Australian Government

AusAID

# Health

## ANNUAL THEMATIC PERFORMANCE REPORT 2006–07

FEBRUARY 2008

www.ausaid.gov.au

ISBN 978-1-921285-06-6

Published by the Australian Agency for International Development (AusAID), Canberra, February 2008.

This document is online at www.ausaid.gov.au/publications

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# Preface

Annual thematic performance reports are among the major new performance assessment mechanisms introduced by AusAID.

Starting in 2007, AusAID will produce an Annual review of development effectiveness, informed by annual program performance updates for country and regional programs, and for key sectors and themes.

The purpose of the annual thematic performance reports is to describe progress against AusAID's policy objectives (including regional progress on the Millennium Development Goals), to identify current challenges in aid delivery and to highlight lessons to inform future investments.

The annual thematic performance reports aim to highlight key issues in aid delivery, focusing on the past 12–18 months, rather than to present a comprehensive analysis of all activities.

Four annual thematic performance reports were produced for 2006–07: on health, education, gender equality and economic governance. As this year was a pilot, these four reports are all structured slightly differently.

The four reports were prepared by the relevant thematic group within AusAID, under the leadership of the relevant adviser for that thematic area. The reports were all peer-reviewed by a combination of internal and/or external experts.

This year's annual thematic performance report for health particularly focuses on health system strengthening and women's and children's health. These are at the centre of the Australian aid health policy launched in August 2006, but also formed a significant part of AusAID programs before the new policy.

The report includes the health system response to HIV. Improved access to water and sanitation is critical to health outcomes; this report, however, does not address this theme, which is defined as a separate sector for international aid reporting purposes.

# Summary

In 2006–07 about 11 per cent of total Australian aid flows went to the health sector. Most of the estimated $289 million was for basic health care, health policy and management, and the international response to HIV.

Australia's development assistance in health has a unifying theme of strengthening health systems in order to deliver basic services in a sustainable way, especially to the most vulnerable population groups, address the priority needs of women and children, support country-specific work on health problems such as malaria, and ensure that systems can reduce vulnerability to HIV and emerging infectious diseases. Although most of the health programs reviewed in this annual thematic performance report were developed prior to the adoption of a specific focus on improved service delivery and health systems strengthening they yield lessons relevant to all policy objectives.

In the Asia–Pacific region there has been progress in meeting health needs of women and children and tackling infectious disease, but several countries are off track to meet the Millennium Development Goals in health. HIV is accelerating in the Asia-Pacific region, and emerging infectious diseases pose threats, such as a possible influenza pandemic, to health and health systems.

Targeted programs of women's and children's health, disease-specific interventions and HIV programs have all been part of previous Australian health assistance and have yielded significant outcomes, as documented in this report. For example, Australia's assistance has helped to make pregnancy and childbirth safer in eastern Indonesia, decrease malaria in the southern Philippines, and train doctors in HIV treatment and the prevention of mother-to-child transmission of HIV in Papua New Guinea.

However, some targeted programs in particular localities have produced little systemic change, thereby undermining sustainability and impact. A guiding principle of Australia's health development assistance is that such targeted programs should be underpinned by efforts to strengthen the wider health system in order to increase the effectiveness of service delivery and make the gains of donor-funded programs more sustainable after assistance ends.

Australia has worked to improve systems through efforts in health management and reform, but this has not always translated into changes in health outcomes. Service delivery is hampered by failures in fundamental components of the health system, especially financing mechanisms and health workforce planning and management. We have learned that efforts are needed at all levels from the community to the health

ministry and beyond, to central ministries such as finance and personnel management that play a critical role in health sector functioning. In some fragile states, health service delivery is in a state of decline and the first priority is to prevent further deterioration.

Donor assistance for major health system transformation is often best delivered through sector-wide support, rather than through individual projects. Internationally, the health sector is at the forefront of the transition to multi-donor, sector-wide support. Australia and Papua New Guinea have been developing this approach, and we are embarking on similar sector-wide health programs with several other countries. This requires new forms of expertise and close relationships with other development partners (and there are more major global stakeholders in health than in any other sector).

The Australian Government previously announced that aid to the health sector is expected to double by 2010. Increased health sector aid will concentrate on improving basic service delivery and the systems that underpin it, and enable expansion into the Mekong and South Asia.

Reporting on changes in health outcomes requires adequate baseline data, robust monitoring and enough time for interventions to have an impact. AusAID is working on its own monitoring and evaluation capacity while also helping to build local capacity for health information systems in partner countries.

The 2006–07 Health annual thematic performance report illustrates the positive outcomes that Australia's health aid is achieving overall. At the same time, it confirms the need for greater emphasis on health system fundamentals such as the way health services are financed and trained, along with supervision and incentives for health workers.

Strengthening health systems is a long-term commitment, and we need to continue to work to help countries in the region deliver needed services now, particularly to underserved population groups, while we support sustainable health development for the future.

# 1 The state of health and health systems in the Asia–Pacific

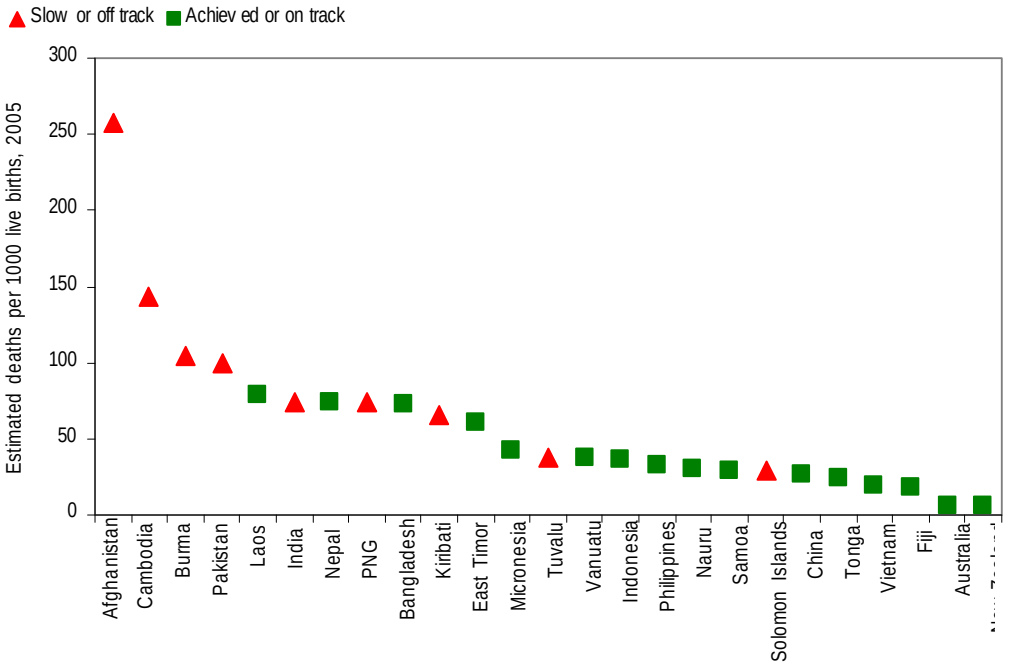
The Asia–Pacific region has made progress in key health indicators over recent years, but some countries are not on track to meet the health Millennium Development Goals (MDGs).

Child mortality (deaths of children under five years old) is a sensitive indicator of both health and wider development. A key health MDG is to reduce the under-5 mortality rate by two-thirds between 1990 and 2015. Figure 1 shows that several Asia–Pacific countries are off track, and that some have very high levels of child mortality. Other health MDG indicators show similar variations in progress with maternal mortality reduction (MDG 5) lagging in a number of countries.

As the rest of this section illustrates, there are many inequalities in health outcomes and access to health services throughout the region. Addressing disparities in health between and within countries remains a major development challenge.

In Indonesia, although there has been a dramatic decline in mortality of under-5 year olds to 36 children per 1000 live births, 162 000 children a year still die before their fifth birthday. In Papua New Guinea (PNG), under-5 mortality is 74 per 1000 and

Figure 1 Progress towards MDG4: reduction in under-5 mortality rate




Source: Mortality rates from UNICEF, State of the world's children, 2007; assessment of MDG progress from ESCAP/UNDP/ADB, The MDGs: Progress in Asia and the Pacific 2006.

99 per 1000 in Pakistan.[1] There are also significant inequities within countries: for example, in Cambodia the under-5 mortality rate is around 50 per 1000 in Phnom Penh but over 200 per 1000 in the north-east.[2] The Australian rate is 6 per 1000.

The causes of child mortality are well known: neonatal illness, pneumonia, diarrhoea and infectious diseases, with malnutrition as an underlying cause. In some Asia- Pacific countries malaria is an additional threat.

Measles immunisation, an MDG indicator for child health, shows good progress in countries such as Cambodia, Indonesia, Bangladesh and Pakistan, but coverage has declined recently in the Philippines, Burma, Fiji and Kiribati.[3] Although overall measles immunisation is over 80 per cent in the East Asia Pacific region, the rate was lower in 2004 than it was in 1990.[4] In Vanuatu, fewer than half the children have been immunised against measles or against the main infectious diseases of infancy and early childhood.[5]

Around 40 per cent of child deaths occur in the first month of life: a child's risk of dying on the first day of life is about 500 times greater than the risk when they are one month old. Recent declines in mortality have been mainly among older infants. Reductions in early newborn mortality are closely related to improvements in care during pregnancy and birth and in postpartum care, so there are benefits from programs that aim to reduce maternal mortality.[6]

Malaria causes more than a million deaths each year, mostly among young children, and is a major cause of illness in many parts of Asia and in Melanesia. It is a leading cause of death and illness in Solomon Islands, Vanuatu and PNG, where malaria program performance has declined in recent years as a result of civil unrest and human and financial constraints. It is hoped that new international funding will help to reverse this trend.[7] Treatment of malaria can reduce death rates by 50 per cent, and should be part of routine child and maternal health care. The disease is preventable and curable, but delivery of health interventions is often limited, especially among the poor. In Vietnam and Laos, fewer than 20 per cent of children in malaria endemic areas sleep under a bed net.[8]

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1 UNICEF, State of the world's children 2007, 2007, Table 1.

2 WHO, WHO/UNICEF Regional Child Survival Strategy: Accelerated and sustained action towards MDG4, 2006. p. 6. Note: International agency estimates of child mortality in Cambodia may be out of date; the 2005 Demographic and Health Survey in Cambodia showed a marked decline in child mortality to 83 per 1000 births.

3 ESCAP/UNDP/ADB 2006. The Millennium Development Goals: Progress in Asia and the Pacific 2006, Annex Goal 4. (www.mdgasiapacific.org)

4 World Bank Millennium Development Goals website: http://ddp-ext.worldbank.org/ext/GMIS/gdmis.do?siteId=2&goalId=8&targetId=19&menuId=LNAV01GOAL4SUB1

5 WHO Statistical Information System: www.who.int/whosis/en/, figures for 2004 (most recent).

6 Maternal mortality estimates are very poor, and few countries have reliable figures over time to monitor trends. Figures in the Asia–Pacific region range from around 300 deaths per 100 000 live births in Nepal (http://www.measuredhs.com/pubs/pdf/FR191/FR191.pdf) to 75 in Fiji. The figure for Australia is 6. (WHO Statistical Information System: www.who.int/whosis/en/, most recent year available)

7 WHO and UNICEF, 2005 World malaria report, 2005, p. 50.

8 WHO Statistical Information System: www.who.int/whosis/en/; figures for 2000 and 2002, respectively (most recent).

Interventions that can prevent most deaths of women and children are well understood, but weak health systems mean they do not reach those who need them – a challenge for all countries in the region. Health system limitations include:

- inadequacies in the mobilisation and management of finances
- inadequate overall planning and administration
- the small size, poor quality and uneven distribution of health workforces
- inadequate infrastructure and supply systems
- poor quality of care
- inadequate health information systems
- poor education of communities, including about demand for and expectations of health care.

In many countries, the decentralisation of health services has further compromised systems. While making those responsible for delivering services more accountable to communities is a defensible aim, implementation often falters because of low human resource capacity, tensions between central and local levels of government, and limited mechanisms to redistribute resources.

Some countries with the worst maternal and child health spend the least on public health: Burma and the countries of South Asia stand out in this regard. Pakistan's public expenditure on health was just 0.7 per cent of gross domestic product (GDP) in 2003, and that was down from 1.1 per cent five years earlier.[9] In Indonesia, 2.7 per cent of GDP goes to health, and only about one-third of that is government expenditure.[10] Asia has the world's highest proportion of out-of-pocket expenditure on health; well-functioning health insurance schemes are rare. In Indonesia, 74 per cent of private health expenditure is out-of-pocket.[11] Although there are some fee exemption schemes in Indonesia, Cambodia, Vietnam and Burma, implementation is neither extensive nor consistent.

In Pacific countries, government and total health expenditure per capita is higher than in Asia, but does not always buy better health outcomes, partly because of high delivery costs in geographically dispersed populations. More than half of the government recurrent health budget in Pacific island countries goes to hospitals. According to a recent World Bank report on improving health sector performance in the Pacific, more funds need to be reallocated to primary and preventive care (some hospitals provide little tertiary-level care, while others treat – at great expense – many advanced cases of diseases that could be prevented).[12]

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9 ESCAP/UNDP/ADB, The Millennium Development Goals: Progress in Asia and the Pacific 2006, p. 11 (www.mdgasiapacific.org).

10 WHO Statistical Information System: www.who.int/whosis/en/, figures for 2005 (most recent).

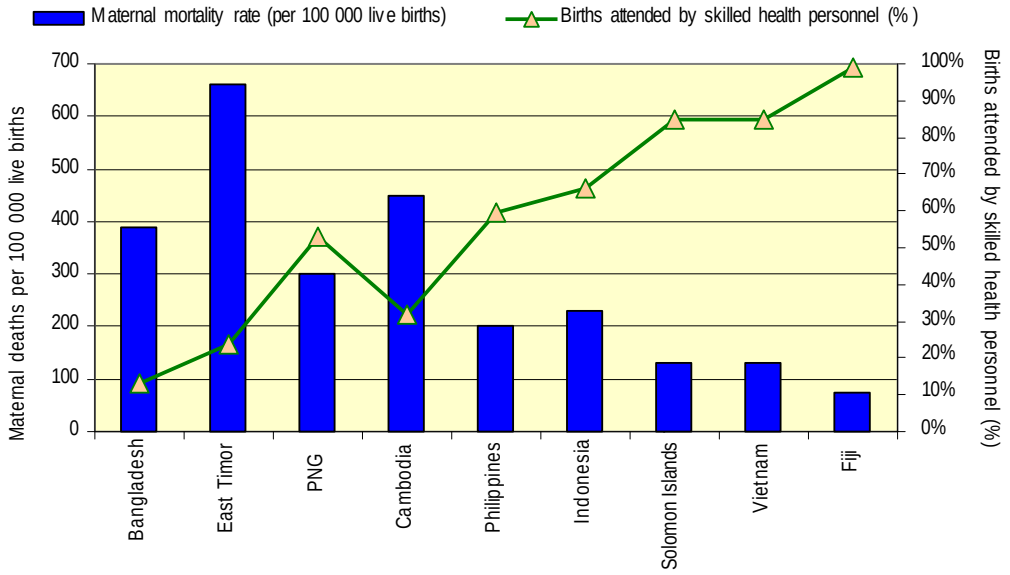
11 WHO Statistical Information System: www.who.int/whosis/en/, figure for 2005 (most recent).

12 World Bank, Human development in the Pacific Islands: Opportunities to improve health sector performance, Summary report, 2007, p. 5.

Although around 40 per cent of government health expenditure in Asia and the Pacific goes to the health workforce,[13] there are still critical shortages of health staff. The World Health Organization (WHO) estimates that a 50 per cent increase of medical personnel – doctors, nurses and midwives – is required in South-East Asia (especially in Bangladesh, India and Indonesia) and around a 120 per cent increase in the Western Pacific.[14] Training of additional health staff needs to be reinforced with a better workforce skills mix, and distribution and performance incentives. Imbalances between rural and urban areas are a challenge, but so is the migration of health workers overseas: over 15 per cent of Pacific doctors and nurses have migrated out of their countries over the past two decades.[15] In the Philippines national policy encourages the outflow, and it is estimated that as many as 85 per cent of employed Filipino nurses are working in other countries.[16]

The proportion of births attended by skilled personnel (an MDG indicator for sound maternal and child health and health systems) reaches over 80 per cent in many Pacific countries and in Vietnam. The situation is poorer in Indonesia and the Philippines and especially in some other countries of South Asia. The absence of emergency obstetric care compounds the danger for women and newborns. In most countries, the proportion of births with a skilled health worker in attendance is increasing, but sometimes from a very low base. Lower maternal mortality is closely associated with this factor, as shown in Figure 2.

Figure 2 Maternal mortality ratio and skilled attendance at birth




Source: WHO Statistical Information System, latest year available, http://www.who.int/whosis/en/ (accessed 18 July 2007).

13 WHO, Working together for health: World health report 2006, 2006, p. 7.

14 WHO, Working together for health, p. 13.

15 World Bank, Human development in the Pacific Islands, p. 5.

16 WHO, International nurse mobility: Trends and policy implications, 2003, p. 30.

Within-country inequities in access to skilled birth attendants are larger than for any other health or education services.[17] In the Philippines, the likelihood of having a skilled attendant at a birth is twice as high in urban areas as in rural areas, and is nearly four times higher for wealthier families than for the poor.[18]

HIV and emerging infectious diseases, such as H5N1 avian influenza with the potential to cause a pandemic in humans, pose major threats to health and place heavy burdens on health systems in the region. The HIV epidemic is expanding in PNG, Indonesia (particularly Papua), Vietnam and border provinces of China. In these areas, there have been invigorated national policy responses and significant new funds from the Global Fund to Fight AIDS, Tuberculosis and Malaria and bilateral donors. Despite these efforts, the epidemic continues to outpace the response.

Aside from PNG, HIV prevalence remains low in the Pacific and in the Philippines. Recent escalation of the Asian HIV epidemic is closely associated with injecting drug use and sex work. The epidemics driven by sexual transmission in PNG and Indonesia's Papua and West Papua provinces are now ranked among the worst in Asia and the Pacific. In these countries the infection of between 1 per cent and 3 per cent of adults has been driven by low condom use, high gender inequalities, sexual violence and labour mobility.

Meeting the threat of avian influenza and other emerging infectious diseases requires us to build the capacity of the underlying animal and human health systems of countries of the region. Indonesia has had the highest number of avian influenza cases and deaths worldwide (101 cases from a global total of 317 laboratory-confirmed cases, and 80 of the world's 191 deaths, by the end of June 2007). Vietnam has also had a significant number of cases, but with proportionally fewer deaths (95 cases and 42 deaths).[19]

Escalating chronic or non-communicable diseases (NCDs) in the region bring the challenges of a higher burden of disease, pressures on health systems, and the budget implications of high-cost treatment. Not all of these diseases have high mortality rates but may result in long-term disability, such as blindness, loss of mobility or impaired function related to mental illness. Preventive measures require multisectoral approaches, including regulatory frameworks, taxation policies, community-based interventions and screening programs.

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17 World Bank, Global monitoring report 2007: Millennium Development Goals: Confronting the challenges of gender equality and fragile states, 2007, p. 5.

18 WHO Statistical Information System (www.who.int/whosis/en/).

19 WHO Epidemic and Pandemic Alert and Response (www.who.int/csr/disease/avian_influenza/country/cases_table_2007_06_29 ).

# 2 Progress against Australia's policy objectives

## 2.1 AUSTRALIA'S AID EXPENDITURE IN HEALTH

Health is a significant sector in the Australian aid program, accounting for between 10 and 12 per cent of total aid expenditure over the past few years. Estimated total expenditure in 2006–07 was $289.5 million or around 11 per cent of total estimated aid expenditure.

Australia's largest aid partners in the health sector (measured by expenditure) are PNG and Indonesia, but Australia's position in relation to total health expenditure in the two countries contrasts markedly. Some 14 per cent of total PNG health spending comes from donors, mainly Australia, whereas Indonesia relies on external sources for only around 1 per cent of health expenditure. In PNG Australia's involvement in health is extensive; in Indonesia the Australian aid program focuses on specific geographical and health system areas.

Other countries where the Australian aid program has major health investments include Solomon Islands, where we provide over 40 per cent of total funding to the Ministry of Health, and Vanuatu. China is also an important partner in terms of Australian aid expenditure, especially in HIV and emerging infectious diseases, but we are a very small donor relative to total funding. Where Australia's assistance is minor we can increase the impact by working closely with other donors.

Also significant in absolute terms are Australia's global donations to multilateral and global organisations such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Health Organization, the GAVI Alliance, the United Nations Population Fund and UNAIDS (the Joint United Nations Programme on HIV).

The Australian Government has previously committed to doubling health aid by 2010. The 2007–08 Budget outlined the four-year $585.2 million Delivering better health initiative, which will help strengthen health systems, address priority health needs of women and children and diseases causing a high burden of death and disability, including tackling malaria and NCDs in the Pacific. Compared with the current regional profile of Australia's health assistance, new budget initiatives will result in increased health investment in Cambodia, Vietnam, South Asia and the Philippines.

## 2.2 AUSTRALIA'S OBJECTIVES FOR DEVELOPMENT ASSISTANCE IN HEALTH

The objectives of Australia's policy for development assistance in health (announced in 2006[20]) are:

- strengthening health system fundamentals that have an impact on service delivery
- addressing priority health needs of women and children
- supporting country-specific health priorities to tackle high-burden health problems – those that result in high levels of premature mortality or disability (for example, malaria and chronic diseases)
- ensuring that systems can reduce regional vulnerability to HIV and emerging infectious diseases.

These objectives are complemented by aid effectiveness objectives, such as:

- improved partnerships
- new aid approaches
- better quality technical assistance
- increased performance orientation
- an expanded program of research
- strengthened analytical approaches.

Targeted programs of women's and children's health, disease-specific intervention programs and HIV programs were all part of earlier Australian health aid. The increased emphasis on systems strengthening in the new health policy aims to institutionalise such efforts to allow them to be scaled up and made more sustainable, while improving the efficiency and effectiveness of service delivery generally. AusAID's International HIV Strategy also stresses the capacity building of systems, as well as promotion of leadership.

AusAID's health policy will be monitored using high-level development indicators (such as the MDGs), as well as measures of health system performance and aid effectiveness, and performance will be summarised in regular annual thematic performance reports.

Because 2006–07 is a baseline year, this initial report discusses key results in the program, organised according to the focus areas of the health policy.[21] Most aid initiatives pre-date the launch of the current health policy, but their experiences yield lessons relevant to all policy objectives.

This section assesses progress against each of the four objectives of the Australian health aid policy and against the general goal of improving aid effectiveness in the

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20 AusAID, Helping health systems deliver: a policy for Australian development assistance in health, 2006.

21 Most of the information available for this initial annual thematic performance report comes from seven key aid partner countries: Indonesia, PNG, Solomon Islands, Fiji, Vanuatu, the Philippines and Vietnam.

health sector (Section 2.7). Some lessons and challenges for the future are identified in this section and summarised and elaborated on in Section 3.

## 2.3 HEALTH SYSTEM STRENGTHENING

Improved service delivery has been the stated objective of many country programs and specific health initiatives. Australia's efforts have centred on capacity building at the central government level and on addressing recent decentralisation moves in several partner countries.

In PNG, assistance to the health system has been a major feature of Australia's aid program. In addition to direct assistance in the Department of Health, Australia's support for central agencies, such as the Department of Finance, underpins the aim of improved service delivery; however, this focus can and should be made more explicit. There have been specific improvements in the alignment of health sector planning and budgeting with national health priorities.

Stronger processes in PNG health system management have not yet translated into improved health outcomes on a major scale. A few indicators show positive trends, including a marginal increase in operational outreach clinics and, possibly related to this, an increase in the immunisation of children. However, some basic indicators, such as antenatal care show low levels and little improvement.[22] Maternal and child mortality remain at high levels in PNG.

Strengthening health systems is a long-term effort that requires a foundation of pre-existing capacity, which is limited in PNG. The challenges are particularly daunting at the subnational level. In future, in order to strengthen basic service delivery the PNG program will work with the Department of Health to support regional and capacity-building teams at the provincial level, as well as teams at facility level to address issues that currently impede service delivery. At the same time, it will continue to support long-term reforms throughout the system. Support for provincial financial management beyond the health sector will reinforce service delivery improvements. The program will also work to identify opportunities to involve non-state health providers more effectively in service delivery.

In Fiji and Solomon Islands, Australian assistance in health institutional strengthening has improved planning and budgeting capabilities. Australian funding through the WHO regional office allowed Fiji and Vanuatu to do their first national health accounts.

Australian support has contributed to a new curriculum for the Fiji School of Nursing, designed to be similar to the standard for an Australian degree. A clinical services plan has been developed by the Ministry of Health to rationalise the

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22 PNG Annual Health Sector Review Performance Monitoring Framework, May 2007.

placement of health facilities, equipment and staff and to standardise procedures. Support for inventory control at the Fiji Pharmaceutical Supplies medical store has improved supply to health facilities, although this remains a challenge. Human resource management improvements in Fiji have resulted in a reduction in recruitment times of 45 per cent, although recruitment remains slow.

Health information systems have been strengthened in both Fiji and Solomon Islands. In Solomon Islands, health information report completion rates are high, and sex-disaggregated data were included during a 2007 redevelopment. However, monitoring systems in both countries require further development to enable their use for planning and management and better evaluation of health outcomes.

In Solomon Islands, a health trust account was established to keep basic services viable and accountable during the post-conflict period. For example, during 2006–07 the trust account met all the Ministry of Health's needs for pharmaceutical supplies. AusAID will remain the principal provider of support for pharmaceuticals and medical supplies and health system operational costs, although we will continue to negotiate with the ministry to reduce its reliance on Australian funding. Major effort in health human resources in the past year resulted in better management, training and staff morale.

However, as in PNG, notwithstanding these systems improvements Solomon Islands health status indicators are lagging, and emergent diseases such as HIV and NCDs are likely to add to the health burden of families and systems alike. Future assistance will give increased focus to primary health care at the provincial level, and impact on health outcomes will be monitored through improved baseline and ongoing data collection. Incentives are being provided to support performance at the delivery level to achieve better results.

In PNG, Solomon Islands and Fiji, AusAID-provided health radio networks have widened communication and resulted in more patient referrals. The networks also provide greater security, particularly for women, and have made staff more willing to work in remote localities.

In Vanuatu, Australia has made a major contribution to human health resources. Australia's contribution has ranged from training village health workers to providing specialist medical personnel and scholarships for regional training. Support for a principal pharmacist helped to ensure that all dispensaries received at least one delivery of drug supplies in 2006. All aid posts in two provinces received training and supervision of village health workers through a subcontracted non-government agency. Nevertheless, some 20 per cent of Vanuatu's population is without access to health services.[23] Although there has been some progress in systems at the national

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[23] C Tidsell, Globalisation, development and poverty in the Pacific Islands: the situation of the least developed nations. International Journal of Social Economics 2002:29.

level, budgetary constraints will require the rigorous prioritisation of expenditure. Most of Australia's assistance is in the tertiary health subsector, and the World Bank has highlighted the country's imbalanced health resource allocation. In future, Australia will work with the Ministry of Health to help implement the government's policy of more equitable distribution of resources.

Although the Pacific faces health financing challenges, Asian countries tend to have even lower per capita government expenditure on health, with much of the financial burden falling on individuals. In the Mekong region, future funding will allow Australia to support Vietnam and Cambodia through the expansion of social health insurance or health equity funds and similar initiatives to improve poor people's access to basic health services.

## 2.4 WOMEN'S AND CHILDREN'S HEALTH

Australia has made significant investments in children's and women's health, including reproductive health, across its health programs. In eastern Indonesia Australia's support has contributed to increases in antenatal and postnatal visits, births by skilled personnel, acceptance of family planning, and community awareness about how to make pregnancy safer. Current support is improving the capacity of local hospitals to train midwives. The positive outcomes of AusAID-funded programs in eastern Indonesia have been recognised nationally. For example, the Ministry of Health expects to use the findings of an AusAID-supported pilot on adolescent girls' health in the development of a national policy. Work on birth
planning has been picked up by the ministry, and it is discussing wider use of a gender mainstreaming book for health workers.

The sustainability of this work will be reinforced in future by strengthening health services delivery at district level and by improving the demand for maternal and neonatal health care. In line with AusAID's health policy, we will also engage more directly in public health administration at the national level, with a focus on health financing, including social health insurance and workforce issues. Improvements in national health systems will support the rollout of future subnational health programs. In turn, lessons learned from subnational programs (such as lessons about the use of incentives for midwives and transportation to access obstetric care) will inform the directions of the national program.

In the Philippines, an Australia–UNICEF program has trained doctors, nurses and midwives in basic emergency obstetric care and has helped to achieve high rates of polio vaccination and distribution of vitamin A capsules to children. Health outcome indicators will be measured through a survey towards the end of the program; work will be needed to ensure that the findings of monitoring and evaluation (M&E) are
fed into ongoing programs. Health financing is a weakness that needs to be addressed

for future sustainability. A recent mid-term review suggested that resources are too thinly spread and should be directed more closely to reducing health disparities, for example by concentrating them geographically.

New funding in 2007–08 allows Australia to expand work in women's and children's health to South Asia, where maternal and child health indicators are among the worst in the world. There will be a strong focus on working with other development partners. Australian funds will strengthen national and subnational capacities in Bangladesh, Pakistan and Nepal to deliver essential maternal and neonatal health services.

Immunisation has received bilateral and regional support in the past, and this year Australia contributed at a global level to the GAVI Alliance, a public–private partnership to increase access to vaccines for children in poor countries. In 2006 the Alliance protected an additional 38 million children with basic vaccines and prevented more than 2.3 million premature deaths worldwide.

An outbreak of measles in Fiji in 2006 highlighted the country's reduced immunisation coverage and preparedness for an epidemic. With AusAID support, measles immunisation coverage of 95 per cent was achieved, and an intensive training effort has been undertaken to upgrade nurses' vaccination skills. In Vanuatu, where immunisation rates are low (around 50 per cent), Australia supported a supplementary immunisation activity in response to the 2006 measles threat. While this achieved 96–100 per cent coverage in rural and urban areas, routine immunisation rates continue to be low, signalling the need for more systemic support.

## 2.5 DISEASE-SPECIFIC PROGRAMS

Recognising the threat posed by malaria to health and productivity, Australia has contributed to efforts to roll back the disease in the Asia-Pacific region. In 2006 AusAID's partnership with WHO in Mindanao in the southern Philippines helped train health workers in malaria diagnosis, treatment and management and quality control; distributed insecticide-treated nets; and provided health education in schools. It is estimated that AusAID and other partners in the Philippines program have achieved a 37 per cent decline in malaria deaths since 2004. Components of the quality control program for malaria were adopted by a recent global expert committee meeting on the subject. Local government units have been involved in all stages of the project to reinforce sustainability; training at local level will be passed on to others using government resources.

New funding will support a major malaria initiative in Vanuatu and Solomon Islands. The initiative aims to reduce malaria morbidity and mortality through improved prevention and management of the disease, strengthening the health system, promoting an intersectoral approach to targeting malaria and undertaking operational

research to inform activity directions. The program will test the feasibility of elimination of malaria, island by island, through a coordinated combination of interventions. The initiative will later be extended to PNG.

In recent years AusAID has addressed non-communicable diseases in the Pacific by supporting the WHO to develop the Framework Convention on Tobacco Control, as well as the Global Strategy on Diet, Physical Activity and Health and the STEPwise Approach to NCD Surveillance in the Pacific. Australian support for the Secretariat of the Pacific Community (SPC) also contributes to its programs on NCDs, including the Pacific Action for Health project. Australia will work with WHO and the SPC within a joint Pacific NCD framework to help countries develop and implement NCD strategies and national plans including community health promotion, primary care, clinical management, disease surveillance, and review and revision of legislation and taxation relating particularly to alcohol, tobacco and food imports.

In line with the new AusAID health policy, future assistance for particular diseases, targeted interventions such as immunisation, and broader women's and children's health programs will increasingly be linked to efforts to improve the wider health systems in which they are embedded.

## 2.6 REDUCING VULNERABILITY TO HIV AND EMERGING INFECTIOUS DISEASES

AusAID's major HIV programs are the bilateral programs in PNG, Indonesia and China and regional projects in the Pacific and Asia (focusing on the Mekong countries). Key to new programs will be assessing the impact of capacity-building relationships with pivotal agencies (for example, Australia's relationship with the PNG National AIDS Council Secretariat and Indonesia's National AIDS Commission). In Indonesia building the capacity of public systems to deliver services has already led to the establishment of harm reduction services through community health centres and prisons (in West Java, Jakarta and Bali).

To address HIV and drug use, programs should build the capacity of public health and public security officials to cooperate in implementing harm reduction. Partnerships between health offices and police to plan and deliver methadone and needle and syringe programs are supported by AusAID HIV programs in Asia. Working with the public sector as well as non-government organisations (NGOs) increases the potential for sustainability. For optimal outcomes, the focus on building public sector capacities in HIV prevention should be complemented by support to civil society groups to provide outreach, peer education and community development.

The Pacific Regional HIV/AIDS Project has strengthened national planning capacities while supporting NGOs to engage in community-based prevention. Work in PNG and Indonesia has also involved increased support for people living with HIV, and training and mentoring to strengthen NGO partners. In PNG collaboration

with the Clinton Foundation (see below) has allowed increased access to cheaper drugs and equipment and trained clinicians in HIV treatment and the prevention of mother-to-child transmission. Future assistance will need to improve monitoring of outcomes and ensure sustainability by PNG systems.

The AusAID HIV Partnership Initiative has supported linkages between Australian HIV technical agencies and regional counterparts, strengthening their technical capacities for testing, social research, prevention and treatment, especially via support to national medical associations and NGOs. Lessons learned from the partnership initiative, including the need to focus on areas where Australia has a comparative advantage (such as clinical education, peer education, social and epidemiological research, and regulatory approaches), are informing the design of a more strategic approach to capacity building in bilateral and regional programs.

Australia plays a role in the international effort to address emerging infectious diseases, with $100 million committed to implement the Pandemics and Emerging Infectious Diseases Strategy from 2006 to 2010. Whole-of-government collaboration has been a feature of planning and implementation. Among the achievements against key objectives so far are community awareness programs implemented by CARE Australia in Mekong countries and funding for developing countries to participate in simulation exercises for pandemic preparedness and planning, with lessons learned disseminated to regional APEC economies. Epidemiologists placed in China, Vietnam, Laos, East Timor and Indonesia are working in close collaboration with national government health authorities. A regional communication and integration strategy for ASEAN+3 member countries has been established, as well as
community-based early warning systems in Indonesia and a twinning program between the Australian Quarantine and Inspection Service and its equivalent in PNG.

## 2.7 INCREASING AID EFFECTIVENESS: NEW APPROACHES, STRENGTHENED PARTNERSHIPS

The new AusAID health policy signals a major shift from stand-alone projects to a focus on working through partner government-led approaches, including government ownership of a single strategic plan (and, for HIV, a single national HIV/AIDS coordinating authority). We are making efforts to align AusAID inputs closely with national strategic plans and priorities, to harmonise aid procedures with other donors and to use government systems rather than create parallel ones. Common M&E frameworks foster a commitment to mutual accountability for results. The approach generally involves significant capacity development of partner government systems. Although these principles are often associated with sector-wide
approaches (SWAps), Australia's health policy stresses that there is no single blueprint for the approach; the principles outlined above will guide Australia's assistance.

In PNG Australia has played a leading role in a health SWAp that has improved collaboration among donors. Sector reviews are carried out by an independent monitoring and review group through a single joint mission for all donors and government. This enables donor resources to be channelled through a single trust account and provides funding to address health sector priorities using PNG Government disbursement, procurement and reporting mechanisms. The burden of multiple projects has been reduced, although all donors, including AusAID, continue to develop some projects outside the sector-wide framework. The risk in transferring support for essential services into the government health system became evident through serious delays in the procurement and distribution of medical supplies after the transfer of that responsibility to the Department of Health. Urgent action is now being taken to ensure that supplies are made available.

Sector-wide programs in health are being developed in Solomon Islands, East Timor and Vanuatu (where the transition means shifting from 15 projects in the sector to a single coherent program). In Cambodia, AusAID is re-engaging in the health sector through a program approach at the national level, in line with the Health Sector Strategic Plan. While there is no national-level sector-wide program involving development partners in Indonesia, we will be supporting the principles of a program approach at the subnational level, working closely with the provincial and district governments and with other donors.

We are complementing HIV capacity building with efforts to promote leadership on HIV as an issue, and increasing technical and advisory support to governments to plan, to manage and, increasingly, to fund the HIV response. In 2006–07, much effort went into design work and establishing new relationships. A new China health and HIV facility has been designed, involving AusAID, the Australian Department of Health and Ageing and the Chinese Government. New programs for PNG and Indonesia will align closely with national AIDS plans and national coordinating authorities – a departure from previous project modalities. Good progress is being made in these countries, including a significant improvement in the quality of relationships with PNG national stakeholders that bodes well for an invigorated HIV response. An important step was the development in PNG of a single national annual HIV plan for 2007, enabling coordination among all main stakeholders. This has been a time-consuming learning process, but it now appears to be heading in the right direction.

AusAID has invested in staff with specialised policy and technical expertise to engage with partner governments directly and at a high level to support national policy development in health and HIV in the region. Advisers are being recruited to work at the sector level in PNG, Indonesia, Vanuatu, Vietnam, Solomon Islands and China. We have established reference groups of global experts for HIV in PNG and for malaria in Vanuatu, Solomon Islands and PNG to support program development

and implementation. New research funding will increase the knowledge base and inform future programs through initiatives such as a health resource centre; a health and development research program; and new partnerships with specialised institutions to deepen the technical capacity of the aid program.

These specific efforts to increase aid effectiveness should be reflected in AusAID aid quality indicators. Table 1 summarises the quality ratings of major health aid initiatives in the implementation stage during 2006–07 in seven key aid partner countries.

Table 1 Major health initiatives assessed, 2006–07

| | Achieving objectives | Implementation progress | Monitoring and evaluation | Sustainability |
|---|---|---|---|---|
| % of initiatives rated satisfactory | 84% | 84% | 61% | 78% |

Note: Total expenditure of $167 904 735 in 2006–07 for 49 major initiatives (>$3 million) in seven key aid partner countries.
Source: AusAID Quality Reporting System, 2007.

Over 80 per cent of health initiatives were judged to be achieving their objectives and to be making adequate implementation progress, and nearly 80 per cent had a satisfactory sustainability rating. Although most initiatives were judged to be achieving their objectives and making adequate implementation progress, a significant number were rated as requiring some improvement (i.e. rated 4), particularly to assist sustainability, and improve M&E (see below). Moreover, objectives are sometimes framed fairly narrowly to refer to health sector reforms, rather than contributing to health outcomes, so meeting objectives does not always mean having a direct health impact.

A lower proportion (just over 60 per cent) were rated satisfactory on M&E. Weak monitoring affects other aspects of quality as well – measuring achievement of the other components is hampered by poor M&E frameworks. Individual initiative reports describe a variety of actions to improve quality, such as recruitment of a specialist M&E consultant, and a twinning program or involvement of non-government service providers to assist sustainability.

New programs designed as part of the expansion in health assistance will give greater attention to areas of identified weakness; quality at design will be monitored closely to ensure that this happens. Cross-cutting aid themes, such as gender equality and anti-corruption, will increasingly be reflected in quality reports. Some health activities have already produced gender manuals to guide implementation and have made progress in gathering sex-disaggregated health data. We have identified gender factors in HIV as an area for more research. Anti-corruption efforts are part of health systems work focusing on mutual accountability, regulation of services, incentives for good performance and improved management more generally.

Donor coordination is a high priority even where Australia is not formally participating in a SWAp. AusAID is working closely with UNICEF in the Philippines

and in eastern Indonesia. AusAID Jakarta is leading efforts to revive donor coordination in the health sector. Also in Indonesia, the United Kingdom Department for International Development (DFID) has delegated to AusAID the management of an independent M&E team that will monitor the performance of DFID- and AusAID-funded maternal and child health initiatives implemented by UNICEF and the German Agency for Technical Cooperation (GTZ). Through the health sector-wide program in Cambodia, AusAID is teaming up with the World Bank, DFID, the United Nations Population Fund (UNFPA) and the Ministry of Health in a program that also includes shared M&E processes.

In Burma, AusAID cooperated with five European donors in 2006 to establish the Three Diseases Fund, which focuses on HIV, tuberculosis and malaria and is managed by the United Nations Office of Project Services. Burmese authorities have agreed to facilitate the fund's operations, consistent with humanitarian principles. In HIV, AusAID helped to establish the Indonesia Partnership Fund as a way for Indonesia and its external partners to jointly resource and monitor Indonesia's HIV/AIDS strategy.

Building on these experiences, we will be working with UNICEF and DFID in Bangladesh and Nepal to support essential maternal and neonatal health promotion and care. In Pakistan, we will use a delegated cooperation agreement with DFID in which AusAID resources will be added to those of DFID to strengthen national and provincial capacity to plan, budget and deliver essential maternal and neonatal health services. The program will likely provide partnership opportunities with midwifery education and regulatory institutions in Australia.

Australia is also supporting harmonised approaches at a global and regional level. In 2006 there was a growing consensus among a number of development partners in the health sector that the absence of coherence inhibits scaling up in the sector. Key donors, including Australia, have agreed to a more coordinated effort. To assist this, we funded a diagnostic study in Cambodia to examine how health issues are integrated into broader planning and the state of harmonisation efforts by donors.

In April 2007 AusAID was the initiator and host of a meeting of bilateral and multilateral partners to commence more strategic collaboration in maternal, newborn and child health in the Asia–Pacific region.

AusAID supports innovative ways of working at the global level, where those innovations are achieving improved health outcomes. Australia sits on the board of the Global Fund to Fight AIDS, Tuberculosis and Malaria in a joint constituency with the United Kingdom. This gives the Asia–Pacific region a greater voice in the administration of the fund. To date, the Global Fund has approved proposals for Asia and the Pacific to the value of US$1.6 billion (20 per cent of all approved proposals). Australia also supports UNAIDS, a leader of multilateral cooperation, and

GAVI, the innovative financing mechanism for immunisation and health systems strengthening. AusAID is developing strategic agreements with WHO and the UNFPA, and expects to develop a closer working relationship with GAVI.

In HIV, AusAID has:

- played a leadership role in working with country partners to negotiate a meaningful Political Declaration on HIV/AIDS at the 2006 UN General Assembly High-Level Meeting on AIDS
- supported UNAIDS at the regional level, including for the Asia–Pacific Leadership Forum on HIV/AIDS and Development
- engaged the business sector by initiating the Asia–Pacific Business Coalition on AIDS, which has already engaged high-profile business figures and mobilised new corporate support
- hosted the July 2007 Third Asia–Pacific Ministerial Meeting on HIV/AIDS, which resulted in commitments to convene business coalitions in India and China.

In PNG, AusAID leadership has helped to increase international health partnership presence in the country. AusAID supports the Clinton Foundation, which is leveraging corporate donations of paediatric drugs and heavily discounted generic antiretroviral drugs. President Clinton's 2006 visit to PNG to mark the start of the AusAID – Clinton Foundation partnership program was a strategic move to mobilise local political leadership.

In work with other international players in PNG, we facilitated the wider participation of NGOs in PNG sexual health care, WHO involvement in emergencies and disease outbreaks, and Global Fund acceptance of a reformulated grant proposal for tuberculosis control.

A new HIV/AIDS Asia Regional Program, administered through a regional unit in Bangkok, is now well placed to play a technical and policy leadership role in HIV associated with drug use in six target countries.

# 3 Key lessons

This section suggests five areas in which the Australian aid program in the health sector may change or increase its emphasis, based on lessons learned to date. The directions outlined are consistent with the health system strengthening and aid-effectiveness components of the AusAID health policy but have a bearing on action in all the priority areas.

## 3.1 STRENGTHENING HEALTH SYSTEMS: ADDRESSING THE FUNDAMENTALS

The emphasis on health system strengthening in the AusAID health policy is echoed in recent new policy emphasis from the World Bank, DFID and WHO, as well as global health partnerships such as the Global Fund and GAVI. Most development partners recognise that focusing on narrow, disease-specific programs can have only limited impact and that their delivery, in any case, depends on the existence of functioning health systems. Health system strengthening is a relatively new focus, in which all partners are finding their way.

AusAID input to improve health systems has focused on better management of finances, personnel and commodities within existing systems. Reform, where it has been addressed, has usually centred on restructuring central health departments and on grappling with the challenges of hasty decentralisation. In some cases, the solutions offered have been inappropriate to the context or unrealistically sophisticated, and have later been assessed as unsustainable. In other cases, well-targeted inputs with realistic levels of resources have brought sustainable improvements in efficiency. Sometimes, however, better management processes have not translated into better services. One reason is that better management of grossly inadequate resources or of an inappropriate system can have only limited benefits.

A complex challenge is ensuring that a systems focus leads to better health service delivery, particularly in underserved areas. How can health systems be adequately and sustainably financed to have a chance of providing at least basic services to the whole population? How can a workforce be built and retained that meets the particular and changing needs of each system? What is the relative importance of the government's role in regulation, financing and provision of services?

In countries where AusAID is the main development partner in the sector, we have an interest in starting to tackle these big questions. In other countries where we are a minor player, we can work with other partners to address them. Often the policy changes that are needed and the authority to implement them lie outside the health

sector. Where AusAID is working with central agencies to improve public financial management or civil service reform or to address governance issues, it is important to link those efforts to developments in the health sector.

Other critical issues are the rational expansion and maintenance of health infrastructure and equipment, and managing the demand for increasingly more expensive pharmaceuticals and medical procedures. In some contexts, legislation is needed for the health sector and other sectors. In all countries, an essential part of the system is a well-informed public engaged in their own health and that of their communities, not least to ensure accountability. Many components of health system strengthening are areas in which Australia has learned valuable lessons through its
own experience. Those lessons could be shared with other countries of the region.

## 3.2 DELIVERING SERVICES NOW, WHILE BUILDING SYSTEMS FOR THE FUTURE: GETTING THE BALANCE RIGHT

The very considerable challenge for AusAID in countries where we are the major donor to the health sector, or among a group of major donors, is to help governments build for the future while improving service delivery now. In some cases, service delivery is in a state of decline and the first priority is to prevent further deterioration.

A 'two-track' approach to health sector support is needed in many countries. System reforms are complex and have political dimensions. They can only proceed at the pace at which common understanding and acceptance can be built and change can be managed. For example, achieving sustainable health financing and developing a workforce with adequate numbers and skills are necessarily long-term undertakings, as is the development of a reliable information system.

In the meantime, ways have to be found to deliver services to all people, and particularly those in greatest need, in the short term despite the constraints of current systems. Special attention may need to be given to services for which coverage is particularly low, such as access to family planning and emergency obstetric care, both essential to reducing maternal mortality. Services may be targeted to particularly vulnerable groups, for example, the disabled.

Immediate improvements in service deliver may involve better use of existing financial resources, including more efficient procurement and distribution of commodities. Performance may be improved through more efficient day-to-day management of health facilities and staff, better incentives for health workers and alternative models of service delivery (for example, through non-government providers). Removing financial barriers to health care for the poor increases the use of services by those most in need. In some countries, such as PNG and Solomon Islands, AusAID needs to work with governments not only to strengthen the central and provincial levels of the system but right down to service delivery level.

## 3.3 NEW APPROACHES, NEW PARTNERSHIPS, NEW CHALLENGES FOR AUSAID

Such are the breadth and complexity of the challenges facing health systems that AusAID will need to work in collaboration with other major development partners, such as other bilateral development agencies, technical health agencies and the development banks. Where those organisations are well established, as in many Asian countries, the impact of AusAID input can be increased by associating with them. In the countries where AusAID is the major development agency, as in much of the Pacific, we can benefit from their technical input and by sharing the load of advocacy and support to the government.

The experience with the AusAID HIV Partnership Initiative has yielded valuable lessons that are being incorporated into the design of new programs, especially flexibility in program design and delivery to match the pace and need of in-country partners. The need to link community-based organisations, researchers and health professionals in developing capacity to conduct community-based operational research is another important lesson, and we are increasing efforts to align the work of Australian HIV organisations in the region with country priorities and coordinate their work with other AusAID programs.

The move towards SWAps in the health sector in close collaboration with other development partners has produced new challenges, as shown in Solomon Islands and East Timor where progress has been slower than expected. Working through fragile government systems without overwhelming them with checks and safeguards poses increased risks and new management challenges. The new health sector support program in Solomon Islands foresees greater reliance on government systems, moving away from the model of using a managing contractor. For HIV, Indonesia is entering a critical phase as we transition to a new partnership program, and in PNG relationships established as the foundation of the new program (which began in January 2007) are being put to the test in the first year of operation.

The move away from contractor-implemented aid projects to broader multi-donor sectoral programs working through partner government systems means learning new ways of working. While potentially reducing transaction costs for the host government, the new approaches initially increase the effort required from AusAID. This requires adequate resourcing, competent technical advice and continuous development and support of staff.

The entry of new global partners in the health sector also poses new challenges: there are more major global stakeholders in health than in any other sector.[24] New players add to the challenge of delivering effective, harmonised development assistance. AusAID contributes to two global partnerships (the Global Fund and GAVI) and has an interest in their functioning on the ground, particularly in countries where AusAID's own funds are invested in the same health program areas. Engagement with the Global Fund at country level is increasingly important to the sustainability of

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24 WHO, Aid effectiveness and health, Making Health Systems Work, working paper no. 9, 2007, p. 3.

HIV and malaria responses in countries where AusAID is a major partner in those areas. The design of new programs needs to factor in global partnerships, which may be able to fund expansion of AusAID-supported activities to a national level. AusAID has a strong interest in providing technical assistance where needed to ensure their success and especially to ensure that they work in a harmonised fashion. Enhanced efforts to tackle malaria in Melanesia, spearheaded by an AusAID-led initiative, will require close collaboration with WHO, the Global Fund and other partners.

## 3.4 PUTTING AUSAID'S CONTRIBUTION IN PERSPECTIVE: OUR ROLE IN EACH COUNTRY IS DIFFERENT

What AusAID can expect from its investment in a country's health sector is partly determined by the size and focus of its contribution relative to the overall health sector. In Fiji, AusAID's funding equals 3 per cent of public spending on health in a relatively well-developed system; in Solomon Islands, it represents around 40 per cent of expenditure in a fragile system. AusAID will adjust its health sector objectives according to the relative size and nature of its contribution to the sector and the degree of development of the health system.

High-level policy advice, with some funding for analytical work and advocacy, and strategic partnership with other development partners may be the most effective use of modest resources. However, in countries where AusAID funding is a significant proportion of non-salary financing of the sector, the use of the agency's funds (particularly as part of the government budget) can very significantly affect the type of services provided by the sector as a whole. In this context AusAID has an interest in promoting a sector-wide program supported by the efficient use of all government and development partner resources. This requires strong technical and coordination leadership on the ground.

## 3.5 MANAGING FOR RESULTS: BETTER INFORMATION IS NEEDED

To ensure mutual accountability, effective management based on reliable information is needed. The high profile of the health MDGs has drawn attention to the need to track progress towards the goals but has also highlighted the lack of reliable data.

Assessment of health outcomes requires adequate baseline data, robust monitoring frameworks, and enough time for interventions to have an impact. AusAID's quality assessment process (see Table 1) showed weaknesses in M&E systems for some health initiatives. Beyond effective monitoring of AusAID-funded programs, we need to help build local capacity for health information systems. Improving poor-quality statistics is an objective of AusAID health initiatives in several countries but needs greater emphasis.

Approaches to gathering information need to be appropriate to each context. In some countries, sustainable routine information systems may be difficult to achieve in the short term and the best option may be sensible use of periodic surveys. Surveys are often relatively costly and complex, so AusAID should join other partners in supporting governments to conduct them, both to share the costs and to ensure the use of common datasets. Where routine information systems are reasonably strong, more attention needs to be given to improving the analysis and use of the information to improve services and resource allocation.

In HIV work, more effort needs to go into epidemiological and social research that tracks incidence and explores social, behavioural and economic determinants and impacts, particularly those related to gender, so efforts can be better targeted. A consistent emphasis of AusAID programs in health and HIV is capacity building, and in HIV there is a strong focus on leadership. More attention should be given to identifying qualitative indicators for success in building capacity and achieving leadership outcomes.

# Acronyms and abbreviations

| | |
|---|---|
| APEC | Asia–Pacific Economic Cooperation ASEAN |
| | Association of South-East Asian Nations ASEAN+3 |
| | ASEAN plus Japan, China, Republic of Korea |
| AusAID | Australian Agency for International Development |
| DFID | Department for International Development (United Kingdom) |
| GAVI | GAVI Alliance (formerly the Global Alliance for Vaccines and Immunisation) |
| GDP | Gross domestic product |
| Global Fund | Global Fund to Fight AIDS, Tuberculosis and Malaria |
| GTZ | Deutsche Gesellschaft für Technische Zusammenarbeit (German Agency for Technical Cooperation) |
| M&E | Monitoring and evaluation |
| MDGs | Millennium Development Goals |
| NCDs | Non-communicable diseases |
| NGO | Non-government organisation |
| PNG | Papua New Guinea |
| SPC | Secretariat of the Pacific Community |
| SWAp | Sector-wide approach |
| UNAIDS | Joint United Nations Programme on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| WHO | World Health Organization |