Supporting Health in the Pacific

A Guidance Note for AusAID staff

October 2011

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ACRONYMS

AusAID	Australian Agency for International Development
EIDs	Emerging infectious diseases
HIV/AIDS	Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HRH	Human resources for health
MCH	Maternal and child health
MDGs	Millennium Development Goals
NCDs	Non-communicable diseases
NZAID	New Zealand Agency for International Development
PEFA	Public Expenditure and Financial Accountability
PIF	Pacific Islands Forum
PNG	Papua New Guinea
SPC	Secretariat of the Pacific Community
STIs	Sexually transmitted infections
SWAp	Sector-wide approach
TB	Tuberculosis
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

KEY MESSAGES

The situation

- The health Millennium Development Goals (four - child mortality; five – maternal health; six – major infectious diseases) and non-communicable diseases present major challenges for Pacific island countries.
- Non-communicable diseases and their complications are responsible for the majority of deaths and a large burden of illness across the Pacific islands region. A significant proportion of this illness and death is preventable yet prevalence is growing.
- There is overwhelming evidence that investing in the health of women and girls means investing in future generations as well as in the health of society today – yet women in the Pacific continue to die of preventable and treatable complications in pregnancy and childbirth, often because of delays in receiving required care.
- In many Pacific island countries, child mortality rates have not improved since 2000 and in some countries they have deteriorated – yet the most common causes of child mortality (diarrhoeal disease and pneumonia) are preventable and treatable.
- Most Pacific island governments spend more per person on health services than other countries with similar levels of income – yet poor planning and inappropriate targeting (e.g. focusing on curative rather than preventive and primary care services) means needed services often fail to reach the poor.

What needs to change?

Whilst the context and burden of disease is unique to each Pacific island country, many required actions are common across all countries.

Basic health services need to be available to all communities at all times to achieve improved health outcomes (notably the Millennium Development Goals and Pacific Partnership for Development targets). In the Pacific, the quality of health service delivery needs to improve and access to health services needs to expand. This requires a strong, service oriented health system that is staffed by quality health workers, resourced with drugs, blood, equipment and communication tools, and informed by information systems that feed back relevant data to ensure service improvements over time. In the Pacific, achieving this requires the following shifts:

- **A more horizontal health systems approach** – an approach that supports health system *functions* (such as long-term care for chronic diseases). Vertical or silo approaches to particular *diseases* or issues can distort health priorities and divert resources, and achievements often regress once dedicated funding ceases. Health systems must also be viewed as a whole, as weaknesses in one area can constrain progress in others. A whole-of-government perspective is needed and cross-sector linkages need to be understood.

- **Human resources for health need to be given priority** by countries and by donor partners – without effective workforce planning and management, health outcomes are unlikely to improve.

- **Performance assessment and risk management must focus on outcomes** and how best to achieve them. Reliable baselines, milestones and data sources need to be identified and tracked.

- **Regional mechanisms can only be effective if used to support regional solutions that are more appropriate than national responses**. They should not be used to deliver country level support where issues can be better addressed at the country level. In the interests of better health outcomes and improved aid effectiveness, the regional architecture and regional processes for health in the Pacific are in urgent need of streamlining and coherence.

How Australia can help

Australia must focus on helping countries to bring all health sector resources together, ideally under one plan, within a single budget and with a single performance assessment framework, equipping them to function better within their constraints. AusAID must focus on:

- Helping improve the capacity of governments to plan and manage their entire resource envelope – by engaging in effective, inclusive dialogue; strengthening public financial management; undertaking analysis of context to improve the evidence base for decision-making and understanding of institutional challenges and incentives; and aligning or integrating its external support with national systems.
- Considering issues of policy first (within and beyond the health sector), and then supporting leadership, managerial and technical needs within that context.
- Maximising the impact on service delivery – this is best done at the country level in support of national health systems.
- Leading or actively supporting donor coordination in line with the *Cairns Compact on Strengthening Development Coordination in the Pacific*.
- Engaging with regional and global organisations based on analysis of their strengths, mandate and track record, and ensuring they are not drawn into unfamiliar roles to suit donor interests.
- Helping countries meet the recurrent costs of operating their health sector – supporting them to use their available resources wisely and providing financing into their system to meet vital but genuinely unaffordable costs.
- Using broader delivery mechanisms (such as program-based and sector-wide approaches, recurrent cost financing, direct budget support, pooled funds) to achieve better continuity and outcomes by ensuring aid funding is predictable, of appropriate duration, and appropriately integrated with other available resources in a single budget.

- Identifying innovative alternatives to providing services that are not cost-effective to provide locally, and supporting them over the long term (e.g., long-term access to referral to Pacific Rim centres for certain services, visiting specialists, telemedicine and organisational links between countries).
- Monitoring and assessing outcomes rather than inputs and outputs (wherever feasible) through measurement of a small number of relevant indicators, preferably those that national systems themselves use. This includes those outlined in the Pacific Partnership for Development schedules.

1. INTRODUCTION

The fundamental reason Australia supports work in the health sector in the Pacific[1] is to obtain better health outcomes for people in Pacific island countries. In AusAID's assessment, improved health outcomes will be achieved by engaging differently and by applying available resources[2] differently. To this end, this internal Guidance Note provides the rationale for and outlines the key principles and overall strategic framework that will underpin and shape Australia's support for health in the Pacific as the aid program increases in size over the period to 2015. It is not intended to be a delivery strategy. Rather, it provides strategic and policy guidance on 'how', 'when' and 'why' AusAID will engage in the health sector in the Pacific. Its purpose is to support AusAID staff who are actively involved in the health sector, developing strategies and programs, engaging on or monitoring issues, and/or deciding on priorities for Australian support. Further guidance papers will be prepared to provide practical advice on questions of 'what' issues and support need to be considered by staff and how best to address those. Examples include maternal and child health (MCH), human resources for health (HRH), non-communicable diseases (NCDs), and working in partner systems.

2. CONTEXT AND LESSONS

Poor health is both a cause and a consequence of poverty. Three of the Millennium Development Goals (MDGs) directly target health[3] and progress towards each of the other MDGs influences and is influenced by progress to improve health.[4] Inadequate health and water and sanitation services intensify disadvantage, impede development and, in fragile environments, can threaten the stability of government.

Pacific island countries face several enduring constraints to development, such as small size, small and externally dependent economies, small and often highly dispersed and mobile populations, and vulnerability to natural disasters, regional and global events and the negative impacts of climate change. These all act as pressures on peoples' health and on national and community health systems.

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1 For the purposes of this Guidance Note, 'Pacific' refers to the Pacific island countries and territories that are members of the Pacific Islands Forum.

2 This includes governments' own resources, those of non-government partners and other external donors, and Australia's growing resources. Australia's contribution to health in the Pacific is estimated to total $65.9 million in 2010-11.

3 MDG 4: reducing child mortality; MDG 5: improving maternal health; and MDG 6: combating HIV, malaria and other major diseases, including NCDs.

4 This is either because progress towards the MDG is imperative for improved health outcomes, and/or because the quality of peoples' health affects achievement of the MDG (e.g., access to education, nutrition, water and sanitation; the status of women; and pollution, food quality and other environmental factors). To give one practical example, the likelihood of a medically assisted delivery in Solomon Islands increases substantially with the mother's education level, from 69% among mothers with no education to 92% among mothers with some secondary education. Clearly health and education are inextricably linked.

This combination of development constraints leads to four broad challenges.[5]

First, **Pacific island countries face evolving challenges in addressing the burden of disease**. Annex A provides a picture of the health status of Pacific island countries, from which one must conclude that there is a need to approach health development differently if there is to be any sustained improvement in health outcomes. Some health indicators, such as infant and child mortality rates, have been improving steadily relative to 1990 baselines; others such as immunisation coverage fluctuate from year to year and even from island to island or province to province; and some, such as diarrhoea and pneumonia rates, remain unacceptably high. MCH indicators have begun to plateau since 2000 in many countries and the data indicate that most of the maternal and child deaths are preventable. Some countries are showing increased rates of sexually transmitted infections (STIs); and malaria remains a significant challenge in Melanesia. NCDs have become the leading causes of morbidity, mortality and falling life expectancy in many countries, and will continue to influence health outcomes over at least the next two generations. For AusAID, these worrying trends suggest there is need for more concerted effort to improve the quality of service delivery.

Second, **the Pacific is an expensive region in which to deliver services**. For most countries, factors such as geographic isolation and remoteness, limited infrastructure, widely dispersed populations and lack of critical mass increase the costs of providing primary and preventive health services. This means it is usually not cost-effective to provide the full range of services that are available in larger or more developed economies. Innovative alternatives need to be developed and maintained, including some continued, long-term access to referral to Pacific Rim centres for certain services, a role for visiting specialists, greater use of telemedicine and stronger institutional links between countries.

Third, **countries are failing to use their limited resources to optimal effect**. Most Pacific governments spend more per person on health services than other countries with similar levels of income.[6] Unfortunately, poor planning means that, in many cases, expenditure is inadequately targeted and services may often fail to reach those who need them most. For example, up to two-thirds of the health budget in many countries may be spent on curative (secondary and tertiary) care and one-third on primary and preventive services.[7] These countries must aim to increase preventive and primary health care services, as these are key to reducing both the incidence of death and disease and future treatment costs. A particular challenge in the Pacific is providing appropriate services to geographically remote and isolated populations.

Fourth, **health workforce planning and management need rigorous attention at all levels**. This must happen in an integrated way if it is to have impact and make more cost effective

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5 Unless otherwise specified, the figures and trends referred to in this section derive from AusAID (2009) *Tracking Development and Governance in the Pacific,* August, www.ausaid.gov.au/publications.

6 For details, see AusAID (2009), Table 7.

7 This disparity is even greater in those countries that have elected to fund renal dialysis and other tertiary care to help address the consequences of the epidemic in NCDs such as diabetes and heart disease – for those countries, tertiary care costs may account for 25% or more of their health expenditure.

use of current staff and skills. The past emphasis on training needs to be replaced with a more comprehensive 'human resources for health' (HRH) approach that also considers issues of effective recruitment, use of skills, capacity development and retention. This requires well trained management and established management systems and procedures. HRH constraints and enablers must be identified in order to strengthen either the numbers or skills of different health professionals effectively.

2.1 Lessons from working with national systems

National health systems in the Pacific need to perform better. In practical terms, a health system[8] involves everything from setting a policy framework to actually getting the right staff, services, equipment, facilities and drugs on the ground in an efficient manner and ensuring equitable access to services of acceptable quality. Most Pacific island countries have identifiable needs for stronger financial, information, human resource, procurement and supply management systems, and most struggle to meet the recurrent costs of operating their health sector. However, recurrent costs receive relatively little donor funding. Development partners are usually reluctant to inject funding as direct budget support into weakly performing systems such as public financial management, accounting, procurement, monitoring and auditing. Another significant systemic problem confronting Pacific island countries right now is how best to ensure external funding for specific diseases contributes to strengthening rather than undermining, duplicating or bypassing national health systems.

Strengthening health systems requires a whole-of-government perspective. Health ministries are ultimately responsible for sector performance, but they are not the only (or often even the major) player in resolving fundamental issues such as inadequate finance and staffing constraints. Central agencies play a key role in determining the health budget and, in many countries, health workforce 'establishment' numbers. The relative priority accorded to health by central governments varies greatly across Pacific countries with the proportion of total government expenditure on health varying from only a few percent to more than 10 per cent.

The work of other sectors such as water and sanitation, agriculture and education also has an important bearing on health outcomes. For example, medical models of care for NCDs need an enabling environment characterised by healthy public policy and ecological models of health promotion (such as that represented by the *Healthy Islands* approach[9]). However,

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[8] One framework that has been developed to describe the essential functions of a health system is the WHO's 'building blocks'. These are: health services; health workforce; health information systems; access to medical products, vaccines and technologies; health financing; and leadership and governance issues (such as policy, regulatory, incentive and accountability frameworks). For details of these six building blocks, see http://www.who.int/healthsystems/topics/en/index.html.

[9] The concept of "healthy islands" was first adopted by Pacific island governments in 1995 as the unifying theme for health promotion and protection for the 21st century. With its emphasis on a multisectoral approach and its commitment to health promotion and protection, it remains a core platform for action in the region, including on climate change and food security. The *Healthy Islands* concept recognises the need for health care processes to become more holistic, better integrated and linked through networks. See http://whqlibdoc.who.int/wpro/1994-99/WPR_RC46_INF_DOC1.pdf. See also Galea, G., Powis, B., &

inter-sectoral collaboration and whole-of-government linkages remain poorly developed in most Pacific island countries and are rarely addressed in other than aspirational terms by national health strategic plans. This is true even in very small countries, where there would not seem to be the fiscal or policy space for sector-specific silos.

For lasting success, relevant ministries and agencies such as finance, public service, education and others must be engaged in meaningful dialogue with the health sector, and development partners need to acknowledge and support this. Effective health ministries will be those that have positive impacts in four 'domains': actions related to the Ministry itself and the services it delivers; actions on a whole-of-government basis (involving central agencies and/or other sectors); actions to influence and harness the support offered by regional and global bodies including donors; and actions to engage communities effectively.

AusAID needs to engage better with country health systems. In the Pacific, health system strengthening is expected to improve the way available funds are spent and to result in better and more sustainable health outcomes. From AusAID's perspective, achieving this depends on effective dialogue involving all partners[10] and on effective analysis of context to determine whether support is needed in all or some elements of the system and how best to sequence support. This level of engagement and analysis will help improve government capacity to plan and manage its entire resource envelope. That in turn will make real alignment of donor resources within national systems achievable, since external partners such as Australia should increasingly be comfortable integrating external support with domestic resources. This could be done through mechanisms such as program-based and potentially broader budget support. Whatever the mechanism, the aim should be to support improved performance in and between all four 'domains'.

Programmatic and sector-wide approaches (SWAps) offer significant potential for health systems strengthening, but they have some way to go in both design and management to be truly effective. The lack of meaningful, sector-wide, prioritised, budgeted and owned national health plans that truly guide health expenditure has been a major inhibitor to effective SWAps in the Pacific. Likely reasons for this include lack of national capacity, lack of 'whole-of-government' coherence, the fact that health is seen as having better access to global and regional funding than other sectors (with the result that health is more likely to be left to 'do its own thing'), and the fact that donors have often tended to earmark health funding for their own or globally-driven priorities rather than for those of the countries. Annex B summarises the international experience, much of which has involved the health sector. Boxes 1 and 2 below outline examples of successes and challenges of two AusAID supported SWAps in the region, and Box 3 examines how a SWAp has contributed to maternal health improvements in Nepal.

Tamplin. S. (2000) Healthy Islands in the Western Pacific — international settings development, *Health Promotion International*, 15: 169-178.

[10] In this document, references to all partners or all stakeholders refer to governments (including central, sector and sub-national agencies), donors, non-government organisations and other faith-based or community groups, academic and research institutions, specialist associations, the private sector, vulnerable groups, communities, and regional and global organisations.

Box 1- A Sector Wide Approach Making Progress in the Solomon Islands

In the Solomon Islands, AusAID is providing funding for health through Solomon Island Government systems, with funding delivered as sectoral budget support through the Health Sector Support Program (HSSP). AusAID's funding contributes to achieving Priority Outcome 1 of the Solomon Islands–Australia Partnership for Development. This funding also supports the Solomon Islands National Health Strategic Plan and is aligned with Solomon Island Government planning, finance and procurement systems.

This means that in the Solomon Islands our funding is integrated into the Ministry's funding to help meet the long term recurrent cost of service delivery. This is appropriate in a sector where AusAID funds about 35% of the health sector budget. HSSP is providing greater value for money through reduced duplication of effort and ensuring resource allocation is prioritised to meet the greatest needs. Although there is scope for achievements to be further realised, results are being achieved by working with and through Solomon Island national systems, including to date:

- ✓ essential operational funding for rural health services
- ✓ provision of essential drugs and supplies
- ✓ improved budget planning and reporting in all provinces, strengthening rural health service planning and delivery
- ✓ better prediction of staffing needs and strategies to place more doctors in provincial hospitals

An essential element of the SWAp is the dialogue between the Solomon Islands Government and the Development Partners. This has led to more effective targeting of technical inputs and early work on improving the evidence and information base. Donor coordination has also improved. For example, the World Bank, with AusAID support, is working with the Solomon Island Ministry of Health and Medical Services to ensure HSSP financing is sound.

HSSP provides a firm basis for Australia increasing assistance in health in the Solomon Islands and holds great potential for enhancing the efficiency of resource use and achieving health outcomes. Sector support programs require consistent long-term support from all partners and AusAID, the Solomon Island Government and development partners will continue to develop and improve the SWAp as it matures. Key elements to the future success of HSSP will include:

- an overall financing strategy, sector budget and performance framework – and agreed reforms that drive efficiency and effectiveness
- a program of analytical work that creates a "virtuous cycle" – with better decision making leading to improved access and service quality
- operational planning and budgeting that supports the Ministry to implement and monitor progress – to improve system functioning and program implementation
- mechanisms that support the Ministry Executive to source and quality assure technical support (including form the UN) that meets their needs
- better collation and communication of results and achievements of HSSP against jointly agreed targets

Box 2 – Redevelopment of the Sector Wide Approach in Samoa

AusAID is working with the Government of Samoa to implement its Health Sector Plan (2008-2018) through the Health Sector Wide Approach (SWAp) - led by the Government of Samoa. Under the SWAp the Ministry of Health uses pooled donor funds to support implementation of the Health Sector Plan. The current focus is on: health promotion and prevention; enhancement of quality health care service delivery; and strengthening policy, monitoring and regulatory oversight of the health system.

Under the SWAp the majority of funds are pooled, aligned, and monitored, along with the Government's own contribution and sector budget. To date the SWAp has enabled:

- ✓ a platform for policy dialogue between Government of Samoa and donors
- ✓ completion and publication of Samoa's first Demographic and Health Survey
- ✓ the procurement of critical information technology, medical equipment, training and technical assistance and funding for a range of community level initiatives promoting activity and nutrition

However most of the anticipated capacity and efficiency benefits of the pooled funding arrangement are yet to be achieved. Although the pooled funds represent approximately 16% of health sector funding they are being used for one-off activities rather than being programmed to support well scoped and planned improvements to health system performance or health promotion strategies. Key constraints include:

- dialogue between the Government of Samoa (Ministries of Finance and Health and the National Health Service) is not at a point where the focus is on the overall allocations within the sector or the strategies for achieving better health outcomes
- no overall financing strategy or sector performance framework as yet
- discussions centred on specific expenditure and procurement decisions rather than whole of sector needs

A Health Redevelopment and Implementation Mission was undertaken in November 2010 which recommended the SWAp redevelopment include:

- encompassing the "whole of sector" expenditure program with all stakeholders in the sector including all development partners regardless of the specific financing arrangements
- more clearly identifying key results and outcomes informed by the health sector plan out of which implementable strategies and programs as well as performance measures would emerge
- options to revise and/or clarify the role of key institutions overseeing and supporting the SWAp
- defining and costing a capacity development program better aligned to sector agency Human Resource Plans
- ensuring there is enough flexibility in the program to cater for emerging health needs and opportunities to reprioritise and to forward plan.

All partners recognise that there is much work to do to improve the ability of the SWAp to lead to effective health outcomes for the people of Samoa. With the support of its partners, Samoa has established many important building blocks for a SWAp and is refining the design and implementation as lessons are learnt. Partners have recognised that a sound dialogue takes considerable preparation, effort and skill on all sides – as well as a shared understanding of the development objectives and context in which the SWAp will be operating. AusAID is addressing these issues through our Partnership for Development discussions as well as within the health sector dialogue.

Box 3 - Impressive Maternal Health Improvements in Nepal

Nepal has made consistent and dramatic improvements to maternal and child health over the period from 1996 to 2009. Maternal mortality, under 5 mortality and neonatal mortality rates have more than halved; the infant mortality rate has almost halved; total fertility and adolescent fertility rates are falling steadily; and the percentage of underweight children has reduced by some 20 per cent. A range of effective health policies, strategies, plans and programs has been introduced since 1991, culminating in the National Health Sector Program (NHSP) Implementation Plan II, 2010 – 2015, which will target the poor and excluded, seeking universal coverage. The NHSP will operate as a SWAp arrangement, aiming to reduce transaction costs, improve management capacity for health sector reform, better plan and coordinate technical assistance, and improve inter-sectoral coordination for such issues as nutrition, environment, potable water supply and sanitation. Efficiency gains and sustained success have been achieved through:

- ✓ Effective leadership
- ✓ Motivated and dedicated health workers
- ✓ Enhancing monitoring and evaluation capacity – including the capacity to collect and analyse relevant, disaggregated data
- ✓ Effectively managing human resource challenges
- ✓ Addressing geographic and social remoteness and marginalisation
- ✓ Integrating reproductive health services in a comprehensive manner
- ✓ Addressing general poverty and malnutrition
- ✓ Improving policy and procedures relating to procurement, financial management, governance, accountability, transparency and knowledge management
- ✓ Community participation, as well as engagement of the private and NGO sectors.

Source: Sharma, S. 2010. *Effective Policies and Coordination of Stakeholders at National Level in Improving Maternal Health*, Panel Discussion on "Accelerating Progress on MDG5: Trends and Lessons Learned from Countries" PowerPoint Presentation by Secretary of Nepal Ministry of Health and Population, UNICEF House, New York, 22 September.

2.2 Lessons from working with global and regional mechanisms

The health sector in the Pacific has many global and regional actors. The principal regional bodies are the Pacific Islands Forum (PIF) and the Secretariat of the Pacific Community (SPC), both of which have received their mandates directly from national governments.[11] In addition, several UN agencies are active in health in the region, notably the World Health Organization (WHO), Children's Fund (UNICEF) and Population Fund (UNFPA) along with global financing mechanisms such as the Global Fund for Fight AIDS, Tuberculosis and Malaria and training institutions such as the Fiji School of Medicine.

Care is needed in determining whether support is most appropriately provided bilaterally or by using regional, global or other multi-country mechanisms. A distinction needs to be made between health problems that are shared by multiple countries in the region (such as NCDs) and regional health problems, which are trans-boundary or those for which a regional solution is more appropriate than a national responses (e.g. emerging infectious diseases; workforce migration; regional provision of specialised clinical services or

[11] The PIF is the only forum that brings all country leaders together to discuss and agree on shared policies and actions, including on a range of development issues. The SPC is a multi-sectoral inter-governmental organisation addressing not only public health but also land, forestry, agricultural and marine resources, animal health and biosecurity, trade, human development and demography. SPC is also the principal recipient for the Global Fund in the Pacific, and partners with WHO in the Pacific Regional NCD Framework (funded jointly by AusAID and NZAID) and other public health initiatives.

medical training). By and large, the former are best addressed at a country level.[12] However, there has been an increasing trend since about 2003 towards using regional mechanisms to deliver health sector support, including through large in-country projects. This has perhaps been driven more by responses to the arrival of global funding instruments in the Pacific than to regional policy priorities; nevertheless it has challenged the historic role, mandate and capacity of regional organisations (which traditionally has mainly been to provide well-targeted technical assistance to support country capacity). Regional approaches can potentially offer greater efficiency, and they can be attractive to donors seeking a streamlined way to disburse funding for health issues that affect multiple countries. However, regional approaches also carry the risk of losing specificity at the country level and they may lack the flexibility to adapt fully to structural, population, geographic and governance differences between countries. Importantly too, smaller countries may require a completely different set of solutions to larger countries, or to countries that have established sector-wide mechanisms for engaging with their development partners.

There are particular circumstances in which regional or multi-country support can be effective, so long as it is appropriately matched to national government priorities. For example, regional approaches can[13]:

- provide economies of scale (especially for shared provision of services that cannot be viably provided by smaller countries), improving the quality, affordability and/or cost (e.g. HIV drugs);
- strengthen regional cohesion and bargaining power, including providing a forum for policy dialogue and a Pacific voice in international for a (e.g. regional representation on the Global Fund Board);
- address transboundary challenges (e.g. pandemics);
- enhance development outcomes – for instance by finding shared solutions to shared problems, aligning policies, developing common frameworks and approaches, benchmarking, considering and communicating lessons across countries and/or establishing mutual responsibility and accountability; and
- act as a catalyst for change in areas where national policy prevents direct local action.

2.3 Lessons from working as donor partners in health

Past health strategies and programs have tended to focus on disease-specific priorities and then to design and implement activities to address them.[14] Results from this approach

[12] For more detailed discussion of the issues, see for example the NCD program report: Lower, A. (2009) *Analysis of NCD Program Logic*, Report prepared for AusAID, 15 May.

[13] For more detailed discussion of Pacific regional issues, see *Australia's regional aid program to the Pacific: 2011-2015* (AusAID, December 2010).

[14] The Global Fund (HIV, tuberculosis and malaria), the NCD Framework and the Pacific Malaria Initiative are examples. For a broader discussion of the positive and negative effects of this type of funding and delivery,

have been mixed at best. It has often reflected donor and technical partner priorities rather than national ones, and offered 'one-size-fits-all' solutions; it has not been coherent or well coordinated; and it has often failed to address underlying systemic constraints. Some of the negative impacts can include unintended loss of efficiency, duplication and parallel systems at the country level; difficulty addressing cross-sectoral synergies; heavy training demands on key staff; and a lack of definitive plans to rotate key national personnel back to the country level after they have worked on disease-specific projects or with regional organisations. Large volumes of disease-specific funding have also had distortionary effects on the financing balance across the sector at country level.[15] Box 4 below provides an example of achievements and inefficiencies of a disease specific initiative in the Pacific.

Box 4 - The Pacific Malaria Initiative: Achievements and Lessons

The Pacific Malaria Initiative is a partnership between Australia and the Governments of the Solomon Islands and Vanuatu, to accelerate malaria control in both countries and progressively eliminate the disease from selected island provinces. The initiative has sustained and accelerated strong results through increased funding (bilateral and Global Fund) and improved national malaria action plans.

In Vanuatu and the Solomon Islands Australian support to the health sector is primarily through direct funding to the Ministries of Health, however the Pacific Malaria Initiative remains separate to the sector based approach and is very much a 'project' model. The result has been that implementation of the initiative has been "vertical" - with planning, funding and reporting managed within the Vector Borne Disease Units rather than the areas of the Ministry normally responsible for those functions.

An independent progress review of the initiative in mid 2010 confirmed the view within AusAID that funding decisions made for one disease had led to inefficiencies such as parallel health information systems and distortion of the allocation of resources for other priorities. The review recommended:

- continued Australian support for malaria efforts be carefully transitioned into existing sector based funding arrangements rather than continued in parallel, to reduce the opportunity cost to the rest of the sector.

Countries can make accelerated progress towards health targets with a systems strengthening approach. This happens when:

- ✓ there are high quality implementation strategies
- ✓ funding is allocated to the right functional areas of the Ministry
- ✓ detailed programming is through the government planning and budget system with appropriate technical assistance from the UN and other sources
- ✓ decision making is under the control of the Ministry Executive will can take a whole of sector view, and are ultimately accountable to Ministers for health sector performance.

The important results in reduction in malaria incidence and deaths in the Solomon Islands and Vanuatu have been largely a result of intensified effort towards malaria and improved quality and resourcing of national malaria action plans. To maintain these results in the long term, AusAID must apply the same rigour to supporting the overall health systems as have been given to systems established to support the malaria program. Therefore a transition to integrated sector based funding will require time and careful management.

see Foster, M. et al (2009) *Evaluation of Australian Aid to Health Service Delivery in PNG, Solomon Islands and Vanuatu*, Main Report, 27 January.

[15] See for example Negin, J. & Robinson, H.M. (2010) *Funding for HIV and Non-Communicable Diseases: Implications for Priority Setting in the Pacific Region*, Health Policy and Health Finance Knowledge Hub Working Paper Series, No. 1, Nossal Institute for Global Health, March, http://www.aihi.unimelb.edu.au/__data/assets/pdf_file/0004/331753/HPHF_hub_WP1.pdf.

External support may well be needed in perpetuity for some interventions in some countries. This can only be determined and appropriately structured through careful sector-wide analysis that identifies not only constraints, but also the strengths and opportunities that may exist.[16] These may vary across countries and may also be unique to particular countries.

Long-standing problems generally require long term commitments to long-term solutions. Aid funding that is predictable, of appropriate duration, and appropriately integrated with other available resources in a single budget will achieve better continuity and outcomes than volatile and parallel funding. Thus, broader delivery mechanisms such as recurrent cost financing and direct budget support need more active consideration. Support may be needed to reduce the risks associated with them.

Development assistance will never remove all of the underlying challenges that constrain health sector development in Pacific island countries. No amount of money or staff will make a resident cardiac surgery service viable in Tuvalu, or reduce the time taken to transport medicines to (or patients from) remote atolls in Kiribati. As external support represents only a minor portion of overall health support in many countries, it is important to learn from past experience. Failure to do so will increase the risk that little is left behind after external support ceases. Across the Pacific, donors and national governments should be working to build long term sustainable systems capable of delivering a basic package of high impact, cost effective and sustainable services - rather than gold standard state of the art systems. In the Pacific, long term external support may well be needed in some countries, yet all partners should be working to build national health systems capable of delivering universal coverage of an essential package of health services, because effective and equitable health systems are an absolute requirement for achieving better health outcomes. In a low-income country an Essential Health Package consists of a limited list of public health and clinical services which will be provided at primary and/or secondary care level. These packages include different interventions in different countries and aim to concentrate scarce resources on interventions which provide the best value for money. The table in Annex C provides a list of the global top ten best buy investments in health. Box 5 below outlines the need for external partners to work outside of a siloed project style approach and work with governments to build the capacity of national health systems.

[16] This is particularly relevant when selecting the most appropriate model of technical assistance.

Box 5 – External Support Needs to Help Build Health Systems

Immunisation is part of a basic package of health services, and is a useful indicator of whether a health system is capable of delivering basic services. In many countries in the Pacific, there is a long way to go to achieve satisfactory immunisation rates. Some Pacific countries are clearly not performing well, falling far below the 80 per cent global benchmark for children immunised against measles.

Partners have traditionally delivered immunisation in a project style approach, for example, through vertical vaccination campaigns. Such campaigns have achieved some good results in the Pacific, for example, an AusAID supported measles vaccination campaign in the Solomon Islands in 2009 increased immunisation coverage to over 90 per cent of children. However campaigns are a short-term solution and immunisation cannot be taken to scale nor results sustained without functioning health systems to ensure vaccines are procured and cold chain maintenance and trained health workers are in place to deliver routine immunisation.

Strong health systems are central to increased immunisation coverage and to ensuring vaccines reach Pacific children. AusAID has a key role to play in encouraging development partners to work with governments to strengthen health systems to ensure basic services are delivered effectively.

3. AUSTRALIA'S ROLE

The region has clearly identified its health policy priorities as being to accelerate progress on achieving the MDGs, with leaders jointly calling for intensified action at the most recent Pacific Islands Forum meeting.[17] As an external development partner, Australia must focus its support on helping countries optimise their performance by equipping them to function better within their constraints.

Australia's role as a development partner is not to specify the health service or disease-based priorities of a particular country – those are primarily for national assessment, judgement and decision. Rather, it is to assess continuously and strengthen the evidence base for such decisions, to understand and respond to the diverse institutional contexts and challenges that foster or constrain health development in each country, and to avoid creating incentives for countries to pursue less efficient models and approaches. Further, as a major health development partner in the region, AusAID has a key role to play in encouraging other partners – multilateral, regional and bilateral – also to explore and pursue more effective development strategies. Box 6 below outlines the need to engage agencies such as the UN more effectively in the Pacific.

[17] Pacific Islands Forum (2010) *Port Vila Declaration on Accelerating Progress on the Achievement of the Millennium Development Goals*, Forum Communiqué, Annex 1, 41st Pacific Islands Forum, Port Vila, Vanuatu, 4-5 August.

Box 6 – Better Health Outcomes Through More Strategic Engagement of Partners

As a donor, AusAID has a responsibility to ensure the effectiveness of our partners such as SPC and UN agencies (at global, regional and country levels) for progress on health outcomes in the Pacific, and to ensure value for money from our investments. AusAID is the largest donor in the Pacific and supports UN agencies such as the United Nations Population Fund (UNFPA), the World Health organization (WHO) and the United Nations Children's Fund (UNICEF) through core funding and earmarked projects. In his address to the 65th United Nations General Assembly, the Australian Minister for Foreign Affairs, the honourable Kevin Rudd said " we need to summon the political will to make the UN work" - and SPC and the UN are signatories to the Cairns Compact.

AusAID also funds the two global health financing mechanisms – the Global Fund and GAVI - and sits on the Board of those organisations. We have committed to ensuring the grant funding arrangements support country efforts to improve service delivery and health outcomes. AusAID has a keen interest in ensuring agencies work with countries to strengthen health policies, planning, budgeting, and analysis, as well as to improve their own efforts in capacity building and coordination.

Maternal and child health is a priority area where the UN can work together to ensure improved maternal and child health outcomes. Rather than a regional MNCH program AusAID is encouraging the UN to work better together and use their core resources more effectively at the country level. There has been some success with this approach in South Asia and Africa. In 2008, UNFPA, WHO, UNICEF and the World Bank came together and agreed to support country led processes and national ownership in a more strategic way and coordinate their various funding mechanisms. Known as the H4 (or H4+ including UNAIDS), these agencies focus on improving family planning, adolescent sexual and reproductive health, delivery care and newborn health. The H4 approach has been used in several countries to date, including Pakistan and Bangladesh, where UN teams are more effectively delivering a coordinated maternal and newborn child health program. In these countries donors have noted that this united approach helps bring out the added value of the UN and has a positive influence on the national government's policy and health sector planning and budgeting cycles.

The ultimate health goal for countries is to achieve better health outcomes for their citizens. In support of this, **Australia's long-term aim is to support the development of countries' capacity** such that they are able to run their own health systems and are equipped to 'commission' external assistance in areas of greatest need. To do this well, countries (and their development partners) need objective analysis; policy coherence across sectors; central agencies that are active, robust and constructive; and responsive regional agencies and technical support mechanisms. At present the shared health priorities in the region are focused on the health MDGs, as highlighted by Pacific Island leaders in the *Port Vila Declaration* (footnote 19). Australia responded immediately to the Declaration's call for action by committing to provide $85 million over four years in support of the health MDGs (reduce child mortality, improve maternal health and combat HIV, malaria and other diseases). Other key policy influences on Australia's health sector support in the Pacific are summarised in Annex D.

The Pacific Partnerships for Development[18] are indicative of Australia's approach to its aid relationships – an approach driven by engagement rather than by specific activity. Australia's future aid relationships in support of the health sector will shift the focus of engagement to consider issues of policy first, and then support technical and managerial needs within that context. This will include consideration of issues outside the health sector,

[18] The Pacific Partnerships for Development are available at: http://www.ausaid.gov.au/country/partnership.cfm

such as budget planning and execution, matching of program priorities and resource allocation, quality and integrity of procurement services, and independence of accountability mechanisms. In this regard, there are several effective tools already available. For example, most Pacific island countries participate in the Public Expenditure and Financial Accountability (PEFA) process, which assesses public financial management against a framework of internationally accepted indicators; the multilateral development banks conduct periodic public expenditure reviews, both nationally and for specific public sector functions, as well as national procurement assessments; and countries themselves are likely to have medium term development strategies, medium term expenditure frameworks, and sector plans. In all these processes, AusAID can and should participate actively; their results should inform priorities and decisions within the health sector.

Australia's vision is for more responsive and less prescriptive aid that can be used by countries and regional organisations wherever and at whatever pace is needed. This should be achievable with deeper engagement, objective analysis, effective governance and mutual accountability. It should also help eliminate the focus on weaknesses and gaps that historically has pervaded aid planning and delivery, an approach that is known to discourage local ownership and leadership and to foster aid dependency.

Countries must ultimately be in control of health service delivery, but the pace, extent, and processes of getting should be tailored to individual country circumstances. In the past, Australia used to do things 'for' countries. Increasingly, we are working with countries to do things. Ultimately, our aim is to focus more on supporting the things that countries are doing for themselves. All three of these approaches are underpinned by partnership principles and can coexist. The strategic issue for countries and their development partners is of changing balance rather than migration from one approach to another. Presumably, as primary and preventive services improve over time, countries will have less need for external support to 'fix' specific health problems. As capacity and governance improve:

- Countries will individually and collectively become better able to manage their relationships with external development partners and more selective in seeking external support in areas where they lack capacity;

- There will be greater scope to develop effective 'within-region' solutions, such as home-grown networks or arrangements enabling larger countries to assist smaller countries;

- The scope of support related to doing things 'for' countries is likely to contract back to higher-end secondary and tertiary care (visiting services, off-shore referral, telemedicine, etc) in areas that require specialised services that are neither feasible nor affordable for the country to provide; and

- Australia's focus will gradually shift from service support towards recurrent funding and budget support[19], provided directly or through arrangements such as SWAps. The pace at which this transition occurs will depend on the quality of policy dialogue and performance monitoring and the practical extent to which all partners embrace mutual accountability.

4. WHAT THIS MEANS FOR AUSTRALIAN HEALTH SUPPORT

This section is intended to provide staff with guidance on some of the key issues to consider when preparing delivery strategies and monitoring programs of support.

4.1 Strengthening health systems

This is a key area where Australia can assist Pacific island countries**.** National and community level systems need to be strong, resilient and affordable so that they (not donors) can deliver health services where and when they are needed. Most Pacific island countries need support within government, but also in strengthening its links with central agencies, civil society, other sectors and other stakeholders. All aspects of the system need to function well and in concert to achieve improved health outcomes. Key elements of a strong health system include[20]:

1. **Effective leadership and governance** – In most countries, this comes from government, but in very fragile states, it may need to come from external partners. There is no blueprint for success, but key components of effective leadership and governance include well-defined policy guidance; effective regulation, oversight and information; collaboration and coalition building; system design; and accountability.

2. **The delivery of safe, effective, quality health care services** to individuals and to the population as a whole, when and where needed, and with minimum waste. The package of services must be based on a picture of population health needs and feasible in terms of available resources (so is likely to be quite basic in fragile states). It must also address barriers to access (e.g., cultural, social, financial or gender-related) and to the equitable expansion of services. Providing affordable health care also helps to avoid 'out-of-pocket' fees that push people into poverty.

3. **Adequate financing that is accessible to all**. A good health financing system will promote treatment according to need and will encourage providers to offer an effective mix of curative and preventive services. WHO advises that achieving this involves (a) collecting revenues (from households, companies or external agencies); (b) pooling pre-

[19] This should be assessed regularly by examining, for example, the operation of procurement systems; the quality of medium term expenditure frameworks and the extent to which they are reflected in practical operations; and the results of objective assessments such as PEFA reports, public expenditure reviews, etc.

[20] This information derives from the WHO's 'building blocks' framework for describing health systems. another frequently cited way of describing the key components of health systems is the World Bank's 'control knobs' approach. The website http://www.who.int/healthsystems/topics/en/ includes links to a range of in-depth research and analysis on each of these issues, including guidance on the issues to consider in different types of countries, as well as on successful and experimental approaches.

paid revenues in ways that allow risks to be shared; and (c) purchasing services. It is the interaction between these three functions that determines the effectiveness, efficiency and equity of health financing systems. Pooling funds (such as through SWAps and multi-donor trust funds) can be an important mechanism for ensuring a country's sources of health sector funding are not fragmented, that the costing of health services is based on reliable information, and that health sector financing is managed efficiently.

4. **An appropriately trained, well performing and appropriated distributed health workforce**, including health service providers and health management and support workers in both the private and public sector. An ideal workforce will have sufficient staff and they will be competent, fairly distributed, responsive and productive. This element of health system strengthening will receive particular attention within the Australian aid program because there is a tendency in any concerted effort to increase health services to overlook limitations in the health workforce, or to address short-term needs only. In terms of priorities:

   - Governments and donors alike must prioritise structural HRH support if they are to improve health outcomes. This support needs to be built on stakeholder engagement, including across sectors and through to communities, and it needs to build planning, monitoring and change management capacity so that HRH constraints on effective service delivery can be identified and addressed.

   - Where the overall health workforce is relatively small, more effective development of community health workers is needed. The skills of nurses and other allied health professionals also need broadening into advanced practice roles, so that they can act as main coordinators of care and be clinical specialists in settings where few or no doctors are available. This may require legislative and regulatory change.

   - Effective management and supervision of staff is critical if overall improvements in the responsiveness, productivity and performance of HRH are to be sustained. Management development, including training in basic HRH components (recruitment, performance appraisal, etc) is a priority for many Pacific island countries.

5. **The production, analysis, dissemination and use of reliable and timely information** on health determinants, health system performance and health status. This is integral to effective leadership and governance and requires the development of health information and surveillance systems[21] as well as standardised tools and instruments, and the collation and publication of national and international health statistics. This is an area of particular weakness in the Pacific, constraining national and regional capacity to identify optimal solutions to health sector challenges.

6. **Equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-**

[21] In this regard, note that surveys pose significant methodological and logistical challenges, and results can be contentious. Nevertheless, they often provide the best available source of data in fragile states.

effective use. WHO advises that this requires: national policies, standards, guidelines and regulations; information on prices, international trade agreements and capacity to set and negotiate prices; reliable manufacturing practices and quality assessment of priority products; procurement, supply, storage and distribution systems that minimise leakage and other waste; and support for rational use of essential medicines, commodities and equipment, through guidelines and strategies that assure adherence, reduce resistance and maximise patient safety and training.

In the context of these six elements of an effective health system, Australia's aid program strategies and support must incorporate (or justify not doing so) the following guidance:

- *Continued emphasis on bilateral assistance*, with countries increasingly leading and guiding where and how that assistance is delivered, and with support to build the capacity of those not yet equipped to make evidence-based choices and decisions.

- *Robust analysis* – preferably undertaken jointly – will provide confidence that the most efficient and effective solutions to country problems are identified and implemented, and that performance and change can be assessed in relation to appropriate baselines, desired outcomes and learning. Improved data on the health workforce are also required.[22] At present there is little investment in research at country level in the Pacific.

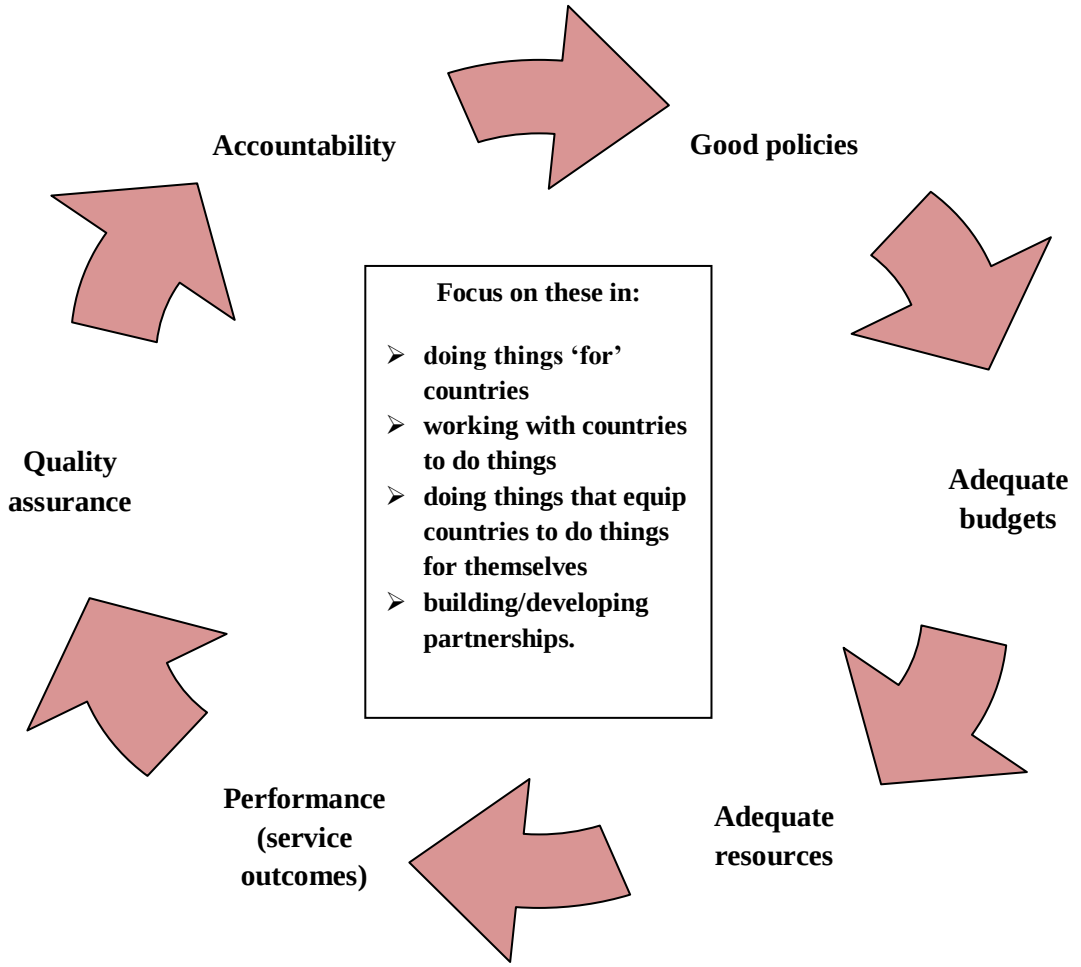
- *Greater predictability of aid flows*, especially longer term support for financial and human resource planning and management. This will require flexible, responsive, programmatic approaches to aid delivery built on policy dialogue.

- *Adopting a cross–sectoral focus*, to understand the health consequences of activities in other sectors and also to recognise the effects that health activities can have on development of other sectors.

- *More direct focus on 'generic' issues of public administration* as well as health-specific priorities in all interactions with a partner government (Diagram 1 refers), since these also have significant influence on health sector capacity and performance.

[22] This is best achieved through the development of HRH components in broader management information systems.

Diagram 1: Public processes supporting improved health service delivery



- *Improving and streamlining monitoring and evaluation*, by aligning with and using national systems (e.g., national health accounts, country health information systems) and by choosing only a limited number of indicators that really matter – indicators that focus on aid effectiveness. Annex E provides 40 WHO indicators that could be considered.[23]

- *Ensuring that disease-specific funding to which AusAID contributes is used to strengthen health systems and does not distort health sector financing*.

- *Conducting effective partnerships* with national and sub-national levels of government, with non-government stakeholders and with other external development partners.

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[23] Annex D lists 40 indicators identified by WHO, which are discussed further in WHO (2010) *Guidance for Monitoring and Evaluation of National Health Strategies*, Draft 5, 6 October. See also WHO (2010) *Monitoring and Evaluation of Health Systems Strengthening: An Operational Framework*, Geneva, October. Available at http://www.who.int/healthinfo/HSS_MandEframework_Oct_2010.pdf; and AusAID Health Resource Facility (2010) *Performance Monitoring*, PowerPoint Presentation by Andrea Neale to Pacific Health Workshop, 19 October.

- *Harmonising technical cooperation* and helping improve HRH planning capacity so that future planning is flexible and responsive to overall health systems requirements – planning for change rather than planning for 'more of the same'.

4.2 Building partnerships that focus on results

Leadership must rest with the countries themselves, so that changes can become embedded in local systems. This will also help encourage greater focus on strengths rather than on weaknesses and gaps. AusAID must resist the temptation to establish parallel mechanisms to manage its assistance or to micromanage monitoring processes. These may deliver short term results and reduce risks but, ultimately, they will create a more cluttered, inefficient operating environment with less sustainable longer-term outcomes.

The key to success lies in linking resources to results. This requires bringing all health sector resources together, ideally under one plan, within a single budget and with a single performance assessment framework.[24] Focusing on the health sector in its entirety, including its enabling environment, provides the most likely means of achieving ownership. Governments and their development partners should consistently and jointly examine all available resources, not just their own contribution, to ensure services do in fact reach the most vulnerable. The extent to which this is possible depends on whether countries have quality sector plans in place, supported by broader budgeting, human resource planning and other central agency processes.

These are all factors AusAID will need to assess and help strengthen if necessary, with a view to being able to support the whole range of activities under a sector budget, including recurrent expenditure. Program-based approaches are intended in part to facilitate local ownership but, in most cases in the Pacific, they are not operating as they should. They are still often donor-driven and therefore at risk of becoming marginalised and unsustained over time. More effort is needed to develop simple program approaches suitable for smaller countries, as well as to make SWAps work well.

Engagement is crucial to understanding the challenges each country is facing, identifying shared development objectives, and establishing meaningful partnerships to achieve improved health outcomes. The *Pacific Partnerships for Development*, with their emphasis on mutual accountability for tangible development results, provide a basis for deeper and more robust engagement than has occurred in the past.[25] Their real value will come from the practical efforts of both country partners and AusAID to engage regularly in dialogue and joint analysis, to identify and support performance incentives jointly, to track performance relative to shared development objectives, and to hold each other accountable for ensuring

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[24] National government spending makes up the vast bulk of total funding available for health. Donor and other financing usually accounts for no more than 20%, although this is highly variable between countries and from one year to the next, especially for countries that are heavily dependent on aid or remittance flows. Fragile and post-conflict states also tend to be more heavily dependent on donor funding.

[25] Partnerships are now in place with seven countries and five of these – Nauru, Samoa, Solomon Islands, Tonga, and Vanuatu – prioritise health sector development.

funding and activity lead to improved health outcomes. At the highest level, this will be driven by the annual Partnership talks and associated reviews of progress against the Partnership implementation schedules. However, the quality of that analysis and engagement will depend on day-to-day efforts by both the government and AusAID to consider and address all of the issues highlighted in Diagram 1 and to draw in central agencies (especially Finance, Treasury and the Public Service Commission or equivalent), relevant line agencies (covering issues such as education, environment, women, youth, water and sanitation, housing and agriculture) and other stakeholders at sub-national and community levels.

Building effective partnerships requires substantial time and resources. The process of deepening engagement, fostering local ownership and leadership, and gathering quality information for analysis may be labour-intensive, especially in countries where public sector systems are weak. However, there should be significant gains in efficiency and effectiveness over time, as AusAID becomes increasingly comfortable about integrating its development support with partner government resources.

Harmonisation and alignment principles will underpin Australia's partnerships. The extent to which alignment with country priorities, systems and procedures is feasible in any particular country will depend on the quality of the partnership.[26] In relation to harmonisation, AusAID will continue to pursue all opportunities to contribute and draw on comparative advantages, ensuring different stakeholders complement each other and harness each others' expertise.[27] In all circumstances, AusAID's core objectives will be to (a) streamline processes and requirements; (b) minimise the transaction costs and other strains placed on weak government systems; and (c) maximise the results of different sources of funding – including those from non-traditional donors.

4.3 Maximising the benefits from regional resources

Excluding the cross-cutting multi-sectoral meetings that are relevant to health and often include a standing health- or HIV-related item on their agenda, regionalism in the health sector in the Pacific currently takes the form of more than 60 different regional mechanisms,

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[26] For example, the nature of Fiji's intergovernmental relations would preclude alignment with government systems at present, but there may well be opportunities to align with non-government systems given its more developed private sector and the higher level of sophistication of its primary, secondary and tertiary care.

[27] This could range from using each others' research and analysis through to accepting their leadership of programs or activities, or delegated cooperation, as already operates in New Zealand's management of Australia's aid program in Cook Islands and Niue. Australia and New Zealand have also entered into a Partnership Agreement in support of the *Cairns Compact on Strengthening Development Coordination*. The Agreement commits both countries to a shared vision, a common strategic direction, agreed principles and, most importantly, practical action to integrate efforts through expanded joint sector programs, combined assessments and monitoring work; and delegated delivery of assistance to each other. A less formal, working level example in the health sector is the *Pacific Health Quintilateral Meeting*, which brings together AusAID, NZAID, SPC, WHO's Western Pacific Regional Office, and the World Bank to (a) develop a shared understanding of the health issues and challenges in the Pacific region; (b) identify options for improving aid effectiveness in health in the region; (c) define roles and division of labour among agencies; and (d) agree a process and actions for moving towards improved effectiveness of development assistance to health.

including governance mechanisms such as the PIF, activity delivery mechanisms (often with their own governance bodies), coordination mechanisms, and regional professional networks and associations that have arisen organically, usually around the clinical interests of key groups of individuals. These regional health mechanisms cover a wide variety of technical emphases, geographic focus, mandates (often mixed mandates) and purposes. Annex F provides a snapshot of the main organisations and networks.

The proliferation of regional mechanisms has added to workloads and led to overlap and inefficiency. Questions about effectiveness and inclusiveness are now also being raised, and there is concern about the substantial time and cost impact on health ministries, with some staff spending more than 25 per cent of their time out of the office for regional commitments. Within this context, Australia's priorities as a major funder of regional programs are as follows.

Regional mechanisms must be responsive to national priorities. Australia could play a useful role in helping equip Pacific island countries to manage and demand more from their relationships with regional bodies, by encouraging them to take greater ownership through their membership; and/or by supporting them to become more active and influential as smart, informed 'consumers' of regional organisations' services. This will help ensure the work of regional mechanisms complements the work being done at national level and enhances national capacities.

Greater coherence is needed across the regional mechanisms engaged in the health sector. There is currently no single body that adequately provides Pacific island countries with a collective voice in relation to health sector issues. Of the existing mechanisms, the Meeting of Ministers of Health for the Pacific Islands offers the best prospects for addressing shared health policy and management interests and for making joint decisions or recommendations, but it is not currently set up to do this. It, or any new mechanism, would need effective vertical links (with the Pacific Islands Forum) on collective priorities, as well as horizontal links with regional networks and program-specific governance mechanisms. Australia could play a useful role in encouraging the development of a more relevant, effective model that addresses the policy links and provides an avenue for decision-making and accountability.

Regional organisations must focus on issues that are genuinely relevant to regional cooperation, integration and shared concern. Australia and other donors have themselves been guilty of allowing the focus of regional organisations to shift over the past 5-10 years, by using them to deliver support that addresses primarily national issues or by allowing them to deliver support for issues that lie beyond their traditional mandates, strengths or expertise, simply because they offer an existing and convenient means of disbursing funds. Global and regional organisations should have clear mandates in the region and in individual countries, be appropriately streamlined and well-coordinated, and be valued by country stakeholders.

Through their periodic quintilateral meetings, AusAID and other development partners are seeking to bring clarity to how they address these issues and jointly identify ways to help

regional mechanisms strengthen their coherence. To do this, the quintilateral forum needs to be connected with in-country development partner coordination groups.

Looking forward, Australia will work to strengthen and streamline regional mechanisms and ensure their mandates in health complement each other. This requires:

- clarifying where regional and global organisations and programs best add value;
- supporting regional organisations to act on their strengths and mandates – and not distracting them from those;
- ensuring regional organisations are funded predictably and in ways that enhance their responsiveness;
- encouraging a restructuring of the regional architecture to support clear, streamlined channels and mechanisms for decision-making and accountability, and processes that allow different countries to embrace different initiatives at different times (rather than seeking region-wide consensus, for example); and
- establishing smooth and workable links between regional and in-country meetings of development partners, including through timely and concise reporting between AusAID Canberra, the Suva regional hub, and country offices throughout the region.

4.4 Resourcing ourselves

Successful implementation of this guidance for future AusAID health sector support will involve doing business differently in many respects, especially in relation to how we engage, the sorts of issues we engage on and monitor, how we build and manage partnerships, and how we shift to and manage sector-wide program support. The in-country capacity of AusAID staff to conduct dialogue effectively at different levels (but especially for policy dialogue and sub-national engagement) will need to be strengthened and supported from Canberra and from the regional hub in Suva. Likewise, we need to bring further coherence to discussions around the *Pacific Partnerships for Development*, so that they:

- take account of regional and global factors as well as bilateral factors;
- consider relevant influences beyond the development relationship; and
- establish complementary links between whole-of-government, sector, local and activity levels on setting priorities and on assessing progress.

For both in-country and Canberra-based staff, these priorities will require new and/or strengthened skills. A regular program of in-house development was established during 2010-11, involving office-based and regional workshops, as well as access to responsive advisory and mentoring services. A major agency-wide as well as health-specific workforce planning effort is underway to define the needs of the AusAID workforce and professional development pathways, including in health.

In order to support dialogue and ensure engagement at different levels is appropriate, AusAID will establish a dedicated Pacific Health Adviser position in Canberra. This position will provide AusAID staff in the region (as well as in Canberra) with relevant, timely and strategic technical advice to help guide policy dialogue with partner countries and organisations, and provide AusAID staff with opportunities for capacity development.

5. FURTHER READING

AusAID (2010) *Maternal and Neonatal Health: Key Issues and Priorities for AusAID*, Internal Draft, May. Available by contacting AusAID's Human Development Section, Pacific Division or Health and HIV Thematic Group.

AusAID (2009) *Intensifying the Response: Halting the Spread of HIV – Australia's International Development Strategy for HIV*, Canberra. Available from http://www.ausaid.gov.au/keyaid/hivaids/default.cfm.

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Pavanello, S. (2008) *Improving the Provision of Basic Services for the Poor in Fragile Environments: Health Sector International Literature Review*, Prepared for Office of Development Effectiveness, AusAID, by Humanitarian Policy Group, Overseas Development Institute, London, December. Available from http://www.ode.ausaid.gov.au/publications/pdf/health_sector.pdf.

6. ANNEXES

Annex A: The Pacific – A Picture of Health?

Unless otherwise specified, the figures used in this annex derive from AusAID (2009) Tracking Development and Governance in the Pacific, August, www.ausaid.gov.au/publications.

Non-communicable diseases NCDs and their complications are now considered the leading causes of death in at least eight Pacific island countries, and their prevalence is growing, despite a significant proportion being preventable. Across the region, NCDs are now responsible for more than three of every four deaths, yet the bulk of health funding (government and donor) continues to be oriented towards HIV, malaria and other emerging or re-emerging infectious diseases. It will take many years for primary prevention to yield results in terms of improved health outcomes, so such efforts must commence or be increased urgently to prevent enormous down-stream costs. In the meantime, secondary prevention of NCDs (i.e., appropriate and affordable clinical management of those with established disease, to prevent or delay the onset of complications) is extremely important. This has potentially huge public health implications.

Maternal and Child Health indicators for the Pacific show variable improvement between 1990 and 2000 but have begun to plateau in many countries since 2000. Women continue to die of preventable and treatable complications in pregnancy and childbirth, often because of delays in receiving required care.[28] Lack of regular antenatal care is also a contributing factor. In some countries, such as Fiji and Kiribati, maternal mortality rates have increased in recent years, raising questions about over the quality of service delivery. Most of the child deaths in the Pacific occur at less than one year old[29] and the most common causes of child mortality – diarrhoeal disease and pneumonia – are also preventable and treatable. In many countries[30], child mortality rates have not improved since 2000. In some cases, they have in fact deteriorated (Fiji, Tonga and Tuvalu).

Women's health is crucial, not only to the women themselves, but to the health of their children and families and to the strength of the health system overall. The importance of women's multiple contributions to society is now well recognised – through their productive and reproductive roles, as consumers and as providers of health care. Investing in the health of women and girls means investing in future generations as well as in the health of society

[28] The 2004 *Pacific Islands Regional Millennium Development Report* prepared by SPC and UNDP reports a high correlation in the Pacific between mortality rates and delays in receiving required care. Indeed, ODE (2008) findings for the broader Asia-Pacific region suggest that more than 80% of the variation in maternal mortality ratios is explained by whether skilled health personnel were in attendance.

[29] In Nauru, Samoa, Tonga, Tuvalu and Vanuatu, infant deaths account for more than 80 per cent of total child deaths.

[30] Cook Islands, Fiji, Kiribati, Marshall Islands, Palau, Samoa, Tonga and Tuvalu.

today.[31] In the Pacific, limited progress in reducing the risk of death or disability from causes related to pregnancy and childbirth, along with the existence of high teenage fertility rates and gender based violence, confirm there is need for more concerted effort to improve women's health, especially maternal health and sexual and reproductive health. Improved health outcomes depend also on addressing several, cross-sectoral issues that affect women's health, notably the education of women and girls, the elimination of gender-based inequalities in income and employment, and the prevention of gender-based violence.

Infectious diseases are no longer causing death in large numbers in the Pacific, thanks to immunisation programs and improved living conditions. Nevertheless:

- *Tuberculosis* (TB) rates range from around 20 cases per 100,000 people in Cook Islands, Samoa, Tonga and Fiji to in excess of 400 in Kiribati and Tuvalu. In FSM, multi-drug resistant TB accounted for more than 10% of all newly diagnosed cases in 2008. TB/HIV co-infections and TB/diabetes links are emerging as major challenges.

- Some countries, such as Fiji, Samoa and Tuvalu are showing alarming rates of *sexually transmitted infections* (STIs) and, although current levels of *HIV infection* are low across the Pacific, all countries are at significant risk of a worsening epidemic because of the existence of multiple risk factors. Of key concern in this region are the lack of empowerment of women; sex among young people from early ages; rates of teenage pregnancy that indicate high levels of unprotected sex; young populations with limited knowledge of HIV; highly mobile populations; and cultural influences that discourage open discussion of sex.

- *Vector-borne diseases* affect many Pacific island countries. Malaria remains a major cause of morbidity in Solomon Islands and Vanuatu.[32] With support from Australia, the Global Fund and WHO, both countries have made considerable progress over the past five years in rebuilding the reach and effectiveness of their malaria control programs. Prior to this however, earlier gains had rapidly been lost in a short period during which there was no external support. This experience raises serious concerns for both the countries and their donor partners – about how quickly development gains can be unravelled when aid-funded activities are not embedded in local systems; and about expensive single-disease programs and how to balance those investments with the rest of the health sector. Dengue fever is a growing challenge for many Pacific island countries now, mainly as a result of increasing urbanisation and greater population movement. Outbreaks of *leptospirosis* also

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[31] For example, maintaining good maternal nutrition during pregnancy and avoidance of gestational diabetes greatly reduce the chances of the baby being born with an inherited predisposition to diabetes, renal failure and other NCDs. See WHO (2009) *Women and Health: Today's Evidence, Tomorrow's Agenda*, available through http://whqlibdoc.who.int/publications/2009/9789241563857_eng.pdf.

[32] The highest incidence of malaria in the world outside Africa is in Solomon Islands. Vanuatu has the next highest reported incidence in the Asia-Pacific region (Pattison, B. (2006) *Background Paper on (i) Malaria in Solomon Islands and Vanuatu, and (ii) Australian and Regional Research Programs and Technical Resources in Malaria*, August).

occur in many countries, especially after flooding of low-lying peri-urban areas during the wet season. Endemic pockets of *lymphatic filariasis* persist in several countries.

- *Emerging infectious diseases* (EIDs) pose a significant threat to small and vulnerable countries, such as those with human and animal health systems that are inadequately developed to detect and respond to EIDs in a timely manner; those with air and sea connections to Asia; and/or those with mobile populations visiting Pacific Rim countries (e.g., for work, sport or family reasons), where EIDs are more likely to originate or be amplified. The risks associated with pandemic influenza, including the current influenza A (H1N1) strain, are taken very seriously in the Pacific, where the decimation of small island populations by the "Spanish Flu" pandemic of 1918-19 is still strong in Pacific folk lore;[33] measles has a similar history in Fiji.[34]

- Deaths due to *diarrhoeal diseases* remain unacceptably high as they are preventable through simple, low-cost interventions. For instance, many infant deaths can be prevented though exclusive breastfeeding practices. Globally, WHO estimates attribute 88% of diarrhoeal disease to unsafe water supply, inadequate sanitation and hygiene, and typhoid remains present in many Pacific island countries. Several Pacific island countries are on track to halve the proportion of households without access to safe water supply and improved sanitation[35], while some countries, including Kiribati, Solomon Islands and Tuvalu, are not. In all Pacific island countries, large disparities persist in the presence of disease and in the availability of treatment between urban and rural populations.

Clinical services remain a key challenge in such small countries, even though the primary focus of effort in the health sector must be primary prevention if we are to improve health outcomes in these countries. Australia has been supporting a range of clinical services in the region for decades now, helping governments to ensure that people suffering from complications of established disease or health emergency receive good standards of care and treatment. The extent to which such services could ever be sustained locally is quite limited but, to the extent such outcomes are possible, they depend on focusing support for clinical services on the broader systems and on skills transfer.

Climate change and health – In the Pacific, rising temperatures, changes in rainfall, rises in sea level and more frequent, intense tropical cyclones and storm surges are expected to lead

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[33] The influenza A pandemic of 1918-19 reached the Pacific in 1919 from New Zealand, which had been slow to prevent ships carrying infected individuals from leaving its ports. The impact was greatest in the then territory of Western Samoa, where an estimated 90% of the population was infected; 30% of adult males, 22% of adult females and 10% of children died. In Tonga, 8% of the population was infected, in Nauru 16% and in Fiji 5%. Twenty-two percent of deaths in Samoa occurred in only a two-week period, and 14% of deaths in Fiji within a similar time. In contrast, strict quarantine measures and, at times, enforced naval blockade ensured that few cases occurred in American Samoa or New Caledonia; neither territory recorded any fatalities. (Rice G. *Black November; the 1918 Influenza Pandemic in New Zealand*. University of Canterbury Press, 2005).

[34] In Fiji, a measles epidemic in 1875 is estimated to have killed 40,000 of the then population of 150,000; the highest case fatality rates were among indigenous Fijians. (Morens, D.M. Measles in Fiji, 1875: thoughts on the history of emerging infectious diseases. *Pacific Health Dialogue*, 1998; 5: 119-128).

[35] Cook Islands, Fiji, Niue, Palau, Samoa and Tonga.

to increased flooding of coastal areas, reduced fishery and reef resources, and local water scarcities. This is likely to result in contamination of air, water and food, increasing the incidence of diarrhoea and respiratory infections (already major killers of children under five), further threatening maternal health; and increasing the prevalence of vector-borne diseases. Many consumer staples in the Pacific are imported, and rising food production costs globally are likely to impact on food security (especially for the poor).[36] Projected population displacement and internal migration will place pressure on resources for shelter and human habitation.

Other health issues – Finally, it is important to note that there are many significant causes of ill-health that do not attract much donor funding, but which are country priorities as they are significant causes of disability or death. These include, for example, acute respiratory infections in children; rheumatic fever; nutrition; childhood malnutrition; injury, including as a result of domestic violence; mental health; and disability.

[36] For further information, see Food Secure Pacific Working Group (2010) *Towards a Food Secure Pacific: Framework for Action on Food Security in the Pacific*, June. Available through http://www.foodsecurepacific.org.

Annex B: The Sector-Wide Approach - Background Notes

The following information has been summarised from literature reporting on case studies of experience working with SWAps, including in particular in the health sector.

Definition – The sector-wide approach (SWAp) is a process in which all funding for the sector (internal and external) supports a single policy and expenditure program, under government leadership; and all partners adopt common approaches across the sector.

The sector-wide approach is a way of working. It is an organising principle, not a blueprint; a means, not an end.

The sector-wide approach is not simply a question of recipient demand and donor supply. It implies a partnership that involves simultaneous deployment of different aid modalities.

Goal – To increase the impact of aid by improving its quality and effectiveness.

Key features & benefits

SWAps have made the most progress in sectors where the partner country government is a major service provider and government responsibilities are managed by a single sector ministry.

Where SWAps are appropriate, they can help to promote greater local involvement, accountability and capacity in partner countries.

Feature	Benefits
Inclusiveness – Design and implementation are based on broad stakeholder consultation	➢ Local ownership ➢ More relevant targeting ➢ Broad-based approach ➢ Regular dialogue ➢ Improved prospects for sustainability
Local ownership and leadership – The Ministry has the explicit mandate for leadership of the SWAp	➢ National ownership strengthens ➢ Sector coordination is improved
Partnership – between donors and government, and among donors	➢ There is regular, joint dialogue on policy and its implementation ➢ Duplication is reduced or eliminated ➢ Transaction costs for the country are reduced
Coherence – around a single sector policy and plan	➢ Serious attention is paid to sector planning, financial management, and improved information systems ➢ District level management capacity is often strengthened, within existing decentralisation policies ➢ Equity of service delivery improves

Feature	Benefits
Single budget – Government and donor funds are combined in a single budget and are only used to support activities in the national sector plan	➢ Recurrent expenditure needs are met
Multi-year perspective – including long term commitments by donors for funding to achieve jointly agreed outcomes	➢ Predictability of sector planning and financing is improved
Institutional capacity – all aspects are strengthened at all levels, including all resources (financial, human, material, etc) and all functions, from policy formulation to implementation and monitoring	➢ Sector management is strengthened through the development or adaptation of management tools, combined with strengthening of implementation capacity ➢ Cross-sector relationships, and those with central agencies, are strengthened ➢ Solutions to cross-sector and cross-cutting issues are supported
Streamlining – Donors are responsible for synchronising their processes (planning, monitoring, review) with those of the partner government	➢ Recurrent expenditure needs are met ➢ Sector management is strengthened ➢ Transaction costs for the country are reduced
Results focus – Sector monitoring and evaluation become institutionalised	➢ Progress and performance are reviewed jointly and systematically ➢ Donor conditions are more relevant to country priorities

Constraints to success

SWAps are not possible in all cases: certain preconditions in the macroeconomic, policy and institutional environment are necessary.

There are several factors to be aware of that may constrain or prevent progress within a SWAp. These include, for example:

- Limited government capacity
- Poor relationship with Ministry of Finance equivalent
- Limited Ministry leverage to secure funds
- Low priority of cross-sectoral collaboration
- Slow shift of ownership
- Changes in senior management
- Global initiatives, which can cut across sector planning, prioritisation and budgeting and cause delivery modalities to be redefined
- Quality of individuals (their experience, expertise, sensitivity)

A Caution

The move away from projects in favour of SWAps should not be undertaken uncritically:

- It is now accepted that project-based approaches generally do not produce sustainable outcomes because they are unable to take sufficient account of the context-specific

processes that generate and perpetuate poverty and constrain development – such as deficient sector policy-making and implementation, weak institutions, inefficient financial institutions, inappropriate macroeconomic policy, and corruption. SWAps on the other hand are designed to address these issues. However, project-based approaches do have a legitimate place in development, for instance where activity objectives are very specific, and/or where achieving results is not dependent on local capacity or ownership (e.g., global scientific research, infrastructure/equipment provision).

- Although there is now case study evidence of the conditions within which a SWAp is likely to work or not work, evidence of their impact on improving development outcomes is mixed at best. Nevertheless, most analyses still conclude that SWAps offer the greatest potential when compared with other delivery mechanisms. Unfortunately, there are no common standards against which to assess tangible benefits to people, and the fact that each SWAp evolves differently means there never will be. Each SWAp must therefore develop accurate and comprehensive monitoring programs tailored to the specific systems and contexts it is operating in.

Annex C: "Best Buys" and Priorities for Action in Developing Countries

Objective	Health service measures	Measures outside health services
Ensure healthier mothers and children	Ensure access to family planning	Improve women's status
	Train skilled birth attendants, including in resuscitation of newborns Provide proper treatment of major childhood killers (e.g. IMCI)	Ensure good nutrition during pregnancy and childbirth
	Immunise all children against major diseases	Teach family to promote hygiene and use oral rehydration therapy
Stop the AIDS Pandemic	Treat other STIs that increase the risk of HIV	Promote 100% condom use, and education, especially among high risk populations
	Provide ART especially for pregnant women	Harm reduction for injecting drug users
	Voluntary Counselling and Testing for HIV	Combat stigma and discrimination
Promote good nutrition	Supplements as a source of micronutrients	Ensure access to micronutrients through diet, fortified foods
		Promote breast feeding
		Regulate salt and saturated fats in food, public education campaigns
Stem TB	Treat active TB cases Manage MDR TB with new drugs Improve treatment of TB in HIV+ Develop a vaccine	
Control malaria	Expand preventive treatment for pregnant women Use cost-effective drugs especially ACTs where needed	Provide universal access to treated bednets Spray insecticide indoors
Reduce burden of cardiovascular disease	Low cost cholesterol reducing drugs for those at risk	Tackle tobacco – see be low Promote less salt, fat, calories
Combat tobacco use	Raise tobacco taxes to increase prices by at least 33% Anti-smoking laws – ban advertising, restrict smoking in public places Nicotine replacement therapy	
Reduce injuries	Emergency medical response and trauma capacity	Enforce traffic laws Make roads safer e.g. speed bumps, barriers Taxes/laws to limit alcohol, drugs
Ensure equal access to health care	Focus providers' efforts on common causes of ill health Expand roles of non-doctors to deliver basic surgery and treat common conditions Choose cost-effective interventions Incentives to recruit and retain health workers	
Forge strong health system	Support viable policies	
	Make funding commitments Provide incentives for research and development Provide knowledge transfer Provide training in specialities with high disease burden	

Source: Disease Control Priorities Project: Investing in Global Health. "Best Buys" and Priorities for Action in Developing Countries 2006. http://www.dcp2.org/file/57/DCPP-InvestGlobalHealth.pdf

Annex D: Key Policies Guiding Australian Health Sector Support in the Pacific

Australia's strategies for supporting health in the Pacific region must be evidence-based to the extent possible. First and foremost therefore, they must be shaped by the challenges and priorities identified nationally, and informed by the lessons of past experience, as summarised in Section 2 of this Guidance Note. They must also take account of a range of policies and imperatives that directly or indirectly will help ensure that external support can achieve effective results. Some of these are joint imperatives; others reflect priorities driven nationally, such as sector plans; and others emerge through regional consensus.

The ***Cairns Compact on Strengthening Development Coordination in the Pacific*** – was adopted by leaders at the 2009 Pacific Islands Forum. It aims to make real progress towards the MDGs by driving more effective coordination of all development resources – both donor and government – in the Pacific. This is in part a response to indications that progress towards the achievement of health MDGs has slowed and in some cases reversed. The Cairns Compact builds on the *Paris Declaration* and the *Accra Agenda for Action*, and acknowledges that effective development is founded on country leadership, mutual accountability and mutual responsibility between Pacific countries and development partners.

http://www.ausaid.gov.au/publications/pdf/CairnsCompact.pdf.

The ***Pacific Partnerships for Development*** – launched in 2008, mark a new era of cooperation between Australia and Pacific Island countries. They are a framework for Australia and its neighbours to commit jointly to achieving shared goals. They are based on principles of mutual respect and responsibility. The *Partnerships* help focus development efforts on achieving concrete outcomes within agreed timeframes. With developing countries in the lead, these new partnerships require commitments from all parties and a readiness to measure and report transparently on results.

http://www.ausaid.gov.au/country/partnership.cfm.

The ***Accra Agenda for Action*** – was drawn up in 2008 and builds on the commitments agreed in the Paris Declaration. It seeks to accelerate progress towards the *Paris Declaration* commitments, focusing on enhancing predictability of aid funding, use of partner country systems, conditionality based on countries' own development objectives, and untying of aid.

http://www.oecd.org/dataoecd/58/16/41202012.pdf.

The ***Pacific Aid Effectiveness Principles*** – are the result of consultation amongst countries. They derive from the *Paris Declaration* principles, and are designed to fit the Pacific context.

http://www.forumsec.org.fj/resources/uploads/attachments/documents/Pacific_Aid_Effectiveness_Principles_Final_2007.pdf.

The ***Pacific Plan*** – endorsed by leaders at the Pacific Islands Forum in Port Moresby in 2005, embraces four themes based on the concept of regionalism 'countries working together for their joint and individual benefit'. The four themes are economic growth, sustainable development, good governance and security through regionalism.

http://www.forumsec.org/pages.cfm/about-us/the-pacific-plan/

The ***Paris Declaration*** – endorsed on 2 March 2005, is an international agreement to which over one hundred Ministers, Heads of Agencies and other Senior Officials adhered and committed their countries and organisations to continue to increase efforts in harmonisation, alignment and managing aid for results with a set of monitorable actions and indicators. The Paris Declaration emphasises principles of local ownership and mutual accountability.

http://www.oecd.org/dataoecd/11/41/34428351.pdf.

The ***Millennium Development Goals*** – agreed by leaders from 189 nations in September 2000, includes 8 goals, 18 targets and 48 indicators, aimed at reducing poverty by 2015. In 2007, the monitoring framework was revised to include 4 new targets, with additional indicators for their measurement.

http://www.ausaid.gov.au/keyaid/mdg.cfm.
For the status of progress as at 2009, see
http://www.un.org/millenniumgoals/pdf/MDG_Report_2009_ENG.pdf.

In addition, Australian support in the Pacific is guided by a range of broader **domestic requirements**. First, Australian support for health development in the Pacific must demonstrably contribute towards the overall objective of Australia's official development cooperation program: "to assist developing countries to reduce poverty and achieve sustainable development in line with Australia's national interest". Second, it must conform to Australia's policy and accountability requirements in relation to issues such as gender[37] and disability[38], both of which are critical factors in sustainable development and both of which influence and are influenced by the quality of health. Third, it must be achievable in the context of available financial and human resources. Finally, it must be transparent – governments must be informed of the full value of any Australian contribution, for example.

AusAID is also accountable to the Australian public through the Parliament. There is a clear expectation that Australia is capable of measuring and monitoring its attribution to clearly defined progress on MCH, NCDs, malaria and other health-related goals. Hence we need effective means of monitoring both progress and our attribution to the progress.

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[37] AusAID (2007) *Gender Equality in Australia's Aid Program – Why and How*, March. Available through www.ausaid.gov.au.

[38] AusAID (2008) *Development for All: Towards a disability-inclusive Australian aid program 2009-2014*. www.ausaid.gov.au/keyaid/disability.cfm.

Annex E: WHO Core Indicators for Health Progress and Performance Reviews

(DRAFT October 4, 2010)

Health financing

1 Total health expenditure per capita

2 General government expenditure on health as % of general government expenditure

Health workforce

3 Health workers per 10,000 population

Information

4 Percent of deaths that are registered

Governance

5 National health strategy having the main attributes (IHP+)

Infrastructure

6 Health facilities per 10,000 population

Service access and readiness

7 Tracer medicines availability in health facilities

8 Median price ratio for tracer medicines

9 Outpatient visits per person per year

Service quality and safety

10 TB treatment success rate (DOTS)

11 30 day hospital case fatality rate acute myocardial infarction

12 Waiting time to elective surgeries: cataract

13 Surgical wound infection rate (% of all surgical operations)

Coverage of interventions

14 Antenatal care (4+)

15 Skilled birth attendance

16 DPT3 Immunization coverage

17 % need of family planning satisfied

18 Children with ARI taken to health facility

19 Children with diarrhoea receiving ORT

20 ITN use among children

21 ARV therapy

22 ARV prophylaxis among HIV+ women

23 Cervical cancer screening (20-64 years)

Risk factors and behaviours

24 Condom use at last higher risk sex

25 Access to safe water

26 Access to improved sanitation

27 Tobacco use (adults)

28 Low birth weight among newborns

29 Breastfeeding exclusively for 6 months

30 Obesity in adults (over 15)

31 Children under 5 who are stunted

32 Alcohol use (adults)

Health status

33 Life expectancy at birth

34 Child mortality (under-5)

35 Maternal mortality ratio

36 Mortality due to major cause of death by sex and age

37 TB prevalence in adult population

38 HIV prevalence among 15-24

39 Notifiablediseases (IHR)

Financial risk protection

40 Out of pocket as % of total health expenditure

Annex F: A Snapshot of Regional Arrangements Addressing Health

Regionalism exists in different forms and is embraced in different ways in the Pacific. The *Pacific Plan*, endorsed by Pacific Islands Forum Leaders in 2005, is based on the concept of countries working together for their mutual benefit; significantly, it does not place any limitation on sovereignty, national or bilateral arrangements. "Improved health" is one of the strategic objectives of the *Pacific Plan*. However, the impact and outcome indicators for the *Pacific Plan* are a relatively narrow mix of HIV, STI and other disease-specific prevalence rates and MDG-related program coverage. They only measure health system performance indirectly.

Regional governance mechanisms

Several regional governance mechanisms are relevant to the health sector in the Pacific. They include:

- The annual Pacific Islands Forum, the only meeting in the region that brings together all national leaders to discuss issues, set priorities and make joint decisions. At present, there is no formal or clear process by which health issues of joint concern could be brought to the Forum for high level consideration;

- The biennial Meeting of Pacific Island Ministers of Health, which exists mainly to strengthen policy dialogue and collaboration on shared regional health issues. This meeting is organised by a joint WHO-SPC Secretariat. Recent meetings have been characterised not so much by genuine policy dialogue as by presentation for endorsement of each agency's work plan to address specific diseases, issues like the health impact of climate change (which is generally viewed through a disease lens anyway), or sub-sectoral programs like human resources. Regional partners are currently assisting countries to review the format and relevance of this Ministerial meeting for 2011;

- The SPC's Conference of the Pacific Community (ministerial level) and Committee of Representatives of Governments and Administrations (officials level), which periodically review health issues affecting the region (often from a multi-sectoral or economic development perspective). However, it is important to note that delegates to the officials' meeting are usually from Foreign Affairs, not Health Ministries, and are therefore not well placed to manage broader health policy issues flowing to the national level; and

- The WHO Western Pacific Regional Committee Meeting , which focuses mainly on WHO policy recommendations and Regional Office work plans. This meeting is also attended by delegates from Asian country members of the WHO Western Pacific Region.

Regional programs

In addition, several whole-of-sector, disease- or issue-specific regional programs and projects address health in the Pacific. Most are coordinated either through regional organisations like the SPC Public Health Programme, UN agencies active in health and/or HIV in the Pacific (principally WHO, UNICEF, UNFPA and UNAIDS), or various groupings of these partners. As such, they generally have their own governance body.

Donor funded disease- or issue-specific programs also have their own governance mechanisms. The sponsor organisation or secretariat convenes semi-regular meetings of participating countries to discuss program implementation and policy implications; these meetings may include donor or technical partner representation. Examples include:

- the Pacific Human Resources for Health Alliance;
- the Pacific Islands Regional Multi-Country Coordination Mechanism, for projects supported by the Global Fund);
- the Pacific Senior Health Officials Network; and
- the Strengthening Specialised Clinical Services in the Pacific initiative, based at the Fiji School of Medicine.

Regional networks

Regional professional networks and associations with specific, shared interests have emerged organically in the Pacific over many years, usually around the clinical interests of key groups of individuals and often with very limited donor involvement or support. They include, for instance:

- The Pacific Islands Surgeons' Association;
- The Pacific Medical Association;
- The Pacific Society of Anaesthetists;
- The Pacific Islands Mental Health Network; and
- The Pacific Public Health Surveillance Network.