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PARLIAMENTARY GROUP ON POPULATION AND
DEVELOPMENT

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PARLIAMENTARY GROUP ON POPULATION AND DEVELOPMENT

Monday, 11 September 2006

Senators and members in attendance: Senators Allison, Crossin, McEwen, Moore, Nettle, Payne, Troeth and Webber and Ms Corcoran, Ms Hoare, Mrs Hull and Dr Stone

Group met at 8.39 am

Sexual and reproductive health and the millennium development goals in the Australian aid program—the way forward

BELTON, Dr Suzanne, Charles Sturt University

CAMP, Dr Sharon, Guttmacher Institute

FORREST, Ms Ruth, MLC Tasmania

GRAY, Dr Gwen, Australian National University

HAIRE, Ms Bridget, Australian Federation of AIDS Organisations

HOLMES, Dr Wendy, Burnet Institute

HULL, Ms Kay, Member for Riverina

JOSEPH, Mrs Rita

O'KEEFFE, Ms Annmaree, Deputy Director-General, Global Programs Division, AusAID, and HIV-AIDS Ambassador for the Asia-Pacific

OPPEN, Ms Alice, Women's Plans Foundation

PEPPARD, Dr Judith, Flinders University

POWELL, Ms Kelsey, Sexual Health and Family Planning Australia

THOROLD, Ms Bridgette, Oxfam Australia

TYNDESKOV VOETMANN, Ms Anne Marie, Department of Foreign Affairs, Denmark

WHITTAKER, Dr Maxine, Senior Adviser, International Health, JTA International

ZWI, Professor Anthony, School of Public Health and Community Medicine and Associate Dean (International) Faculty of Health, University of New South Wales

CHAIR (Dr Stone)—Welcome. This is the second roundtable discussion of our forum. We are looking at sexual and reproductive health and the millennium development goals in the Australian aid program—the way forward. We want to particularly acknowledge the support of DFAT in this two-session forum, which has been most helpful to us. I want to say too that we have numbers of people sitting up here because we are very egalitarian and with each separate speaker there will be an introduction from one of the members of the Australian Population Development Group.

We want this to be a discussion as much as possible—though, of course, we acknowledge people are here to get information, to learn from experts who are in the field or who are working in different parts of Australia. We are also very keen to learn about international best practice. We hope there will be plenty of opportunity for discussion, for questions and for dialogue. We are recording this session which means for those of you who want to know exactly how it all went after the session, or who have friends who want to know how it has all transpired, we will have a *Hansard* record.

The first of our forums on this issue of sexual and reproductive health in the Australian aid program was on 14 August. There we discussed the benefits of investing in sexual and reproductive health, which are fairly self-evident, microbicides, sexual and reproductive health in crisis and fragile states and sexual and reproductive rights. We also want to welcome, besides our own PGPD members, a group member from Tasmania, Ruth Forrest. We still do not seem to have quite got Ruth. I do not know whether she has been held up on a plane or whether there are issues but we hope Ruth will be joining us. We are very much trying to build our parliamentary support in all states and territories in Australia and Ruth is one of our colleagues in Tasmania.

We also have with us Professor Terry Hull from the ANU, Professor Anthony Zwi from the University of New South Wales and other academics from both universities. Amongst us are practitioners, representatives of private contractors, students, interested members of the public and fellow members of parliament. We also want to welcome back Dr Sharon Camp who was one of our key speakers at the last forum and gave us a very excellent address. She is from the Guttmacher Institute and has returned from New York to join us. We are very pleased that you are able to join us today, Sharon. Anne Marie Tyndeskov has made the journey all the way from Denmark and just arrived yesterday. We welcome you. You look pretty alive and with us, despite having taken a very long plane trip just yesterday. We very much welcome you and thank you for joining us. We look forward to your presentation.

We also have Annmaree O’Keeffe from AusAID, who will be making the opening statement. Welcome to other AusAID representatives, including Philippe Allen and Alexandra Robinson. AusAID, of course, is very much a part of these roundtable meetings. We very much welcome the recent white paper from AusAID. As a group we have found it to be a very useful and important document to help us deliver aid into our region. We thank you for being part of that AusAID white paper development.

The topics for discussion this morning include the Danish strategy, the promotion of sexual and reproductive health and rights, integration of HIV-AIDS and sexual and reproductive health, family planning and post abortion care. The secretariat will give some indication reminding speakers when they are nearing the end of their allotted time because we have a lot of speakers and we are most keen to keep to our time.

Let me move straight on to welcoming Annmaree O’Keeffe who is going to make an opening statement. She is Deputy Director-General of AusAID’s Global Programs Division and Ambassador on HIV-AIDS for the Asia-Pacific. Annmaree was appointed Australia’s Special Representative for HIV-AIDS by, of course, our Minister for Foreign Affairs, Alexander Downer, in July 2004. In conjunction with the release of the white paper on Australia’s aid program in April 2006, Annmaree was appointed Australia’s Ambassador on HIV-AIDS. The focus of this

position is to encourage political, business and community leaders in the Asia-Pacific to provide the direction and support needed to meet our HIV-AIDS threat. Of course, we live in a region where our very near neighbours, particularly PNG, are experiencing a catastrophic situation in relation to HIV-AIDS infection, and we are most concerned that we do all we can to support our nearest neighbours, as well as being very vigilant and appropriate in what we do in our own country.

Ms O’Keeffe has more than 20 years experience in development. Therefore, she is very well placed for further cooperation with Australia’s regional partners in advancing the fight against HIV-AIDS. She is a steering committee member of the UN’s Asia Pacific Leadership Forum on HIV-AIDS and Development, a consultative council member of the Australian National University’s Centre for Democratic Institutions, as well as being on the advisory council of Griffith University’s Asia Institute. As I said to you before, she is concurrently Deputy Director-General of Australia’s agency for international development, AusAID, and responsible for global programs, so who better to kick off our forum today than Annmaree O’Keeffe? We welcome you, Annmaree, and invite you to speak to our forum.

Ms O’KEEFFE—Thank you very much, and thank you very much for the opportunity to be able to brief the Parliamentary Group on Population and Development on the aid program’s work in sexual and reproductive health and also HIV-AIDS—not so much the broad brush of what we are doing in HIV-AIDS, otherwise I will be here all morning and longer, but that work which is very important not just for women’s health but for women in a broader sense.

I want to kick off with mentioning that there have been three particularly important developments this year for the aid program, and they all feed into the significant strengthening of the aid program’s work in the area of sexual and reproductive health. The first one, already referred to this morning by Minister Stone, was the release of the aid program’s white paper in April this year. This paper not only recognised the critical importance of strengthening the aid program’s focus on women and children’s health, but also actually highlighted it as part of a three-pronged approach to improving health services in the region where we are operating either on a bilateral basis or on a regional basis. The three prongs are: firstly, addressing the health needs of women and children; secondly, strengthening health systems; and, thirdly, targeting country-specific health priorities. Let me focus just for the moment on the health needs of women and children.

The white paper identified the core elements as being a focus on maternal health, sexual and reproductive health, access to safe and effective contraception based on informed choice, nutrition and education for girls, and programs to combat gender based violence. Improved nutrition, tetanus immunisations for pregnant women, clean childbirth facilities, breastfeeding programs, and antibiotics for infections were also singled out as significant areas for support by the aid program. That was the first important development.

The second one was the placement by the white paper of gender equality as one of three overarching principles for the way in which Australia must implement the aid program. I want to reassure you that advancing gender equality has been an objective of the aid program for over 30 years, but the prominence given to it by the first-ever white paper on the aid program provides us now with an unprecedented opportunity to ensure that not just the principles of gender equality

but also the practicalities of it, the actual implementation of it, are more effectively and very deeply entrenched within the aid program.

I will give you a little bit of background on how we are going to do this. We are currently in the process of developing a new gender equality policy and strategy to guide the whole program. In the broader sense of the program, the white paper has made it very important—in fact, imperative—for us to revisit the different country and regional strategies we have and look at them again in the light of what the white paper is instructing us to do. This gives us a fantastic opportunity to ensure that, from the very beginning of a new country or regional strategy, we have built in all the principles and requirements that we see as essential to ensure that gender equality is part of the program.

This does not just mean saying gender equality is important. I get really impatient with that because it is a motherhood statement. It is really looking at why it is important and how we are going to ensure that people not just understand why it is important but do something about it, so we have it up front as something that needs to be done. I will come to what the full focus will be.

What is also really important is having indicators built into each of the programs to see how we respond to the rhetoric. There is too much rhetoric on this issue, and there has to be a real response in terms of what we have achieved out of what we said we would achieve. What are we saying we are going to achieve? In the broader sense it is improved economic status of women; equal participation of women in decision-making and leadership, including in fragile states; improved and equitable health and education outcomes for women and men; and gender equality advanced in regional cooperation efforts. That was the second most important development.

The third development was the launch of the health policy, which was referred to in the white paper. This policy, *Helping health systems deliver*, lives up to the promise of the white paper. It says:

To help achieve the MDG targets of reducing maternal mortality by three-quarters and child mortality by two-thirds by 2015 Australia will provide both long-term support to strengthen health systems and targeted programs for women's and children's health that contribute to rather than undermine health systems.

The new policy—I have brought a copy along today, but it is available on our website as well—has involved extensive consultation from international and national health experts and a very wide community of stakeholders. In particular, in the area of sexual and reproductive health, the policy highlights our commitment to the ICPD. It also stresses the role of female education and the fact that male roles also need to be considered in programs aimed at improving women's and children's health.

This brings me to an underlying and very important point which I would really like to stress. It is essential that we all see the work that we are doing in women's and children's health not in isolation from the rest of the program. For example, even within the health sector work we are doing, while we have a very strong emphasis on women's and children's health, we also have a very strong emphasis on strengthening health systems. I think international experience and our experience have shown that, while we can have these injections of support into particular aspects of health—be it women's and children's health, HIV-AIDS or malaria—if the underlying health

systems in the countries in which we are operating are inadequate at best and mostly dysfunctional then whatever we do is going to be very short term. We can immunise a whole bunch of kids today, but if the health systems do not work they will die of diarrhoea tomorrow. It is a fundamental of what we are trying to do to strengthen those health systems.

The other very important point is the symbiotic relationship between health and education. While we are focusing today in this forum on women's health, I want to—more than reassure you—point out very strongly that we are also developing a policy on education, and a very key, important part of that policy is going to be increasing the access for the education of the girl child. I think all of us in this room understand the importance of any success in reproductive and sexual health also rests very much on how successful we have been in terms of strengthening education for the girl child in a broader sense.

I am conscious of the time, so I just want to move very quickly to HIV-AIDS and the response of the aid program. We have a very, very significant program of work in HIV-AIDS, so today I am just going to focus on feminisation of HIV and the response of the aid program. Anybody who has had anything to do with HIV, even just very briefly, understands very clearly the strong links between HIV and development. It is not a health issue; it is a development issue. Health is just one part of the whole broad spectrum of what HIV is doing and how it evolves and develops. I think the importance of it in terms of its impact on developing countries is a ghastly statistic—and that is, nine out of every 10 people in the world who are infected with HIV come from developing countries. That is a symptom of the fragility of the fault lines in these developing countries.

The fault lines vary from country to country and so today I am going to talk about one particular fault line, and that is gender inequality and the feminisation of HIV. Women in sub-Saharan Africa are infected more often and earlier than men. Young women aged 15 to 24 are between two and six times as likely to be HIV positive as men of a similar age. Similar patterns are found in the Caribbean, although not as exaggerated. In our own region of Asia-Pacific, Papua New Guinea stands out as a country where the trend of feminisation is increasingly visible.

If I had a PowerPoint—I did not bring it because time was too short—there is a pretty telling graph which shows the way in which that balance has been changing between men and women in terms of infection since the first case of HIV in PNG in the mid-1980s. It is a telling graph. So why is this happening in PNG? One really has to look at the drivers of the epidemic there. In other parts of Asia, the epidemic is largely propelled by injecting drug use, men having sex with men or commercial sex work. But in PNG it is an epidemic which has as its drivers sexual violence, high rates of sexually transmitted infection, pretty ghastly health facilities and, most importantly, a very low status of women. This obviously is a poisonous mixture which has seen the infection rate between men and women steadily change since, as I mentioned before, the first case reported, in 1987.

Taking a broader view of gender inequality that is imbedded in many cultural traditions and its relationship to HIV, the impact on women, even if not infected, sees the domestic burden of AIDS fall most heavily on them because they are the traditional carers and they are the traditional homemakers. The latest report from UNAIDS 2006—it is a tome but well worth reading; I do recommend it to you—pragmatically says that, while care is a compassionate

undertaking, it is also a burden that limits the educational and economic opportunities for women and girls. And of course, if infected, the stigma suffered by women is more acute because of negative assumptions. A recent study in India found that, while almost 90 per cent of HIV-positive women were infected by their husbands, they faced more stigma and more discrimination than men and were often blamed for their husband's illness and banished from the family home.

I will just go back to PNG for a moment and to recognising gender inequality and associated sexual violence as fundamental factors driving the epidemic there. AusAID's approach—because we have a very significant program responding to the HIV epidemic in PNG—to tackling HIV has at its core the essentiality of dealing with gender inequality. Without it, it is a bit like health systems without gender inequality: whatever we attempt to do to respond to the HIV epidemic will have limited enduring success.

We know it is going to be very slow; it is going to require a generational effort. But I find it kind of ironic that HIV has presented an opportunity for this and other countries where gender and equality is an issue. For so many reasons, until now it has been very easy and convenient to ignore or place less energy into seriously tackling gender issues and development because the risks of not doing so—the costs of not doing so—did not affect us today. It was not so visible. But it was not so easy to translate this action into critically damaging economic and social consequences. HIV has demonstrated profoundly and acutely that to ignore gender issues does lead to significant, damaging economic and social consequences. We see that in sub-Saharan Africa. We cannot allow it to happen in the Asia-Pacific region. Thank you.

CHAIR—Thank you very much. It was a very timely reminder of the core issue, gender inequality, leading to life and death in terms of a society's long-term survival. We did not slot in a question time immediately after Annmaree O'Keeffe's paper or opening remarks, but Annmaree will be here for the rest of the morning and we will invite you later on to address any particular issues to her. I am sure she will be happy to respond. I thank you very sincerely, Annmaree, that was an excellent introduction.

Let us move on. It is my privilege to introduce our very special visitor, Anne Marie Tyndeskov Voetmann, who, as we mentioned before, is fresh off a plane and who is going to discuss the development of the Danish policy document *The promotion of sexual and reproductive health and rights*. We welcome you most sincerely, Anne Marie. Depending on how time is going, we will either have time for some questions or move to the next speaker and then have questions in a group after that.

Ms TYNDESKOV VOETMANN—Thank you. Good morning ladies and gentleman. I would now like to take you through my presentation.

A PowerPoint presentation was then given—

Ms TYNDESKOV VOETMANN—I have four babies: Andreas is 11, Elisabet is nine, Carl Christian is seven—and my baby, this strategy document, is only four months old. I have been responsible for developing this year the Danish strategy on sexual and reproductive health and rights. This subject is dear not only to me; the Minister for Development Corporation in

Denmark also feels very strongly about promoting sexual and reproductive health and rights, as do all the parties in the Danish parliament.

I would like to thank the Parliamentarian Group on Population and Development for inviting me here to Australia to talk about my baby, the strategy document. I have been looking forward to coming here. I am very encouraged by the growing Australian interest in sexual and reproductive health. I hope to be able to contribute to your discussion here in Australia on how to move forward on sexual and reproductive health in your aid program. I hope we will be able to cooperate more closely with Australia in the future. There is certainly a need for more political and financial support for sexual and reproductive health if we want to realise the Cairo agenda and if we want to reach the MDGs.

I will start by going briefly through the process of producing the new strategy. In 2004 the Danish government decided to develop a new strategy. It was announced in the yearly priority plan of the government, and it was also announced that the focus would be on women and the link between HIV-AIDS and sexual and reproductive health and rights. We also wrote a report on Danish efforts to the Danida Board. Danida used to be a separate agency but it is now in the ministry. Maybe you all know it. It is comparable to AusAID.

In 2005 we had an ICPD Plus 10 conference in Denmark. We organised it together with the Danish family planning association. It was a conference where we had Danish and international NGOs and partners. We took stock of progress. We pointed to the challenges ahead, and we also discussed how to further strengthen efforts to implement the Cairo agenda.

We had a concept paper written in August. We also had focused theme group discussions with a number of selected Danish NGOs and partners. The writing of the strategy did not take much time. It was written from August to October. Then in November we had a first draft, which we took for internal hearing at the departments and embassies of the Danish ministry.

In November I flew to Mozambique with the draft. We had what we call a stakeholder consultation that was arranged by UNFPA. We had the chance to discuss the strategy with national representatives, international organisations and partners. They could give us feedback on how they felt this was working in their environment.

In December we had the public hearing. That is a tradition we have in Denmark. When we are developing new strategies in the aid area, we put it on the web and everybody can give their comments on it. In January and March we had internal hearings of the Danida Board—the senior management and the minister. The final hearing was in April, when we had the foreign affairs committee. They had to see the strategy. They have to formally approve the strategy before it becomes an official strategy in Denmark. Then there was the launch in May by the minister and Garca Machel, who is a well-known champion of women's health and women's rights.

Why did we have a new strategy in Denmark? First of all, for many years sexual reproductive health and rights have been a high priority. The last strategy was written more than 10 years ago. It was in line with the Cairo spirit but it was time to update it. We believe the Cairo agenda is crucial for fighting poverty and for promoting development. Also, 2004 was a good chance. We had the ICPD Plus 10 stages. A number of reports were written and there were also several conferences. We knew what the results were so far and we also knew the challenges. It was clear

to us that we needed to strengthen our implementation efforts if we wanted to reach the Cairo agenda and reach the MDGs.

Then there was another thing coming up, and that was the September 2005 UN summit. We have always believed that there is a need to link those two areas, and there seemed to be a possibility to do something about that at the summit in 2005. I would like to go into a little detail about that, because it is an important part of the strategy. Denmark, like others, believed that the Cairo agenda was not fully reflected in the MDGs, especially the central ICPD goal of access to services and information.

Denmark was very happy when the UN summit created an important momentum for the Cairo agenda last year. Heads of governments committed themselves to achieving the ICPD goal of universal access to reproductive health by 2015 and to integrate this goal into strategies to achieve the MDGs. This was, we believe, the major achievement at the summit and something we can build on. This commitment has given us the basis for including a new MDG target on universal access to reproductive health information and services. This is expected to be announced very soon by the Secretary-General of the UN in his report to UNGASS.

Furthermore, it was decided at the summit that that part of the reduction strategy paper should be based on the MDGs. If we have a new subtarget on access to reproductive health services and information, this should ensure that the Cairo agenda will have a much higher priority, especially in the discussions at a country level. Denmark was strongly involved in ensuring this result at the summit, and we believe that it is important that we use the momentum created now to move on.

What are the overall objectives of the Danish strategy? They are to achieve the ICPD goal of sexual and reproductive health and rights for all by 2015, to strengthen the Danish contribution through the implementation of the Cairo agenda and the Cairo program for action, to ensure that the ICPD goals are integrated into objectives, plans, strategies and indicators for the achievement of the MDGs, and to strength cooperation internationally and at a country level.

To achieve these goals we have four thematic priorities structured within the MDG framework. This is of course done to underline the link between the two, but the four thematic priorities are also based on the results of the ICPD+10 status reports which I talked about earlier. The four thematic priority areas are: promoting gender equality and empowering women, which is related to MDG3; improving sexual and reproductive health, which is related to MDG5, improving maternal health; young people's access to information and services—and, as you know, there is not a specific target for youth in the MDGs, but I think we should relate it to No. 5; and linking the response of HIV-AIDS with sexual and reproductive health and vice versa, which is related to MDG6, combating HIV-AIDS. I know the last one is related to other illnesses as well, but that is where the focus is. Underscoring these priorities is a rights based approach. The strategy lists a number of actions under each thematic priority area which I will not go into detail on right now.

I would like to focus a bit more on gender and resources. Sexual and reproductive health and rights is a crucial factor for sustainable poverty reduction and for sustainable development. If families have fewer children, they have a healthier economy and more resources for the family. Children are more likely to get education, have more to eat and have better health. All these

outcomes will, of course, feed back into strengthening sexual and reproductive health in the long run. It is like a good circle started by this. Globally, reducing population growth means less pressure on resources and on the environment. These are very important issues. The last one is, of course, linked to MDG7.

With regard to gender equality and the empowering of women, we believe it is important to see women as a driving force for development. The previous speaker already emphasised this link, but I would like to go into detail on how we see it from our point of view. Sexual and reproductive health and rights are closely connected with gender equality and the possibility for women to contribute actively to development. We need to focus more on women in development processes. Many women experience marginalisation, violence and oppression. This not only is a rights violation but also deprives them of the opportunity to contribute actively to development. Deciding freely over one's own body, including deciding if, when and how many children to have, and being able to make informed choices and access services has consequences for the individual woman, her family and society at large.

It is a pity that each year millions of reproductive sources are lost due to sexual and reproductive ill health. I know this is especially the case in Africa south of the Sahara where I think about 60 per cent of the health burden is due to sexual reproductive ill health, and I think it is also very much the case in Asia where you have your main focus.

I would like to come back to how we are going to implement the strategy. The strategy has a paper on international and bilateral efforts to implement these thematic priorities. I would like to start with the bilateral efforts to promote sexual reproductive health and rights and the Cairo agenda. We need to cooperate with governments and other partners including NGOs. We need to integrate the Cairo program of action into international sector programs and powerful reduction strategies, including strategies to fight HIV AIDS, and promote gender equality. It is not only the health sector which is important; it is also very much the education sector that needs to be taken into account. Then we need to strengthen coordination and cooperation among partners and players and to encourage and support political leadership vis-a-vis sexual reproductive health and rights, gender equality and HIV AIDS prevention.

Then we have international efforts, and here the strategy underlines the need to promote sexual reproductive health and rights and the full implementation of the ICDP program of action in international agreements and resolutions. We would very much like to draw more donors and partners into development coalitions around sexual reproductive health and rights, ensuring greater political and financial commitment and reducing opposition. I have highlighted this one because, hopefully, we will see Australia among the partners that will cooperate more closely in the future. We also need to influence political and technical organisations to further promote gender equality and sexual reproductive health and rights, among which are UNESCO and WHO.

Finally, we want to strengthen dialogue on sexual reproductive health and rights in UN executive boards with and among UN organisations. There are more interventions listed in the actual strategy but I think it will be too much to go through all of them today. I would once again like to thank you for inviting me here to talk about 'my baby'. We are looking forward to seeing what comes out of your process here in Australia and we are hoping that we will be able to cooperate more closely in the future. If we are able to contribute to your process, we hope you

will call us and come to us. For our part; we would very much like to help you in any way. Thank you very much.

CHAIR—Thank you very, Anne Marie. Obviously there is a lot of similarity, and understandably so, between Australia's approach and Denmark's. I suppose the proof is ultimately in the pudding—what happens on the ground—isn't it, and that is why we have got to make sure that it is a properly funded resource.

Senator ALLISON—You hinted earlier that Australia might join with Denmark in these efforts. What is your perception of our commitment to sexual and reproductive health on the world stage?

Ms TYNDESKOV VOETMANN—It is for Australia to decide if you want to join us. If I had to point to where there might be some differences, in Denmark the rights-based approach is very important to us, and I am not so sure whether that is a point you focus on very much here in Australia. Of course this one of the difficult issues when we discuss the situation internationally. When we have the discussion the UN this is really the area where it is a bit difficult. But I think maybe too much time has been spent on these very difficult negotiations related to human rights, and so on. There is so much to do that we should not just spend all our time discussing forth and back. I think it has not been very productive and I hope that we can move forward in really implanting the Cairo agenda and looking at what can we do at the country level to implement it. I think there is a lot to be done and even though we do not totally agree on everything that would be my hope.

Ms GOLDIE—I will be talking about men as partners and reproductive health later, but to what extent does your 'baby' incorporate the concept of men as partners in delivering reproductive health?

Ms TYNDESKOV VOETMANN—We have also taken this into consideration. We find that very important because they should have a responsibility and they should also be involved in this, so it is written within the strategy. We think it is important. I have not of course covered everything in the strategy here but it does have a mention in the strategy.

Prof. ZWI—I was interested in your comments and also in Ann Marie's earlier, and I was wondering whether you could draw attention to a few things. One is the role of research in influencing any of your key policies. You did not specifically refer to it but I know within the white paper and within the health policy over here the issue of research in forming development practice is a major new thrust. It would be very interesting to hear how in Denmark you have facilitated research and how that has been taken on board in policy development.

The second issue I wanted to raise was something that you drew attention to, which was the stakeholder meeting in Mozambique and the value of working in the particular regions where you are providing donor support in terms of consulting with local organisations, government, local NGOs and the UN and how best that feeds into the policy process. There is a third issue I wanted to raise. Denmark is a small country, a small donor, and Australia is also a small donor in the big scheme of things in terms of who is providing major development cooperation funding.

What has been learnt in Denmark about developing strategic niches like this and really pursuing those very actively?

Ms TYNDESKOV VOETMANN—I hope I remember all the questions or you may have to come back. Firstly, you asked about research. I am not a researcher myself, but as part of preparing this strategy we had people from the university coming and contributing to this. They also emphasised the importance of this area and we worked together with them. We support different organisations that do research, like the Population Council. We recognise the importance and also the importance of building up capacity at country level to take care of research. It is important to have some of these local issues in the local environment and build up this area. I do not think I will go much more into detail on that.

Secondly, you asked about the country process. In Denmark we have what we call a partnership approach. It is very important for us, when we start programs and cooperation, that we discuss with the country their actual strategies. We like to build our cooperation on what they would like to have as a priority. It is clear that, having the MDGs and poverty reduction strategies, it would very much build around this focus. We hope that, as partners in a sexual approach, we will be able to bring this issue of sexual and reproductive health and rights higher up on the agenda, but we also expect the UN organisations that have mandates within this area to do their work. The WHO and UNFPA especially should be able to influence this process at the country level so that we will have strong efforts to implement the Cairo agenda at the country level. I do not know whether that was what you asked about. I went to Mozambique to discuss how they felt they could use this paper, this strategy, to work more constructively at the country level. You had a third question, but I have forgotten it.

Prof. ZWI—It was about strategic niche development efforts. Strategically, as you are aware, Denmark and Australia are relatively small players. How best can they focus their efforts on achieving important points?

Ms TYNDESKOV VOETMANN—I am not quite sure. Even though we are a small donor, we have been able to influence this agenda somewhat—for instance, what we have done with regard to the UN summit. We have been working very hard with the EU partners, because we are not able to do this on our own. There has always been strong support for the Cairo agenda in the EU. There are maybe new countries that are not as positive towards the Cairo agenda as the old ones were, but we have been working very hard with our colleagues in the EU to make them request this link between the MDGs and the Cairo agenda. We are also very used to working with a small number of donors internationally, and I think we have been able to produce results, but we need more people to come in. Sometimes we feel like the usual suspects screaming or shouting to have this agenda taken more seriously. We would certainly welcome more donors and partners.

CHAIR—Thank you very much for that. I am sure that as the morning goes by we will be keen to hear about actual on-the-ground programs—perhaps what you are doing in the Asia-Pacific area, where we might be able to work together into the future. Can we all join hands and thank Anne Marie Tyndeskov Voetmann from the Department of Foreign Affairs in Denmark. We trust that you will enjoy the rest of your stay in Australia, Anne Marie. I will now pass on to Senator Kerry Nettle, who will introduce our next speaker, Dr Maxine Whittaker.

Senator NETTLE—My job here today is to introduce Dr Whittaker, who is a Senior Adviser in International Health from JTA International. In her work, she specialises in health policy, health development and health aid effectiveness. When I look through the list of topics that people are giving talks on, ‘Awareness to implementation’ is obviously something we are all very interested in—how we can we get from awareness and knowledge about the importance of these issues to the implementation on the ground and effectiveness of particular programs. I ask you all to welcome Dr Whittaker here this morning.

Dr WHITTAKER—Honourable members, guests, colleagues, ladies and gentlemen: thank you very much for the opportunity to present a paper to this important committee and for the opportunity to speak on this topic. Before I start, I would like to acknowledge the traditional landowners of this site.

Today I wanted to elaborate a bit on some of the points that were in the paper. I will very briefly reiterate some of the epidemiological and demographic profiles of reproductive health issues in the world, situating this within a rights agenda as well as a reproductive health approach. One of the other aims throughout my paper is to remind us of what we are talking about in the developing world and to provide some voices and faces to the problem. I would like to acknowledge that any photos of people that appear in this presentation were included with their permission.

Very briefly, reproductive health has been defined as a state of complete physical, mental and social wellbeing, not merely the absence of disease or infirmity, in all matters relating to the reproductive system and its functions and processes. Reproductive health implies that people are able to have a satisfying and safe sexual life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. That last point also includes the rights of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for the regulation of fertility which are not against the law in their country, and the right of access to appropriate healthcare services that will enable women to go safely through pregnancy and childbirth and to provide couples with the best chance of having a healthy infant.

The focus is on the link between MDGs and reproductive and sexual health. The previous speaker showed some good linkages between some of the MDGs—MDG 3, relating to gender equality and inequitable access to basic services and benefits; MDG 7, relating to the country’s economic and development base and how these link to sexual and reproductive health; and particularly MDGs 4 through 6, which relate specifically to health. Also, what is important to note is that not only does the lack of achievement of these MDGs contribute to poor reproductive and sexual health; poor reproductive and sexual health again comes back and exacerbates the ability to achieve these and to achieve development.

Basically, good development practices contribute to improved sexual and reproductive health and improved sexual and reproductive health contributes to improvements in the development of nations. This was summarised quite well in the statement by Louise Frechette, the UN Deputy Secretary-General:

The more we are able to help girls and women gain life skills and control of their sexual and reproductive lives, the more we can help them gain financial and social empowerment, and the more we can help them protect themselves against HIV and other sexually transmitted infections.

As has already been mentioned, sexual and reproductive ill health accounts for a large percentage of the global burden of disease in women of child-bearing age in the whole world. It represents one-third of the global burden of disease for women in this age group and it accounts for one-fifth of the total burden of disease in all ages, male and female. Reproductive and sexual ill health is a public health priority for every country and for a development agenda.

About 50 per cent of conceptions in the world are unplanned and about 25 per cent are unwanted. Three hundred million couples do not have access to family planning services and it has been estimated that this unmet need for family planning is a problem for about 17 per cent of currently partnered women. Meeting this unmet need would avert 52 million unintended pregnancies annually and prevent 142,000 pregnancy related deaths and 1.4 million infant deaths. Family planning in development assistance should include access to all methods of fertility regulation which are safe and effective and not against the law in that country, and this includes emergency contraception, advocacy for improved quality of care and support, and support for a focus on increased access to female controlled methods and dual protection.

Every minute of the day one woman dies from a pregnancy related cause. About every third or fourth of those women dies due to unsafe abortion. It has been estimated that about 800,000 women die annually from complications of pregnancy and childbirth, all but 4,000 of whom are in the developing world. This is more than four times the death toll of the Aceh tsunami. This is about five to six Qantas 747 fatal crashes daily. For every woman who dies, up to 10 more women will have significant morbidity. For many, this lasts the rest of their lives.

In Australia, women have a lifetime risk of dying due to a maternal death of one in 6½ thousand, but our sisters in Eastern and Southern Africa have a one in 15 risk. So supporting the implementation of the safe motherhood package and approaches, including neonatal care, should be a priority for development assistance. This may include in many locations actual investment in infrastructure for safe motherhood services and for accessibility to services and referrals. An important point that was brought up by our first speaker is to look at the synergism between other development assistance in other sectors and its impact upon sexual and reproductive health, which can be a positive impact. An example I can think of, particularly in Papua New Guinea, where I spend a lot of my time, is the link between road infrastructure and access to services. It is very important that when we design a whole country program that we look at those interrelationships between all aspects of the development program.

Every year four million babies die in the first month of life and four million are stillborn. The causes of these are often pregnancy related and related to other conditions that exacerbate sexual and reproductive health, including malaria in pregnancy, gender violence and, of course, what many people call another gender violence, inequity of access to services and poor quality of the services that are accessible. One hundred and fifty thousand pregnancies are terminated daily, a third of these in unsafe conditions, and they result in 500 deaths a day.

In circumstances where abortion is not against the law, health systems should train and equip health service providers and take other measures to ensure that abortions are safe and accessible.

In 2005, WHO has included medical abortion drugs as part of the essential drugs kit, medicines that it considers satisfy priority healthcare needs of developing country populations and that are efficacious, safe and cost effective. Manual vacuum aspiration is also a safe, effective method of surgical abortion but is also part of a package of safe post abortion care. Safe post abortion care services should be available in all countries to reduce maternal mortality and morbidity and other family health consequences. Providing access to these technologies will increase equity of access to a safe motherhood package. This next overhead represents a Thai woman's voice about an unsafe traditional abortion that she experienced.

Six out of 10 women in many countries have sexually transmitted diseases. All of these face higher risks of infertility, cervical cancer and other serious health problems. STIs also lead to complications for men, and recent research suggests linkages between STIs and prostatic cancer as one example. So the prevention and treatment of STIs is an important part of a development assistance package in health. It is quite shattering, I think, to see that annually in the world there may be 120 million new cases of trichomonas, 50 million new cases of chlamydia and 25 million new cases gonorrhoea. These rates are 10 to 100 times higher than you would expect in the developed world.

In PNG, our nearest neighbour, some field based studies conducted by the PNG Institute of Medical Research found that, amongst a rural women population in the Asaro Valley in the eastern highlands, almost 60 per cent of the women had at least one proven sexually transmitted disease and 14 per cent had clinical evidence of pelvic inflammatory disease. Not only are these statistics; these also impact upon the quality of a woman's life. This Vietnamese woman described it to me like this: 'Sometimes I have an infection with itch and vaginal discharge like fish blood. This is very harmful. It is so itchy that I want to put a finger inside and hook it out. I scratch and I scratch. Many women have the same and all want to do the same.'

Every minute of the day 11 people are infected with HIV. Six to seven of those are women. Worldwide, less than one in five people at risk of HIV has access to the means of preventing it and only one in eight has access to testing. Again, if we look at our nearest neighbour, Papua New Guinea, we can see the effect that, even with low scenario rates of prevalence of HIV, it is estimated that by 2020 there will be 13 per cent fewer people of a working age in the population than if we did not have the epidemic at all. So a focus on the prevention of HIV and the care of people living with HIV and their families is a major development that is required. In health, the integration of HIV into health service delivery, health system strengthening and other aspects of HIV mainstreaming are important.

STIs are one of the major causes of infertility for men and women. The WHO estimates that 60 to 80 million infertile couples are living worldwide, and childlessness is not just a sad situation for women and men who want children but can be a factor that contributes to gender violence and divorce. In many settings these lead to poverty and commercial sex work for the women.

Worldwide at least one in three women is beaten, coerced into sex or somehow otherwise abused during her lifetime. The prevention of gender violence and safe, appropriate, humane care provided to women who have suffered, including the provision of emergency contraception, post-exposure ARV prophylaxis and programs of support to women and their families, need to

be an essential part of a public health package. I will not go through the diagram that I am showing, but it shows the intimate links between violence against women, STIs and unwanted fertility.

In adolescent reproductive health worldwide, at least two-thirds of all reported sexually transmitted infections occur in men and women under 25. Previous speakers have also talked about young women's vulnerability to HIV. The needs of adolescents for sexual and reproductive health care needs to be a stronger focus in development assistance programs. Reproductive cancers are a major and increasing problem. The majority of these cases can be prevented by existing cost-effective interventions. The prevention of reproductive cancers and palliative care such as pain relief, oral morphine, for example, should be part of an essential public health development assistance package. There are other health issues, such as malaria, maternal tetanus, tuberculosis and poor nutrition, that impact upon reproductive and sexual health.

In my paper I say that one of the reasons we need to focus on sexual and reproductive health is that it is a human right. The International Planned Parenthood Federation analysed UN charters, rights documents et cetera to determine what are the 12 reproductive rights. I think the statement by Gro Harlem Brundtland, who was the former DG of WHO, is particularly important. It focuses on the link between poverty, which is not only a lack of money but a lack of choice, and how, when people are denied this choice, they are denied opportunities to improve their lives and the lives of their loved ones. So giving opportunities that address particularly sexual and reproductive lives and their links to poverty is an obligation of all of us.

We know what the services are, we know we have a problem and we know what the interventions are, but we still have access gaps. A reproductive health approach is well defined, and the table I am showing elaborates what those elements are. We also have a well defined quality of care approach to safe motherhood, reproductive health services and family planning. So we know what that package is.

But we know that accessibility is a vital factor to ensure that these needs for quality of care and aspects of reproductive health are required. That includes physical access, cultural and gender acceptability, women's autonomy and the ability of the services to provide a competent non-judgemental quality service. But access is affected by a woman's ability to make decisions for herself, physical access, affordability, quality of services and the attitude of staff. So support to health development programs needs to include improved equitable access to prevention, treatment and care as a major objective of the program. Both speakers before me talked about women's autonomy as being a major factor that affects reproductive and health services, and this Vietnamese woman quoted in the slide elaborates upon that herself.

If we just look at some figures about lack of access to services, only 42 per cent of all people at risk of sexual exposure to HIV can actually obtain a condom, nine out of 10 people in the developing world who need antiretroviral treatment are not receiving it and only 12 per cent of people worldwide who want to be tested for HIV can actually access voluntary counselling and testing services. So we know what is needed, what it costs and that it is cost effective. It has been estimated that to provide family planning services only costs US90c a person; antenatal and delivery care, \$US3; and STI care, US20c. These costs are less than a cup of coffee or tea or a can of coke.

It has been estimated by the ICPD 10 that we need about \$US18.5 billion to reach the worldwide financial commitment in 2005 for reproductive and sexual health care. This has not been met. If you look at those figures we talked about, Australia's health expenditure is \$72 billion a year; we need \$US18.5 billion for the whole world for sexual and reproductive health services. Global military expenditure in 2003 was estimated to be \$US950 billion. I know one of the other speakers will be talking about reproductive health commodities and financing gaps. That line there shows that, if we do not increase donor financing, even just to reproductive health commodities, there will be a \$US210 million gap between what we need to reach targets and what funding we presently have.

In conclusion, the transformation of reproductive and sexual rights and health into reality for many women and men demands a big step requiring political will, national and international financing, monitoring and evaluation and equal participation of all citizens. It needs concerted efforts by all, nationally and internationally, to advocate for reproductive rights, for funding for reproductive and sexual healthcare services and for maintaining and increasing allocations from developed countries to development assistance, not only for health but also for the interrelated sectors of health, education, poverty alleviation and human rights. I think these women from a Vietnamese commune where I worked summarise it well:

We only hope that the government gives priority to women, provides medicine to treat women's diseases and protects us against these diseases. ... So help rural women have the information and education to study about and protect themselves against these diseases.

CHAIR—Thank you very much. Does anyone have any questions that they would like to ask Dr Whittaker?

Senator ALLISON—You stressed several times, in referring to abortion, the laws with regard to abortion in those countries. I presume that those countries still have unsafe abortion in great numbers. Is there not an agenda for reforming law in those countries where it is illegal?

Dr WHITTAKER—There definitely is an agenda for being involved in advocacy for, and maybe legal support to, reform of abortion in many countries. In Papua New Guinea, there is interest among many public health practitioners—obstetricians and gynaecologists—to be involved in some reform. One of the laws that inhibit access to even a medical abortion in Papua New Guinea is an 1876 law that has been carried over from Queensland. You are talking about very ancient laws, that we have passed by a long time ago, that inhibits access even for conditions such as rape or a risk of women's lives. There is an agenda for that, I believe. But even in countries where it may be difficult to openly start that agenda—because some of these things take a long time and you need to be very cognisant of the possible consequences of pushing too hard too early—there is the role of post abortion care, so that at least women who do have an abortion, whether it is self-induced or miscarriage, can have access to safe services after the abortion has occurred. I think that is an important part of a package that we should be supporting.

Senator NETTLE—Does anyone else want to ask Dr Whittaker a question?

Ms GOLDIE—Several times through that I wanted to burst into tears. On one occasion, it was the woman whose husband did not want her to go and get treatment and said he would not care for her if she did come back. I am wondering to what extent countries like ours—the givers—can impose gender equality on recipient countries. What is the scope for changing a culture such that men and women are more equal, given that we do not yet have it in our own country?

Dr WHITTAKER—Thank you for that question. If I knew the answer to that, I would probably be a world renowned cultural anthropologist, which I am not; I dabble in it. Firstly, I keep reminding people, when they sometimes feel frustrated about this, that we are talking about development. Development means it is a step-by-step process. It takes time and it needs to be relevant and acceptable and informed by the people where you are working. Just last week, for example, we finally had a meeting where we videoconferenced, with people in Washington, Canberra and other places, to Papua New Guinea to finally talk about gender violence as a public health issue. We have had that on the agenda for a long time, and many people have worked on it, but it has had to be a very slow process, because some of the women in Papua New Guinea put themselves at risk if they stand out and talk about this.

One female doctor up there—who has been an advocate for a long time—has been harangued in meetings when she has raised the issue of gender equality and gender violence. The medical society of Papua New Guinea and a whole range of people there have been involved, and there may be a statement coming out—we hope this week—from two government ministers in Papua New Guinea about gender violence being a public health emergency for Papua New Guinea.

That has taken five or six years. It has taken time behind the scenes; it has taken time, slowly working through with people and building up their understanding of the impact of it, and getting them to inform us about how we should approach it. In Papua New Guinea they advise it has to be a male and female issue. It is the same with a lot of these issues about gender equality: many men are not getting equitable access to services either. We need to look at it from a family point of view, and from a male and female point of view, and try in both cases to do no harm.

Senator NETTLE—Are there any further questions for Dr Whittaker?

CHAIR—That was very excellent information and a real clarion call for us. We had a talk from a UNFPA last week and they reminded us that in PNG as well, they have the highest rates of violence against children in the world.

Dr WHITTAKER—Yes.

CHAIR—This is serious violence, sometimes leading to permanent impairment and so on, so it is not just women and men but also their children who are suffering very substantially. As our nearest neighbours, we really have an enormous need to somehow assist in helping those families to survive.

Dr WHITTAKER—Yes.

Senator NETTLE—I would ask everyone to thank with applause Dr Whittaker for her contribution. I will hand over to Senator Moore, who will introduce our next speaker.

Senator MOORE—She is Dr Wendy Holmes from the Burnet Institute. Wendy's CV is astoundingly impressive but I just want to mention that she is currently the Senior Research Fellow at the Burnet Institute Centre for International Health, where she is currently the deputy director for technical programs. Her very impressive CV mentions that she worked in Aboriginal communities in Central Australia, in Zimbabwe and in the Victorian Aboriginal community before studying for her master's degree, in community health in developing countries, at the London School of Hygiene and Tropical Medicine in 1992. The topic of Dr Holmes's presentation is the integration of HIV and sexual and reproductive health services.

Dr HOLMES—I would like to thank the chair and the Parliamentary Group on Population and Development for the opportunity to speak to you this morning. I would like to thank Maxine for her acknowledgment of the Indigenous people of this place. I would also like to thank you, Maxine, for your talk. It was excellent for preceding what I am going to talk about, in particular for setting out that terrible spectrum of the burden of sexual and reproductive ill-health for women, men and their families.

I am going to talk a bit about the integration of HIV infection prevention and care with sexual and reproductive health and with maternal and newborn health. In talking about that, I think one of the key important issues is that there is a great deal more money allocated currently for HIV prevention and care than for sexual and reproductive health. I think all over the world, but especially in our region, where HIV is less prevalent than in African countries, it is especially important that the things that we do to try to prevent HIV infection in children are things that also contribute to improving the reproductive health of women, men and their families. I want to tell you this morning about a meeting that is going to be taking place in November—a very large and significant meeting in Malaysia. It is a combination of WHO, UNFPA, UNICEF and UNAIDS representatives, who are collaborating in this meeting.

I would also mention, as Maxine did—and I think it is an important thing—that all the people in the photographs in my presentation gave their permission for this use. I want to talk a bit about the meeting in Kuala Lumpur in November. I want to talk about the history of policy on preventing mother to child transmission of HIV and tell you why I think the policy has been flawed, what I think we do need to do about preventing mother to child transmission in the Asia-Pacific region and then perhaps make some suggestions for what the parliamentary group could do to assist.

Of course, this is relevant to a number of Millennium Development Goals, and I particularly want to highlight the development goal that relates to the global partnership for development—our side of the compact, if you like. The meeting is actually two separate meetings and there has been recognition of the overlapping agendas of these meetings. One is that WHO has an agenda, together with the other UN agencies, of integrating sexual and reproductive health, maternal and newborn health and HIV prevention and care. And the UN PMTCT task force for Asia and the Pacific region has an agenda of promoting primary prevention—preventing mothers and fathers from getting HIV in the first place—and assisting men and women who want to avoid pregnancy to do so. What I have been pointing out is that there are two agendas—one of people promoting the integration of these services and health promotion, and one of those who are trying to prevent HIV infection in children and have more comprehensive approaches towards that—and

really the actions we need for those two agendas are the same. So I am very glad that we are having an integrated meeting—a joint forum—in Kuala Lumpur.

Just a little bit of background about the transmission of HIV from mother to child: if there are a hundred positive pregnant women, on average 35 of their babies will be infected. The timing of transmission is also important. The majority become infected during labour and delivery. A smaller proportion become infected earlier in pregnancy, but most towards the end of pregnancy, and about 13 on average will become infected through breastfeeding, most in the early weeks. We know that there are several influences on that risk of transmission, but the greatest influence is the level of virus in the woman's blood. That is also reflected in her breast milk. We know that viral load is high in the weeks after infection and then it drops down as the body makes antibodies that reduce the level of virus to a very low level and it will remain at that low level often for many years until it starts to go up again once the virus has damaged the immune system.

There are many things that influence the level of virus in the blood but one of them is any infection that occurs, and there is increasing evidence now that any illness during pregnancy will increase viral load and thus increase the risk of mother to child transmission of HIV. So we know that antenatal care, even without specific PMTCT services involved in it, is very important for reducing the number of babies with HIV.

The UN interagency task team has a four-pronged strategy. You will note that this slide has the UNICEF's logo on it. It is not one of my slides. It shows, though, what the thinking has been about the approach to preventing HIV infection in children, which is that of course they emphasise primary prevention—preventing young men and women from becoming infected with HIV—and then, if they should become infected, preventing unintended pregnancies. If pregnancy has occurred and there is an HIV positive pregnant woman, the next prong is to prevent transmission from the infected woman to their infant, through providing antiretroviral drugs as prophylaxis. And then the fourth part is care and support.

In reality the focus has been on prong 3 alone, which is preventing transmission from an infected woman to her infant. Within prong 3, the focus has been on providing antiretroviral prophylaxis to the mother; HIV and infant feed counselling; and, where it is safe, caesarean section to reduce the risk. This looks a busy slide, but I want to go through it and explain to you why there is such a problem with this very narrow focus on preventing HIV infection in children. I have put the babies at the top. So if we imagine there are lots of babies with HIV, let us think about where those babies come from. They come from both HIV positive women and HIV negative women. As Maxine reminded us, the majority of these women, whether they are positive or negative, do not know their status. Less than 10 per cent of people in the world with HIV know their status.

Some of the babies come from mothers who were already infected before they became pregnant who then attended antenatal care. Some of them will have received voluntary counselling and testing and the intervention. They will have a lower risk of transmission to their babies—between two and 10 per cent. The ones who attend antenatal care but do not get the intervention, which is the majority of women currently, have a risk between 25 and 50 per cent. I have made this arrow a little smaller than this other arrow just because they have attended antenatal care. I think if they have had any sexually transmitted infections treated, if they have

had malaria treated and prevented and other infections treated, they will have a lower risk of transmission to their baby. The ones who do not attend antenatal care will also have a risk between 25 and 50 per cent, depending on whether they are ill already with HIV infection and have a high viral load.

Now I want to draw your attention to these negative women who become pregnant. This is a point of intervention to prevent the babies getting HIV; to prevent these unintended pregnancies. There is approximately 25 per cent unmet demand for family planning services in our region. So if we imagine that 25 per cent of these women did not want to become pregnant, that is one way that we could reduce the number of babies with HIV. And that is something that we could do across the board not just for women that we know to be HIV positive. These women become pregnant, but when they are pregnant they are still susceptible to HIV. In fact we know that they are more susceptible to HIV infection. There are many reasons why women are more physiologically susceptible during pregnancy. They are also more likely to be exposed to sexual transmission and to transmission through blood transfusion.

This now shows the men. During pregnancy and the post-partum period, it is very common for there to be a period, often quite a long period, of abstinence between the husband and wife. If you imagine this young man, he has maybe been married for a while to his beautiful young wife, he has probably been used to having sex every day and suddenly he is not having sex with his wife anymore. It is most likely that he will go and have sex with someone else during that time. Men really lack information. They have a very high risk. If they become infected, they will have their peak in viral load in the weeks when they return to having sex with their wife. And if she is in those early weeks of breastfeeding, she then has a very high risk of transmission to the baby. So this man has, without knowing it, thinking that he is just doing something a bit reprehensible, has actually put his baby's life at risk, his wife's life at risk and his own life at risk. I think it is a men's rights issue that they have a right to this information. The importance of this is that these women have a much higher risk of transmission to the baby. So even though there will be fewer of these women becoming infected compared to the transmission occurring from the infected women, the risk is much higher.

This is a graph that shows the impact of primary prevention. It is very difficult, of course, to get good prevalence and incidence data from many settings, but in Thailand they have had very good prevalence and incidence data. If we look at 21-year-old male military conscripts, in the early 1990s there was that huge increase of infection in Thailand. This turned downwards once the 100 per cent condom promotion program was introduced. A few years later, paediatric AIDS cases followed exactly the same pattern and came down. So the men were infected, then the women got infected, they had their babies, the babies became ill and presented as paediatric AIDS cases. At this stage the antiretroviral program was introduced nationwide in Thailand. Certainly it saved thousands of babies' lives and there has been a dramatic decrease since it was introduced. But the decrease had begun already. I have been at so many conferences and meetings where this chart of paediatric AIDS cases has been presented to show the success of antiretroviral prophylaxis. I think it is very important to look at the reason that Thailand has been so successful at preventing HIV infection in babies, which is because of their excellent primary prevention and the amount of money they invested in that. And there has also been some impact from the antenatal testing program.

In Toronto, Nigel Rollins presented an important study in which they tested six-week-old infants for antibodies in the antenatal clinic. He presented this as being an important way of screening the success of the PMTCT program. He did not highlight—but I am highlighting—that 7.6 per cent of the women who tested negative in the antenatal clinic had babies that tested positive at six weeks. This is in quite a mature HIV epidemic, and women were very susceptible during pregnancy and had a high rate of transmission to the babies.

We need a human rights perspective and we do not need to talk about are we worrying about the mothers or are we worrying about the babies because we are worrying about both the mothers and the babies. Mothers care for their children and, even if they are not being treated themselves, they often want help to prevent the baby being infected. Mothers are mothers within families and mothers are mothers within communities. The new WHO PMTCT guidelines from last August say that their comprehensive approach is built around the routine offer of HIV testing and counselling to all pregnant women. This is where I disagree with them for our region. They see testing and counselling in the antenatal clinic as the entry point to all the prongs: if they are HIV negative then you do primary prevention, if they are positive you provide the prophylaxis, referral for follow-up care, support and treatment and advice about contraception. They do not see the population level interventions that could be achieved without necessarily testing and counselling all women.

We have developed a model. You do not need to understand all of it, but I want to show you how it is based on a series of decisions about whether people are able to attend antenatal care or not, whether they have HIV or not and whether they get the intervention or not. From this we can calculate the proportion of all HIV infection in children that could be averted with the intervention. When looking at some of the countries in the region, the assumption is that all women can attend antenatal care equally and that women who can attend antenatal care are no more or less vulnerable to HIV than women who cannot. Of course, that is not the case. Most women who are vulnerable to HIV are marginalised in some way. They may be young, part of an injecting drug using community or sex workers, so they may have greater barriers to accessing antenatal care. If the efficacy was the same as with single dose nevirapine, which is the most commonly used intervention at the moment, then we can see that in Cambodia, even if you had 80 per cent coverage and uptake, which is much higher than is the case, you could only prevent 21 per cent of HIV infection in children using this intervention. This highlights the importance of having a broader spread of interventions and making sure that what we do contributes to the other reproductive health problems, especially maternal health.

This is just a diagram about how integrating maternal and child health care and promotion, HIV prevention and care, and sexual and reproductive health care and promotion—all of these are activities—will contribute to preventing HIV infection in children as well as addressing the underlying causes that Annmaree talked about at the beginning. Then, within that, there are some specific interventions to prevent mother-to-child transmissions of HIV—for example, and this is the one I most want to emphasise, the value of introducing a routine couple visit as the second antenatal visit. We can do this even where we are not arguing for voluntary counselling and testing during the antenatal clinic. If we think of Laos or Sri Lanka, for example, these two countries have very low prevalence of HIV and it would be madness to invest a lot of resources in testing every woman in the antenatal clinic when there is so much need for strengthening health care systems more generally and improving reproductive health more generally.

It might take a while for a couple visit to become the norm. It is not the norm anywhere in the world currently, but most public health interventions take five to seven years to be introduced and to become accepted. It need not be presented as an HIV couple visit; it can be talked about as a need to discuss and test for other infectious diseases that could affect the baby such as TB and STIs, to talk with the man about discussing warning signs in labour and plans for emergency transport.

If men are appealed to as the decision-makers in their families then there is evidence from a number of countries that shows men are willing to attend antenatal care. They can be told about the risk to the baby if they have unprotected sex, they can be told that sex during pregnancy with their wife is safe and they can be provided with condoms. We need community education about parent-to-child transmission, especially appealing to men's sense of responsibility to protect their family. If we talk generally in primary HIV prevention about the appeal to men's desire to procreate and to have children, to have descendants, then I think that would be a motivator for behaviour change.

I want to mention the role of the workplace and that we should be promoting HIV testing in the workplace. I think that would lead to a greater uptake of antiretroviral prophylaxis for pregnant women than the testing of women in the antenatal clinic because they often cannot disclose to their husbands and they suffer terrible stigma and discrimination when they are tested. But we should be testing men as well as women, and preferably couples together. We can counsel men before marriage on a number of interventions.

I will go through why the policy has been flawed—because I had that trouble with the computer—and talk perhaps for a minute about what I think the Parliamentary Group on Population and Development can do. I think you have a very important role in advocacy within the government of Australia and with AusAID. I am not suggesting that AusAID need convincing. I think the health policy, as we heard from Annmaree earlier, has followed an excellent process of consultation and is a very useful and important document highlighting very important priorities. ASEAN has an HIV work plan, and I think that parliamentarians are in a position to talk with their colleagues in ASEAN about their agenda, which includes this emphasis that I am describing in their HIV work plan, and with the Asian Forum of Parliamentarians on Population and Development.

The key messages are the importance of investing in strengthening healthcare systems, because we cannot have this integration of services without greater investment in healthcare systems; focusing on women's and men's rights—it is not just women's rights, although it certainly is about women's rights—and that a child survival approach needs a focus on women's health, that we are not just trying to prevent transmission to the baby but we want the mother to be alive to look after all of her children; involving men; reaching out to marginalise vulnerable women with services and referral; and promoting the appeal to the desire to procreate in general HIV prevention. Thank you.

Senator MOORE—Thank you, Dr Holmes. Are there any questions for Dr Holmes?

Mrs HULL—Thank you, that was extremely informative and I am wondering if we might be able to get a copy of your presentation? That would be fabulous.

Dr HOLMES—Certainly.

Mrs HULL—I will just go a bit left field. We all recall back in Australia, well over 20 years ago, the most public case of Eve van Grafhorst who was a child infected with HIV through blood transfusion as a premie baby. We actually ostracised that child out of Australia because she was not able to attend a preschool for the fear that she may bite a child or something might take place that could transfer HIV to other children. Could I just ask a question out of left field? Some 20-odd years later, how are we dealing with that same issue for children entering school who are HIV positive? Outside of giving them the right to stay quiet, and for their parents to not have to disclose this, how would we manage this process now? What would be different today in Australia if I was taking a HIV positive child to preschool for the first time and confronting exactly the same issues with parents because of the lack of supposed outside education on this? How would we deal with that now?

Dr HOLMES—I think that is a very interesting question. I am not sure I am any better placed to answer it than others because my work is not based in Australia. However, I am very familiar with the HIV positive women's groups and the group Straight Arrows, which is a group for families living with HIV in Victoria. I think that, because relatively few women in Australia have been infected with HIV compared with men—and we have very few children with HIV in Australia—similarly to 20 years ago people are very unfamiliar with the idea of children having HIV infection in Australia. So I think any school would be likely to be very ignorant. What would happen now, I hope, is that any mother with HIV or a child with HIV infection would be in touch with a support group—would be referred to an HIV positive support group. Those support groups have been through this many times before and would be able to assist them to talk with the school. Once people are well informed about the way that HIV spreads and does not spread then I think that they would tend to be very accepting.

Senator MOORE—There are no waving hands—oh, yes, there are two waving hands. We have five minutes for questions. We will go to Sharon first.

Dr CAMP—I have two comments. One is that I believe there is now data that indicates that family planning programs, primary prevention through the prevention of unintended pregnancy, are preventing more HIV positive children than are the specific programs designed to have that impact. Have you seen that data and would you care to comment on that? The other comment probably reflects the fact that I am from the Guttmacher Institute—and therefore from the United States and a little cynical given our political climate. I am wondering if the wrongheadedness of this policy and its sort of focus on the innocent victims does not reflect a hesitation to deal with the basic issues of human sexuality and how this disease is actually transmitted. That may be a particularly US view at this point.

Dr HOLMES—I really think that that is very true and I think it is true in a number of ways. I think one of the reasons why the increased susceptibility of women during pregnancy has not been looked at is because people do not think about women having sex when they are pregnant. When Gisselquist wrote his ill-conceived paper about sexual transmission not being the main cause of transmission in Africa, he put together all the different studies, which was a really useful thing to do, showing the very high—higher than expected—incidence during pregnancy and concluded that this was because of unsafe injection practice in the antenatal clinic. I do not think it ever crossed his mind that women have sex during pregnancy. Even where there are

taboos against sex during pregnancy, they no longer tend to be strictly adhered to. So you have the taboo, so you have sex outside marriage, and then you have people coming back. I think that is one of the reasons.

I think it is also that policy has been influenced primarily by clinical trial researchers and clinicians. I view all this as inevitable. There is no criticism really. It was inevitable that, once it was found that zidovudine, the antiretroviral drug, could reduce the risk to babies, they would look to do it in a more cost-effective way in developing countries. It was inevitable they would do that in countries that have good infrastructure, such as Thailand and South Africa. And it was inevitable that WHO would then call together PMTCT experts who would be the clinical trial researchers. That they have a clinical perspective that begins with the positive pregnant woman is also natural. As you have just said, politicians and bureaucrats often find it easier to talk about babies, tests and medicines than sex, condoms and injecting drug use. There is political pressure. Women with HIV, quite rightly, are saying: 'We want access. We want to be able to have babies. You must provide us with services.' And they are quite right. But vulnerable women are not calling out saying, 'You must protect us from getting HIV,' so there is no political pressure for primary prevention.

Then there is organisational inertia. It is so hard to turn a big ship around, even once some of them recognise the problem. There are guidelines, training materials, indicators for antenatal screening and PMTCT programs. But for the other interventions the tools are much less well developed. Most reviews on PMTCT in the literature still focus only on what I call antenatal screening PMTCT.

Then it is so complicated to explain it. It always takes so long to talk about antiretroviral drugs. These guidelines—the latest guidelines from WHO—are worth a look. They are so complicated that it is going to be very difficult to use them at all. That cannot be helped; it is the nature of the subject. Then they are often being introduced as vertical programs.

You also asked about the impact of family planning services. I have done some modelling which I would love to share with you. And there have been previous models looking at family planning. Being able to prevent unintended pregnancies and prevent HIV infection in the first place can certainly contribute, currently, more than antenatal screening PMTCT programs.

Ms HAIRE—Thank you for that wonderful presentation. I am going to ask you to speculate, on how misunderstanding of the partial effectiveness of circumcision might be going to affect men's willingness to adopt condoms.

Dr HOLMES—Yes, it is a worry, isn't it? You come around here and look at it and it seems absolutely fantastic, for those who do not know that there is a randomised control study providing very good evidence that adult male circumcision is extremely—amazingly—effective at reducing the risk of HIV infection. Nevertheless, it does not reduce it by 100 per cent, and so any man who is circumcised can still transmit HIV to his wife.

Across the board, if there were adult male circumcision the risk to women would be much less—no question. If the men are not getting HIV, women are not going to get HIV. So, on the one hand, it is a good thing. On the other hand, of course, the fear is that, as Bridget mentioned,

self-perception of risk is lowered. If you feel that since you are circumcised you are not going to get it, then you are going to be even less willing to use a condom when a woman suggests it. So I think it is a real problem.

Circumcision is an interesting subject that everybody talks about. This evidence, and the evidence that will be coming we presume from the other clinical trials that are currently under way, is going to be heard about by Asian politicians. I fear that countries have widespread circumcision, such as Indonesia, Malaysia and the Philippines, may then say, 'We don't have to worry about it in this country. We've got 76 per cent protection in our population against HIV.' So it is going to be very important to keep emphasising that there still is a risk of transmission with circumcision.

Senator MOORE—Thank you, Dr Holmes.

Proceedings suspended from 10.31 am to 10.44 am

CHAIR—Kelly Hoare is going to introduce our next speaker.

Ms HOARE—Thank you, Sharman. I have great pleasure today in introducing Bridgette Thorold, from Oxfam Australia. Bridgette has worked for 10 years in the mental health sector in South Africa. For the past 15 years she has worked in various capacities in HIV and AIDS programming. This included 10 years in the health sector in direct service provision through HIV testing and counselling, as well as support for people with HIV and for those affected. A key role during this time was also provision of HIV related training for various health and other professionals and for laypersons.

Bridgette managed the joint Oxfam HIV and AIDS program in Durban, South Africa, from 2002 to 2004, and she moved to Australia in 2004 to take on the post of Southern Africa Program Coordinator responsible for Oxfam Australia programs in Zimbabwe and Mozambique, where the thematic focus of the programs are HIV and food security. Thank you for joining us and sharing with us, Bridgette. Please give her a warm welcome.

A PowerPoint presentation was then given—

Ms THOROLD—Thank you. I thought the way to approach this presentation would be just to give a quick, short orientation to the way that Oxfam Australia approaches development work and then a little bit around how we see the links between sexual and reproductive health, HIV and the MDGs. Then—probably more importantly from our side—I will share some anecdotal evidence and experience of what we have learned from some of our programming, most especially in southern Africa but also more recently in the Pacific and South and South-East Asia, in relation to the subject and to see where there may be opportunities for Australian government or AusAID directed aid.

We are quite conscious that as Oxfam Australia we are very small-scale donors and some of the way in which we direct what we do would be different from high-level government aid. But, at the same time, I think there are many valuable lessons to be learned from those very small-scale examples that can be scaled up.

In terms of Oxfam Australia's approach to development, obviously our overarching goal is to try and reduce poverty and address injustice in the world. We achieve that through a focus on a rights based approach which brings together a range of strategies from supporting direct services right through to various forms of advocacy. Our philosophy is really that the realization of five core basic rights is fundamental to human wellbeing in the world and to reducing poverty and injustice. A cross-cutting theme across all of our work is HIV, which we see as one of the key development challenges that really has application in any form of development work at the moment and that, if it is not taken into account in some way, has the capacity to undermine many of the development gains that have been made in other forms of programming.

I have far too many slides, so I am going to try to be over quickly here! In terms of our understanding of the links between those three areas—sexual and reproductive health, HIV and AIDS and the MDGs, and that is probably spelt out more clearly in our initial written submission—is how inequality fuels the spread and the impacts of HIV and AIDS. Gender inequality in particular contributes to the vulnerability of everybody but most specifically women and children. Within that context, realizing sexual and reproductive health rights is key—it is a critical element of addressing women's inequality.

What we see are the results of situations where sexual and reproductive health issues are not addressed. They leave women more vulnerable; they lead to a lack of economic security, a lack of access to resources, a lack of access to education. Ensuring sexual and reproductive health—I am probably speaking to the converted—we know has a very positive flow-on to all the eight MDGs that are mentioned, in enabling women especially to have better control over their lives, over decisions that affect them. More especially, having access to options is the key thing that we need to address, whether addressing sexual and reproductive health in its broadest sense or HIV programming or development work broadly.

We see too the ripple effects on communities where sexual and reproductive health rights are attained. That links quite well to the previous speaker in seeing the role of women and the fundamental function they play in sustaining communities, in that improved livelihoods of women have a ripple effect in improving wellbeing for communities and societies as a whole. We are very keen to ensure that the MDGs address women's vulnerability to HIV as part of a broad strategy of ensuring their sexual and reproductive rights.

I have a framework—which some of you are probably very familiar with—developed by a South African economist, Alan Whiteside, who was looking at the determinants of the HIV epidemic. What I found particularly useful—I will put it up just now—is it not only helps one to understand the various levels and factors that contribute to the spread and impacts of HIV but also in helping us to look at where we locate different interventions. Where would sexual and reproductive health rights make a difference in responding to the impact of HIV and AIDS or preventing the spread and where does development work more broadly? How does it all fit together, basically? We are pretty conscious that HIV is driven by and contributes to poverty and inequality.

I know that has too many words so I am not going through it in any detail, but it is useful to see that the drivers of the HIV epidemic include the biological factors, physical predisposing factors that range from health status to the type of virus you might have been exposed to, your

age at the time of infection and the type of transmission that happened. Many interventions have been directed at looking at how to prevent transmission in that biological way. I am sure that resonates with what some of the other speakers have shared before.

A lot of the science—of which there is much—in the HIV field has focused on that, and of course it is core, but if it is the only area in which we are looking, it is a limited response. We need a broad developmental picture that sees HIV as a biological factor that needs a scientific response but it also needs something that is mindful of the broader context in which it occurs so that strategies in some way target each and every set of factors. The behavioural factors that lead to the spread of HIV have very obvious links with sexual and reproductive health and behaviour. We have learnt a lot in the last decades. HIV has been with us a long time and much has been learnt but with some of the challenges we find it is hard to apply what we know works in certain situations to broader settings. What we realise contributes to enhancing or hampering the success of those approaches is our understanding of the third and fourth columns—how the macro factors and the social context impact on how we design our programs, what we choose to target and the extent to which we involve people that are directly affected—and infected, for that matter—in developing strategies that will work in a particular context. In some ways our experience in Oxfam is that in those very small scale community based responses we see some successes that have the potential to be translated into other contexts. It is some of those that we would like to share.

Those social factors, again, apply to any kind of development issue but we need to be mindful of the socioeconomic context in which disease happens and more especially in terms of HIV. We know of factors like social mobility, migration and gender discrimination. We know the range of issues here that contribute to the spread of HIV and AIDS and so we can target intervention similarly there that will address issues, for example, like gender based violence. We do not see that as a factor that directly contributes to women being vulnerable to HIV infection but there is some very interesting research that shows that, in a culture of violence, where women are generally exposed to more violence, in some ways they internalise a sense of helplessness and are more likely in those contexts where they have been violated in some way to not cope with a variety of other social pressures.

The macro factor has specific relevance to where one targets aid in working government to government. South Africa is a prime example in terms of national wealth. It is a wealthy country but its allocation of resources and its priorities are often skewed and do not necessarily target those who are most vulnerable or do not target equitably the resources that it has, which leaves a context of growing disparities—a widening gap between rich and poor, between haves and have nots. In some ways, it is reinforced by a culture of entitlement that has been inherited from many years of the apartheid system. I will not go through any of those further; I am sure you have had a chance to read them.

So we see here that HIV is fuelled by, among other things, a lack of access to services, a lack of provision of services—and inequality and lack of realisation of rights is key. I will leave that little bit there. What we proposed in our written submission was that there were many strategies, but we outlined seven that we felt in terms of our own experience within Oxfam Australia could be relevant here and to provide some direction for where we feel aid needs to be directed and supported. In terms of addressing gender and equality, which was one of the key strategies which we felt was necessary, we need to explore whether we are targeting appropriately.

I only caught the tail end of the second last speaker, but the last speaker identified some very key and concrete areas about targeting particular interventions—again with circumcision as the sort of flavour of the moment of where something works and everybody gets excited—and how we use our knowledge and understanding about that. I think there are many opportunities for supporting research to explore in different contexts where circumcision happens how acceptable it is, how it is happening—with further research to look at whether it is actually working as a protective measure in other situations beyond where the study was undertaken—and how to introduce it or introduce conversation about it in contexts where it is not practised. One key context obviously for that is South Africa, where for some large groups of people it is a very unpopular practice. There it is not routinely carried out and has all sorts of cultural associations with loss of manhood. I think there is important research that we need to undertake in understanding that better. Supporting post-exposure prophylaxis in cases of needle stick injuries or rape, or any kind of sexual violence, is a concrete thing that we can do. Again, it does not respond to underlying causes. If one looks at those four columns that I presented earlier, one needs to see where what you are doing fits into the response—making sure that there is a continuum of responsiveness in various ways.

I have a couple of examples from our own experience of organisations that we support that address gender issues: one is an interesting organisation called Targeted AIDS Interventions, a partner based in Zimbabwe who work with men. As we are also learning, one of the key aspects of addressing gender inequality is working not only with women but also with men, and in areas that engage men not in a blameful way but in a way that enhances their own sense of themselves and how they can then, if they take responsibility for themselves, think about taking responsibility for others. The TAI example is a soccer program, an HIV program really but one that looks at trying to build a different kind of identity among men who engage in playing soccer, which is a very key thing in southern Africa. Similarly another organisation, SHAPE Zimbabwe, is a very interesting university based program where the students themselves are exploring their own conceptions of masculinity. They talk about toxic masculinity and the need to change it. It has become a very trendy thing. You hear people ask, ‘Are you toxic or aren’t you?’ I think those innovative strategies have great application in other contexts.

Since I only have about three minutes left now I will talk about female initiated prevention methods. The main thing I want to say there is that in giving women greater control over prevention, the real opportunity we see is in the development of microbicides—where it gets away from women having to directly negotiate sexual encounters. Obviously condoms are a great asset, but for those women who do not have the power to negotiate condoms what would be very empowering would be a successful microbicide.

As we have said in our paper, strengthening health systems is key. There are various ways in which that can be done, whether it is through supporting the development of infrastructure or—in situations where there is infrastructure, like in South Africa and Zimbabwe—investing in health workers and in the resources that keep those facilities operating in some sort of meaningful way. I think there are many opportunities that we can explore, both in research and among NGO and other community based groups. There is great involvement by traditional healers and remedies in responses, especially to HIV.

Acts of participation of communities and of people living with HIV: we all know that is key, and there is a lot written on greater ways to involve both communities and people living with HIV and AIDS. The issue I want to draw attention to here is the value of having HIV workplace policies and the opportunities, if you are a donor or you receive proposals of some sort, to try and make it a condition that HIV policies become part of the requirement of funding proposals or are going to be part of the program. It creates an enabling environment for people that are HIV positive and an opportunity for HIV prevention and protection.

Partnerships—and I have only one minute left. I refer to building partnerships and engaging the private sector. We have had very interesting and useful experience of that, both in Mozambique and South Africa, where we have seen a greater involvement of NGOs working alongside government service providers in the provision of HIV services where they provide complementary services, one to the other. It is similarly so in the private sector, where we have one partner that we support in north-eastern South Africa. There is a partnership between the department of health, the NGO and a mining company. The mining company provides access to workers for the NGO to carry out peer education counselling and a variety of services but at the same time provides the infrastructure, the vehicle and all sorts of resources to make that facility work effectively. The department of health provides the staffing.

Similarly, in Mozambique we are providing an organisation that specifically works with HIV-positive people. They produce uniforms for petrol station workers. It is a partnership with the private sector. I think there are many opportunities that could be explored there in other settings. I am probably out of time. Are there any questions?

Ms HOARE—Thank you, Bridgette. It is always difficult as we never have enough time for some of these fascinating presentations. We do though have a little bit of time for questions.

Dr WHITTAKER—Bridgette, in your opening comments you said maybe there were lessons from the work you have done on how to scale up some of these smaller scale programs into larger programs. Would you elaborate a little bit on an example that you have of how that has occurred.

Dr THOROLD—Yes. I think there are risks and possibilities in that. We have learned quite a few lessons in terms of scale-up, not necessarily meaning that the organisation which is undertaking that good practice needs to necessarily expand its geographic scope but that it needs to share its approach with other organisations undertaking similar work. Obviously, the potential risk we have found is that something might work well because of the context in which it is in, so we need to caution against making assumptions that it will automatically work.

A quite strong component of our southern African program is linking the service providers and NGOs that we support with each other. For example, our HIV and food security programs annually bring them together in Zimbabwe, Mozambique and South Africa—in one setting around a particular theme—to share lessons and challenges. I guess it is still a work in progress, seeing the extent of scale-up, but it certainly has given new ground and new ideas. These are not coming from the donor, to which there is often resistance. They are coming from others engaged in the work themselves.

CHAIR—Are there any further questions?

Ms HOARE—Yes. Can I make a very quick comment. I was interested in what you called the ‘toxic masculinity’ matter. I wondered what usefulness that might have in a country like Australia, particularly with our Indigenous population, which, as you know, has a lot of issues in terms of discussing dysfunctional family and inappropriate behavioural action in sexuality and child care and so on. Is that written up somewhere? Have you got examples?

Ms THOROLD—Yes. In fact, we are in the process of developing a case study that highlights it. There are some issues with it in the sense that there is great enthusiasm that we see among young university students on that particular campus to change the way they behave but we are not totally sure at this stage—which is why we are doing the case study, and we know they are thinking differently—how it actually translates from a conceptual level into behavioural change and how sustainable it will be once they leave university. But the fact that there is this groundswell of interest in it, with a lively and quite encouraging debate, is really what makes us confident that it has some potential. I would guess that it is transferable.

If it is driven by the young people themselves, which in this particular case it is, the students themselves lead the organisation and we just provide the funding and technical support to try and get some good practice into what they are doing. One of the particular activities that they do is have student debates, so they will choose a particular topic—the last time I was there it was ‘premarital sex is wrong’; it is something that is going to catch the attention of everyone—they will have a debate about it and then bring gender dimensions into the debate. It is an effort not just to try and say the right thing—and I think that is also really important in a lot of these strategies, because people have begun to know what the donors want to hear and so they will say that while you are there but what they say actually does not have depth. So the honesty they are about? Actually I think it is okay or actually I think it isn’t. What am I personally going to do in my own behaviour to respect myself and others? Maybe the last point about it is that it is not anti-male. I think that is an important shift in gender programming, which at one time took quite a few dimensions of ‘men are bad and women are good’ and you cannot get access to work with men with that kind of attitude. But we can certainly share it with you.

Dr GRAY—You passed over the ‘macro’ factors in that four-column thing quite quickly. I guess we are all reasonably familiar with things like lack of political will and leadership and so on, but are there any optimistic kind of signs on that ‘macro’ front at all in terms of reducing inequalities?

Ms THOROLD—Yes, I think so. From Oxfam’s point of view, our emphasis is on strengthening civil society. I think there are huge opportunities in a variety of countries to strengthen the civil society sector through having a lively NGO sector that does not stand necessarily opposed to government but could support that small-scale good practice. Similarly, there would be a greater openness as well to working with governments to develop solutions. I think, and obviously this is from my experiences in southern Africa, a lot of it depends on the tone with which you approach the government sector. If we are working in a complementary way, if there is a way that we can support and strengthen service provision, there is a lot of opportunity.

I think a lot of governments also feel quite hamstrung. For example, in South Africa, where there is a very good policy environment, the legal framework is very protective. But the gap is in

people having the opportunity to access their rights, where they are experienced in some real kind of way, and I think there are many opportunities to work there. You might not change it in every country—South Africa is far from resolved about HIV; in fact, it is probably the least resolved—but that does not mean that there are not opportunities for successful engagement and good practice to happen.

Ms HOARE—Thank you. We have one final question at the front here.

Prof. ZWI—I have a comment and then a question. The comment is that, coming through your presentation and a number of the others’—including both Wendy Holmes’s and Maxine Whittaker’s—is the importance of hearing of perspectives and voices from the ground. It is important to hear a variety of different voices—voices of women, of men, of health workers and of the other stakeholders that are involved—if one is going to formulate any effective responses. So I think the first point is just to reiterate the importance of doing that. It requires a major investment. Whether you call it research, or consultation and participation, or engagement with communities, I think it requires investment and support and funding to do that effectively, whatever the sort of organisation. So I think that is a key point to make, drawing from points that you and others have made.

The second comment, which is also a question, is on the issue that you raised about lesson learning—that there are emerging lessons from your organisation’s practice in particular settings. Could you put on the table some good practice ideas about how organisations—be they NGOs, aid agencies, researchers or public services—can use to describe, capture, analyse and reflect on their experiences in terms of lessons learnt, good and bad practice, things from which we can learn things, and how that can be placed in the public domain so that others can also learn from that?

Ms THOROLD—There are a variety of means by which we are trying to explore that issue ourselves, apart from the one that I mentioned of bringing organisations together. The one thing we are doing is trying to support NGOs, especially, but also, to some degree, community based organisations, to document what they are doing better. So we have put quite a large investment into not only us coming in and documenting what they do, but also them building their own capacity to analyse what they do, and recording that, not only in a way that they can reflect on, but also in a way that it can be shared with others. So we have undertaken a variety of case studies. Most of those have been done in South Africa, but we are also starting to do some in Zimbabwe and Mozambique. Those are also available on the Oxfam Australia website—those that are complete.

We have also tried to encourage, within each country program—which I think is probably something that could also be encouraged elsewhere—a reflection workshop. So, not only do we bring all three countries together once a year, but also we have an in-country national meeting once a year, called an annual reflection, where there are presentations by the organisations themselves around a particular theme. That encourages them to reflect on what they are doing—they have to document it in order to be there—and then that is printed and shared with others.

We are also looking at sharing across regions, and my colleague Kathryn, who is here today, has recently documented some emerging lessons from our work in southern Africa and explored what might be transferable for our HIV programming in the Pacific. Again, we are not making

assumptions that it is automatically all transferable, but where there are commonalities in how HIV seems to be spread or other factors within the context that might resonate with what has happened in South Africa there could be lessons learnt and mistakes avoided in the future. As with Oxfam, there is a growing consciousness of the need to do that. It is a challenge because it is time consuming and it takes a large investment, but the value we have found in sharing those lessons—in improving organisations' own practices and in sharing with others—cannot be underestimated.

To pick up on the point you made that not everything is good practice: we actually really struggled about whether we should even use the term. The UN aids booklets that used to use best practice made everybody a bit nervous, so it got changed to good practice. Then we thought, 'Maybe we should say promising practice'. If you call it lessons, they can be lessons learnt from what you did badly, and that is what we have tried to take. So it is not just what has been done well but also what we have learnt from the mistakes that have been made.

CHAIR—Thank you to Bridgette Thorold.

Senator McEWEN—It is my pleasure to introduce the next two speakers: Kelsey Powell and Alice Oppen. They are both going to speak for 10 minutes along the theme of family planning and the aid program. First of all, we will hear from Kelsey. Kelsey is the Chief Executive Officer at Family Planning Queensland and has been involved in sexuality and reproductive health services for 20 years. She is responsible for Sexual Health and Family Planning Australia's international program. It manages projects in the Pacific and Papua New Guinea, which are of course of immediate relevance to us. Thank you very much, Kelsey.

Ms POWELL—Thank you. I would like to take this opportunity to thank the parliamentary group for giving Sexual Health and Family Planning Australia the opportunity to present. We want to talk specifically about contraceptive supplies, and I would like to highlight some of the key points in the submission we have presented and then briefly talk about some specific issues of access to contraceptives in the Pacific and PNG. While there are clear links between family planning—and that has certainly been highlighted today—and lowered fertility rates and poverty reduction, recent estimates suggest that there is a \$US700 million shortfall in funding for condoms and other contraceptive supplies in the developing world. The United Nations Population Fund estimates that there are currently around 120 million women worldwide with unmet needs for contraception.

The global gag rule bars US family planning assistance to foreign non-government organisations that, with their own non-US funds, engage in abortion-related activities. This rule, too, has impacted on the level of funding for family planning programs and is eroding family planning and reproductive health services in developing countries. There is evidence that this has not reduced instances of abortion globally. Rather, it impedes the very services that help women avoid unwanted pregnancies from the start. It is really important for family planning programs not to include conditions that restrict people's reproductive health choices. Numbers of people in the developing world are seeking condoms and contraceptives for both family planning and prevention of sexually transmitted infections. However, funding to meet this growing demand is declining, and this is creating a gap between what is needed in terms of demand and what is actually available.

The United Nations Population Fund estimates that this gap could grow to \$US737 million by 2015. This would lead to 265 million unwanted pregnancies, 110 million unnecessary abortions, 590,000 avoidable maternal deaths and eight million preventable infant deaths. As speakers have been saying today, it is really important also to recognise the importance of linking HIV prevention with reproductive health issues. Protecting against unwanted pregnancies is often dealt with separately to protecting against sexually transmitted infections despite the common linkage of sexual activity, and recent research found that generally there were very weak linkages between agencies obtaining condoms for HIV prevention and those obtaining them for family planning.

I would like to highlight some of the issues identified by family planning organisations in the Pacific and PNG with regard to contraceptive supply and people's access to contraception. In some Pacific countries, the lack of supplies is not always the issue, but there is an inconsistency of supplies. For example, there may be an undersupply of some oral contraceptive pills that are actually used and prescribed and an oversupply of pills that are rarely prescribed. Supplies of contraception can also be very erratic—large amounts might be distributed that are unable to be used because they are out of date by the time that they are needed. That leads to a concern about the use of contraceptive supplies that are out of date.

As well as security and inconsistency of supplies, there is often stigma associated with condoms and sexuality issues in general, and this needs to be addressed with promotion of condoms as a protection against pregnancy and STIs. One of the big problems identified by the family planning organisations was the attitude of the workers in the community, particularly community health nurses. This often makes it difficult for people to access contraceptives. The community health nurses may restrict access—for example, to the number of condoms that they distribute—on moral grounds. People who do try to access contraception might go to a lot of trouble to get to a health service and then be given two condoms because that is what the nurse considers that they need for the next few days or something like that. That is a real issue.

There are also issues around the age and marital status of the clients. Judgements are made about whether they should be using contraception if they are not married or if they are very young. There are also negative attitudes at times towards high-risk groups such as sex workers. Value judgements by the community health workers make it really difficult for those people who are making the effort to access contraceptives and condoms. There is also the real issue, especially in smaller regions, of confidentiality. People need to feel confident that their confidentiality will be respected when they are accessing these services. I think that is often a problem because they do not feel confident when they go to services that their confidentiality will be respected.

It is really important that these issues are addressed by adequate training and education that involves addressing the values and attitudes of community health workers and local governments. I think that often the training that is given focuses on the knowledge and clinical skills of the health workers but does not really look at the values and attitudes of those workers. With any programs and training programs, we really need to address the issue of learning the values and attitudes and providing those services in a non-judgemental way.

Senator McEWEN—Thank you very much, Kelsey. Now I ask Alice Oppen, who is the Chair of the Women's Plans Foundation, to come forward and give her presentation. Kelsey, you

might want to just sit at the front and we will have questions from both of you after Alice's presentation. Alice is an advocate for family planning and has made a significant contribution to raising awareness of family planning issues in developing countries and raising funds to support projects in South-East Asia and the South Pacific. She is a member of the International Projects Advisory Committee of the Sexual Health and Family Planning Association and, in response to the reduction in overseas aid for family planning in recent years, Alice established the Women's Plans Foundation, which is a charitable trust that raises funds for education in reproductive health and contraception and advocates for the integration of a family planning component in all overseas aid programs. Thanks very much, Alice.

Ms OPPEN—Thank you, Chairman, Senators, Members of Parliament and all of the experts here. It is wonderful to be here with many of us singing the same song. I would also like to acknowledge the traditional respecters of this land.

A PowerPoint presentation was then given—

We raise funds because we feel that the benefits of access to contraception are being overshadowed by the emerging disasters of an overpopulated world. AIDS, famines, ethnic wars and land degradation are all signals of population stress. At the same time, women are having more children than they can nurture in conditions of poverty. Women most readily respond to other women's need for contraception, seeing this as an affirmation of women's ability to live responsibly. It is not easy to compete with other fundraising groups—particularly those which focus on domestic health or sponsoring children—but our fundraising gives an opportunity to make people aware of broader world sympathies and issues. We believe that family planning is the most fundamental and constructive way to help the pressures exacerbated by population growth.

Our donors wish to reach overseas aid projects and, just as AusAID leverages on the infrastructure of NGOs and requires a high percentage of government money to go for work overseas, so our donors would not give for administration costs. This leaves the organisations we give to in a fix—having to add fundraising to their business of delivering programs, and this is a heavy impost we bring to your attention. Many well-designed programs increase their effectiveness when there is a family planning component included. With sex education, the incidence of sexually transmitted diseases decreases, and reduction of wives' fear of pregnancy reduces husbands resorting to prostitutes, therefore decreasing the spread of HIV-AIDS. Women particularly welcome the ability to care for a viable number of children, rather than to mourn for many, and men's perspectives are widened.

Access and understanding of modern contraceptives enables women to participate in microcredit loans, developing small enterprises and thus contributing to their community's welfare and economic structure. Nutrition, maternal and infant health are natural partners with child spacing to maximise survival rates for a healthy society. Women and girls can increasingly participate in education, and children's wellbeing and social integration can improve. Agricultural and water sanitation programs benefit from steadying population numbers rather than increases leading to recurrence of soil depletion, deforestation and water pollution.

Relationship and gender equity sensitive training greatly improve the sharing of reproductive responsibility and decision making, and these are things that many people have said earlier today. But if programs reduce mortality rates without providing access to contraception then conditions causing poverty and the spread of disease will continue their spiral. Lack of contraception turned a CCF USA program I have been involved in—what is now ChildFund—which is very happily partnered with the Danish organisation Bornefonden, but the US program we visited in Brazil some years ago had the old-style welfare handout because rising numbers made it impossible to brave the poverty cycle. I heard about the previous generation's recipients of aid returning with their nine children each for help.

In Guatemala, 60 per cent of the richest adults use contraceptives, and five per cent of the poorest. In Laos—sorry, Laos was the previous one—communities were enthusiastic about the family-planning component. Men had said that their wives were healthier, and the women said that their husbands did not go off to the young girls. So I would like to convince you—and I think perhaps you are already convinced—that, unless family planning capacity is included, overseas aid development programs focus on disaster relief resulting from overpopulation, bypassing prevention.

Worldwide, actual expenditure for population activities reveals what we expect—that is, as aid funding has increased as a matter of dire urgency, resources have been taken from the family-planning effort. The United Nations Commission on Population and Development report published in 2005 stated:

Funding for family planning services decreased in absolute dollar amounts—

you would think the population was decreasing, wouldn't you—

from \$723 million in 1995 to \$461 million in 2003, a decrease of 36 per cent.

Their tables for 2002 show funding, top left, trending downwards for family planning, while of course it trended upwards for STDs and HIV-AIDS.

Our contention is that major epidemic disease is one end product of population crowding and that to ameliorate the disease without treating this cause lessens program effectiveness. Funding for all aspects of reproductive health needs to be increased dramatically in combined reproductive health programs in order to have real effectiveness. Of course, we are not arguing that much more aid should not be going to AIDS; it is simply that this has to be balanced as it goes.

Because Women's Plans Foundation funds are directed to NGOs accredited by AusAID to deliver reproductive health, we are fascinated by the white paper and greatly encouraged by its general objectives and the deep understanding shown. We have some questions, and some of them have already been answered today, I think. But I would like to know—and I have searched and have not been able to find statistics—what proportion of the reproductive health allocation will actually be spent on family planning, defined as education and access to contraceptive methods, and will there be a proportion spent on HIV-AIDS but with no linking to contraceptives? I worry that the time frame for this may be slower than for some of the trade-aid issues which may be propelled more quickly.

In addition, does the government plan to initiate its own activities which will draw upon the skills of Australian specialists in the field? We have heard a great many skills demonstrated here today, and it would be a pity if those people were not employed as consultants and appreciated. We wonder whether programs initiated by the government will be subject to tender by Australian NGOs, costing them limited resources in the tendering process, and whether funding to the International Planned Parenthood Federation and the UN Population Fund will increase. I think this actually has been the case, and I would hope that the funding for aid to trade will not be instead of any of the reproductive health issues.

The reproductive health pie dish has new appetites sharing the pie with family planning. I have not been able to find the actual spending on family planning over successive years in comparable formats. Sometimes you can find it over five years, sometimes you can find it for 2003-2004, but it is very hard to get good tracking statistics. We would like to know that this fundamental ability for humans can underpin Australia's overseas aid and development contribution in the Asia-Pacific region.

We appreciate very much the work of the Parliamentary Group on Population and Development. We wish you well in your examination of issues, and we hope that you will pursue the supporting research. I was thinking as I was listening yesterday and again today about how a sentence which is said again and again in this world and has been said for thousands of years is applicable to what we are considering today—that is the sentence: 'For we all share in the one bread'. Thank you.

Senator McEWEN—Thank you very much, Alice and Kelsey. Are there any questions of either of our two speakers? Are there any responses to some of the questions that Alice posed?

Dr PEPPARD—First of all, thank you so much for putting education on the agenda. Thank you for the emphasis on education and access to contraception. We know from research that has been done that the combination of good comprehensive school education—sexuality education that includes relationships, not just disease prevention—plus access to good contraceptive services has been important in delaying young people engaging in sexual relationships or having intercourse, putting themselves at risk. Also, when they do become sexually active, they tend to use contraception. So I think this is an incredibly important area of work, and I am wondering whether you are seeing any developments in that direction in the work that you have been doing.

Ms POWELL—Yes. The program that Sexual Health and Family Planning Australia has coordinated in the Pacific has been a three-pronged approach. It has been working with nurses through the schools of nursing. One of the interesting things with that was the integration of the sexual and reproductive health component in the curriculum at the school of nursing, which not only impacts, hopefully, on the nurses' attitudes when they go out and work in the community but in some of the schools of nursing actually had a direct impact on the decrease in pregnancy within the nursing school, because that was one of the problems that they were finding. What we have been trying to do—and again, as Maxine says, it is developmental; it is slow—is to implement some programs, working with the ministry of education. At this stage it has been usually in the upper primary school. Of course, we would like to see sex education start a lot earlier, but integrating a sexuality education component in upper primary school in some of the Pacific countries as well. So it is that too. It is also looking at the parents as well. I think the

parents are the key people for sexuality education of children, so we need to work with them as well.

Senator McEWEN—Thank you. We are going to hear from Annmaree O’Keeffe responding to the questions raised by Alice.

Ms O’KEEFFE—Actually there were a couple of questions. I think Kelsey made an observation which I would like to comment on as well. That was just talking about the problem with out-of-date contraceptive supplies. This gets back to the point that I made in my opening statement about the essentiality of working to ensure that the board of health system is actually operating, because that whole issue of out-of-date pharmaceutical supplies or contraceptive supplies is one that bedevils so many of our other efforts not just to improve the health of women, children and men, but in terms of the overall approach that we might have in the health system. I just want to recognise that that is such an issue.

How we respond to that, how we deal with it, is an issue that I think from the Australian aid perspective we have been grappling with. PNG is a very good example of where that is a significant issue. Earlier this year we signed an MOU with the Clinton Foundation to help scale up access to antiretroviral treatment in China and Vietnam and, most importantly, in PNG. I was having a meeting with the Clinton people about a month or so ago, and they said to me, ‘Look, we’ve discovered there’s a real problem with pharmaceutical distribution in PNG’, and I thought, ‘Welcome to the developing world’.

They actually looked at it in a different way. Sometimes I think that from a government perspective, because we deal in government to government, we look for solutions government to government. They were not confounded by that sort of framework. They actually looked at a solution in the private sector, and they think they might have found one—that is, working with a commercial pharmacy group that works very effectively in PNG. I mention this because I think we always see solutions in the way that we ourselves frame solutions—be it in Australia, be it in Denmark or be it in other developed countries. I think we have to be a lot more willing to look more broadly in terms of how we find the solutions. This applies to NGOs as well. I encourage all of us to look more creatively in terms of how we might find those solutions. Instead of trying to make things work the way they work here, we need to look and see what actually does work in the countries in which we are operating and what it is that we can do with the things that do work to meet the sorts of objectives that we have, particularly in this area of reproductive and sexual health. That is one point.

The other two questions that I want to talk about are the concern about the allocation of funds to sexual and reproductive health and how the HIV injection of funds may be distorting the look of the amount that is going in. There are two important issues here. We have heard a lot this morning about the importance of keeping them intertwined because of the importance of prevention and the overall impact on women and children’s health. So on the one hand we have that dilemma to make sure that we are not divorcing HIV from the broader issue of reproductive and sexual health but on the other hand we are trying to make sure that there is sufficient money going into, if you like, a more mainstream approach to this whole area and that it is not all going in to HIV.

We have, as a government aid agency, a responsibility to report to the development assistance committee of the OECD which gives all the donor agencies—and Denmark will have the same problem—certain codes. The development assistance committee has put HIV and family planning all in the one code. We have actually started working with the development assistance committee to get those separated out so that we ourselves, along with everyone else, have a much clearer idea of what is going into HIV and what is going into the broader area of family planning. But that does not resolve the overall issue that we have, and which we have talked about this morning: the need to recognise that HIV prevention and treatment plays a very, very important role in terms of the broader reproductive and sexual health issue. So there is not an easy solution in sort of simply carving it out.

Again I will use PNG as an example. There we are spending \$100 million over the next five years on the HIV program. I told you this morning, and others in this room are much better qualified than I to talk about this, about the way in which the whole issue of women's rights in PNG and the whole issue of sexual health is tied up with the success or failure of any HIV intervention in PNG. How do you separate that out? That is our biggest program and that is so fundamental in terms of what we are trying to do with the broader issue of reproductive and sexual health. So there is not going to be an easy answer. We will give you answers, but everybody has to be conscious that there is no neat dividing line—and we do not want one; we obviously do not want one. The last point which I think Alice made was on the use of Australian expertise. That is our bread and butter. AusAID is not the one delivering the programs. It is not just Australian expertise; it is international expertise and it is the expertise of our developing country partners also. So it is a real partnership approach. That is the second overarching theme—not only gender equality but also partnerships are a really fundamental aspect of what we are trying to do in the aid program.

Dr WHITTAKER—Both of your presentations focused on how the development assistance money for family planning and associated programs has decreased, but in most developing countries the contribution to family planning programs is also decreasing. I was recently in Indonesia, where this has been exacerbated further by decentralisation and expecting provinces, including quite poor provinces, to find increasing amounts of their own money to purchase contraceptives. I think that is an important point—that it is not just a development assistance gap; it is also the countries themselves not contributing the amounts they used to to family planning.

Senator McEWEN—I ask you to again thank Kelsey and Alice.

Senator TROETH—It is now my great pleasure to introduce Ms Jenny Goldie from the Australian Reproductive Health Alliance. Jenny has a Bachelor of Science and an MA in journalism. She is a former science teacher, a science communicator with CSIRO and a parliamentary staffer. She has been active in various NGO's and political parties and, prior to her recent appointment to the Australian Reproductive Health Alliance staff, she was national director and then president of Sustainable Population Australia Inc.

Ms GOLDIE—I too would like to acknowledge the Ngunnawal people as the traditional owners of the land. Since the International Conference on Population and Development in Cairo in 1994, there has been a paradigm shift away from programs focusing solely on women's health

and family planning towards sexual and reproductive health more generally. For too long, men's sexual and reproductive health needs were overlooked and, as the Guttmacher Institute said in their splendid paper that was developed five years ago—and we are lucky to have Sharon here today from the Guttmacher Institute—significant numbers of men, particularly in poorer countries, still engage in unprotected sex. Men want and need reliable and accessible information and services that can help them lead healthy sexual lives, but often they do not get them, especially in developing countries.

Many maternal and child health programs in the Pacific, for instance, simply do not cater enough to the needs of men and adolescents. Around the world, even where the sexual and reproductive health needs of married men might get some attention, those of young men are neglected. While men have specific and often neglected needs, their roles and responsibilities also impact on the health and wellbeing of women and children. Thus, in those cultures—notably the Asia Pacific, where men are the main decision makers in the family and the community—if men are supportive of the goals of reproductive health programs then it might reasonably be expected that the programs are more likely to achieve success.

The ICPD was the first of the international conferences to recognise the role of men in reproductive health, and its program of action stated:

Innovative programs must be developed to make information, counselling and services for reproductive health accessible to adolescents and adult men. Such programs must both educate and enable men to share more equally in family planning and in domestic and child rearing responsibilities and to accept the major responsibility for prevention of sexually transmitted diseases.

It also noted that, given men play a significant role in women's sexual and reproductive health outcomes, it adds value to women's health to engage men as partners in programs. That same message was reinforced a year later at the 1995 World Conference on Women in Beijing, which said:

Shared responsibility between men and women in matters related to reproductive and sexual behaviour is essential to improving women's health.

We had a splendid example from Wendy Holmes, who talked of the need to include men in the second antenatal visit, which would ultimately protect women and children's health.

ARHA—the Australian Reproductive Health Alliance—had a project to provide for men's reproductive needs. This was developed by Maggie Kenyon, who is in the audience today. I bow to the far greater expertise of Maggie on this issue. It was a program and a manual about men as partners that included such issues as good fatherhood. However, in researching the issue of men as partners in reproductive health, there is a lack of clarity or clear distinction between providing for men's needs on one hand and having them as partners on the other. The question arises as to what extent does the mere provision of information and services for men fulfil the definition of men as partners. I do not know the answer. There is obviously an area of great overlap.

In designing programs that involve men, there is often a lack of information about men's perspectives that might help in designing the programs. In addition, because reproductive health services were directed solely at women for so long, many men feel out of place or unwelcome at

reproductive health clinics. As we know in our own culture, men are hesitant to seek medical care. Often men are viewed as irresponsible. Bridgette Thorold brought this up. She said that in designing programs we cannot treat men as bad if we really want to involve them.

That is one of the stumbling blocks. In some societies, men are very often regarded as irresponsible or not appropriate clientele for reproductive health services. Sometimes there are unfavourable policies such as prohibitions on condom advertising, which only exacerbates the problem that there is not the same range of contraceptives for men as there is for women. Or there may be logistical constraints such as lack of trained male staff, male-friendly clinics, convenient hours or separate waiting areas and services for men.

Tending to men's needs may include a number of strategies such as adding services for men to existing clinic-based services, as in Bangladesh where it has been quite successful, or establishing separate services. Men can be reached through the workplace, the military or men's groups with information and services. Condoms can be distributed using male field workers or through social marketing. There may be outreach programs to male use through popular sporting events or mass media educational campaigns.

Some of these strategies were used in a broader family planning program in Zimbabwe. Despite a relatively successful family planning program in that country that had achieved 36 per cent contraceptive prevalence by 1988, average family size still remained high at about 1.5 children per woman. The program in the past had, up to that point, been largely directed at women and most of the contraceptive use was short term—namely, the pill.

However, recognising that men exerted great influence on family size and family planning decisions, the Zimbabwe National Family Planning Council pioneered a successful male motivation campaign in 1988 and 1989 and again in 1993. The second round included radio dramas in two vernacular languages as well as the lingua franca—English—radio and television spots, posters, newspaper and magazine advertisements, pamphlets, and a football tournament with giant puppet shows at half time. Planners also used messages and images designed to appeal to men, such as language borrowed from competitive sports and pictures of local football heroes.

Contraceptive use had been declining prior to the campaign, probably as a result of higher contraceptive and primary health care costs. However, the trend reversed with the onset of the campaign and the demand for long-term contraception such as IUDs or permanent methods such as vasectomies. They all began to rise. Most encouragingly, couples exposed to the campaign discussed family planning more, and men involved themselves more in decisions on contraceptive methods.

Despite the overall success of involving men in programs such as this, there have been genuine fears that involving men in family planning education and services would further erode women's control over reproductive health decisions. Reproductive health services have allowed many women a degree of autonomy over their own lives. Many fear that without genuine gender equity, involving men will perpetuate existing gender inequalities.

One unexpected result of involving men in the otherwise successful family planning campaign in Zimbabwe that I just mentioned, which encouraged men to play a greater role in family planning decisions, was an increase in the percentage of men who thought they should have sole control over contraceptive decision making. It is also feared by some that involving men in decisions over abortion could have similar negative consequences. I will finish at that point. There is more in the paper as a whole.

Ms FORREST—Thank you for that presentation. I want to go to one of your comments about the fear of involving men in these services, particularly in the promotional activities and stuff. You say it is seen as a potential risk of eroding women's control over reproductive services and the provision of education and how it is presented. That is something I had not really considered—that it could swing the other way. What are your views as to how we can avoid that happening? It is really important to involve men, to give them some ownership, even to the point of being more comfortable talking about things such as sex in pregnancy. A lot of women have trouble talking about that. It is one of the topics that is rarely discussed with a midwife or a doctor unless the woman raises it herself. I am interested in your views on how best to reduce that risk.

Ms GOLDIE—I do not know either, but I think the answer lies in gender equality. Men's programs have to go hand in hand with greater gender equality, which is No. 3 on the list of Millennium Development Goals—and that is why we are here today, focusing on the MDGs. In developing programs for men, we simply have to avoid enhancing male dominance. We have to enhance genuine gender equality. That is the only way we can avoid the pitfalls I have mentioned.

Senator TROETH—I expect that that would also bring in the thought of the patriarchal nature of most developing Third World societies. As well as bringing men laterally into the field of family planning, we need them not only to get, as you say, more gender equality but also to come down from the usual position of the males making the decisions in the family.

Ms GOLDIE—Yes. That is why I asked the question earlier today, because I am not quite sure how to achieve it. It really constitutes a massive cultural change, a revolution. It would be nice if it could be achieved overnight, but I am not quite sure how to achieve it. There might be others in the audience who have more ideas than I about how to achieve it. But things change. There has been a paradigm shift in Australia in the last generation. Maybe it will take a generation in the developing world as well. I think it can be achieved but I am not sure how.

CHAIR—When you say that the window is always open, we had a delegation from Pakistan here last week. That included ministers who were very pleased that they were introducing women's rights legislation, literally as we were together—it was being introduced last week in Pakistan—and particularly making sure that there was a correct interpretation of Sharia law in relation to women's rights. They were really focusing on that in Pakistan, which is to be applauded. They were very proud of themselves. The visiting ministers were all men. One of them said to me, 'Have you got women's rights in Australia yet?' I was able to say: 'Yes, but it is a long road. The beginning is the law.' Pakistan is a country we need to applaud for going down this path.

He said one of the things that prompted them to do this was that they were so shocked that the first people to get up into areas of shocking devastation after the earthquakes were people traffickers, particularly people who were taking the children, who were so vulnerable at that point because they had lost the protection of their mothers or their parents per se. It shocked them so profoundly that there were people in their country who were exploiting their children so effectively and that they were first up into these mountain passes where no-one else could get. That was one of issues that prompted them to really get a move on in terms of women's rights in their country.

Ms GOLDIE—To go back one step in terms of how to achieve greater equality, I think one critical method has to be getting more women elected. I am not sure how many women are elected in the Pakistani parliament—

CHAIR—Quite a few.

Ms GOLDIE—but in the Asia-Pacific, particularly in the Pacific regions, there is an appalling dearth of women. There is Dame Carol Kidu in Papua New Guinea, there are three in Vanuatu and very few in any of the other parliaments. So that has to be an essential lever for creating better gender equality.

Dr PEPPARD—This is as much a comment as a question. I think there is a lot of liberation for men within better reproductive health programs and information, and I think there is evidence from research done in South-East Asia to show that. When men do not have accurate information, there are a lot of myths that prevent them having good sexual relationships with their partners. There is a lot of benefit that can be gained in those programs.

Senator TROETH—As there are no further questions, I thank Jenny very much for her very informative presentation.

Senator WEBBER—It is my very great pleasure to introduce Dr Suzanne Belton to you all. Suzanne, like most of our other speakers today, has a CV that is too long for me to possibly outline, but needless to say she has had a mixture of practical experience and research interests—in service provision, in the retention of key health care professionals in remote areas and in servicing Indigenous communities in Australia, and in looking at maternal mortality and morbidity in parts of China. Suzanne comes to us from the Graduate School for Health Practice in the Institute of Advanced Studies at Charles Darwin University and has been part of some advance publicity for today's roundtable, where in a quote which I think will help focus some of our minds and some of our future policy reviews she says, in framing our policies:

We cannot continue to cordon off abortion as though it does not happen.

Without any further ado, please welcome Dr Belton.

Dr BELTON—Thank you very much for inviting me to speak today. I acknowledge the Indigenous people of Canberra. I want to focus on Millennium Development Goal No. 5. My paper is in three parts. It looks at rights and law to do with reducing maternal death and disability, particularly focusing on unwanted pregnancy and unsafe abortion in the Asia-Pacific

region. It also looks at the combination of our programs from AusAID and at what our parliamentarians can do about this.

Most of the speakers today have addressed human rights, and I do not want to take up a lot of time on that. I support the idea that human rights and women's rights are absolutely vital to having a framework to work from. They are a philosophy that should underpin our research, our clinical practice and our foreign policy. This is just one particular international convention; there are number. All of us in this room are aware of the various sorts. This one is CEDAW, the Convention on Elimination of all Forms of Discrimination Against Women. Australia signed it in 1983. Around the world, 184 countries have also ratified this convention. It specifically addresses family planning and a woman's right to choose the number and timing of children they have. Burma, Cambodia, the Cook Islands, Fiji, Samoa, Timor Leste and Nepal have also signed up, and all of us should now be working to transform these fine words into policy, programs and real outcomes.

That is what we all want and we are all working towards. There also should not be internal laws that conflict with those types of words. In Australia women embrace CEDAW, they embody CEDAW: they have high participation in family planning, they often choose to have abortions and they certainly choose the number of children they want to have. I cannot understand why, in our foreign policy particularly and in the way we deliver aid programs, we restrict that, even to countries where it is legal to have an abortion. It really does not make a lot of sense to me.

This graph shows figures for maternal mortality in abortion. A lot of these figures the other speakers have mentioned, and I am not going to go into them. But the causes of maternal mortality are very clear. We know them; there is boundless research on them and I do not need to keep going over them. Haemorrhage, infection, blood pressure issues and obstructed labour—we know how to deal with all of those. It is not rocket science. It can be done and is done in developing countries. Women rarely die of any of these causes anymore, and women should not be dying in our neighbouring region either.

I want to draw your attention to unsafe abortion, which makes up 13 percent of deaths of women globally. This is also entirely preventable. We can work on this; it is an issue we should not be ignoring but we are in fact ignoring. These figures are also very similar to figures that Maxine, I think, showed before. I know a lot of you in the room are very aware of them. The figures show the number of deaths from unsafe abortion per 100,000 abortions. The figures are very clear: in developed countries women rarely die from having a safe abortion; in developing countries women die too frequently. This shows that access to family planning, safe abortion and post-abortion care saves lives. It is as simple as that.

Access to safe abortion is regulated through a number of different sorts of mechanisms: law, and how it is played out; the attitudes of the medical practitioners, also mentioned today by another speaker; religious and moral teachings; public opinion; and, of course, the availability of services.

I think Australia is way out of step with what is happening globally. If you look at the trend in abortion law and how it has been reformed across the world, you can see there is a clear trend that countries are moving towards liberalising abortion, and thinking along those lines is how we should be working with our colleagues in ASEAN. There is good research that shows this. Even

when the law is permissive and allows abortion there can be inbuilt barriers within other laws that inhibit the process. There is a study from the Philippines that shows how public health has not been interpreted in law and has blocked things like family planning supplies getting out to people.

The next slide shows a number of countries that have liberalised their abortion laws since the 1984 gag rule introduced by George Bush Sr, and followed on by George Bush Jr. Countries in our region such as Cambodia and Malaysia have liberalised their laws. In Nepal women were put in prison for having an abortion, for goodness sake, but there is change there. In Pakistan, as members have already mentioned, there is a movement towards looking at women's rights. Most recently, this year, Thailand further liberalised its abortion law. These are the issues we can be engaging ASEAN on and discussing with the members of parliaments of other countries.

These next slide, again, looks at global laws. You can look up this information yourself in the Harvard annual law review. It is not as simple as: there is access to abortion; there is not access to abortion. There is a whole raft of criteria written out in law. If you look at some of the laws you will find them very interesting. Some of you must be lawyers. The way that these laws are written is incredibly rudimentary, and it would be interesting to engage with some countries and ask them how they developed their laws. We know that a lot of these countries have a colonial history and that the laws have been passed down from European countries in their most rudimentary form. I think this is a way we could expand some of the criteria that would allow our sisters to have safe abortions in some of our partner countries.

These are the questions I am grappling with. How can we work with other countries to foster some debate and discussion on these issues? Does AusAID talk to these countries as well? Do they see a role for promoting that, for assisting researchers, academics and lawyers to talk with each other and to form coalitions?

We need to look at what the realities are for women who have an unsafe abortion. What does the research tell us? We know that many of the indicators are actually not known. We use a lot of numbers but, basically, many of them are guesstimates. But we know that there is a very serious problem. We know that the maternal death rates in Burma, Cambodia, Laos, Nepal, PNG and Timor-Leste are far too high. They are extraordinarily high. We know that unsafe abortion is a very common way to manage fertility. We have come from a Western tradition of discussing pro life and pro choice. We get caught up in a very polarised discourse.

From my experience of working in Asia, that does not exist. It causes a space where you can go in and discuss these things from a public health point of view and by using evidence. The either/or agenda we have does not exist. When you talk with women at ground level, they also do not think like this. They will say things to you like, 'My period is late. It is two to three weeks late.' As a clinician I would say, 'Do you think you are pregnant?' They would say, 'Oh, I don't know. We'll have to see.' They then use herbals, almost like a pregnancy test, to end a pregnancy. If the pregnancy ends or the period is reintroduced, they clearly were not pregnant. They have recommenced menstruation.

We need to throw away some of the concepts we have in our heads about abortion. We have to actually talk with the women on the ground about what they want. As my colleagues have already said, there is an unmet demand for family planning. I do not need to say that again.

Post-abortion care has been brought in because people feel queasy about talking about safe abortion. They think, 'What can we talk about that is safe?' Post-abortion care is a very safe thing to talk about. I do not want to diminish it in any way. It is an absolutely vital piece of obstetrics that saves women's lives, but we should be training health workers how to do it much better. Even when it is practised, particularly in Asia where I have seen it practised, it is often practised with poor quality. Old techniques are used. Women are discharged after being admitted into a hospital after a botched abortion, and they are not given any information or counselling about family planning whatsoever. A lot of people in the audience are nodding. This is a very well-informed audience that I am speaking to.

It blows my mind that this kind of stuff can continue. It is very simple. It is all about training your health workers and increasing their capacity to provide much better care. Post-abortion care is a suite of ideas. It is about treatment, but it also should include counselling and contraception—the whole raft of ideas. It is very good. But I am also arguing for access to safe abortion. This is an end-point intervention, and it looks like what you are seeing here. This is reality. This woman gave her consent for this. She wants you to know what it is like to have an unsafe abortion. She is haemorrhaging after using these sticks. This is what they do. When you refuse to provide any good quality family planning services, when you refuse to participate in providing safe abortion information, education or programs, this is what women end up like. For the television, these are abortion sticks. They are from Thailand. This is what women resort to when they have no other choice.

I also was interested in thinking about how much money we are spending in this area, because dollars are one way of measuring what you do—only one way; money is not everything, but it certainly counts for something. When I went to the literature and tried to draw out this information, I found it extremely difficult to find. I am not saying there is a conspiracy in AusAID or anything like that, but this is as detailed as I could get. That is not really very clear. This has to have 'thousands'—three noughts—up the top. I do not want to be seen to be misleading anyone here that AusAID only spent \$2,000 on family planning in 2004, so add three noughts to the end of that. But you can see there is a vast difference—and this has been highlighted here today by several of my colleagues—between the huge emphasis on this but not on this and this.

What is reproductive health care? We need good tracking systems. Thank goodness Annmaree mentioned it, because my next question is: how can we monitor our dollars? We know all of these things are important; I am not arguing one is more important than the other. They are all vital to women's health, but there must be some clever people in Australia who have done health informatics and economics who can track this stuff. I noticed in *Hansard* that Senator Lyn Allison and Senator Moore also asked these questions recently, and they probably came back with something as vague and wishy-washy as this. This is not good enough. We need to track this a whole lot better, and I think that in Australia we have the capacity to do so.

My argument today is that in order to seriously reduce maternal mortality and disability we have to include high-quality family planning services and we also have to include safe abortion

and post-abortion care. On that last table I specifically asked: how many dollars did we spend during the last five years on post-abortion care or anything to do with abortion? I could not find out. If I could have that information or if the committee could pass that on to me, I would be very interested to know. If we actually want to address MDG5, we are going to have to find that out.

I know that in this room we all know what reproductive health care means. But perhaps our tracking system needs to be tracked including all of these things: safe motherhood; all that stuff around hygienic delivery and emergency obstetric care, which we know, evidence based, saves lives; family planning; safe abortion; gender based violence; HIV-AIDS; and other sexual health issues. That is the whole gamut of sexuality and enjoying sex, being gay or not being gay or what have you. All of that other stuff is really important too. It would be really interesting if we could break our programs down into these categories and also some of our economic tracking systems to get some very good baseline data. That is also missing in many countries.

We know, from the research, that the interventions that work are: high-quality, accessible contraceptive services for women and men; education programs in sexual health; legislative reform—as an academic, I do not have a lot of access into that stuff but I think you probably do; and high-quality, accessible abortion services. I do not know if you have seen the AusAID family planning guidelines. When I read them, I have to ask myself a question. We know where they have originated from—they come from a very particular point in political history in Australia. I ask myself whether it is the time now to have a look at these guidelines again and see whether they actually assist us with MDG5 or hinder us. I am not sure that anyone has been asked that lately. I would like the NGOs in Australia to respond to that question. Do these family planning guidelines help or do they hinder you delivering your programs? My gut feeling is they probably hinder, but I would like to see some evidence on that too. That is all I have to say today. Thank you.

Senator WEBBER—Thank you very much. That has certainly outlined a few activities for us to undertake as parliamentarians. Are there any questions or comments?

Dr CAMP—I just want to put in a plug for a report from the Guttmacher Institute entitled, *Unintended pregnancy and induced abortion in the Philippines: causes and consequences*. This is downloadable from the Guttmacher website without charge. I have a couple of copies here, one of which I hope the chairpeople will take. I am happy to send copies along to anyone who might like them. We presented some of the data in this report in our last session. That data indicates that unsafe abortion appears to be on the rise, probably as a result of attacks on family planning services. I am happy to make that available.

Mrs JOSEPH—Dr Belton, thank you for your presentation. I can understand where people are coming from, but I wonder if you would be interested in allowing me to explain something to you. You said you did not understand why abortion services would not be provided for people in the developing world. I have worked in this area for a long time. I have worked with Senator Harradine. I was an adviser to Cairo Plus 5—and so on.

Dr BELTON—Yes, I know what you mean.

Mrs JOSEPH—From this other point of view, can I say first of all that there is a mistake there in your saying that the international conventions do have abortion as an—

Dr BELTON—I did not say that.

Mrs JOSEPH—But it can be understood that the conventions support the provision of abortion as—

Dr BELTON—I did not say that.

Mrs JOSEPH—Could we just have a look at the second one?

Dr BELTON—I said that CEDAW actually mentions family planning and the woman's right to choose the timing of her pregnancies.

Mrs JOSEPH—Yes, correct.

Dr BELTON—I never said the other.

Mrs JOSEPH—Yes. Can I just explain a little bit further?

Dr BELTON—What point are you making? Would you like to come to your point or your question ?

Senator WEBBER—I think we need a question. The chair has to wrap up the entire session in about a minute. The Senate is going to start sitting, so the bells are going to go off in a minute.

Mrs JOSEPH—I am sorry. I guess the question is that right now it is understood in the UN—in debates, in all the recent conferences and discussions—that abortion is not a human right, that abortion was never part of the human rights language.

Senator WEBBER—Is there a question mark coming at the end of this?

Dr BELTON—Women will continue to die if we do not deliver these services—and they are legal. What I am saying is that in many countries we deliver aid to this is actually legal. We could stand here all day and debate whether it is a human right, which I am not going to do with you. It is actually, in fact, legal in many countries.

Mrs JOSEPH—But one issue that is emerging—

Dr BELTON—It is also legal in many countries to deliver post-abortion care. I am arguing that we should be doing more of that too.

Mrs JOSEPH—I certainly agree with that.

Senator WEBBER—Can I intervene. I am sorry but it is now the kind of process where we are going to have a Stalinist chair. Can I ask you all to yet again thank Dr Belton for me. I will now hand back to our chair.

CHAIR—Thank you very much. As with our first seminar, we have had an excellent range of speakers. We could have sat here all day and burrowed into and drilled down into each of the different papers. The good news is that we are going to have access to all of those, including the incidental comments and so on. They have all been recorded. They will be available on the PGPD and AHAR websites. I do not know how long it will take to get them up. I am told that all the papers are up already. The *Hansard* will take about a week. The bells are ringing for the Senate. We are losing our senators fast, and you will lose me too because both chambers are starting to sit.

Let me say to you very quickly that you might wonder where we go from here. The idea of these seminars is to help inform us as a parliamentary group on population and development, and we want to produce a paper that will help us better understand our AusAID family planning guidelines. I need to tell you that I have had a letter back from Alexander Downer, who has helped us very much—through AusAID and DFAT—in support of this forum—and we thank very much our contributors today, particularly Annmaree O’Keeffe. Mr Downer writes:

I note that the Parliamentary Group on Population and Development roundtable discussions on reproductive health and the aid program have commenced and that an objective of the roundtable is to conclude with a report on sexual and reproductive health and population issues in the region. I also understand that the report will consider the priorities and directions outlined in the White Paper on the Australian Government’s overseas aid program.

I look forward to receiving the final report. Regarding the *AusAID Family Planning Guidelines*, AusAID is undertaking a limited review of the Aid Program’s Family Planning Guidelines with a focus on streamlining the procedures within the guidelines.

We will have been better informed by all of the participation we have had over the last two of these roundtables, although they have not been ‘round’; they have been square rather than round. I hope you have a sense that you have been able to ask questions. I think we have had an extraordinarily well informed series of contributions. They have all been excellent. Now that we have her here, I want to acknowledge Tasmanian MLA Ruth Forrest, who was in the wrong place. She was here on time but she had gone to the wrong venue. We do acknowledge one of our state parliamentary colleagues who, like other state and territory members of the upper and lower houses around Australia, is also keen to make sure our population development agenda in Australia is as it should be. Annmaree, would you like to make a final contribution before we all have to rush off?

Ms O’KEEFFE—Yes, Chair. I just want to say it has been a particularly useful session for me. I am sorry I was not able to be here for the first one. I was actually with the Australian delegation at the Toronto HIV-AIDS meeting, but I know that my colleague was here and that she reported very favourably on the discussions. As we undertake the review of the family planning guidelines, it is going to be very useful to have had this feedback, so thank you.

CHAIR—Thank you very much, Annmaree. We do not have with us the President of ARHA, Heather McDonald. She was here just last week when we launched the UN population report. She would very much have liked to have been here but she is currently engaged in a work commitment and could not be with us. We thank her very much for her apology. Anne Marie Tyndeskov Voetmann from Denmark is going to be here for a few more days. If anyone would like to catch up with Anne Marie, I can tell them her program is being organised by Regan, who is with our secretariat and supports us very well. Once again I thank ARHA, who look after us so very well. Chris, who looks after the secretariat in particular, has been very much doing the hard work behind the scenes.

We have had a very informative last couple of days. I thank everybody who has come along—some of you have come a very long way—including all of my parliamentary colleagues—the senators and members who have shared the managing of these discussions. Some have had to come and go—that is the nature of this place. We were very fortunate that the chambers do not sit on Monday mornings so we did not have the usual bells ringing all the time. But now that the bells are ringing we will have to depart. Watch the web for the *Hansard* of the discussion that took place today. You already have access to the papers on the website. Thank you very much, Anne Marie from Denmark, as you have come a long way. You are looking after our princess very nicely over there, and we thank you for that! Our parliamentary group will now put together our discussion paper very carefully. Thank you for having been part of informing us so that we can make the best possible contribution.

Group adjourned at 12.30 pm