

Developing a Country Compact:

what does it take and
what are the gains?

December 2012

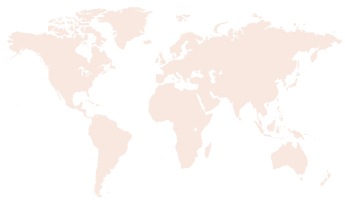


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Introduction

Country Compacts¹ and similar partnership agreements² aim to define the roles of government, development partners and implementing partners in improving health systems and achieving better health outcomes. Compacts outline how domestic and external resources for the health sector will be better coordinated and managed. They do not replace or duplicate a national health strategy, but they supplement it by capturing the agreement of all partners on how they will support the national strategy. As such, they include commitments and indicators that each signatory commits to. These are not legally binding, but carry the moral power of an agreement that has been negotiated.

Compacts are not new and they do not exist in a vacuum. Many countries have longstanding aid coordination mechanisms in the health sector such as Sector Wide Approaches (SWAps). Eighteen IHP+ countries (and many other countries) have Compacts or equivalents.³ These countries have very different histories of aid coordination in the health sector: Uganda and Mali had a long history of health SWAps to build on, Mauritania and Benin have developed Compacts for the first time, Kenya and Cambodia had existing agreements that they have maintained.

The purpose of this paper is to summarise experience of developing and implementing the agreements in Compacts. It explores the question of “was it worth the effort to develop the Compact?” The paper explores the experience of nine countries: Benin, Ethiopia, Mali⁴, Mauritania, Nepal, Nigeria, Sierra Leone, Togo and Uganda. It draws on existing literature to limit the burden on countries: in particular country Compacts, joint annual review reports, country case studies of aid effectiveness implementation and IHP+Results 2012 report. The literature was supplemented by interviews with ministry of health officials, development partners and technical specialists.

1 A synthesis review prepared by Martin Taylor and Carmen Dolea, November 2012.

2 This kind of agreement has variously been termed a country Compact, a partnership agreement, a memorandum of understanding or a code of conduct. For ease of reading we use the term Compact to refer to any such country level agreement between government, development partners and implementing partners.

3 Benin, Burundi, Cambodia, DRC, Ethiopia, Kenya, Mali, Mauritania, Mozambique, Nepal, Niger, Nigeria, Rwanda, Sierra Leone, Togo, Uganda, Vietnam and Zambia

4 It is at present unclear to what extent the process and results of the Mali aid coordination efforts will be sustained because of the coup d'état in March 2012.

The key conclusions from this review are:

1. Compacts have improved the quality of the dialogue and partnership for aid coordination.
2. Countries highly value knowing what support their development partners are providing and aligning this to support their national plans.
3. Countries have followed Compacts by developing concrete tools like Joint Financing Arrangements (JFAs) to make progress.
4. There is little evidence that development partners are delivering more aid effective development assistance for health as a result of signing a Compact.
5. The commitments and indicators for improved partnership and aid effectiveness that are agreed in Compacts are not routinely reported on as the basis for mutual accountability.
6. The key value of Compacts is as an overarching guide that sets the direction of travel and high level objectives for the partnership to improve the efficient use of all health resources (domestic and external).
7. Achievement of Compact commitments requires on-going work to develop and implement specific tools and instruments such as agreements on joint financing, joint reporting, and harmonised technical assistance.
8. Compacts can bring international legitimacy and moral strength to aid coordination efforts.

This paper has the following four sections:

1. Compact content, purpose and development
2. Compact results and achievements
3. Compact use and added value
4. Limitations, issues and lessons learned



1. Compact content, purpose and development

Country Compacts and similar partnership agreements aim to define the respective roles of government, development partners and implementing partners in improving health systems and achieving health outcomes. These agreements can have different names or titles.⁵ Compact equivalents existed before the IHP+: for example, in Cambodia and Zambia (2006), and Rwanda and Kenya (2007).

Compacts were signed by representatives of governments, development partners and civil society. The ministry of health was the main government representative in all agreements. The ministry of finance was a signatory in half of the Compacts⁶. Other government ministries have also signed Compacts.⁷ All development partners are welcome to sign Compacts. The UN Country Team, WHO and the World Bank have signed all Compacts. Not all partners active in the country health sector sign Compacts. The US Government (USG) does sign some country Compacts despite not being an IHP+ signatory globally. Civil society has increasingly become a signatory to Compacts – and has signed most Compacts since mid-2010.⁸

Compacts generally specify commitments to improve management of domestic and external resources for health by applying the Paris Declaration aid effectiveness principles to the health sector, and to implement the “three ones”: one national health sector plan, one budget and one monitoring and evaluation framework. Virtually all Compacts include the government’s preferred aid modality (usually sector budget support), but only the Ethiopia Compact provides more specific detail on how to move to this. The most common commitments and indicators are for predictable disbursement of development assistance for health (11 Compacts) and use of joint assessments of results (9 Compacts). Other indicators include the proportion of public funding allocated to health (6 Compacts) and the quality and use of country financial management systems (5 Compacts). Only one Compact includes an indicator on engagement of the civil society in policy and planning processes.

5 The agreement is called a Compact in 10 countries: Benín, Ethiopia, Mali, Mauritania, Mozambique, Niger, Nigeria, Sierra Leone, Togo, Uganda; Pre-pact in Chad; Memorandum of Understanding in Burundi, the Democratic Republic of Congo; Rwanda; Zambia; Code of Conduct in Kenya; Joint Partnership Arrangement in Cambodia; Health Development Partnership in Nepal; Statement of Intent in Vietnam.

6 Benin, Burundi, Cambodia, DRC, Ethiopia, Mali, Niger, Nigeria, Sierra Leone, and Togo

7 Other government signatories include the ministry of planning and development (Chad, DRC, Nigeria, and Togo), the ministry of foreign affairs or international cooperation (Chad, DRC, Mauritania and Togo), the ministry of local government or territorial administration (Chad and Sierra Leone), and the ministry of civil service and labour (Chad)

8 WHO desk analysis of Country Compacts.

65% of Compacts outline a system to review Compact commitments; in the majority of cases this system is the Joint Annual Health Sector Review (JAR). Two thirds of Compacts have indicators for tracking progress on implementing commitments (all Compacts signed after mid-2010 have indicators), but few countries have baselines for these indicators and only three countries have included specific targets for these indicators (Ethiopia, Sierra Leone, and Uganda).

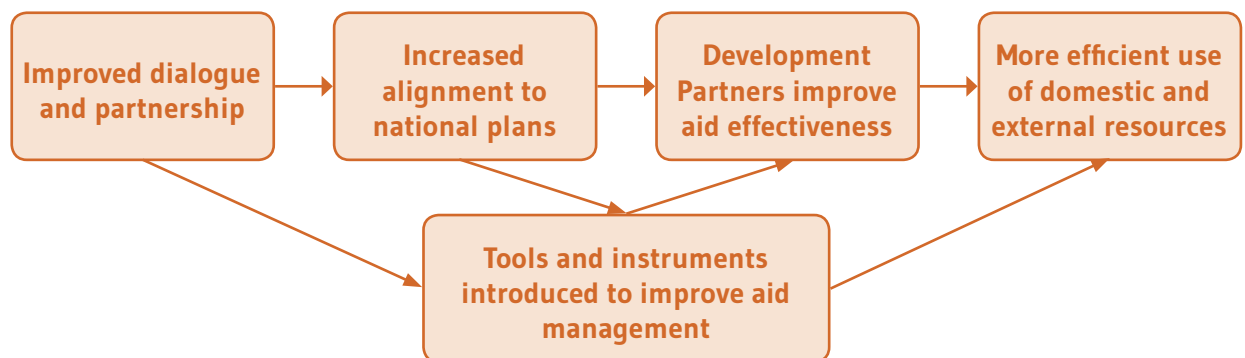
There is no standard process, level of effort or amount of time required to develop a Compact. It generally took between four months to just over a year to develop a Compact, for example four months in Benin, five months in Uganda, nine months in Sierra Leone and around 13 months in Togo. Many countries started by agreeing a roadmap, aide memoire or other agreement which mapped out the timeline, process and roles of partners in developing a Compact. The inputs required vary according to the country choice but generally included routine meetings of steering groups or health sector coordination bodies, retreats, and working and writing groups. Some used external consultants to help facilitate the process, draft documents and bring in international good practice. Drafting and circulation of documents for review and approval with development partners' headquarters can be time consuming, especially if legal departments are required to clear Compacts for signature.



2. Compact results and achievements

This section presents findings on the potential results and achievements of a Compact into four levels of results that link the process of developing a Compact to achieving more efficient use of resources. These four levels are (i) dialogue and partnership, (ii) alignment, (iii) introduction of tools and mechanisms and, (iv) measurable changes in aid effectiveness.

Figure 1. Potential Benefits Chain from a Country Compact



2.1 Compacts have increased trust among partners and improved the quality of the dialogue and coordination mechanisms between them

The process of developing a Compact can result in more benefits than the signed document. Country experience suggests that the process of developing a Compact has resulted in improving the quality of the sector dialogue, increased trust between partners, brought international legitimacy and moral strength to aid coordination efforts, increased the inclusiveness of partnership to include civil society, and contributed to strengthening health sector coordination mechanisms.

The Compact resulted in improved dialogue and increased trust between partners

- The quality of the sectoral dialogue improved as a result of the work to develop the Compact in Nepal, Sierra Leone and Benin.
- The Compact process built trust between partners. Although the health SWAp dated back to 1999 the process of developing the Compact built further trust in Mali.
- Negotiating the Compact brought a new dynamism towards more urgent concerted action to improve health in Benin and in Mali.

The Compact brought international legitimacy and moral strength to aid coordination efforts

- In Ethiopia, the support of IHP+ lent international legitimacy to harmonisation and alignment arrangements that the government had been leading before the IHP+.
- The Compact increases the moral strength of the partnership because the commitments and indicators exist. Partners know the commitments exist in Nigeria and Mali, even if they are not formally reporting progress against them.

The Compact increased inclusiveness and strengthened coordination mechanisms

- Planning processes have become more inclusive and brought civil society into health aid coordination discussions. In Benin, Mauritania, Ethiopia and Mali, civil society participation began or increased. In Benin the process resulted in more joint work by government with development partners. In Mauritania the process also engaged other government departments including Ministry of Finance and Ministry of Planning and Development.
- Coordination mechanisms have been introduced or improved. Technical working groups have been established in Mauritania. Existing coordination mechanisms were strengthened in Sierra Leone to form a Health Sector Steering Group with stronger team work.

2.2 Compacts have enabled countries to better understand the external support they receive, and to align it to their national health strategies.

Much attention has been invested in supporting country ownership and laying the foundations to improve delivery of development assistance for health. A key element of this has been strengthening leadership and ownership with support for one national health strategy or plan.

Countries value the role of Compacts in bringing all partners in support of One Plan

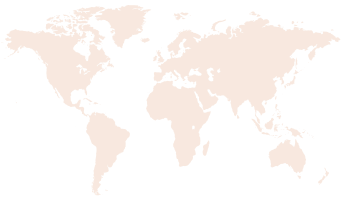
- Governments have a stronger understanding of what their development partners are funding in the health sector. In Benin, Mauritania and Togo there was previously little tradition of development partners informing the Ministry of Health about their programmes so the Compact helped clarify the roles of all partners.
- The support of more, if not all, development partners are reflected in and aligned with the national plan, including in Benin, Mali (except some donors), Ethiopia, Nepal, Togo, Sierra Leone, Mauritania, and Nigeria. This is a significant benefit for governments that can exercise stronger leadership and planning to meet their own priorities. In Nepal and Sierra Leone development partners' programmes are included in government-led workplans and budgets. District level coordination improved in some districts in Sierra Leone.

2.3 Compacts have not resulted in development partners providing substantially more aid effective development assistance for health.

Most Compacts have objectives and commitments to improve alignment, harmonisation, and for development partners to increase use of country systems. The evidence suggests that development partner performance on these objectives and indicators is not changing substantially.

There are a few reports of mobilisation of additional resources for health:

- There is a reported increase in domestic resources for health in Mauritania where the MoH budget increased by 35% in 2012 as a result of national plan and Compact.
- Reports suggest that some financial commitments made in Compacts are not being met by development partners in Mali and Nepal.
- There may be some increased development partner funding in Sierra Leone (although this cannot be attributed directly to Compact).



Development Partners (DPs) are making commitments to provide longer term support to the health sector, but few are translating these commitments into more predictable disbursement of aid.

- Development partners are increasing their long term commitments to the health sector in some countries. Benin, Ethiopia, Mali and Uganda received more multi-year commitments, Mali, Mauritania, Nepal and Sierra Leone has less multi-year commitments (from the 16 DPs that participated in IHP+Results monitoring).⁹
- Development partners are improving aid delivery, but not improving predictability. Seven countries¹⁰ had an increased percentage of scheduled aid delivered in the year it was planned for (from the 16 DPs that participated in IHP+Results monitoring), but of these four countries (Benin, Ethiopia, Mali and Nepal) had significant over-delivery whereby the country received much more health aid than it had anticipated.¹¹

Development partners have not met their Compact commitments to record health aid on national budgets and channel more of it through country public financial management systems.

- There is no clear trend of increased or decreased health aid recorded on national budgets as a result of Compacts. Ethiopia, Mali, and Nepal saw increases in the aid on budget from the 16 development partners (excluding USG) that participated in IHP+Results monitoring, while Uganda, Nigeria, Benin, Mauritania and Sierra Leone saw less (that means from the subset of total development assistance for health that is provided by 16 IHP+ development partners). When looking at the total development assistance for health, including all development partners, only 39% of assistance was actually on budget.¹²
- There is no significant increase of development assistance for health using country public financial management systems.¹³ Overall Ethiopia saw a smaller proportion of aid through country systems, but a greater proportion from the subset of development partners who participated in the IHP+Results monitoring exercise.¹⁴ US Government is the largest donor and does not participate in IHP+Results monitoring. Mali received more aid through country systems from IHP+Results, but Uganda and Sierra Leone saw a big decrease in aid through country systems and the rest had no data. Benin saw no change.
- There does not appear to be a shift of development partner funding to governments' preferred modality as outlined in the Compact. In Ethiopia there is a higher absolute value of aid through the governments preferred MDG Fund, but this is a lower proportion of the total aid for health. The nine donors that fund the MDG Fund provide a relatively lower volume of funding than the total volume of USG and Global Fund resources outside the MDG Fund.
- The sentiment in Sierra Leone was that development partners prefer the status quo than to change modality for the delivery of aid.

9 IHP+Results Progress in the International Health Partnership+: 2012 Annual Performance Report.

10 Ethiopia, Mali, Nepal, Nigeria, Benin, Mauritania, Sierra Leone

11 IHP+Results Progress in the International Health Partnership+: 2012 Annual Performance Report.

12 Waddington et al, 'Roadmap for Enhancing the implementation of One Plan, One Budget and One Report in Ethiopia', January 2012.

13 Ibid

14 IHP+Results Progress in the International Health Partnership+: 2012 Annual Performance Report.

2.4 Compacts have supported, enabled, or co-existed with the development of other concrete tools and instruments to improve health aid management.

Country Compacts do not exist in isolation. Compacts contribute to a partnership dialogue that also develops other tools to further aid effectiveness, for example Joint Financing Arrangements and Single Results Frameworks. These agreements may have occurred without a Compact, but they may also have benefited indirectly from the Compact and the dialogue they encouraged. We list here some of these achievements without seeking attribution to the Compact.

Countries are developing Joint Financing Arrangements (JFA) and conducting Financial Management Assessments

- Ethiopia and Nepal have both developed Joint JFAs with their partners as a tool to manage external development assistance for health to align with national plans and priorities. Some observers consider these as more important documents than the Compact. In Sierra Leone a Financial Management Assessment has been conducted and an improvement plan is being developed as the basis for a draft JFA for partners to review in first quarter 2013.
- At the same time as developing the Compact work began in Benin to take forward the Health Systems Funding Platform to better harmonise Health Systems Strengthening support behind the national plan. This work is on-going and the platform has just been launched.
- There has been work in Nepal to draft an agreement on Joint Technical Cooperation to improve harmonisation.
- In Nepal it was suggested that the multitude of documents and arrangements has caused confusion on the distinct purpose of each document or agreement, the relationship between them, and the list of signatories to each agreement. This may also be the case in other countries with multiple agreements.

Compacts have supported or encouraged the development of One Results Framework

- Results frameworks for tracking progress are often developed at the same time or soon after a Compact. In Nigeria the National Results Framework for the National Strategic Health Development Plan 2010 – 2015 was developed at the same time as the Compact. Mali developed a Joint Matrix on Evaluation and Monitoring and Sierra Leone a Results and Accountability Framework that also links to the recommendations from the Commission on Information and Accountability. All partners are using a single results framework in Ethiopia. This has resulted in a decline in development partners requiring separate reports in Ethiopia, although some still require reporting on additional indicators.
- Government leads more or better joint sector reviews. Sierra Leone conducted joint reviews in 2010 and 2011 and held its first Health Summit in 2011. This is important in a country which is making the transformation from humanitarian to development processes.



3. Compact use and added value

3.1 Compact commitments and indicators are rarely being reported on and used for mutual accountability

The Compact is viewed as a relevant tool to manage development assistance for health in many countries because the issues that a Compact is designed to address still pertain: the need for better coordinated aid that translates into stronger health systems and better health outcomes. However, the commitments and indicators in Compacts are rarely used as the basis for systematic and routine monitoring of the performance of all partners. Some countries have undertaken one off assessments to monitor progress, and some countries incorporate some partnership indicators in their JAR of the health sector. These indicators may overlap with some of the Compact indicators.

The commitments and indicators in Compacts are rarely monitored as the basis for mutual accountability

- There has been limited routine reporting on Compact commitments and indicators in most countries. It is too soon to tell in Mauritania and Togo where Compacts were signed in 2012. Sierra Leone prioritised developing other tools like JFAs in the first year of implementation and plan to begin routine reporting in 2013.
- The commitments and indicators in Compacts have been used for a progress review in Ethiopia in 2011. This provided data against a baseline to identify progress and guide the development of a roadmap. In Mauritania there is consideration of reviewing partnership indicators as part of the 2015 mid-term evaluation of the national health plan.
- Countries and development partners do review progress on some partnership indicators within other existing country review processes including Joint Annual Reviews and Annual Review Meetings. In Mali some of the commitments are linked to and part of the Programme de Développement Sanitaire et Social (PRODESS). Progress on aid effectiveness is reviewed as part of country annual reviews in Ethiopia, Kenya, Mali, and Nepal. This does not have to be a result of Compacts: Tanzania and Mozambique also monitor partnership indicators in their JAR.
- Reporting on indicators can be complicated in some countries because there are different sets of indicators in different agreements: the Compact, the national health plan, the national results framework, the JFA, the SWAp, the pooled funding and others. This is the case in Nepal which has a plethora of agreements.
- Compact partners developed a Plan of Action (POA) in a matrix with activities linked to the indicators and commitments in Nigeria. This has recently been reviewed at the development partners meetings and presented to the Ministry of Health.
- Mauritania, Nigeria, Sierra Leone and Togo are planning to link their reporting on the Commission for Information and Accountability indicators with their Compact reporting. In Nigeria this will link to the national results framework and be based on the JAR.
- Many Compacts have too many commitments that are too vague. This is particularly the case in Ethiopia, Mali, Benin and Nepal. Some commitments are more like general statements of intent – that are not measurable.

3.2 Compacts add value to efforts to improve the management of resources for health

It is futile to try to attribute to a Compact any improvements in aid effectiveness in the health sector. Some countries have had longstanding sector wide coordination processes or mechanisms which have been the basis for efforts to improve aid effectiveness in the health sector. The value added that a Compact brings depends on the context and what already exists in the country.

- Compact brought international credibility to the government's efforts to improve harmonisation and alignment in Ethiopia.
- Compact process can help suggest and concretise commitments and indicators for signatories to the Compact. In Mali it helped to make aid effectiveness more tangible and measurable, and in Nepal it helped define more precisely the commitments and indicators.
- Compacts can help reshaped coordination and steering bodies (as in Mali and Sierra Leone).
- Joint Financing Arrangements could have happened without the Compact, but linking them to the IHP+ and the Compact may have given them more credibility.
- The Compact can be a catalyst for joint planning in countries as was the case in Benin.
- While not legally binding, Compacts do carry symbolic or moral power that can encourage partners to implement commitments.



4. Limitations, issues and lessons learned

4.1 Limitations and issues

The limitations of Compacts can include: (i) which development partners elect not to sign the Compact, (ii) the unrealistically large content and ambitious objectives and indicators, (iii) the implicit funding expectations that have not materialised, and (iv) the level of on-going leadership and implementation.

Some key funders to the health sector are outside the Compact

- In some countries the largest external funders to the health sector do not sign up to or support the Compact. For example this is the case with USG and the Global Fund in Ethiopia, and with USAID, China, France and the EC in Benin. Transaction costs of managing aid can remain high because the largest donors sit outside the Compact arrangements.

Compact content and objectives

- All Compacts contain some commitments which are not clearly defined, with indicators that are not measurable, and often without clear targets.
- Most Compacts focus on the objectives of improving the management of development assistance for health in support of national health strategies. However, some Compacts also include elements of other national health strategies and plans. Compacts in countries such as Mali, Benin, Togo, and Mauritania combine elements of a health strategy (analysis of the health sector and measures to strengthen the delivery of health services) with elements of how to improve coordination of domestic and external resources for the health sector (aid effectiveness and aid management). The Nepal Compact combines aid effectiveness and partnership indicators in with other more traditional health indicators on equity, service delivery and other more traditional health indicators.
- All Compacts have many indicators which are not reported on. Indicators are often drawn from the Paris Declaration which helps global comparisons, but does not necessarily address priority issues in the country

Expectations of additional external funding for health

- When the IHP+ was launched in 2007 some Ministries of Health formed the implicit understanding that agreeing a country Compact could be the key to mobilise additional external funding to the health sector. Evidence is scarce but informal reports suggest that additional external funding has not materialised and some Ministries of Health feel misled.

Leadership and ownership

- Some Compacts are seen as led and driven by development partners, as was the case in Benin and Nepal. Government ownership and leadership of the process can be limited.
- Development partner leadership on aid effectiveness must complement government leadership. When development partner representation rotates, or staff leave, it can reduce trust and leadership.

4.2 Lessons learned

Countries and development partners have learned many lessons from developing and implementing Compacts. We summarise the key lessons under three broad headings.

Government leadership and mutual trust

A Compact is a tool and a sign of mutual trust. Like any tool, its value partially depends on the hand(s) that hold it. Government leadership is vital. Some Ministries of Health have developed a Compact after writing a national health strategy as a tool to reinforce leadership of the national strategy, as in Togo, Sierra Leone, Nigeria and Mauritania. Development partners also need to exercise support for government and leadership in implementing their own commitments.

Compact content and communication

The content of the Compact matters, and there is not a perfect blueprint to follow. Some Compacts included too many vague, overly ambitious, or un-measurable commitments and indicators. The sound advice from some signatories is to keep the commitments and indicators limited, manageable and focused. Finally, a Compact needs to be communicated to partners who are not necessarily in the room when it is negotiated. Some observers suggest a few clear messages would help communication to secure understanding and buy-in.

Implementation and monitoring for mutual accountability

Ensuring that a Compact gathers momentum rather than dust is a challenge. Leadership, trust, and clarity of objectives have already been identified as important. While a Compact does not need to include all the details of how it will be implemented, it does benefit from outlining the key tools, instruments and implementation arrangements that will be required to achieve the objectives. Country experience suggests that it is also important to have an effective coordination mechanism which maintains the dialogue and sense of joint problem solving. Finally mutual accountability requires a small set of well-chosen measurable indicators that are relevant to the country situation. Reporting on these can be integrated into an existing country-led joint annual health sector review.



Annex 1: Conclusions and questions for the Country Health Sector Team Meeting

Here we offer three broad conclusions from this review and suggest questions for consideration at the IHP+ Country Health Sector Team Meeting in December 2012.

1. Compacts have improved the quality of the dialogue and partnership for aid coordination. Countries highly value knowing what support their development partners are providing and aligning this to support their national plan. Countries have followed Compacts by developing concrete tools like JFAs to make progress. But there is little evidence that development partners are delivering more aid effective development assistance for health as a result of signing a Compact.

Question: is this the experience in your country or development partner, and what would it take (which priority issues need to be addressed) for a Compact to improve the delivery of more effective aid in the health sector in the specific areas you identified for your own context?

2. The commitments and indicators for improved partnership and aid effectiveness that are agreed in Compacts are not routinely reported on as the basis for mutual accountability.

Question: what is necessary to ensure that countries and development partners routinely monitor and jointly report on their key partnership and aid effectiveness indicators? Is the JAR the most appropriate mechanism for the review – and if so what would it take for progress on partners commitments to be sufficiently integrated?

3. The value of Compacts is as an overarching guide that sets the direction of travel and high level objectives for the partnership to improve the efficient use of all health resources (domestic and external). Achievement of Compact commitments requires on-going work to develop and implement specific tools and instruments like agreements on joint financing, joint reporting, and harmonised technical assistance.

Question: what concrete actions, tools or instruments are required to implement the commitments and meet the objectives laid out in your country Compact?

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