. *Accounting, Organisations and Society*, Vol. 33, pp. 292 – 297.

Ahrens, T. and Chapman, C.S. (2006). Doing qualitative field research in management accounting: Positioning data to contribute to theory. *Accounting, Organisations and Society*, Vol. 31, pp. 819 – 841.

Annisette, M. (2004). The true nature of the World Bank. *Critical Perspectives on Accounting,* Vol. 15, pp. 303–323.

Bourdieu, P. and Wacquant, L.J.D. (1992). *An invitation to reflexive sociology*. University of Chicago Press, Chicago, IL.

Bourdieu, P. (1986). *The forms of capital*, in Richardson, J.G. (Ed.), Handbook of Theory and Research for the Sociology of Education. Greenwood Press, New York, NY, pp. 241-258.

Cassels, A. and Janovsky, K. (1998). Better health in developing countries: Are sector-wide approaches the way of the future?' *The Lancet*, Vol. 352, November 1998, pp. 1777 – 79.

Dobbin, F. (2008). The poverty of organizational theory: comment on Bourdieu and organizational analysis. *Theory and Society*, Vol. 37(1), pp. 53-63.

Emirbayer, M. and Johnson, V. (2008). Bourdieu and organizational analysis. *Theory and Society*, Vol. 37(1), pp. 1-44.

Friedland, R. (2009). The endless fields of Pierre Bourdieu. *Organisation*, Vol. 16(6), pp. 887-917.

Freeman, R. E. (1984). *Strategic management: A stakeholder approach*. Massachusetts: Pitman.

Gomes, R.C. (2006). Stakeholder management in the local government decision-making area: Evidences from a triangulation study with the English local government. *Brazilian Administrative Review*, Vol. 3(1), pp. 46-63.

Heath, J. and Norman, W. (2004). Stakeholder theory, corporate governance and public management: What can the history of state-run enterprises teach us in the post-Enron era? *Journal of Business Ethics*, Vol. 53, pp. 247–265.

Jawahar, I.M. and McLaughlin, G.L. (2001). Toward a descriptive stakeholder theory: An organisational life cycle approach. *Academy of Management Review*, Vol. 26(3), pp. 397 – 414.

Jayasinghe, K. and Wickramasinghe, D. (2011). Power over empowerment: Encountering development accounting in a Sri Lankan fishing village. *Critical Perspectives on Accounting*, Vol. 22, pp. 396–414.

Lounsbury, M. (2008). Institutional rationality and practice variation: new directions in the institutional analysis of practice. *Accounting, Organizations and Society*, Vol. 33(4/5), pp. 349-361.

Lukka, K. and Modell, S. (2010). Validation in interpretive management accounting research. *Accounting, Organisations and Society*, Vol. 35, pp. 462-477

MacKellar, L. (2005). Priorities in global assistance for health, AIDS and population. *Population and Development Review*, Vol. 31(2), pp. 293 – 312.

Ministry of Finance (2013). *2014 budget address by Honourable Alexander B. Chikwanda, MP, Minister of Finance, delivered to the National Assembly on Friday 11th October 2013.* Lusaka, Ministry of Finance.

Ministry of Health (2011). *National health strategic plan 2011 – 2015.* Lusaka, Ministry of Health.

Ministry of Health (2012). *2012 joint annual review of the health sector.* Lusaka, Ministry of Health.

Ministry of Health (2013). *National health policy – A nation of healthy and productive people.* Lusaka, Ministry of Health.

Ministry of Health and World Bank (2010). *Country health status report.* Lusaka, Ministry of Health and World Bank African Region Human Development.

Modell, S. (2001). Performance measurement and institutional processes: A study of managerial responses to public sector reform. *Management Accounting Research*, Vol. 12, pp. 437-464.

Modell, S. (2003). Goals versus institutions: The development of performance measurement in the Swedish university sector. *Management Accounting Research*, Vol. 14, pp. 333-359.

Modell, S. (2015). Making institutional accounting research critical: dead end or new beginning?' *Accounting, Auditing & Accountability Journal*, Vol. 28(5), pp. 773-808.

OAU (2001) *Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases*', Abuja, OAU.

OECD (2005a). *The Paris Declaration on Aid Effectiveness*. Paris, OECD.

OECD (2005b). *International development statistics 2005*. Paris: OECD.

Orij, R. (2010). Corporate social disclosures in the context of national cultures and stakeholder theory. Accounting, *Auditing & Accountability Journal*, Vol. 23(7), pp. 868 – 889

Powell-Jackson, T. and Mills, A. (2007). A review of health resource tracking in developing countries. *Health Policy and Planning*, Vol. 22, pp. 353 – 362.

Republic of Zambia (2006). *Vision 2030: A prosperous middle-income nation by 2030.* Lusaka, Republic of Zambia.

Republic of Zambia (2011). *Sixth national development plan 2011 – 2015: Sustained economic growth and poverty reduction.* Lusaka, Republic of Zambia.

Shiffman, J. (2006). *Donor funding priorities for communicable disease control in the developing world*. Oxford, Oxford University Press.

United Nations (2000). *United Nations Millennium Declaration*. New York, United Nations.

Usher, A.D. (2010). Donors lose faith in Zambian Health Ministry. *The Lancet*, Vol. 376, August 7, 2010.

Vaivio, J. (2008). Qualitative management accounting research: Rationale, pitfalls and potential. *Qualitative Research in Accounting and Management*. Vol. 5(1), pp. 64 – 86.

Waddington, C. (2004). Does earmarked donor funding make it more or less likely that developing countries will allocate their resources towards programmes that yield the greatest health benefits?' *Bulletin of the World Health Organisation*, Vol. 82(9), pp. 20 – 36.

World Health Organisation (2007). *Strengthening health systems to improve health outcomes – WHO's framework for action.* Geneva, World Health Organisation.