Global Health, Aid and Corruption: Can We Escape the Scandal Cycle?

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Abstract

Global health action has been remarkably successful at saving lives and preventing illness in many of the world's poorest countries. This is a key reason that funding for global health initiatives has increased in the last twenty years. Nevertheless, financial support is periodically jeopardized when scandals erupt over allegations of corruption, sometimes halting health programs altogether.

This paper reviews four cases involving the World Bank, USAID, the Global Fund, and European donors in terms of the severity of abuses, the quality of evidence, the responses of funders and recipients, and the impact on health and institutions. It argues that, from a funder's perspective, the main way to address the dynamics of the scandal cycle is to make sure that the decision of whether or not to disrupt health aid is influenced as much by program results as by the amount and character of corruption. It suggests three strategies to accomplish this goal: (1) communicate using program results; (2) differentiate responses by program results; and (3) disburse program funding in proportion to results.

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William Savedoff, Amanda Glassman, and Janeen Madan. 2016. "Global Health, Aid and Corruption: Can We Escape the Scandal Cycle?." CGD Policy Paper 086. Washington DC: Center for Global Development.
http://www.cgdev.org/publication/global-health-aid-and-corruption-can-we-escape-scandal-cycle

CGD is grateful for contributions from the UK Department for International Development and the Omidyar Network in support of this work.

The authors would like to thank Kate McQueston for earlier research on this topic, many CGD colleagues who offered constructive critiques, and especially the informants who gave us their time and insights into the complexity of each case study

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CGD Policy Paper 086
June 2016

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Acronyms

ACC	Zambian Anti-Corruption Commission
AP	Associated Press
CIDA	Canadian International Development Agency
DFID	UK Department for International Development
DIR	Detailed Implementation Review
GF-OIG	Global Fund Office of the Inspector General
INT	World Banks's Department of Institutional Integrity
NORAD	Norwegian Agency for Development Cooperation
OECD DAC	OECD Development Assistance Committee
OECD	Organization for Economic Cooperation and Development
OHSDP	Orissa Health Systems Development Project
PCH	Partnership Contracts for Health
RCH	Reproductive and Child Health project
Sida	Swedish International Development Cooperation
SIGAR	Special Inspector General for Afghanistan's Reconstruction
UNDP	United Nations Development Program
USAID	United States Agency for International Development
Z-OAG	Zambian Office of the Auditor General

Global health action has been remarkably successful at saving lives and preventing illness in many of the world's poorest countries. This is a key reason that funding for global health initiatives has increased in the last twenty years. Nevertheless, financial support is periodically jeopardized when scandals erupt over allegations of corruption, sometimes halting health programs altogether.

This paper reviews four cases involving the World Bank, USAID, the Global Fund, and European donors in terms of the severity of abuses, the quality of evidence, the responses of funders and recipients, and the impact on health and institutions. It argues that, from a funder's perspective, the main way to address the dynamics of the scandal cycle is to make sure that the decision of whether or not to disrupt health aid is influenced as much by program results as by the amount and character of corruption. It suggests three strategies to accomplish this goal: (1) communicate using program results; (2) differentiate responses by program results; and (3) disburse program funding in proportion to results.

Responses to corruption may be a bigger problem for health aid than corruption itself

Health programs financed through foreign aid have been one of the clearest success stories of the last half century (Millions Saved 2004 and 2016), acknowledged even by some of foreign aid's most renowned critics (Deaton 2013; Easterly 2011). This effectiveness, along with the humanitarian appeal of health programs, may explain why health aid[1] has grown so dramatically in the last 25 years. Between 1990 and 2014, health aid from all donors grew from US$5 billion to US$23 billion.[2] By comparison, non-health aid also grew over the same period, but only by 50 percent from US$100 billion to US$150 billion.

Taxpayers strongly support health aid but are wary of corruption, which they see as the biggest obstacle to improving health in recipient countries.[3] For example, over 60 percent of Americans think US health aid is "too little" or "just right", but 47 percent of them think "corruption and misuse of funds" is the main reason that health aid is ineffective (See Figure 1, Kaiser 2013). In Britain, too, a rising share of the population agrees with the statement

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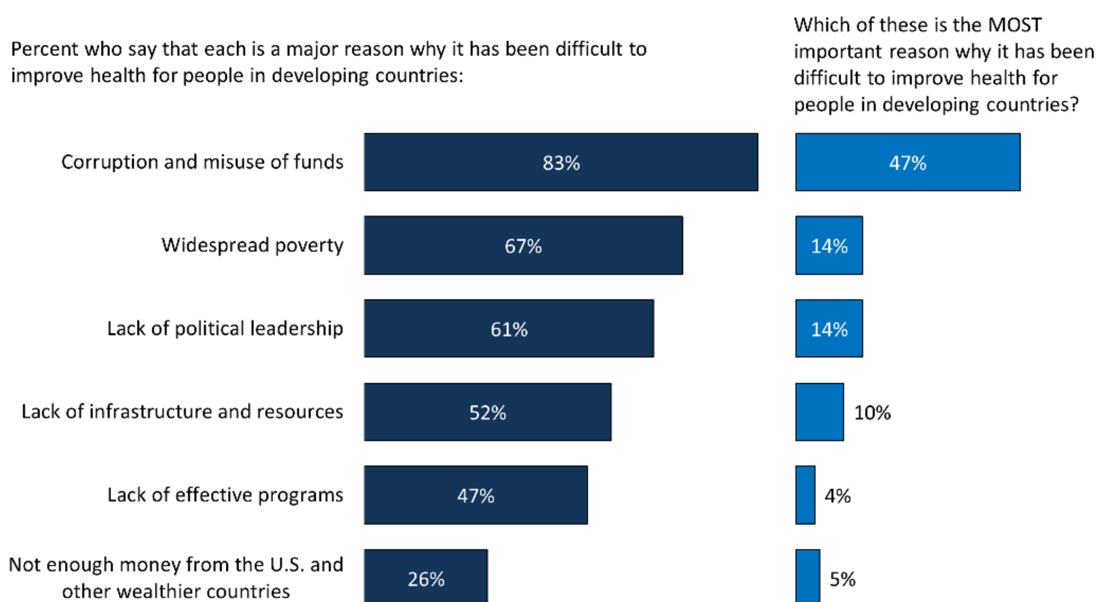
[1] For the purposes of this paper, we will use "health aid" to refer to bilateral and multilateral foreign assistance programs in the form of grants or concessionary lending with the primary intention of improving population health or the delivery of health services. We exclude aid to other sectors, even if they have strong direct or indirect health benefits if their primary justification is not health. So, for example, water and sanitation programs are likely to yield health benefits but their primary goal is the provision of water and sanitation services.

[2] Figures are calculated based on Official Development Assistance flows reported to the OECD. Health aid is as defined by OECD's Creditor Reporting System. All values represent 2014 constant prices.

[3] "Recipient countries" are those that receive health aid. They are typically classified as low- and middle-income countries by the World Bank.

that “corruption in governments in poor countries make it pointless donating money to help reduce poverty.”[4]

Figure 1: Barriers to improving health in developing countries



The agencies that provide health aid are quite aware of the threats posed by corruption. Corruption can undermine the agencies' health aid programs by diverting resources (fiduciary risk) in ways that reduce impact (failure costs). In addition, public views on corruption – whether well-founded or not – affect aid agencies' budgets and political support (reputational risk). To address these threats, agencies track funds, monitor spending, and urge recipient countries to reform their public financial management and governance.

For the most part, aid agencies work behind the scenes to address signs of corruption as they arise, but for a number of reasons corruption allegations can become public and generate a scandal. Sometimes scandals are generated by media attention and sometimes by aid agencies who want to use the allegations of corruption to pressure recipient countries to reform. In rare cases, funding countries may create the scandal to address their domestic political goals or to rebuild support for foreign aid by demonstrating that they are quick to react to problems.

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[4] David and Jennifer Hudson, “Does Talking about Corruption Make it Seem Worse?” *The Guardian*, June 22, 2015.

Financial control systems are the main way that agencies seek to convince their managers, the politicians who oversee them, and the public within funding countries that money is appropriately spent. Yet agencies are typically alerted to corruption not by their financial control systems but by whistleblowers. Anti-corruption efforts are implemented with weak evidence that they reduce corruption and little attention to whether they reduce the effectiveness of health aid. Thus, the typical health aid program functions out of the limelight until the day that a scandal erupts, after which agencies respond by halting programs and reaffirming their policy of "zero tolerance for corruption." Actions are taken to strengthen the financial control system and eventually funding resumes. At the end of the cycle, it is not evident that the new system will be any better at controlling corruption and, in the meantime, health aid programs have been disrupted, sometimes with serious consequences for recipients' health.[5]

This paper asks whether the responses by aid agencies to corruption in health aid could be improved by paying greater attention to the costs of disruption and communicating more effectively about anti-corruption efforts. We hypothesize that weak information on the results of health aid lead funding countries to respond more forcefully to allegations of corruption than is merited. That is, agencies' concerns over losing public support for health aid lead them to overreact relative to the magnitude of corruption or its impact on health. We ask specifically:

- Do disruptions in health aid interrupt the institutional development of health systems?
- Do disruptions in health aid thereby affect health outcomes?
- Do the prescribed anti-corruption measures reduce the likelihood of corruption being a problem in the future?
- Can the scandal cycle be ameliorated by getting better information on health aid results and establishing clearer and more highly differentiated rules for disrupting aid?

[5] For a discussion on how health outcomes can be susceptible to funding levels, see the case about malaria rates in Zanzibar at: http://bit.ly/1SKrgwe (accessed Dec. 7, 2015).

Box 1: Select statements on corruption and foreign aid

Statements from key leaders in the aid and development field reflect a range of views on the extent of corruption and its implications for foreign aid.

World Bank President Jim Kim claimed corruption is "public enemy no. 1", and declared that corruption must be at the center of the development lender's work.[6]

The Global Fund's Executive Director Michel Kazatchkine stated that, "The Global Fund has zero tolerance for corruption and actively seeks to uncover any evidence of misuse of its funds."[7]

In his 2013 Annual Letter Bill Gates wrote, "We need to root out fraud and squeeze more out of every dollar… but we should also remember the relative size of the problem."[8]

Corruption, aid, and anti-corruption

Corruption has been long recognized as a problem for development in general and for the delivery of public services in particular (Myrdal 1968, Rose-Ackerman 1978, Elliott 1997). A common definition of corruption, which we will follow here, is "the abuse of public office for personal gain" (Bardhan 1997). Corruption is a problem for development not only when public officials embezzle public funds but also when they resist reforms that would improve governance and reveal their abuses. It is a problem for public service delivery when kickbacks consume resources that could otherwise expand output but also when decision makers distort administrative procedures to hide and facilitate abuses. It is also a problem for foreign aid, which becomes less effective in corrupt contexts and can end up sustaining and legitimating corrupt regimes (Cammack 2007).

Yet aid agencies did not explicitly address corruption until the 1990s. In that decade, a combination of factors made it possible for aid agencies to tackle an issue which had until then been considered politically untouchable. Some of these factors included the end of the Cold War, the creation of Transparency International in 1993, the signing of the first international agreement on the matter in 1996 (the Inter-American Convention on Corruption). Open debate and public action became common after the World Bank's

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[6] "World Bank president calls corruption 'Public Enemy No. 1,'" *Reuters*, Dec. 19, 2013.

[7] Eliza Barclay, "Global Health Fund Finds Some Fraud, Recoups Losses," *National Public Radio*, Jan. 24, 2011.

[8] Bill Gates' 2013 Annual Letter is here: http://gates.ly/1fypBtJ (accessed Dec. 7, 2015).

president, James Wolfensohn, publicly declared that "we need to deal with the cancer of corruption" in 1996.[9]

From the mid-1990s onward, aid agencies explicitly addressed corruption by financing initiatives to improve governance, including reforms of public financial management systems and the creation of anti-corruption commissions (Fagan & Weth 2010; Savedoff 2016). They also established new investigative offices and auditing standards for their own programs, putting resources into more detailed monitoring, tracking and fiduciary controls. In some cases, corruption became a factor that disqualified recipients for receiving aid, as is the case at the Millennium Challenge Corporation.[10] In addition, anti-corruption conventions proposed by organizations such as the OECD encouraged sanctions against bribing foreign public officials;[11] while international campaigns such as the International Aid Transparency Initiative established new standards for reporting on aid flows.[12] Through such efforts, aid agencies tried simultaneously to reduce the incidence of corruption in recipient countries and assure that aid monies would not be diverted.

For a number of reasons, foreign aid may be more susceptible to fraud and abuse than domestic public funds, but health aid could be even riskier. Foreign aid procedures aimed at making procurement more transparent, competitive, and rule-bound might limit corruption relative to domestic spending by recipients. Yet this additional scrutiny to public spending in recipient countries may also be quite weak. The actors in funding countries who exert oversight tend to be distant from program implementation, are less effective at understanding and monitoring actions due to differences in language and institutions, and lack authority to take legal actions within recipient countries. Thus far, researchers have been unable to conclusively demonstrate that foreign aid has either a positive or negative impact on corruption (Svennson 2000; Tavares 2003; Alesina and Weder 1999; Asongu 2012; Charron 2011; Brautigan and Knack 2004; Okada and Samreth 2012).

Health spending in general is particularly susceptible to corruption because of its mix of uncertainty, asymmetric information and large numbers of dispersed actors (Savedoff and Hussman 2006). These characteristics create difficulties in ascertaining whether goods and services were actually purchased, necessary, used appropriately, and of the expected quality. The scope of corruption in health is also wider than in other sectors because societies invest private actors with public responsibilities. Private pharmaceutical companies, hospitals or

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[9] See Wolfensohn's address to the Board of Governors at the Annual Meetings of the World Bank and the International Monetary Fund in Washington DC on Oct. 1, 1996, reprinted here: http://bit.ly/1TTqf61.

[10] MCC uses "Control of Corruption" as one selection indicator to determine country eligibility for program assistance. For more information see http://1.usa.gov/1XW6LxR.

[11] OECD Convention on Combatting Bribery of Foreign Public Officials in International Transactions (accessed Dec. 7, 2015).

[12] International Aid Transparency Initiative (accessed Dec. 7, 2015).

insurers are expected to earn reasonable incomes from their services but not to enrich themselves at the expense of their clients' health or the public purse. Finally, the health sector is vulnerable to corruption because it involves so much money, as much as 15 percent of GDP in rich countries.[13] In low-income countries, health spending may be low but health aid is consequently a large target in relative terms. For example, in 2013, Ethiopia's public sector spent about US$1.4 billion of which health aid accounted for US$740 million. For Cambodia the comparable figures are US$225 million and US$140 million.[14]

Corruption in health aid takes many forms, some of which have large effects on results. The most obvious category of health aid corruption involves payments for which no goods or services are delivered. In India, a World Bank loan was paid out for construction of a hospital that was never built while government officials allegedly invented reports to document that it was completed and operating (World Bank 2008a). In Ethiopia, hospital parking lights and electrical equipment were paid for without any evidence that they were delivered (Grepin and Savedoff 2009). In Mali, funds were disbursed for training workshops that were never held (Global Fund 2011a). In Sub-Saharan Africa, countries with higher levels of corruption derived less health gain from importing HIV medicines than those with less corruption (Friedman 2015). In each case, funds may have been diverted to shell companies or to other budget lines from which public officials could benefit; however, funds may also have been used for legitimate public goals. Investigations in most cases cannot determine with certainty just where the money goes.

In other cases, public officials derive benefits by steering contracts to companies that deliver poor quality. For example, under India's Malaria Control Project, firms that won contracts through fraudulent practices supplied inferior quality bed nets (World Bank 2008b, p. 462). In addition, under the Second National HIV/AIDS Control Project, procurement officials received bribes to award contracts to companies that supplied faulty HIV test kits and to NGOs that were not qualified to provide HIV prevention services (World Bank 2008b, p. 339).

Another way that health aid is diverted is through kickbacks and collusion that results in paying excessive prices. The director of the Costa Rican Social Security Institution (CCSS—Caja Costarricense de Seguro Social) arranged kickbacks amounting to 30 percent of US$8 million worth of hospital equipment from a Finnish company in a scam that used a public sector loan from Finland to Costa Rica (Vian, Savedoff and Mathisen 2010).[15] Under the Food and Drug Capacity building project in India, procurement officials unfairly disqualified

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[13] Data are from the World Bank's World Development Indicators, 2013.

[14] Figures on public spending in health for 2013 are from the World Health Organization's Global Health Expenditure database.

[15] For more information, see the *2007 Global Integrity Report*, Notebook for Costa Rica (accessed Dec. 7, 2015).

lower cost bidders on questionable claims of non-compliance with criteria, resulting in higher costs for equipment (World Bank 2008a, p. 105-106).

To address corruption in health aid, agencies channel their funds through different intermediaries depending on their assessment of a recipient country's domestic capacity to control corruption. In some countries, aid agencies will *disburse funds directly to governments* but only after conducting due diligence on their public financial management systems. More typically, they will provide financial and technical support to *improve the recipient government's public financial management and procurement system*. When aid agencies assess a country to have a higher risk of corruption, they may establish separate "*project implementation units*" within the public sector but following a set of rules and procedures that are closely aligned with the procedures of the foreign aid agency. These units are typically staffed by people with higher qualifications and pay than in the rest of the public sector and are hired in consultation with the foreign aid agency. In countries where public sector capacity to prevent corruption is considered so poor that even this kind of separate public unit is unlikely to be successful, aid agencies will simply *bypass the government* and finance non-governmental organizations and private firms directly to provide goods and services.

Regardless of the particular channel for funds, the approach to limiting corruption in health aid programs is relatively similar across funding agencies. In each case, efforts to prevent corruption involve:

- Implementing procurement rules that encourage transparency and competition while constraining award decisions to consider only price and technical quality of bids;
- Separating management functions that allocate, authorize, and disburse public funds;
- Reporting on financial transactions promptly and transparently;
- Instituting regular internal audits and periodic external audits;
- Establishing systems to investigate and prosecute malfeasance when discovered or alerted by whistleblowers;
- Conducting performance audits; and
- Enacting provisions to require repayment or to withholding future funding in the event abuses occur.

As a result, the majority of health aid programs rely on these measures to address signs of corruption on a case by case basis, sometimes effectively and sometimes not. And in some cases, health aid programs end up facing a scandal and the subsequent prospect of reducing or cancelling programs.

Anti-corruption efforts, agency strategies, and health aid

To our knowledge, no one has specifically looked at the scandal cycle in health aid. However, researchers and aid agencies have done considerable work to understand the drivers of corruption, to evaluate interventions aimed at reducing the likelihood of corruption, and to encourage coordinated and effective action among funders.

The OECD Development Assistance Committee (DAC) has been an important focus for these efforts with studies of foreign aid and corruption that indirectly address the problem of scandals. In 2007, the OECD issued a policy paper outlining procedures and principles for aid agency work against corruption (OECD 2007). It placed anti-corruption efforts within the context of improving good governance in recipient countries and argued for a rational process of assessment, benchmarking, and coordinated response. The first country where funders put these ideas into practice was Uganda where a joint response was implemented in 2009 (de Vibe et al. 2013). The OECD also initiated a series of studies to inform their work and to test the utility of this approach.

Unfortunately, research and evaluations have continued to question the utility of anti-corruption efforts, particularly when the domestic political context is not favorable (Norad 2008; Persson et al. 2012). Evaluations that specifically assess the way aid agencies address corruption have similarly found weak adherence to the anti-corruption principles outlined by the OECD (2007), some short-term successes from concerted action, and limited evidence of long-term impact on corruption. Two evaluations that relied on case studies encompassing seven recipient countries found that aid agencies tend to be unprepared when corruption reaches the public's attention (ITAD & LDP 2011; de Vibe et al. 2013). Both of these evaluations stress the need for coordination among aid agencies; preparation through analytical work; advance agreement on graduated responses; predictability in actions; and continued engagement and dialogue with both recipient governments and non-state actors.

The one health program that received attention in these evaluations was in Zambia where high-level officials embezzled funds intended for training. Aid agencies responded by suspending health programs and initiating detailed investigations. While both evaluations (ITAD & LDP 2011; de Vibe et al. 2013) relate similar facts about the case, they choose to emphasize different aspects of the aid agency response. The 2011 evaluation highlighted the context within which the corruption scandal emerged – both in terms of Zambia's domestic politics and the engagement of aid agencies in support of explicit anti-corruption initiatives (ITAD & LDP 2011). This evaluation viewed aid agency coordination favorably and focused its recommendations on the deficiencies it identified in poor use of information and analytical tools, weak understanding of the drivers of corruption, and the need for more refined attention to tools and procedures like service delivery charters, internal auditing and external oversight. The 2013 evaluation, chose to highlight very different characteristics (de Vibe et al 2013). It noted the rapidity with which several aid agencies halted aid, lack of coordination among aid agencies (two of which subsequently increased their funding), and limited engagement with non-state actors (de Vibe et al. 2013).

In general, evaluations of foreign aid – and health aid more particularly – mirror the two ways of approaching corruption stressed by these different evaluations. They either focus on the details of policy engagement and public management (e.g., internal auditing and oversight mechanisms) or on the preparation and effectiveness with which aid agencies respond to scandals. While some studies mention the costs of anti-corruption measures[16] and the failures to improve outcomes that result from corruption, few address the consequences of disrupting aid for development outcomes or the apparent disregard to program results when aid agencies choose how to respond to scandals.

Analyzing the scandal cycle

Corruption is fundamentally invisible, making public scandals a weak indicator of the presence or absence of abuses. It is impossible to investigate specific incidents of corruption unless they are detected and reported. Consequently, scandals will only occur for a subset of health aid programs affected by corruption. Furthermore, the nature of corruption often makes it difficult to distinguish evidence of intentional malfeasance from inefficiencies, errors, judgment, and differing priorities. For example, diverting health aid from its assigned purpose to another public health program would probably be classified by an audit as fraud or abuse even in cases where no public official personally benefited from the diversion of funds. Auditors and investigators are not infallible so that their reports can be in error. Thus, scandals can erupt even in the absence of corruption. While a full and thorough analysis would benefit from looking at health aid programs with and without scandals, we chose for practical reasons to focus on cases studies in which public scandals occurred.

We selected four cases to explore our hypotheses and the idea of a scandal cycle. The cases were not chosen systematically but they were chosen purposefully. We looked for cases that were politically visible, involved a range of different funders and recipient countries, had different outcomes, and occurred in the recent past (last 8 years). By definition, we did not investigate cases in which corruption either remained undiscovered or failed to elicit a public scandal. We did however include cases where the evidence that corruption actually occurred ranged from strong to weak. We also included cases that covered a range of aid agency responses, from minor adjustments to halting an entire program. Therefore, the cases are not representative in a statistical sense though they do illustrate a variety of experiences with publicly reported corruption in health aid.

The four cases we chose are relatively well known among health sector experts who work on corruption and often represent points of reference for debates about addressing corruption in health aid (See Table 1).

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[16] ITAD & LDP 2011 notes that the Anti-Corruption investigations in Zambia recovered US$36 million at a cost of US$18 million and judged this to be costly. Others (see, for example, Sparrow 2000) would argue that a US$2 return for every US$1 invested is worthwhile both financially and in terms of its impact on the future likelihood of fraud and abuse.

1. Allegations of corruption in the **World Bank**'s health portfolio in **India** emerged as early as 2004. A 2005 Bank investigation found systematic corruption. These findings were expanded in a subsequent World Bank "Detailed Implementation Review" of five health projects published in 2008.

2. In **Zambia**, allegations emerged in early 2009 that high-level officials at the Ministry of Health had embezzled funds from **multiple donors** (Pereira 2009).

3. In 2011, the Associated Press (AP) published an article about the **Global Fund**'s investigations of fraud and abuse in its grants, with particular reference to irregularities in **Mali, Djibouti, and Mauritania** (Heilprin 2011).

4. In 2013, the US Special Inspector General for Afghanistan's Reconstruction (SIGAR) issued a report and testified before Congress on irregularities in **USAID**'s Partnership Contracts for Health program **in Afghanistan** (SIGAR 2013).

The health programs that were affected ranged from US$50 million in Mali, Djibouti and Mauritania to US$569 million in India. The amount of funds identified as being diverted by fraud or abuse ranged from US$11.5 million in Zambia to US$17 million in Mali, Djibouti and Mauritania. Each case was rather different in terms of the original source of information about corruption and how it became a scandal. In India and Zambia, the original allegations came from local people but were transformed into international scandals by decisions at the World Bank (for India) and among bilateral funders (in the case of Zambia). The evidence of abuses uncovered by the Global Fund were being managed without public fanfare or disruptions in aid until publication of the AP article, after which several funding countries halted transfers to the Global Fund. Finally, the initial report on abuse in the Afghanistan health program came from SIGAR, which reports directly to Congress on the integrity of US relief and reconstruction efforts in Afghanistan.

The cases also differed in terms of the types of evidence that were ultimately used to justify aid agency responses. The World Bank's Detailed Implementation Review (DIR) was among the most thorough, including evidence of procedural failures, abuse, and results failures (see box 2 for definitions). Evidence in the investigations of Global Fund programs and Zambia was primarily focused on procedural failures and abuse. By contrast, the SIGAR report was largely focused on documenting procedural failures.

Table 1: Four health aid scandals and selected characteristics

	World Bank in India	GF in Mali, Djibouti, Mauritania	Multiple funders in Zambia	USAID in Afghanistan
Total funding (US$ millions)	569	50	Sweden: 18 Canada: 15 GF: 272	236
Funds affected (US$ millions)	- *	17	Sweden: 0.85 Canada: 0.88 GF: 10	- *
Who detected?	Whistleblower /WB	GF-OIG /AP	Whistleblower /Zambia	SIGAR
Procedural failures	√	√	√	√
Evidence of abuse	√	√	√	
Results failures	√			

Notes: AP=Associated Press; GF=Global Fund; GF-OIG=Global Fund Office of the Inspector General; SIGAR=Special Inspector General for Afghanistan Reconstruction; WB=World Bank.
* The World Bank's Detailed Implementation Review and SIGAR's report did not provide specific estimates of funds affected by corruption.

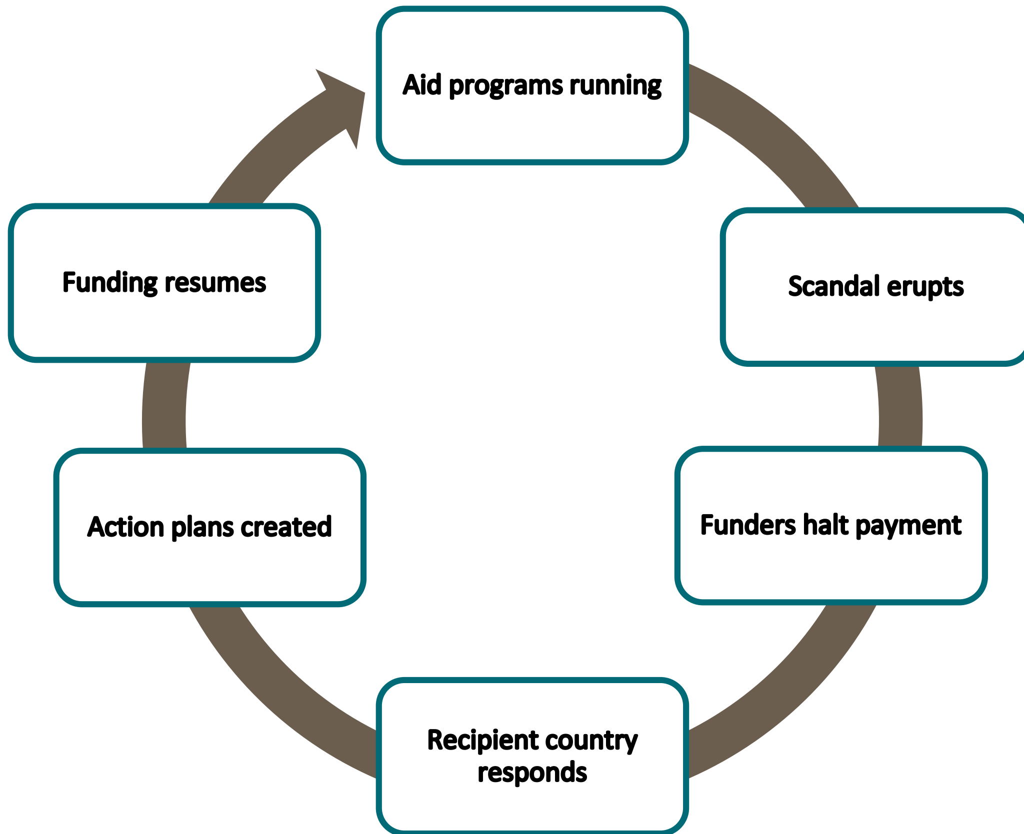
Though every scandal evolves differently, a typical scandal has six phases: aid programs are running normally, a scandal erupts, funders halt payments, the recipient country responds, remedial action plans are negotiated, and funding resumes with a return to normal operations (See Figure 2). Each case study addresses three questions:

1. **What happened?**
   Information about the health program itself in terms of goals and total funding, the nature and source of the allegations, and how much funding was affected by irregularities. We also paid attention to whether the scandal was substantiated by evidence of procedural failures, evidence of fraud or results failures.

2. **How did funders and recipients respond?**
   Information on evidence gathering and negotiations, the speed and scale of disruptions in aid flows, and recipient country actions to deny, qualify, investigate, or prosecute crimes.

3. **What were the consequences?**
   Information on how outcomes were affected by the disruption of aid in terms of institutional development goals, service provision, health impact. We also looked at the character of action plans that were initiated, their level of implementation and whether these changes would reduce the likelihood of future corruption.

Figure 2: A typical scandal cycle for health aid



Box 2: Definitions for select corruption-related terminology

Corruption – the abuse of public office for personal gain.

Fraud—intentionally obtaining money or property by false or fictitious representations or promises, or material omissions.

Abuse – a general term that encompasses fraud, corruption, bribery, embezzlement, theft, and other malfeasance in the private or public sector whether for personal financial gain, political power, or other ends.

Embezzlement or theft—the act of dishonestly taking, appropriating or secreting money or assets not rightfully belonging to the individual or entity, including diversion of monies entrusted to the individual or entity as a fiduciary or in connection with an official responsibility.

Procedural failures – cases in which procedures are not followed, regardless of whether there is evidence of abuse, including practices for documenting expenditures, procuring goods, contracting services, and hiring staff.

Results failures – cases in which a program is implemented without having the desired impact.

Misappropriation—the intentional misuse or misdirection of grant funds for purposes that are inconsistent with the stated goal of the project or program, including for the benefit of the individual, entity or person they favor, either directly or indirectly.

Unsupported expenditures—expenses that are not traceable, for example due to missing receipts.

Ineligible expenditures—expenses that are documented but not approved in the budget or work plan.

Case 1: Detailed Implementation Review of the Indian health sector

"Serious" indicators of fraud and corruption emerge

Raw sewage, exposed electrical wires, molded walls, and rusted hospital equipment were some of the sights described by investigators reviewing the Orissa Health Systems Development Project (OHSDP) (World Bank 2008a, p. 13). This US$90 million World Bank-supported project aimed to improve the quality and effectiveness of the health care system in the eastern Indian state.[17] Along with four other projects, OHSDP was the subject of a Detailed Implementation Review (DIR) conducted by the World Banks's Department of Institutional Integrity (INT) between 2006 and 2007. The review of the Indian health sector also covered the Food and Drug Capacity Building Project, the Malaria Control Project, the Tuberculosis Control Project, and the Second National AIDS Control Project.[18] A DIR investigation identifies "red flags", or indicators, of fraudulent practices; it does not provide specific evidence of corruption (World Bank 2008a, p. 4). To investigate the Bank's health portfolio, the DIR team conducted interviews with Bank staff and Indian counterparts, and also reviewed documentation from procurement procedures, bid processes and performance reports. The India DIR report was first presented to the Bank's Board, and then made public in January 2008. It reported "serious indicators of fraud and corruption" in all 5 of the Bank-assisted health projects that were reviewed. Altogether, the five loans totaled US$569 million but the DIR did not provide specific estimates of funds lost to corruption.[19]

There were repeated allegations of endemic corruption in the Indian health sector long before the DIR was launched. In one case, Dr. Kunal Saha, a US-based physician hired by the World Bank to review the National Aids Control Organization, found evidence that the government had procured faulty HIV diagnostic kits using World Bank funds.[20] The kits, which had been distributed to hospitals and blood banks around the country, gave false-negative results, thereby allowing HIV-positive blood to be used in transfusions. Despite stirring a frenzy in the media, neither Indian government officials nor World Bank staff responded to Dr. Saha's warnings. When Dr. Saha brought his complaints directly to the

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[17] Details about the Orissa Health Systems Development Project are here: http://bit.ly/1IFNBE6 (accessed Aug. 31, 2015).

[18] Four of the projects had ended; the Food and Drug Capacity Building Project closed in June 2008, but disbursements were discontinued in February 2008 due to the lack of "acceptable audit reports from both the center and state components for the year 2006-2007". More information is http://bit.ly/1N8cUXg and http://bit.ly/25BuKeT.

[19] "Government of India and World Bank Group Join Forces to Stamp Out Corruption in Health Sector Projects," *The World Bank*, Jan. 11, 2008.

[20] The Government Accountability Project provides more background at: http://bit.ly/1JLa831 (accessed Aug. 31, 2015).

World Bank's President, Paul Wolfowitz, in 2007, his evidence was dismissed as "personal opinions".[21] These allegations were not new. Complaints about faulty kits had been reported as early as 2004, with no subsequent action by government officials or the World Bank.

In addition to the problems surrounding procurement, program results were also misreported by the World Bank. In 2005, a group of researchers questioned World Bank claims about the success of its Malaria Control Project in India (Attaran et al. 2006). The researchers contacted the World Bank and checked its sources, only to find glaring inconsistencies between the World Bank report and published Indian government data. The researchers were unable to explain the inconsistencies when the World Bank refused to provide the source report received from the Indian government; they then published their findings in *The Lancet* (Attaran et al. 2006). Claims that the program reduced malaria in the western states of Rajasthan, Gujarat and Maharashtra by 90.3, 80.8 and 40.3 percent, respectively, remain on the World Bank's website without correction or comment (World Bank 2005).[22]

In addition to these external allegations, a 2005 World Bank investigation of the Reproductive and Child Health (RCH) project exposed systematic corruption through bid-rigging and false performance certificates. These allegations prompted the Bank to initiate the DIR in 2007 (World Bank 2008a, p. 4).

The INT team detailed its findings from the five health sector projects in two 300-page volumes. The DIR report's executive summary highlights systemic weaknesses within the World Bank's portfolio in four strategic areas: insufficient focus on the risk of corruption in project design; inadequate supervision systems and bid review processes; inconsistencies in evaluation ratings and actual project implementation as observed by the DIR team; and weak procurement review methodology for decentralized procurement through local contracts (2008a, p. 21-24). The report identifies specific indicators of procurement fraud, including awards for contracts to bidders without adequate justification. For example, Indian officials gave preferential treatment to certain bidders by sharing budget estimates and technical details beforehand (Kirk 2011, p. 185). In some instances, contractors submitted false expenditure reports. In others, NGOs were invented as a front to siphon off funds. Some specific examples from the DIR report include:

- Under the US$54 million Food and Drug Capacity Building Project, the INT identified "questionable procurement practices, some of which indicate fraud and corruption, in contracts representing 87 percent of the number of pieces and 88 percent of the total value of equipment procured" (World Bank 2008a, p. 10).

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[21] Ibid.

[22] World Bank. 2005. Rolling Back Malaria: the World Bank Global Strategy & Booster Program. Washington, DC: World Bank (accessed Feb. 23, 2016).

- Investigators visited 55 hospitals supported by the Orissa Health Systems Development Project, and reported appalling conditions in 51 of them. Problems included raw sewage, moldy walls and leaking roofs. Four hospitals were closed and appeared unused. Investigators also reported hazardous electrical equipment potentially exposing babies and their medical staff to electrical shocks (World Bank 2008a, p. 171).

- In the US$114 million Malaria Control Project, the review detected indicators of bid rigging and collusion, as well as reports of poor quality bed nets supplied by the firms. The report also claims, "There are indicators that suggest that the collusive behavior subverted open competition, resulted in inflated prices, and likely involved individuals within the project's Procurement Support Agencies" (World Bank 2008a, p. 18).

- Contracts under the US$194 million Second National AIDS Control Project were awarded to fictitious NGOs and organizations with inadequate controls to track disbursements of funds. In addition, medical suppliers that had provided faulty testing kits were awarded contracts through procurement processes that involved bid rigging (Kirk 2011, p. 185).

- In the US$125 million Tuberculosis Control Project, the INT discovered widespread collusion in procurement by the state and district offices. Indicators of collusion include, "bidders sharing the same address and telephone numbers, unit prices showing a common formula, and indicators of intent to split contract awards among several bidders" (World Bank 2008a, p. 20).

According to the report, Bank staff failed to adequately supervise project oversight and paid little attention to project performance. There were multiple cases where staff turned a blind eye to indicators of fraudulent practices. INT staff reported "appalling conditions" at 51 hospitals they visited in Orissa. However, construction management consultants, who were overseeing the Bank-financed hospital construction projects had certified 38 of these hospitals were complete and met project specifications. Furthermore, in the National AIDS Control Project, "the bank appeared to pay scant attention to the performance and quality of the goods supplied to the blood banks and testing centers, instead focusing on the number of such facilities being erected."[23]

[23] "World Bank Disgrace," *The Wall Street Journal*, Jan. 14 2008.

The World Bank and the Indian Government react

The DIR investigation began during the World Bank presidency of Paul Wolfowitz who made anti-corruption efforts a signature part of his tenure. *The Wall Street Journal* wrote that Wolfowitz had "shown real spine" in confronting the Indian Government about rampant corruption, noting he had cut off lending after the discovery of fraud in a health project.[24] However, Wolfowitz himself ended up at the center of an ethics inquiry and resigned in 2007. He was replaced by Robert Zoellick just as the DIR investigation drew to a close. When the DIR report was released in January 2008, Zoellick moved to control the public embarrassment. Through public statements, his office emphasized the Indian government's role in taking the lead to fight corruption. In a press statement marking the report's release, Zoellick wrote, "The Government of India and the World Bank are committed to getting to the bottom of how these problems occurred. I appreciate the resolute commitment of the Government which will be in the lead in pursuing criminal wrongdoing."[25] Zoellick also acknowledged the Bank's shortcomings: "On the Bank side, there were weaknesses in project design, supervision and evaluation. There are also systemic flaws. I am determined to fix these problems." The statement pointed out the need to strengthen weaknesses identified by the DIR, including the Bank's supervision procedures.

The Indian government also acknowledging widespread corruption, promised "exemplary punishment" for individuals implicated in fraud. But although scathing, the report's findings of systemic corruption revealed nothing new. As India's health secretary, Naresh Dayal noted, "We are not very surprised by it, but certainly these are matters of concern" (Solberg 2008). Following the 2005 RCH investigation, the Indian government had already started to institute anti-corruption measures. Some of the planned actions included:

- Publishing all procurement processes, bidding and contract awards to promote transparency;
- Using Community Score Cards and social audits to ensure implementation oversight by project beneficiaries and civil society groups;
- Tightening oversight of contracts and recruitment of NGOs;
- Using independent validation of WHO Good Manufacturing Practice certificates and disclosing full results on Government websites to ensure the quality of procured pharmaceuticals;
- Initiating annual procurement audits for all projects; and
- Tightening procurement controls to detect collusive bidding, including designing new software detectors.[26]

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[24] Ibid.

[25] "Government of India and World Bank Group Join Forces to Stamp Out Corruption in Health Sector Projects," *The World Bank*, Jan. 11, 2008.

[26] "Government of India and World Bank Group Join Forces to Stamp Out Corruption in Health Sector Projects," *The World Bank*, Jan. 11, 2008.

These plans were efforts to show the Bank's leadership that the Indian government considered the weaknesses in procurement and project management to be serious, and was committed to addressing them. Referring to the Bank's long history of partnership in India, Managing Director Ngozi Okonjo-Iweala noted, "I am encouraged by the Government of India's serious resolve to address these issues based on the lessons of the DIR and have confidence in their capacity to do so."[27]

However, the Indian Ministry of Health did challenge some of the DIR's findings. It accused the INT team of narrating a story that was "one-sided", by describing corruption as endemic to the country's entire health sector, and not adequately crediting successful campaigns, such as the national TB initiative (Kirk 2011, p. 186). The Ministry's 60-page response reviews the DIR's claims on a point-by-point basis, refuting some and accepting others.[28] The Government also detailed actions it had already taken prior to the DIR, as well as a timeline for additional corrective measures planned for implementation.

In March 2008, the World Bank and the Government of India publically announced a joint Action Plan to respond to the DIR's findings. The plan, which was praised by the Bank's Board of Executive Directors as "strong, comprehensive, and ambitious," proposed actions across four themes:[29]

- Strengthened monitoring and financial management, selection and oversight of NGOs, centralized procurement, and decentralized procurement;
- Fixing the problems observed in the five DIR projects;
- Mitigating the risks to the nine ongoing projects in the portfolio; and
- Reviewing future Bank lending in the sector.

The joint Action Plan proposed performance reviews by independent third-party agents, comprehensive procurement audits, increased use of community-monitoring and oversight, and qualification requirements in bank-financed bids to reduce the risks of collusion. The Bank and the Indian government agreed to conduct follow-ups every 6 months to assess progress. The Action Plan displayed a joint commitment to address corruption, but the degree of implementation and the impact on corruption are unknown. This period was also characterized by a shift in World Bank lending to India in the form of "Flagship Programs" at the federal level, which shifted the burden of controlling (and the costs of) corruption more squarely on India.

The World Bank loans to India were affected by the initial 2005 investigation when Wolfowitz suspended an US$850 million loan for the second RCH (Kirk 2011, p. 181).

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[27] Ibid.

[28] "Detailed response of the Ministry of Health and Family Welfare, Government of India to the DIR of India Health Sector Projects," *Government of India*, March, 2008.

[29] "World Bank and Government of India agree action to stamp out health project fraud and corruption." *The World Bank*, March 13, 2008.

Several other health projects were put on hold in 2006 pending review as a signal of concern over corruption. After publication of the DIR, Bank lending to the Indian health sector continued to slow. However, this slowdown in Bank lending does not appear to have affected the health sector's finances. India's public sector health spending doubled from about US$7 per capita in 2005 to US$14 per capita in 2009 by reallocating domestic resources and obtaining grants from other funders. In fact, external aid to India's health sector also grew overall from $0.10 per capita in 2005 to $0.15 per capita in 2009.[30]

Questions remain

The DIR process was criticized for going too far. First, the quality of evidence it generated was weakened by changing the methodology while it was underway. Specifically, the investigation shifted from a document review to a more in-depth performance audit once the pervasiveness of fraud was identified. However, the DIR inquiry was not designed to substantiate evidence of fraud that could be used to support criminal investigation. Second, the government of India and others criticized the DIR's tone and treatment of evidence. The DIR specifically identified individuals and companies that were suspected of involvement in collusive practices, but did not include evidence to confirm these allegations. Acknowledging these concerns, the Bank agreed to make changes to the DIR methodology going forward. These included: providing governments 30 days to comment on draft DIR reports before they are made public and not publishing names of people or companies involved until allegations have been confirmed.[31]

Other critics, however, argued that the investigation did not go far enough. Professor Amir Attaran at the University of Ottawa accused the Bank's managers of being "too cozy" with their Indian counterpart, saying, "This is a corrupt party investigating itself."[32] These differing views reflect the tension that the World Bank faces in maintaining good working relationship with clients, while also independently investigating and evaluating program implementation.

Beyond the methodological weaknesses, did the corrective measures outlined in the joint Action Plan make a positive difference? Some of our informants viewed the Action Plan as mere rhetoric—an instrument used by senior leadership to appease the Board that the Indian government was taking change seriously. Another informant thought that the Action Plan may have successfully reduced corruption in centrally-managed health projects while displacing it to the state level. Jason Kirk criticized these efforts for adding to the already-burdensome bureaucracy of project management, writing, "The [Action] Plan promised improved safeguards and fiduciary controls, which reasonable skepticism might regard as

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[30] Data obtained from WHO "Global Health Observatory data repository" at http://bit.ly/1Kv0EfJ (accessed May 24, 2016).

[31] "World Bank and Government of India agree action to stamp out health project fraud and corruption." *The World Bank*, March 13, 2008.

[32] "Dirty Linen: Can a Big Lender fight sleaze?" *The Economist*, March 19, 2008.

adding to the 'hassle factor', thus further decreasing the appeal of World Bank project loans for borrowers such as India, with uncertain effectiveness against corruption" (2011, p. 185).

To conclude this case, systematic corruption had been common in India's health sector and in Bank-supported projects prior to the DIR. However, the scandal seems to have erupted only when the Bank investigation coincided with Wolfowitz's interest in demonstrating his commitment to root out corruption. Unlike the other cases we discuss, the DIR documented significant results failures in all five health projects along with procedural failures and fraud. However, the DIR still failed to convince critics who questioned the DIR's conclusions. The DIR process was criticized as heavy handed and, in some cases, overstating the extent of fraudulent practices. This reflects challenges associated with generating consensus on the extent of corruption and collecting the right type of evidence for pursuing legal action in courts.

When the DIR report was released in January 2008, its findings generated significant public controversy. The dynamics which initially favored a hardline stance, however, gave way before pressures to minimize the problem. The World Bank's management attempted to rebuild its relationship with India by applauding the Indian government's commitments to the joint Action Plan. It remains unclear whether these corrective measures led to lasting changes or a continuation of business as usual within the Indian health sector and at the World Bank.

Case 2: Multiple donors in Zambia

Whistleblower sets off series of investigations

In March 2009, a whistleblower at the Ministry of Health alerted Zambia's Anti-Corruption Commission (ACC) to US$2 million in embezzled funds.[33] Top Ministry officials had allegedly stolen funds by claiming per diem payments for trainings and workshops that never took place. In response to the allegations, Zambian President Rupiah Banda ordered the Office of the Auditor General (Z-OAG) to launch a detailed investigation. On May 14, *The Post*, a Zambian newspaper, ran a story confirming the OAG's ongoing investigation into corruption allegations (de Vibe et al. 2013, p. 67). As findings became available later that month, the Zambian government suspended 30 officials implicated in the incident, including the Ministry's former permanent secretary.

Based on the OAG's interim results released on May 27, the Zambian government reported to donors that embezzled and unaccounted funds at the Ministry totaled US$5.2 million (de Vibe et al. 2013, p. 15). However, the final report released in July provided a more complete picture of the extent of corruption. Investigators uncovered an extensive network of officials at various levels of the Ministry who had signed off on receipts and bank slips to cover up traces of stolen funds. In addition to embezzlement, the investigation also identified evidence of weak accounting systems at the Ministry. These findings confirmed irregularities and accountability lapses in financial accounts reported by the Z-OAG earlier that year (Pereira 2009, p.9). According to the July 2009 report, the Z-OAG was unable to account for a total of US$ 7.7 million (ZMK 36 billion) between 2006 and 2009. Approximately US$3.5 million (ZMK 17 billion) came from the Expanded Basket Fund supported by a range of international funders including Sweden, Netherlands, and Canada; US$ 413,000 (ZMK 1.9 billion) constituted Global Fund grants; and the rest were all government funds (Global Fund 2009, p. 2).

Following the suspected mishandling of Global Fund grants, the Fund's Inspector General (GF-OIG) launched its own independent investigation. Between July and September 2009, the GF-OIG investigated 7 grants to the Ministry of Health totaling US$272 million over the period 2003 to 2009 (2009, p. 11). Investigators concluded that fraud was more widespread than previously reported. In addition to fraud, the Ministry's weak procurement capacity and inadequate accounting systems had also resulted in considerable financial mismanagement. To this end, the investigation identified US$4.4 million in unsupported costs that lacked sufficient documentation, and an additional US$1.6 million in ineligible expenditures that had been used to cover costs outside approved budgets and agreed work plans (2009, p. 11). The GF-OIG report concluded it could not give assurance that the Ministry of Health had adequate financial managing systems in place to manage Global Fund grants.

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[33] "Zambia: Health funding frozen after corruption alleged," *IRIN,* May 27, 2009.

Donors react swiftly and severely

Donors reacted swiftly and severely to the corruption allegations. On May 15, the day after the story appeared in *The Post*, Sweden halted a recently-authorized disbursement to the health program. Canada also moved quickly to freeze a US$5 million commitment to support the health sector's human resource capacity. Despite the Zambian government's immediate steps to suspend Ministry officials suspected of being involved, and its commitment to fully investigate the case, donors continued to express concern.

When the Z-OAG's interim findings were released on May 27, a host of funders announced decisions to suspend and delay contributions to the Zambian health sector. Sweden and the Netherlands suspended additional contributions worth US$ 38 million to the expanded health basket (de Vibe et al. 2013, 15). The head of the Swedish International Development Agency (Sida) in Zambia—the largest donor to the health sector—condemned embezzlement, declaring that "Sida will not accept any abuse of development money."[34] The Netherlands—which contributes an estimated US$18 million annually to Zambia's health sector—also condemned corruption. The Dutch Development Cooperation Minister stated, "The misuse of Dutch taxpayers' money is unacceptable."[35] In June, the Canadian International Development Agency (CIDA) also halted further disbursements to Zambia's Ministry of Health.[36]

Sweden went even further, suspending general budget support to the Zambian government (Usher 2010). This was not driven primarily by the corruption scandal but seems to have provided additional justification for closing down an aid modality that a newly-elected coalition government viewed skeptically.

These decisions to disrupt aid disbursements were not well received by the Zambian government, which relies on international funding for more than 50% of the health sector budget. Zambia's President was highly critical of the funders' strong stance on the issue. "We must not allow donors to feel they can interfere in the internal affairs of this country because it is a sovereign and independent state. We did not ask anyone to fund the road sector or the health sector, so they must not use that as blackmail. We are very grateful for whatever help they give us, but we will not be turned into their puppets," he declared on a state owned radio station.[37] Notably, these decisions were made before the final Z-OAG report became available in July with further details of the magnitude of corruption and the exact amount of donor funds affected (ITAD & LDP 2011, p. 44).

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[34] "Zambia: Health funding frozen after corruption alleged," *IRIN,* May 27, 2009.

[35] Ibid.

[36] More information on CIDA's health project in Zambia is here: http://bit.ly/1t29H43.

[37] "Zambian president says donors must not interfere," *Reuters*, June 26, 2010.

However, donors did not act in unison. The Global Fund did not suspend funding until August, when its initial investigations were concluded. The Global Fund then requested the return of US$8 million in unspent funds and suspended US$137 million in disbursements to Zambia's Ministry of Health.[38] Based on findings from the GF-OAG investigation mission, the Global Fund also announced its decision to transfer grant management functions to the United Nations Development Program (UNDP). Meanwhile, the European Union and African Development Bank actually *increased* their contributions to Zambia's health sector in the aftermath of the scandal (de Vibe et al. 2013, 15).

Funders also reacted differently to information about how the Zambians detected and addressed the corruption allegations. In particular, the government's own system alerted authorities to the problem, and Zambia's President subsequently requesting the Z-OAG to investigate the case. As a result, some funders questioned the need to strengthen their own internal audit mechanisms since their systems were unable to detect the misuse of funds.[39] Others felt this was the positive result of prior investments to strengthen Zambia's government accountability, and called for continued support in this area (Wahlstedt and Sundewall 2010, p. 8).

The different responses by funders suggest that the gravity of the events in Zambia was less important than the funders' domestic politics, priorities and audit standards (de Vibe et al. 2013, 69). Some funders (Sweden, Netherlands, and Canada) responded before complete details were available regarding the magnitude of corruption and the extent to which their funds were affected. Public statements from agencies suggest that the decision to disrupt aid was driven by the need to address reputational risk, rather than results failures. Sweden's parallel reduction in budget support to Zambia also strengthens the argument that funders' political priorities, rather than the magnitude of corruption in the recipient country, are the primary driver for disrupting aid.

In July 2009, the Zambian government, in collaboration with funders, developed a three-stage Governance Action Plan to reform the health sectors' financial management system and safeguard mechanisms (de Vibe et al. 2013, p. 70). The first stage involved strengthening the Ministry's internal audit functions and laying the ground work for a more comprehensive systems audit. The second stage included completion of the audits (systems, procurement, and financial). During the third stage, the Ministry would take steps to address the recommendations resulting from the audits. As the government met conditions under each stage, funders would release a portion of aid after an independent verification was

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[38] "Global Fund Confirms Freeze on Cash Disbursements to Zambia's Ministry of Health, Grants To Be Transferred To UNDP," *Global Fund,* June 16, 2010.

[39] Brady Yauch, "Zambia corruption scandal links back to Canada," *Probe International*, Nov. 15, 2010.

conducted; but aid would not be fully reinstated until funders felt the government had taken satisfactory steps to address corruption.

In October 2009, the government declared it had met conditions under stage one of the plan, but donors did not release disbursements. This upset the Zambian government. A spokesperson from the Ministry of Health explained, "It is now surprising that the same donors who set the conditions in phase one are now insisting that they can only resume funding to the Ministry if we meet the conditions of phase two of the action plan."[40] Government officials highlighted that the suspension of disbursements to the Ministry of Health was taking a heavy toll on the health sector. But, donors felt reforms were being made too slowly. Funders criticized the pace of progress, citing the government's slow response to refunding embezzled funds. Furthermore, the Global Fund's investigation report stated that "Zambian authorities had failed thus far to provide assurances of appropriate action" (2009, p. 2). A Swedish official in Lusaka claimed that although financial management systems had improved as a result of reforms, the Ministry was taking too long to implement changes (Usher 2015). While the Plan prioritized actions to strengthen accountability during the year after the scandal, the sustainability of anti-corruption efforts in the longer-run was not evident (de Vibe at al. 2013, p. 73).

Costs to the health sector

Funders' reactions to the corruption scandal had two main consequences for Zambia's health sector. First, the sector experienced a funding shortfall due to cuts from multiple funders. Second, several parallel structures were created as donors bypassed the Ministry of Health, and channeled funds through UN agencies and NGOs instead.

With half of its budget supported by international funders, the Ministry of Health was hit hard by the aid cuts (Pereira 2009, p. 8-10). A 2010 government review of the health sector called attention to the Ministry's "turbulent financial situation" resulting from the "dramatic and acute resource reduction."[41] Between 2009 and 2010, the Ministry reported a 40% fall in disbursements to health care providers. Service delivery also experienced significant reductions in coverage. For example, government statistics indicated coverage of antenatal care dropped from 95% in the first quarter of 2009 to 78% at the end of 2010. By 2012, the government's health sector review described the "overburdened and under-supported" health workforce that was unable to deliver quality care services." Both the government and funders made public references to the high "human costs of [these] anti-corruption measures."

Nevertheless, there is little evidence on the impact of the cutback in aid on health outcomes in Zambia. No assessments were conducted to measure the direct impact of the anti-

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[40] "Ministry of Health Accesses Donors," *Lusaka Times*, Oct. 5, 2009.

[41] Quotes and statistics on the challenges for the Zambian health sector are from Usher 2015.

corruption policies on the Zambian health sector. The best data available comes from DHS Surveys conducted in 2007 and 2013/2014 which show overall positive health trends, with the exception of immunization coverage. It is, therefore, impossible to say how much of an effect the disruption of health services had on health, if any.

The scandal did not only have implications on health service delivery, but also derailed institutional development. Funders redirected aid from the Ministry of Health to UN agencies and NGOs, creating parallel structures that undermined previous efforts to strengthen the national health system. For example, the EU directed funds for its Maternal and Child Health projects through UNICEF and the Global Fund charged UNDP with managing its grants (Usher 2015).

Furthermore, Sida provided a greater proportion of health funding through NGOs. Before 2010, less than 5% of its health aid envelope was allocated to NGOs. In the years since 2011 however, Sida has directed close to, or more than, 50% of funding to NGOs (Usher 2015). Channeling funds via non-state mechanisms contradicts Sida's own policy, which states, "Swedish engagements in the field of health shall be designed so that they contribute towards more effective health systems."[42] When faced with a corruption scandal, however, the agency's anti-corruption policy—"always prevent; never accept; always inform; and always act"—took precedence.[43] Therefore in this context, addressing the reputational risk arising from the corruption scandal outweighed Sida's policy on delivering aid more effectively.[44]

Donors reinstate funding but was the response effective?

For nearly six years, Zambia's health sector continued to experience aftershocks from the scandal. Overall funding declined and funders ceased channeling contributions through the Ministry of Health. The Global Fund only reinstated the Ministry of Health as its principal recipient in January 2015.[45] With this move, the Global Fund recognized the Zambian government's efforts to establish improved financial management and accounting systems. And in December-2015, Sida granted a SEK 409 million package for 2015-2019 to support reproductive, maternal, neonatal, child and adolescent health and nutrition.

The case of the Zambian health sector reflects a key dilemma that funders face when corruption scandals affect their aid portfolios. To that end, the case sheds light on whether a zero tolerance policy towards corruption is realistic. Considering the reversal of results

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[42] "Aid Policy Framework – the Direction of Swedish Aid," Government of Sweden, 2014, p. 35.

[43] SIDA, "Our work against corruption" (accessed Sept. 28, 2015).

[44] Sida staff took exception to this interpretation. They say that Sida was planning to approve a large health program through government channels in 2013 but it was delayed when Zambia shifted primary health care responsibilities from the Ministry of Health to the Ministry of Community Development. Since that program was signed in 2015, most health aid from Sida and DFID are flowing through government channels again.

[45] "Zambia and Global Fund Sign $234 Million in New Grants," *Global Fund,* Jan. 9, 2015.

achieved in certain areas, particularly national capacity building, did the suspension of large amounts of health aid reflect the seriousness of the crime? As the table below shows, donor funds affected by fraud and corruption were relatively small, compared to the amounts that donors withheld from the Zambian health sector between 2009 and 2014. During this period for example, Sida withheld an estimated US$60 million (SEK 0.5 billion) from Zambia's health sector, about 100 times greater than the amount initially affected by fraud (Usher 2015). With regard to Canadian funding, CIDA publically reported in 2010 that US$880,000 had been lost to corrupt practices in Zambia. However, the agency suspended over US$14 million in health aid between 2009 and 2014.[46]

Table 2: Health sector funds affected and withheld for select funders in Zambia (US$ millions)

Funder	Total funding	Funds affected	Funds withheld ('09-'14)
Sweden (SIDA)	18	0.85	60
Canada (CIDA)	15	0.88	14
The Global Fund	272	10	137

Source: Authors' own calculations based on reporting from Sida, CIDA, and the Global Fund.

A zero tolerance policy is a popular mantra among funders, who repeatedly emphasize that corruption in any form or size is an immediate concern. Their response to cut aid aims to uphold the integrity of taxpayers' contributions, even when this response comes at a cost to health. Referring to her agency's response to the scandal, Sida Director General, Charlotte Petri Gotnitzka argued, "[the actions] were necessary to send a clear signal. We are ready to stop payments again if and when fraud is detected. When we take that step we do not compare the amount of money stolen to the total amount of planned disbursements" (Usher 2015). In the Zambian context, funders prioritized integrity over development objectives.

However, this case also points to challenges surrounding the inconsistency with which donors responded to the corruption allegations. The fact that corruption was detected and being investigated by Zambia's own institutions did not influence donors to continue health aid while strengthening those institutions. Rather some donors, such as Sweden, Netherlands, and Canada, chose to suspend aid instead of adopting a differentiated response. The amounts withheld were large compared to the funds affected by corruption. However, it is impossible to objectively assess whether fraudulent practices merited such a response from funders and if the government was doing enough to respond to the problem without reliable information on the health impact of these programs, although it is clear that disrupting health aid slowed institutional development and health service delivery. As in the other cases, it is impossible to tell whether the action plans instituted in response to the external

[46] Brady Yauch, "Zambia corruption scandal links back to Canada," *Probe International*, Nov. 15, 2010.

pressures have substantially reduced the likelihood of corruption occurring again in the future.

Case 3: The Global Fund: Mali, Mauritania, and Djibouti

A scandal unfolds

In October 2010, the Global Fund's Office of the Inspector General (GF-OIG) published a Progress Report summarizing findings from a series of audits and investigations in 11 countries (Global Fund 2010). The report was subsequently shared with the Board in December 2010. Misuse of grant funds in four countries, Mali, Mauritania, Djibouti, and Zambia accounted for most of the identified losses. On January 23, 2011, the Associated Press (AP) ran a story titled, "Fraud plagues Global Fund grants." The article described fraudulent practices amounting to US$34 million in Global Fund grants to the four countries.[47] Labeling the level of fraud "astonishing", AP declared "as much as two-thirds of some grants [were] eaten up by corruption." This claim created a storm in the media, catching the public's attention, raising questions among donors, and triggering the alarm at the Global Fund.

A public-private partnership, the Global Fund was created in 2002 to mobilize and allocate additional donor resources to combat AIDS, Tuberculosis, and Malaria.[48] Its formation was the result of a global consensus on the need for a mechanism to ensure the efficient allocation of much-needed medications, treatments, and other resources. To emphasize the Global Fund's commitment to transparency, the GF-OIG was established in 2005 to investigate grants and report its findings directly to the Board. After taking office as the second Inspector General in 2008, John Parsons committed to upholding accountability in the Fund's grant portfolio. His office established annual plans to conduct systematic country audits, in addition to investigations into allegations of fraud triggered by whistleblowers. His ambitious target involved completing audits in half of the 144 Global Fund grant recipient countries by the end of 2012.[49]

The findings disclosed by the GF-OIG in December 2010 were the result of a series of audits and investigations to identify and report cases of corruption. A summary of findings from Mali, Mauritania, and Djibouti—the three countries covered by this case study—is below:

- In Mali, the GF-OIG reviewed expenditures of US$9.7 million under four Malaria and TB grants worth US$13 million. The final investigation report concluded that US$4.1 million was diverted through criminal acts of fraud and misappropriation, and an additional US$1.1 million lacked proper supporting documentation (representing 53% of the funds reviewed) (Global Fund 2011a, p. 9). After examining over 50,000 pages of documentation, the GF-OIG found extensive proof

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[47] John Heilprin, "Fraud plagues global health fund," *Associated Press*, Jan. 23, 2011.

[48] Global Fund, "About the Global Fund" (accessed Aug. 17, 2015).

[49] Susan Linnee, "John Parsons, the Global Fund's Inspector General," *Global Fund Observer Newsletter*, issue 128.

of improper accounting used to cover up travel expenses and per diems for phony training events. Investigators also uncovered fake bid documents and falsified documentation used to support costs of fictitious training events. In addition, the accountant within the Ministry of Health's Directorate of Administration and Finance tasked to oversee the grant had forged checks and falsified bank statements.

- In Mauritania, the GF-OIG reviewed expenditures totaling US$9.7 million under five grants (two malaria, two TB, and, and one HIV), and concluded that US$6.6 million was affected by fraud (representing 70% of funds reviewed) (Global Fund 2012b, p. 7-8). Similar to the findings in Mali, OIG-GF investigators found proof that grants had been used to pay for fictitious training events. In another example, the principal recipient SENLS (the National Committee for the Fight against HIV/AIDS) organized a kickback scheme with its sub-recipients who submitted fake documentation for activities that were never implemented (Global Fund 2012b, p. 8-9). There were also instances of collusion among local merchants who worked with grant sub-recipients to submit fake invoices (Global Fund 2010, p. 14).

- In Djibouti, the GF-OIG reviewed the Global Fund's US$23 million portfolio, and concluded that over US$5 million was affected by improper bookkeeping and not used for intended purposes (this represented over 20% of funds investigated) (Global Fund 2012a, p. 5). These findings differ from the cases in Mali and Mauritania, where unsupported expenditures affected a smaller proportion of funds. The investigation report describes the lack of documentation to validate purchases made using grant funds, diversion of grant funds for unauthorized procurements, as well as the absence of procedures for selecting sub-recipients.

The investigation reports for these 3 countries provided detailed evidence of widespread fraud and procedural failures. However, there was limited evidence on results failures. To cover up the fraud in Mauritania, program officers falsely reported the number of people trained during workshops paid for by Global Fund grants (Global Fund 2012b, p. 10). In another example, funds were used to build and supply a TB clinic in Mali which investigators reported was unused (Global Fund 2011a, p. 9). Except for these limited examples, the evidence in the GF-OIG investigation reports did not focus on results failures linked to health outcomes, such as malaria morbidity or HIV prevalence.

Although the AP story was criticized for its sensationalist reporting, it was picked up by over 250 media outlets around the world.[50] Some critics used the story to expose widespread

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[50] Bernard Rivers, "Corruption by Global Fund Grant Implementers," *The Global Fund Observer* no. 139, Jan. 27, 2011.

waste and justify cutting aid budgets. In an interview with Bill O'Reilly on Fox News, Nile Gardiner of the Heritage Foundation said, "We could be looking at billions of dollars in missing funds, which would make this one of the biggest financial scandals of the 21st century. We need congressional investigations into where US money is going."[51] In response to the fierce criticism, the GF-OIG pointed out, "the issues the Global Fund was facing was common to all donors and entities operating in these risky environments (Global Fund 2011d, p. 3) Echoing this sentiment, others highlighted the Global Fund's commitment to transparency by emphasizing that the GF-OIG had itself disclosed the misuse of grant money.[52]

Donors rescind commitments; Global Fund reacts swiftly

After the GF-OIG released its findings on fraud and corruption in October 2010, Sweden was the first donor to suspend its 2011-2013 contribution, cancelling an US$85 million payment.[53] Sweden also called attention to the need to strengthen the Global Fund's fiduciary system. A spokesman for the Swedish Foreign Ministry explained, "For Sweden, the issues of greatest importance are risk management, combating corruption and ultimately ensuring that the funds managed by the Global Fund really do contribute to improved health."[54]

The AP article's misleading generalization about the extent of corruption within Global Fund grants triggered a heightened concern among other donors that funds were being siphoned off.

Just days after the article was released, Germany—the Global Fund's third largest donor—suspended its US$270 million contribution for 2011.[55] A spokesman for the German development ministry argued that the decision "aimed to safeguard the interests of German taxpayers."[56] Following suit, Spain, Denmark and the European Union also temporarily suspended contributions to the Global Fund, pending further investigations.[57] In the aftermath of the global financial crisis of 2008-2009 and the decision by many European

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[51] "Corruption revealed in major charitable fund," *The O'Reilly Factor*, Jan. 24, 2011.

[52] Nandini Ooman, "What Can We Learn from the Global Fund's "Massive Fraud"?" *Center for Global Development*, Jan. 25, 2011.

[53] "Sweden announces increased three-year pledge to The Global Fund," *Global Fund,* Oct. 18, 2011.

[54] John Heilprin, "Fraud plagues global health fund," *Associated Press*, Jan. 23, 2011.

[55] "Cleaning Up: Can the Global Fund to fight Aids, Tuberculosis and Malaria restore its reputation as the best and cleanest in the aid business?" *The Economist*, Feb. 7, 2011.

[56] "Germany halts Aids fund payment over corruption claims," *BBC,* Jan. 27, 2011.

[57] "Cleaning Up: Can the Global Fund to fight Aids, Tuberculosis and Malaria restore its reputation as the best and cleanest in the aid business?" *The Economist*, Feb. 7, 2011.

governments to pursue austerity policies, some questioned whether donor governments were using the corruption scandal as an opportunity to cut their aid budgets.[58]

The Global Fund reacted swiftly to the controversy generated by the AP article. In an official statement released the day after the story broke, the Global Fund reiterated its "zero tolerance" policy on corruption and claimed "[it] deploys some of the most rigorous procedures to detect fraud and fight corruption of any organization financing development."[59] Furthermore, the statement pointed out "the news report that has caused concerns refers to well-known incidents that have been reported by the Global Fund and acted on last year. There are no new revelations in yesterday's media reports." Indeed, these findings were already in the public domain. Aid Span, an independent observer of the Global Fund, had reported about the Mali case in its December newsletter, for example.[60]

To this end, the Global Fund's statement described the immediate steps it had already taken when the GF-OIG released findings in October 2010. The Global Fund suspended or terminated payments, attempted to recoup misused funds, and in some cases requested repayments.[61] To ensure grant activities in these countries are adequately scrutinized, the Global Fund took additional measures, including increasing staff and improving capacity of Local Fund Agents to detect fraud and misuse in grants. Considering that a significant portion of misused funds in multiple countries were related to trainings, the Global Fund temporarily halted training events in all 140 countries until a system to pre-approve plans was in place. In collaboration with national law enforcement authorities, the Global Fund had been working to ensure the arrest of individuals involved in misappropriating funds.

Following the increased scrutiny from donors and stakeholders triggered by the AP story, the Global Fund released a follow-up statement on February 4, 2011, in which it announced the creation of a High Level Independent Review Panel to conduct an external review of the Global Fund's audit controls and financial oversight mechanisms. To uphold its credibility, the statement also reiterated several ongoing measures aimed to ensuring the highest standards of fraud prevention and detection. These included:

- Expanding the mandate of firms that monitor expenditure in countries in order to enhance fraud;
- prevention and detection;
- Strengthening the role of country coordinating bodies in grant oversight;

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[58] Ibid.

[59] "Global Fund statement on abuse of funds in some countries," *Global Fund,* Jan. 24, 2011.

[60] David Garmaise, "Global Fund Terminates One Mali Grant and Suspends Two Others," *Global Fund Observer* issue 136 (17).

[61] "The Global Fund announces measures to enhance financial safeguards and strengthen fraud prevention," *Global Fund,* Feb. 4, 2011.

- Additional scrutiny of activities considered at higher risk of fraud, such as training;
- Redirecting a proportion of all grants to assess and strengthen financial controls at country level;
- Increasing the number of the Global Fund's staff responsible for financial management; and
- Doubling the budget of the Global Fund's independent Inspector General.[62]

Challenges in interpreting the extent of fraud

In April 2011, the Global Fund released a report titled, *Results with Integrity: The Global Fund's Response to Fraud*, in which it disclosed a detailed breakdown of cases of fraud, unsupported expenditures, and ineligible expenditures in 11 countries (See table 1). The Global Fund called the AP article "misleading", accusing the reporter of making "broad and sweeping claims about the nature and extent of fraud and corruption in Global Fund financed programs" (Global Fund 2011b, p. 2). In a statement, the Global Fund reported US$39 million was unaccounted for in several countries out of a total disbursement of US$13 billion between 2002 and 2010, amounting to 0.3%.[63] But the GF-OIG investigations did not cover the Global Fund's entire portfolio. Therefore, it would be a mistake to conclude that *only* US$39 million was misappropriated. Investigations or audits have only been conducted in 33 of the 145 countries that receive Global Fund grants; and in certain countries not all grants were audited (Global Fund 2011c, p. 3). Without additional information to contextualize the absolute figure, the full extent of the fraud, as well as the representativeness of these cases is not clear.

There is another important caveat to interpreting the extent of corruption. Only a portion of the reported amount was identified as "fraud", as defined by the GF-OIG. The investigators also uncovered "unsupported expenditures"—expenses that are not traceable due to missing receipts. This reflects the distinction between intentional fraud and mismanagement in bookkeeping, which may be—but is not always—used to disguise fraud.[64]

Acknowledging these limitations, the Global Fund's Secretariat admitted its claim that fraud represented 0.3% of the Global Fund's entire portfolio "led to misinterpretations of the statistics and percentages, and a minimization of the level of fraud and loss in the portfolio overall" (Global Fund 2011c, p. 3). In collaboration with the GF-OIG, the Secretariat released additional analysis in July 2012, concluding that 3% of audited or investigated grants

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[62] "The Global Fund announces measures to enhance financial safeguards and strengthen fraud prevention," *Global Fund,* Feb. 4, 2011.

[63] Bernard Rivers, "Corruption by Global Fund Grant Implementers," *The Global Fund Observer* no. 139, Jan. 27, 2011.

[64] Bernard Rivers, "Corruption by Global Fund Grant Implementers," *The Global Fund Observer* no. 139, Jan. 27, 2011.

between 2005 and 2012 had been "misspent, fraudulently misappropriated, or inadequately accounted for."[65] While this represented a commendable effort to provide a more accurate measure of the extent of corruption, the analysis remained fraught with limitations. Specifically, as the Global Fund's own IG pointed out, "[the] audits and investigations are not a representative sampling of all Global Fund grants," because the GF-OIG tends to focus on high risk grants. The Global Fund's concerted effort to provide an honest and detailed accounting of the misused funds should be praised. However, our understanding of the representativeness of these corruption cases remains incomplete.

Table 3: Summary of fraud and misused grant funds

Country	Fraud	Unsupported expenditures	Other	Total affected
		All figures in US$ millions		
Djibouti	0.1	4.3	0.9	5.3
Mali	4.1	1.0	0.1	5.2
Mauritania	6.6	-	-	6.6
8 other countries	0.3	9.7	17	26.9
Total in 11 countries	**11**	**15**	**18**	**44**

Source: Results with Integrity: The Global Fund's Response to Fraud (2011)
Note: The "fraud" category includes fraud, theft, embezzlement, and unlawful conversion. "Unsupported expenditures" are expenses that are not traceable due to missing receipts. "Other" category includes ineligible expenditures (expenditures that are documented but not approved in the budget) and unaccounted income/drugs. Totals do not sum exactly due to rounding.

[65] "Global Fund Releases an Analysis of Audits and Investigations – 2012," *Global Fund*, Jul. 10, 2012.

Comprehensive reform agenda gets underway at Global Fund

Eight years following its creation, donors and board members were highlighting the need for a broad set of reforms to strengthen the Global Fund. The Secretariat launched a *Reform Agenda for a More Effective and Efficient Global Fund* in early 2010, with the aim of improving risk management within its grant portfolio (Global Fund 2011d, p. 6). Thus, the corruption scandal that erupted in 2011 fed into a change process that was already underway, but led the Secretariat to increasingly emphasize fraud detection measures.

In September 2011, the High Level Independent Review Panel completed its external review of the Global Fund's audit controls and financial oversight mechanisms. The report called attention to the lack of adequate oversight to prevent fraud and insufficient budget scrutiny at the grant approval stage. The panel's recommendations included moving from an emergency to a more sustainable response to fraud, applying a new risk-management framework to the Global Fund's current portfolio, instituting a two-stage grant process, and a stronger commitment to results by measuring outcomes, rather than inputs (2011, p. 60). The report's findings and recommendations were incorporated into the November 2011 Consolidated Transformation Plan—a detailed implementation framework to guide the Global Fund's five-year reform agenda between 2012 and 2016 (Duran and Silverman 2013, p. 8).

Donors, including Sweden and Germany, that had suspended contributions to the Global Fund had strongly emphasized the need for strengthening financial safeguards. This reform agenda apparently restored their confidence in the Global Fund's assurance mechanisms and fiduciary controls or at least allowed them to assure their political constituencies that action had been taken. In August, Germany released half of its US$270 million pledge for 2011, and disbursed the remaining amount in November once the comprehensive reform agenda was formally adopted. [66] Sweden disbursed its 2011 contribution in October 2011, and in turn committed US$300 million over three years, an 11 percent increase above its previous contribution.[67]

The rapid transformation took place against the backdrop of a shake-up in the Global Fund's leadership. Executive Director, Dr. Kazatchkine resigned in January 2012 when the Board appointed a new General Manager, Gabriel Jaramillo to lead the restructuring process.[68] Later that year, the Board named Mark Dybul, former head of PEPFAR, as the new Executive Director, who led the roll out of the "New Funding Model" (Duran and Silverman 2013, p. 9). In November 2012, the Global Fund's Board fired the Inspector General, who was responsible for systematically tracking down on corruption in the first

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[66] "Global Fund Welcomes Germany's Contribution for 2011," *Global Fund*, Nov. 23, 2011.

[67] Sweden announces increased three-year pledge to The Global Fund," *Global Fund*, Oct. 18, 2011.

[68] "The Global Fund Appoints Gabriel Jaramillo as General Manager," *Global Fund*, Jan. 24, 2012.

place. The decision to terminate Parson's employment was "unsatisfactory".[69] A review conducted by the Australian Institute of Internal Auditors found the OIG's work "only partially" followed international audit standards. Furthermore, Parsons' approval within the Global Fund had waned; the Audit and Ethics Committee—to which Parsons reported—issued a complaint against him to the Board. However, some stakeholders, such as the AIDS Healthcare Foundation, called his dismissal a "hatchet job", speculating whether Parsons' termination was an attempt to stifle additional cases of corruption from being exposed.[70] In 2016, the ILO Administrative Tribunal ruled that the process followed in dismissing Parson was flawed and ordered the Global Fund to pay material and moral damages.[71]

This case, unlike the others we discuss, was generated by systematic investigations led by the aid agency's own inspector general. Corrupt practices were detected in 11 countries, with three countries, Mali, Mauritania and Djibouti, accounting for a significant share of the detected fraud. The amounts lost, or unaccounted for, due to weak accounting represent a large portion of the grants examined in these three countries. However, they are a small share of the grants investigated in all 11 countries, and an even smaller share of the Global Fund's overall grant portfolio of US$30 billion.[72] The GF-OIG investigations focused on the weaknesses in the Global Fund's own procedures to ensure grants were being used for the intended purposes. This is in contrast to the other cases where investigative efforts focus on corruption and governance failures in recipient countries. Furthermore, the investigations overwhelmingly focus on procedural failures and fraud, with little emphasis on results.

In terms of funder dynamics, Sweden halted its contribution to the Global Fund when the OIG released its findings in October 2010. While other donors, such as Germany, Spain and Denmark, only suspended contributions for 2011 after the AP story was published. The scandal brought increased attention to risk management and fraud prevention within the wide-ranging reform agenda that was already underway at the Global Fund. However, firing Parsons has probably constrained the investigative process that was systematically monitoring grants and publishing audit findings.

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[69] "Global Fund Terminates the Employment of Inspector General," *Global Fund*, Nov. 15, 2012.

[70] Bernard Rivers, "Five Reasons Why the Inspector General Was Fired, and Another One Why He Should Have Been," *The Global Fund Observer*, no. 203.

[71] The ILO ruling is here: http://bit.ly/1PfIbtD (accessed March 25, 2016).

[72] Figures on the Global Fund's Portfolio are available here: http://bit.ly/1WuM9Ro (accessed Dec. 14, 2015).

Case 4: USAID in Afghanistan

SIGAR audits USAID's Partnership Contracts for Health Program

"Along with waging war in Afghanistan, the United States has worked to rebuild the country. But, after more than a decade and nearly US$93 billion spent on reconstruction and security programs, there are still worrisome lapses in accountability, management and effectiveness."[73] This was the argument put forth by a New York Times editorial published in July 2013, in reference to misused funds in a USAID health program reported by the Special Inspector General for Afghanistan's Reconstruction (SIGAR). Established by Congress in 2008, SIGAR is charged with investigating US spending in Afghanistan to ensure effectiveness and detect waste, fraud, and abuse.[74] The Inspector General, John Sopko describes his office's mandate as ensuring reconstruction "will be done better, faster, and more safely not only for our taxpayers but for our troops and civilians working in Afghanistan."[75] Sopko's outspoken criticism of US spending in Afghanistan has repeatedly made headlines in the media.

In August 2012, SIGAR initiated an audit of USAID's Partnership Contracts for Health (PCH) program, which supports improved health service delivery in clinics and hospitals across Afghanistan. The US$236 million PCH program was launched in November 2009, and is unique for several reasons.[76] First, PCH is a direct assistance program implemented through a host country contract. Under this arrangement, US government funds are provided directly to the Afghan Ministry of Health's Grants and Contracts Management Unit (GCMU), and deposited to Da Afghanistan Bank, the country's Central Bank.[77] GCMU requests the funds from USAID, which are provided in advance to cover operational costs for the following 45 days. The Ministry then submits financial reports to USAID documenting incurred costs over that period. Program implementation, however, is still contracted to international and domestic NGOs. The Ministry plays a "stewardship" role, coordinating monitoring and evaluation, policy development, human resources, and accreditation and regulation of the private sector. At the time, USAID had four other active direct assistance programs; PCH is the largest in terms of funds contributed.[78] In addition to its unique funding arrangement, the program contributes to a broader multilateral effort. US assistance complements funding from the European Union and World Bank, which together

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[73] Editorial Board, "The Afghan Legacy," *The New York Times*, Jul. 4, 2013.

[74] For more information about The Special Inspector General for Afghanistan Reconstruction see: http://bit.ly/1IRZsQY.

[75] "America's Afghan whistleblower John Sopko," *BCC*, Sept. 28, 2013.

[76] This case study draws on research conducted by Justin Sandefur (2013).

[77] Background on the program's funding arrangement is explained in SIGAR (2013) p. 1-2.

[78] Four other direct-assistance programs: Agriculture Development Fund (Ministry of Agriculture, Irrigation and Livestock); Basic Education and Literacy and Vocational Education Training (Ministry of Education); Civilian Technical Assistance Program (Ministry of Finance); Grant Agreement to Support Civil Service Reform (Ministry of Finance/Independent Administrative Reform and Civil Service Commission).

aim to strengthen the national health system. Third, PCH targets the entire country, unlike other US programs in Afghanistan that are limited to Taliban-controlled areas (Sandefur 2013, p. 3).

The audit's primary objective was to scrutinize the assessment and oversight procedures USAID had put in place for the PCH program. Specifically, the audit aimed to determine the extent to which USAID had assessed the financial management capability of the Afghan Ministry of Health, and whether the Ministry had followed appropriate procedures in developing project cost estimates (SIGAR 2013, p. 1). To answer these questions, SIGAR staff reviewed documentation on cost estimates, previous assessments of the Ministry's control systems, as well as accounting records. Interviews with USAID staff and Ministry officials also helped the SIGAR team better understand how project oversight was managed, and whether both parties had followed necessary procedures (SIGAR 2013, p. 11).

SIGAR report sets off alarm bells; USAID rejects recommendations

SIGAR released its report in September 2013, concluding that "USAID funding is at high risk of waste, fraud, and abuse" (SIGAR 2013, p. 8). The report highlights lapses in accounting systems and internal controls at the Ministry of Health. In one finding, SIGAR judged that USAID's pre-award assessment of the Ministry's financial management capability was inadequate, and did not meet requirements to assess internal control systems. SIGAR's findings on these procedural failures were not new to USAID. In fact, USAID's own Inspector General had expressed similar concerns in November 2010 (SIGAR 2013, p. 3). Subsequently, USAID had contracted an accounting firm to conduct an external assessment. This exercise revealed several weaknesses at the Ministry related to accounting, procurement, internal audit, and budgeting functions. Specific examples include: salary payments in cash, lack of a double entry accounting system; no documentation of policies and procedures for procurement; and inadequate qualifications of the internal audit team (SIGAR 2013, p. 5). The external assessment team also made recommendations to address these weaknesses. After reviewing documentation and talking to staff, SIGAR faulted USAID for not following up with the Ministry to ensure corrective actions were being taken. Finally, SIGAR also criticized USAID for failing to follow project cost-estimation guidelines, which require an exhaustive independent verification of the Ministry's submission.

Based on these findings, SIGAR issued 3 recommendations to USAID (SIGAR 2013, p. 9):

1. Provide no further funding to the PCH program until program cost estimates are validated as legitimate;
2. Develop, in coordination with the Ministry, a comprehensive action plan to address deficiencies identified in the April 2012 Ministry capability assessment, establish key milestones to monitor progress in executing this action plan, and make additional funding for the PCH program contingent upon the successful completion of established milestones;

3. Validate the funds obligated and expended under the PCH program since its inception and de-obligate any excess funds and return the funds to the U.S. Treasury or put these funds to better use (see table 4).

Table 4: Funding and Disbursements for the PCH Program (US$ millions)

USAID Program	Ministry	Estimated Contribution	Total Obligations	Total Disbursements
PCH	Ministry of Public Health	236	190	147

Source: SIGAR, based on data provided by USAID.[79]
Note: Data as of September 30, 2013.

When SIGAR shared a draft of the report with USAID, the agency expressed strong disagreement. This led to a slew of back-and-forth correspondence between the two offices.[80] First, the agency pointed out the lack of evidence of fraud, instead emphasizing that the PCH program "has been hailed as a success story because of the dramatic improvements in health" (SIGAR 2013, p. 12). The agency also provided supplemental documentation to prove adequate scrutiny of cost estimates, thereby rejecting SIGAR's recommendation to freeze funding. Furthermore, USAID rejected the second recommendation by noting its ongoing collaboration with its counterparts at the Afghan Ministry to address the inefficiencies and weaknesses identified by previous assessments. And in response to the third recommendation, USAID claimed it verified all costs, and found there were no excess funds to de-obligate.

Weighing evidence

SIGAR's report cites multiple examples of procedural failures to support its claim that US funding is at high risk of fraud. But SIGAR's findings did not include evidence of fraud or results failures. Rather, the recommendation to USAID to freeze funding was based on the high probability that US funding *could* be subject to waste, fraud, and abuse. The tenor of this debate might have been different had USAID provided information about PCH's apparent success at improving health, for how could a program riddled by corruption be producing positive results?

Indeed, Afghanistan was experiencing improvements in health service delivery and subsequent upward trends in health outcomes—the key objective of the PCH program. In

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[79] Data are from SIGAR (2014).

[80] See SIGAR (2013) p 9-10; comments from USAID's Afghanistan Mission Director are included in appendix II.

2011, the Afghan Mortality Survey revealed a large increase in life expectancy. Speaking about the survey results on National Public Radio, USAID's Alex Thier explained, "Afghanistan, in 2001, had an estimated life expectancy of about 45 years. And today, that has gone up to between 62 and 64 years, which is probably the greatest single increase anywhere on the planet in the last decade."[81] The data suggested that the increase in life expectancy could be explained by a decline in child mortality. In 2013, UNICEF validated the hypothesis that the large increase in life expectancy was driven by declining child mortality when it reported a 25 percent drop in deaths among children under 5 years between 2000 and 2012 (Sandefur 2013, p. 1).

While these data suggest improvements in health outcomes, there is no rigorous evaluation that directly attributes these results to the PCH program. The weight of the evidence does however suggest that PCH contributed to declines in mortality and increases in life expectancy.

Data from the program's monitoring and evaluation system reveal that the PCH program was contributing to improvements in access, quality, and utilization of health care. Reflecting the program's commitment to robust monitoring and independent evaluation, PCH contracted Johns Hopkins University to measure and track changes in health service delivery. Using the Balanced Scorecard methodology, the team collected data from 600 randomly selected health facilities across the country. [82]

First, results indicate that the program was making significant contributions to improve the delivery of a basic health package across Afghanistan. Thier cited the example of US-funded training programs for midwives and nurses that were helping to reduce birth complications, thereby improving health outcomes for newborns and mothers.[83] Second, evidence shows there was an increase in the availability of health services. Between 2002 and 2012, the number of functioning primary health care facilities in rural areas increased from 498 to 2100 and the number of Community Health Workers staffing these clinics rose from 624 to 4,950 (SIGAR 2013, p 14).

In addition to expanding availability, the program was also ensuring that services met high quality standards and were accessible to vulnerable groups. Between 2004 and 2010 the proportion of health facilities that had the minimum required number of staff increased from 40 to nearly 90 percent, and the share of clinics that achieved the target level of 750 new outpatient visits annually rose from 20 percent in 2004 to 80 percent in 2010 (Sandefur 2013, p. 5). The PCH program was also helping to ensure that communities, and especially women and children were utilizing health services. USAID reported that US-supported PCH

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[81] Quil Lawrence, "Gains in Afghan Health: Too Good to be True?" *All Things Considered National Public Radio*, Jan. 17, 2012.

[82] More information on the Balanced Scorecard methodology is available here: http://bit.ly/1jMuqDE.

[83] Quil Lawrence, "Gains in Afghan Health: Too Good to be True?" *All Things Considered National Public Radio*, Jan. 17, 2012.

health facilities served an average of one million patients each month, 75 percent of whom were women and children (SIGAR 2013, p. 14). These improvements in service delivery—to which the PCH program was contributing—are a possible mechanism driving the decline in infant mortality and subsequent improvements in life expectancy.

Thus, the Afghanistan case differs significantly from the others presented in this paper. There was no disruption to the program because USAID did not freeze funding to the PCH program despite SIGAR's recommendation. A number of additional factors also set this case apart. The public debate that underpinned this scandal was generated by the funder, and not by actions or whistleblowers in the recipient country. USAID had detected and was in the process of addressing the procedural failures within the Afghan Ministry of Health even if the impact of the action plan created to address these deficiencies is unclear.

This case shows that investigations can make recommendations that go far beyond the evidence they produce. The 2013 SIGAR report relied primarily on documenting procedural failures such as inadequate accounting systems and poor internal control mechanisms within the Ministry of Health. However, it failed to find specific evidence that these procedural failures were associated with diversion of funds, nor did it ask how a program riddled with corruption could be associated with generally positive indicators of expanded healthcare delivery and improving health status. The weaknesses of the 2013 report are not unique; critics have questioned the quality of SIGAR's investigations and its brash style of reporting under Sopko's leadership. In November, 2015, US Senators McCain and Reed directly questioned whether SIGAR is following generally accepted government audit standards.[84]

Findings from the four cases

Considering all four cases, three main issues come to the fore. First, funders are the ones who determined whether a case turned into a scandal or not, regardless of whether they initially discovered problems. Second, the decision to deal with corruption allegations by disrupting health aid is influenced by more visible information (allegations, fraud, procedural failures) and not by less visible information – particularly scale (e.g., share of funding lost) and results (e.g., health impact). Finally, funders and recipients respond by designing and implementing action plans which address visible procedural failings without clear evidence that they are effective at preventing future corruption.

To state that funders determine whether or not an allegation of corruption turns into a scandal is almost tautological. Recipient governments have few incentives to disrupt health aid even when they are well-intentioned and choose to take strong anti-corruption measures. The four cases we looked at became noticeable precisely because the funder decided to withhold or delay funding. Had we been able to investigate a full sample of health programs in which allegations of corruption arose, we would no doubt find many which were handled

[84] See the letter from Senators McCain and Reed here: http://1.usa.gov/1O1M9Wu (accessed May 25, 2016).

diplomatically as part of ongoing engagement and policy dialogues (Kenny 2007). This was, indeed, the case with the Global Fund's OIG studies until some of the results were highlighted in the international press.

Detection and disruption

The original allegations in India and Zambia came from local sources but were transformed into international scandals by decisions at the World Bank (for India) and among bilateral funders (in the case of Zambia). The funders' actions in the World Bank and Sweden appear to have been motivated by high-level interest in reforming aid agency practices – a new president at the World Bank and a new coalition government in Sweden. Once past the initial benefits of disruption – in terms of publicity, political support, and reputational risk – the groups within funding countries who wanted to resume health aid came to the fore and repaired relations with the recipient country.

The Global Fund experience was quite different. The evidence of abuses uncovered by the GF-OIG were being managed without fanfare or public disruptions in aid until publication of the AP article, after which several funding countries halted transfers to the Global Fund. Thus, the Global Fund experience shows us (pre-scandal) what a more routine approach to detecting and addressing corruption allegations might look like. By studying eleven countries, the OIG provided GF's board with benchmarks with which to assess the gravity of evidence in the three countries with the most problematic grants. The Board had the opportunity to demand repayment of unsupported expenditures, insist on stricter oversight, etc. without disrupting aid to other countries and with proportional responses in the countries with the worst practices. However, once the allegations were highlighted in the international press, funding countries – Germany, Spain, Denmark, and the EU – responded by withholding their contributions, questioning the Global Fund's entire approach and jeopardizing funding to other grants within the Global Fund portfolio regardless of the impact on institutional development or health.

As with the Global Fund experience, USAID had already identified procedural weaknesses in the Afghanistan PCH program. USAID's strategy was to work with the government in addressing those weaknesses. The threat of halting the health aid was not put on the agenda until the Special Inspector General issued its report and presented it to Congress. Yet in this case, the interest groups favorable to maintaining health aid retained the upper hand. The SIGAR report failed to halt the USAID program for a number of reasons but some of the factors that assisted those who wanted to maintain funding included: Afghanistan's geopolitical importance to the United States, the focus of the SIGAR report on procedural failures (with little evidence of actual fraud), and USAID's detailed response to the report's evidentiary flaws.

Evidence and disruption

Of the four cases, only the World Bank's DIR reported significant results failures. Some of the most critical results failures that it documented were inoperative hospitals, the persistence of high malarial prevalence, and people infected with HIV through tainted blood transfusions (due to faulty diagnostic kits). Despite reporting on these results failures, the DIR did not seek to assess the scale of results failures relative to the results generated by other components of the health program. Thus, the documented results failures served primarily to underscore the gravity of the findings on procedural failings and fraud. In other words, it was difficult for people to minimize the importance of the corruption allegations with such clear health consequences, strengthening the hand of those in the World Bank who wanted to disrupt the health aid programs.

The Global Fund and Zambian investigations provided evidence of procedural failures and fraud but little if any information about results failures. For example, the Global Fund audits documented results failures related to a non-functional TB clinic in Mauritania and to the inflated numbers of people trained in Mali, but firm and extensive evidence on results was not included. Consequently, the funders who chose to take a hardline and withhold health aid relied more heavily on the evidence of fraud and mismanagement in accounting. The SIGAR report on the health program in Afghanistan was focused entirely on procedural failures. This may account for the lack of response by Congress or the executive branch to calls for halting funding. The outrage expressed in the SIGAR report over procedural irregularities was not as compelling without specific evidence of fraud. Furthermore, the best available evidence on results suggested, to the contrary, that the health programs were reasonably successful. This made it harder to maintain that substantial fraud had taken place despite the identified risks.

Amounts and disruption

The amounts of funding in each case that was "at risk" was quite large, yet except in the case of three Global Fund programs, the amount of funds alleged to have been diverted was rather modest (see Table 3). In Zambia for example, Global Fund grants totaled US$270 million, and US$10 million was diverted through a combination of fraud, as well as unsupported and ineligible expenditures. In the three GF programs discussed here – Djibouti, Mali, and Mauritania – grants totaled US$50 million, while the GF-OIG's investigations found close to US$6 million might have been misused as evidence by procedural failures (unsupported and ineligible expenditures) and close to US$11 million was alleged to have been diverted through fraud. However, these are the three countries with the highest levels of corruption. Notably, they account for more than 95% of the fraud detected in all 11 countries. Given that the GF investigated 8 other countries, taken as a whole, the figures would look quite different if considered from a portfolio perspective. For all 11 countries, the total grants investigated between 2005 and 2012 amounted to an estimated

$1.5 billion, while GF-OIG found US$33 million might have been misused as evidence by procedural failures and another US$11 million was diverted through fraud.[85]

Consequently, the amount of documented fraud in most of these programs is small relative to the magnitude of health aid. To justify halting disbursements in these circumstances requires that the proven cases (1) can be extrapolated to suggest much larger (but unproven) amounts of abuse or (2) reveal systemic failures that will inevitably lead to larger amounts of abuse. The appropriate response to the former case would be to investigate a more representative sample of contracts. When the World Bank followed this approach, they did indeed discover that the procedural failures (including its own supervision) were widespread; for example, affecting 87 percent of the equipment procured under the Food and Drug Capacity Building Project. In other cases, though, the evidence of procedural failures (let alone abuse or results failures) was much more limited. The SIGAR report on procedural failures in the Afghanistan PCH program made claims about systemic failures, emphasizing that funds were "at risk", without apparently being persuasive that this was sufficient to halt the program.

The costs and benefits of disruption

Once the corruption allegations were in the public domain and funding agencies were choosing whether or not to disrupt aid, decisions tended to be driven more by the visible costs and benefits rather than the hidden ones. The potential costs of disrupting health aid include interrupting the flow of services and commodities, capacity building, institutional development, and health status improvements among the population. But there are potential benefits, as well, including protecting public support for aid programs, improving corruption control, and reallocating funds to more cost-effective activities.

In the four cases considered here, the *disruption of services and commodities* was most severe in the countries that rely more heavily on health aid – and not necessarily the ones with the most corruption. So for example, Zambia depended on health aid for about 50% percent of its national health expenditures. When donors suspended health aid, Zambian spending on health care providers fell by 40 percent. Antenatal coverage declined from 95 percent in early 2009 to 78 percent by the end of 2010. By contrast, health spending in India was modestly affected if at all by the delays in World Bank health loans. The disruption was problematic for the Indian Treasury, but officials were able to identify and mobilize other funds to preserve their programs.[86]

While service disruptions are highly visible to the local health care providers and the clients they serve, the disruptions have low visibility to the national level authorities and funders who are negotiating over health aid. To be visible, such disruptions would have to be

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[85] This figure is based on the Global Fund's analysis released in July 2012. For more details, see case 3.

[86] Interview with Anit Mukherjee, August 2015.

documented and reported in real time with accuracy. One of the features of health systems in low- and middle-income countries are the weakness of these kinds of reporting systems. So, for example, child morality was declining significantly in Zambia prior to the disruption of health aid and continued to decline afterwards. Whether the *rate* of improved slowed or not as a consequence of health aid disruption is difficult to determine. Without more reliable data, the claims that health aid disruptions will compromise health care service delivery are entirely plausible but have less force than highly salient corruption allegations.

Institutional development and capacity building are also affected by disruptions in health aid. In the Zambian case, programs that had been working with and through the government's public financial management system were replaced by transferring responsibilities to international agencies like UNDP or NGOs. For example, international support was credited with strengthening Zambia's national drug procurement system until all this capacity building work was disrupted by the Global Fund's decision to transfer grant management functions from the Ministry of Health to UNDP.[87] Furthermore, funders may have inadvertently weakened Zambia's anti-corruption institutions by creating incentives to become less forthcoming about the corruption allegations it uncovers.

While the costs of disrupting aid are weakly visible, the potential *benefits of disrupting aid* in the presence of corruption allegations seem much more salient. When funders withheld aid or demanded repayment, they immediately reaped benefits in terms of reputational risk. The action is a visible demonstration of the seriousness with which politicians or organizations face misuse of public funds (even if it is a single, short-lived action that has no demonstrable effect on the integrity with which funds are spent). Furthermore, when choosing to halt aid, funders are facing the visible threat that money may be cut from health aid budgets.

The second benefit perceived by funders is to *save taxpayer money from being wasted* or stolen and having the possibility of reallocating it to places (e.g., other aid programs, countries, or domestic spending) where it might be deployed. The salience of relatively small amounts of funds that have been proven to be stolen, in this case, far outweigh the uncertainty regarding the integrity of spending in the rest of the health aid program or the effectiveness of spending on programs which have not been subjected to investigation. Without visible information on these aspects of public spending, the benefits of eliminating a relatively small amount of fraud has outsized importance.

Finally, statements by funders show that they view *health aid disruption as having strategic value* in creating pressure for recipient countries to improve the integrity of their public finances and implementation of health aid programs. This strategic value is high in the short-run. In the three cases where health aid was disrupted, recipient countries expended a great deal of effort to contest the scale and nature of the problem and, eventually, to negotiate action plans and implement them. With time, high-level political attention to the original problems

[87] Interview with Prashant Yadav, September 2015.

waned and negotiations between funders and recipients began to focus on details of implementation. Thus, as most studies have concluded, it appears that using aid disruption to pressure recipients has transitory strategic value. The initial responses are quite visible while subsequent compliance with action plans are lost in the routine bureaucratic and political processes.

The dynamics that sustain the scandal cycle

The dynamics that sustain the scandal cycle and make it problematic are driven in part by the informational asymmetries outlined above – that certain costs and benefits are more visible than others – but also by asymmetries between funders and recipients in terms of their interests and the pressures they experience. The political, institutional and technical dynamics of funders create tensions between groups who are more and less willing to disrupt health aid. By contrast, the dynamics within recipient countries tend to be aligned in the direction of trying to sustain and justify the continuity of health aid. Some actors in recipient countries do support disruptions in health aid, but they tend to be few and marginal.

Among funders one of the strongest motivations is to demonstrate effectiveness by disbursing funds (even when programs themselves may not be effective at achieving impact). The pressures to disburse among aid agencies lead them to minimize allegations of corruption whenever possible by applying strict standards of evidence and stressing that amounts diverted are small relative to overall programs. These pressures also make them more likely to interpret evidence of fraud as non-systemic, either by describing it as an isolated incident, blaming it on former officials who are no longer in office, or stressing the benefits of continued engagement precisely as a way to prevent future corruption.

But funders also have constituencies demanding guarantees for the integrity of health aid programs. These groups are inclined to amplify corruption allegations by treating procedural failures as if they were actual evidence of abuse. They also tend to interpret evidence as an indication of systemic problems that will not be resolved by changes in personnel or administrations. They also view continued engagement as condoning corruption and are more likely to believe that disrupting aid is an effective strategy for making recipients undertake significant reforms.

Thus, funder behavior can be interpreted as if it were driven by two competing forces – for and against disrupting aid. The ascendancy of one over the other will depend on the political context and bureaucratic exigencies of each funder. For example, the World Bank could have moved against India as early as 2004 when allegations first came to light or in 2006 when the allegations were published in *The Lancet*, but it was only when the President chose to take a strong stand that the DIR investigation was started. Subsequently, Wolfowitz's attention shifted to other issues and after his resignation, the forces for continuity gained the upper hand and those trying to repair relations with India prevailed.

In Zambia's case, the corruption charges would probably have been handled very differently if the Swedish Social Democrats had still been in office due to their favorable view of budget support and institutional development. Though the Social Democrats also maintain a "zero tolerance" approach to corruption, it is possible that they would have responded with continued engagement and less disruption. However, the election of a conservative-led coalition government in 2006 shifted Sweden's policy stance away from budget support and toward stricter input controls. Thus the coalition government could respond to corruption allegations by withholding budget or sector support and lay claim to being forceful in addressing corruption.

Within recipient countries, most actors are inclined to preserve continuity in health aid. The health officials and institutions receiving aid want to continue; the Finance Ministry wants continued funding; even individuals engaged in corruption are interested in preserving the flow of funds. So these actors will all minimize the problem; provide plausible excuses; and maintain that future funding will be used appropriately.

Domestic constituencies which want services and honest government will, at times, applaud health aid disruption as a way to assist them in holding their own government accountable. Thus, it is not unusual to have anti-Corruption commissions, opposition parties, and civil society groups issue statements in support of reforms. However, the resolve and attention of these groups is easily deflected by the government or by other actors interested in continuity. First, those interested in continuing aid can claim that foreigners are misinterpreting and exaggerating the problem. Second, they can contest the facts and argue that demands for reform are insults to sovereignty. Third, they can argue that the foreign agency was confrontational and should have handled the issue more diplomatically (even if there were years of behind-the-scenes diplomatic efforts). Finally, if aid is disrupted, the recipient government can blame the aid agency for causing harm to the population by withholding funds (regardless of whether or not the program was delivering services or had any health impact).

Consequently, when faced with the threat of disrupting health aid, most governments respond by questioning the integrity of the allegations or investigations, then minimize the problem, and finally deflect blame. Domestic continuities in favor of disruption are few and weak, so the recipient can exert consistent pressure to sustain or resume health aid as quickly as possible. The only example among these four cases where recipient constituency favored disruption was Zambia where the Anti-Corruption Commission and Z-OAG were pursuing investigations cases and appreciated the high-level external support. However, this had little impact on the actual government actions as demonstrated by slow implementation of the anti-corruption plan.

Results, Results, Results

The main finding from these cases is that the actors involved rarely pay attention to the results that programs are trying to achieve. The scandal cycle is driven by two unspoken

assumptions: (1) that eliminating corruption is a prerequisite for effective health aid and (2) that evidence of procedural failures and abuse is sufficient to justify disrupting aid. The amount of funding at risk and the most visible and egregious acts of corruption dominate the public debate. Yet, the results of health aid in terms of improving population health and/or building the domestic institutions that promote population health are ignored. Unless objective data on how much health aid is contributing to service delivery, institutional development and health impact are considered, the responses to corruption may cause more harm than good.

Consequently, the debate over responding to allegations of corruption tends to rest on anecdotal, subjective, and speculative claims. In particular:

- assertions that the incidents demonstrate that corruption is systemic versus isolated
- assertions that disrupting aid is necessary to induce change versus not necessary
- assertions that proposed reforms will make corruption less likely
- assertions that costs of disruption in terms of institutional development or health impact exceed benefits of disrupting aid and introducing additional controls

Until this broader range of information is made visible, the scandal cycle will always respond more strongly to the immediate and short-term effects of corruption allegations rather than to the systemic and long-term effects of health aid.

Thus, the ways funders and recipients respond to corruption emphasize institutional and governance reforms that may very well reduce corruption, but are missing the one key piece of information that would fundamentally alter the dynamics of the scandal cycle: the impact of health aid on results. With better direct information on results – mostly health impact but even institutional development and service delivery – decision makers could better assess the gravity of corruption allegations in terms of what really matters. This is essentially the calculus carried out routinely by funders in their own domestic programs. For example, estimates suggest that billions of dollars are wasted or stolen from the US Medicare and Medicaid programs (Dalye 2011). Funding continues for these domestic programs in the face of evidence of abuse because the overall impact of these programs is judged to be positive. Anti-corruption measures are taken concurrently to investigate, punish and recover specific funds while other measures are taken to reduce the likelihood of future abuse.

What to do?

Funders and recipients are actively addressing the risk of corruption all the time through staffing and paying for financial and operational management. Most of these efforts are focused on improving the integrity of programs and fund management in recipient countries via procedural and institutional reforms, or by actions aimed to enhance citizen oversight and accountability mechanisms (See Box 3). These efforts may limit but cannot eliminate the opportunities for corruption and the likelihood of scandals, and are in any case focused on the domestic policymaking arena.

From a funder's perspective, the main way to address the dynamics of the scandal cycle is to make sure that the decision of whether or not to disrupt health aid is influenced as much by program results as by the amount and character of corruption. We suggest three strategies to accomplish this goal: (1) communicate using program results; (2) differentiate responses by program results; and (3) disburse program funding in proportion to results.

Box 3

Reducing corruption in recipient countries: Procedural and institutional reforms

Procedural and institutional reforms are the most visible and prominent efforts aimed at reducing corruption and avoiding scandals. Funders provide substantial sums of money and technical assistance to design and implement risk management and fiduciary control systems that reflect best practice principles utilized in high-income countries. Reforms typically include risk management to prioritize attention to activities that are most prone to abuse. They include public procurement regulations that encourage competition, discourage collusion and limit opportunities for kickbacks and favoritism. Additional measures include regular internal audits, timely budget and expenditure reporting, oversight by relatively independent agencies, the creation of special investigative units or commissions, and improvements in the efficiency and professionalism of the judiciary (Augilar et al. 2000; Fagan and Weth 2010).

Reducing corruption in recipient countries: Accountability and governance reforms

Another set of initiatives aimed at reducing corruption in recipient countries addresses the political dimensions of the problem by trying to increase public accountability. Some initiatives establish specific mechanisms for communities to provide oversight for health programs while others provide financial and technical support to civil society organizations that monitor government actions. Greater transparency is also promoted as a way to improve integrity. For example, the International Budget Project helps local NGOs to analyze and report government financial information in ways that are useful to the public. Another initiative is aimed at getting governments to put all contracts in a publicly accessible database (Kenny and Karver 2012).

Communicate using program results

The aid agencies in these four cases did not generally cite program results when discussing corruption with their governance bodies, their funders, the media, or the public. In the case of the World Bank and India, the World Bank response focused on "pursuing criminal wrongdoing" while the Government of India promised "exemplary punishment." Sweden's public statements on the Global Fund cases focused on "bringing the guilty to justice." Yet, neither funder has the tools or leverage to deliver on this kind of rhetoric.

In lieu of this strategy, researchers working with the OECD have recommended that donors be proactive in developing communication messages that can be used when allegations emerge. In particular, they recommend a combination of forthright acknowledgment of corruption when there is sufficient evidence along with communication regarding the measures being taken to control or reduce corruption. Based on surveys in donor countries, they note that even aid skeptics are more supportive of maintaining aid programs when they have been informed of anti-corruption efforts (Marquette et al. 2014).

Our analysis of four cases yields a further suggestion: that funders should develop communication strategies that emphasize program results throughout the scandal cycle. Doing so will evidently require a clear understanding of the results themselves and how spending relates to performance, which will mean measuring results better and regularly publishing progress in the public domain. Silverman et al. 2015 provide practical suggestions for doing this, with specific applications to the Global Fund.

A second recommendation would be to design communications that give greater weight to results. Ideally such messages would be developed ahead of time, in consultation with funders and stakeholders, to assure that the results narrative is well understood, persuasive, and influential among global health funders and their constituencies. Such communication strategies should, of course, be tested along with the other approaches discussed in OECD 2014 to see whether they protect spending on essential programs while building accountability for results.

Differentiate responses by program results

Differentiating responses to corruption allegations by paying attention to program results is another way to deal with the scandal cycle. This requires more accurate and timely data on health aid program outputs and outcomes. However, the benefits of obtaining this information will generally far exceed the costs, especially in cases where monitoring results allows funders and recipients to dispense with the transaction costs of monitoring inputs. Further, the measurement of results generates benefits well beyond its utility as a means to address corruption and misuse of spending.

Funders' current strategies for dealing with corruption do not incorporate information about results. Rather, they are a reasonable approach characterized as a "graduated response" which pays attention primarily to the evidence of fraud and the recipient government's commitment to controlling corruption (ITAD & LDP 2011; OECD 2007). This graduated response begins with funders coordinating with one another in assessing risks, implementing controls, and monitoring the flow of funds (See Figure 3). When corruption allegations arise, funders are supposed to continue coordinating with other funders, demand repayment of funds that were misapplied, and work with the government to address the problems. Disruption of aid programs is a last resort occasioned by an assessment, again jointly with other funders, that the recipient government is not serious about implementing reforms.

By contrast, a strategy that paid attention to results would have two interconnected decision processes – one monitoring results and the other responding to allegations of corruption (See Figure 4 and Figure 5). By monitoring results more carefully, funders would be able to address corruption in two different ways. First, failure to achieve results does not prove the existence of corruption, but it certainly provides enough reason to investigate whether fraud and abuse are the cause. Most corruption allegations come from whistleblowers and thus tend to detect particular kinds of fraud that harm someone and motivate them to come forward. Monitoring results provides an additional source of information, helping to flag any kind of corruption that interferes with achieving results. Second, the amount by which a program fails to achieve results provides a scale for assessing the significance of any corruption that is getting in the way. For example, if the World Bank had properly monitored the quality of HIV diagnostic tests or the number of hospital consultations, investigations of corruption would have been initiated much earlier. Furthermore, discussions over whether or not to halt disbursements would have been informed by an understanding of whether the abuses were making a big difference, or not, in the delivery of services.

Monitoring of health aid results is advocated for many reasons: to assist in evaluating programs, choosing more cost-effective strategies, and building public support for health programs (Levine and Savedoff 2015; Glassman, Fan and Over 2013; Millions Saved 2004 and 2016). This analysis of health aid scandals suggests two additional benefits of monitoring results: flagging programs that require investigation and providing context for differentiating responses to corruption on the basis of health aid impact. With information on results, funders can tailor their responses to disrupt programs only in those cases where corruption is materially interfering in health aid success.

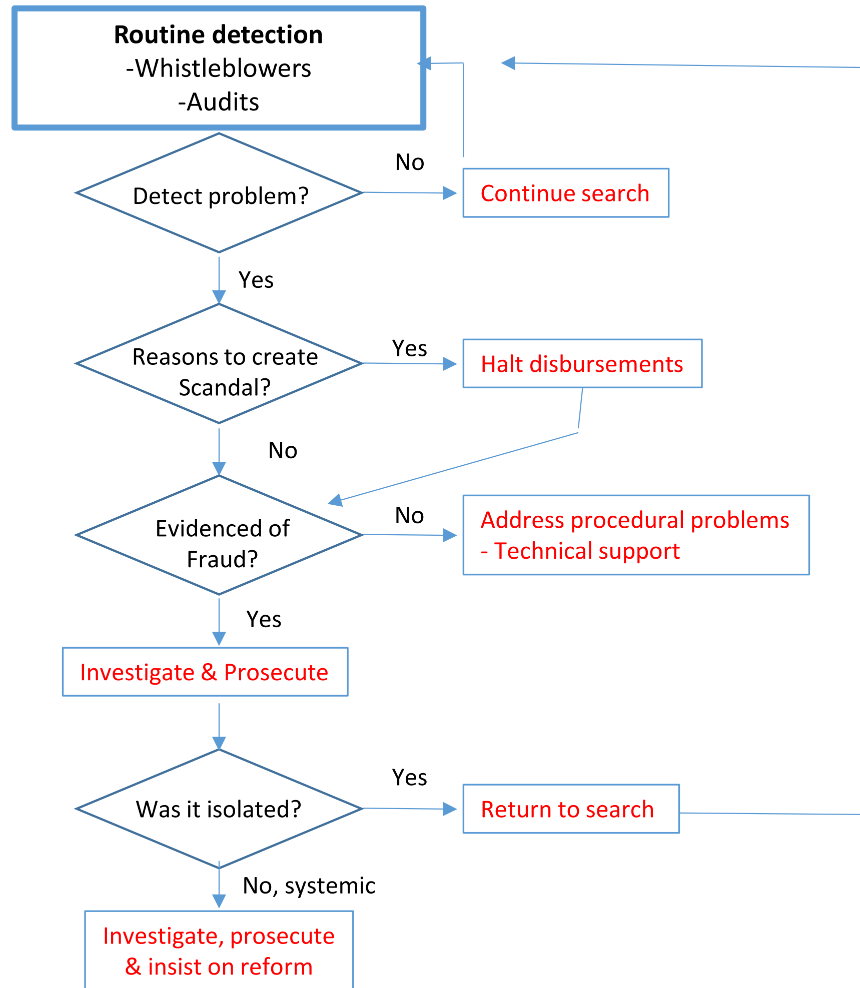
Addressing the scandal cycle: disburse in proportion to results

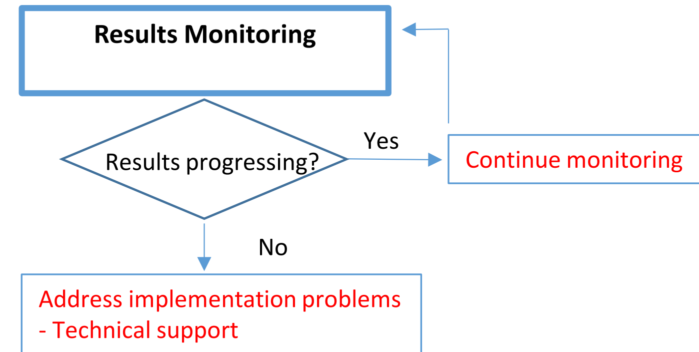
An additional option for controlling corruption and changing the dynamics associated with scandals is for health programs to pay for results, when it is feasible. Health aid has been designed to pay out for different kinds of results, ranging from completed Tuberculosis treatment to improved quality of primary care consultations to reductions in the prevalence of malaria (Eichler and Levine 2009). Proposals for more ambitious pay-for-results programs that would disburse against reductions in child mortality or HIV/AIDS prevalence have also been proposed (Savedoff and Martell 2011).

By paying for results, health aid would necessarily have to generate more reliable information about the degree to which programs are succeeding. Paying for results assures that funding goes where it is generating outputs and outcomes. In addition, results are often easier to observe and monitor than detailed transactions and processes in the public sector. A Tb patient who has been cured can be tested today whereas the integrity of the procurement process for antibiotics is difficult to prove after the fact.

Figure 3: Current Decision Trees for Addressing Corruption

Funders are more responsive to external factors for halting disbursements than program effectiveness in achieving results

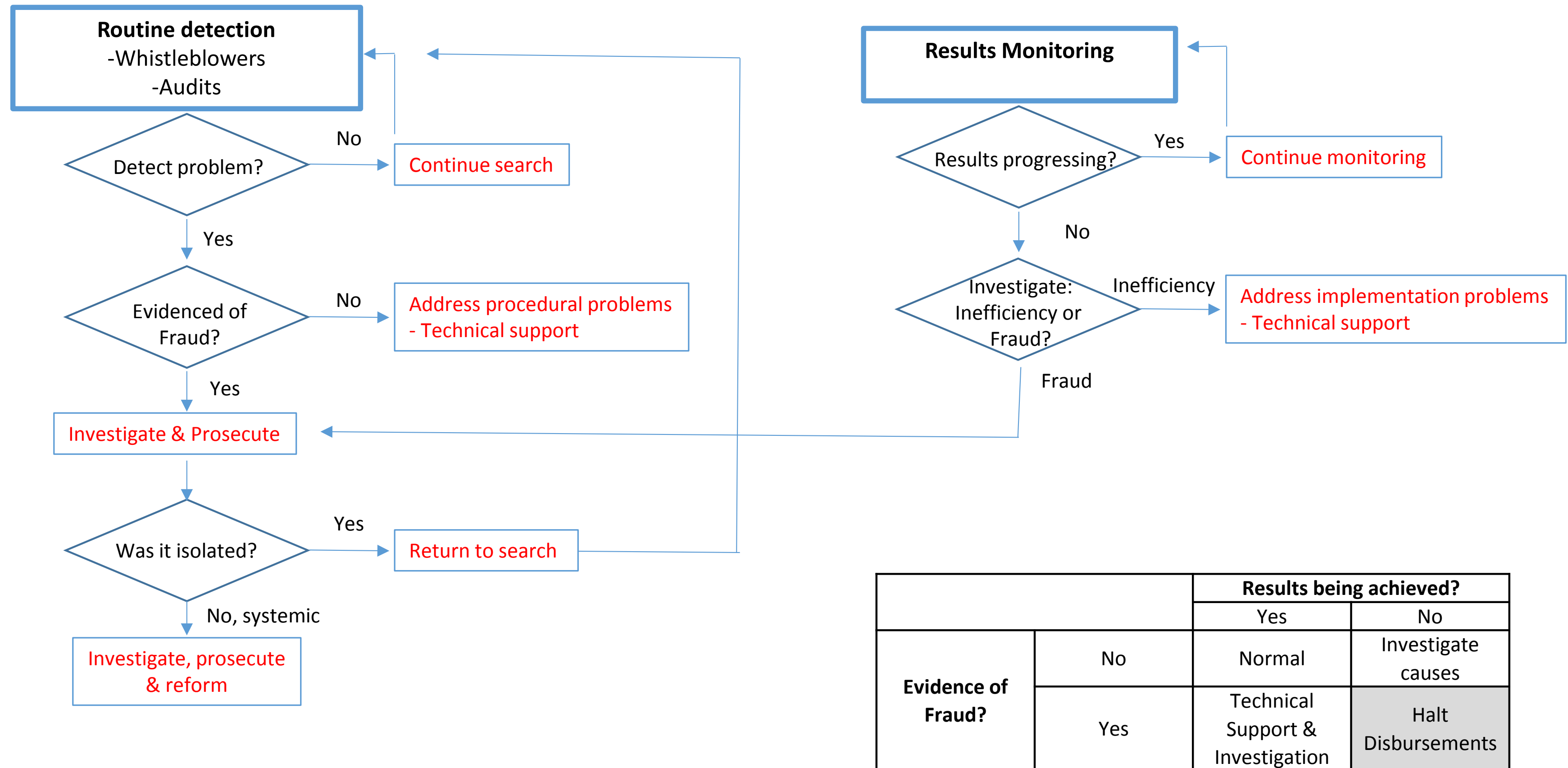




		External reasons to create a scandal?	
		No	Yes
Evidence of Fraud?	No	Normal	Halt Disbursements
	Yes	Technical Support & Investigation	Halt Disbursements

Figure 4: Proposed Decision Tree for Addressing Corruption

Funders explicitly incorporate program effectiveness in achieving results when choosing responses to allegations



		Results being achieved?	
		Yes	No
Evidence of Fraud?	No	Normal	Investigate causes
	Yes	Technical Support & Investigation	Halt Disbursements

Figure 5: Scandal responses driven by external reasons versus results information

Current practice: scandals respond to external reasons

		External reasons to create a scandal?			
		No		Yes	
		Results being achieved?		**Results being achieved?**	
		Yes	No	Yes	No
Evidence of Fraud?	No	Normal	Normal	Halt Disbursements	Halt Disbursements
	Yes	Technical Support & Investigation	Technical Support & Investigation	Halt Disbursements	Halt Disbursements

Proposed practice: scandals managed by reference to results

		External reasons to create a scandal?			
		No		Yes	
		Results being achieved?		**Results being achieved?**	
		Yes	No	Yes	No
Evidence of Fraud?	No	Normal	Investigate causes	Normal	Investigate causes
	Yes	Technical Support & Investigation	Halt Disbursements	Technical Support & Investigation	Halt Disbursements

A well designed pay-for-results program uses performance indicators that are highly correlated with recipients spending on the right things – where "right" is defined by its effectiveness at producing results. In this regard, such programs reveal the recipients' commitment and integrity. Funders with conventional programs have to assess whether recipients are committed and closely monitor their actions. By contrast, funders with pay-for-results programs need only focus on the results that are being delivered and the level of funding will automatically rise or fall in proportion to the effectiveness and integrity with which the recipient is spending money. Thus, paying for results controls corruption by making it harder for dishonest people to divert funds (because funds only flow when services are delivered) and by making it easier for honest ones to do their work (because they can focus on delivering services rather than reporting on activities) (Kenny and Savedoff 2013).

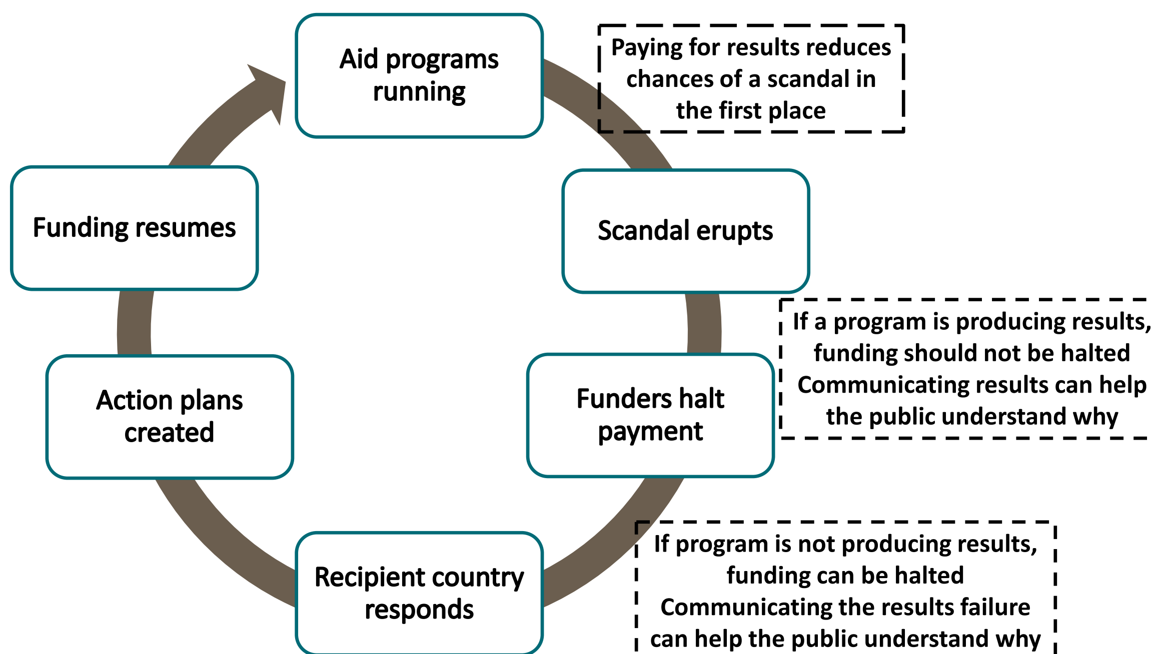
The advantage for recipients is that they can focus on achieving results, act with greater autonomy, and reduce transaction costs associated with aid. Funders have to accept that paying for results limits their discretion – independently verified results determine how much gets paid out – but in return, they have an automatic check on corruption. Paying for results would have eliminated many of the scandals discussed in this paper – the ones that resulted from evidence of procedural failures. Without conditions on how money is utilized, funders would be able to focus on the relationship between particular achievements and money disbursed. If success was achieved despite corrupt practices in the government, then funders and recipients can still work on reducing corruption but without disrupting an effective health aid program. When results are not being achieved, funds are not disbursed and cannot be diverted.

It is not possible to pay for results in all cases. Such programs require that goals can be quantitatively measured, that indicators are sufficiently precise and reliable, that the annual flow of results (and hence funding) is not too volatile, and that the recipient's actions account for a significant part of outcomes. Practical solutions exist to deal with upfront investment requirements and procedural rules among funding agencies (Birdsall and Savedoff 2010). In cases where results are difficult to measure, where recipients have limited impact on outcomes, and where funders are unwilling to grant autonomy in the use of funds, paying for results may not be feasible.

In sum, using information about results can attenuate the scandal cycle at key points (See Figure 6). Disbursing programs in proportion to results can actually prevent many scandals in the first place by reducing the chances that procedural failures will be interpreted as evidence of fraud even when fraud is absent. Paying for results also reduces disbursements automatically in cases where corruption is interfering with program impact. When corruption allegations do arise, programs that are achieving results do not have to be halted. Rather the evidence of impact is an indication that corruption is not significant enough to justify disrupting the program. Furthermore, the evidence of results can be used in communication to the public to demonstrate why a strategy of continuing funding while investigating and prosecuting wrongdoing is justified. In cases where corruption arises and results are not

being achieved, the decision to stop a program not only makes sense but the availability of information about results failures provides funders with backing when critics claim that disrupting aid will cause harm.

Figure 6: Addressing the scandal cycle with results information



Conclusion

Corruption compromises the effectiveness of health aid and the public's perception of corruption can undermine support for global health programs, despite evidence demonstrating its contribution to longer healthier lives. Periodically, funders react to allegations of corruption by disrupting health aid programs without paying attention to the less visible costs of halting aid on service delivery, institutional development and population health.

Current efforts to improve how aid agencies address corruption emphasize better policy engagement and public management (e.g., internal auditing and oversight mechanisms) and supporting accountability and governance reforms. They also recommend that aid agencies better prepare themselves to respond to scandals in graduated and coordinated fashion. But the literature also notes that these efforts are most likely to be successful when recipients themselves are committed to reducing corruption and have a favorable political context. This means, that funders are caught in a bind: seeking to provide health aid in all countries regardless of political support for controlling corruption while monitoring and disrupting aid

in those countries that fail to make adequate progress. Without information on program results, aid agencies decide whether or not to disrupt aid primarily on the basis of their own need to demonstrate seriousness to their publics and after making subjective assessments of a recipient's commitment to anti-corruption efforts.

Making the results of health aid programs more visible would help address corruption in ways that could markedly improve health aid effectiveness by changing the number and severity of scandals and subsequent disruptions. If funders were able to move toward paying for results, they might find that the control and response to corruption becomes substantially easier. Measuring results would distinguish projects where corruption is hindering the achievement of goals from those where it is relatively insignificant, allowing decisions about halting disbursements to rely on objective criteria. Communicating program results to the public would give funders information to justify the decision about disbursements more powerfully. In these ways, measuring and using program results can help agencies attenuate the scandal cycle.

Interviews

Name	Title and affiliation	Case	Interview date
Anonymous	Consultant, World Bank	India	August, 2015
Peter Berman	Professor, Harvard T. H. Chan School of Public Health and former Lead Economist for Health, Nutrition, and Population, World Bank	India	September, 2015
Michael Carroll	Comprehensive Health Services and former Acting Inspector General, USAID	India	August, 2015
Pia Engstrand	Lead Policy Specialist for Health, SIDA	Zambia	October, 2015
Jerry La Forgia	Chief Technical Officer, Aceso Global and former Lead Health Specialist, World Bank	India	August, 2015
Anit Mukherjee	Policy Fellow, CGD	India	August, 2015
Audrey Mwendapole	Program Officer, Embassy of Sweden - Zambia	Zambia	October, 2015
Eva Nathanson	Health Advisor, Embassy of Sweden - Zambia	Zambia	October, 2015
Sarah Thomsen	Health Policy Specialist, SIDA	Zambia	October, 2015
Aneta Wierzynska	Senior Advisor Risk and Assurance, Global Fund	GF and India	September, 2015
David Wiking	Head of Development Cooperation, Embassy of Sweden - Zambia	Zambia	October, 2015
Prashant Yadav	Senior Fellow, William Davidson Institute at the University of Michigan and Non-resident Fellow, CGD	Zambia	September, 2015

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