

# Annual Thematic Performance Report: Health 2008-09

June 2010



**Australian Government**  

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# Abbreviations

DBH	Delivering Better Health
GAVI	Global Alliance for Vaccines and Immunisation
HAARP	HIV/AIDS Asia Regional Program
HSSP-SP	Health Sector Strategic Plan Support Program
IHP	International Health Partnership
MNCH	maternal, neonatal and child health
MDG	Millennium Development Goal
NDoH	National Department of Health
ODE	Office for Development Effectiveness
PDR	People's Democratic Republic (Lao)
PEIDS	Pandemic and Emerging Infectious Diseases Strategy
PNG	Papua New Guinea
STI	sexually transmissible infection
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
WHO	World Health Organization

# Summary

This Annual Thematic Performance Report (ATPR) provides a snapshot of Australian assistance in the health sector in 2008-09 and identifies key results and lessons that can be used to improve the effectiveness of future support. The report does not address health-related activities that have been carried out in a conflict or crisis context (for example, in Afghanistan and Sri Lanka) or in response to natural disasters. It is not a full sector review and is therefore cursory and selective in its approach.

In 2008-09, Australia spent approximately \$420 million—or 12 per cent of the aid budget—in the health sector. Over recent years there has been a realignment of Australia's priorities for the aid program, including increased emphasis on achieving the Millennium Development Goals (MDGs). Within the health sector, priority areas include fixing health systems, addressing the needs of women and children, tackling regional threats such as HIV and emerging infectious diseases, and addressing specific country or region health problems such as malaria and non-communicable diseases in the Pacific.

Improving public health outcomes takes time and is a complex undertaking, requiring action on a number of fronts to achieve impact. Nevertheless, AusAID's commitment to improving health outcomes in the Asia-Pacific region is seeing tangible results. Examples of the impact of AusAID's development assistance include:

- > In East Timor, childhood illnesses are being reduced through achieving 79 per cent coverage of diphtheria, whooping cough and tetanus vaccinations, up from 56 per cent in 2003.
- > In Papua New Guinea (PNG) the government has established new mechanisms to improve funding for rural health services.
- > In Indonesia, AusAID is supporting the government through targeted and strategic technical assistance which in 2008 helped build government systems to collect and analyse data on the sources of health funding and expenditure.
- > In Solomon Islands, AusAID helped reduce new cases of malaria from 199 per 1000 in 2003 to 82 per 1000 in 2008.
- > In Bangladesh, improvements were gained with maternal mortality. In one district, for example, the mortality rate has halved since 2007.
- > Through the HIV/AIDS Asia Regional Program (HAARP), AusAID is helping to ensure that HIV prevention among people who inject drugs is not impeded by unsupportive laws.

However, vast challenges remain. Most countries in the Asia-Pacific region are well off-track to reach the MDG targets for reducing child mortality, improving maternal health and combating major diseases. Health systems are struggling without adequate financial management capacity and there are too few well-trained and supervised health workers, particularly in rural and remote areas. As a result, most people in the region continue to have poor access to quality basic health services overall.

Australia's reinvigorated focus on aid effectiveness and mutual accountability has seen diversification in the way AusAID engages and delivers aid in the health sector. Recent years have witnessed an increasing shift towards working through program-based approaches in line with Australia's commitment to an increased focus on: supporting country-owned and country-led responses; one agreed set of priorities and budget framework; formalised coordination among donors; and use of local systems. This is in addition to continuing to provide project support, where necessary.

# How is the health sector performing?

## Health of the Asia-Pacific region

An abbreviated overview of the health of the region in selected areas is provided in this section. It focuses on areas of priority for Australia's aid program, in particular those covered by the MDGs that specifically address health outcomes. The health of populations does not change rapidly from year to year, unless there are major epidemics of disease. Also, reliable updated health trend data is not available every year making reporting annually on the health status of the region difficult.

### MDG 4—Reducing child mortality

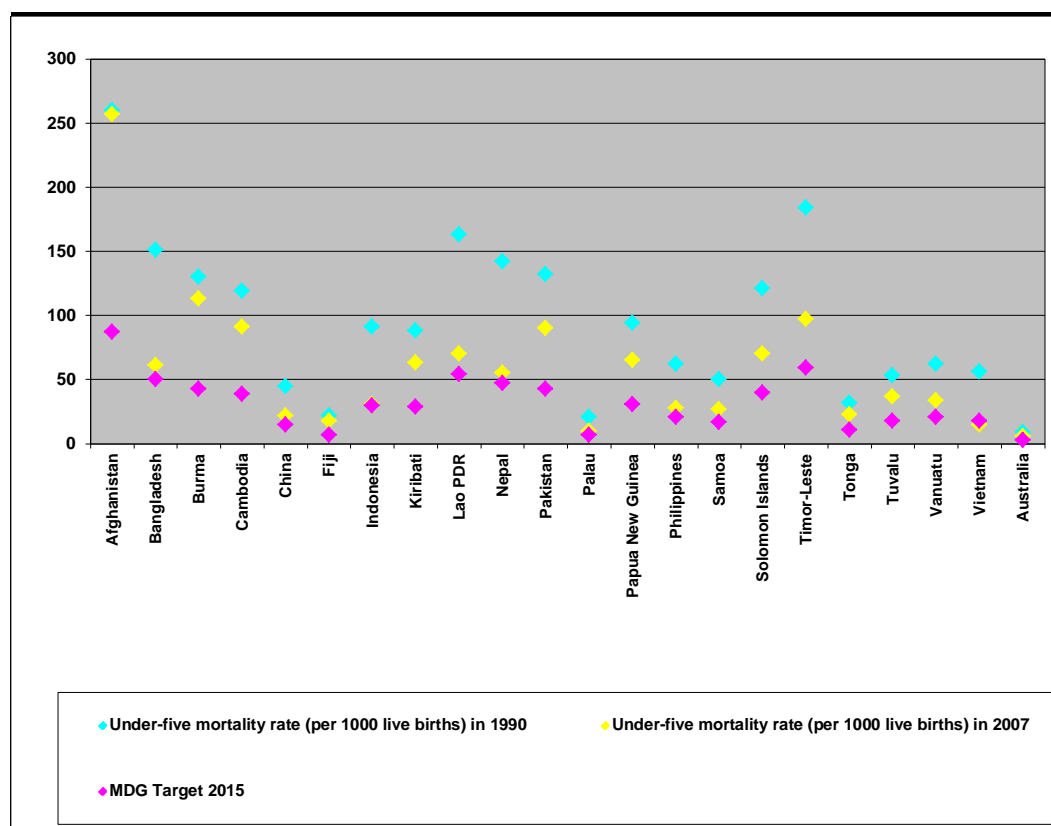
Good progress has been made in reducing child mortality across Asia and the Pacific. Figure 1 compares under-five mortality rates in 1990 and 2007 against the MDG level set for 2015. Figure 1 shows that the rate reduced by two-thirds in countries where AusAID supports health activities. During this period, for example, the number of children in Indonesia who died before turning five years old dropped from 91 to 31 per 1000 live births. The number dropped from 251 to 61 in Bangladesh, from 94 to 65 in PNG and from 121 to 70 in Solomon Islands. However child mortality remains unacceptably high in a number of countries—at least one in every 20 children will not survive to the age of five years in 11 Asian and Pacific countries.

Pneumonia and diarrhoea together account for 37 per cent of deaths among children under five in the World Health Organization (WHO) South-East Asia region and 22 per cent in the Western Pacific region. Malnutrition underlies at least one-third of all childhood deaths with Asia having the highest proportion and number of malnourished children globally.

Bangladesh, Lao People's Democratic Republic, Nepal and the Philippines are likely to meet their MDG 4 target by 2015, but only if sufficient effort is invested to maintain current trends. However, Afghanistan, Burma, Pakistan, PNG and East Timor are well off-track; and most Pacific island countries may also fail to reach the MDG targets on current trends. Although the situation is mixed, it is clear that much more needs to be done if the majority of countries are to reach MDG 4 for reducing child mortality.



Figure 1: Progress towards the MDG 4 target for 2015<sup>1</sup>



## MDG 5—Improving maternal health

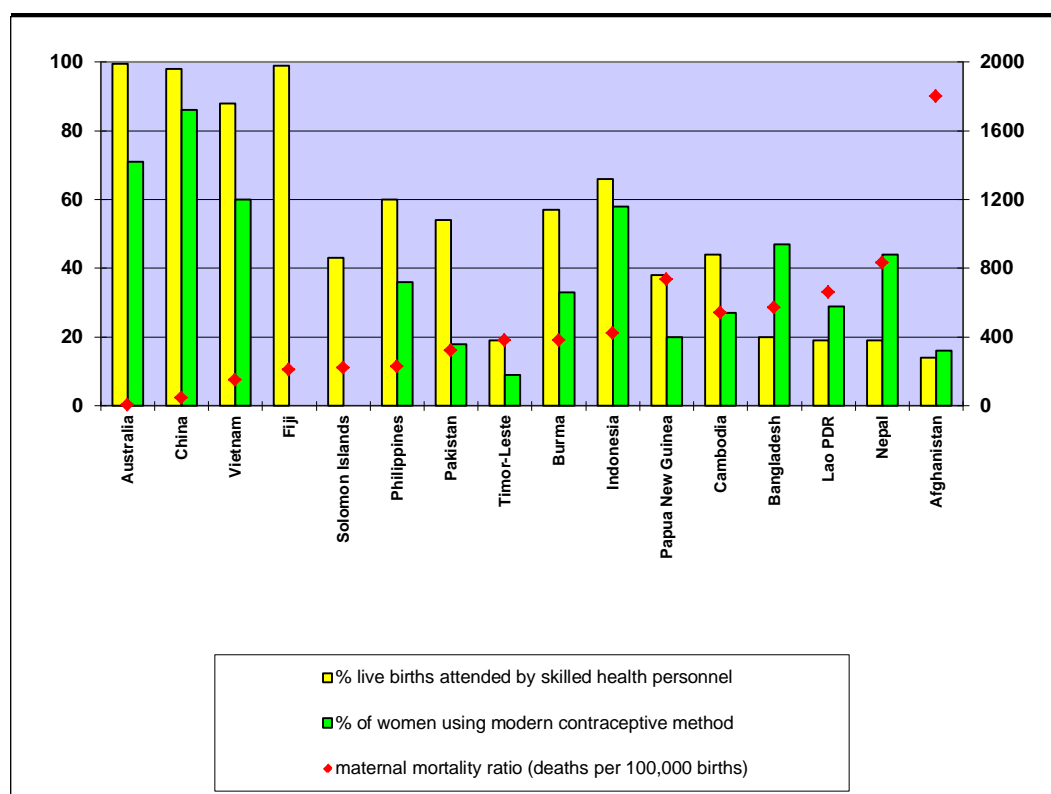
Data on progress towards the 2015 target for maternal mortality—a reduction of three-quarters compared to the 1990 level—are not readily available, as monitoring maternal mortality is difficult. Appendix A, Table A1, presents the maternal mortality ratios in 1990 and 2008 for 14 Asian and Pacific island countries as reported by the United Nations Population Fund (UNFPA). Five countries significantly reduced their maternal mortality ratio during this period—Nepal, Bangladesh, Cambodia, Indonesia and Burma, although the ratios remain very high. Afghanistan, Fiji and Laos reported rates increased during the same period. The national average figures conceal very large differences within countries. In Indonesia, for example, maternal mortality ratios are much higher in the Eastern provinces than elsewhere.

The causes of maternal mortality are well known and most could be prevented or treated through more timely care seeking, improved transport to health facilities and good-quality reproductive health services, including contraception, antenatal care, skilled health workers assisting at birth, and access to basic emergency obstetric care. As a generalisation, where access to skilled birth attendance is low, the maternal mortality ratio is high (Figure 2). This is also the case where access to contraception is low. According to the most recent WHO estimates, less than 50 per cent of women in Afghanistan, Bangladesh, Laos, Nepal, Pakistan and East Timor are seen at all by a trained health worker during pregnancy.<sup>2</sup>

<sup>1</sup> Source: WHO, *World Health Statistics 2009* report, World Health Organization, Geneva (2009); UNICEF, *Progress for Children 2007* report, United Nations Children's Fund, New York (2007).

<sup>2</sup> Source: WHO, *World Health Statistics 2009* report, World Health Organization, Geneva (2009).

**Figure 2: Births attended by skilled personnel, contraceptive use<sup>a</sup> and maternal mortality rates<sup>3</sup>**



<sup>a</sup> Contraceptive Prevalence Rate—the proportion of women of child-bearing age using (or whose partners are using) contraception.

## MDG 6—Combating major diseases

### HIV

Health service coverage for people living with HIV varies across the Asia-Pacific region. The most significant achievement has been with antiretroviral therapy coverage, which increased across all countries in the region between 2004 and 2007 (except in Indonesia), with very significant increases in most individual countries (Appendix A, Table A2). Access to treatment with antiretroviral drugs is still limited, however, with the exception of Laos and Cambodia, where coverage reached 95 and 67 per cent respectively.

In a small number of Asian countries such as Burma, Cambodia and Nepal, HIV prevalence is now stable or in decline (Appendix A, Table A2). Most low- and middle-income countries worldwide are, however, well off-track for achieving the MDG 6 target of having halted and begun to reverse the spread of HIV by 2015. New infections continue to rise rapidly in Vietnam, China, PNG and parts of Indonesia. PNG has the highest prevalence rate in the Asia-Pacific region and is one of the two countries in the region, along with Thailand, with an adult prevalence greater than one per cent.<sup>4</sup>

<sup>3</sup> Source: UNFPA, *The State of the World Population 2008* report, United Nations Population Fund, New York (2008); *Papua New Guinea Demographic and Health Survey, 2006 National Report*, National Statistical Office, October 2009.

<sup>4</sup> Source: UNFPA, *The State of the World Population 2008* report, United Nations Population Fund, New York (2008); UN *The MDGs Report 2007*, United Nations, New York (2007).

Accurate reporting on progress towards achieving HIV-related targets for MDG 6 is particularly difficult as data for other indicators of the HIV component of MDG 6 are not widely available. Very limited up-to-date information exists, for example, on the proportion of young people who correctly identify ways of preventing HIV or on condom usage.

## Malaria

In the Asia-Pacific region, large increases in funding for, and much greater attention to, malaria have together accelerated malaria control activities in many countries. This resulted in significant reductions in reported malaria cases between 2003 and 2007 in Bangladesh, Burma, Cambodia, Laos, the Philippines, Solomon Islands and Vanuatu.

However, a number of countries do not yet have adequate health information systems and therefore many cases of malaria do not get reported. A significant issue for the region is the body of research suggesting there is an emergence of resistance of malaria parasites to artemisinin-based drugs in Cambodia along the Thai border. This is likely to be linked to the use of counterfeit drugs.

## Tuberculosis

In most countries in the Asia-Pacific region, tuberculosis prevalence is declining despite resurgence in Africa and parts of Europe. For example, Indonesia, Solomon Islands and Nepal report dramatic drops of between 50 and 70 per cent from 1990 to 2007.<sup>5</sup>

In many countries tuberculosis rates remain very high. In 2007, the numbers of cases per 100 000 in Kiribati, PNG, the Philippines and Cambodia ranged from 430 to 665 compared with 234 for all developing countries and 14 for developed countries. Oceania and Western Asian countries are considered not to be making sufficient progress to halt and reverse the spread of tuberculosis, whereas Southern and Eastern Asia are performing better.

## Non-communicable diseases

Non-communicable diseases account for the greatest proportion of the burden of disease in all Asia-Pacific countries except for Afghanistan, Cambodia, Burma, Laos, PNG and East Timor. Even in the countries where communicable diseases prevail, the burden of non-communicable diseases (especially cardiovascular conditions, diabetes, cancers and neuropsychiatric conditions) is rapidly increasing. Non-communicable diseases are of particular concern in Pacific island countries, where prevalence rates are extremely high. Most non-communicable diseases have four common risk factors: smoking; poor nutrition; excessive alcohol use; and lack of physical activity. Pacific island countries rate poorly on several of these risk factors; for example, they account for eight of the world's 10 most obese countries.

## The state of the health system

Access to and use of health services is poor in many Asia-Pacific countries and there are many reasons for this. Among the most important reasons is the serious lack of funding and health workers where they are most needed. This affects other essential elements of the health system such as infrastructure maintenance, the availability of equipment and pharmaceuticals, and non-functioning management and information systems. Inadequate information flow to the

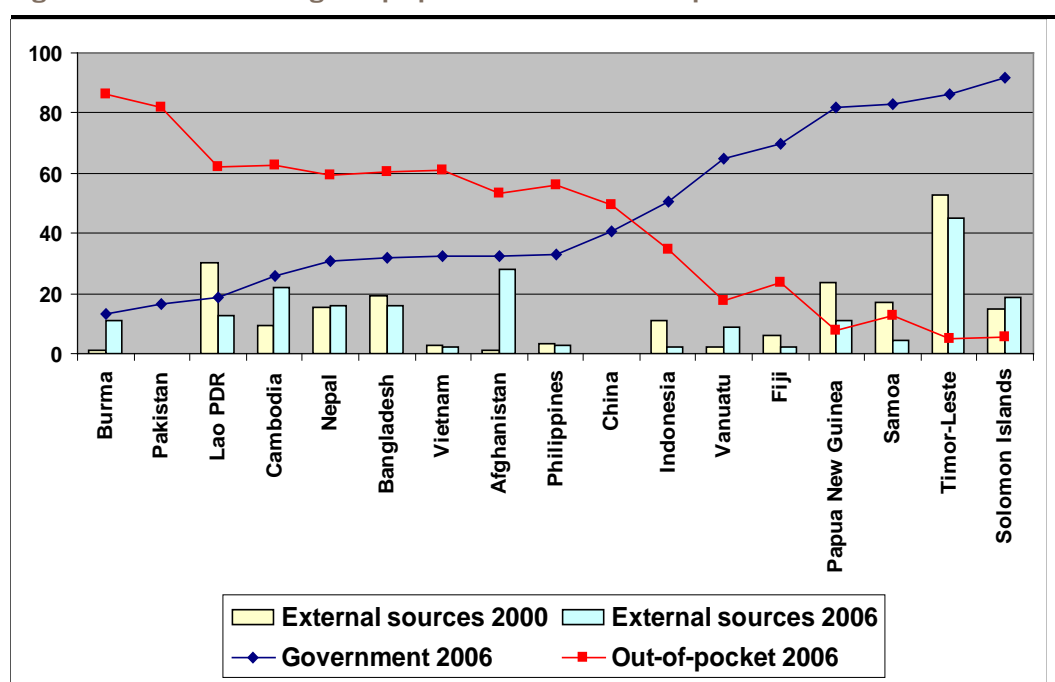
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<sup>5</sup> Source: WHO *World Health Statistics 2009* report, World Health Organization, Geneva (2009).

public means people are often ill-informed about what services are available and/or what services they should expect.

External resources are often a significant source of health funding in low-income countries, making predictability of aid an important concern. Several countries in the Asia-Pacific region significantly increased their dependence on external support between 2000 and 2006. The largest increases occurred in Afghanistan, Cambodia, Burma and Vanuatu (Figure 3).

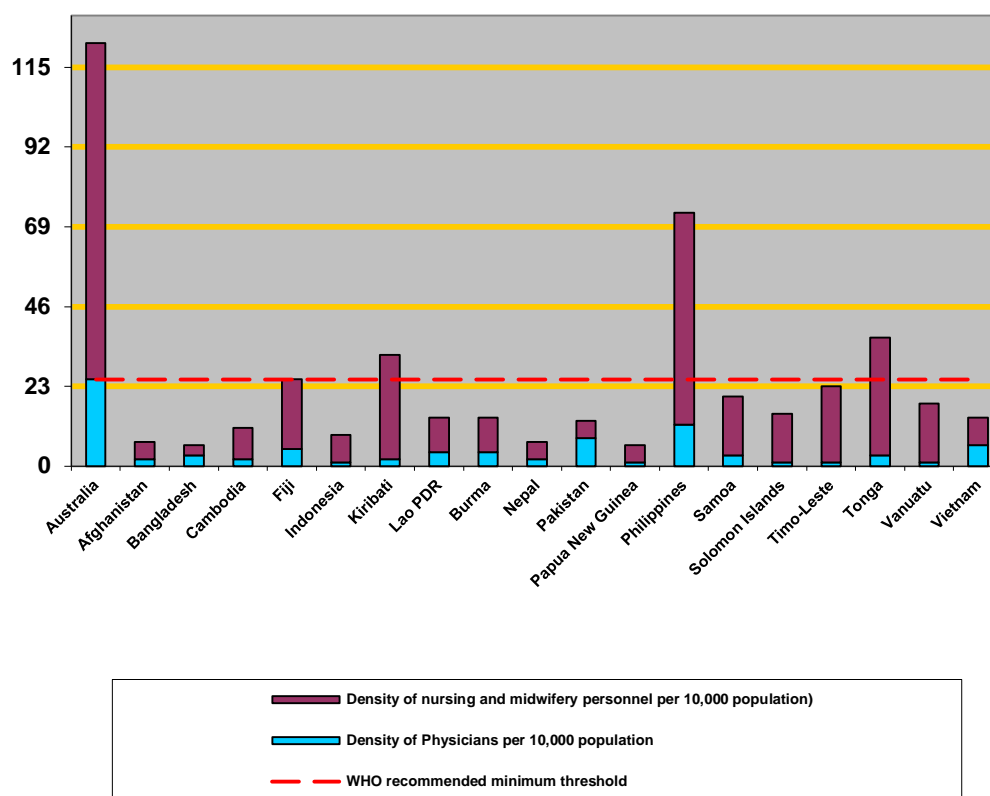
**Figure 3: Sources of funding as a proportion of total health expenditure**



Between 2000 and 2006, Asia had the highest proportion of out-of-pocket expenditures on health—the form of expenditure that is least equitable because the poor have greater needs, pay a much higher proportion of their income for health care and may not have funds available when needed. In the Pacific, most health expenditure for this same period came from the government. While this has benefits in terms of equity of access it also means that the population depends on the adequacy and efficiency of the government financial management.

For many countries the lack of sufficient, well-trained health workers—along with their uneven distribution—are significant factors limiting progress towards the MDGs. WHO estimates that countries with fewer than 25 health professionals (counting only physicians, nurses and midwives) per 10 000 population will be unlikely to achieve adequate health outcomes, with higher ratios of staff-to-population needed in countries with highly dispersed populations such as those in the Pacific region. At least 13 countries in the Asia-Pacific region are below this threshold, with the exceptions being Fiji, Kiribati, the Philippines and Tonga (Figure 4).

Figure 4: Health workforce across the Asia-Pacific region (density per 10,000 population)



## The global recession

The global recession is having negative effects on developing countries that are challenging progress in poverty reduction and achievements against the MDGs. Most of these countries are likely to continue to experience economic downturn into 2010. There has, however, been faster than expected recovery in the global economy and the impact has been less severe than expected in many of AusAID's partner countries. Despite this, some countries—such as Cambodia, the Philippines, Samoa and Solomon Islands—are experiencing worse than expected economic slowdown, which is impacting on, for example, high deficits, substantial job losses and increased poverty.

There is limited hard evidence for the level of impact the global recession is having on delivery of basic services now and into the future, yet history shows that health outcomes deteriorate rapidly in times of economic slowdown, especially among the poor. Governments react to financial pressures by compressing spending, including on key services such as health. Families do the same. In Pakistan, for instance, where out-of-pocket payments account for 70 to 80 per cent of health care expenditure, the number who will seek health care is expected to decline significantly.

The global recession coming on top of the global food crisis is likely to affect nutrition throughout Asia and the Pacific. In Cambodia, recent surveys conclude there has been an increase in malnutrition among children one to five years old, as household incomes drop. In the Pacific, the impact of the global recession and the global food crisis is likely to exacerbate the problem of non-communicable diseases associated with poor diet.

A recent evaluation of health services in Melanesia by AusAID's Office of Development Effectiveness (ODE)<sup>6</sup> found that Australia's support for operating costs was crucial in sustaining the health system during the conflict in Solomon Islands during the early 2000s. This prevented the health system from collapsing, which often happens during periods of instability and it could be argued that this is equally relevant for fragile countries experiencing downturn from the recession.

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<sup>6</sup> ODE, *Australian aid to health service delivery in Papua New Guinea, Solomon Islands and Vanuatu. Evaluation Report*, June 2009, AusAID, Commonwealth of Australia, Canberra (2009).

# Program achievements in Australia's health development assistance in 2008-09

## Box 1: Australia's global health leadership

The 2008-09 period saw a heightening of leadership in global health by Australia at the highest political levels.

Australia's Prime Minister Kevin Rudd became a member of the Network of Global Leaders for the health MDGs which provides political backing and advocacy for global efforts to achieve the target set for these MDGs. This network brings together leaders of both the developed and developing world who are committed to advancing progress on the health MDGs. Mr Rudd contributed to the 2008 and 2009 reports of the Global Campaign for the Health MDGs. In 2008, the Prime Minister also committed Australia to joining the International Health Partnership (IHP), which is closely linked with the Global Campaign for the Health MDGs. The IHP aims to improve development effectiveness in the health sector in order to accelerate progress towards the health MDGs and to build sustainable health systems for the future. Australia has joined the multi-donor sector programs in Cambodia and Nepal, the two countries in the Asia-Pacific region that have signed up to the IHP.

During his participation at the High-level Event on the MDGs in New York in September 2008, the Prime Minister announced that Australia would host the inaugural meeting of the Asia Pacific Malaria Elimination Network. This was subsequently held in Brisbane, Queensland, in February 2009.

The international community has recognised that progress on the health MDGs and beyond will not be achieved without significantly greater financing. To consider how this could be achieved, the high-level Task Force on Innovative International Financing for Health Systems was established. Australia's Minister for Foreign Affairs, Stephen Smith, is a member. Throughout 2008-09 Australia participated in a series of preparatory meetings to discuss options for innovative financing in the health sector. This culminated in an announcement at another High-level Event—*Investing in Our Common Future: Healthy Women, Healthy Children*, held at the United Nations (UN) in New York on 23 September 2009—of Australia's contribution of \$250 million over 20 years to a new international finance facility for health systems. This new finance facility will provide grants to low-income countries to support key health system components such as training health staff, buying essential drugs and providing basic maternal and child health care services.

In the area of HIV, Australia has revitalised its leadership in the Asia-Pacific region. In April 2009, the Minister for Foreign Affairs launched *Intensifying the Response: Halting the Spread of HIV*, Australia's new international development strategy for HIV. An Asia regional launch by the Parliamentary Secretary for International Development Assistance, Bob McMullan, was held in Bangkok on 1 May 2009.

## Support for service delivery and health system improvements

Strengthening health systems is the cornerstone of AusAID's approach to health development, an approach that is recognised internationally as the most effective way to achieve sustainable improvements in health outcomes.

AusAID is working with a range of international and domestic partners to help countries develop and implement better policies and improve public sector administration in health. In particular, AusAID's support to WHO and the World Bank contributes to sound technical support on health system improvements in countries throughout the region.

## Health financing

**Pacific countries**, as well as **PNG and East Timor**, have or are developing medium-term expenditure frameworks for health to guide sector budgeting and engagement with central agencies. Most countries now also have National Health Accounts and are using other analytical and costing tools to improve the evidence base for the allocation of health resources and the development of sector financing strategies which will improve equitable access to service delivery.

In **PNG**, lack of funds at the service delivery level is a critical constraint affecting health care delivery. AusAID has supported improved analysis, policy development and implementation of guidelines to address these constraints in the context of PNG's decentralised health care system. At the sub-national level AusAID is providing coordinated support across the health and provincial support programs for improved public financial management.

In **Solomon Islands**, AusAID is supporting financial management and budgeting for the sector as a whole. This, in turn, is enabling the Solomon Island Government to determine priorities within the total resource envelope for the health sector (government and donor) and to put those priorities into effect.

While there is no coordinated sector program-based approach to health development in **Indonesia**, a defining feature of AusAID's health initiatives is the strengthening and progressive use of Government of Indonesia systems for program delivery and monitoring. In 2008 substantial work was undertaken to build government systems to collect and analyse data on the sources of health funding and on expenditure. A draft strategy to institutionalise National Health Accounts processes was developed for implementation in 2009. A review of sub-national health insurance schemes was undertaken and its recommendations endorsed by the Government of Indonesia.

At central level, high-level engagement with the Ministry of Health has been difficult, delaying incorporation of technical input into government policy. At provincial and district level, in Nusa Tenggara Timur province, engagement with the government has been stronger although limited capacity is a major challenge.

Similarly, in **Vietnam** AusAID's support to health system strengthening aims to help the Government of Vietnam coordinate, manage and finance the health sector more effectively. Key achievements in 2008-09 enabled through Australian assistance include: drafting of legislation for a national accreditation system for health professionals and facilities; piloting of a new financing and quality control model to rationalise health services and pave the way to a 'pay-for-performance' approach; and standardising treatment and costs for selected common diseases.

In **Pakistan**, AusAID and the United Kingdom jointly fund a Technical Resource Facility that complements budgetary support provided by the latter for the maternal neonatal and child health program. The facility provides technical assistance to strengthen government policy development, strategic planning, financial management, health workforce development, and monitoring and evaluation systems, and it is aligned with the governance mechanisms of the national program. Australia's partnership with the United Kingdom has contributed to donor



coordination and enabled AusAID to gain leverage beyond the size of its investment in terms of access to policy and reform discussions.

## Health workforce

Having an adequate number of well trained health workers is essential if countries are to deliver health services. AusAID's core support to the University of PNG's School of Medicine and Health Sciences and the Fiji School of Medicine has enabled these institutions to expand and develop their own capacity to train essential health workers for **PNG** and the **Pacific**. These schools train not only doctors but also pharmacists, laboratory technicians and others. They also support public health training for all health workers.

As outlined in the section 'Support for achievements of MDGs 4 & 5', AusAID also supports training for health workers as part of maternal and child health activities across the region.

The newly established Pacific Human Resources for Health Alliance has the potential to address a range of critical human resource issues in the Pacific by bringing together governments, training institutions and professional networks. AusAID supports the alliance jointly with New Zealand and in partnership with WHO and others.

## Health information systems

The Pacific Partnerships for Development and sector-wide approaches have renewed emphasis on improving health information systems so data is available to monitor sector performance (particularly in relation to maternal and child health) and to support better health system management. With the assistance of AusAID, New Zealand, WHO and the Health Information Systems Knowledge Hub, countries across the **Pacific** are improving their information and monitoring systems and policies.

## Support for achievement of MDGs 4 and 5, child and maternal mortality

AusAID supports many programs aimed at improving maternal, neonatal and child health (MNCH) in line with the government's commitment to MDGs 4 and 5. In several countries it is the exclusive focus, in others MNCH is supported as part of a broader sector program, such as those described in the section 'Special theme-working through health sector program-based approaches'. Many MNCH initiatives focus on health worker training and others on specific system strengthening measures. Australian support for the Global Alliance for Vaccines and Immunisation (GAVI), WHO, UNFPA and the United Nations Children's Fund (UNICEF) also contribute to MNCH outcomes across the region.

In eastern **Indonesia** the Australia – Indonesia Partnership for Maternal and Neonatal Health is a four-year program focused initially on Nusa Tenggara Timur province. It assists nine district governments to implement the national strategy. Early results include the training of 600 health workers (95 per cent of whom are women) to upgrade their skills. This has been facilitated by the purchase of new equipment for three provincial and district clinical training centres and a midwifery school. An increased number of pregnant women have registered with midwives for assisted deliveries, and around 450 health officials, village-based health cadre and government officials have received management training.

In the **Philippines**, AusAID support through UNICEF and UNFPA is enabling selected local governments to improve MNCH services. In 2008-09 teams from 54 health facilities in Mindanao and Visayas were trained in basic emergency obstetrics and newborn care, around 650 rural midwives were trained in community MNCH care, and equipment and supplies were provided to about 145 health facilities for emergency obstetric care.

In **Bangladesh**, AusAID supports MNCH through two linked initiatives—one is implemented by UNICEF and the other by Bangladesh's largest Non-Government Organisation, BRAC. These initiatives are initially targeting the poor and socially excluded populations of four districts (almost 11 million people). Achievements to date are impressive. The proportion of births attended by community health workers has increased from almost none in 2007 to two-thirds in 2009, while identification of maternal complications has increased from three per cent to 23 per cent over the same period. AusAID also supports UNICEF to provide high-impact interventions targeting more than four million children in 14 low-performing districts. These interventions cover antenatal care, essential newborn care, post natal care and prevention and management of childhood illness.

AusAID support to the national MNCH program in **Pakistan** is implemented jointly with the United Kingdom. Key achievements in 2008-09 included the enrolment of 6300 people for training as midwives and the training of 4500 health providers in various technical areas. While encouraging, more effort is required in the coming years to recruit, train and deploy the targeted numbers of health personnel. AusAID is working with the program to develop a workforce plan and support its implementation.

In **Nepal**, AusAID supports a UNICEF child survival and nutrition initiative that complements the sector program and aims to prevent 15 000 childhood deaths.

AusAID support has helped to maintain the national Vitamin A supplementation coverage at more than 95 per cent, with around 3.6 million children dosed. The 2008 measles immunisation campaign reached 96 per cent of districts. The measles campaign has also facilitated expansion of community-based integrated management of childhood illness to all 75 districts in 2008-09.

AusAID support for the health sector in **Cambodia** is provided within the framework of multi-donor support to the national health sector plan, which strongly prioritises MNCH. Recent results have been very encouraging. Seventy-nine additional health centres will have midwives in 2009 and the number trained this year has increased to 200 compared with 30 in 2008. AusAID support has enabled 10 Operational Districts to strengthen reproductive health in their minimum package of activities. AusAID support has also enabled UNFPA to expand MNCH support in nine provinces, resulting in an 80 per cent increase in post natal care visits—an eight per cent increase in deliveries by trained staff and a similar rise in women accepting new birth-spacing methods.

In **East Timor**, AusAID works through a sector program-based approach but gives special priority to maternal and child health outcomes. While improvements in maternal health are slow to come there are some signs of progress. The percentage of births attended by skilled health personnel increased from 27 per cent in 2006 to 35.6 per cent in 2008. Coverage of children with three doses of vaccine against diphtheria-pertussis-tetanus increased from 56 per cent in 2003 to 79 per cent in 2008, and measles vaccine coverage increased to 73 per cent in 2008 from 61 per cent two years earlier.

In **PNG**, AusAID is supporting national health priorities through a sector program-based approach. In the past year more than 900 000 children were reported immunised against

measles and other childhood illnesses, with six provinces reaching more than 95 per cent of children.

**Pacific island countries** have also seen improvements in MNCH facilitated by AusAID support. In Vanuatu, for example, the rate of maternal deaths in Port Vila Hospital is reported to have fallen considerably. AusAID continues to support UNICEF to assist governments with their childhood immunisation programs across the Pacific.

## Support for achievement of MDG 6, major diseases

In addition to funding national and regional HIV, malaria and tuberculosis programs, Australia provides considerable support to the Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund), which in turn finances programs in many countries in the region. AusAID support for WHO and the Joint United Nations Programme on HIV/AIDS (UNAIDS) contributes to technical and policy assistance to all countries in the region. A number of countries, especially in the Pacific, also consider that non-communicable diseases also fall under this MDG.

### HIV

Australian support for addressing the HIV epidemic in **PNG** is considerable. In 2008, Australia provided around 57 per cent of the total resources available to respond to the disease. Australia provided financial and technical support to help build capacity of key national and provincial HIV agencies as well as non-state service providers. This is strengthening national level policy-setting and planning as well as monitoring and evaluation to inform the response. Nevertheless, fundamental capacity and organisational constraints within PNG's National AIDS Council Secretariat continued to undermine its ability to lead the national response.

Australian support has helped extend voluntary counselling and testing services into new districts and provinces with 201 voluntary counselling and testing sites operating by the end of 2008, up from nine sites in 2005. About 93 000 people accessed these services in 2008, 48 per cent more than in 2007. Other key achievements are the distribution of more than five million condoms through Non-Government Organisations (up from three million in 2007) and the extension of anti-retroviral therapy into more regional and provincial hospitals, including training 450 health workers to administer the therapy.

The HIV/AIDS Partnership in **Indonesia** continued to influence development of a national HIV harm reduction policy and program. Under the partnership, provincial governments are taking increasing responsibility for funding harm reduction activities. Jakarta has led the way and is now providing more than 70 per cent of the budget for implementation of a harm reduction program for drug users in the province which will enhance sustainability of outcomes.

HAARP, an eight-year program funded by Australia that began in May 2007, continues Australia's contribution to reducing HIV-related harm associated with injecting drug use. HAARP works in six countries: China (Guangxi and Yunnan provinces), Burma, Vietnam, Laos, Cambodia and the Philippines. In 2008-09 operations increased to 42 sites in three countries, providing services to more than 7500 people who inject drugs; distributing more than two million sterile needles and syringes and more than 350 000 condoms; and referring

more than 3500 people for HIV testing and counselling, treatment and health care services. HAARP also facilitated inclusion of harm reduction in a new Cambodian Law on Drug Control.

An independent evaluation of the AusAID-supported Pacific Regional HIV/AIDS Project found it to be highly effective. It resulted in 10 Pacific countries developing national HIV response plans and a more coordinated and comprehensive approach to capacity building and planning. In turn, this led to a significant improvement in HIV prevention activities and anti-retroviral therapy for all those known to require it across the 14 participating countries in the Pacific. The program, which finished in September 2008, was replaced by the Pacific Islands HIV and Sexually Transmissible Infection (STI) Response Fund jointly funded by Australia and New Zealand. Managed by the Secretariat of the Pacific Community, the fund supports implementation of national and regional HIV and STI strategic plans. In the first nine months of operation, 24 competitive grants were given to local civil society organisations and 20 support grants to regional and multilateral agencies.

In **Vietnam**, the Clinton HIV/AIDS Initiative, funded by AusAID, brings high-quality medical care and treatment to people living with HIV, especially children and mothers. By August 2008, 1400 children in 17 provinces were receiving antiretroviral therapy, a significant increase from the 2006 baseline of 200.

In **India**, AusAID is funding an HIV prevention and care initiative implemented by UNAIDS in the Northeast states where rates of HIV infection are higher than in the rest of India. In the first year of implementation, the project made good progress with the National AIDS Control Office completing preparation of operational guidelines and procedural manuals and recruitment and training for administrative and technical staff in the control office and State AIDS Control Societies.

In **Burma**, Australia—along with five other donors—is supporting the Three Diseases Fund, developed as a joint donor response to HIV, tuberculosis and malaria. Projects implemented under the Three Diseases Fund have reached almost 100 000 people with HIV counselling and testing services, more than 28 000 people who use drugs with harm reduction programs and almost 6000 people with antiretroviral drug treatment.

## Malaria

At the UN High-level Event on MDGs in September 2008, Prime Minister Kevin Rudd committed Australia to sponsor the inaugural meeting of the **Asia Pacific Malaria Elimination Network**. The meeting was held in Brisbane in February 2009, formally establishing the network of participating countries and institutes. Progress was made on developing work plans and governance structures for the network in 2008-09 and these will be presented to the network for discussion and endorsement at the 2010 meeting.

The Pacific Malaria Initiative continues to support **Solomon Islands** and **Vanuatu** in malaria control and moving towards progressive elimination of the disease. AusAID provides significant financial support to the national malaria control programs in both countries, alongside support from the Global Fund and other donors, most significantly WHO. The Solomon Islands malaria control program resulted in malaria incidence decreasing from 199 cases per thousand people in 2003, to 82 cases per thousand in 2008. In Vanuatu, malaria incidence decreased from 74 cases per thousand people in 2003, to 14 cases per thousand in 2008.

The Roll Back Malaria Partnership in the **Philippines** continues to have a positive impact with AusAID financial and technical support through WHO. In 2008, research through the

partnership led to improved government policy and guidelines on the diagnosis and treatment of malaria. A range of initiatives contributed to the 32 per cent reduction in cases and 86 per cent reduction in deaths since 2004, and the number of provinces with endemic malaria reduced from 22 to nine.

In 2008, Australia and other development partners supported **PNG** to develop a National Malaria Control Strategic Plan as a platform for renewed effort to control the disease with Australian and Global Fund support.

In **Burma**, through the Three Diseases Fund, AusAID has helped protect 837 000 people with insecticide-treated bed nets and insecticide residual spraying in their houses. A total of 117 000 malaria cases were treated in accordance with national malaria treatment guidelines.

## Tuberculosis

AusAID provides support to the Secretariat for the Pacific Community to implement a Tuberculosis Epidemic Control Project in **Kiribati**, which has the highest rate of the disease in the Pacific. The project has resulted in detection and treatment success rates of more than 90 per cent and a reduction in the number of confirmed tuberculosis cases from 745 in 2007 to 337 in 2008.

In **PNG** coverage of the National Tuberculosis Program increased from 15 per cent of the population in 2007 to 34 per cent in 2008.

With funding through the Three Diseases Fund in **Burma** more than 20 000 new sputum smear positive tests were detected and 91 per cent of cases were successfully treated.

## Non-communicable diseases

The new AusAID funded non-communicable diseases program in the **Pacific** launched in 2008 has improved collaboration between WHO and the Secretariat of the Pacific Community in their support to countries for the control of non-communicable diseases.

Support for non-communicable disease control is also included within bilateral support for health. In **Samoa**, for example, a small grants scheme to support communities in promoting healthy lifestyles selected 146 proposals for physical activity and 136 for nutrition activities. Country-wide media campaigns to promote awareness of healthy lifestyles, tobacco control and injury prevention have been initiated. In **Nauru**, AusAID supported the development of legislation to address non-communicable disease risk factors, including a new Tobacco Bill.

### Box 2: Contribution of the budget measure to health sector achievements

In 2008-09, approximately \$75 million was allocated to the Delivering Better Health (DBH) Budget Measure allowing AusAID to provide increased support to health programs across Asia and the Pacific and to key international health organisations. This funding allowed AusAID to implement, or expand, critical activities in a way which would not otherwise have been possible.

In several countries, DBH funding allowed Australia to re-engage or significantly engage for the first time in the health sector. In some it represented the main source of funding for AusAID's health interventions. In Bangladesh, Cambodia, Indonesia, Nepal, Pakistan, the Philippines and Vietnam, DBH funding was the only or predominant source of financial support to AusAID's health activities in 2008-09. Some country programs have raised the issue of unpredictability of new budget measure funding as having a negative impact on priority setting within the aid program.

The DBH budget measure funding also supported the Pacific regional program on non-communicable diseases and the Pacific Malaria Initiative. It enabled AusAID's Health and HIV Thematic Group to provide high-quality technical support to country programs through AusAID's newly established Health Resource Facility, to form partnerships with a number of Australian institutions working in international health to improve the knowledge base for the Australia aid program, to support a research initiative, and to participate in global initiatives on results-based financing of health development.

## Emerging infectious diseases

The third year of implementation of the AusAID Pandemic and Emerging Infectious Diseases Strategy 2006 – 2010 (PEIDS) saw continued support for a suite of activities to strengthen the skills and systems necessary to reduce the risks of, and improve responses to, outbreaks of emerging infectious diseases.

While the focus of PEIDS has been primarily on Highly Pathogenic Avian Influenza ('bird flu') and 'foot and mouth' disease, the system development and capacity building supported in the past five years, including that supported by Australia in the Asia-Pacific region, resulted in improved epidemic preparedness in most countries and facilitated a faster and more skilful response to the outbreak of H1N1 influenza ('swine flu') in April 2009.

Programs supported through PEIDS and led by organisations such as WHO, the Secretariat of the Pacific Community and the Association of Southeast Asian Nations Secretariat, played an important role in assessing response capabilities and coordinating support to reduce the risks from the pandemic.

The WHO Asia-Pacific Strategy for Emerging Diseases is the core of the regional response to emerging infectious diseases. With AusAID support it contributed to developing pandemic preparedness plans in all countries, establishing stockpiles of anti-influenza medicines, boosting laboratory capacity and assisting countries to adopt the revised International Health Regulations.

The Pacific Regional Influenza Pandemic Preparedness Project, managed through the Secretariat of the Pacific Community and supported by both Australia and New Zealand, assisted countries in developing pandemic preparedness and response plans; improved coordination of key agencies; provided training; and formulated standardised disease surveillance and infection control procedures for animal and human health. Following the outbreak of H1N1 the project provided anti-influenza drugs and personal protective equipment to 22 Pacific island countries and territories.

## Australian support to international organisations

Australia continued to support key international organisations in the health sector throughout 2008-09. In general, Australia has moved more towards core support for UN agencies, rather than strongly earmarked funding, to better enable these agencies to carry out their mandates. Adequately funded UN technical agencies enhance the impact of Australia's bilateral investments in health. WHO, UNAIDS and UNFPA in particular play an important role in providing partner governments with technical assistance.

In March 2009, as part of deepening Australian engagement with effective multilateral organisations to achieve the MDGs, AusAID finalised a multi-year partnership framework with WHO, committing \$64 million in core funding over four years (2009–2013). Agreed priorities under the framework include: strengthening health systems fundamentals that have an impact on service delivery; addressing the priority needs of women and children; and reducing the health, social and economic burden of communicable and non-communicable disease.

Other organisations, such as the Global Fund and GAVI, are funding mechanisms that focus on specific health outcomes. Australia has committed to funding the Global Fund over seven years (2004–10), including \$46.5 million in 2008-09, and provided funding support to WHO, UNAIDS and others to assist East Timor, PNG, Indonesia and the Pacific region to access and implement Global Fund grants. Australia also contributed \$6.2 million to GAVI in 2008-09.

UNICEF received the largest contribution of the UN agencies—\$14.5 million—as core support for its overall program (Table 1). A significant proportion of this was spent in 2008-09 on programs for improving maternal and child health.

**Table 1: Australia's contribution to the main international health organisations in 2008-09**

Organisation	Contribution <sup>7</sup> (2008-09)
<i>Technical support and coordination agencies</i>	
WHO	\$13,430,000
UNICEF	\$14,500,000 <sup>8</sup>
UNFPA	\$7,214,000
UNAIDS	\$5,000,000
International Planned Parenthood Federation (IPPF)	\$3,000,000
<i>Global financing initiatives</i>	
Global Fund to Fight AIDS, Tuberculosis & Malaria	\$46,500,000
GAVI	\$6,211,180

<sup>7</sup> Contributions to the UN agencies by individual AusAID country programs are not captured in these figures.

<sup>8</sup> Only a portion of this contribution is towards health as UNICEF's portfolio is broader than health.



# What is the quality of our aid activities?

Appendix B presents information available for 51 initiatives in the health sector that were assessed for their quality in 2008-09. Fifty of these were assessed for quality at implementation and one for quality at entry (the beginning of the initiative). The scoring ratings are explained in the table immediately below. Each initiative under implementation was assessed in four areas: implementation progress, achievement of objectives, monitoring and evaluation and sustainability.

Satisfactory		Less than satisfactory	
6	Very high quality; needs ongoing management and monitoring only	3	Less than adequate quality; needs work to improve in core areas
5	Good quality; needs minor work to improve in some areas	2	Poor quality; needs major work to improve
4	Adequate quality; needs some work to improve	1	Very poor quality; needs major overhaul

Of the 50 initiatives assessed for quality at implementation only four received scores of 5 or 6 across all areas of assessment; another four were rated as good quality for all areas except sustainability where they were assessed as adequate. A further 18 initiatives scored 4 or above in all areas, with seven receiving at least two scores of 5. In summary, 26 initiatives (or 52 per cent) were rated as adequate or above in all four areas of assessment. Together this means that nine initiatives (18 per cent) were rated as less than adequate or worse in two or more areas. In several of these the poorer scores were related to poor performance of partner organisations.

Twelve initiatives were let down in their ratings by a single score of 3 for one area of assessment. In two-thirds of these initiatives it was for either monitoring and evaluation or sustainability. Overall these two areas produced the lowest scores in 2008-09, as in previous years. In the case of monitoring and evaluation this reflected, in part, the difficulty most initiatives faced in obtaining sound information. The score for sustainability may have been low because of confusion about the purpose of this assessment and inconsistent application. In some cases, sustainability of initiative activities or impacts would indeed be low if funding were withdrawn at the end of the currently agreed funding. This underlines the need for aid programs to take a long-term approach to most issues.

Comparison of these ratings against those given for 2007-08 yielded an interesting result. In that financial year, 46 health and HIV initiatives were assessed. Of these, 34 (74 per cent) were rated as adequate or above in all four areas of assessment—a better result than in

2008-09. Twelve initiatives (26 per cent), however, scored less than adequate or worse in 2007-08, a higher proportion than in 2008-09.



It is important to note that the composition of initiatives assessed over the two sets of financial years varied considerably with a tendency towards larger initiatives and a number of new ones in 2008-09. A very encouraging result is the change in scores for the initiatives assessed in both timeframes. Of the 27 initiatives assessed in both financial years, 20 showed an overall improvement in their scores in 2008-09, three remained unchanged and four showed some deterioration. This suggests that the quality of implementation improves as problems are identified and addressed.

# Special theme—working through health sector program-based approaches

## Rationale for program-based approaches

### Box 3: Program-based approaches<sup>9</sup>

Program-based approaches deliver aid based on the principles of coordinated support for a locally owned program of development, such as a national development strategy or a sectoral program. In principle, these approaches should provide a stronger basis for engaging in policy dialogue on sector priorities and resources and progressing partner ownership and alignment, donor harmonisation and results management. Program-based approaches share the following features:

- > leadership by the host country or organisation
- > a single comprehensive program and budget framework
- > a formalised process for donor coordination and for harmonisation of donor procedures for reporting, budgeting, financial management and procurement
- > effort to increase the use of local systems for program design and implementation, financial management and monitoring and evaluation.

In keeping with Australian Government bilateral and international agreements, AusAID health programs are increasingly delivered through sector program-based approaches (Box 3 above). Programs are now focusing on more effective coordinating, better allocating all resources (government and donor), reducing transaction costs (especially for partner countries), and establishing mutual accountability for agreed priorities and results. These are all principles embodied within the PNG and Pacific Partnerships for Development as well as the Cairns Compact on Strengthening Development Coordination in the Pacific.

In the medium to long term this is the most effective way for aid to contribute to the development of sustainable and effective health systems that deliver the good quality health services necessary to achieve the MDGs.

Working through program-based approaches and partner government systems does not imply diminished recognition of the role of non-state actors. On the contrary, a well-developed national health strategy and a strong government stewardship role will ensure that the contribution of all stakeholders and providers to achievement of health outcomes. The role of both for-profit and not-for-profit private health sectors is important.

The increasing use of sector program-based approaches is strongly supported by the findings of the independent evaluation of Australian aid to health service delivery in PNG, Solomon Islands and Vanuatu commissioned by ODE in 2008-09.<sup>10</sup> This evaluation also

<sup>9</sup> ODE, *Annual Review of Development Effectiveness 2008*, p. 43, AusAID, Commonwealth of Australia, Canberra (2009).

<sup>10</sup> ODE, *Australian aid to health service delivery in Papua New Guinea, Solomon Islands and Vanuatu. Evaluation Report*, June 2009, AusAID, Commonwealth of Australia, Canberra (2009).

reported that AusAID is experiencing difficulty in implementing the changes necessary to adapt to this different way of working and in managing unrealistic expectations about the pace of progress possible. The report made eight recommendations to improve the establishment and implementation of health sector programs. AusAID is continuing to implement management's response to the report, through the approaches detailed below, as part of a longer-term strategy for improving aid effectiveness.

Supporting sector program-based approaches does not mean that focus at the health service delivery level should diminish. Focusing on program implementation for specific health outcomes—for example HIV or maternal health—is also important. While some argue that disease-specific programs can have a distorting effect on resource allocation in the long run, evidence suggests that these programs, and program-based approaches that focus on strengthening the health system, can have a mutually reinforcing effect.<sup>11,12</sup>

## AusAID engagement in sector program-based approaches

Since 2006, the number of countries supported by AusAID in the health sector that have adopted a program-based approach has increased from just a few to six. As described below, Australia is significantly engaged in the sector-wide programs of all of these countries and has played a leading role in establishing these programs in several countries. In other countries, while there is no sector program-based approach in place, AusAID has opted to work with partner governments to strengthen aspects of their health system.

Australia's significantly expanded assistance to the health sector in **East Timor** is primarily provided through the Health Sector Strategic Plan Support Program (HSSP-SP), led by the Ministry of Health with support through a multi-donor trust fund managed by the World Bank. HSSP-SP is helping to improve the capacity of the Ministry of Health to finance and administer the health system. Donor coordination and planning has been improved through the Joint Annual Health Sector Review and Joint Annual Planning Summit.

Progress with implementation of the HSSP-SP in East Timor has been slow, as have improvements in service delivery. While the overall arrangements and policy settings are sound, the Ministry of Health has limited capacity to manage donor funds and limited understanding of World Bank procurement procedures. Further support to the Ministry from the World Bank should help address these constraints.

AusAID continues to support a sector program-based approach led by the National Department of Health (NDoH) in **PNG**, including through an NDoH-managed joint donor trust fund. The Capacity Building Service Centre, jointly managed by NDoH and AusAID, provided extensive technical assistance to the health sector in PNG throughout 2008, including support to the department itself, as well as to provincial health offices and hospitals.

The existence of a centrally managed trust fund and a technical assistance facility have had positive impacts but they also represent a parallel system in which the NDoH has decision-making power over provincial resources. Provincial responsibility for delivering services needs to be clearer and the NDoH could focus more directly on its core role of providing whole-of-government leadership for the sector's strategy and budget. The low priority accorded to the

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<sup>11</sup> WHO Maximizing Positive Synergies Collaborative Group (2009), An assessment of interactions between global health initiatives and country health systems. *The Lancet* 373, pp. 2137–2169.

<sup>12</sup> Pilot P., M. Kazatchkine, M. Dubul and J. Lob-Levyt (2009), AIDS: Lesson learnt and myths dispelled. *The Lancet* 373, pp. 260–63.

health sector by many provincial governments, and inadequate funding and capacity to deliver health services at the provincial and lower levels, remained a crucial constraint to improving health outcomes in 2008.

Recognition of these issues by the Government of PNG and development partners has led to concerted action. Positive signs of improvement in the management of the health sector in 2009 compared to 2008 included: increased funds available to provinces for the operational costs of delivering health services; a new sense of purpose and leadership in the NDoH (including stronger relationships with the Department of Provincial and Local Government and central agencies); and rolling out the Provincial Health Authorities Act to streamline the management of provincial health services under one entity.

In 2008-09 Australia strengthened its bilateral policy dialogue with PNG on health through the negotiation of the health schedule under the Partnership for Development. A challenge for 2009-10 is to ensure that the development of the partnership implementation strategy is coordinated with the government-led revision of the national health plan and medium-term expenditure framework and the re-alignment of the sector program-based approach mechanisms. Support for implementation of priority reforms is a focus for technical cooperation by all partners.

Major areas of concern and policy discussion between the NDoH and development partners, through the established coordination mechanisms in 2008-09, included: medical supplies; health sector governance (especially the need for central agency engagement); the supplementary budget for health infrastructure; human resources for health; and health financing.

Since 2006, AusAID has assisted the **Solomon Islands** Ministry of Health and Medical Services to establish a health program-based approach involving all key partners through the Health Sector Support Program. The initial focus is on three of the eight strategic areas of the National Health Strategic Plan 2006–2010: people; malaria control and progressive elimination; and health system strengthening. Support to the Ministry of Health and Medical Services in 2008 resulted in an increased budget for health in 2009, better financial and health information reporting, improved access to essential medicines and additional staff housing to improve staff retention.

One major challenge is that AusAID continues to provide almost one-third of total public expenditure in the health sector in Solomon Islands. Obvious risks are associated with this, including dependence on donor funding for the supply of nearly all essential medicines. Another challenge is to ensure that the well-funded malaria control activities are fully integrated into the broader sector program and result in durable health system improvements with benefits beyond malaria control.

In **Samoa**, AusAID's support to health is also predominantly through a multi-donor sector program-based approach, which is beginning to demonstrate tangible outcomes. The health sector is considered exemplary for the partnership approach in action, building on strong government ownership and leadership, a results orientation and long-established relationships. AusAID and two other donors pool their funds through a mechanism using World Bank procurement and management systems. Concerns raised about the potential for undue bureaucracy and delays in implementation using these systems have now been addressed. Nevertheless the timeliness of program spending requires ongoing monitoring.

One milestone in 2008-09 was the establishment of the Samoa – Australia Partnership for Development with one of its six thematic working groups focused on health. Partnership

support will ensure increased action on non-communicable diseases and on the revitalisation of primary health care, but this has been delayed due to the impact of the tsunami and the need to reprioritise funding.

While the multi-donor sector program-based approach and the Partnership for Development both emphasise a strong commitment to Government of Samoa control and ownership, it remains a challenge to accommodate the strongly bilateral nature of the partnership within the Government of Samoa's expectation of a well-integrated, multi-partner program-based approach. In addition, a number of Pacific regional health programs, including many funded by AusAID, are not under the control of the Government of Samoa and this has an impact on the coordination of effort. Increased integration of initiatives under the partnership and of regional programs into the sector-wide approach will be important in moving forward.

In 2008, Australia re-engaged significantly in the health sector in **Cambodia** with AusAID's support designed to assist the Government of Cambodia in coordinating, managing and financing the health sector more effectively to deliver priority services, with a focus on maternal and child health.

Cambodia is one of two countries in Asia and the Pacific that is in the initial phase of the International Health Partnership (IHP), which aims to accelerate progress towards health-related MDGs through improved coordination of donor and country activities based around the national health plan. A group of seven development partners, five using pooled funding and two using discrete accounts—but all using a single financial system—now accounts for more than 20 per cent of the government health expenditure.

In 2008-09, Australia agreed to support the second IHP country in the region, **Nepal**. AusAID has joined a pooled funding mechanism along with the World Bank and United Kingdom. Coordination is ensured through six-monthly joint sector review and planning exercises in which all stakeholders participate. Nepal is also part of the IHP and is likely to be a test site for joint assessment of the next national health strategic plan which would provide a basis for Global Fund and GAVI vaccine financing to be harmonised and aligned.

In **Vanuatu**, AusAID has provided planning support to facilitate the transition by the Government of Vanuatu to a sector program-based approach. AusAID is as yet the only donor focusing on addressing system-level issues, which are essential for sustained improvements in services and the resulting health outcomes. The 2008 Organisation for Economic Co-operation and Development – Development Assistance Commission's Peer Review of Australia noted that regional projects, particularly in health, are generally perceived by Vanuatu authorities as being imposed without connection to other national programs. In response to this and the ODE evaluation, AusAID is moving to a more coordinated and coherent program of support to the health sector.

## Lessons learned

The varied experiences of AusAID in working through program-based approaches in the health sector have revealed a number of lessons that are informing ongoing efforts. The lessons proposed below are based on AusAID's experience with sector program-based approaches as described in the section 'Special theme-working through health sector program-based approaches'. They are not an attempt to cover the full spectrum of activities.

## Lesson 1

Assessment of many country programs against stated objectives continued to be difficult because they were set at an outcome level and their achievement depends on the effort of many stakeholders, including partner governments, other development partners and civil society. This is appropriate as more effective outcomes will be gained when AusAID works with others and the comparative advantage of each is acknowledged and maximised.

## Lesson 2

Program-based approaches and policy discussion are more successful when the partner government has owned and led the process and where there are existing strong relationships between donor and government. Building relationships between partner governments and working through their systems is time intensive and requires senior management engagement at key points. This must be factored into delivery strategies and expectations. Supporting government ownership and leadership also requires sound analysis of key issues.

## Lesson 3

As AusAID moves to work more closely with government systems, dependency on the capacity of government to effectively manage them is increasing. Working through program-based approaches represents the only viable option for sustainable development that is compatible with Australia's endorsement of the principles of aid effectiveness. However, a focus on implementation of agreed policy and programs (e.g., malaria or maternal health programs, or drug procurement and distribution) is still necessary, and priority programs need to be adequately resourced and supported.

## Lesson 4

Australia is re-aligning its partnership with countries (for example, through the Pacific Partnerships for Development). AusAID needs to also play a role in facilitating broader partnerships with other donors and multilateral agencies.

## Lesson 5

Australia has taken a strong leadership role in developing and implementing global health partnerships aimed at system strengthening approaches, such as the IHP. However, these are not without risk, particularly the risk that priority setting and planning will be designed to suit international demands and that the results achieved will be appropriated by high-level international bodies anxious to demonstrate the effectiveness of their aid.

## ASelected data on health and health system status

**Table A1: Maternal Mortality Ratio (per 100 000 live births) since 1990<sup>1</sup>**

COUNTRY	1990	Most recent 2005-08)
Afghanistan	1700	1800
Nepal	1500	830
Lao People's Democratic Republic	650	660
East Timor	-	660
Bangladesh	850	570
Cambodia	900	540
Papua New Guinea	930	733 <sup>2</sup>
Indonesia	650	420 <sup>a</sup>
Burma	580	380
Pakistan	340	320
Philippines	280	230
Solomon Islands	-	220
Fiji	90	210
Vietnam	160	150 <sup>b</sup>
Australia	9	4

<sup>a</sup> The Government of Indonesia uses a national average figure of 228.

<sup>b</sup> The Joint Annual Health Review in Vietnam in 2008 reported a figure of 75.

Sources:

(1) UNFPA, *The State of the World Population 2008* report, United Nations Population Fund, New York, (2008); UN *The MDGs Report 2007*, the United Nations, New York (2007).

(2) *Papua New Guinea Demographic and Health Survey, 2006*, National Report. National Statistical Office, October 2009.

**Table A2: Adult HIV prevalence in 2001 and 2007<sup>1</sup> and ARV<sup>a</sup> coverage in 2004 and 2007<sup>2</sup>**

COUNTRY	HIV prevalence: % of population 15-49 years				ARV coverage (%)	
	2001	2007			2004	2007
		Men	Women	Total		
Burma	0.9	0.8	0.6	<b>0.7</b>	3	15
Cambodia	1.5	1.2	0.5	<b>0.8</b>	23	67
China	0.1	0.1	0.1	<b>0.1</b>	7	19
Fiji	0.1	0.1	0.1	<b>0.1</b>		
Indonesia	0.1	0.3	0.1	<b>0.2</b>	24	15
Lao People's Democratic Republic	<0.1	0.3	0.1	<b>0.2</b>	64	95
Nepal	0.5	0.7	0.3	<b>0.5</b>	1	7
Pakistan	<0.1	0.1	0.1	<b>0.1</b>	2 <sup>b</sup>	3
Papua New Guinea	0.3			<b>2<sup>c</sup></b>	15 <sup>b</sup>	38
Philippines					5 <sup>b</sup>	31
Vietnam	0.3	0.8	0.3	<b>0.5</b>	1	26

<sup>a</sup> Coverage with antiretroviral drug treatment for people with advanced HIV infection.

<sup>b</sup> Figures are for 2005 and 2007.

<sup>c</sup> Estimated at 1.5 per cent in 2007 but then revised to 2.03 per cent according to the *2007 Estimation Report on the HIV Epidemic in Papua New Guinea*, by PNG Department of Health and National AIDS Council Secretariat.

Sources:

(1) UNAIDS, *2008 Report on the Global AIDS Epidemic*.

(2) WHO *World Health Statistics 2009* and *World Health Statistics 2005* reports.



## B Quality of AusAID's aid activities at implementation in 2008-09

Table B1: Quality of AusAID's aid activities at implementation in 2008-09

COUNTRIES				
Initiatives	Implementation progress	Achievement of objectives	Monitoring and evaluation	Sustainability
<b>BANGLADESH</b>				
BRAC – UNICEF support for Maternal and Child Health	3	4	5	4
UNICEF integrated package of MNCH interventions	4	4	3	5
Support to International Centre for Diarrhoeal Disease Research, Bangladesh	6	6	5	4
<b>NEPAL</b>				
IHP plus Sector Wide Approach—Nepal Health Sector Program <sup>a</sup>	5	5	5	5
<b>EAST TIMOR</b>				
Health Sector Support Program	2	2	3	2
Australia – Timor-Leste Program of Assistance for Specialist Services	5	5	5	5
<b>INDONESIA</b>				
Australia Indonesia Partnership for Maternal and Neonatal Health	4	5	4	5
Australia Indonesia Partnership for HIV	5	5	4	4
Australia Indonesia Partnership for Health System Strengthening	4	4	5	5
<b>PAKISTAN</b>				
Improving Maternal Neonatal and Child Health – Department for International Development (United Kingdom) Cooperation	4	4	5	5
Pakistan Australia District Eye Care Project, Phase 2	4	4	5	4
<b>BURMA</b>				
Three Diseases Fund	5	5	4	3
<b>CAMBODIA</b>				
Delivering Better Health Program	5	5	5	4

COUNTRIES				
Initiatives	Implementation progress	Achievement of objectives	Monitoring and evaluation	Sustainability
<b>VIETNAM</b>				
<b>Delivering Better Health Program</b>	6	6	5	5
Clinton Foundation – HIV/AIDS Treatment	5	5	4	3
<b>PAPUA NEW GUINEA</b>				
<b>Health Capacity Building Service Centre</b>	5	4	3	4
Health Sector Resourcing Framework	4	3	5	4
Institute of Medical Research Support, Phase II	4	4	5	4
WHO Technical Support to the Health Sector	5	4	5	4
Tertiary Health Services, Phase III	5	5	4	4
Pandemics and Emerging Infectious Diseases Program	5	3	3	3
<i>Sanap Wantaim</i> —PNG Australia HIV and AIDS Program	5	4	4	4
HIV/AIDS Prevention and Control—Co financing	4	4	4	4
Health Program Response to HIV/AIDS	5	5	5	5
<b>PHILIPPINES</b>				
<b>Support for Population Initiatives—UNFPA</b>	4	3	3	4
Roll Back Malaria—Support to WHO Country Program	5	5	5	3
Maternal Mortality Reduction—UNICEF	3	3	2	2
<b>ASIA REGIONAL</b>				
<b>Emerging Infectious Diseases—World Bank Trust Fund for Avian Influenza</b>	3	4	3	4
WHO Asia Pacific Strategy for Emerging Diseases	3	4	4	4
HIV/AIDS Asia Regional Program	3	4	4	4
Emerging Infectious Diseases CARE Australia Mekong Local Risk Reduction	4	4	3	3
ATS – EID – Association of Southeast Asian Nations plus Three Emerging Infectious Diseases	4	5	4	4
Sanitary and Phytosanitary Capacity Building Program	4	4	4	4
Emerging Infectious Diseases – APEC Pandemics and Emerging Infectious Diseases initiatives support	3	3	2	4
<b>PACIFIC REGIONAL</b>				
<b>Pacific Regional Influenza Pandemic Preparedness Project</b>	4	4	4	4
Tackling Non Communicable Diseases in the Pacific	4	4	4	4
Pacific Regional HIV/STIs Project	5	5	5	4
Pacific – Health Systems Strengthening	4	4	4	4
Tertiary Health, Phase III Extension	5	4	4	3

COUNTRIES				
Initiatives	Implementation progress	Achievement of objectives	Monitoring and evaluation	Sustainability
Pacific Malaria Initiative–Solomon Islands Malaria Program	3	4	3	4
Pacific Sexual and Reproductive Health Program	4	4	4	3
UNICEF Pacific Program	4	5	4	4
Fiji School of Medicine	4	4	4	4
SAMOA				
Samoa Health Sector Wide Approach	5	5	4	4
VANUATU				
Vanuatu Malaria Program	5	5	5	4
Health Sector Support–Workforce Capacity	4	4	4	3
Health Sector Planning Support	4	3	4	5
TONGA				
Tonga Pacific Technical Assistance Mechanism (PACTAM)	5	5	4	3
KIRIBATI				
Nurse Skills Upgrading (KANI)	5	5	5	4
NAURU				
Nauru Health Sector Program	4	3	2	2
SOLOMON ISLANDS				
Bilateral Health Sector Support Program	3	4	3	4
<b>TOTAL AVERAGE</b>	<b>4.25</b>	<b>4.24</b>	<b>4.04</b>	<b>3.88</b>

<sup>a</sup> Quality at Entry report

Note: Definitions of rating scale

Satisfactory (4, 5 and 6)

6	Very high quality; needs ongoing management and monitoring only
5	Good quality; needs minor work to improve in some areas
4	Adequate quality; needs some work to improve

Less than satisfactory (1, 2 and 3)

3	Less than adequate quality; needs work to improve in core areas
2	Poor quality; needs major work to improve
1	Very poor quality; needs major overhaul