Burnet Institute
Submission to the Independent Aid Review
February 2011

Burnet Institute
Medical Research. Practical Action.

Focus Areas for the Review

a. Structure of the aid program

Appropriate geographic focus

Priority Regions and Countries:

South, South-East, and East Asia; Pacific Island countries and territories; and African countries in and bordering the Indian Ocean (Mozambique, Mauritius, Seychelles, Comoros, Madagascar, Kenya and Tanzania) with the addition of Zimbabwe should remain a high priority for Australian development assistance. Within SE Asia and the Pacific, we believe that there should be greater support for health development in those countries where key health indicators remain poor -- PNG, Solomon Islands, Timor Leste, Lao PDR, Cambodia, and Burma.

We welcome the recent increase in Australian assistance to health, education, and livelihoods in **Burma** and urge the Review to support this trend. Burma spends the second lowest percentage of GNI on health in the world and is unlikely to achieve the Health MDGs by 2015. We encourage greater Australian support to the health and education sectors in Burma, including continuing support to the multi-donor Three Diseases Fund as it evolves into a Fund that will help reduce child and maternal mortality.

In relation to Africa, we support a re-focusing of the aid program on **Southern and Eastern Africa** rather than trying to cover the whole of the continent. Despite recent and planned increases to aid for Africa, resources are still modest. Therefore a more focused geographic scope is needed to ensure the Africa program can have some lasting impact.

There is also a strong case for Australian aid to **South Sudan**, as it embarks on the challenging task of reconstruction and nation-building from a base that is one of the least developed in the continent.

In addition, Australia could foster partnerships between Australian institutions and key technical and development institutions in **South Africa**. While this could add value to programs in lesser developed African countries, it could also help South Africa evolve as a provider of aid in the region.

***Within countries*:**

- In addition to a focus on rural areas with the worst health and other development indicators, the aid program should increase its focus on and support for the poor living in urban and peri-urban areas.
- In relation to Burma, the dry zone of the central region and Chin and Rakhine States should be prioritised.

Appropriate sectoral focus

The Burnet Institute supports a focus of the aid program on education, health, and poverty alleviation, as well as increased attention to climate change and the environment. Gender considerations should be integrated within all sectors. As a health-focused agency, our comments will mainly address health issues, whilst acknowledging the importance of social determinants.

Reproductive Health:

- In recognition of its partnership with DFID, USAID and the Gates Foundation in the newly formed International Alliance for Reproductive, Maternal and Newborn Health, AusAID should develop a comprehensive Reproductive, Maternal and Newborn Health Policy. A strategy for increased investment in this area, and indicators to track effectiveness of this investment,

should also be developed and made public.

- The Australian aid program should explicitly recognise the role of family planning in achieving all of the MDGs, particularly those relating to maternal and child mortality, education, poverty reduction, and women's empowerment.
- Australian aid for family planning should focus on scaling up evidence-based interventions known to increase access to family planning in Asia and the Pacific. The well-established role of NGOs in facilitating increased access to family planning at the community level should be recognised and their skills and community expertise should be utilised.
- The aid program should also fund operational research to assess the effectiveness of innovative approaches to increasing access to family planning.
- Reproductive health, with a specific focus on family planning, needs to be prioritised as an essential strategy for achieving MDG 5 and funding should increase from the current 5% allocation within the Health and HIV budget, to at least 15%.

Bilateral aid: Bilateral support should complement the work of Australian and local NGOs by focusing on strengthening service provision and supply and distribution of a variety of contraceptive methods within countries with high unmet need for contraception.

Maternal, Newborn and Child Health (MNCH):

- In addition to the strategies above, Australian aid should continue its emphasis on increasing pregnant women's access to skilled birth attendants, expanding the number and quality of health centres, supporting greater access to emergency obstetric services, and funding research to combat common infections and complications arising in pregnancy and childbirth, including health systems research into new forms of service delivery.
- The Australian aid program should enhance and expand its current engagement in MNCH through:
  - Focusing resources on specific target settings where mortality rates are high, and home births are common;
  - Support for health system strengthening should explicitly call for measures to deliver maternal and newborn care services at community level, working through community groups and volunteers if necessary;
  - Dedicate at least 10% of resources to operational research that presents policy-makers with new models for service delivery, or new information on health threats;
  - Allocate resources to discover and test new synergies between programs, such combining the delivery of birth-dose vaccination to control hepatitis B, with early post-natal care to reduce deaths of mothers and newborns.
- Increase overall funding for health to $900 million per annum.
- Introduce a requirement that at least 50% of Australian aid directed to community and district health services be allocated to the areas most in need, that is areas with the highest maternal mortality rates and those with the highest proportions of home-births.
- Promote the integration of sexual and reproductive health, maternal and newborn care, and parent-to-child HIV transmission prevention services.

Addressing the Demographic Transition

- Low income countries in the Asia and Pacific region are undergoing a demographic transition with a dramatic increase in the proportion of older people. Together with modern influences on diet, exercise, smoking and stress this is resulting in a change in the pattern of health problems with a shift towards chronic diseases, such as cardiovascular disease, diabetes, chronic lung disease and cancers, as well as problems of ageing such as arthritis, urinary incontinence, and blindness.
- Older people contribute significantly to the social, economic and emotional well-being of their

families and communities, but are prevented from doing so when suffering from disease or disability. Older people are among the poorest in populations in low income countries, and the ageing of populations is a significant development issue.

- The Australian aid program is well-placed to demonstrate innovation by supporting governments to adapt their health systems to ageing populations. The most rapidly growing populations of older people are in Asian countries, such as Sri Lanka, Thailand, Viet Nam, China, and Indonesia. There is an urgent need for operational research into healthy ageing to inform policy makers and planners in the region as they reorient primary health care services towards the needs of older people and their carers in resource poor settings.

HIV and AIDS and Harm Reduction:

- MDG 6 – ***Combat HIV/AIDS, malaria and other diseases*** should be a high sectoral priority for the Australian aid program in Asia, the Pacific, and Africa as delivered via a range of mechanisms/partners, particularly Australian NGOs. The new AusAID NGO program for **Africa** excluded MDG 6 and relegated HIV and AIDS to a cross-cutting issue. We feel HIV and AIDS should be given greater prominence in recognition of the magnitude of HIV epidemic, especially in sub-Saharan Africa, and in recognition of the significant expertise Australian NGOs and their local partners have in responding effectively to HIV and AIDS in Africa.
- For effective HIV prevention, in hyper endemic and concentrated epidemic scenarios, the aid program should promote the use of a "settings" approach to engage communities as a whole, rather than focusing on identifiable population groups at high risk which can contribute to increased marginalisation and stigma. In low level epidemics, the efforts should focus specifically on identified most as risk groups, (e.g. men who have sex with men, sex workers and their clients, people who inject drugs etc.)
- Activities supported through the aid program should be based on comprehensive contextual analysis with an emphasis on religious and other cultural factors which present challenges to effective HIV prevention, treatment or care.
- AusAID HIV strategies and programs should continue to place strong emphasis on prevention. Despite significant increases, the roll-out of treatment in high HIV prevalence settings has not reached all those in need of treatment. Furthermore, related issues such as food insecurity and drug toxicity are contributing to treatment non-compliance and resistance.
- While recognising the vulnerability of women to HIV infection, Australian aid activities should recognise the critical role that men can play in reducing women's vulnerability. There should be increased support for programs that engage with men, explore their sexuality and sexual attitudes, and foster greater sexual responsibility.
- Australia has a considerable comparative advantage in regards to harm reduction as it relates to injecting drugs and HIV. This needs to be acknowledged in strategies and programs (e.g. Africa) where injecting drug use is emerging at an alarming rate. Australia has an opportunity to lead the response to emerging epidemics of injecting drug use in East Africa, where there is a dearth of current responses and to promote the UN-endorsed comprehensive prevention package.
- The concept of harm reduction needs to be broadened in the Pacific context to include alcohol and other non-injecting drugs, adopting and adapting existing skills and competencies and developing capacity in the region.
- The Australian aid program should look for ways to support the integration of HIV with sexual and reproductive health programs and services, as well as other services, such as maternal and child health care, wherever possible in order to promote synergies and increase efficiency.

Emerging and Re-Emerging Infectious diseases

- The Australian aid program should maintain its support for prevention and control of malaria, tuberculosis, and new emerging infectious diseases taking into consideration their potential

burden of disease and socio-economic impact.

- The initiatives instigated in response to SARS and potential and actual influenza pandemics should continue to enhance collaboration between human, animal and wildlife health sectors, as well as increasing capacities to achieve international normative standards as defined by the International Health Regulations 2005 and the Animal Health Act.
- In comparison to pandemic preparedness measures, prevention initiatives have been relatively neglected. The Australian aid program can provide support for risk determination and mapping efforts to better address diseases at their source(s).
- The Australian aid program should increase its focus on ensuring capacity is built at the district and community levels for prevention, early detection and control of EIDs as well to improve community resilience.
- Australia has supported behaviour change communication (BCC) projects related to highly pathogenic avian influenza in the region. These activities need to move beyond the provision of information and awareness raising for the general public to more targeted, proven measures for behaviour change based on an understanding of what works locally.
- The Australian aid program should acknowledge and look for synergies between activities specific for emerging infectious diseases and other health activities, and integrate important elements wherever possible. All emerging infectious diseases initiatives should aim to contribute to the strengthening of critical public health systems such as human and animal surveillance, public health laboratory networks, emergency preparedness, and health communications.
- A regional approach to prioritizing and coordinating research should continue to be supported by the Australian aid program to improve efficiencies and ensure knowledge, best practice and lessons learned in particular settings are disseminated throughout the region.

Malaria

- The Australian Aid Program should continue its support for malaria activities in the Asia Pacific Region, with flexible approaches that ensure a balance between control and elimination; this is particularly true for the Pacific Islands of PNG, Solomons and Vanuatu.
- The Australian Aid Program should also ensure that the unique knowledge on malaria in Australia more effectively benefits regional and national approaches to tackling drug resistance. The use of scientific and operational research to provide evidence for policy making is of particular importance.

Tuberculosis

- The Australian Aid program should consider the increasing burden of Tuberculosis and multiple drug resistant (MDR) TB within a very holistic approach which tackles TB as a whole rather than only MDR TB and consider TB as a regional rather than national issue.
- AusAID should consider increasing assistance to tackle the growing problem of MDR TB in Burma, where the current Global Fund grant aims to treat only an estimated 10% of MDR TB cases in the country.

Poliomyelitis

- We recommend that Australia significantly increase its funding to the **Global Polio Eradication Initiative** (GPEI).
- In the mid-1980s, around 400,000 people – mainly children – were newly paralysed ***annually*** by the polio virus. By 2010, that figure had declined to fewer than one thousand. Polio remains endemic in four countries – Afghanistan, India, Nigeria and Pakistan – with a further four countries known to have (Angola, Chad and Democratic Republic of the Congo) or suspected of having (Sudan) re-established transmission of poliovirus. Several more countries had ongoing outbreaks in 2010 due to importations of poliovirus.
- The World Health Organization has drawn up a new strategic plan to ensure that polio is

eradicated from the world by the end of 2012. However, the funding for the GPEI has been steadily shrinking over the past three years. While Rotary International and the Gates Foundation have maintained (or increased) their support, G8 contributions have been declining steadily. In 2010, funding shortfalls led to a 25% cut in surveillance in Q1-2 (which may have led to the tardy detection of outbreaks in Tajikistan, Congo, and Uganda/Kenya). Also, OPV campaigns were cut by 12% and some campaigns were cancelled, including in some re-infected and/or high-risk countries (eg, Uganda, Yemen, Djibouti, Ethiopia, Congo, and Burundi).

- There is a $700 million funding shortfall in 2011-2012, out of a total budget of $1.86 billion.

Relative focus on low and middle income countries

The aid program should be flexible to ensure that people living in poverty in middle income countries, such as Papua New Guinea, Indonesia, and China have access to appropriate assistance. In China, Australian aid should be in the form of technical assistance to help build national capacity but also ensure that the people of Western China are the main beneficiaries.

Relative costs and benefits of different forms of aid, including the role of NGOs and the appropriate balance between multilateral and bilateral aid funding arrangements.

- While applauding the core principles deriving from the Rome, Paris, and Accra meetings on aid effectiveness, we feel that AusAID may have acted too quickly in some countries to move to sector-wide approaches, in particular in the health sector. In PNG, for example, sector-wide support to health and HIV/AIDS has led to bottlenecks at the central level and may have led to decreased service quality in remote areas.
- We recommend a more flexible range of aid mechanisms in the health sector while maintaining the Paris Declaration principles of alignment and harmonisation. This could be achieved by combining technical and funding support to the Ministry of Health with more focused support to vulnerable and under-served populations and geographic areas. This might be achieved through partnerships between NGOs and provincial/district health services, coordinated centrally by the MOH.
- Overall, we believe that health assistance programs should re-focus on the district level, where the ultimate responsibility for health service delivery lies and where the health system interacts directly with communities. It is at this level that NGOs can make a difference by nurturing relationships between communities and service providers. Two example of this are the Save the Children primary health care program in Sayabouly Province of the Lao PDR and Burnet's East New Britain Sexual Health Improvement Project in PNG.
- Because NGOs play such a critical role at the community and district levels, we believe that the proportion of Australian ODA delivered through NGOs should gradually increase from the 8% reported in 2009/2010 to 15% by 2015.

Other funding mechanisms:

- **The scholarship program** has been scaled up yet there is no evidence of its development effectiveness. In relation to increased aid to Africa, scholarships account for a significant portion of planned increases in development assistance (target is 1000 scholarships by 2012/2013). Furthermore, it is typically the elite or children of the elite who access AusAID scholarships and these individuals already have far greater access to further education opportunities than the rest of the population.
- **Technical assistance facilities,** which prioritise the introduction of external consultants, such as *The Australia-Africa Partnerships Facility* need to justify the investment through the provision of evidence of development effectiveness.
- We commend the Facility approach that AusAID supports in China – the **China Australia Health and HIV Facility (CAHHF)**. This aid mechanism has sufficient flexibility and responsiveness to engage a high level of country ownership and marry capacity-building with the promotion of partnerships between Chinese and Australian institutions, to their mutual

benefit. The Facility model of aid has, in this instance, also enabled support to locally-led policy-relevant research with a focus on remote, poor or minorities areas. This flexibility and emphasis on knowledge generation has fostered a higher level of engagement with health policy than might otherwise be expected in such a setting. Such innovative aid mechanisms may have a role in other settings in Asia.

- We support Australia's generous contributions to the **Global Fund** to Fight AIDS, TB, and malaria and the Global Alliance for Vaccines and Immunization. These new health funding mechanisms have demonstrated impact on the target diseases. In addition to funding, Australia should play an active role in the governance of these funds to ensure that they do not evolve into the large bureaucracies that have hampered efficient implementation by other global funding bodies.

b. Performance of the aid program and lessons learned from Australia's approach to aid effectiveness

- As noted above, we believe that more effective health policy engagement can be achieved through flexible and responsive aid mechanisms that prioritise locally-led knowledge generation on topics chosen by the partner government or similar national stakeholders.
- Technical assistance, *per se,* is not necessarily ineffective – it can be effective in strengthening health systems when long-term inputs take precedence over short-term consultancies, when national counterparts are in place and assistance aligns within a national health plan that has true local ownership, and when the aid mechanism provides sufficient flexibility for both technical advisors and local counterparts to work together on knowledge generation to discover the best local application of international good practice.
- Many of the most sustainable and high impact aid outcomes over the past ten years, in our experience, have been innovations developed 'on the side', additional to a program's annual plan. Effective aid mechanisms will both recognise and promote space for such innovation.
- However, there needs to be more consistency across AusAID in how the new principles of aid effectiveness are actually implemented. Approaches to design and partnership vary considerably between different branches and country missions. There is an urgent need for ONE policy on aid effectiveness that is applied evenly across the aid program and is applied consistently with all development partners, including Australian Management Contractors, Australian Government Departments, multilateral agencies, and NGOs.

c. Program approach to efficiency and effectiveness and whether the current systems, policies and procedures maximise effectiveness

- Australian NGOs are subject to a rigorous process of AusAID accreditation every five years and an industry Code of Conduct. The independent review should consider how the effectiveness and accountability of other organisations delivering Australian aid are being assessed and whether assessment measures are appropriate.
- In order to improve program quality, AusAID procedures currently allow Australian NGOs to use up to 10% of grants for design, monitoring and evaluation. We would encourage AusAID to extend this provision to include operational research in order to enhance our evidence-informed programming and to encourage innovative and novel interventions. We would also encourage AusAID to provide additional support to assist NGOs and their implementing partners to write up and publish operational research in order to expand the evidence base informing international and national policy, strategy and guideline development. In a recent Lancet article, Zachariah et al[1] discuss the increasingly influential nature of published research papers in relation to the production of international guidelines such as those produced by WHO which directly inform the work of frontline health workers. Further investment in operational research and publication of research findings would increase the

[1] Zachariah R. et al, The Published research paper: is it an important indicator of successful operational research at programme level? Tropical Medicine and International Health, 2010, 15:1274-1277

potential for improvements in the efficiency, effectiveness and relevance of Australian funded programs.

d. Future organisational structure for the aid program and coordination with other donors

AusAID's organisation structure for aid delivery

With the shift to 'partnership approaches' and the subsequent necessity for AusAID to become increasingly involved in program management, often in joint management arrangements with partners, there may be a need to rethink both the skill sets required and the organisational structures – especially at Post. In the past, when AusAID worked mainly through contractors, AusAID staff were largely involved in the management of contractors with those intermediaries. However, with the shift to direct program management, there may be a need to either recruit more people experienced in this area, or run specific training for AusAID desk staff.

Coordination of ODA across the public service

A Review in 2009 of the Pandemics and Emerging Infectious Diseases Strategy found that standards of monitoring and evaluation across different Australian Government implementing partners varied significantly. If the whole-of-government approach to development assistance is to be effective, current standards (eg, assessing Quality at Design and Quality at Implementation) must be adhered to by all government partners, not just AusAID.

Coordination of Australia's ODA with other donors and institutions

The idea of donor coordination is very sound and makes a lot of sense; however, the reality is that this is extremely difficult to achieve in practice, even in the most basic form. Policies regarding coordination and program design need to reflect these difficulties so that they do not claim best practice, immediately setting the program up for failure in this area. Efforts at coordination need to continue but should be based on pragmatism and seeking out and capitalising on opportunities when and if they arise. One excellent example of donor coordination led by AusAID is the Malaria Reference Groups in Vanuatu and Solomon Islands.

e. Appropriateness of current arrangements for:

Review and evaluation of the aid program

There needs to be a balance in the ODE's mandate and activities between reporting upwards to parliament and outwards and downwards for program accountability and learning.

Further development of the ANCP strategies for evaluation needs to be a priority – if effective ways are not found to capture the achievements of this very successful program, the ANCP will suffer and lose ground within the overall aid program.

Management of fraud and risk in the aid program

AusAID is already risk averse in the extreme; this is not necessarily a bad thing. However, further measurements around fraud and responsibility, certainly for the NGO program, are not necessary.