D2.2 Canadian and Australian health aid

Official development assistance (ODA) is becoming an increasing feature of the public health landscape in low- and middle-income countries (LMICs). However, questions about the appropriateness and efficacy of such aid has been raised with some commentators suggesting that ODA reflects the strategic interests of the donor country rather than the developmental needs of countries that receive the aid. This chapter reviews some of the structures, policies and programmes of Canadian and Australian ODA. It reflects on the recent trends that have emerged from these countries' giving patterns, analyses the impact that the respective ODA has had in recipient countries, and then provides a snapshot of the Cuban approach to development assistance in juxtaposition to the Canadian and Australian systems. A more detailed version of this chapter can be found on the GHW website.

Canadian aid

Canada is a high-income country whose role in the world is often portrayed as that of a middle power. In 1976, Canada joined with the world's most powerful economies to form the Group of Seven (now the G8 with the addition of Russia), positioning itself to play a leadership role in promoting development. This built on the favourable international image Canada had established in the 1950s by championing peacekeeping, diplomacy and multilateral cooperation. In spite of this legacy and despite Canada being among the wealthiest countries in the world, the country's actual delivery of ODA tells a story that undermines its benevolent reputation.

Overview of players and policies

Canada's lead agency for development assistance is the Canadian International Development Agency (CIDA). Among its stated objectives are to 'support sustainable development in developing countries in order to reduce poverty and contribute to a more secure, equitable, and prosperous world; to support democratic development and economic liberalization … and to support international efforts to reduce threats to international and Canadian security' (CIDA 2006). Its humanitarian goals are thus intermixed with Canadian commercial, political and security objectives, with conflicting results for health programming. For example, Canada continues to export asbestos, a known carcinogen banned domestically, to LMICs in order to support Canadian commercial interests.

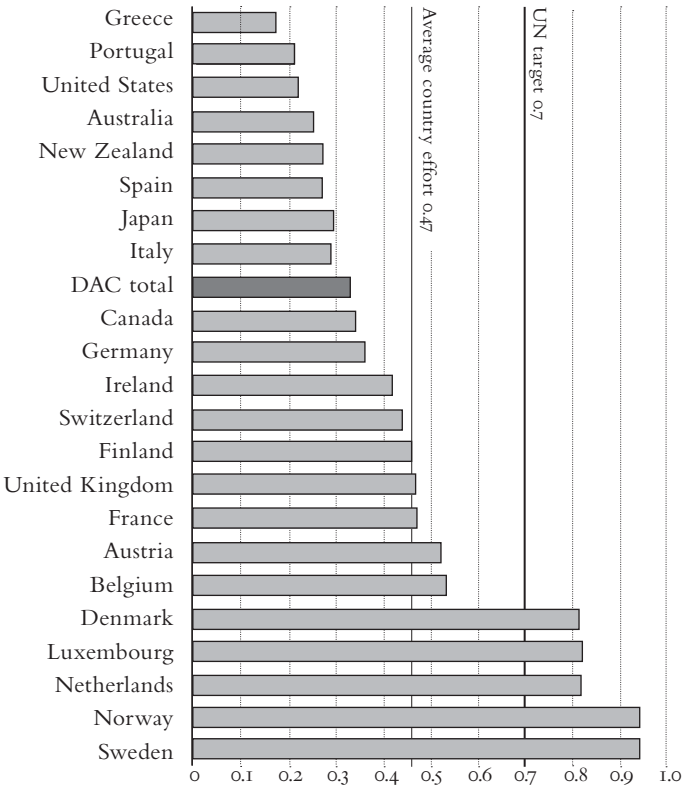
Health has always been part of CIDA's mandate, although a specific 'Strategy for Health' was only published in 1996. CIDA has also recently expressed commitments to increase support for HIV/AIDS and health systems strengthening. Its focus on HIV/AIDS, in particular, may be seen as a response to public pressure. In addition to its own bilateral and targeted programmes, CIDA channels funds through multilateral efforts, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria.

Nevertheless, Stephen Lewis, the former UN special envoy for HIV/AIDS in Africa and a respected Canadian, has observed that the government 'seems to have all the time in the world for conflict and very little time for the human condition' (quoted in Collier 2007). When the government published its International Policy Statement (IPS) in 2005, it stopped short of any dramatic reorientation towards the needs of vulnerable population groups, an issue that had been raised during the extensive consultation period prior to the release of the IPS. Health is limited to the development sector of the document and is not mentioned in relation to diplomacy, defence or commerce. The 2006 election of Conservative prime minister Stephen Harper appears to have further reduced the chances of a more substantive focus on health in Canadian foreign policy, with anti-terrorism and the promotion of Canadian business interests being primary preoccupations for the government.

Official expression of Canadian health aid priorities tends to focus on globally defined objectives such as the Millennium Development Goals (MDGs). However, CIDA's 2002 strategic statement also stresses a comprehensive approach to development cooperation based on a set of principles, including local ownership of strategic initiatives, improved donor coordination, and greater coherence between aid and non-aid policies.

While this statement represents an important step away from the critical weaknesses of traditional vertical, narrowly focused, non-sustainable

FIGURE D2.2.1 **Net ODA as a percentage of GNI, 2005**



Source: Adapted from *OECD Factbook 2007* (OECD 2007).

donor projects, CIDA is still criticised for its high degree of dependency on IMF and World Bank conditionalities, and the limited participation of civil society actors representing the poor and marginalised (Tomlinson and Foster 2004).

One positive dimension of Canada's international development effort in the health sector is its support of research for and with partners in LMICs. The drivers for this effort are the International Development Research Centre (IDRC) and the Global Health Research Initiative (GHRI).

IDRC was established in 1970 to 'initiate, encourage, support, and conduct research into the problems of the developing regions of the world and into the means for applying and adapting scientific, technical, and other knowledge to the economic and social advancement of those regions'.[1] It provides assistance almost exclusively to researchers and institutions based

in LMICs. While health has not been a primary focus, several initiatives have explicitly targeted health-related issues, including: the 'Ecosystem Approaches to Human Health' initiative; the 'Governance, Equity and Health' programme; the 'Research for International Tobacco Control' initiative; and the 'Tanzania Essential Health Interventions Project' (TEHIP).

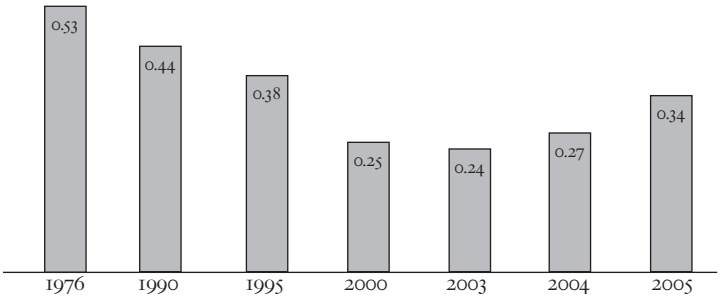
Canada's GHRI was launched in 2001 to promote coordination among four key funding agencies: CIDA, IDRC, the Canadian Institutes of Health Research, and Health Canada (the Canadian Federal Ministry of Health). From 2002 to 2005, the GHRI invested about CAN$8 million in new funding for global health research, supporting the work of more than seventy collaborative teams of researchers from Canada and several LMICs (Neufeld and Spiegel 2006). In addition, a new CAN$10 million fund, the Teasdale–Corti programme, was launched in 2006 to provide longer-term funding (IDRC 2007a).

Trends in Canadian ODA disbursements

Although it was a Canadian prime minister who headed the 1969 UN Commission that recommended that all developed countries contribute 0.7 per cent of their gross national products to ODA, there has never been a government policy to ensure implementation of this objective.

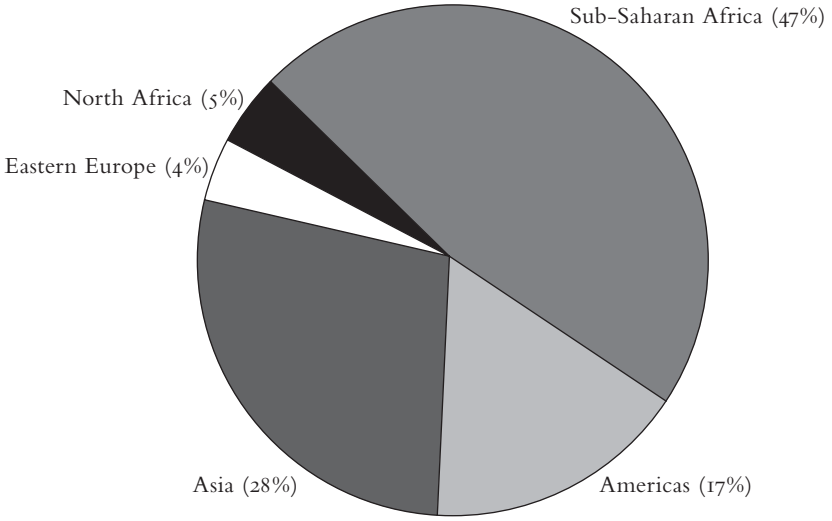
While Canadian ODA grew steadily in the first few years of CIDA's and IDRC's existence, the overall funding trend has been one of declining commitments, which has been reversed only very recently (Figure D2.2.2). The high point of 0.53 per cent of GNI in 1976 was reduced to less than half this level by 2000.

FIGURE D2.2.2 **Net Canadian ODA as a percentage of GNI, 1976–2005**



Source: OECD ODA Statistics 2004–05 (OECD 2006).

FIGURE D2.2.3 **Proportion of CIDA expenditure by region, FY 2005–06** (total expenditure CAN$2.782 billion)



Source: CIDA 2007.

TABLE D2.2.1 **Top ten recipients of gross ODA, 2004–05**

Rank	Country	Amount (US$ million)
1	Iraq	229
2	Afghanistan	73
3	Ethiopia	62
4	Haiti	60
5	Indonesia	56
6	Ghana	50
7	Bangladesh	50
8	Mozambique	42
9	Mali	40
10	Cameroon	39

Source: OECD ODA Statistics 2004–05 (OECD 2006).

TABLE D2.2.2 **Untied aid as a percentage of total ODA, 1990/91–2004**

Country	1990–91	2004
Norway	61	100
Ireland	–	100
Switzerland	78	97
Japan	89	94
Netherlands	56	87
Sweden	87	87
Australia	33	77
Canada	47	57

Source: Human Development Report 2006 (OECD 2006).

The IPS did, however, pledge to double ODA by 2010, and to give particular attention to the needs of Africa (see Figure D2.2.3). The Conservative government elected in 2006 reasserted this pledge and in 2007 the Canadian parliament passed an all-party Better Aid Bill. Nevertheless, the implications of this for ODA remains to be seen – policy statements in 2007 have notably indicated a move away from the targeting of increased aid to Africa (Riley 2007).

In recent years, there has also been a heightened commitment to military involvement in Afghanistan, and the portion of ODA associated with security-related issues has grown substantially, with Iraq and Afghanistan now being the largest recipient countries (Table D2.2.1).

Furthermore, in spite of being a signatory of the *Paris Declaration on Aid Effectiveness*, a very significant percentage of Canada's ODA is still tied (i.e. restricted to the procurement of goods and/or services from mainly Canada, or some other specific countries).

Health-sector aid

Strengths and weaknesses of the Canadian approach to health-related ODA are illustrated in the example of the Tanzania Essential Health Interventions Project (TEHIP), funded by IDRC in the 1990s. TEHIP was praised for its degree of local community involvement, systematic application of health information to guide interventions and, ultimately, its impact on improving health outcomes (IDRC 2007b). Despite the widely acclaimed success of TEHIP, there have been delays in the 'roll-out' of this project. Indeed,

under the auspices of CIDA's African Health Systems Initiative (AHSI), the expansion of TEHIP is barely in progress.

AHSI aims to improve access to basic health care by providing assistance to train, equip and deploy existing and new African health-care workers. As with the majority of CIDA's health-sector work, these aims are undermined by tacit acceptance of delivery models and privatisation policies drawn from international financial institutions. The extent of private-sector involvement in CIDA health-care reform projects is unclear, but CIDA does have a general mandate to target private-sector development in its work (CIDA 2003), a possible source of tension in the case of health-related ODA.

AHSI is also a useful starting point to stress another contradiction. While it sets out to strengthen health-care systems and support human resources in health, several Canadian provinces are simultaneously recruiting physicians and nurses from the very same countries and regions, compromising efforts to build health systems, and contributing to large financial losses incurred by the source countries. Some of the authors of this chapter have witnessed, in various forums, an inexcusable lack of communication between Canadian ODA officials and provincial health officials on this issue.

Another dimension along which Canadian ODA can be assessed is its humanitarian disaster relief interventions. In the mid-1990s, Canada established the Disaster Assistance Response Team (DART), a military organisation designed to deploy rapidly anywhere in the world to help in crises ranging from natural disasters to complex humanitarian emergencies. This programme has produced mixed results.

Following the October 2005 earthquake in Pakistan that killed 73,000 people and displaced an additional 3 million, Canada's official response came through DART at a cost of over CAN$15 million. Conceived to provide immediate support *for up to forty days*, until more permanent aid takes over, DART became fully operational in Pakistan fourteen days after the earthquake. While the Department of National Defense viewed the operation as 'an unconditional success', DART's own members (Agrell 2005), as well as independent observers (Valler 2005), questioned the actual value of the operation. It was especially criticised for the excessive emphasis given to technological solutions, contrasting greatly with the approach of Cuba (discussed in Box D2.2.1 later in the chapter). This type of criticism has been expressed at least as early as Canada's 1985 relief operation following the earthquake in Mexico City (Montoya 1987). It also followed DART's deployment for the 2004 Asia–Pacific tsunami disaster (CBC 2005). As in the case of Pakistan, it was suggested that a more effective response would have included the rapid deployment of human resources able to venture out and reach victims in the shortest possible time.

Australian aid

Most of Australia's aid (about 90 per cent) is absorbed by the Asia–Pacific region (AusAID 2005). Table D2.2.3 shows the top ten recipients of Australia's bilateral aid budget for 2007–08 by partner country or region. Africa receives limited aid from Australia; and more of the 2007–08 budget is allocated to Afghanistan than to the whole of Africa (see Table D2.2.3). Note that this excludes aid allocated to regional efforts and multilateral organisations.

When it comes to generosity, Australia's record is poor. It has not reached the UN's target of allocating 0.7 per cent of GNI to aid. The general trend has been a decline from a high of 0.5 per cent in 1974–75, which has only been partially reversed in recent years (see Figure D2.2.4). Although the 2007–08 Australian federal aid budget represents a AU$209 million increase over the previous year's budget, aid still only accounts for 0.3 per cent of GNI. However, the newly elected federal Labor government has pledged to raise Australia's official aid to 0.5 per cent of GNI by 2015–16, with a vague commitment to work towards the UN goal of 0.7 per cent (Rudd 2007).

Most of Australia's aid budget is managed by AusAID, an agency within the Department of Foreign Affairs and Trade. However, a notable feature

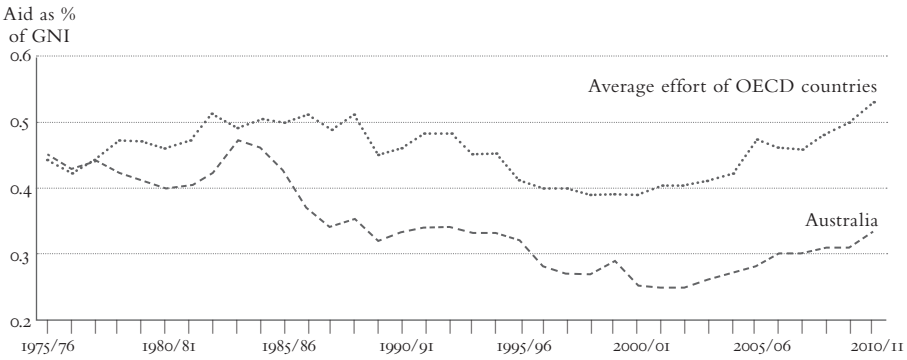
TABLE D2.2.3 **Top ten recipients of the 2007–08 Australian aid budget**

Country/region	Budget estimate (AU$ million)	% of total budget
Indonesia	458.8	14.5
Papua New Guinea	355.9	11.3
Solomon Islands	223.9	7.1
Philippines	100.6	3.2
Afghanistan	99.6	3.2
Africa	94.4	3.0
Vietnam	90.8	2.9
Timor-Leste	72.8	2.3
Cambodia	54.0	1.7
Bangladesh	47.6	1.5

Source: Australian Government 2007.

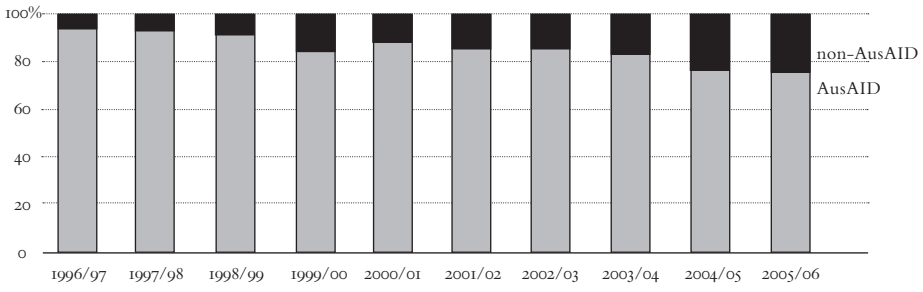
of Australia's aid is that as much as a quarter of it is delivered by 'other government departments' including the Australian Centre for International Agricultural Research, the Treasury and the Australian Federal Police (Duxfield, Flint and Wheen 2007) – a trend that increased under the Howard government (see Figure D2.2.5).

FIGURE D2.2.4 **Australian aid levels compared with the average effort of OECD countries**



Source: AusAID 2005. *Note*: The 'average effort' of OECD countries is the unweighted average of their ODA/GNI ratios.

FIGURE D2.2.5 **Proportion of Australian aid administered by AusAID and other agencies**



Source: AusAID 2005.

Overview of players and policies

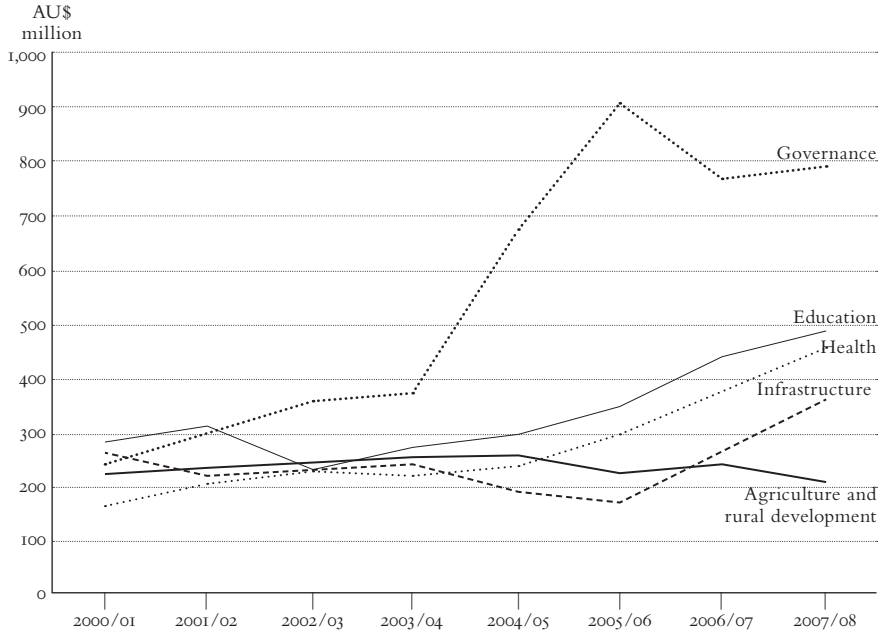
As with other donors, Australia is explicit about the use of aid to further its own strategic interests. Development assistance is expected to be 'in line with Australia's national interest' (AusAID 2007). By helping to reduce poverty and promote development, 'the aid program is an integral part of Australia's foreign policy and security agenda' (Australian Government 2006).

The priorities and approaches laid down during the Howard government's term of office from 1996 to 2007 have been criticised for accentuating the use of aid to serve Australian security, foreign policy and economic interests, particularly following the terrorist attacks on the US in 2001 and the Bali bombings in 2002. In addition, the government introduced a 'whole of government' approach whereby all public service departments were encouraged to align their work with Australia's overall foreign policy and security objectives (Pettitt 2006). The approach of the new Rudd government appears promising for improving the effectiveness of Australia's aid programme. Labor has pledged to consider separating AusAID from the Department of Foreign Affairs and Trade 'to ensure its independence in policymaking', along with 'establishing a Legislative Charter on Australian Development Assistance to guarantee that aid is spent on poverty reduction and not political agendas'. These actions would be greatly enhanced by the creation of a Global Development Institute to conduct research into 'creative responses to aid delivery', which Labor says it will also consider. NGOs therefore need to keep pressuring the government to deliver on these commendable pledges.

One of the ways in which aid has been used to promote Australia's foreign policy interests is through the funding of 'good governance' programmes. Figure D2.2.6 reveals that much of the increase in the Australian aid budget in recent years has comprised funding for 'governance' and 'security' issues, while allocations to health, education and agriculture have remained static (with health generally comprising around 12 per cent of the aid budget). Under Howard, spending on 'governance programs' grew to become the largest sector of the aid budget for 2007–08 (Australian Government 2007).

The emphasis on law, security and governance is illustrated by Australia's aid to the Solomon Islands – the poorest country in the Pacific. In 2003, following political tension and conflict, Australia agreed to work with the Pacific Islands Forum to field the Regional Assistance Mission to Solomon Islands (RAMSI), the aims of which are to stabilise and strengthen the state, particularly through the reform of the core institutions of government

FIGURE D2.2.6 **Australian aid budget, 2000–2007**



Source: AusAID 2007.

(Baser 2007). Australia's four-year contribution to RAMSI includes the provision of 235 Australian Federal Police and 130 technical advisers. Of the $95.4 million of aid budgeted for the Solomon Islands in 2007–08, over 70 per cent will be directed through RAMSI.

Justification for channelling so much aid through RAMSI was based on the long-standing view within the Australian Department of Defence that the island nations to the north and east (referred to as the 'arc of instability') pose a security threat to Australia (Ayson 2007; Hameiri and Carroll 2007; Pettitt 2006). By 2005 the view that neighbouring countries had the potential to become breeding grounds and refuges for transnational criminal groups and terrorists had become so entrenched within AusAID that an OECD Development Assistance Committee (DAC) review concluded that Australia's development programme was at risk of being 'dominated by an Australian-driven law and order agenda rather than a broader development agenda with strengthening local ownership' (OECD 2005). The increased concern with regional and national security has been criticised and questioned by other commentators (e.g. Davis 2006).

It is also difficult to see how the allocation of AU$160 million for detaining asylum-seekers in offshore detention centres and sending others home

(Nicholson 2007), as well as the allocation of AU$2.5 million for improving the customs and quarantine standards of Pacific Island nations (Commonwealth of Australia 2005), would have assisted in reducing poverty.

Furthermore, Cirillo (2006) asserts that problems of 'governance' are only described as such when they are perceived to impede the Australian interest. It has been argued that Australia's intervention in the Solomon Islands is related to economic interests in the Gold Ridge mine, the islands' oil palm plantations and the business activities of Australian companies (Action in Solidarity with Asia and the Pacific 2003). Anderson (2006) goes so far as saying that Australia uses its military and security aid in Asia and the Pacific to protect foreign investments by containing the social disruption caused by Australian logging, mining and gas industries.

In light of worsening development indicators in Asia–Pacific, the decision to assign so much of the aid budget to 'governance', counterterrorism and migration management has been extensively critiqued (Hameiri and Carroll 2007; Pettitt 2006). Others have also called for a higher proportion of aid to be allocated to health, education and other basic needs (Duxfield and Wheen 2007; Zwi et al. 2005; Zwi and Grove 2006). Even a government-commissioned review of the aid programme in 1996 warned that 'the pursuit of short-term commercial or diplomatic advantage through the aid program can seriously compromise its effectiveness and should play no part in determining project and program priorities' (Simons Committee 1997)

Kilby (2007) asserts that AusAID's preference for dealing with absolute poverty rather than inequality may have actually exacerbated poverty among some groups, and increased the rural–urban divide. He sees part of the problem as a product of poverty analyses which 'provide an overview of where the poor are, but not much about who the poor are or why they are poor'. Without a deeper analysis of the drivers of poverty in each country, merely alluding to poverty reduction does not guarantee poverty-reduction outcomes.

Hopefully, with a commitment by the new Rudd government to use the MDGs as the basis for the aid programme's strategy (which the former government was unwilling to do), and Labor's emphasis on human rights and respect for indigenous rights and culture, Australia's aid programme will become more effective in bringing about long-term health and development gains in the Asia–Pacific region – where two-thirds of the world's poor live.

Health-sector aid

The characteristics of global development assistance for health described in Chapter D1.1 apply as much to the Asia–Pacific region as elsewhere: vertical

disease-based programmes and a tendency to fund lots of small and often short-term projects through Australian NGOs and contracting agencies. The extensive use of technical cooperation provided by firms based in Australia (AusAID 1997) has come at the expense of high transaction costs and the failure to develop capacity in recipient countries.

Another area of controversy is AusAID's policy prohibiting the use of funds for 'activities that involve abortion training or services, or research trials or activities, which directly involve abortion drugs'. The United Nations Association of Australia stated that Australia's aid programme 'denies funds for activities that educate about safe abortion and denies assistance until a woman seeks post abortion care, assuming she survives the unsafe procedure' and that the guidelines 'have the effect of driving women down the path to unsafe abortion with the associated shame, disability, and often, death' (United Nations Association of Australia 2007). According to Christina Richards, former CEO of the Australian Reproductive Health Alliance, AusAID restrictions are 'more restrictive than domestic policies, and seek to influence practice and values in recipient countries in ways that contravene international human rights' (Richards 2007).

Despite the Howard government formally untying all aid in 2006, Australia's development assistance has been termed 'boomerang aid' because one-third of official aid never leaves Australia and up to 90 per cent of contracts are won by Australian-based companies (Duxfield and Wheen 2007).

In fact AU$88.5 million of official aid budgeted for 2007–08 has been earmarked for government departments other than AusAID without being earmarked for any particular region or country. Some of this funding will reach the shores of Australia's developing-country partners, but much will not. For example, a significant portion of Australian aid is effectively used to support Australia's tertiary education sector – one of Australia's largest export industries – through the provision of scholarships for students from the Asia–Pacific region to study at Australian universities. This is arguably designed to subsidise Australian universities, which have suffered from public funding cuts (Anderson 2006).

Conclusion

This chapter shows that ODA is often informed by self-interest and in general has failed to provide catalytic support for health systems development. There is a strong need for ODA to support health systems rather than discrete health services and vertical programmes. Civil society organisations have a role to play in ensuring that their governments move away from a

BOX D2.2.1 **Cuba's approach to foreign aid for health**

In August 2005, following the disaster of Hurricane Katrina in the US, Cuba offered to send a medical brigade of 1,586 health professionals along with 36 tons of supplies to the affected region. The brigade was assembled and ready for deployment within days of the hurricane. While Washington refused the offer, the brigade eventually applied its services a few months later, following the devastating Pakistan earthquake. By the time Canada's foreign affairs team arrived in Pakistan, Cuba already had 300 health professionals in the affected region. By the time the first Canadian doctors landed in Pakistan, the Cuban brigade had 600 health professionals on the ground, had constructed several field hospitals, and was already journeying to outlying regions, on foot, to treat victims in their home communities.

Altogether, 1,481 Cuban physicians and 900 Cuban paramedics served in Pakistan (Gorry 2005). The brigade managed to treat 103,000 patients over a three-month period (Granma International 2006). Upon leaving Pakistan, Cuba offered 1,000 medical scholarships for young Pakistanis to receive free medical training so that they could carry on the work the Cuban brigade had begun.

Cuban medical internationalism is a long-standing cornerstone of its foreign policy, dating back to assistance given to Chile after an earthquake levelled Santiago in 1960. Cuba has provided medical assistance to over 100 countries worldwide, including ideologically hostile nations, such as Nicaragua, following the 1973 earthquake that struck during the reign of the Somoza dictatorship.

For a poor country that has struggled with interminable economic shortcomings, Cuba has provided widespread health-care services to some of the poorest regions in the world. In response to Hurricane Mitch in 1998, Cuba sent medical brigades to Honduras, El Salvador, Guatemala and Nicaragua, countries that still receive Cuban assistance. As of 2007, Cuba had 31,000 health-care professionals working in 71 countries (CubaCoopera 2007).

Unlike many ODA interventions in times of disaster, Cuba, more often than not, remains on site well after other countries have pulled out. In East Timor, Cuban physicians remained for a year following earthquakes and landslides that left the country in peril (Gorry 2006). Cuba's approach involves strong investment in human resources – more so than material resources – to achieve long-term stability rather than short-term relief. Since 1999, Cuba has trained over 11,000 medical students from twenty-nine different countries, including the US (Huish and Kirk 2007). Aid is not a short-term endeavour but is seen as long-standing cooperation, knowing that achieving impact in communities takes as much time as it takes effort.

'donor interest' model of ODA to a 'recipient need' model, and must call for comprehensive and detailed evaluations of their countries' ODA and for the pledge of countries committing 0.7 per cent of its gross national income to aid to be realised.

The case study in Box D2.2.1 provides an alternate model of international aid and offers some salutary lessons for countries wanting to examine their own aid programmes.

Note

1. For more information, see www.idrc.ca.

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