



Burnet Institute

Medical Research. Practical Action.

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**Submission to the inquiry into the
implications of the COVID-19 pandemic
for Australia's foreign affairs, defence
and trade**

June 30, 2020

Committee Secretary

Joint Standing Committee on Foreign Affairs, Defence and Trade

PO Box 6100

Parliament House

CANBERRA ACT 2600

28th June, 2020

Re: Summary of Submission: Inquiry into the implications of the COVID-19 pandemic for Australia's foreign affairs, defence and trade

This submission focuses on the following item in the terms of reference: "Implications for Australia's Foreign Affairs, Defence and Trade policy, particularly with respect to strategic alliances and regional security". We interpret "regional security" as including health security, which is the existence of strong and resilient public health systems that can prevent, detect, and respond to infectious disease threats, wherever they occur in the region. Supporting health security in the region will help protect Australia not only from emerging health threats but also the broader destabilising impact wrought by the consequences of the pandemic on countries in this region. It is therefore, is clearly in the national interest.

Australia has so far acted robustly to provide assistance to countries in the Indo-Pacific region during the pandemic, especially in PNG, Pacific Island Countries and Timor-Leste. We also welcome the generous pledges to Gavi, The Vaccine Alliance, and to the European Commission-led COVID-19 vaccine research fund. The *Partnerships for Recovery* initiative by DFAT clearly sets out how Australia's development efforts will work alongside the full suite of our national capabilities to address the challenges of COVID-19 in the Indo-Pacific.

The direct impact of COVID-19 across the region has varied widely. The South Asian countries of India, Pakistan, and Bangladesh, as well as Afghanistan, are experiencing severe outbreaks. In South-East Asia, Indonesia is the worst affected country and its Papua province has one of the highest attack rates in the country. This poses the threat of exportation across the border into Papua New Guinea (PNG).

The Mekong sub-region countries of Vietnam, Cambodia, Lao PDR, and Thailand appear to have effectively controlled their outbreaks and are now reporting very few new cases. Independent Pacific Island Countries and Timor-Leste have been relatively spared; however, PNG has reported three new cases in the past week indicating that community transmission continues.

Our recommendations are divided between immediate needs for assistance in countries that have advanced outbreaks and those with few or no cases. In the first group, there is a need for technical assistance to fight the pandemic, especially to increase testing capability. In the less directly affected countries, support will be needed to alleviate poverty and food insecurity and to ensure that essential health services are maintained to minimise the negative impact on the prevention and management of other infectious diseases and health conditions.

In the medium-to-long term, Australia must make a firm commitment to strengthen prevention and preparedness for future outbreaks of emerging infectious diseases (EID) and pandemics in the region by strengthening health systems. The Indo-Pacific Centre for Health Security is ideally placed to lead this effort and its budget should be significantly increased and its mandate expanded.

Summary of Recommendations

1. The Australian government should increase its contributions to multilateral agencies that address poverty, such as the World Bank, IMF and the Asian Development Bank, and hunger, such as the World Food Programme and the Food and Agriculture Organization.
2. The Australian government should leverage strong existing relationships between Indonesian and Australian public health and research institutions to support the Indonesian Government's response to COVID-19 in **Indonesia**.
3. The Australian government should strengthen its current financial support to the refugee program in **Bangladesh** by contributions to testing, personal protective equipment, and treatment facilities focused on Cox's Bazar where most refugees are located. This could be channelled either through UNHCR or the international NGOs working in the camps.
4. The Australian Government should provide supplemental, targeted assistance to help **Afghanistan** to respond to a severe COVID-19 outbreak, particularly through increasing testing capability. While health is not currently a priority of the aid program, supporting the COVID-19 response would be consistent with Objective 3 of the program: "*Building resilience and supporting at-risk populations*". This supplemental funding could be provided directly by DFAT or through the Afghanistan Common Humanitarian Fund managed by UNOCHA.
5. DFAT should examine the need for support to enhanced COVID-19 surveillance and testing along the **PNG border** with Papua province. This could build on a number of existing DFAT-funded activities in border provinces such as STRIVE PNG and RID-TB.
6. The Australian government should increase the proportion of the aid budget allocated to the health sector and provide immediate support to partner countries to restore the following health services at pre-pandemic levels of access and coverage.
 - Maternal, neonatal and child health services, including routine immunisation services, provision of safe and respectful pregnancy, labour and birth and postnatal care and access to skilled birth attendants, addressing nutrition needs, and the management of childhood illnesses;
 - Sexual and reproductive health services, including access to contraceptives and the management of sexually transmitted infections, including HIV;
 - Malaria and tuberculosis treatment and control, especially in PNG where there is a resurgence of malaria and a high rate of drug-resistant TB;
 - The prevention and management of chronic diseases, including renal and cardiac disease and mental health conditions, especially in high priority PICs; and
 - Public health monitoring and surveillance.
7. The Australian Government should substantially increase the aid budget in the 2020/2021 national budget and also increase the proportion of the aid budget allocated to health to pre-

2014/15 levels. This will allow for the flexibility required to expand programming and address indirect and direct effects of COVID-19.

8. The Australian Government should continue to support and significantly strengthen the Indo-Pacific Centre for Health Security. **The definition of health security should be broadened** to emphasise the need to strengthen the health systems that have the responsibility to “prevent, detect and respond” to emerging infectious diseases and potential pandemics.

The Government should make a commitment to at least ten years of regional support for pandemic and EID preparedness, prevention and mitigation. This support needs to be informed by solid evidence generated by **applied health systems research** such as the eight studies being supported currently by CHS in PNG.

9. Recognising the interconnections between people, animals, plants and our shared environment the current commitment to the “One Health” approach should continue. Australia should play a strong advocacy role and be a global champion for this approach. Appropriate strategies to strengthen preparedness have been extensively described both in Australia’s own health security strategy and by the Global Health Security Agenda alliance. The time has come for these words to be translated into action to prevent and/or prepare for the next pandemic.

About the Burnet Institute

Burnet Institute is unique in Australia in being both a medical research institute accredited by the National Health and Medical Research Council and a development NGO fully accredited by the Department of Foreign Affairs and Trade (DFAT). The Institute’s vision is to achieve *equity through better health*.

The Institute’s mission is *to achieve better health for vulnerable communities in Australia and internationally by accelerating the translation of research, discovery and evidence into sustainable health solutions*.

While our headquarters are in Melbourne, the Institute has offices in PNG and Myanmar, as well as public health and research programs in [Cambodia](#), [Vietnam](#), [China](#), [Indonesia](#), [Lao PDR](#), [South Africa](#), [Timor-Leste](#), [Pacific Island Countries](#) and [Zimbabwe](#).

Underpinning our research and development focus are four multi-disciplinary programs which bring together our diverse staff skills to share their research and technical expertise across: (i) Disease Elimination (including malaria, HIV and viral hepatitis); (ii) Maternal, Child and Adolescent Health, including Nutrition; (iii) Behaviours and Health Risk; and (iv) Health Security, including drug-resistant tuberculosis.

The Institute is currently implementing a number of COVID-19 related activities, including:

- **Diagnostics**
Development of a rapid diagnostic point of care test to identify people who have been infected and cleared of COVID-19.
- **Antivirals**

Identification of potential drug treatments by screening of novel drugs with antiviral action for their ability to prevent or treat COVID-19 infection.

- **Vaccine**
Supporting vaccine research by the development and evaluation of antibody assays to understand the immune response to COVID-19.
- **Advocacy**
Providing strategic advice to Australia's Chief Medical Officer, state Chief Health Officers and Departments of Health.
- **Public Health**
Improving our knowledge through public health measures to strengthen care and stop community transmission of COVID-19 and studying the experiences of people who have recently or are currently undertaking self-isolation at home for COVID-19 to inform current and future pandemic response.
- **International health**
Supporting COVID-19 responses in Papua New Guinea, Myanmar and other countries through COVID-19 response training, public health awareness activities, modelling and other strategies

The Institute has an annual turnover of approximately \$53 million, of which more than one-half supports our overseas research and development programs.

Direct impact of COVID-19 on low and middle income countries (LMIC) in the Indo-Pacific region

South Asia

As of 28 June, India had the fourth highest number of COVID-19 cases in the world having reported more than 529,000 cases. In addition, Pakistan (200,000) and Bangladesh (134,000) have reported high numbers of cases. These three countries have reported 8.6% of the global total of COVID-19 cases. Afghanistan is also experiencing an escalating epidemic with low testing capacity and a fragile health system.

South-East Asia

A number of South-East Asian countries have responded effectively to the pandemic; for example, Vietnam, Cambodia and Laos have reported zero deaths between them. Thailand has also responded relatively well and has been reporting fewer than ten new daily cases during June. Myanmar has reported only 293 cases; however, its testing rate of 132 per 100,000 is one of the lowest in the world (compared with 9,151 per 100,000 in Australia). The Philippines has reported almost 35,000 cases and continues to report between 500 and 1,000 new cases daily.

The most severe epidemic is in **Indonesia**, which has reported more than 52,000 cases and continues to report more than 1,000 cases daily. Indonesia has reported the second highest number of cases in South-East Asia, after Singapore. However, the cumulative testing rate in Indonesia is 275 per 100,000 compared with 11,698 per 100,000 in Singapore.

Papua province has reported 1,670 cases (47 per 100,000 compared with national attack rate of 19 per 100,000), which is the second highest provincial rate in the country. Papua province borders with three provinces in PNG: East and West Sepik and Western, which poses a high risk of importation from Indonesia into PNG.

Pacific Island Countries

The Pacific region has been the least directly affected region in the world. Most cases have been in the US and French territories of Guam, French Polynesia and New Caledonia. Timor-Leste has reported 24 cases, Fiji 18 cases, and PNG 11 cases. Neither Timor-Leste nor Fiji has reported a new case for more than 2 months. **However, three new cases were reported in PNG's capital Port Moresby during the week of 21-27 June.**

Indirect impact of COVID-19 on LMICs in the region

While it is still too early to detect real-time effects, a number of modelling studies have predicted widespread impacts in LMICs on poverty, food security, health services and population health status.

Poverty

In normal times, people in poor countries have many ways to cope with shocks. If one member of a family falls sick, the others can work longer hours to make up for the lost income. Or they can ask cousins or neighbours for help. Or, if a whole village is impoverished by a bad harvest, they can ask a nephew working in a big city or a foreign country to send some extra cash. All these "coping mechanisms" depend on calamity not striking everywhere at once. However, COVID-19 has done just that.

In many places during the pandemic, workers cannot make up for lost income by working harder because demand for their labour has collapsed. Empty restaurants need no waiters; shuttered malls need no cleaning; and few motorists are rolling down their windows to buy fruit from street hawkers. The International Labour Organization estimates a decline in working hours in the second quarter of 2020 of around 10.7 per cent relative to the last quarter of 2019, which is equivalent to 305 million full-time jobs¹.

Previous viral epidemics had a profound economic impact on our neighbouring countries. The fear generated by the SARS outbreak in 2003 which caused nearly 800 deaths, resulted in a reduction of consumption expenditure, trade, tourism, business confidence and stock prices, costing \$50 billion in lost economic productivity². The outbreak sharply reduced tourist numbers to Australia from most Asian destinations by between 40 and 80 per cent³. Avian Influenza (H5N1) resulted in losses of between US\$10 – 20 billion across the region with significant impacts on small farmers and trade.

¹ https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/documents/briefingnote/wcms_745963.pdf

² JW Lee, WJ McKibbin. Globalization and Disease: the case of SARS. Asian Economic Papers, 2004 - MIT Press.

³ Australia Bureau of Statistics Catalogue No. 3401.0 Jonas, O, 2014, Pandemic Risk: background paper, World Bank in Huszar, A. and Pearson, M. 2015 Modelling of Health and Economic Impacts in 10 Indo-Pacific Countries.

The World Bank predicts that remittances from migrant workers will drop by 20% this year⁴. In Nepal, remittances form 27% of GDP, 67% of which comes from migrant workers in the Gulf countries. Severe COVID-19 outbreaks in Saudi Arabia, Qatar, UAE, Kuwait, and Singapore have largely affected migrant workers who have to cope with sickness and unemployment. Most of these migrant workers are from LMICs in South and East Asia, especially India, Nepal, Sri Lanka and the Philippines.

From 1990 until 2019 the number of extremely poor people—those who subsist on less than US\$1.90 per day—fell from 2 billion, or 36% of the world's population, to around 630 million, or just 8%. The World Bank estimates that national lockdowns and the global economic collapse will push at least 49 million people into extreme poverty, eliminating nearly all the gains made since 2017. Even that estimate may be optimistic as it was based on data published in April. In a worst-case scenario, more than half a billion people — almost 8% of the global population — could be pushed into poverty as a result of the pandemic, according to modelling by researchers at United Nations University's World Institute for Development Economics Research⁵.

Food insecurity

The loss of income caused by the pandemic could increase the number of people suffering acute hunger to more than quarter a billion by December, according to the World Food Programme⁶. In the last four years, conflicts, climate change and economic instability raised the number of people suffering acute hunger — when the absence of food endangers people's livelihoods and, in some cases, their lives — from 80 million to 135 million people. The pandemic could drive 130 million more people into that state by December. More than a quarter of a billion people are likely to be acutely hungry in 2020.

Workers employed in the informal economy and in service and manufacturing sectors in urban and peri-urban areas are particularly vulnerable. Many have already experienced job losses during extended lockdowns: A staggering 94% of the global work force lives in countries where workplaces have been closed.

The decline in export revenues and incoming remittances creates greater challenges for food-importing countries like Afghanistan, Ethiopia, Lebanon, Malawi and Solomon Islands, which will find it difficult to cover their import bills, risking significant currency devaluation and inflation.

Famines are not about food availability; they are about physical and economic access to food. The pandemic has worsened both, placing commercial transport under severe pressure and reducing purchasing power. Governments need to ensure that the production and supply of food is not disrupted. If farmers can't plant or harvest, if seeds and fertilizer are not available, if agricultural produce cannot reach markets, it will create dangerous food shortages.

⁴ <https://www.economist.com/international/2020/05/23/covid-19-is-undoing-years-of-progress-in-curbing-global-poverty>

⁵ <https://www.kcl.ac.uk/news/half-a-billion-people-could-be-pushed-into-poverty-by-COVID-19>

⁶ <https://www.nytimes.com/2020/06/12/opinion/coronavirus-global-hunger.html>

Disruption to health services

There are so far few concrete data on the impact of COVID-19 on essential health services in the Indo-Pacific region or elsewhere. However, there have been a number of modelling studies of the potential impact of COVID-19 on other disease control programs (such as TB, malaria and HIV), maternal and child health, and the management of chronic diseases. For example, in an article on the ReliefWeb website, the authors warned that even as the pandemic accelerates, governments must also protect other essential health services⁷. They note that one study estimated that a 50% reduction in access to services during the 2014-2015 West Africa Ebola outbreak led to an additional 10,600 deaths from malaria, HIV/AIDS and TB—almost equal to the 11,300 deaths directly caused by Ebola⁸.

Immunisation

Earlier this year, after the World Health Organization and UNICEF warned that the pandemic could spread swiftly when children gathered for vaccination, many countries suspended their inoculation programs. Even in countries that tried to keep them going, cargo flights with vaccine supplies were halted by the pandemic and health workers diverted to fight it.

Now, diphtheria is appearing in Pakistan, Bangladesh and Nepal. Cholera is in South Sudan, Cameroon, Mozambique, Yemen and Bangladesh. A mutated strain of poliovirus derived from the oral vaccine has been reported in more than 30 countries and cases of wild poliovirus in Pakistan have doubled compared with the same period last year.

Measles is flaring around the globe, including in Bangladesh, Brazil, Cambodia, Central African Republic, Democratic Republic of Congo, Iraq, Kazakhstan, Nepal, Nigeria and Uzbekistan⁹. Of 29 countries that have currently suspended measles campaigns because of the pandemic, 18 are reporting outbreaks. An additional 13 countries are considering postponement of campaigns. According to the Measles and Rubella Initiative, 117 million people are at risk of missing measles shots in 2020¹⁰.

Measles virus spreads easily by aerosol — tiny particles or droplets suspended in the air — and is far more contagious than the coronavirus. In poorer countries, the measles mortality rate for children under 5 ranges between 3 and 6 percent; conditions like malnutrition or an overcrowded refugee camp can increase the fatality rate. Children may succumb to complications such as pneumonia, encephalitis and severe diarrhoea.

The following summarises a number of studies on various aspects of public health in LMICs:

Maternal and Child Health: Modelling by a team at Johns Hopkins University found that their least severe scenario (program coverage reductions of 9·8–18·5% and wasting increase of 10%) over 6 months would result in 253,500 additional child deaths and 12,200 additional maternal deaths. Their

⁷ <https://reliefweb.int/report/world/balancing-covid-19-response-wider-health-needs-key-decision-making-considerations-low>

⁸ https://wwwnc.cdc.gov/eid/article/22/3/15-0977_article

⁹ <https://www.nytimes.com/2020/06/14/health/coronavirus-vaccines-measles.html>

¹⁰ <https://measlesrubellainitiative.org/measles-news/more-than-117-million-children-at-risk-of-missing-out-on-measles-vaccines-as-covid-19-surges/>

most severe scenario (coverage reductions of 39.3–51.9% and wasting increase of 50%) over 6 months would result in 1,157,000 additional child deaths and 56,700 additional maternal deaths¹¹.

Sexual and reproductive health (SRH): UNFPA has projected that some 47 million women in 114 low- and middle-income countries will be unable to access modern contraceptives if the average lockdown, or COVID-19-related disruption, continues for 6 months with major disruptions to services¹².

For every 3 months the lockdown continues, assuming high levels of disruption, up to 2 million additional women may be unable to use modern contraceptives. If the lockdown continues for 6 months and there are major service disruptions due to COVID-19, an additional 7 million unintended pregnancies are expected to occur.

The International Planned Parenthood Federation (IPPF) has reported that 5,633 static and mobile clinics and community-based SRH care outlets have already closed because of the outbreak, across 64 countries, including India, Pakistan and Malaysia¹³. They make up 14 % of the total service delivery points that IPPF members ran in 2018.

Tuberculosis: A survey by the Stop TB Partnership (STP) of 16 high-burden countries found that all National TB Programs (NTP) have observed a decrease in the number of people presenting/accessing services for TB. In India, there is approximately an 80% decline in daily TB notifications during the lockdown period compared to the average daily notifications; the only country that had real-time data to analyse¹⁴.

Modelling by the STP has suggested that globally there would be 608,400 excess TB cases and 126,100 excess deaths for every month of lockdown and a further 420,400 excess cases and 83,200 excess deaths for every month of restoring services after lockdown¹⁵.

Malaria: The Global Malaria Program has modelled the impact of nine scenarios based on various levels of disruption to the distribution of insecticide treated nets (ITN) and to effective malaria treatment¹⁶. If the 2020 ITN campaigns are cancelled and continuous distributions and access to effective malaria treatment are also severely disrupted (i.e., reduced by 75%) malaria cases are estimated to increase by 23%, while deaths would increase by 102%.

HIV and AIDS: WHO and UNAIDS brought together five teams of modellers that looked at the potential impact of treatment disruptions of three months or six months on AIDS mortality and HIV incidence in

¹¹ [https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X\(20\)30229-1.pdf](https://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(20)30229-1.pdf)

¹² <https://www.unfpa.org/resources/impact-covid-19-pandemic-family-planning-and-ending-gender-based-violence-female-genital>

¹³ <https://www.ippf.org/news/covid-19-pandemic-cuts-access-sexual-and-reproductive-healthcare-women-around-world>

¹⁴ http://www.stoptb.org/news/stories/2020/ns20_014.html

¹⁵ http://www.stoptb.org/assets/documents/news/Modeling%20Report_1%20May%202020_FINAL.pdf

¹⁶ Tailoring malaria interventions in the COVID-19 response. Geneva: World Health Organization; 2019 (<https://www.who.int/malaria/publications/atoz/tailoring-malaria-interventions-covid-19.pdf>, 20 April 2020).

sub-Saharan Africa¹⁷. In the six-month disruption scenario, estimates of excess AIDS-related deaths in one year ranged from 471 000 to 673 000, making it inevitable that the world will miss the global 2020 target of fewer than 500 000 AIDS-related deaths worldwide.

Australia's response so far

Australia's existing Indo Pacific Centre for Health Security (CHS) has played a positive role in coordinating Australia's response to the pandemic in the region thus far. This has included providing personal protective equipment, diagnostic testing assistance and support for infection prevention across Australia's neighbourhood. In Timor-Leste, the Centre and its partners are concentrating on disease surveillance and control, critical to stopping the spread of the coronavirus. CHS is jointly funding the WHO's Pacific regional coronavirus response plan with New Zealand. Epidemiologists from the ASEAN-Australian Health Security Fellowship Program, funded by CHS, are working with incident response leaders and frontline health workers in efforts to contain the COVID-19 pandemic across South-East Asia.

The *Partnerships for Recovery* initiative by DFAT sets out how Australia's development efforts will work alongside the full suite of our national capabilities—diplomacy, defence, security, commercial links, scientific skill, people-to-people ties—to address the challenges of COVID-19 in the Indo-Pacific. It places a clear priority on our near neighbours, particularly the Pacific, Timor-Leste and Indonesia. These are the places where Australia has the most extensive partnerships and can have most impact. It quite rightly focuses on strengthening health security, maintaining social stability, and stimulating economic recovery, as the underpinnings of our shared prosperity and the foundations that will allow us to emerge from this crisis.

We recognise the development, along with New Zealand, of the 'Australia-Pacific Corridor' to the Pacific and Timor-Leste. The humanitarian corridor—a complex logistical system of flights, consular, health and quarantine support—has ensured the continued supply of essential medical and testing equipment, critical personnel, and food and essential supplies in a time of strict border controls and reduced commercial flights.

We applaud the Australian government's recent pledge of \$300 million to Gavi, The Vaccine Alliance, which will help create equal access to life saving vaccines for children throughout the world. Moreover, we welcome Australia's pledge of \$352 million to the European Commission-led COVID-19 vaccine research fund.

In addition to the assistance announced within the Partnerships for Recovery that will focus on Australia's near neighbours, we recommend that Australia also generously support global programs that will address poverty and food insecurity in the poorest countries of the world.

¹⁷ <https://www.who.int/news-room/detail/11-05-2020-the-cost-of-inaction-covid-19-related-service-disruptions-could-cause-hundreds-of-thousands-of-extra-deaths-from-hiv>

Needs analysis and recommendations

The development cooperation and humanitarian assistance needs of countries in the Indo-Pacific region will be broad, varied, and challenging. The needs to address the immediate health impact of the pandemic are greatest in South Asia (including Afghanistan) and Indonesia. Australia has not had a development cooperation role in India for many years; however, quite recently there were Australian aid programs in Bangladesh and Pakistan. Australia still provides humanitarian assistance to Afghanistan.

While this analysis will focus on the health sector, we recognise that poverty and food insecurity are powerful predictors of poor health outcomes.

Recommendation: The Australian government should increase its contributions to multilateral agencies that address poverty, such as the World Bank, IMF and the Asian Development Bank, and hunger, such as the World Food Programme and the Food and Agriculture Organization.

Countries currently experiencing severe outbreaks

Indonesia: One of Indonesia's key requirements at this stage is to increase its testing capability. Its current testing rate is one of the lowest in the world. Australia should employ its diplomatic expertise to engage with Indonesia at the technical level. Many Australian health and research institutes and universities have long-lasting relationships with Indonesian institutions that could provide platforms for technical cooperation.

Recommendation: The Australian government should leverage strong existing relationships between Indonesian and Australian public health and research institutions to support the Indonesian Government's response to COVID-19 in Indonesia.

Bangladesh has a rapidly expanding outbreak and also has a low testing rate. Moreover, the country hosts almost one million Rohingya refugees from Myanmar. In one of the world's most densely populated refugee camps, 38 cases and two deaths have been reported. The coronavirus could spread rapidly through the crowded camp.

Recommendation: The Australian government should strengthen its current financial support to the refugee program by contributions to testing, personal protective equipment, and treatment facilities focused on Cox's Bazar where most refugees are located. This could be channelled either through UNHCR or the international NGOs working in the camps.

Afghanistan has reported more than 25,000 cases and 660 deaths. The outbreak was precipitated by the return of almost 300,000 refugees from Iran and Pakistan. The country continues to report between 600 and 800 new cases daily. The attack rate is 44 per 100,000, which is higher than India, Pakistan, Bangladesh, and Indonesia. The test rate is 109 per 100,000, which is lower than all four of those populous Asian countries.

A key constraint hindering a meaningful response to the pandemic is the low capacity for testing. Eight testing facilities established since January have a daily capacity of 100-150 tests each. However, there is a significant shortage of trained lab technicians and more testing kits are urgently needed. According to the International Organization for Migration, movement and quarantine restrictions have a limited

impact despite being in place countrywide but based on the socio-economic realities in the country - families cannot go for more than a few days without working in order to keep themselves afloat.

In 2019-20, the Australian Government has allocated an estimated \$82.1 million in total Official Development Assistance to Afghanistan, including an estimated \$80 million in bilateral country program funding managed by DFAT.

Recommendation: The Australian Government should provide supplemental, targeted assistance to help Afghanistan to respond to a severe COVID-19 outbreak, particularly through increasing testing capability. While health is not currently a priority of the aid program, supporting the COVID-19 response would be consistent with Objective 3 of the program: *“Building resilience and supporting at-risk populations”*. This supplemental funding could be provided directly by DFAT or through the Afghanistan Common Humanitarian Fund managed by UNOCHA.

Countries with no or low numbers of cases

These countries include the Mekong sub-region, including Vietnam, Laos, Cambodia and Myanmar, all Pacific Island countries, and Timor-Leste.

Based on individual country needs analyses, some of these countries will need assistance to help address food insecurity and economic recovery, as noted in the first recommendation above. We will focus on the health sector in this section, focusing on Pacific Island Countries (PIC).

Short-to-medium term

According to the World Health Organization (WHO) the following are the priority needs of PICs at this stage¹⁸:

- Expansion of testing capability including exploring alternative testing platforms
- Planning for the relaxation or lifting of lockdown, social distancing and other non-pharmaceutical interventions
- Monitoring consumption rates of personal protective equipment (PPE), and procurement pipelines
- Case management protocols for mild, moderate, severe, critical, and convalescent cases
- Risk Communication and Community Engagement
- Continuity of health care service delivery

Papua New Guinea: a special case

As noted in the earlier section on Indonesia, Papua province is reporting an increasing number of COVID-19 cases in areas that border West Sepik Province and North Fly District in Western Province. While the border is officially closed, it is porous and there is high risk of importation of COVID-19 cases. There is still much movement of the population due to trade, traditional family ties, school, work and health

¹⁸ https://www.who.int/docs/default-source/wpro---documents/dps/outbreaks-and-emergencies/covid-19/covid-19-external-situation-report-19.pdf?sfvrsn=ea24f9e7_2

care. While East and West Sepik provinces are submitting 100% of expected surveillance reports, Western province has not submitted any reports since the end of May.

Recommendation: DFAT should examine the need for support to enhanced COVID-19 surveillance and testing along the PNG border with Papua province. This could build on a number of existing DFAT-funded activities in border provinces such as STRIVE PNG and RID-TB.

Health system strengthening

Short-to-medium term assistance in the Pacific and South-East Asia should aim to ensure the continuation of essential health services, especially those that protect the lives of women and children, as well as the prevention and management of chronic diseases, such as diabetes.

The decrease by 27% in the Australian aid budget has disproportionately affected the health sector and -- given the impact of the COVID-19 pandemic globally and in the region -- Australia's response will require flexibility and a re-think on supporting the health sector.

Recommendation: The Australian government should increase the proportion of the aid budget allocated to the health sector and provide immediate support to partner countries to restore the following health services at pre-pandemic levels of access and coverage.

- Maternal, neonatal and child health services, including routine immunisation services, provision of safe and respectful pregnancy, labour and birth and postnatal care and access to skilled birth attendants, addressing nutrition needs, and the management of childhood illnesses;
- Sexual and reproductive health services, including family planning and the management of sexually transmitted infections, such as HIV and AIDS;
- Malaria and tuberculosis treatment and control, especially in PNG where there is a resurgence of malaria and a high rate of drug-resistant TB;
- The prevention and management of chronic diseases, an especially high priority in PICs; and
- Public health monitoring and surveillance.

Medium-to-long term

For many years, experts predicted that a pandemic of infectious disease, most likely transmitted by a virus, would occur soon. However, very few countries were prepared to cope with a pandemic of the magnitude of COVID-19. The most important lesson from this pandemic must surely be that in the future, significant resources need to be devoted to preparedness. A number of existing initiatives could provide platforms for preparedness:

- Launched in February 2014, the **Global Health Security Agenda (GHSa)** is a coalition of 67 countries (including Australia), international organisations and civil society promoting a multi-sectoral approach to spur progress toward full implementation of the WHO International Health Regulations (IHR), the Program for Strengthening Veterinary Services, and other relevant global health security frameworks.¹⁹ GHSa pursues a multilateral and multi-sectoral approach to strengthen both the global capacity and the capacity of individual countries'

¹⁹ GHSa, <https://ghsagenda.org/about.html>

health systems to **prevent, detect, and respond** to human and animal infectious disease threats whether naturally occurring or accidentally or deliberately spread. GHSA promotes the *One Health* model of collaboration between the human and animal health sectors to prevent, detect and respond to EIDs.

- **Asia Pacific Strategy for Emerging Diseases (APSED)**. It has been 15 years since APSED was conceived as the main strategic framework for the Asia Pacific Region to develop the IHR core capacity requirements. APSED pursues five interrelated objectives: 1) reduce risk; 2) strengthen early detection; 3) strengthen rapid response; 4) strengthen effective preparedness; and 5) build sustainable partnerships. Separate streams of work and technical advisory groups have operated for the two WHO regions – South East Asia and Western Pacific, respectively. Australia has been an active partner and funder since APSED's inception.

Relevant Australian experience

Australia has considerable previous experience in supporting regional initiatives of pandemic preparedness. In 2005, following the SARS epidemic, Australia developed the first Pandemics and Emerging Infectious Diseases (EID) Framework 2005–2010. The then Prime Minister John Howard allocated A\$100 million to fund various initiatives, including APSED (see above), the Pacific Regional Influenza Pandemic Preparedness Project, Australian Epidemiology Regional Assistance Program, World Organization for Animal Health (OIE) Project for Strengthening Veterinary Services, AusReady Facility, Pandemics and EID Program in PNG, and APEC Pandemics and EID Initiatives. Australia no longer funds these initiatives with the exception of APSED. A second Emerging Infectious Diseases (EID) Framework, 2010–2015 was launched in 2010. The Australian Government spent around \$194 million between 2006 and 2015 through the aid program to help countries in Asia and the Pacific combat EIDs—this was around 4 per cent of Australia's total aid expenditure on health during this period.

An evaluation of activities funded under the two strategies by DFAT's Office of Development Effectiveness in 2017 found that Australia's EID investments had contributed to substantial improvements in the availability and sharing of EID data in Asia and the Pacific over the last decade. This has resulted in timelier and more open exchange about EID threats and greater awareness of the EID situation within and between countries²⁰.

The Australian Government's Health Security Initiative for the Indo-Pacific region was launched by the Minister for Foreign Affairs on 8 October 2017²¹. With funding of AU\$300 million over five years from 2017, the Health Security Initiative aims to inform evidence-based planning, help prevent avoidable epidemics, strengthen early detection capacity, and support rapid, effective national and international outbreak responses. It does this by accelerating research on new drugs and diagnostics, expanding partnerships at the national, regional and global level to strengthen human and animal health systems,

²⁰ <https://www.dfat.gov.au/aid/how-we-measure-performance/ode/strategic-evaluations/Pages/pandemics-and-emerging-infectious-diseases>

²¹ <https://www.dfat.gov.au/aid/topics/investment-priorities/education-health/health/Pages/health-security-initiative-indo-pacific-region>

and deepening people-to-people linkages that build national and regional health security capacity. The initiative is implemented by the Indo-Pacific Centre for Health Security within DFAT²².

Recommendation: The Australian Government should substantially increase the aid budget in the 2020/2021 national budget and also increase the proportion of the aid budget allocated to health to pre-2014/15 levels.

Recommendation: The Australian Government should continue to support and significantly strengthen the Indo-Pacific Centre for Health Security. **The definition of health security should be broadened** to emphasise the need to strengthen the health systems that have the responsibility to “prevent, detect and respond” to emerging infectious diseases and potential pandemics.

The Government should make a commitment to at least 10 years of regional support for pandemic and EID preparedness, prevention and mitigation. This support needs to be informed by solid evidence generated by applied health systems research such as the eight studies being supported currently by CHS in PNG.

Recommendation: Recognising the interconnections between people, animals, plants and our shared environment the current commitment to the “One Health” approach should continue. Australia should play a strong advocacy role and be a global champion for this approach. Appropriate strategies to strengthen preparedness have been extensively described both in Australia’s own health security strategy and by the Global Health Security Agenda alliance. The time has come for these words to be translated into action to prevent and/or prepare for the next pandemic.

²² <https://indopacifichealthsecurity.dfat.gov.au/>