



COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

**HOUSE OF
REPRESENTATIVES**

STANDING COMMITTEE ON HEALTH AND AGEING

Reference: Regional health issues jointly affecting Australia and the South Pacific

FRIDAY, 11 SEPTEMBER 2009

CANBERRA

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HOUSE OF REPRESENTATIVES
STANDING COMMITTEE ON HEALTH AND AGEING

Friday, 11 September 2009

Members: Mr Georganas (*Chair*), Mr Irons (*Deputy Chair*), Mr Bidgood, Mr Coulton, Mrs Gash, Ms Hall, Mrs Irwin, Ms King, Mrs May and Ms Rishworth

Members in attendance: Mr Bidgood, Mr Coulton, Mr Georganas and Ms Hall

Terms of reference for the inquiry:

To inquire into and report on:

Regional health issues jointly affecting Australia and the South Pacific

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Committee met at 9.04 am

CHAIR (Mr Georganas)—Good morning and welcome to all the participants in today's forum. I declare the forum on regional health issues jointly affecting Australia and the South Pacific open.

The committee resolved to conduct this roundtable in order to be better informed on a range of regional health issues in advance of a committee delegation to Papua New Guinea and the Solomon Islands that will take place in the next month or so. This roundtable also complements the committee's recent meetings and inspections in Cairns and the Torres Strait to discuss cross-border health concerns such as malaria, dengue fever and the spread of communicable diseases such as drug-resistant tuberculosis and HIV-AIDS. The committee expects to touch again on these subjects as well as others today. In addition to communicable diseases there is a range of non-communicable diseases that increasingly affect countries in the region, including chronic diseases like diabetes and cardiovascular disease.

The committee has also taken an interest this year in examining the health impacts of climate change, something which affects us all in the Asia-Pacific region. The committee has also undertaken consultations in remote Australia with Indigenous communities and shares an interest with our Pacific neighbours in improving equitable access to health services and closing the gap in respect of a number of health indicators, including eye and ear health, child and maternal health, and nutrition.

I would like to extend a special welcome to the High Commissioners of Papua New Guinea and the Solomon Islands who are with us today, together with all the other witnesses from various Australian government agencies, institutes, universities and NGOs. We look forward to hearing your views on the key regional health priorities of the region that jointly affect Australia and our Pacific neighbours, the nature of our existing cooperation, what scope there is for further collaboration and what new approaches, initiatives and partnerships we can forge to enhance the health and wellbeing of citizens in the region.

Today's proceedings are being broadcast live and recorded. Is it the wish of the committee that that occur? There being no objection, it is so ordered.

[9.08 am]

BOOTLE, Ms Heidi, Director, Solomon Islands Section, Pacific Islands Branch, Pacific Division, Department of Foreign Affairs and Trade

BOWTELL, Mr Bill, Executive Director, Pacific Friends of the Global Fund, Lowy Institute for International Policy

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WHITTAKER, Professor Maxine Anne, Director, Australian Centre for International and Tropical Health, University of Queensland

Session 1: Overview of regional health issues

CHAIR—Our first session is an overview of regional issues. We will open up the discussion in an orderly fashion, with people speaking for two to three minutes—no longer than three minutes because we are on a tight schedule and there are many people here. On the two-minute mark I will make a little noise to let you know that you have another minute. Although the committee does not require you to speak under oath, you should understand that these hearings are formal proceedings of the Commonwealth parliament and giving false or misleading evidence is a serious matter and may be regarded as a contempt of parliament. We will hear from all of you round the table, starting with Your Excellency, Mr Charles Lepani.

High Commissioner Lepani—Thank you, Chair, and your colleagues the honourable members of your committee. I am here not in my capacity as the High Commissioner but as an interested party for the record because I do not have a formal position to put to your committee on this issue. I do have an invitation to come as a matter of interest and to help your committee's travels in Papua New Guinea I would like to share some information with you.

Papua New Guinea's health record is very well publicised internationally. It is not something we are very proud of in our policy implementation efforts. We do have very good policies, recognising health as one of the existing seven priority areas for our government's interventions and resource allocations. We have two specific areas of priority: preventative and primary health care, and HIV-AIDS. These are the two health priority areas that the government has focused on in allocating its priority resources. But in terms of recurrent spending, in last year's budget health received the second highest allocation of all the priority areas. Transport infrastructure in recurrent spending received 50 million kina and health received 46 million kina. That reflected an awareness of and response to the sad state of affairs in our health system.

Papua New Guinea's health problems are not an issue of resources. I think we do have sufficient resources, both domestically provided from our budget and other sources as well as assistance from our international development partners and NGOs. It is a matter of flows in these resources because of the constraints that we have in capacity as well as the various levels of government that we have. Some of us believe that Papua New Guinea has too many layers of government: district, provincial and local levels as well as the national government. In terms of implementation, we have a piece of draft legislation awaiting formal approval which will give the national health authority the powers to implement policy as well, not just provincial and district health services. That may bring some improvement. It is a reverse of decentralisation. We realise that decentralisation has not really brought about development generally in terms of implementation. I will stop here, with that general picture, and we can tackle the other two subjects later.

CHAIR—Do the committee members have a question to ask His Excellency? If not, we will continue.

High Commissioner Ngele—I would like to thank the committee for inviting me to participate this morning. Like my colleague from Papua New Guinea, I come not to make an official presentation. I am equally interested in what is being done in the interests of the people of the Pacific region and more so of the people of the Solomon Islands.

The Solomon Islands, as you know, is a small country and we have a myriad of problems trying to administer health care in our country. We have problems of financing and we have problems of logistics, as the country is quite widespread. We have a referral hospital that is situated in the capital but for most people in the outlying islands it would sometimes take a week to get to that facility or to any reasonable healthcare facility.

We know that the government is putting in a lot of resources. But, in the same vein, that is not enough to provide the kind of health care that we see our neighbours—Australia, New Zealand and other developed countries—enjoying. We believe we are improving somewhat in terms of the indicators that have been issued in recent years. The Solomon Islands, as you know, is experiencing problems with most of the new health-style diseases. People are experiencing difficulties in attaining the level of health that is enjoyed in other countries.

I do not have a presentation but as we go along I shall assist in whatever way I can. Mostly I will be able to assist in the preparation for the visit to the Solomon Islands.

CHAIR—Thank you. At this point I will ask if any of our committee members have a question.

Ms HALL—I have a question for Mr Lepani and Mr Ngele. The one issue that I pick up is the lack of capacity within your countries to deal with the issues that are outlined here. I was wondering if you might like to comment on what you think needs to happen in relation to developing the capacity, as opposed to just putting more resources in.

High Commissioner Ngele—I would think that more partnering with the health institutions in the islands would be a way to go. I know that there are countries that have established relations with particular institutions in Australia and are benefiting from this arrangement. For example, I

am aware of an arrangement the James Cook University in Townsville has with Fiji on nursing training and things like that. We do not, in fact, have that kind of privilege in the Solomon Islands. Such an arrangement would help the capacities of our own people back on the islands.

High Commissioner Lepani—In terms of physical infrastructure, the government—with Australian development assistance—has a huge investment in roads and transportation infrastructure generally that is going on at the moment. In terms of training, output from our medical schools is about 40 doctors a year compared to Australia's thousands of skilled doctors, and that goes down to nurses and paramedical-type skilled training. So in that area there is the potential for cooperation and partnerships with Australian institutions and other international countries and this would be very useful.

We do have existing arrangements for this, but a lot has to come back to us as a government, as a people, as a country, realising where our needs are. We have excess lawyers and accountants but not doctors and agricultural extension officers and that sort of thing, so we need to rethink where the important areas of our development are and retrain our people.

Mr Milner—I am very pleased to be here today and to assist the committee as I can. I will defer to my other Public Service colleagues on some of the substantive issues.

Ms Bootle—The Pacific Islands Branch of the Department of Foreign Affairs and Trade, which I am representing, covers all of the Pacific countries except PNG, Fiji and New Zealand, so of particular interest to us today is the Solomon Islands. I do not have a statement to make at this stage but am happy to be here and participate in the discussions. I do want to support the statement made by my colleague the High Commissioner, Mr Victor Ngele, about partnerships. I think that is a very constructive point. In that regard I want to mention the arrangement we have, which is working quite well in terms of practical cooperation, between St Vincent's Hospital in Sydney and the National Referral Hospital of the Solomon Islands. My AusAID colleagues might want to comment on that separately but I would just like to acknowledge that idea of partnership arrangements that the high commissioner mentioned.

Ms Shipley—It is a great pleasure to be here today to assist the committee. I want to make a couple of very brief comments. One is to draw the committee's attention to the Millennium Development Goals, which are the lens through which the aid program looks at assistance particularly in the health arena. The Millennium Development Goals are internationally agreed goals to reduce poverty by 2015. What we have done in relation to the Millennium Development Goals is to produce a tracking report and looking at development and governance across the Pacific against those Millennium Development Goals. I have provided copies of the report to the committee. I will not go into detail about the contents of the report but I feel that that may be very useful in your deliberations.

The other comment I would make in response to the question that Ms Hall raised is on the issue of partnering and strengthening health systems. This is something that we look at as we work through the Millennium Development Goals. We look at strengthening the health systems in PNG, the Solomon Islands and our other Pacific partner countries. The pillars of our initiatives to do that health workforce strengthening include improving management capacity, the curriculum, development and infrastructure of the Fiji School of Medicine as a source of training and capacity building throughout the region, looking at doctors and other health workers. We are

also enabling WHO to help Pacific island countries to address constraints in the healthcare workforce by providing assistance to develop medium-term health workforce plans and appropriate regional standards for healthcare worker training and accreditation through the Pacific Human Resources for Health Alliance. The third pillar there is the development of an improved, demand led coordination mechanism to strengthen specialised clinical services in the Pacific. We can provide separate detail to the committee on that.

CHAIR—Before we move on, would you like to ensure that the booklet you have given us is tabled as evidence for our inquiry?

Ms Shipley—Yes.

CHAIR—Is it the wish of the committee that the booklet from AusAID be accepted as evidence? There being no objection, it is so ordered. You have a question, Jill.

Ms HALL—Other people might like to comment on this as well. In relation to capacity, I am aware of the Millennium Villages project. Please comment on how you think that approach goes towards developing capacity as well as just partnering, and any other initiatives and ideas that are a little different.

Ms Shipley—I can make a general comment on the Millennium Villages project and we will be happy to provide you with additional briefing in preparation for the visit.

Ms HALL—I would like that.

Ms Shipley—The project seeks to create alternative mechanisms to draw together new relationships to build capacity at the local level. I think the challenge that rests with the Millennium Villages project is to ensure that it works within the systems in Papua New Guinea, because that is where the project is proposed, so that it does not create a duplicate strand of relationships and systems that competes with the Papua New Guinea health system structures. High Commissioner Lepani spoke earlier about the desire to streamline that process. So, while we are very interested in the project, we are still working both with donors in Papua New Guinea and the Papua New Guinea government to make sure that the project meets that goal, which is part of our overall development goals working with our partners and is underpinned by the Cairns compact, which was recently announced after the Pacific Islands Forum and committed the US to work through our partner-government systems.

CHAIR—I might now ask the representatives of the Department of Health and Ageing to make a statement.

Ms Gardner—As well as being with the Department of Health and Ageing, I am the Chair of the Torres Strait Health Issues Committee. Thank you for having us here today. We are very pleased to be able to assist the committee and to contribute to today's discussions. The department's involvement in regional health issues is mainly through the Torres Strait Health Issues Committee. The committee was established in 2003 as a subcommittee of the Joint Advisory Council on the implementation of the Torres Strait Treaty. It examines health issues associated with the free movement of PNG nationals and Torres Strait Islanders and looks at practical ways to address these health issues. The HIC comprises representatives of the

Australian government, Queensland government and PNG government agencies and aims to strengthen the health service capacity in the Torres Strait and the Western Province of PNG, and increase surveillance and communication around communicable diseases in the treaty zone.

The department also has established the Pacific Senior Health Officials Network, which aims to facilitate communication between senior health officials with an aim of supporting health system governance and the development and implementation of sound and effective health policies within the region. The network promotes a partnership and technical exchanges between health officials through a policy partnerships initiative and middle managers program.

Mr COULTON—This committee was in Torres Strait two weeks ago and we met with health professionals and academics in Cairns as well. One of the things suggested was the need for capacity building in PNG and health clinics, particularly in the Western Province area that joins Torres Strait. One of the things that became obvious to me when visiting Saibai Island was that even with quite a modern facility at Daru—which would probably be an obvious place to put something like that—it is still about a two-hour trip to Daru compared to 10 minutes to Saibai Island. We found some resistance from the residents of Saibai Island to a number of people from PNG coming across, but is it not more practical to have the facility on the islands closest to PNG that would service Torres Strait Islanders and people from Papua New Guinea?

Ms Gardner—Within the capacity of the Torres Strait Health Issues Committee we have looked at a joint health service on one of the islands. We have certainly looked at different mechanisms to increase the capacity of the health services that are on those islands and also the ones in the villages within the Western Province. We have also looked at how we can support communication between the two so that there are different ways to increase their capacity and ensure continued support of patients who have been treated within Australian territory when they return to the Western Province.

There is also work underway, which my colleagues from DFAT may wish to comment on, to facilitate the movement of health professionals across the borders to reduce the time and expense that can be incurred, enabling them to cross at those areas where the border is very close rather than having to go through official ports. I would prefer for DFAT to comment further on that proposal, but I think it would have a significant impact in terms of the health services capacity on both sides.

CHAIR—Any further questions? Would DFAT like to respond?

Mr Milner—Just to endorse what my health colleague has said, this is a proposal to try and facilitate the movement of health professionals across the border, but it is a proposal that we have actually put to the Papua New Guinea government and it is currently being considered by them.

CHAIR—We will go on to the next participant. Let me just remind people that you do not have to make a statement at every session. Just indicate if you do not wish to make a statement.

Professor Whittaker—The Australian Centre for International Tropical Health is involved in a lot of work in the Pacific, particularly the Solomon Islands and Papua New Guinea, in malaria, health information systems, and training and research development. Thank you for this

opportunity. Your Excellencies, it is good to have you here as well. I will not go through the statistics as both High Commissioners have mentioned, they are well known. But I think there are a number of things worth emphasising.

First, both between the two countries and within the countries the disease burden is not homogeneous. There are differences both across countries and within those countries. The increasing urbanisation in both countries is starting to show the burden of non-communicable diseases as being a double burden to those countries. The problem there is that health systems that are already having trouble responding to the communicable disease burden are now also having to orientate themselves to different interventions and different ways of doing business for non-communicable diseases like obesity, diabetes and issues related to tobacco, alcohol and injury.

Second, both the Solomon Islands and Papua New Guinea are still suffering from diseases and health problems for which we have a lot of interventions that we know can work. But children and mothers are still dying or suffering from preventable illnesses. As the PNG High Commissioner mentioned, the capacity of the health system to respond is a very important one to look at. And looking at health system strengthening is important.

Ms Hall, on your point about capacity, WHO recommends that there should be 2.3 health workers per 1,000 people in order for infant, child and maternal mortality to be reduced. In Papua New Guinea, that figure is 0.6. In the Solomon Islands, it is 1. So trying to scale up the doctors, nurses, midwives and community health workers is extremely important. Finding a way to quickly scale that up to make the changes is an important issue we need to look at. Partnering is one of those.

Ms HALL—Professor, do you have any other suggestions as to how the number of health workers could be increased?

Prof. Whittaker—I had the pleasure of being on the PNG maternal mortality ministerial taskforce. In our deliberations, one of the things we were considering was ways to quickly increase the capacity, say, for midwifery training by getting Australian/New Zealand midwives to have secondments for three to six months, to provide more training opportunities. It is a catch-22 in some ways. There are not enough midwives or obstetricians to do training, so you cannot actually have enough registrars and midwives getting supervised clinical training. So we need to find some ways, in the short term, to increase that training capacity, to meet the immediate needs. That is one suggestion that came out of that taskforce.

Mr COULTON—One of the things that was discussed was the ‘grow your own’ model of health professional but this cannot be simply started at the end of schooling. Perhaps students should be identified at an earlier age, so they have a lot of the basic skills to undertake the medical training later on. Have you done any work on identifying and encouraging students from a younger age, rather than trying to identify school leavers?

Prof. Whittaker—Not when I was living in Papua New Guinea. However, by trying to improve the science curricula and science understanding from primary school levels upwards—and there are quite a few groups who are working on trying to increase science literacy, which is very important—and also looking even in the school education, embedding health skills or

health literacy as part of the underlying curriculum in primary and secondary education is a very important start, so that even within the home people are empowered to look after their own health. There are also some well-known ways of doing child-to-child and child-to-parent education by using the schools as the entry point to increase health literacy and basic science understanding.

Prof. Kelly—Thank you for the invitation to be at the committee. I once had to give a summary of my PhD in two minutes, so I will see how I will go with this very major issue that you are facing. I would also like to applaud the committee for taking on this purview, which I have been trying to do for about 20 years—to get Australians to think about health outside our borders and how we relate to the rest of the world. I will give a short background and the sorts of things I might be able to assist the committee with.

I have been working in East Timor and Indonesia mostly for the last 10 years or so and have been involved with capacity building in both of those countries in relation to infectious diseases. My particular interest and expertise is in tuberculosis and HIV and those are the things I might be able to help with. I think there are a couple of issues here. Firstly, capacity building is very important. If you are looking to assist in closing a gap you need to be able to measure it and you need to be able to measure whether that gap is being closed. The course I run at the Australian National University—the Master of Applied Epidemiology program—has been doing that, mostly within Australia, for almost the last 20 years. One of my staff members is going to Fiji in two weeks to continue discussions with the Fiji School of Medicine, around setting up a similar program for the Pacific. I think those sorts of things, particularly those which His Excellency, Mr Lepani, was mentioning around that sort of partnering and capacity building in that way, we would be very interested in assisting with.

The other thing we need to be conscious of is that, whilst it is important to concentrate on very specific things and show that you can actually make a difference—for example, with multi-drug-resistant TB—it has to be seen in the context that there is other TB, and drug resistance is just a microscope. You need to look more broadly than the TB control program, to the issues of the health system in the Western Province and also more broadly. I think we can concentrate on that as the discussion goes on and I will not make a further comment at the moment.

Ms HALL—We are talking about treatment. Should we be looking at going back a step towards prevention?

Prof. Kelly—Do you mean particularly in relation to tuberculosis?

Ms HALL—Yes.

Prof. Kelly—Yes. I think that the two go together and one of the best ways to prevent TB is to treat the people with TB, and I think that is the problem. TB is an infectious disease and if there are a lot of people with that infection then it spreads very quickly. The best way to prevent it is to find people with tuberculosis and to treat them effectively. This has obviously been an issue in the Western Province and more broadly in PNG, fuelled by the HIV epidemic.

Ms Duituturaga—I am very pleased to be here as a Pacific Islander and, in addition to their excellencies, to bring voice for the many Pacific voices that cannot be in the room today,

especially as a Pacific Island woman. The first point that I would like to make is that if you look at the profile of the Pacific Islands, 50 per cent of the population are women—especially in the countries that we are talking about, 65 per cent are under the age of 29 years, 40 per cent are under the age of 15 years, and 80 per cent of them are the rural majority. I think it is really important to have that at the top of your minds.

In speaking about the role of women, while we need to work with women we also have to understand that Papua New Guinea and Solomon Islands have the 'big man' Melanesian leadership systems, so whatever approaches we take have to both target women and also involve men and boys in particular. We have real gender issues that need to be addressed. I am pleased to hear that there are now some innovative programs involving men and women, particularly with respect to issues like maternal health because in these countries women have no choice over their bodies. It is very important to address this. In the area of maternal health, as has already been said, women still die of curable diseases, particularly to do with pregnancy. I am sure you would have received the latest information on violence against women statistics. In the Solomon Islands it is now revealed that two out of three women suffer from domestic violence.

In terms of the rural majority, it is important to understand that the village is the centre of the universe. Whatever programs we roll out have to start at the village and work backwards, not from Canberra to the village, if you do not mind my saying. In this context, the state machinery has very limited reach, making the role of churches in particular very important in delivering health services and education and reaching young people, as well as NGOs and community based organisations.

Very quickly on climate change, many of our people still do not understand the impact in terms of mitigation and adaptation, particularly how it affects food security, which then affects health. On the issue of capacity building, we have professionals. I prefer the approach of capacity development because often people think we do not have capacity and they have to come and build capacity. We already have capacity, it just needs to be developed and enhanced in looking at what our strengths are, because ultimately that is what sustains ourselves and our communities.

Our conditions for workers, as their excellencies know, are not that great, so we lose a lot of our professionals, but again when we are looking at working with villagers we have to work with communities in existence, and this is where NGOs and churches can reach. I will talk about some of the other strategies and innovations, but I thought I would make those points.

Finally, in Papua New Guinea there is only one woman in parliament. In the Solomon Islands there is no woman in parliament and there has only been one since independence 30 years ago. While it might not be clearly a health issue, I am sure that if there were more female voices in parliament we could get policies, legislation and more involvement of women.

Mr Carrigan—GRM International does not have a formal submission for this session. It is very good for us to be in front of the committee, though, and I thank the committee for the invitation to attend. We definitely see ourselves as an implementation partner on some of the programs and policies going forward, so it is good for us to be here and be informed at the ground level.

Mr Purdy—GRM International is a private company. We are a managing contractor and work on behalf of our clients, which are mainly bilateral donors, including AusAID and UKaid, and we work on behalf of our beneficiaries and counterparts in many countries around the world, including Papua New Guinea and the Solomon Islands. Most of our comments are probably in relation to the next session but in order to address some of the key health issues facing the region—and it has been touched on by their Excellencies and others—a totally holistic approach needs to be taken. If we want to strengthen health systems we need to look at a multisectoral approach. As Emele suggested, it starts at the community development level. It covers education. As His Excellency Mr Lepani said, it also includes agriculture in terms of emerging infectious diseases, it includes infrastructure, roads and hospitals, and so to sustainably address those issues we need to look at fairly broad and integrated approaches.

Dr Morgan—I prepared a statement for the next session but I would like to make a very quick point. I am sure other speakers will mention the fact that maternal mortality has doubled in PNG, but PNG has seen successes in declining child mortality. Picking up the fact that there is capacity in these countries, I think we can do a lot of good work by looking at what has gone right and trying to learn what has gone right. There are officers in charge of health centres and district health officers out there who are delivering services even though the system is dysfunctional, even though the environment is harsh. I think my main point is that we need to seek out cooperation and partnership mechanisms that allow us to learn those lessons from the grassroots, from the village up.

If I count up the different ways I have been involved in PNG in cooperation mechanisms, there are at least five different ways that go beyond the traditional aid paradigm. I think it is no coincidence that child health has improved, and if you look at which of the medical specialties is the best home-grown specialty in PNG it is paediatrics. They have done the best at having their own postgraduate qualification and they have received a lot of support from different groups in Australia in making that happen. If we look at other forms of cooperation, such as NGOs and church groups for both service delivery and researching new knowledge, then partnerships that go beyond traditional aid structures will be helpful at bringing knowledge and new forms of service delivery to bear. I will make a statement in the next session perhaps about that. Thank you very much for the opportunity.

Ms Knight—I have a statement prepared for session 3 which will cover off many of the issues that Emele has raised in terms of our work with community organisations in Papua New Guinea and the Solomon Islands. Sexual Health and Family Planning Australia has been working in the Pacific and Asia for over 30 years and most of our work is at the community level focusing on development and capacity building around sexual and reproductive health and family planning. Our view is that family planning is one of the key drivers to the eradication of poverty and that, when women have the capacity to plan and time the number and spacing of their children, they are able to act in the best interests of their own children and the community. One of the key things we have been working with, particularly in the Solomon Islands, is making the connection between population and the environment, but I will hold my comments for session 3.

Ms Clement—I have also prepared for session 3, but I will respond to some of the questions and comments so far. There has been a bit of talk about building capacity, and I would like to ask how we define capacity. It is not just the skill sets of individuals, which is important, it is also how we have the resources and infrastructure in the location so that people want to work there

and will stay there. I have been working reasonably closely with the Gulf Christian Services, which are in Gulf Province, and they run two hospitals in Kikori and Kapuna. Over the ten years that I have worked with them, they have found it virtually impossible to attract any national medical staff to stay there. They also run the community health worker program there. They get their government funding, but it is a very small pool of funding that they have got to stretch. So they rely a lot on foreign doctors who come as volunteers and stay for a year or two, but that is clearly not sustainable. On the question about building up the capacity of kids, one of the things they are trying to do is use donor funding to train local people—send them off for training so they come back. That way you have got the local people who will come back and live in that community. Otherwise, I will talk in session 3.

Mr Ekin-Smyth—Aspen Medical is a commercial provider of healthcare solutions. We specialise in the delivery of integrated health solutions in austere or challenging environments, and also in rapid response and disaster relief. We predominantly do that for the Australian government, particularly for Defence, the Australia Federal Police, DoHA, and OATSIH for Indigenous health, but also to a lesser extent for AusAID and private donor organisations in the Pacific. We have a very significant presence in the Solomon Islands as part of RAMSI. We have been there for about five years. We have a similar presence in Timor-Leste. We also have some limited presence in Papua New Guinea. I am not here to make a submission; I am here to assist the committee as far as I can, particularly in terms of the next session. I would like to thank you for the invitation.

Ms HALL—I have noticed that we have had two private organisations presenting as part of the roundtable. I was wondering if you could clarify for me how you interact with the agencies and departments of the governments of PNG, the Solomon Islands and Australia. Can you tell me how it all comes together so that I can understand?

Mr Ekin-Smyth—We are contracted by departments of the Australian government. In Aspen's case, it is primarily to deliver health services to the forces of Australia or Australian departments deployed in those countries. That is our prime remit. Those departments and agencies generally give us a limited remit to do work in terms of community engagement and health delivery. For example, in the Solomons we provide a very considerable capacity in aeromedical evacuation and engagement with the national referral hospital.

Mr Purdy—It is of relevance to the topics being discussed here that GRM International are contracted by AusAID. We are paid by AusAID to implement and manage development interventions. With respect to the Solomon Islands, we manage a governance support facility under the auspices of RAMSI, and we work together with our counterparts, which are the relevant government departments in the countries where we work—that is, the beneficiaries or recipients of the activities and programs that we have been contracted by AusAID to deliver. That effectively works in a tripartite arrangement. Our client is AusAID and the beneficiary of the donor funds, which come through us as an organisation, is the relevant government department that is receiving the benefit of the funds. I would be happy to provide a written submission that explains that relationship. It can be a little bit complex at times.

Ms McMahon—Caritas is an agency of the Australian Catholic Bishops Conference, but we are part of the wider Caritas confederation that works in more than 160 countries around the world. In the Pacific region we have quite a substantial program. Our biggest program by far is

in Papua New Guinea, where we do quite a significant amount of work in health and education service delivery, predominantly but not exclusively with partners from the Catholic Church. I would like to focus on the role of the churches more generally in health service delivery in Papua New Guinea and some of the challenges they face, which are similar to those of government and other health service providers but a little bit different in some ways. I would also like to look at the importance of evidence based research in understanding attitudes and management practices in health service delivery in Papua New Guinea.

Ms Kennon—World Vision Australia welcomes the opportunity to brief the committee. I am here representing Sue Ndwala, the Maternal and Child Health Adviser for World Vision Australia, who unfortunately is unable to travel to Canberra today. Our brief presentation will provide an overview of maternal mortality, a key health issue in PNG, and look at how Australia can support midwifery service provision to PNG. The current maternal mortality rate in Papua New Guinea is 733 per 100,000 live births and appears to have increased in the last 10 years. The proportion of mothers dying during pregnancy and childbirth is the second highest in the Asia-Pacific region after Afghanistan and constitutes a health emergency, with similar maternal mortality ratios to those in Sub-Saharan Africa.

Australia has allocated over \$40 million in funding to maternal and child health in PNG between 1999 and 2004. Despite this, more mothers and babies are suffering and dying during pregnancy and childbirth than 10 years ago. Millennium Development Goal 5, to reduce maternal mortality by two-thirds between 1990 and 2015, is unlikely to be met unless the PNG government shows strong political leadership in implementing the recommendations of the ministerial task force on maternal health in PNG. Those recommendations were produced in May this year and will be tabled for the committee's reference.

Increased access to family planning, contraceptive services and ensuring all births are supervised by skilled birth attendants would decrease the maternal and newborn mortality rate in PNG. In particular, increased resources to expand the midwifery workforce and to ensure the numbers of midwives and the standard of the curriculum are meeting the needs of the PNG people are essential to reducing PNG's maternal mortality. There is clear evidence from other low-income countries that the availability of skilled midwives located in close proximity to the community complemented by village based health workers can significantly improve maternal and child health outcomes. This has been achieved to some extent in the Solomon Islands. I will leave my specific proposal for the second session.

CHAIR—Thank you. The committee has accepted your submission as evidence.

Ms HALL—Is there another document that you wish to table?

Ms Kennon—Yes, it is the ministerial task force which was referred to before. It is just the executive summary. That has the key recommendations and plans of action that have been suggested.

CHAIR—Is it the wish of the committee that that be tabled? There being no objection, it is so ordered. Now for our next participant. Professor, do you have anything to say about the capacity in which you appear?

Prof. Toole—I am participating on behalf of the Australian Council for International Development. Thank you for the opportunity to participate, Mr Chairman. I have a few comments on key health issues, and I will try not to repeat comments already made. Firstly, on HIV, since the beginning of the HIV epidemic 97 per cent of all newly diagnosed infections in the Pacific region have been reported in Papua New Guinea. While the 5,000 or more new cases reported in 2007, which is the most recent data available, represent a 30 per cent increase over the previous year, these figures need to be interpreted with caution, as there has been a great increase in the number of people being tested. For example, in 2002 around 1,000 people were tested for HIV. In 2007 that reached more than 32,000. With more people being tested, of course, more new infections will be reported.

Our best estimate is that between one and two per cent of the adult population is infected with HIV in Papua New Guinea. While this is bad, we believe it is not alarming. To illustrate that, the prevalence of HIV in Papua New Guinea in 1990 was zero among pregnant women. It was also zero in South Africa that same year. By 2003 the HIV prevalence among pregnant women reached one per cent in Port Moresby; in the same year it reached 25 per cent in South Africa. So this is not an African epidemic, as you will often hear when you are in the country. It is not a South-East Asian epidemic. It is a PNG epidemic with its own characteristics linked to the very particular behaviours that are common in that country.

The epidemic is focused in seven highlands and central provinces. Reading the report of your Cairns committee meeting, I noticed questions around why HIV had not spread from Papua New Guinea into the Torres Strait. That may be because the prevalence of HIV is quite low in Western Province. The latest figure in Daru is 0.6 per cent of pregnant women, and in the south-lying villages it is likely to be much closer to zero, so that may explain it. Nevertheless, we should be cautious. Large projects such as the new liquid petroleum gas project will increase vulnerability through the movement of what we call ‘mobile men with money’, who often spend that money on sex.

By contrast, in the Solomon Islands only 12 new infections were reported in 2008. The epidemic has not spread throughout that country or at all. Nevertheless, we should note that experience in other countries, particularly in Africa, has shown that when there is an armed conflict in a country that tends to slow the spread of HIV—which is counterintuitive, but it is very much supported by evidence from Sierra Leone, Angola, southern Sudan, Bosnia and a number of countries affected by conflict. So it may be that following the end of the conflict, with more investment and more plantation industries attracting men away from their families, vulnerability may increase in the Solomon Islands.

Just on women’s and children’s health, I support the comments of my World Vision colleague and also Chris Morgan that, while child mortality has declined in Papua New Guinea, it has been the opposite with maternal mortality. On child mortality we can see that most of the decline has been due to decreases in the incidence, or new cases, of killers of children such as malaria, measles and pneumonia. However, what is called the case fatality rate, or the proportion of children with those diseases treated in health facilities who die, has not changed. That may reflect the continued inadequate quality of clinical services.

CHAIR—Thank you very much.

Ms HALL—In relation to HIV, would you be arguing that the simple fact that limited access and infrastructure between the different communities is working towards stopping the spread of HIV AIDS? There has been talk of a new highway being opened in PNG in the Western Province. Is that right?

CHAIR—Western Province, that is correct.

Ms HALL—With that highway making it easier for people to move from community to community, do you see that that could lead to an escalation in the number of cases?

Prof. Toole—Yes, certainly, and that is the experience in many countries around the world. In fact, probably the main reason why HIV prevalence is so high in southern Africa is the degree of mobility. That is exacerbated by the commonness of multiple sexual partners and also the very low circumcision rates in southern Africa.

In Papua New Guinea, as I mentioned, the epidemic has very much been concentrated along the Highlands Highway. Some coastal and island provinces continue to have a zero prevalence of HIV. Certainly, the development of mines, plantation industries such as oil palms, and new roads exacerbate the spread of HIV. Those projects need to be accompanied by very rigorous HIV prevention programs. That is the case in Papua New Guinea. I will mention that in the second section.

Ms Gersbeck—I would like to start this morning by giving a very brief overview of eye health issues in Australia and then my colleague, Richard, will talk about eye health issues in the Solomons and Papua New Guinea. Over 500,000 Australians are blind or vision impaired. As Australia's ageing population grows, the prevalence of eye conditions is expected to double in the next 20 years. In 2004 the annual economic impact of blindness and vision loss was estimated at \$9.85 billion. It is important to note that 75 per cent of all eye health conditions are either preventable or treatable.

In 2004 the Australian health ministers agreed to a national plan for Australia to promote eye health and reduce the incidence of avoidable blindness. Key population groups targeted in a national framework are Aboriginal and Torres Strait Islander people. The eye health of Indigenous Australians is far worse than other Australians and worse than in many developing countries. Eye problems have a total prevalence of around 30 per cent and are the most commonly reported long-term health condition among Indigenous people. Diabetic retinopathy is a major problem for Indigenous Australians—four times that of the Australian average. The eye disease trachoma is found almost exclusively within the Indigenous population and remains endemic in large areas of Central and Western Australia. The prevalence of cataracts amongst Indigenous Australians is also much higher than the Australian average. Overall, Indigenous eye health is on par or worse than eye health in developing countries including those in our region.

Prof. Le Mesurier—In the Pacific Islands region there are approximately 80,000 people who are blind and nearly 250,000 people with severe vision impairment. Most of this—70 per cent of it—is due to two easily treated conditions. One is cataract, which takes 20 minutes or so and costs about \$20 to \$30 to treat in most developing country situations. The other is the provision of glasses or the lack of provision of glasses.

The problems that we face and the main barriers to restoring sight are ones that have been mentioned by many people here. Poor infrastructure and difficult working conditions, particularly in places like the Solomon Islands where you have small scattered populations and so access for the patients is very difficult, have resulted in a sort of depression almost so that there are very few nurses and ophthalmologists trained. This combination of poor infrastructure and a lack of human resources means that the capacity is very low and becomes very NGO dependent and aid dependent.

There is not very much in the way of eye health promotion to the communities themselves and what is done is lip-service mostly. There is very little attempt being made to share the cost between patients and government so there is no real sustainability because you are lacking human resources and infrastructure and you have got no cost sharing. Ultimately this all comes down to political will, or lack of it, and we have found that there is relatively weak leadership at the ophthalmic level, ministerial level and with most, but not all, of the health bureaucracy because eye care has a low priority. Nevertheless blindness is both the cause and the consequence of poverty and if it is dealt with effectively, and it is very, very cost-effective to do so, this will make a difference to the economic situations in these countries and help towards the MDGs. Thank you.

Ms HALL—What strategies do you think we could introduce to address the issues that you have just identified?

Prof. Le Mesurier—We will bring those up in the next session—

Ms HALL—In the next session—I am jumping ahead, sorry.

CHAIR—In the next session there will be ample opportunities for questions on specifics.

Mr Bowtell—I am the Director of the HIV-AIDS project at the Lowy Institute for International Policy in Sydney. The Lowy Institute is an independent non-partisan think-tank that looks at international issues. But I am here today in my capacity as executive director of a recently formed organisation, Pacific Friends of the Global Fund to fight AIDS, TB and Malaria. Perhaps it might assist the committee if I just sketch out a macro look at the situation we face.

Firstly, I would to congratulate the committee for undertaking its forthcoming trip to the region. In my earlier capacity as senior adviser to the health minister 20 years ago when we had to confront the HIV epidemic in Australia and how to respond to that, I was very struck then by the work of your predecessors from all parties, who really did apply themselves in a non-political, non-party political way to dealing with the problem at hand. It is really vital that when we try to confront the serious health problems in the Pacific that parliamentarians and members of parliament have this interaction because they are the gatekeepers of the resources. We all know that more resources are needed but how and why they are to be applied, and at the expense of what other projects, is a serious question of national health policy. So I commend you on that.

The Global Fund was founded in 2002 as a public-private partnership. It was founded in the wake of the lamentable and the regrettable failure of the international community to come to terms with HIV-AIDS in the 80s and 90s, which as we know, resulted in out-of-control expansion of the epidemic in Africa and elsewhere in the world. By the late 1990s it had become

apparent that there was neither the strategy nor the money to control the epidemic and large donors, very eminent people, got together and said that this had to change.

In 1996 we saw the first production of antiretroviral therapies which started to transform the HIV pandemic from being a problem of death after infection to something more approaching long-term care and treatment. In 1996 we had a treatment; therefore we had reason to test. UNAIDS was created in the wake of great dissatisfaction with the performance of the World Health Organisation, and in 2002 the G8 countries came together to create the Global Fund to Fight AIDS, TB and Malaria as a proper base for bringing in the billions of dollars that have become necessary to apply around the world and in the Pacific to bring these problems under control.

Since it was founded, the Global Fund has raised about US\$19 billion and has allocated about \$11 billion. So really for the first time in the lamentable history of HIV-AIDS we have money behind realistic strategies. This is a tremendous achievement and step forward because many people have gone onto treatment and their lives have been saved and improved by the money that has been allocated through the fund and other mechanisms, such as the Bill and Melinda Gates Foundation and the PEPFAR program, which President Bush and the last administration created. Some \$50 billion from the United States has gone into this. For the first time we are getting the money roughly where we need it and the results are on the ground.

As a consequence of the expansion of the fund, the Bill and Melinda Gates Foundation and others have generously funded the creation of so-called Friends of the Fund groups. There are eight around the world. The most recent one was established in the Pacific region in February this year. The purpose of the Pacific Friends of the Global Fund is to raise awareness of the three diseases, to talk to national leaders and eminent leaders in the region, to raise awareness of the fund's existence and that applications can be made to it, and to closely monitor and evaluate it so that we do the most good for the money we invest.

The Governor-General of Australia is the patron of the Pacific Friends of the Global Fund. Wendy McCarthy is the chair. We have eminent leaders from around the region, including Lady Ros Morauta from Papua New Guinea, Dr Rodgers from the South Pacific community, Senator Payne from this parliament, Michael Kirby, Bill Whittaker, Ann Sherry from Carnival cruise lines and Dr Mboi from Indonesia.

Internationally we depend on this substantial increasing flow of money to be directed into the big multilateral engines of fund collection to apply to these diseases to complement the work of AusAID and the other bilateral donors of the Pacific region, but the financial crisis really does require us to think very hard about how we are going to source these funds and apply them in the next two, three or four years. The funds we enjoyed in the last 10 years are not going to be as readily available to us to apply to these diseases.

I think this requires even more openness, accountability and transparency on the part of the agencies that direct funds, particularly on the part of the implementing countries, particularly in the Pacific. We are on the cusp of putting more resources in, but it is incumbent upon the implementing countries to be accountable, transparent and open because the old way of doing things—of having a cheque being handed over and in some cases that being the end of the process—I do not think will apply in the tough period we are coming to.

I am very happy to answer questions or to assist. We have some material there for the committee and for members here today.

CHAIR—Just before I close this first session, which was the overview of the regional health issues, I invite the High Commissioners to add to what was said throughout the discussion if they wish.

High Commissioner Lepani—I am very grateful for the technical input you are getting from the experts. It is really interesting for me also. There is an office of climate change that has been set up in the Prime Minister's office. It is very significant in its role in terms of dealing with issues related to climate change. I want to let you know that, while you are in Port Moresby, your committee members could have chat with the director there. PNG has, as you know, forest management issues related to climate change as well as the smaller islands being gradually lost as the sea level rises. There will be implications on health in these areas. I wanted to make that point about the setting up of the climate change office to recognise its importance in Papua New Guinea.

High Commissioner Ngele—I want to comment on HIV-AIDS in the Solomon Islands. The prevalence of STIs in the Solomon Islands is very high and is an indicator of those at risk of HIV infection, although we know that HIV infection is somewhat being managed at the lower level. If the prevalence of STIs is anything to go by, it certainly points to the incidence of HIV. The World Health Organisation estimates it could rise to about 350 HIV cases in 2010. We are very mindful of that vulnerability. I hope we can all work together to prevent an increase of that.

CHAIR—I thank everyone for their input to this first session.

Proceedings suspended from 10.21 am to 10.34 am

Session 2: Cooperation on regional health issues - successes and challenges

Session 3: Scope for further collaboration on regional health issues

CHAIR—It has been suggested by the committee that we combine sessions 2 and 3 because of their many similarities and because the issues do intertwine. We will follow the same format as we followed in the first session, but witnesses will have a bit more time in which to make statements, and there will be more time for questions afterwards. Perhaps the High Commissioner to the Solomon Islands can begin with his statement, followed by His Excellency the High Commissioner to Papua New Guinea. Then we will go to witnesses on the other side of the table and move around. If committee members wish to ask questions they may do so at the end of each statement.

High Commissioner Ngele—On behalf of the government and the people of the Solomon Islands I would like to thank Australia, and also Papua New Guinea, for their assistance by way of financial support as well as training of manpower in both countries for the Solomon Islands. The notable cooperation that we have received from Australia and from international organisations has been in the work done for the malaria program in the Solomon Islands. Our goal for the national malaria program for 2008-14 is in fact the control and progressive elimination of malaria in the Solomon Islands by 2014. I think there has been cooperation in this

area by the World Health Organisation, AusAID, SBC, the Health Sector Support Program and other NGOs. We are grateful for this cooperation and we hope it will be kept up as we feel that malaria is a health threat to the Solomon Islands in terms of its workforce and also its economic production. We would like to salute the ongoing cooperation and we hope that eventually we may be able to realise the elimination of malaria as a source of disease in the Solomon Islands. Thank you.

High Commissioner Lepani—I want to say thank you to Australia for its development assistance to Papua New Guinea, particularly in the priority areas. They have historically funded most of our development priorities. I have been involved in two reviews of overseas development assistance flowing to PNG, one generally and the other specifically on Australia's aid, looking at how effective it has been with some colleagues as part of an independent review team. My comments are mainly on the issue of redirecting Australia's aid at this point in time. Our two prime ministers agreed to that early this year. I am sure your committee would have been apprised of this latest development.

Papua New Guinea is mainly concerned now with the effective delivery of services, not with policy reviews. Historically we have had Australian consultants. As we were told by AusAID during the ministerial forum meeting this year, \$100 million of the A\$300 million provided by Australia's aid goes to Australian management companies. The cheque stays here, the funds stay here and you send your consultants to Papua New Guinea. They are mainly policy reviewers, policy evaluators.

Our Prime Minister has made the point to your Prime Minister that we now want to move forward from there to actually concern ourselves with delivering services—health, education—to rural people. In that context, our Prime Minister suggested some use of NGOs, some doctors from Australia, teachers who have taught here and judges who have worked in Papua New Guinea to come for short-term visits but, as well as that, to build capacity, but based in rural areas; a redirection of Australia's official support, to be in that context; and the use of private-sector capacity. The private sector, as we know, has become quite a common anecdote: if South Pacific Brewery can deliver beer right to the villages and medicines cannot be delivered, there is some problem. Why can't we use South Pacific Brewery's transport and delivery mechanism rather than the health system we have? The private sector contributes enormously to delivering services that have not been recognised as much as they should—and NGOs.

So our two prime ministers have agreed on that joint ministerial forum. They have agreed to set up a review of Australia's development assistance treaty to allow, in the future, for this redirection and, in the end, to measure the effectiveness of Australia's development assistance and to reduce Australia's aid. That is the objective. I just want to make the general comment on that that there are developments going on between our two countries. In particular, PNG has to also step forward and take its share of its priorities—put money where its mouth is. The 80-20 issue of 80 per cent donor funding of our priorities and 20 per cent from our own budget is not good enough. It is moving now towards 50 per cent of our own funds, but we still have not spent that money—that is the problem—over the last few years of this allocation because of capacity constraints in building roads and bridges as well as health facilities. So there is that constraint, but the government is recognising the problem that we have. We have to take on our own priorities and put our resources in those areas.

The other issue I just want to briefly raise is that donor efforts in delivery of services are commendable, but they need to also recognise that setting up parallel systems of delivery of services is not going to help Papua New Guinea in the long term. They have to somehow work within even the constraints that we have, because in the end we will be the ones to do our own delivery of services and development. It is becoming apparent that some donor agencies not only come to provide the resources but actually continue to set up the delivery of services right out to the rural areas. It may be working now, but in the long run it defeats its own purpose. Politically, it is saying to Papua New Guineans and the Papua New Guinea government, 'You are incapable of doing this yourselves.' Our people at the grassroots level see this happening. They say, 'Okay, our government's not helping us; we'll go for other governments, other sources,' so it creates a tension. It is something I would like to request you to have a look at when you are in Port Moresby, to discuss it with the donor partners as well as the Papua New Guinea government. They also have to step forward, and some direct questions to our bureaucrats in Papua New Guinea would serve both our countries well—if I may request that of you and your committee—in their efforts in delivery of services in Papua New Guinea. Thank you.

Ms HALL—Can I say that that is something that has made me feel very uncomfortable—the fact that outside organisations come in, do it all and provide all the assistance and then it does nothing to develop the capacity of communities and the resources within Papua New Guinea, so nothing ever changes. It is just more coming in and the same old way of doing things. I was also wondering—and you just touched on it a little bit—about infrastructure and the importance of infrastructure, and earlier you mentioned, too, the government structures, in working towards or maybe even being a barrier to providing and enhancing the health services within PNG. I am sorry, Your Excellency; I missed your presentation earlier.

High Commissioner Lepani—Yes, it is a chicken-and-egg situation, and it builds and compounds itself in the long term. We are very grateful, I must say. Do not get me wrong that we are not grateful for the assistance we are getting and also the NGOs' efforts. We do have direct funding to churches for the work that they do—it is a church subsidy—throughout Papua New Guinea from the government budget, and they are on a health council deciding on policy. But it reacts to the bureaucrats: 'All right, if you can do this work, go ahead and do it.'

In a lot of ways the 80-20 dilemma we have of donor funding—that is one of my personal grudges—is that it exonerates the Papua New Guinea government from its responsibility to face up to its own priorities, to its own responsibility for its policy development and policy implementation. You have donors coming in and saying: 'Okay, you can't do this, so we'll do it for you. We'll not only give you the money but we'll go and do it for you out there.' In the short term, yes, because people are dying; people are suffering. But you have to tackle the issue in our government also. It is a two-way thing. It has to respond. It cannot just say, 'All right, donors want to do this; let them do it.' What does all our money do? Only 20 per cent goes to our priorities. Where does the 80 per cent go? That is the question. It is a dilemma. This present government over the last two sessions of its term is responding, but, again, physical capacity constraints are there.

Mr COULTON—Your Excellency, I understand what you are saying, but we talked earlier and other witnesses talked about partnerships. What about partnerships with individual facilities? I do not mean just government-to government partnerships but I mean perhaps with some of our medical schools and your medical school on the north coast of New Guinea—I am sorry; I

cannot think of the town. That would be with the idea of training interns and students from Australia in New Guinea and likewise students from New Guinea coming to Australia for part of their training so that there are people with experience on the ground right from a very early stage. Rather than basing them in the capital cities, I guess I am talking about medical schools in regional areas. How would you feel about a relationship like that? There could be three or four partners in something like that.

High Commissioner Lepani—I think that addresses the issue that the two prime ministers agreed on. As far as training generally, and specifically in health services skills, is concerned, yes, it could be wonderful. We have had that partnership in the past in a big way, not only in health but in other areas such as agriculture. People came to Gatton Agricultural College for instance in the early days. We had excellent Papua New Guinean workers there. They are now, in my generation, dinosaurs dying out and there is no replacement. This is what the two prime ministers discussed and a lot of training. Both governments should also focus on the resources of funding these training partnerships.

Mr BIDGOOD—Thank you I really appreciate the contribution from both of you this morning. I have to give my apologies as I have to go and catch a plane, unfortunately. I am looking forward to my trip to both countries and this inquiry certainly has been informative. I do take up, Your Excellency, your comment concerning \$300 million going to consultants' reviews and things like that. I would like to put on the record and request from AusAID the full facts and figures of dollar amounts, dates and purpose of funding given to each country in the Asia-Pacific region. I would like a breakdown in the use of those funds, particularly with reference to what His Excellency said about commissions. I would like that evidence to be placed before the committee. You do not have to provide it now, but I would like it in due course.

CHAIR—We will now go to the Department of Health and Ageing. I remind the committee that the idea of combining the two sessions was that we can ask questions at the end.

Ms Gardner—One of the key focuses of the Torres Strait Health Issues Committee over the last year has been around the development of a package of measures. At the 2008 Australia-Papua New Guinea Ministerial Forum the HIC was tasked to develop a package of measures to address cross-border health concerns and present it to the 2009 ministerial forum. The focus of the package was to be on measures that would strengthen health services in the Torres Strait and Western Province of PNG and reduce the incidence and transmission of communicable diseases such as TB.

The HIC has made good progress to date on developing this package and it was presented as a draft package to the ministerial forum that was held in Brisbane this year. There will be a lot of work to continue profitably between both governments to finalise the package. The Australian government's component of the package was the \$13.8 million Torres Strait Health Protection Strategy which had three core elements. It provided \$9.2 million for capital infrastructure spending to upgrade and extend the Saibai Island clinic, provide staff housing and deliver a sexual health program in the Torres Strait. There was \$2.9 million to the ongoing joint Australian and Queensland government mosquito control program in the Torres Strait and \$0.7 million to extend the existing Torres Strait communications officer position to facilitate better cross-border sharing of clinical and disease surveillance information.

As part of the package, also announced at the 2008 ministerial forum, the Australian government has committed funding towards a TB clinical management and laboratory capacity building project which is continuing to be implemented. There has been progress in relation to the TB project. We have had clinical workshops to help strengthen the mentoring arrangements and some scoping has been done in terms of upgrading the laboratory in Daru although there continue to be challenges with progressing that again in terms of identifying funding to finalise the upgrades to the lab. The upgrades to the lab will provide the capacity to test for TB. The project as a whole was intended to have quite a comprehensive approach, firstly, to increase the capacity to diagnose TB within PNG and secondly, to increase the capacity of health service providers to be able to manage their patients.

There have been a number of other successes around the development of the package of measures and, while it is not finalised yet, it has strengthened the work that has been going on around a number of different areas—in particular, the establishment of communication officers on both sides of the border: one in the Western Province and one in Torres Strait. The Western Province communications officer position, which is based on Daru Island, has commenced, and they have commenced the provision of clinical outreach visits to the village aid posts and health centres along the South Fly coast to provide support in following up treatment of PNG nationals diagnosed with TB in Torres Strait Island clinics. There is also work that is progressing on the PNG side around the upgrade of the Buzi aid post to a two-person facility, including the recent installation of a solar refrigerator to store vaccines.

I think the challenges over the next while will be to continue to finalise the package of measures. There is a commitment from the Australian government side on a number of different measures, and we need to ensure that they are implemented. On the PNG side, they have quite a significant range of measures that they have committed to and agreed in principle; however, the challenge remains in identifying the funding to support those and the appropriate mechanisms for ensuring the funding flows from the national department of health down to the Western Province as well. I think that is generally.

CHAIR—Can I just ask a question on the centre on Daru. You said it was challenging. Is that challenging because of trying find that last bit of funding, or challenging in the setup of the implementation of the—

Ms Gardner—the upgrade of the laboratory. It is identifying the last lot of the full funding for it. So some funding has been identified through the World Health Organisation, and there is a significant shortfall in the actual cost of the upgrade to—

CHAIR—Are there any challenges that you are facing with the implementation of it, getting it up and running?

Ms Gardner—I think there are always challenges in building in various places and having the workforce to be able to do it, although I think the scoping projects identified a number of possibilities for undertaking that work, and I think there is some additional work that is happening at the moment to look at other options, like using more local based labour, which might help reduce the costs.

Mr Klaucke—Just to briefly add to my colleague's comments, our branch auspices a body known as the Pacific Senior Health Officials Network. We receive funding from the AusAID Pacific Governance Support Program to manage that network. It has been established since 2004 and it is essentially a forum for chief executive officers and other senior health managers from Pacific health ministries to come together and share information on the challenges they face and the solutions that they have brought to bear. The members of the network are Papua New Guinea, Solomon Islands, Fiji, Kiribati, Nauru, Samoa, Timor-Leste, Tonga, Tuvalu, Vanuatu, Australia and New Zealand. There is very much a focus on bringing together the expertise they have around health planning, health financing and human resource planning to leverage some discussion on common good practice within the region. The funding that we receive supports an annual meeting of the network and also some specific policy projects that we develop through partnerships between the interested Pacific members and specialist areas within our own department. So, for example, last year we developed a library partnership between experts in library and health information management in our department and Samoa and Tonga. We seek to disseminate the outcomes of those projects quite widely within the network.

It is probably fair to say that a lot of the issues that network faces are very common to the different countries, particularly around getting information that they need for a senior manager to deliver their outcomes within their ministries. Last year we also developed a program specifically for middle managers at the request of that network.

CHAIR—We will go to AusAID and then we will continue from there.

Ms Shipley—I will address some remarks to the topic for session 2 then I will hand over to my colleague, Ms Connell, to address session 3.

Australia is a major donor in the health sector in the Pacific, working very closely with Pacific island governments and other donors primarily through bilateral programs and in alignment with national health strategies. Australia works increasingly through partner government systems to deliver its assistance in health. I take this opportunity to gratefully acknowledge the thanks of our partner governments as expressed by both high commissioners. We really value that.

Our contribution in health to the Pacific for 2009-10 is estimated at \$133 million. This does not include scholarships, research, seminars and other governance programs but does cover an estimated \$35.6 million in bilateral health assistance to the Solomon Islands, Fiji, Samoa, Vanuatu, Nauru, Kiribati and Tonga, and \$72 million for the PNG health and HIV/AIDS programs. In addition there is \$25.4 million in regional programs on HIV and sexually transmitted illnesses, non-communicable diseases, immunisations and child protection, visiting specialist clinicians, training health workers, malaria, influenza pandemic preparedness, avoidable blindness, sexual and reproductive health and human resources for health.

Health is a primary priority for the Pacific Partnerships for Development that we have developed with Papua New Guinea, Samoa, Vanuatu, Tonga, Nauru and the Solomon Islands, and is a secondary priority for Kiribati and Tuvalu. No partnership is in place with Fiji, but Australia continues to support basic health service delivery as a major part of its remaining assistance to Fiji. The regional health program provides additional support to bilateral programs by addressing common development issues and emerging concerns in non-communicable

diseases and communicable diseases, and also in addressing constraints to health workforce capacity.

In the PNG health program in particular, Australia's approach to delivering support for health is aligned with the government of PNG's health priorities, which means working within the PNG government's health systems to support institutional strengthening and sustainability. This focuses on efficient use of all the resources, both peak government of PNG and donor resources, to ensure effective service delivery. It supports a systemic approach to health in PNG by ensuring that all activities are coordinated and cohesive, avoiding fragmentation of service delivery and donor-driven initiatives. It also builds on the capacity of health institutions, ensuring local counterparts are engaged and providing leadership on inputs.

Our support to the health sector in the Solomon Islands health program is in the form of a sector-wide approach, where health priorities are determined by the Solomon Islands government. AusAID is providing predictable long-term funding of up to \$69 million over four years from 2008-09 to 2011-12, comprising one-third of total public expenditure in the health sector.

Australia's engagement in the sector focuses on ensuring achievements on the priority outcomes agreed under the Partnership for Development, which focus on accelerating progress towards the Health Millennium Development Goals. At this point I commend to the committee, and formally table, the evaluation that has been done on Australian aid to health service delivery in Papua New Guinea, the Solomon Islands and Vanuatu. Copies of this are available to the committee and also at the back of the room for other members participating today.

Our Office of Development Effectiveness released this report on Australia's contribution to health service delivery in PNG, Solomon Islands and Vanuatu, which will guide our future assistance. The report finds that the effectiveness of Australia's contribution on health service delivery has been mixed, but there have been some notable achievements. In PNG, Australian support has ensured adequate drug supplies and facilities when local drug supply systems had failed, and it has helped to improve the distribution of health spending at the provincial level. In the Solomon Islands, Australian support has been essential for maintaining basic service delivery during a period of instability and tension and has installed a radio system and developed a health information system which has improved management and effectiveness in the health system.

But the findings also indicate that our approach has also sometimes limited the potential impact of our assistance. In PNG, the full potential of the sector-wide approach has not yet been realised. An overly cautious approach to risk management has delayed financing for health service delivery at the required levels, and technical assistance did not deliver the improvements in health systems capacity commensurate with the cost. In the Solomon Islands, the focus in the past has been on fragmented technical inputs, rather than impact at the sectoral level. Not enough attention has been paid to policy dialogue to encourage a greater emphasis on outreach, family planning and non-communicable diseases. We take very seriously the evaluation's findings, and we are working with our partners to address the issues that have been raised.

CHAIR—Thank you, Ms Shipley. Is it the wish of the committee that this AusAID document be accepted as an exhibit and be received as evidence to the inquiry into the regional health

issues jointly affecting Australia and the South Pacific? There being no objection, it is so ordered.

Ms Connell—I would like to add to my colleague's comments in order to focus a little bit further on the further collaboration. I want to highlight the very recent agreement at the Pacific Islands Forum leaders meeting held in August 2009, where leaders adopted the Cairns Compact on Strengthening Development Coordination in the Pacific. As we have heard from His Excellency, it is recognised that the effectiveness of some of the development assistance has not been as great as we would have liked. Therefore, to address that, the leaders have agreed to the Cairns compact. The Cairns compact builds on the Pacific Partnerships for Development and is a commitment to working in a harmonised and government driven way in the Pacific. Harmonisation focuses on donors, including Australia, New Zealand, the multilaterals—we have heard about the Global Fund, WHO, SPC—and all of the other donors that are working in the Pacific, working together. The harmonisation element focuses on working together as donors. The government driven way is often referred to as mutual accountability. We have also heard from His Excellency about the importance of governments understanding how their resources are allocated. Development is not only about what donors can do; it is about what governments can do for themselves.

The compact aims to accelerate progress towards the Millennium Development Goals by driving more effective coordination of all development resources—those of both the donors and of the governments in the Pacific. This is a response to indications that progress towards the health MDGs is insufficient. We have also heard that today. There is an acknowledgement that fragmentation in aid is preventing achievement of better long-term development outcomes. In line with this approach, AusAID is working to reduce the number of ad hoc projects in the health sector. We want to reduce the number of small activities which may have very good and well-meaning goals but on their own they are not going to have the long-term benefits. We will increasingly put support behind national health sector programs. Stand-alone projects, while sometimes delivering impressive results, can be supply driven, create fragmentation, place pressure on fragile health systems and reduce government leadership in the sector. AusAID's priority is to build up national health systems to be able to respond to the whole range of health concerns facing Pacific island nations and, in particular, to meet the health MDGs.

I would also like to mention in relation to PNG the agreement between our prime ministers in April this year to review how Australia's aid can best support Papua New Guinea's long-term development. This is part of the review of the treaty. That work is progressing so that we are examining the total treaty. I think I might leave it there. My colleagues mentioned the partnerships.

CHAIR—We are going to Mr Bill Bowtell.

Mr Bowtell—In the broader sense, one of the great challenges in the period ahead is to think clearly what we mean by health systems. We concentrate a lot on the process of health, that is the caring and the treating, which of course is very important. But good health outcomes rely a great deal on strengthening prevention, and we must get this clear in our mind, because the great temptation is to look at the next \$100 million and then say, 'We need more doctors or nurses or health-care workers on the ground.' Of course that is true; there is always a need for that. But in the Pacific, just as in Australia, I think we have to be realistic and understand that good health

outcomes are about prevention, and we have not invested in prevention in the Pacific at the level that we should have. I think the outcome in Papua New Guinea in HIV-AIDS is a failure of a worldwide system where the assumption was, don't do anything until the problem becomes apparent and then throw a large amount of resources at it for care and treatment. But it is a dog chasing its tail: you never catch up. That was so when we had a lot of money, and in a world situation where we are going to have constrained resources I really seriously doubt whether if we keep going in the same old way we will have enough resources to even care for and treat people with HIV, TB and malaria. So we have to come back to the question of prevention.

Treatment is a part of prevention, as Professor Kelly said, but it is not the whole story. Prevention takes place in the family, in the village, and women are vital in this. But if we do not pay for prevention we will not get it. So we must assess what we are going to do in terms of our policy and our money in terms of saying, 'Will this help prevent the problem becoming worse? Will we be able to bring about the behaviour change in this huge demographic bulge of young people, to persuade them or cajole them to make the necessary behaviour changes, through their mothers, grandmothers and so on particularly, that will help us reduce the pressure of the rising burden of disease. So in this sense, while we should fund nurses, doctors, healthcare workers, statisticians and management become really important. I really commend AusAID for this report on tracking development and governance because this goes to the question of management to reduce fragmentation, to reduce duplication, to have a better understanding between the bilateral donors and donors like the Global Fund and the implementing countries, Papua New Guinea, Solomon Islands, about how we are going to most effectively spend the next bit of money that we can all bring to bear on the problem. We have not done a very good job of that, as the AusAID report points out. Particularly you get to the point where statisticians and statistics really are important. A statistician is probably as important as another nurse in the broader scheme of things as we tackle the problems in the Pacific over the longer term.

So I would really try to say to the committee that of course you should look at the problem you see in front of you and say, 'My goodness, couldn't we do with another healthcare post here?' But understand that behind that there is a role for consultants, people who understand the big financial flows, trying to get the best value for the dollar that we have now got to invest. I think this is a big challenge as we look at the health system—not just the health inputs that we see in front of us but how we are going to secure outcomes that are better than the very poor outcomes, it has to be said, that have been recorded in the last decade or so.

CHAIR—You said earlier that we need to pay for preventative care—in other words, to have preventative outcomes. Could you give us an example of that? For example, you were talking about education. What barriers are there at the local level for preventative care? We heard of some barriers when we were in the Torres Strait recently. I know it is on our side, but people there were explaining to us that a lot of parents would not agree to their children having sex education, for example, which we know is a great form of preventative care for HIV, for example. There was a huge brick wall in that area.

Mr Bowtell—That is right. Education is the key, and I mean education in the broadest sense. When you come down to a village or community level, are there resources, for example, for mothers or grandmothers or all women, expressed clearly and simply, that explain the transmission of HIV? I realise that this can come up against cultural and other barriers, but the virus HIV knows no cultural or political barriers. If we do not learn from the lessons elsewhere

in the world and apply them, we will repent at leisure if the situation gets worse. So we need to transform all the knowledge we have about transmission of HIV down to a level that is comprehensible and understandable to the people who have the most influence on young people. I think that is it in a nutshell.

We have a lot of experience and a lot of development in other parts of the world that could be applied usefully to the Pacific, where some countries have really turned things around because they have used simple and effective methods of communication. Once you have that understanding at a basic level about what behaviour has to change, then, of course, you have to have the tools at hand, the simple technologies in relation to HIV: condoms, needles and that sort of thing. All of this is a problem. If this were easy, we would not be sitting here. But it is difficult. I understand the barriers we run up against, but we must put this case clearly and simply. I very much believe that the properly educated and informed people at the grassroots level will respond effectively and well. That has been the history elsewhere in the world where it has been tried.

So this is a very important question, but it is not one that is often looked at in the context of the health system. People look at pills, treatments, health workers and care workers, all of which are immensely important. But in terms of good outcomes, it misses the point to some degree.

Ms HALL—I believe very strongly that we need to look at the prevention side as opposed to just the treatment side. It is much better if we can look at the cause rather than deal with the consequences of that cause. I agree that education is very important, as is the role that is played by the hierarchies within society. But aren't there some very basic types of measures that money can be directed towards, such as hygiene, clean water and mosquito eradication, rather than just looking at the treatment end, that would solve a lot of the problems?

Mr Bowtell—Absolutely. You are completely correct. I know that the Global Fund programs include malaria eradication, and there is a very good AusAID program drawing on this underway in the Solomon Islands. But in Africa and elsewhere, where we have had treated bed nets, the decline in malaria has been tremendous—really a great thing. I am not a scientist, but those who know these things, like Sir Richard Feacham, who is dealing with AusAID in the Solomon Islands on this question, have a glint in their eye that there might be cause for some optimism that in the not-too-distant future we can really talk about the eradication of malaria. That would be a tremendous return on investment—my goodness!—for the only several billions of dollars it would cost. The long-term outcome would be great.

So it is not all gloom and doom. But I do think we have to be clear: when you are as responsible, as you are in the parliament, for allocating and suggesting the way that funding goes, by all means look at the health system as we know it, but also ask where that extra dollar is really going to go and do the most good. I think this is a debate that is emerging internationally now as the resources are so constrained by the financial crisis in the United States and in Europe and so on—in the big donor countries.

Ms HALL—Maybe you are not the person this question should be directed at, but in our first session someone mentioned the increase in obesity.

CHAIR—Perhaps we can ask that question as we get around to that area.

Ms HALL—Fine. You might like to address that, as a presenter.

Prof. Whittaker—Yes.

Ms Gersbeck—As before, Richard and I will share our responses here. I will speak more to the topic in session 3 first, and then Richard will speak to the topics in session 2. The Australian government has provided an initial \$45 million to implement the Avoidable Blindness Initiative. The initiative, known as the ABI, is a central element of the AusAID's broader Development for All disability strategy and has placed Australia as a world leader in this area. Vision 2020 Australia's global consortium has been established to coordinate implementation of the ABI. The global consortium comprises nine leading eye health agencies and reflects a growing consensus in Australia's aid program and more broadly in the international development sector that partnership and collaboration are effective means through which to provide assistance to the world's poorest people.

Following a review of their existing partnership frameworks, AusAID have decided to develop and enter into a new strategic partnership framework arrangement with Vision 2020 Australia. This is an innovative response to the changing nature of Australian aid. Governance processes and implementation are undertaken by the consortium, and the cooperative, representative nature of the consortium ensures that the capacities of the sector are utilised and further developed, the key program learnings are shared and inefficiency is minimised.

The Parliamentary Secretary for International Development Assistance, the Hon. Bob McMullan, will officially launch the global consortium on 19 November in Canberra. Mr McMullan's ongoing engagement with Vision 2020 Australia demonstrates his personal commitment to improving eye care globally but also demonstrates the importance of cooperative, inclusive networks and a professional approach to relationship building. As such, the global consortium provides a good example of the changing face of Australian aid delivery and provides a potential model for other sectors across the aid continuum.

While the ABI and the development of the global consortium are an important and valuable response to one of the region's pressing public health challenges, much work needs to be done. There is scope for further regional eye health networking between governments, agencies and other stakeholders. This will be achieved through the ongoing efforts of the sector, but further funding from the Australian government and from other donors in the region will also be required.

Prof. Le Mesurier—To address some of the constraints that I mentioned in the first session, this consortium and the Avoidable Blindness Initiative have been a complete godsend and have allowed the NGOs who work mostly in Papua New Guinea and the Solomon Islands to look at much closer partnerships and much better coordination of what they do. This has actually focused the way they think in terms of delivering assistance to these two countries in particular.

In Papua New Guinea, for example, the International Centre for Eye Health has done a lot of work in developing services, including training, particularly of optical technicians, and providing affordable glasses for people in Port Moresby, at the Port Moresby General Hospital, in Lae and in Mount Hagen. This has been very successful so far. It is a capacity development exercise, in that there is an exit time for these services, using cost recovery—because luckily glasses come

outside the normal health delivery system, so we can introduce cost recovery there and this helps generate income that is kept within the vision centres that have been developed by ICEH. This is working very well.

Alongside that success, they are having workshops to help Papua New Guinea look at developing a national eye care plan that is integrated into the national health plan and in turn integrated into the national development plan. It is not there yet and there is a lot of work to be done, but that is one of the points of assistance. There is also technical assistance and training, helping develop local eye health systems in those places I have mentioned.

In the Solomon Islands the Royal Australasian College of Surgeons delivers quite a few services that includes ophthalmology. This is now done in coordination with RANZCO and the other members of the ABI consortium. There are developments to upgrade Honiara main referral hospital, but also provincial hospitals in Malaita and in the western division in Gizo. So there is a lot going on. That ties in very well and is coordinated with assistance that is coming from the Pacific Eye Institute in Fiji, where a lot of the local nurses and doctors are being trained through assistance that came from AusAID but is being implemented by NZAID. There is a good example of both international and inter-NGO cooperation going on. Everybody is looking carefully at innovative ways to find successful examples where we can build on those and in the meanwhile remain patient where there seemed to be brick walls where we cannot break through. But that patience is beginning to pay off.

IAPB, of which I am the chair for the region, has an overall umbrella coordinating function and it works very closely with the World Health Organisation. There are, as part of the same Avoidable Blindness Initiative, we are working towards a stronger partnership with WHO, because where that has happened, like in the Solomon Islands, things have started to move a lot faster. That is the summary I wanted to provide.

Prof. Toole—I would like to speak to one success, one challenge and one area for further collaboration. The first—and when I use the word ‘success’ it is successful in its approach but not yet proven in its impact—is the AusAID funded Tingim Laip Program, which means ‘think about/consider life’. It has been supported by AusAID for the last six years in Papua New Guinea. It is really the largest community based HIV prevention program in the country and is currently operating in 35 sites in 14 provinces. These sites were identified following social mapping that found high levels of sexual and other risk behaviours. It is innovative in that it has not been modelled on programs that have been, or responses developed, in sub-Saharan Africa or in South-East Asia that have often focused on what are called ‘high-risk groups’. Over the last 10 years it has been fairly evident in Papua New Guinea that these so-called high risk groups—female sex workers, men who have sex with men, injecting drug users—do not fit very neatly into the Papua New Guinea society and the way in which behaviour is expressed. So it really is based on the concept of a high-risk setting. The sites include seven military barracks, a number of mining sites, the RD Sugar cannery in Madang, palm oil plantations, border posts, urban settlements in Papua New Guinea et cetera. It has had a very big focus on young people and has included a youth leader mentorship program, which has been very important in a society where young people are often very reluctant to speak out. So in this program young people were placed in various organisations where they developed leadership skills. In support of that, AusAID has also funding what is called the PNG-Australia Sexual Health Improvement Program, which is an

attempt to address sexually transmitted infections, which are an underlying risk factor for HIV spread. That is being implemented by five Australian NGOs.

The challenge that I would like to mention is what I often call the 'Orphan child of international health' and that is nutrition. In Papua New Guinea two-thirds of child deaths in 2006 were associated with malnutrition. A national nutrition survey found that 18 per cent of children were underweight and 44 per cent of them were stunted or with a low height for their age, and that is associated with intellectual impairment. Health aid programs often neglect to include community based nutrition promotion which is an intervention for which there is ample evidence of effectiveness. There seems to be an instinctive response to nutritional issues, which is to grow more food. Yet there is a lot of scientific evidence that shows that much, if not most, child malnutrition is due to poor nutrition practices such as lack of exclusive breastfeeding. I would like to propose that area of child health as something that could be increasingly focused on in Australia's assistance program.

Finally, in terms of scope for further collaboration, you may or may not be aware that recently there has been an outbreak of cholera in Morobe Province of PNG. This is the first time cholera has occurred in Papua New Guinea for more than 60 years. It underscores a number of weaknesses in the country, including inadequate access to clean water and sanitation and less than adequate quality health facilities in order to treat this lethal condition. The weakness that I would like to underscore here is inadequate epidemic preparedness and response capacity. While we talk a lot about and spend a lot of money on preparedness and response programs for the newly emerging infections such as avian flu, swine flu et cetera, cholera is a very ancient disease and is one that requires much surveillance and preparedness and certainly requires a very vigorous response. So I would put that on table as another area for further collaboration between Australian institutions, including Paul Kelly's group at the ANU and the Department of Health in PNG.

In terms of the first success example, I was thinking that this could be an approach that is just as relevant to the Solomon Islands, and one that would be best initiated prior to a significant increase in HIV cases. As Your Excellency pointed out, the rate of sexually transmitted infections in the Solomons is very high, and there is no reason why this approach to HIV or STI prevention in high-risk settings could not work in the Solomon Islands.

Ms HALL—Thank you very much. I wonder if you could give a little bit more detail on the youth mentorship program.

Prof. Toole—As I mentioned there are 35 sites for the Tingim Laip Program of which, if we exclude the military and certain plantations and mining sites, around 18 to 20 were true community sites. For example, at the Umi market, which is a very small settlement along the highlands highway where the buses and other passenger vehicles stop and rest, there is a lot of sexual exchange for money and drugs for money. Young people from those communities were selected by the site committees for placement in the leadership or mentorship program. That mentorship took place in a range of organisations, including local Papua New Guinea NGOs, church societies or organisations and even commercial companies. The mentorship program was monitored very carefully so that all these young people would come together every six months to exchange experiences and write stories, which were then used to monitor the development of their leadership skills. Once a year there was a national symposium of the Tingim Laip Program

which included a session completely organised by these young people and run by these young people.

CHAIR—You said that in some of these settlements there was exchange for sex and drugs. What type of drugs—intravenous?

Prof. Toole—No, so far very little, if any, injecting drug use has been identified.

CHAIR—So the transmission of HIV—

Prof. Toole—In large part, it is marijuana combined with home brew.

CHAIR—So HIV is mainly transmitted through sexual contact.

Prof. Toole—Drugs basically cause inhibition and increase the likelihood of high-risk sexual behaviour, including—and this is something that is unpopular to say but very well-documented—sex between men, which is often very opportunistic. We found in the settlements of Port Moresby that 14 per cent of young men said that they had had sex with another man, something that is not acknowledged in the country. That is a much higher than you would find in Australia.

Ms HALL—Is the use of drugs like cannabis in the Solomon Islands an issue?

Prof. Toole—The combination of cannabis and home-brew is also a considerable problem in the Solomon Islands and other Pacific nations. AusAID is supporting the development of a network in 15 Pacific countries to develop capacity to do research on the risks associated with drug and alcohol use. There was a meeting in Vanuatu which reviewed the outcomes of that drug and alcohol research. That research has been done by Pacific islanders with support from Australian based institutes.

Ms HALL—This committee did an inquiry into breastfeeding in the last parliament. What is the percentage of women that do not breastfeed in PNG and the Solomon Islands, what are the issues surrounding them not breastfeeding and what strategies need to be put in place to improve the rate of breastfeeding and the positive health outcomes that come from it?

Prof. Toole—I can only speak for Papua New Guinea. Almost all women commence breastfeeding their babies, but a very high percentage start to give some other form of food in the first month of life. Combining breastmilk with nonbreastmilk is a very high risk feeding behaviour. It is particularly dangerous if the mother is infected with HIV because it increases the likelihood of passing the virus to her infant. It also has a lot of other disadvantages, in that it introduces a range of microbes, viruses and bacteria, into the baby's gut when its immune system is ill developed. True exclusive breastfeeding, which is recommended for the first six months of life, is quite unusual in Papua New Guinea. In terms of addressing it, as I mentioned in my statement, there is ample evidence that good community based nutrition promotion works. It has to be through village volunteers that are trained well. In most studies you would find that even at weaning most villagers have access to a range of foods but often do not give them to children.

Ms HALL—So it is about building community capacity.

Prof. Toole—Yes.

CHAIR—Regarding exclusive breastfeeding lasting only a month, is there a marketing campaign from some of the producers of baby formulas in Papua New Guinea?

Prof. Toole—They never give up! I do not think that is the core of the problem. The main problem is lack of knowledge. It is mostly not a competition between breastmilk and artificial formula. It is a tradition passed on from grandmother to granddaughter that an infant needs more than breastmilk. So they give these other usually very low-quality foods which fill the infant so that they then lose the appetite for breastmilk.

Ms Kennon—I want to make two quick recommendations. I want to urge the committee to continue to conduct regular consultations in country between Australian parliamentarians, officials and AusAID representatives. Whilst you are in country I urge you to meet with the newly established PNG Parliamentary Group on Population and Development, which has been funded through the United Nations Population Fund with AusAID funding. Contact details have been provided for that group. In terms of successes and examples for further cooperation, I have one example of success and then one for future collaboration or consideration. I refer to the report that has already been tabled. On page 7 there is a case study example of the Solomon Islands Diploma in Midwifery which was established in 2001. Thus far over 110 midwives have trained throughout the Solomon Islands. The success of the diploma highlights the potential for producing skilled midwives over a relatively short period of time. The student midwives spend 18 weeks in the capital, Honiara, learning theory in classrooms. In the remainder of the course, which is a further 23 weeks, practical training is undertaken at the National Referral Hospital in Honiara and in provincial hospitals under the supervision of trained clinical educators. At the conclusion of their studies, the graduate midwives then return to the provinces where they were originally posted by the government.

I would also like to draw your attention to the community midwife model that has been proposed as a solution to the enormous geographical and cultural diversity challenges in PNG. Currently, community health workers are predominantly trained in faith based organisations and provide many of the birthing services in rural PNG, as we have already heard. An increase in this cohort will meet the short-term goal of adequate staffing for attending births at village level in the newly proposed community health posts, but these workers will not replace the vital skills of a midwife or doctor which are needed to save lives during obstetrics emergencies. Finally, World Vision recognises that addressing health workforce issues will not solve other important ways of reducing maternal deaths, such as investing in family planning, improved education for girls, law and order, transport and communications.

CHAIR—Thank you. I know we will be visiting the hospital in Honiara and we will have a look at that program.

Ms McMahon—As I mentioned in the first session, I want to highlight the work of the churches in health service delivery, particularly in Papua New Guinea. The churches are estimated to provide little more than 40 per cent of all health service delivery in Papua New Guinea. In remote and rural areas, that can go up to about 80 per cent, so it is really quite significant. Caritas Australia, with AusAID support in several programs we work in, is looking at how we can strengthen and support the health service delivery in Papua New Guinea. The

partners that we are working through, mainly Catholic Church partners, have been operating there for more than a hundred years in some places, so, as His Excellency Mr Lepani mentioned when he spoke before, it is very much supporting existing structures. We are not coming in and setting up something different.

Like health service providers across the country the church health services experience quite significant challenges, and I will not go through them all because I know there is limited time. But a few of the challenges are poor communication and transport infrastructure, poor housing and education which make it difficult to attract health workers in remote places, particularly those who have families. In many areas there is an absence of banking facilities, so that if health workers need to get money or go to the bank they have to be away from their posts for some days at a time and in some places the health care shuts down.

One thing that we are also finding—and it is not often mentioned or highlighted—is the stress of health workers. This is quite a significant issue. There are different strategies that are being used to try and overcome some of these issues. In some areas we are trialling upgrading the radio so that the health centres can access email. This has met with a few problems at the moment, but we will persevere with that. In the absence of banking arrangements they are trying to give money to the local priests so that if they need money they can get the money from him as an advance and then it is reimbursed. So we are trying different things to try and keep health workers at their posts.

One of the biggest issues that the church health workers face is that they get paid less than their counterparts in the government system. This is a very significant issue. I think it is fair to say that the motivation of the church health workers is high, but their pay is low. We have been working with the Catholic health services in particular to see how some of these things can be overcome, but it is certainly a work in progress.

Another point is that in recent times we have commissioned two pieces of research that have highlighted, amongst other things, the need to support and to continue to motivate the health and workers in remote places. Another thing that has come out of the research that I just alluded to is the importance of understanding issues relating to health, in terms of not just providing health care but also looking at the social and cultural issues that contribute to people's attitude and behaviour in regard to health.

At the medical symposium last week it became clear that there is quite a lot of research being done in PNG, particularly around these issues. I recommend that anyone who is working in this area in PNG look at that research because I think that there is a lot that can be learned from it and incorporated from that in trying to have more effective health service delivery. I will finish on that note.

CHAIR—Thank you. Questions?

Mr COULTON—Caritas had visions in the past of the sisters setting up hospitals and missions. Is Caritas involved in religious work in those areas still or is it purely an aid organisation?

Ms McMahon—We are not related to the sisters. We are an NGO that provides support to anyone, regardless of religious affiliation. We do not proselytise at all.

Mr COULTON—Okay. Thank you.

Ms HALL—You spoke a lot about the challenges. I am sure you have had some successes along the way. Would you like to share those with us?

Ms McMahon—That is an excellent point. I think, particularly in relation to the Pacific, unfortunately, we have a tendency to dwell on the challenges but not always highlight their successes, so thank you for giving me that opportunity. You are right that there are many successes and good things happening. One program I would like to highlight is the MeriPath program, a cervical screening program. Cervical cancer is quite a significant issue for women in Papua New Guinea. The program comprises a small group of incredibly committed women scientists in Sydney who have set up a very strong network among some health centres in Papua New Guinea. They have provided training in how to take Pap smears and label them. The tests are then sent down to Sydney and, within 24 to 36 hours, the results are sent back. They have also set up ways of providing follow-up support to the women. So far, in the eight years that it has been running, they have screened close to 20,000 women, and we are aware that there are at least 300 women whose lives have been saved as a result of that program.

Ms HALL—Excellent. Thank you.

Ms Clement—I am Jenny Clement, from Care Australia. Care Australia has actually been in PNG since about 1989. Initially we went in on emergency responses, but in recent years we have been implementing longer term programs in remote areas. Poverty and inaccessibility are central to the poor health and also to the low life expectancy in these areas. While there is rarely starvation in PNG as such, the diets, as we have noticed, tend to be quite poor; they are high in carbohydrates but can be low in protein and nutrition. Having said that, though, it is a concern that there are reports recently coming out of food shortages in Kantiba, in Gulf Province. There is also the potential for increased food security with the impact of global climate change, through changes in the rainfall patterns. I would also just note, as has been noted, women suffer disproportionately poorer health because of the poor reproductive health and because of gender based violence. So poverty and health outcomes are closely interwoven, and I think the solutions also need to be multisectoral. For instance, providing education, especially for women, is known to lead to better health outcomes, as does increasing subsistence and economic production. The current cholera and shigella outbreaks in PNG highlight the need for better water sanitation and hygiene practices.

As well as being multisectoral I think any responses need partnership and coordination. The PNG Department of Health and the provincial governments at present are not capable of delivering the health services adequately. While I agree with other speakers that it is critical that we keep working with the government to strengthen those systems, in the immediate term there is also a need for other partnerships and approaches. Indigenous and international NGOs, including church groups, have often been seen by policymakers as filling gaps in poor government services, and I think that we are a large part of the solution, but the role of other agencies has to be contextualised: we all still rely on at least a basic level of government

functionality. As Mr Charles Lepani has noted, we do not want to set up parallel systems; we want to create a partnership.

Australian NGOs are an important player. Agencies such as Care have a recognised comparative advantage because we work in remote areas, working through local partner NGOs, and we are addressing not only health but also the other, associated issues of literacy, education, food security, water and sanitation. We also work in support of the government's decentralisation process, so we are trying to strengthen local communities and build bridges between the people and those who are meant to deliver services to them.

One of the questions earlier was about the Millennium Village, which I do not have a lot of knowledge about, but I know that our model is in some ways quite similar in that it is a localised, integrated approach to development. The idea is to be able to replicate that in other areas and expand that outwards. We are also working closely with AusAID, as is the Millennium Village, and hoping to share lessons across the two activities.

In conclusion, NGOs and church groups are part of an integrated and multisectoral approach that we can scale up to work more effectively with donors and government to improve the delivery of health services and services in the other, related sectors, but it must be appreciated too that, for agencies to scale up, particularly in terms of being able to extend our geographic coverage, it takes time to establish the networks and partnerships and time to recruit, train and build capacity of staff. And it not only takes time; it also takes a strategic increase in assured funding—knowing that there will be adequate resources to keep that going in the longer term. Thank you.

Ms Knight—As I mentioned before, Sexual Health and Family Planning Australia has been involved in international development work in Asia and the Pacific for over 30 years. Our work seeks to enhance the capacity of in-country organisations to deliver family planning, sexual and reproductive health education, and health promotion and prevention programs. As I mentioned before, family planning is a key driver to achieving the reduction of poverty. When women are able to determine and plan the number, timing and spacing of their children they increase the quality of life of living children and the community. The achievement of universal education, gender equity and universal access to family planning all support the prevention of STIs and HIV, the reduction of maternal and infant mortality, and achieve sustainable development or Millennium Development Goals.

The achievement of Millennium Development Goal 8, a global partnerships for development, is dependent on having trusted and effective relationships across national borders. Over our 30-year history of working with family planning organisations across the Pacific, including PNG and Solomon Islands, we have got a number of examples of very successful outcomes that have been built on trusted relationships based on capacity-building frameworks and records of effective program development and implementation.

One very successful program, which we have now rolled out across PNG, Solomon Islands and Timor-Leste has been the Men and Boys Behaviour Change Program. Working with in-country partners, well-trained male sexual health volunteers who are highly committed and active community role models deliver education and train-the-trainer programs to engage men and boys in positive health-seeking behaviours in regard to their own reproductive and sexual

health, including HIV and STIs, and impact on men's behaviour in regard to gender based violence. The program works with men and boys to refine their masculinity and roles as man, father and decision maker in their own personal and community lives, set in a recognisable cultural context.

SHFPA began this program in Solomon Islands and built on its success by implementing it in PNG. A recent evaluation of the program has highlighted extremely positive results in the areas of making pregnancies safer in PNG, and gender based violence and STI-HIV prevention, treatment, care and support. SHFPA has committed to expanding this project in PNG through to 2012 as a part of the PNG-Australia Sexual Health Improvement Program. In 2007 we began implementing this in Timor-Leste.

In 2009-10 SHFPA will be working with Timor-Leste civil society partners to expand the implementation of the Men and Boys Behaviour Change Program. Interestingly, this program has many learnings for the Australian context. Currently, SHFPA's member organisation, Family Planning New South Wales, is incorporating the Men and Boys Behaviour Change Program with a number of other Indigenous men and boys programs and will be developing a culturally appropriate program to roll out through New South Wales based on men and boys as well as developing a women and girls program in the youth programs that are already being delivered.

In the Solomon Islands, as you know, 40 per cent of the population are under 15 years. We know that the knowledge of sexual and reproductive health is incredibly poor. Sexual health problems, prostitution and drug usage are increasing. Young people and families are relocating to urban areas in search of employment, and national statistics show that teenage pregnancies and STIs are on the rise. We also know that population and environment are closely linked and interdependent.

High population growth puts stress on existing land and resources while resulting poverty often forces communities to sell national resources. Conversely, 70 per cent of people living in poverty need a sustainable environment in order to survive. Over the last four years, SHFPA has been working on two programs in the Solomon Islands, one with our sister family planning organisation and their community based educators to raise the profile of sexual and reproductive health issues—including the testing and screening for STIs as well as family planning—with young people through a range of community radio, school and community based workshops, outreach and working with church organisations in the communities.

Our second program has been working with community learning and rural training centres to enable schools and communities to explore the links between environmental and population issues and the impacts on social and economic issues, and to support outreach activities on population, environmental and livelihood themes and topics. One of the issues that we have discovered—that we will be focusing on in the next three years—is supporting the two in-country partner organisations to enhance their capacity to work collaboratively and in partnership together so that they can share their resources and expertise across these and other programs.

Lastly, I want to raise with the committee a new cross-border collaboration network that SHFPA is working on with our family planning sister organisations in Papua New Guinea, Solomon Islands and Indonesia to create dialogue and develop strategies to jointly address the

cross-border management of HIV and STIs. We have had to face-to-face meetings over the last 18 months and have agreed on a work plan and advocacy strategy to garner the commitment and leadership of national governments to address these issues in the coming months, hopefully, with the view of all member associations seeking national government agreement to a meeting between the four nations and developing an effective national response. SHFPA will be making a formal submission to further outline some of the programs that I have mentioned.

Ms HALL—I think you have just answered my question because I was going to ask if you could give us some more details on the programs. Thank you, that is great.

Mr COULTON—I cannot remember the name, but I was interested in your program for the behaviour of men and boys. I have been married to a teacher for 30 years and she would probably suggest we could do that in Australia as well with the male attitude to women and girls. Just briefly could you explain what that program is?

Ms Knight—It is an adult learning education program that is rolled out through communities and identifies key community leaders to work inside their own communities to develop and deliver messages around masculinity. I can probably provide better detail through a formal submission.

Mr COULTON—Something that I have been thinking about since this discussion has been going on is that it was pointed out that in relation to AIDS the vulnerable are the younger women. If it is an education program targeted at young women but the men do not also have the same thing, I could imagine it is going to add to a huge amount of conflict. In the cultures that we are talking about, is that presenting a difficulty, because the cultures have not adapted with these particular diseases as part of their history? I understand from the health workers at Saibai Island that sexual matters are something that people from PNG are very reluctant to discuss. Is that a big problem?

Ms Knight—Yes, it is. I think that is the reason why the approach of working with community leaders and role models and raising these issues with men and boys in the cultural context of being the man, the father and the decision maker in the community allows the discussion of a whole range of issues, including sexual and reproductive health, to start to take place. Certainly the feedback that we have through our evaluation from women has been that there is a significant change in the way men and boys approach sexual matters and approach sexual engagement and the way that they are able to develop positive relationships and positive health seeking behaviours. I am more than happy to make sure that there is quite an extensive overview of how the program works and what some of the outcomes have been.

Mr COULTON—Thank you very much.

CHAIR—I do not want to delay the proceedings any further but a similar question was asked earlier of Professor Michael. Do you agree with Professor Michael that in these education programs we have to actually target the grandmothers and the grandfathers, who actually are the decision makers as you said, but also who may have these barriers in terms of educating some of the younger people in sexual matters?

Ms Knight—I think that is certainly the case.

CHAIR—Instead of just targeting the young people?

Ms Knight—I think you have to work at both ends and focus on young people, where you can access young people through the communities and through schools, but you have to be working with the key decision makers in order to make sure that the messages are being communicated and that there is significant change happening.

Dr Morgan—I will be brief. I just want to make a couple of comments about cooperation mechanisms for building capacity in PNG. Measles was a significant killer of children in PNG up until recently. It is a public health success in that country that not many know about. In 2002 there were 17,000 cases and more than 300 deaths. In the last three or four years there have been around about 10 cases of measles each year and no deaths reported. What happened? I think there were three different cooperation mechanisms that contributed to that. The first was an old-style AusAID cooperation project with the family health services of the PNG government Department of Health, which made sure that there were new vaccine refrigerators and a little bit of training in nearly all of the rural health facilities in the country. That alone was not enough because service delivery was down. It was only reaching about 60 per cent of children. To get that next jump in service delivery, a new type of partnership was needed. It took the form of supporting a measles campaign.

There was some scepticism in 2003 because the previous measles campaign had failed, and it had been run according to international standards. In 2003, the campaign was designed by a partnership of WHO, UNICEF, the government of PNG, AusAID, the Japanese government and some external consultants. They designed one that worked district by district and moved slowly around the country. This also looked like a failure, because it took three to four times as long as it was supposed to, but it was not because there is less measles and there have been fewer deaths. Unpacking why it was not a failure was the work of a third type of partnership, a partnership between research institutions. If medical research is to go on in PNG, a partnership such as the one Burnet has with the institute of medical research in Garoca—if it is a partnership approach to medical research, where you get input from the local researchers and those who direct research—is more likely to be relevant. In this case the research was able to unpack what it was that made that 2003-05 campaign a success. It was mostly about local leadership—that is, giving district managers autonomy and scope. Then that was able to be replayed into the planning for the current measles campaign, which now is much more comfortably led by the Department of Health with support from the WHO and AusAID. But they are more in the driver's seat.

Can I finish with just two innovations in cooperation. One is on the report that Ms Shipley tabled on the external evaluation of the Australian aid program. The No. 1 recommendation was around finding new knowledge about how to improve service delivery. The AusAID Health and HIV Thematic Group in Canberra has funded a series of health system knowledge hubs with different academic centres in Australia. All of those knowledge hubs—ours is one centre; Professor Whittaker's is another—are working on issues of core interest to Papua New Guinea and the Pacific. They are trying to find new ways of delivering services that are of direct relevance to those countries. From my observation of the range of different knowledge generation activities that are being done in collaboration with local AusAID posts, with local government advisers and with local research institutes, they are generating knowledge that is useful and fits the national health plan and so on. That initiative of AusAID's, of using a

different mechanism for partnership for generating knowledge, I think has been useful and will be useful in the long term.

My final comment is this. We manage a new AusAID funding mechanism called a 'facility' in China. This is a different way of delivering development assistance that is more flexible and more responsive and may be suitable in some of these settings in allowing more local priorities for health to receive development support. Thank you very much.

Mr Purdy—I will be very quick. I just want to make a suggestion to the committee, particularly in relation to whether you will be considering the use of donor funding aid programs as a mechanism to address some of the health challenges. You may get drawn into discussions about aid effectiveness and mechanisms for delivering aid and you may hear the words 'technical assistance' and 'consultants'. I would like to suggest to the committee that it should think about what technical assistance actually is. To do that, we just need to think about what we all do and the words being mentioned here today. We build capacity, we strengthen institutions, we teach individuals and we educate individuals. We do not build bridges or roads.

If you break it down to the key elements, the only way we are going to build capacity is through skills transfer, experience transfer and lesson learning. The only way that that happens is through human interaction. It is not about laying bricks or pouring concrete. That is really what technical assistance is. It can be done in a whole number of different ways. It can be done through people attending training courses. It can be done through long-term tertiary level education programs and scholarships. It can be done through twinning and other sorts of partnership arrangements between government departments, institutions or whatever. It can be done simply through someone sitting next to a counterpart at their desk mentoring them, advising them and helping them do their work programs. Who that individual might be can be a whole number of different things, and AusAID and other donors are continuing to look at better ways to do it. It can be an Australian public servant, for example, or it can be a private individual employed for a company who is earning a fee to do that job. That is all technical assistance; that is all human interaction imparting some skills and experience to work with our colleagues in the countries that need that assistance. I think all of those different mechanisms have a role to play in effective aid and are all consistent with the new ways of delivering aid in terms of mutual accountability, ownership by the recipient governments and use of government systems. They all have a role to play.

I would like to invite the committee to come and see some of the work that we are doing with AusAID and the governments of PNG and the Solomon Islands that shows how this particular form of technical assistance is working and is consistent with the overall principles that we are all working to achieve.

Ms Duituturaga—Firstly I would like to make the point that when you look at a lot of the regional organisations, most of them are intergovernmental mechanisms. I would like to make the case that some of my colleagues have already made in terms of supporting NGO channels. I would like to explain how you can get to some of these invisible mechanisms.

I do want to say that there is a place for managing contractors. I myself am an independent consultant through GRM. That is useful in terms of mobilising procurement. I think working through NGOs does bring the added value not just of the skills transfer but of organisational

mentoring and best practices. This morning, for example, I heard about the men and boys behaviour change program. I am going to the Solomon Islands. I am told the case needs to be made from the Solomons, so I will be working with the Solomon Islands parents association to see how we can follow through with that given that the Solomon Islands government is in the process of developing a policy in response to violence against women, with information that has recently come up.

I guess one of the ways in which this can happen, given I am making this case, is through PIANGO, which is the Pacific Islands Association of Non-Governmental Organisations. Chair, I would like to offer this document to the committee. We do have our umbrella organisations in Papua New Guinea and the Solomon Islands and we would be very happy to ensure that they can offer meetings with NGOs when you visit there. The contact addresses are there. Our 24 NGO liaison units also include New Zealand and Australia.

At this point I would like to acknowledge and recognise the relationship we have with ACFID, the Australian Council for International Development. They have 73 members, 47 of whom already work in the Pacific; you have heard some of them today. Their networks and our networks have worked closely together in terms of NGO capacity building at the community level. In addition to that, there is now what is called the Pacific Regional NGO Alliance. We also have the Pacific Conference of Churches, the Pacific Youth Council, the Fiji Women's Crisis Centre, and the Pacific Foundation for the Advancement of Women and the Pacific Disability Forum. These organisations are led by Pacific Island leaders who lead civil society organisations but, even though we exist, we find that we are invisible.

Often, when Australia, New Zealand and others are looking to channel support, these mechanisms are not there, and I would like to say that we would be very happy to support your work and the work of AusAID in this case. I guess I am also making the case for public-private community partnerships instead of either-or. It has often been said by my colleagues that resources to NGO channels are often little but could be a lot more value for money. The work that is done at the Pacific regional level in terms of regional strategies can also help support the work that NGOs do at the national level. An example of this is the Pacific Regional Strategy on HIV/AIDs, which supports national work, and the opportunity for lessons learnt across the Pacific region. Those are the key points that I wanted to add to what has already been said.

CHAIR—Thank you. Is it the wish of the committee that the document tabled by Emele Duituturaga be received as evidence into the inquiry into regional health issues jointly affecting Australia and the South Pacific? There being no objection, it is so ordered.

Prof. Kelly—I think a lot of the larger issues have been covered by other members and people giving their responses today, so I will not reiterate those. But, to give a couple of specifics, my main role in this area, as I mentioned, has been content expertise in some of the diseases that the committee has outlined and also giving input into the health issues committee through the Department of Health and Ageing over some time. I have links with many of the people you met in Cairns a couple of weeks ago and also several Torres Strait Islander students whom we have had through our course, which was mentioned by Professor Toole amongst others. I have never worked in Papua New Guinea, but I have and continue to work with people on the Indonesian side of the border of that island in relation to HIV and tuberculosis issues.

The course I run at the Australian National University, a Master of Applied Epidemiology, picks up a lot of the issues that have been mentioned today in terms of gathering statistics and evidence and so forth to support health services delivery and health service planning. Epidemic response and preparedness, as mentioned previously, is our key issue, and we would certainly welcome any possibility of partnering with Papua New Guinea and the Solomon Islands as well as more broadly in the Pacific in this particular area.

I would like to bring up an example of a success in this relationship. It is not in either of those two countries but in one of our other close neighbours, Indonesia, where a large amount of money was brought in by donors to look at a specific emergency issue. This was to do with avian influenza, H5N1 influenza, some years ago and included substantial support from AusAID to look at that specific issue. Due to very strong national leadership in the communicable disease area in Indonesia, the head of that department within the Ministry of Health was able to really look at a much broader picture.

Maybe this is an approach that the committee might be able to look at. Whilst you may be looking at very specific issues around drug-resistant TB in the Torres Strait and cross-border issues like that, you could actually think about this initiative and the money that will come with that through national leadership, very closely looking at either the government or the non-government sector in Papua New Guinea and the Solomon Islands. You could look more broadly than those specific issues, particularly looking at capacity building for this long-term approach.

In Indonesia Pak Kandun, who was the head of that area in the ministry at the time, recognised that he had an opportunity here to build capacity throughout the country in relation to recognising health issues and responding quickly where they occurred. So everything that was done, particularly in the capacity-building area, was not just specifically for that one issue but was more broadly looking at what was required, long-term planning and so forth. Through that mechanism there have been a number of staff exchanges from my institution and also from the Department of Health and Ageing to assist the Indonesians to revitalise their field epidemiology training program. That is now up and running. They have 30 students newly enrolled, and it is fantastic to see. In fact, we have two of our colleagues from that program visiting the Australian National University this week to further that staff exchange.

I think there are a couple of issues there to raise. One is: do not forget the need for ongoing longer term planning in this area, think about longer term capacity building within country and think about partnerships and ways of facilitating that between Australian institutions and our neighbours. Also, look at structural issues in relation to how that funding might flow, because for example it took a lot of convincing from the Indonesian side to allow those moneys to be used in that way, which was identified by them as being an important issue. I think I will leave my submission there.

CHAIR—Thank you. Now for our last participant—but not least—Professor Maxine Whittaker.

Prof. Whittaker—Thank you very much. I will wrap some of my points into the issues about prevention particularly. Firstly, I think it is important for us to recognise that health also has social and environmental determinants. Particularly when you are coming to prevention, it is understanding the social and environmental aspects of what makes people healthy and allows

them to live healthy lives. The second thing, as quite a few speakers have said today, is the need to understand the cultural understandings of illness, the appropriate ways to communicate and the appropriate ways to work with those communication channels to be able to get the messages across in a way that people will understand. That means working and listening with the community, as others have talked about: men, women, adolescents, leaders, women's groups, older persons—in the Pacific, particularly, older persons are probably far more valued than in Australia—and children and their teachers. It is working with them to find solutions and partnering with groups in the communities, districts and provinces such as civil society organisations and NGOs to do that work. That may need some strengthening as well to give them the skills to do some of that applied qualitative research and analyse it.

Examples of doing this include working with men and boys and, in Papua New Guinea, looking at trialling a hausman approach to providing services and information to men and boys. There have been concerns about indoor residual spraying in consultations we have done earlier this week with Vanuatu communities. We should listen to them before we go and spray as a prevention for malaria control in certain targeted areas. In talking about obesity, you have to understand the question: do people value the same body sizes that, from a health point of view, we think are healthy? A PhD student of mine came back quite amazed at how it is still strongly the case in her own indigenous Fijian communities that big is beautiful, and she is starting to tackle the ideas. How do you then do work about non-communicable diseases when being big is part of what is beauty, what is wealth and what is valued? So you need to have those understandings. You need to ensure that the tools to help people change and maintain those behaviour changes are there. Again, if you look at non-communicable diseases, are there healthy foods available to the majority of the people who need them? Are there places for people to exercise that are safe? If women are concerned about violence, they are not going to go out and do exercise to try to address some of those problems.

There is the issue of making sure that long-life bed nets are there. That really is a success story in the Solomon Islands and Papua New Guinea. There are partnerships between development agencies, communities and non-government organisations like Rotary Against Malaria, and with the global fund money they are getting bed nets quickly scaled up and into communities but also making sure that people know how to use them, maintain them, care for them and value them. It is very important to make sure prevention works for communicable and non-communicable diseases.

There are a couple of other issues to raise. Firstly, there is measurement—and a few people have talked about ensuring you have a good, strong health information system so that you can measure the size of the problem and the success of approaches taken and so that you can identify emerging problems or hard to reach pockets or hotspots that need special approaches. We need to be very careful, including my institution—we do a lot of work on the burden of disease. Sometimes these problems are not a burden yet, but in 10 or 20 years time they will be a major burden. Often our resource allocation tools look at what is a burden now and do not value as much what is going to be a burden in the future, and that is particularly for non-communicable diseases. The capacity to do prevention well is a health system strengthening thing that is important.

There are another two points I wanted to make on capacity development. There have been many discussions about appropriate models. Partnerships between state and non-state actors are

important, but recognising who those non-state actors are in Papua New Guinea and Solomon Islands. They may be different from what we call them in Asia. The knowledge hub on health policy has been focusing quite a lot on that, and particularly the role of the churches in those two countries. They are an important non-state actor.

Another issue is making sure that you have core funding to some of the institutions in country that can actually be internally capacity strengthening—for example, the PNG Institute of Medical Research. If they get good long-term core funding to supplement government funding, which is increasing, then they can leverage major international research, and they are international leaders in malaria and pneumonia research. You can provide long-term support to people in Papua New Guinea—to community health worker trainers—so that over time they can develop a curriculum that is appropriate to them and can update it themselves. That is an example of the success in Papua New Guinea of updating that whole community health worker curriculum and also putting a focus on health promotion. The work that DoHA mentioned was important.

You briefly asked a pointed question about breastfeeding in Papua New Guinea and the role of the agencies. The department of health has been concerned. It is not the same approaches that some of the breast milk substitute companies have used in the past but in particular the advertising around appropriate food for children in HIV environments may be breaching the voluntary code, and IBFAN—the international breastfeeding alliance network—is helping the Ministry for Health investigate if there are breaches occurring in Papua New Guinea

Finally, I want to also mention that one of the partners that you have had represented here today, the Australian academic institutions, help in their capacity to maintain an ability to support appropriately when asked. The models of care and capacity development are important. If there is not a strong base in relation to some decisions about models of tertiary funding, models of helping support public health and international public health research, it is going to be hard to leverage some of the other opportunities we have talked about today from Australian academic universities. Sometimes, a multisectoral approach in considering how decisions in one sector may affect decisions in the development sector needs to be taken.

Last but not least in talking about models of development cooperation, particularly for non-communicable diseases, it is not as easy as just providing money to a health sector, because the other sectors are so important. We should be trying to find new ways, both in country and within development programs, of having multisectoral agencies funded—perhaps a non-communicable disease sector-wide approach—or find other ways through NGOs to channel money to a range of sectors to address obesity, tobacco and alcohol consumption. They are not models we have been as successful in. But as it becomes an increasing problem—it is about 25 per cent of the burden in the Solomon Islands and Papua New Guinea now—we will need to find better ways of building multisectoral funding for those problems. Thank you very much.

CHAIR—Thank you very much, Professor. This brings our roundtable to a close. I would like to thank everyone for participating today, especially our special guests, the High Commissioner of the Solomon Islands, His Excellency Mr Victor Ngele; and His Excellency Mr Charles Lepani, the High Commissioner of Papua New Guinea. I am sure that over the next few weeks we will have a lot more to do with your high commissions. To everyone else who attended, if you have not submitted anything in writing there is still ample opportunity if you wish to do so.

If you wish to submit a supplementary submission, feel free to do so. I am sure we will be liaising with many of you over the next few weeks. Certainly we will keep you all up to date when we come up with our recommendations, after our return from the Solomons.

Before I declare the meeting closed, I would like to thank everyone for their attendance. I thank Broadcasting and Hansard for ensuring that everything was broadcast today and for the good work that they do. Sometimes they are the people we do not see at these committee meetings, but they ensure that everything that was said today is on the record for us to go back to and investigate and read and ensure that we do our research correctly. So thank you. I also thank the committee secretariat, Sara Edson and Penny and the others who assist in putting it together. I thank the committee members and I thank all the witnesses for attending.

Resolved (on motion by **Ms Hall**):

That this committee authorises publication, including publication on the parliamentary database, of the transcript of the evidence given before it at public hearing this day.

Committee adjourned at 12.31 pm