

Health

annual thematic performance report 2007–08

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Abbreviations

ADB	Asian Development Bank
AIDS	Acquired Immune Deficiency Syndrome
CIDA	Canadian International Development Agency
DFID	United Kingdom's Department for International Development
GAVI	GAVI Alliance, formerly the Global Alliance for Vaccines and Immunization
MDG	Millennium Development Goal
NZAID	New Zealand's International Aid and Development Agency
IPPF	International Planned Parenthood Federation
PMNCH	Partnership for Maternal, Newborn and Child Health
PNG	Papua New Guinea
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Introduction

This report deliberately responds to the Australian Government's strong commitment to do more to contribute to the achievement of Millennium Development Goals (MDGs) 4 and 5 (reducing child mortality and improving maternal health, respectively) in the Asia-Pacific region. It does not attempt to review progress in the aid program across the whole health sector. It reviews progress towards these two MDGs, highlighting the issue of inequity, and examines underlying causes of inadequate progress—in particular, the financing and human resource challenges facing the health system in many countries. It looks at what the Australian aid program is doing to support MDGs 4 and 5 and points out that most of the initiatives in this area started only in 2007–08. It provides a summary of quality-at-implementation ratings for the aid program's initiatives most directly related to MDGs 4 and 5. And it concludes with a summary of challenges and implications for the aid program.

To examine progress the report uses data from 23 countries¹ across the region where AusAID funding is used for health activities through either bilateral or regional programs. The magnitude of AusAID spending and engagement in the health sector varies considerably from country to country. In the reporting on AusAID initiatives more emphasis is given to the countries where Australia is a significant contributor to the sector.

Many of the initiatives specifically addressing MDGs 4 and 5, and many of the broader sectoral support programs in which maternal and child health are an integral part, are in their early stages. This report, therefore, provides an overview of the current status and the way forward rather than providing an in depth assessment of the performance of the program in 2007–08.

¹ Afghanistan, Bangladesh, Burma, Cambodia, China, East Timor, Fiji, Indonesia, Iraq, Kiribati, Laos, Nauru, Nepal, Pakistan, Palau, Papua New Guinea, the Philippines, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu and Vietnam.

Progress towards MDGs 4 and 5 in the Asia-Pacific region

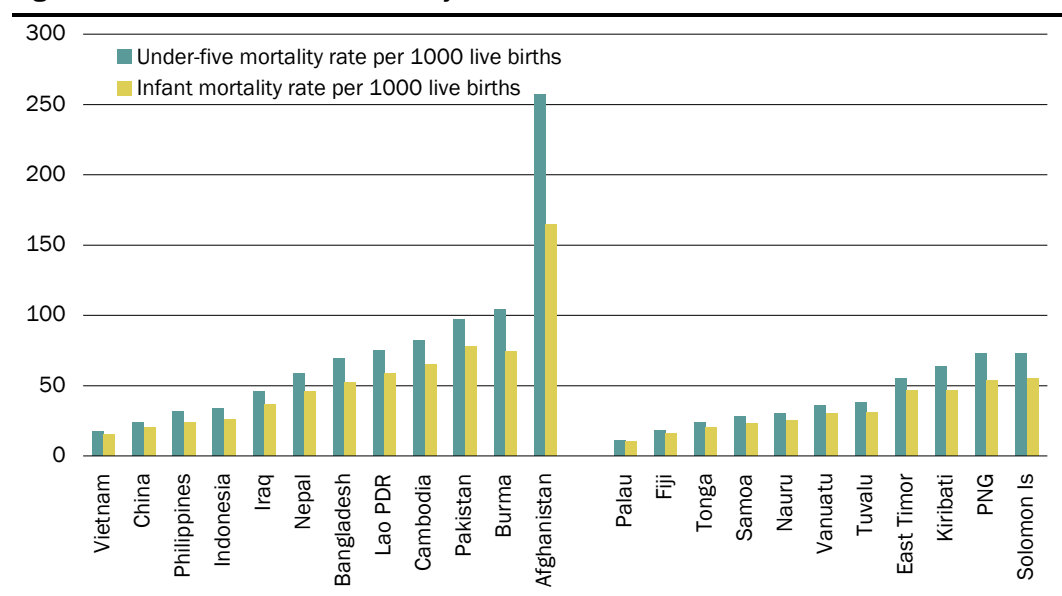
Progress towards MDG 4

Although the countries of Asia and the Pacific do not have the high rates of child mortality seen in Sub-Saharan Africa those rates are still unacceptably high in some countries and in parts of others. As shown in Figure 1, overall, child mortality is much higher in Asia than in the Pacific. In seven Asian countries and four Pacific countries one in every twenty children will not survive to the age of five years (that is, the under-five mortality rate is greater than 50 per 1000 live births). The figure also shows that in all countries the majority of child deaths are in the first year of life. As mortality falls from very high to lower levels an increasing proportion of deaths are in the first weeks, or even, days of life. This underlines the importance of a combined package of antenatal, delivery and newborn care to reduce deaths in women and children.

As a comparison with the rates shown in Figure 1 the under-five and infant mortality rates in Australia are 6 and 5 per 1000 live births, respectively.

Based on figures from the World Health Organization (WHO), 13 Asian countries along with Papua New Guinea and East Timor account for 53 per cent of the global total of neonatal deaths.² In these countries neonatal causes account for 26–56 per cent of deaths and pneumonia and diarrhoea together account for 25–43 per cent. Malnutrition underlies at least

Figure 1: Under-five and infant mortality rates in Asia and the Pacific



Data sources: Countdown to 2015, *Tracking progress in maternal, newborn and child survival: the 2008 report*, Geneva, 2008; WHO, *World health statistics 2008*, World Health Organization, Geneva, 2008.

² WHO Department of Making Pregnancy Safer, *Annual Report 2007*, World Health Organization
http://www.who.int/making_pregnancy_safer/documents/report_2007/en/index.html.

one-third of all childhood deaths, with Asia being the part of the world with the highest proportions and numbers of malnourished children. Most childhood deaths can be prevented by well-proven affordable interventions.

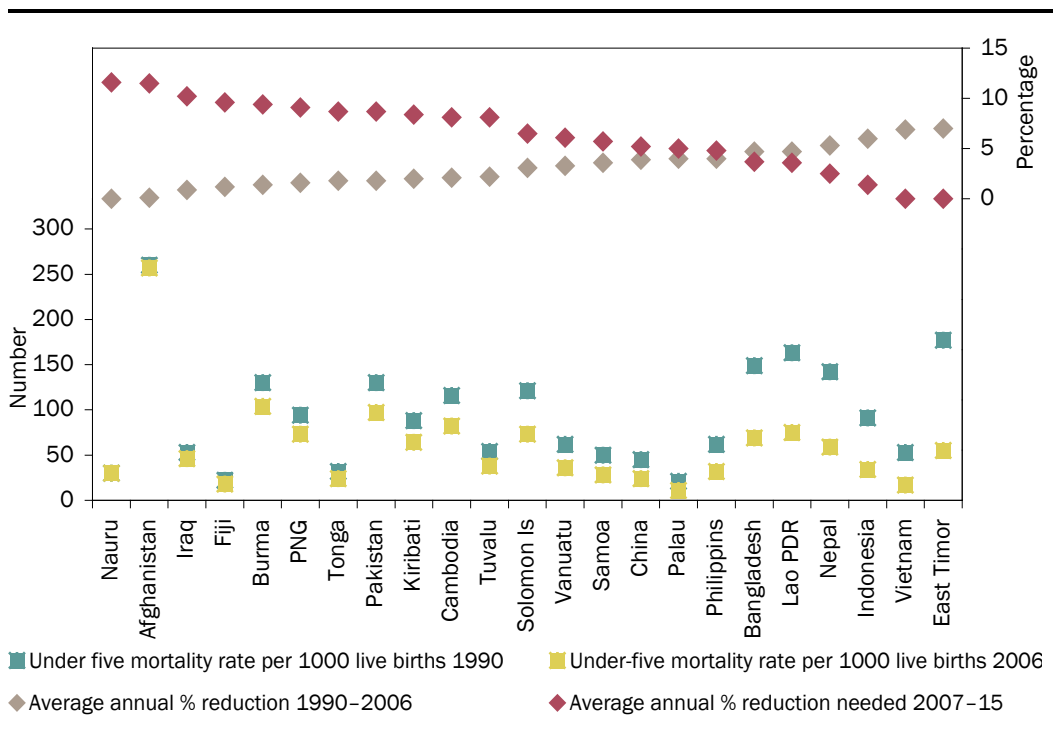
Figure 2 shows the under-five mortality rates in 1990 and 2006 for 23 Asia-Pacific countries and compares the average annual rates of decline needed between 2007 and 2015 to reach the MDG 4 target with those achieved from 1990 to 2006.

Only 9 of 23 countries—Bangladesh, China, Indonesia, Laos, Nepal, Palau, the Philippines, East Timor and Vietnam—showed annual rates of decline in the under-five mortality rate from 1990 to 2006 (with sustained progress during the years 2000 to 2006) that put them on track to meet the 2015 MDG 4 target (assuming application of the global target of achieving a two-thirds reduction compared with the 1990 level). Samoa, Solomon Islands and Vanuatu reduced their under-five mortality rate by more than 40 per cent from 1990 to 2006 but are not yet on track to reach the MDG 4 target.

In 13 of the 23 countries the average annual percentage decline in the under-five mortality rate from 2000 to 2006 slowed compared with the decade 1990 to 2000. On the positive side, of the countries not yet on track to the MDG target, Vanuatu and Cambodia have showed encouraging acceleration in the percentage decline in their under-five mortality rates since 2000.

Although the picture is mixed, with some countries showing remarkable progress, it is clear that much more needs to be done if the majority of countries are to reach the MDG for child mortality reduction.

Figure 2: Progress towards the MDG 4 target for 2015



Progress towards MDG 5

In Papua New Guinea, Cambodia and Bangladesh one in every 50 women will die as a result of pregnancy or child birth, in Laos and Nepal one in every 30 and in Afghanistan one in every 8.

Based on WHO figures 13 Asian countries along with Papua New Guinea and East Timor account for 44 per cent the global total of maternal deaths, or almost 240 000 a year.³

According to UN estimates haemorrhage is the leading cause of maternal mortality in Asian countries, accounting for a third of all deaths.⁴ Other common causes include hypertensive disorders, sepsis and infections, obstructed labour, anaemia and abortion. Most of these causes could be prevented or treated through a combination of contraception, antenatal care, skilled attendance at birth and access to basic emergency obstetric care.

Data on progress towards the MDG 5 target for 2015 (reducing maternal mortality by three-quarters compared with the 1990 level) are not as readily available as for MDG 4. This is in part because of the difficulty in measuring the maternal mortality ratio and the lack of confidence in some of the estimates that do exist. Table 1 shows maternal mortality ratios for 1996 and 2007 for Australia, Papua New Guinea and nine Asian countries as reported by the United Nations Population Fund (UNFPA). Although 4 of the 10 developing countries reduced by half or more their maternal mortality ratios in that period the ratios remain very high. In four other countries the reduction was minimal or there was no change and in Pakistan and Afghanistan there was an increase. There are few reliable estimates of maternal mortality ratios for Pacific countries.

High rates of death in pregnancy and childbirth continue to occur despite repeated assertions by developing countries and development agencies alike of the importance of reducing maternal mortality.

Table 1: Maternal mortality ratios^a in selected countries, 1996 and 2007

Country	1996 report	2007 report
Indonesia	650	230
Papua New Guinea	930	830
Bangladesh	850	380
Cambodia	900	450
Pakistan	340	500
India	570	540
Laos	650	650
East Timor	–	660
Nepal	1500	740
Afghanistan	1700	1900
Australia	9	8

^a The number of maternal deaths per 100 000 live births.

Source: UNFPA State of the World Population 1996 & 2007, except for Papua New Guinea's later figure, which is based on the 2006 National Demographic and Health Survey.

Two other indicators under MDG 5 are the proportion of births attended by skilled personnel and the contraceptive prevalence rate—the proportion of women of child-bearing age using (or whose partners are using) contraception. Figure 3 shows recent estimates for these indicators

³ World Health Organization.

⁴ United Nations, *The Millennium Development Goals report 2007*.

along with the maternal mortality ratio. As a generalisation, where access to skilled birth attendance is low, the maternal mortality ratio is high. It is also the case that where access to contraception is low, women who are too young become pregnant, pregnancies occur too close together and women have too many pregnancies—all increasing the risk of maternal mortality.

Few countries have reliable estimates of coverage rates for essential reproductive health services that allow trends to be tracked over time. This is the case for two other MDG 5 indicators—the proportion of pregnancies with at least one and with at least four antenatal visits, respectively. According to the most recent WHO estimates, in Afghanistan, Bangladesh, Laos, Nepal, Pakistan and East Timor, less than 50 per cent of women are seen at all during pregnancy by a trained health worker.

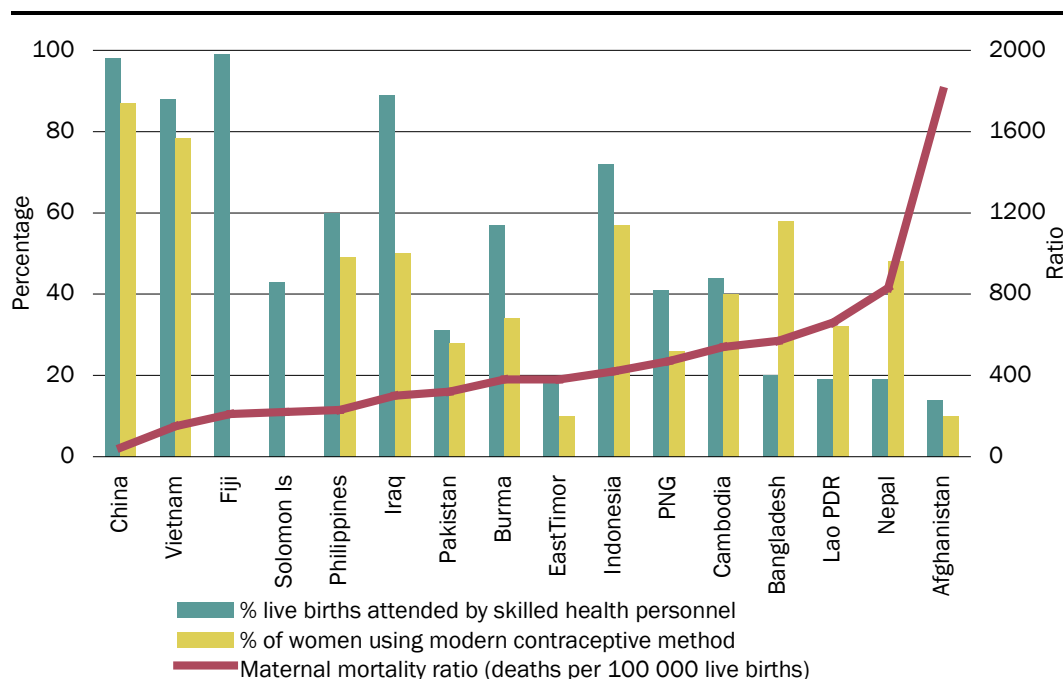
WHO data from 17 countries with at least two estimates for the proportion of births attended by skilled personnel indicate that all but two countries showed progress from the 1990s to the period 2000–06. In Solomon Islands and Papua New Guinea coverage of this critical service is reported to have deteriorated. Recently questions have been raised about the reliability of the high reported rates of coverage for some of the Pacific islands. Even allowing for some inaccuracy in the estimates it is clear that much more needs to be done in most countries to ensure that births are attended by health personnel able to provide basic life-saving care. The shortage of well-trained midwives is a major constraint.

It is clear from this brief overview that much more needs to be done to reduce maternal mortality in Asia and the Pacific.

Inequity in service coverage

National average estimates of health outcomes and health service coverage mask gross

Figure 3: Births attended by skilled personnel, contraceptive use and maternal mortality ratio

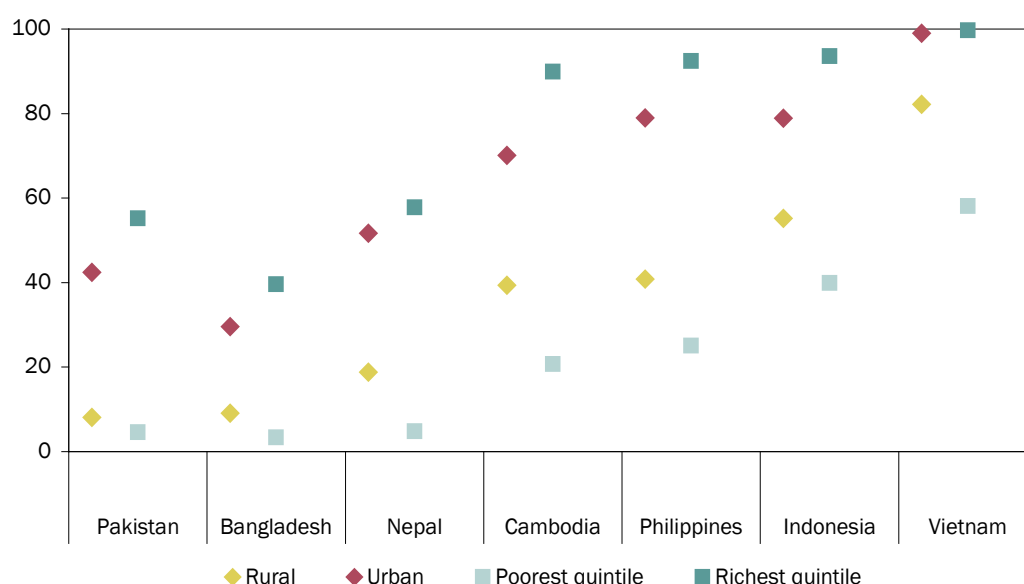


Data source: WHO, *Primary health care: now more than ever*, World health report 2008, World Health Organization, Geneva, 2008.

inequities—for example, between the urban and rural areas and between the rich and the poor.

In Cambodia, Indonesia, the Philippines and Vietnam children from the poorest quintile (20 per cent) of society are three or more times more likely to die before reaching the age of five than those from the richest quintile. Similar discrepancies can be expected in maternal mortality ratios. While these differences can be explained partly by lesser educational attainment and worse nutritional status among the poor, limited access to and use of health services are other critical factors. Not surprisingly, it is consistently the poor who suffer most from the deficiencies of health services. Research by the ICDDR,B in Bangladesh showed, for example, that women in the highest asset group were 13 times more likely to deliver their babies in a health facility than those in the lowest group. Figure 4 shows that services available differ significantly according to where people live and their level of income.

Figure 4: Proportion of births attended by skilled personnel by location and by economic status



Data source: WHO, *Primary health care: now more than ever*, World health report 2008, World Health Organization, Geneva, 2008.

In countries where overall health service coverage of the population is low (or the gap between needed and actual coverage is high), as in those in the bottom rows of Table 2, the difference between the rich and poor may not be great; almost everyone misses out. In countries with better average population coverage, as in those in the top rows of the table, this has often been achieved without improving coverage among the poorest people. These patterns can be used to argue for approaches that aim for improved coverage of basic services across the population as a whole in the former countries while specifically targeting the poorest in the latter group.

Clearly, the achievement of national targets for MDGs 4 and 5 accompanied by growing inequity is not the outcome that is wanted. Therefore, attention must be given to measures of inequity as well as overall population coverage.

Table 2: Increased average population coverage with health services may be accompanied by increased inequity

Gap between needed and actual population coverage for a package of child health interventions	Ratio of coverage richest:poorest	Difference in coverage richest:poorest
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	Gap between needed and actual population coverage for a package of child health interventions	Ratio of coverage richest:poorest	Difference in coverage richest:poorest
	%	ratio	%
Philippines	26	3.1	27
Indonesia	27	2.4	22
Cambodia	37	1.8	22
Bangladesh	38	2.0	27
Nepal	41	2.2	29
Pakistan	60	2.0	37
Burma	61	1.1	8
Laos	70	1.1	10

Source: *The Lancet*, vol. 371, April 2008, pp. 1259–67.

Why is progress on MDGs 4 and 5 inadequate?

Progress on MDGs 4 and 5 in Asia and the Pacific is variable across countries but overall insufficient. The lack of progress can be attributed to a number of factors, but high among them is poor access to and use of health services. In 6 of the 10 countries for which data were available, less than half of the children with symptoms suggesting pneumonia were taken to an appropriate source of health care and less than half of the children with diarrhoea received life-saving oral rehydration therapy and continued feeding. In at least six Asia-Pacific countries the most recent estimate showed that less than 50 per cent of births were attended by a skilled attendant.

There are many reasons for poor access to and use of health services. Among the most important, on which this report puts emphasis, is the serious lack of resources and skills where they are most needed. Funds are often not available due to overall low expenditure on health, inequitable allocation, inefficient financing and 'leakage'. Human resources and skills are lacking where they are needed because of low workforce numbers, the inequitable allocation of staffing, the reluctance of staff to work outside of the urban centres and inadequate incentives to do so, and poor training and supervision.

Financing and human resources directly affect other essential elements of the health system such as infrastructure maintenance, the availability of equipment and pharmaceuticals and the functioning of management and information systems. In addition, an inadequate flow of information to the public means they are often ill-informed about the services they should expect or that are available.

Where there are alternatives to government health services these services are also often under-resourced, as in the case of faith-based and non-governmental organisations. If a private medical sector exists, it is often unregulated and its services may be of poor quality and expensive and, in the worst cases, exploitative or dangerous. These deficiencies are also expressions of inadequate policies and regulation in relation to health financing.

In most countries health services are not free and health insurance coverage is minimal. The cost of health care (or of transport to obtain it) often prevents people from seeking care at all, may delay seeking care that is urgently needed or may result in indebtedness.

The position of women in society is reflected, for example, in their not being able to take decisions independently about their own health care and that of their children and their limited access to financial resources. This can be a major factor in maternal and child health.

The combination of these factors results in mothers and children not being able to access the preventive and curative care they need, even for everyday conditions. The lack of attention afforded common, easily treatable diseases often leads to worsening of the conditions, complications and too often death.

Health financing mechanisms can limit access and exacerbate inequity

Clearly the total amount of money spent on health services is one factor influencing the coverage and quality of services. In countries of Asia and the Pacific, expenditure per person on health differs greatly (Table 3).

Table 3: Health expenditure per person in selected Asian and Pacific developing countries and Australia

		Total per person health expenditure
		PPP US\$
12 Asian countries	Average	110
	Median	78
	Range	26–315
11 Pacific countries	Average	303
	Median	218
	Range	92–901
Australia		3001

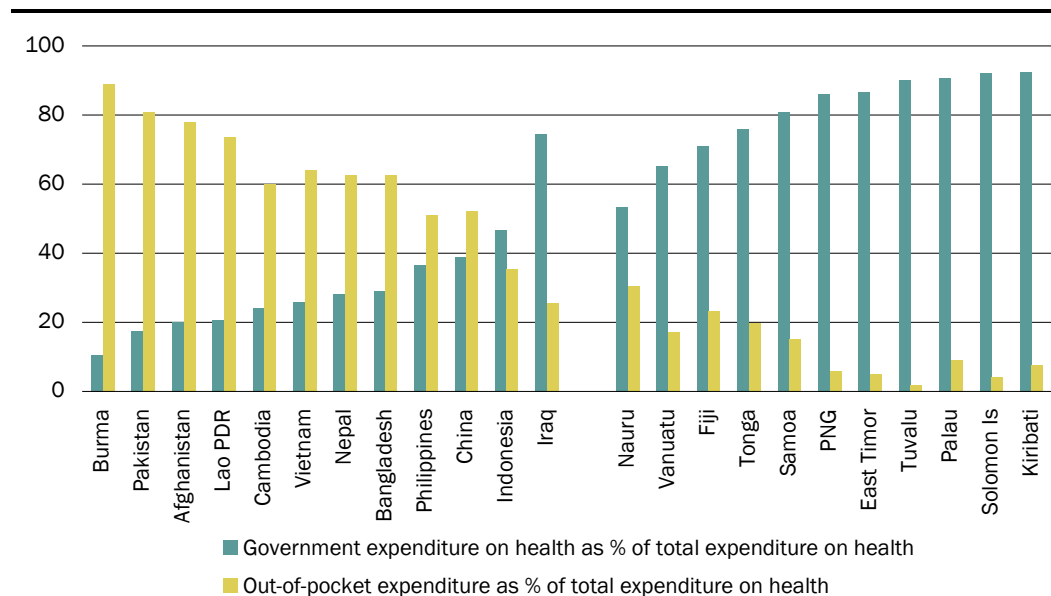
Note: PPP is purchasing power parity.

Source: WHO, *World health statistics 2008*, World Health Organization, Geneva, 2008.

It is clear also that the distribution of financial resources across different types of services (primary/secondary/tertiary, and promotive/preventive/curative) and different parts of the country (rural/urban, and richer/poorer provinces) has an impact on different population groups' access to services, and on health outcomes.

The dominant mechanism for financing the delivery of health services has an important impact on who can access services as well as the sustainability of the financing. Figure 5 shows two components of health financing—government expenditure and individual out-of-pocket expenditure at the point of service delivery—as a proportion of total expenditure. For comparison, figures from the same source show that 67 per cent of Australian health expenditure is from the government and 18 per cent is out of pocket. The Asian and the Pacific countries have broadly different patterns of financing health care.

Figure 5: Government and out-of-pocket expenditure as a proportion on total expenditure on health in selected countries



Data source: WHO, *World health statistics 2008*, World Health Organization, Geneva, 2008.

Asia is the region of the world that has the highest out-of-pocket expenditure on health—the form of expenditure that is least equitable as the poor have greater needs, pay a much higher proportion of their income for health care and may not have funds available when needed. This often leads them to sell assets or go into debt. For example, a study by the ICDDR,B in Bangladesh looking at the financial consequences of caesarean section delivery found that 33 per cent of concerned households incurred catastrophic costs (more than 10 per cent of their annual income) and that the greatest out-of-pocket expenses were in private facilities.

In the Pacific, most health expenditure comes from the government and there is very little out-of-pocket expenditure. While this has benefits in terms of equity of access it is due in part to the absence of an alternative to government services in many places. This means that the population depends on government services and therefore on the efficiency of the government financing mechanism to ensure that funds get to where they are needed and are spent on the right things. Unfortunately, this is often not the case.

In both contexts, the form of financing is a constraint on access to health care. The solutions, however, are different; both require clear policies and continuous efforts to implement them.

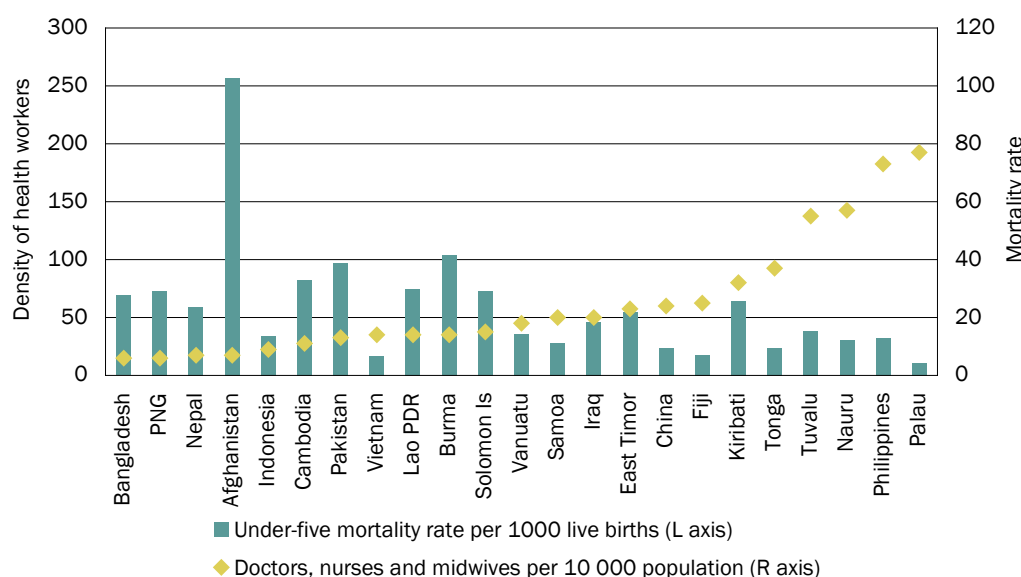
Low health worker numbers and inequitable distribution affect key services

In Australia, on average there is one doctor for every 400 inhabitants. In nine countries of the Asia-Pacific region each doctor serves an average of at least 5000 people. As in Australia, distribution is inequitable. Urban populations may have good access while those living in rural areas have no access at all without making difficult journeys to the cities or large towns. Although there are more nurses than doctors, in 10 countries in the region there are more than 1000 people for every nurse (in Australia, around 100); again distribution favours urban areas.

Difficult access to trained health staff is more than just an inconvenience or additional expense; it costs lives. Many maternal and child deaths occur because of the time taken to obtain care due to poor access to facilities with trained staff or insufficient staff at the facilities

when they are reached. Although there is not a close correlation between mortality and availability of health workers, Figure 6 shows the trend; 9 of the 12 countries with an average of fewer than 50 doctors, nurses and midwives per 10 000 people had an the under-five mortality rate above 50, whereas only 2 of 11 countries with a larger number of health workers had equivalent under-five mortality rates.

Figure 6: Density of health workers and under-five mortality rate



Note: Australia has 25 doctors and 97 nurses/midwives per 10 000.

Source: WHO, *World health statistics 2008*, World Health Organization, Geneva, 2008.

According to WHO, globally around 75 per cent of doctors and almost two-thirds of nurses work in urban areas where a little more than 50 per cent of the world's population lives. In some countries the urban–rural imbalance is even more pronounced. This situation is exacerbated by the migration of health workers to countries with better salaries, working conditions and opportunities.

It is clear that for many countries the lack of sufficient well-trained health workers along with their uneven distribution are significant factors limiting the provision of the services needed to progress towards MDGs 4 and 5. This constraint cannot continue to be ignored if delivery of basic services to all is to be assured.

The Australian aid program's contribution to achieving MDGs 4 and 5

The Australian aid program has a strong focus on addressing the priority health needs of women and children. Under the Labor Government's leadership, the Australian aid program is increasing its support for achieving MDGs 4 and 5. In particular, there is a focus on maternal health, reproductive and sexual health (including access to safe and effective contraception based on informed choice), nutrition and education for girls. Ensuring children have access to care for the major causes of child mortality is also a priority.

AusAID has established a broad range of partnerships and funding arrangements with a range of partner governments, multilateral agencies, non-government organisations and other stakeholders to address maternal and child mortality in the Asia-Pacific region.

Differentiated approaches to countries

The Australian aid program does not have a one-size-fits-all approach to assisting countries with progress towards MDGs 4 and 5. In some countries its predominant focus is to improve the delivery of services that are most likely to accelerate progress towards MDGs. In others, maternal and child health are among the priorities of a national strategic plan for health that Australia, along with other donors, supports broadly. In yet other countries the emphasis is on assisting to overcome barriers to access or the delivery of services that result from failures in the health system such as in health financing, human resources or supply chains.

This support can be broadly categorised as in Table 4. The table does not cover all activities of the aid program that might support MDGs 4 and 5. Activities focused on HIV and tuberculosis (related to MDG 6) are not included. Malaria is mentioned, however, as it is a critical component of the prevention and treatment of common diseases affecting women and children. In those countries presented in bold type in Table 4, significant new initiatives were started in 2007–08; some were a re-entry into the health sector for the Australian aid program.

The table shows clearly that the majority of current initiatives in support of MDGs 4 and 5 were started during 2007–08. The exceptions are in Fiji, Papua New Guinea and Solomon Islands, where broad sectoral programs that include maternal and child health related objectives were under way prior to 2007–08. In the Indonesia, Nepal and the Philippines support, including through UN agencies, was also in place before 2007–08 and is being built on in the design of new programs.

Table 4: Australian aid program support to achieve MDGs 4 and 5

Country	Comments
Initiative specifically focused on MDGs 4 and 5	
Afghanistan	Funding for the Catalytic Initiative under negotiation.
Bangladesh	Funding for UNICEF and BRAC program activities in defined geographic areas.

Country	Comments
Indonesia	Financial and technical support to Government of Indonesia at provincial and district levels in East Nusa Tenggara Province. Funding for UNICEF program activities in Papua.
Nepal	Support for vitamin A supplementation and community-based integrated management of childhood illness through non-government organisations and UNICEF. Moving toward broader sectoral support.
Pakistan	Support to National Maternal Neonatal Health Program through DFID.
Philippines	Support to UNICEF, UNFPA and WHO (malaria control) program activities with a focus on southern Philippines.
Broad sector program in which MDGs 4 and 5 are a priority	
Cambodia	Moving to pooled funding with DFID, World Bank and UNFPA within a multi-partner sector-wide approach. Interim activities through UNFPA and WHO.
Fiji	Ongoing Health Sector Improvement Program.
Papua New Guinea	Ongoing sector-wide approach. Comprehensive support to a national strategic plan that prioritises maternal and child health.
Solomon Islands	Lead development partner for a newly established sector-wide approach in support of a national strategic plan that includes maternal and child health. Pacific Malaria Initiative.
Samoa	Pooled funding with NZAID and World Bank for a newly established sector-wide approach.
East Timor	Pooled funding with World Bank for a newly established sector-wide approach in support of a national strategic plan that prioritises maternal and child health.
Focused health system strengthening	
Vietnam	Working closely with World Bank, ADB and WHO on health financing and human resources.
Indonesia	Working closely with World Bank, ADB and WHO with a focus on health financing.
Other	
Pacific regional	Support to national reproductive health non-government organisations through IPPF.
Vanuatu	Ongoing support for sectoral reforms, the Village Health Worker Program and tertiary care. Pacific Malaria Initiative.

Achievements

For most of the initiatives listed in Table 4 it is too early to report on their contribution to a quantitative change in an MDG-related indicator. Some specific achievements of ongoing programs in relation to MDGs 4 and 5 are shown in Table 5. In broad sectoral program support, where AusAID is working with partner governments and multiple development partners, it is more difficult to draw a direct line between Australian inputs and specific outcomes.

Attribution of national-level health outcomes, such as mortality reduction, to AusAID inputs is not possible and even on a subnational level such attribution is difficult because of the range of other inputs and factors that have an impact on such outcomes. In Tibet the Regional Bureau of Health reported maternal and infant mortality rates have improved in the project sites in Lhasa Municipality targeted by the AusAID-supported Tibet Health Sector Support Program. The maternal mortality ratio dropped from 321 per 100 000 live births in 2004 to 223 in 2006 and the infant mortality rate from 49.3 per 1000 live births to 32.2. Counterparts attributed this improvement to improved services, to which the program contributed.

In keeping with global thinking on development aid effectiveness it is considered less important to try to attribute outcomes to individual development partner inputs than to work in a coordinated fashion with others to ensure that the collective effort is bringing measurable results.

Table 5: Selected achievements related to MDGs 4 and 5 attributable to AusAID funding through country and regional programs

Country or regional program	Selected achievements
Afghanistan	> International Federation of Red Cross and Red Crescent Societies provided maternal and child health services to approximately 110 000 women and children.
Bangladesh	> Research at the ICDDR,B (to which AusAID provides core funding) has resulted in recommendations on managing severe malnutrition, reducing costs for caesarean delivery and improving immunisation coverage and has influenced national policy and plans on the integrated management of childhood illness.
China/Tibet	> The regional blood centre has been strengthened to a level of national accreditation. A safe blood supply is crucial to the provision of comprehensive obstetric care.
Indonesia	<ul style="list-style-type: none"> > Three hospital sites in Eastern Indonesia can now provide high-quality and affordable training for midwives. > Midwives have been trained to become trainers for courses in normal delivery care. > Program research revealed that midwives were spending only 28–42 per cent of their time on key midwifery services. This finding is being used to advocate for policy changes that will increase the number of women able to access skilled assistance during pregnancy. > In Papua, through support to the UNICEF Women's and Children's Health Program, 60 midwives have been trained in normal delivery care, medical supply management and supervision. This will improve access to life-saving care in remote areas.
Nepal	> In AusAID-supported districts, 6232 female community health volunteers and 1200 health facility staff were trained to provide pneumonia and diarrhoea treatment.
Papua New Guinea	<ul style="list-style-type: none"> > In 2008 children will receive for the first time immunisation against <i>Haemophilus influenzae</i> type b, which causes meningitis and pneumonia, two of the commonest causes of death among children in Papua New Guinea. > In 1996 only five provinces outside of Port Moresby had paediatricians; there are now 15 due to long-term support for paediatrician training and mentoring. > There has been a reduction in case fatality rates for pneumonia in children admitted to hospitals. This may be linked to the distribution of oxygen concentrators to ensure a more reliable supply of oxygen needed for treating severe pneumonia.
Philippines	<ul style="list-style-type: none"> > With UNICEF support the Philippine government programs fully immunised 213 000 children 0–11 months old (82 per cent) against common vaccine-preventable diseases in AusAID-supported provinces and a further 700 000 children in high-risk areas. > Approximately 26 000 school children in 70 public schools and their communities gained better access to safe drinking water and sanitation facilities.
Vanuatu	> The Health Sector Support Program is building workforce capacity, including through specialist support (including obstetrics and gynaecology) to Vila Central Hospital. Nurses and paediatric staff are now better able to provide enhanced care for newborns.
Regional	<ul style="list-style-type: none"> > The Sexual and Reproductive Health Program in Crisis and Post Crisis Situations in East, Southeast Asia and the Pacific (SPRINT), with IPPF, UNFPA, the University of New South Wales and the Australian Reproductive Health Alliance, was launched. The SPRINT approach was adopted in Burma following Cyclone Nargis and in China following the Sichuan earthquake. > An agreement for a knowledge hub on maternal and child health was established with three Australian institutions around key health priorities, to assist in improving the evidence base for the aid program in this area. > The Pacific Malaria Initiative (and an associated support centre) was created to enhance support for malaria control in Solomon Islands and Vanuatu. Malaria is a major health problem of women and children.

Australian support to international organisations

The Australian aid program is increasing its support to multilateral and global health institutions working on MDGs 4 and 5 (Table 6). These institutions remain grossly underfunded relative to their mandate. While there is a move away from tightly earmarking

this support it is specifically designed to complement the bilateral and regional activities of the aid program. Where funding is at the global rather than the regional level there is a clear understanding that attention will be given to the Asia-Pacific region.

Australia has increased its funding to WHO, for example, stating that it should be used for four of the organisation's strategic objectives that are most closely aligned with Australian interests. These include maternal and child health, and health system strengthening. It is clear that Australia expects to see these areas of work strengthened in Asia and the Pacific and this will be taken into account in assessing future contributions.

Table 6: Australia's contribution to the main international health organisations whose work is related to MDGs 4 and 5

Organisation	Type of Australian funding	Contribution in 2007–08
WHO	Focused on four strategic objectives, including maternal and child health	Estimated \$5 000 000 for MDGs 4 and 5
UNICEF	Core funding to total UNICEF program (undetermined but significant proportion for maternal and child health)	Unknown proportion of \$13 700 000
UNFPA	Core funding and includes \$1 million for Pacific (primarily for reproductive health commodities)	\$7 000 000
IPPF	Core funding for sexual and reproductive health	\$2 750 000
GAVI Alliance	Core funding	\$5 202 117
PMNCH	Funding for advocacy/coordination in Asia and Pacific region	\$250 000

WHO and UNFPA play a key role in setting the norms and standards for maternal and child health and provide technical support in prevention and care to countries of the Asia-Pacific region through country or regional offices. UNFPA also assists in procuring commodities for family planning and is often the main voice of advocacy in this area. UNICEF has a strong presence on the ground in many countries assisting partner governments to implement child health programs and to procure vaccines.

The GAVI Alliance is a public–private funding mechanism that, with technical and operational support from WHO and UNICEF, has increased access to vaccines for children in poor countries. Estimates for the period 2000–07 show that the GAVI Alliance averted 2.9 million future deaths through vaccination, 36.8 million children were supplied with basic vaccines and 176 million additional children were protected with new and underused vaccines.⁵

The Partnership for Maternal, Newborn and Child Health (PMNCH) consists of more than 240 member international, government and non-government organisations working to achieve MDGs 4 and 5. AusAID support assists the partnership to have a permanent staff presence in the Asia-Pacific region.

Australia has recently joined the International Health Partnership, which will help to align donor assistance to the health sector plans and strategies of the recipient countries, to reduce transaction costs and increase efficiency. The partnership places emphasis on strengthening health systems and securing predictable long-term funding necessary for addressing the more complex health system challenges to ensure progress towards MDGs 4 and 5.

⁵ GAVI Alliance website <http://www.gavialliance.org/performance/global_results/index.php>.

Quality assessments of the aid program's initiatives

Quality-at-implementation ratings for 2007–08 are available for 11 AusAID initiatives focused on MDGs 4 and 5 or where the goals are supported through a broader sectoral initiative (Table 7).

Overall there were slightly higher scores for implementation progress and achieving objectives than for monitoring and evaluation and sustainability. None of initiatives' quality at implementation received a rating of less than 3 in 2007–08. However, the summary of ratings in Table 7 indicates that at least 60 per cent of initiatives—those rated 3 or 4—require improvement in all criteria.

Table 7: Quality-at-implementation ratings of initiatives focused on MDGs 4 and 5 or where the goals are supported through a broader sectoral initiative

Criteria	Rating of 3: Less than adequate quality	Rating of 4: Adequate quality	Rating of 5: Good quality	Rating of 6: Very high quality
Implementation progress	3	5	2	1
Achieving objectives	3	4	3	1
Monitoring and evaluation	4	5	2	0
Sustainability	2	7	2	0

As examples of the challenges faced by initiatives, one was hampered by the poor flow of funds due in part to the complexity of the financial management procedures put in place to address accountability concerns and another made slow progress due to the unstable political situation.

Challenges and implications for the aid program

Global health priorities and funding

- > Globally, including in the Asia-Pacific region, MDGs 4 and 5 are underfunded, accounting for only 2–3 per cent of global expenditure of official development assistance. With the current level of expenditure on MDGs 4 and 5 it will not be possible to reach the 2015 goals. While there has been a huge increase in funding for health development over the past decade, this has been largely focused on specific diseases (especially AIDS, tuberculosis and malaria) and technology-based interventions (especially vaccines). (Australia's contribution to achieve MDG 6 is three to four times greater than its contributions to meet MDGs 4 and 5 combined.)
- > Globally, more development assistance has been directed to the African continent than to Asia and the Pacific, which, while well justified, ignores the fact that around half of all maternal and child deaths occur in Asia.
- > Despite commitments to the Paris Declaration on Aid Effectiveness, and numerous gatherings promoting aid alignment and harmonisation, most aid for MDGs 4 and 5 is as project funding. In 2006 an estimated 95 per cent of global official development assistance for maternal and child health was in this form.⁶ Much of this support is focused on specific interventions rather than the integrated approaches needed to have a major impact.

Implications for the aid program

- > Australia should continue to advocate strongly for increased funding for MDGs 4 and 5, globally and in the Asia-Pacific region. This is being addressed in part by AusAID's active participation in the Asia-Pacific Maternal, Newborn and Child Health Network⁷ including the development of an investment case for MDGs 4 and 5 for Asia and the Pacific.
- > Australia should take a stronger evidence-based approach to funding allocations, using data on the burden of disease and inequity. This would result in more resources being allocated for activities that will support progress in MDGs 4 and 5, with an aim of at least matching MDG 6 funding. This would also enhance Australia's position as a leader for MDGs 4 and 5 in Asia and the Pacific.
- > The Australian aid program should increase its financial support to:
 - health policy dialogue, system improvements and recurrent costs that support basic service delivery, with a strong focus on MDGs 4 and 5 outcomes as indicators of success
 - increasing the number and skills of the health workforce, both at management and service delivery levels

⁶ G Greco, et al, *Lancet*, vol. 371, 2008, p. 1269.

⁷ An informal network of representatives of WHO, UNICEF, UNFPA, ADB, World Bank, AusAID, DFID, CIDA, USAID, Gates Foundation, and PMNCH.

- international organisations that provide effective technical support to MDGs 4 and 5.
- > Having recently joined the International Health Partnership (focused on aid effectiveness and health system strengthening, with an emphasis on MDGs 4 and 5) Australia should become an active and constructive participant in the partnership's implementation in the two pilot countries in Asia (Cambodia and Nepal) and promoting the principles in other countries.
- > Australia should continue to strongly advocate for the MDGs 4 and 5 indicators being the most appropriate 'bottom-line' indicators for the impact of initiatives for strengthening health systems.

Health system issues

- > Addressing the challenges of health system reform, including those of health financing and human resources, requires long-term sustained effort. As the timeline for the MDGs is short, it is important to ensure that efforts to strengthen the health system translate rapidly into improvements in service delivery.
- > The access to and use of basic health services are limited by the lack of well-trained human resources and by financial barriers.
- > There is a lack of reliable data to track progress towards the health MDGs, especially in Pacific island countries and at subnational levels in larger countries.
- > Progress towards national targets in relation to MDGs 4 and 5 is likely to be achieved in existing health systems while inequity persists or is even exacerbated.

Implications for the aid program

- > Efforts to strengthen health systems need to be complemented by support for service delivery now. In practice this means ensuring sufficient recurrent funding for service delivery, longer term investments in the health workforce and sustained policy dialogue on system reform. This should include working with partner governments to discuss and gain support for innovative approaches and alternative models for providing services.
- > Australia should increase its support to address the health workforce crisis, with a special emphasis on the Pacific. Australia should work with partner governments and other development partners to improve financing mechanisms for health that increase the level of resources, ensure sustainability of financing and remove financial barriers to accessing basic services.
- > Australia should help to build local capacity for health information systems. Work in this direction has started through the AusAID-funded Health Information Systems Knowledge Hub at the University of Queensland.
- > Australia should work with partner governments and development partners to ensure that joint monitoring and evaluation systems explicitly and routinely include equity indicators.

Beyond the health sector

- > The status and value of women in society, reflected in gender inequity in many dimensions of daily life, are a major constraint to progress, especially in relation to MDG 5. Nevertheless, gender inequity continues to be overlooked in the design of most health programs.

- > The global food crisis will increase the prevalence and severity of inadequate nutrition, already a major factor in maternal and child health. The Asia-Pacific region accounts for two-thirds of the world's underweight children. Unless it can be effectively and rapidly addressed, one impact of the food crisis may well be increasing mortality rates, slowing or even reversing progress towards MDGs 4 and 5. Similarly, rising fuel prices have an effect on health care costs for service providers and users.
- > Reforms in the health sector, especially those related to financing and human resources, depend on policies and reforms outside of the sector—for example, in budget allocation, public financial management and the civil service.

Implications for the aid program

- > Experts in gender equity should be included in the early stages of design of all new health initiatives.
- > Australia should foster links between its efforts to address the food crisis and MDG 1 and those to address MDGs 4 and 5.
- > Where Australia is working with central agencies to improve public financial management, reform civil services or address governance issues, it is important to link those efforts to developments in the health sector.

Conclusions

Progress towards MDGs 4 and 5 in Asia and the Pacific is mixed, with many countries still facing very high rates of child and/or maternal mortality and ill health. Achieving MDGs 4 and 5 is a strong focus of Australia's aid program, but many of the programs that more specifically focus on maternal and child health were initiated only recently.

It is clear that health system constraints are a major cause of slow progress towards these two MDGs. Many challenges exist, for example, in relation to health financing and the health workforce.

The Australian aid program will focus attention on supporting countries to improve their coverage of basic health services for women and children while supporting longer term changes that will strengthen their health systems for the future.