2

Committee inquiry activities in Australia

2.1 As outlined in Chapter 1, the Committee participated in a range of activities in Australia, including travelling to the Torres Strait, prior to the Committee delegation's departure overseas, in order to better inform itself on the cross-border and other health issues facing Australia and its South Pacific neighbours.

2.2 Before the delegation travelled to Papua New Guinea (PNG), the Committee wanted to learn more about the Torres Strait treaty, the status of health services in the Western Province of PNG, Australian assistance to the health sector in Western Province, the health concerns of Torres Strait residents and the jointly agreed Package of Measures designed to address health problems on both sides of the border.

2.3 The Committee also sought information on some of the major health issues jointly affecting PNG, Solomon Islands (SI) and Australia alike, including, avoidable blindness; child and maternal health; violence against women; water and sanitation; HIV/AIDS; tuberculosis (TB); mosquito borne diseases (malaria and dengue fever); the health impacts of climate change; and a rise in non-communicable diseases like diabetes.

2.4 From discussions on these topics the Committee gleaned a number of underlying and recurrent themes which usefully 'set the scene' for the delegation visits and discussions in country.

Cross-border framework

Torres Strait Treaty

Figure 1.0 Map of Torres Strait Treaty Area

Summary

2.5 There is not a widespread awareness amongst Australians on the mainland of the Torres Strait Treaty and how it operates, or attendant border issues. The Department of Foreign Affairs and Trade (DFAT) has overall responsibility for the treaty and their website contains information on it. [1]

2.6 Essentially, the Torres Strait Treaty (in operation since 1978) is a unique arrangement that defines the territorial boundaries between Australia and PNG and establishes a protected zone that safeguards the traditional way of life and livelihood of inhabitants including fishing for food, trade, and ceremonial activities such as marriages, funerals and social events.

2.7 It allows for traditional inhabitants of both sides of the border to cross the border without passports and visas, under community guidelines.

1 See DFAT website, http://www.dfat.gov.au/geo/torres_strait/index.html

2.8 Presently, 13 PNG villages have free movement privileges – that is, they are allowed to travel freely in the protected zone. There are 14 treaty communities on the Australia side. Whilst not named in the treaty, free movement is also granted to those from 4 treaty village 'corners' within the Western Province capital Daru (i.e. people who have ancestral ties to the treaty villages of Mawatta, Mabaduan, Ture Ture, Parama) and descendents of the Daru pioneers (children of the original missionaries and people mobile in the area in the century before last who ended up settling on Daru but had a traditional and longstanding range through the area). For the purposes of the treaty these two groups are considered traditional inhabitants as well. There is also a further 10 villages in PNG that would like to join the treaty, currently in a submission with the PNG Government.[2]

2.9 A prior approval system applies whereby a permit is granted following agreement between elected representatives of each community, indicating that a certain individual or group of individuals can travel and visit that community.[3]

2.10 DFAT is aware that the contemporary relevance of the treaty in a post September 11 world could be questioned with all the restrictions we now have on borders across the world. However, the Department believes that the treaty largely works well and that one of its inherent strengths is self-regulation, namely that the traditional inhabitants are guardians of the treaty. DFAT says that activities that are not permissible (such as an illegal entry outside the normal movement stipulations) are swiftly brought to the attention of authorities.[4]

2.11 The Department of Immigration and Citizenship (DIAC) has six staff based on Thursday Island (TI), with 17 local Movement Monitoring Officers (MMOs), who are 'the eyes and ears of the Department,' scattered around the 14 island communities on the Australian side, with a focus for all agencies on the top western cluster of Saibai, Dauan and Boigu Islands. MMOs undertake quarantine clearances where there is no Australian Quarantine and Inspection Service (AQIS) officer. The Committee was told that MMOs can easily identify who is not from a treaty village through asking questions about their families, and discerning facial features and skin complexions.[5]

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2 DFAT, Briefing, 19 August 2009, pp. 2-3.

3 DFAT, Briefing, 2 September 2009, p. 6.

4 DFAT, Briefing, 19 August 2009, p. 3.

5 DIAC, Briefing, 2 September 2009, p. 9-12.

2.12 According to DFAT, inevitably, there are issues that arise from time to time as a consequence of the numbers of crossings (including health ones) and that constant vigilance and attention to these is required. However, it is the Department's view that, while sometimes used as a scapegoat, the treaty actually resolves more problems than it creates.[6]

2.13 In its submission to the Senate Foreign Affairs Committee, the Torres Strait Regional Authority (TSRA)[7] concurred that the treaty 'itself was sound'. In their view,

> …the problems associated with its operation lie with the poor socio-economic circumstances of PNG and the resources that are needed on the Australian side of the border to 'carry' the resultant burden.[8]

Traditional movements

A PNG treaty villager coming ashore Saibai Island

6 DFAT, Briefing, 19 August 2009, p. 3.

7 The TSRA is an Australian Government Statutory Authority established in 1994 to improve the lifestyle and wellbeing of the Torres Strait Islander and Aboriginal people living in the Torres Strait Region. For more information see the website: http://www.tsra.gov.au/

8 TSRA Submission no 18, Senate Foreign Affairs Committee Inquiry into matters relating to the Torres Strait, https://senate.aph.gov.au/submissions/comittees/viewdocument.aspx?id=0c9da83c-41c0-4252-b4d5-65121c27a573

2.14 The Torres Strait Regional Authority provided statistics to the Committee on the number and distribution of traditional movements made under the treaty for the 2008-2009 year.

Table1: 2008-2009 Traditional Movements

Island	PNG Visitors
Saibai	17,388
Boigu	8,554
Dauan	1,279
Erub (Darnley)	742
Iama (Yam)	566
Ugar (Stephen)	498
Masig (Yorke)	172
Mer (Murray)	137
Badu	95
Mabuiag	63
Warraber (Sue)	53
Poruma (Coconut)	34
Kubin (Moa)	23
St Pauls (Moa)	22
Total	**29,626**

2.15 The figures from 2008-2009 totalling nearly 30, 000 are a decrease from the previous year, 2007-2008, which saw some 52, 674 traditional movements.[9] The decrease is attributable to travel restrictions put in place as a precautionary measure to prevent the spread of swine flu.[10]

2.16 As can be seen from Table 1, the majority of movements by far involve PNG nationals travelling to Saibai Island.

PNG nationals use of Australian health services and impact on Torres Strait communities

2.17 The Torres Strait Treaty does not make mention of nor specific provision for health treatment for PNG villagers in the protected zone. However, if inhabitants from the PNG side are visiting the Australian side and fall ill, or, there is a medical emergency, they are able to be treated at a health care facility in the Torres Strait on a needs basis. Treatment takes place principally at a clinic on Saibai or Boigu, with referral to Thursday Island

9 Torres Strait Regional Authority, Submission no. 5, page. 1, http://www.aph.gov.au/house/committee/haa/pacifichealth/subs/sub005.pdf

10 DIAC, Briefing, 2 September, p. 10.

Hospital, if necessary, or to Cairns Base Hospital, for more serious conditions.

2.18 DFAT reiterated that while poor health is not a valid reason under the treaty to travel to Australia (something which is communicated to communities during treaty awareness visits) it is difficult to prohibit because it is a function of humanitarian need met by an Australian style humanitarian provision.[11]

2.19 A Senior Medical Officer with Thursday Island (TI) Hospital, Dr Stuckey, told the Committee that in addition to treating PNG patients because of their human right to emergency medical care, Australia also treats patients for public health reasons, namely…to slow or stop the spread of infectious diseases into Australia and throughout the Western Province region. Dr Stuckey said that from time to time patients with chronic conditions are treated but that would be an exception to their general medical care.[12]

2.20 Overall, a relatively small proportion of traditional movements involve health clinic visits and hospital stays. According to DIAC, the numbers of PNG nationals seeking medical treatment at time of arrival is very low – about 1 percent of all arrivals on Saibai Island.[13]

2.21 Table 3 below from the Torres Strait Regional Authority (TSRA) submission shows the numbers of PNG nationals presenting to the Saibai health clinic.

Table 3: PNG Nationals number of presentation to Saibai PHC

Year	Number of presentations
2006 & 2007	Average of 90 per month over two years
2008	Average of 36 per month

2.22 The TSRA estimated that about 2000 (3.79%) traditional movements from PNG involved visits to health clinics in the Torres Strait in 2007-2008.[14]

2.23 Dr Stuckey informed the Committee that TI Hospital had treated 92 PNG nationals as inpatients in the previous 12 months, approximately 15 of which were TB patients (25 per cent of whom had multi-drug resistant forms of the illness, requiring at least 6 months of treatment). Another 15

11 DFAT, Briefing, 2 September 2009.

12 Thursday Island Hospital, Briefing 2 September 2009, p. 27.

13 DIAC, Briefing, 2 September 2009, p. 13.

14 TSRA Submission no. 5, p. 5.

were obstetrics cases. Some 10 patients were quite severe malaria cases. The remaining cases were mainly trauma or medical care (falls, fractures, burns from children who have wandered into campfires, violent injuries from machetes and spears - often from domestic violence, snake bites and acute and chronic eye injuries).[15]

2.24 The TSRA and Saibai community representatives expressed concern to the Committee about the impact on their small communities and especially the strain placed on Saibai's health clinic. The TSRA said that approximately 253 people presented at the clinic during 2008-2009 which is about 75 per cent on top of the population of the community which stands at about 337 people.[16]

2.25 There is concern in the community about the potential for people-to-people transfer of contagious diseases from the PNG side to Saibai Islanders, be these sexually transmitted diseases, HIV/AIDs or respiratory illnesses like TB, and especially its more virulent drug resistant forms.[17]

2.26 The TSRA described a 'boxing sea effect.'[18] Namely, the Torres Strait is already one of the most socio-economically disadvantaged regions of the country – trying to catch up with the rest of Australia on health statistics – and it is also carrying the humanitarian burden of assisting PNG nationals.[19]

2.27 In addition to the impact on the Saibai health clinic, the TSRA and Saibai residents noted other pressures from a regular influx of PNG visitors on other services and infrastructure on the island. These include pressures on food security (the community shop only gets food supplies once a week), petrol supplies and Saibai's already limited water supplies.[20] Queensland Health acknowledged that that lack of water is an issue and that desalination plants are required to supplement natural supplies.[21]

2.28 Compounding locals' concerns is uncertainty surrounding the implications of the proposed closure of the large OK Tedi[22] mine in

15 TI Hospital, Briefing, 2 September 2009, pp. 29 – 31.

16 TSRA Briefing, 2 September 2009, p.21.

17 Private communications on Saibai Island, 1 September 2009.

18 The boxing sea effect refers to when you go out on a boat and get hit from two sides by waves.

19 TSRA Briefing, 2 September 2009, p. 23.

20 TSRA briefing, 2 September 2009 , p.21 and private communications, Saibai, 1 September 2009.

21 Queensland Health, Official Transcript, 31 August 2009, p. 19.

22 The OK Tedi mine is a large scale producer of copper concentrate for the world smelting market. The mine is majority owned by an Australian company called PNG Sustainable Development Program Limited (replacing the 52% stake previously held by BHP Billiton). See

Western Province in 2013 (which currently provides employment and health services to some 2000 employees, 95% of whom are PNG citizens) and proposed improved transport infrastructure capacity in Western Province. In their view, these factors may result in increased mobility and additional strains placed on Saibai's resources.[23]

Committee, DFAT Treaty Liaison Officer and Saibai Island community

Health screening of PNG nationals

2.29 One of the main concerns raised by the Torres Strait Regional Authority (and, also in meetings with Saibai community leaders) is the fact that visitors from PNG are not required to have had or be given health screens prior to entry, something they say was required prior to the Torres Strait Treaty, under old community by-laws. It was suggested by some that the AQIS requirements for animal and plant matter are more stringent than health ones for humans.[24]

2.30 DIAC told the committee that immigration officers ask visitors their reason for entry and if they are sick (not a valid reason for visiting, bar an

the OK Tedi mine website for more information on the mine and its activities: http://www.oktedi.com/

23 TSRA, Submission no. 5, http://www.aph.gov.au/house/committee/haa/pacifichealth/subs/sub005.pdf and private communications on Saibai Island, 1 September 2009.

24 TSRA, Briefing, 2 September 2009, p. 18, and private communications on Saibai Island, 1 September 2009.

emergency) but the Department does not keep track of who accesses health services during their stay because their role is to manage entry to and exit from the country.[25]

2.31 The Committee appreciates that there are a host of practical and logistical considerations surrounding the notion of health screening each of the traditional movements. Regular border control measures at airports and the like do not conduct health screens for these same reasons.

2.32 The Committee notes that imposing a health screen on PNG nationals would also be contrary to free movement, which is one of the central tenets of the treaty (enshrined in Article 11).

Photo identity

2.33 Other issues brought to the Committee's attention on Saibai were the desire to identity visitors and to deal with overstayers on the island.[26] It was suggested that new measures, including the introduction of photo ID and a single entry access point to the island, would assist in these regards.

2.34 DIAC told the Committee that – putting the logistics and practicalities of introducing an identity document aside, it would help them to be assured of a person's identity.[27]

2.35 That said, DIAC was of the view (similar to DFAT's on the level of respect inhabitants have for the treaty) that it does not see many people abusing the treaty, especially from the treaty villages.[28]

2.36 The Committee is aware that the consideration of a photo ID pass is something that has been mooted for some time. There are practical difficulties in issuing and administering such passes and, once again, it is not something currently required under the treaty.

Consultative mechanisms

2.37 The Committee wanted to know what consultative mechanisms exist for residents on both sides of the border to air views about the treaty provisions, and to discuss issues such as health screening and the introduction of photo identification.

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25 DIAC, Briefing, 2 September 2009, p. 10.

26 Private communications to the Committee, Saibai Island, 1 September 2009.

27 DIAC, Briefing, 2 September 2009. p. 17.

28 DIAC, Briefing, 2 September 2009, p. 13.

2.38 The Committee was advised that there are treaty awareness visits, with whole-of-government official delegations from PNG and Australia whereby officials travel to every treaty community on the Australian and PNG sides to conduct community meetings, open to all, about the provisions of the treaty and to answer questions.

2.39 There is also a traditional inhabitants meeting (TIM) which is an official meeting of the leaders of the traditional communities on both sides. It is held in alternate years in PNG and Australia. The positions of the DFAT Liaison Officer (based on Thursday Island) and PNG equivalent (based in Daru) are named in the Treaty and comprise the secretariat for the TIM. A set of recommendations comes out of these meetings which goes to the Joint Advisory Council (JAC) – the peak consultative body - for consideration. The Council is required to submit its report to the foreign ministers of Australia and Papua New Guinea.[29]

Health Issues Committee (HIC)

2.40 Under the JAC, there is a Torres Strait Health Issues Committee, otherwise known as the HIC, which examines health issues associated with the free, cross-border movement of PNG nationals and Torres Strait Islanders, and looks for practical ways to address contentious health issues – such as those mentioned above.[30]

2.41 The HIC meets twice a year and comprises representatives from the Australian Government, including the Department of Health and Ageing (which is the lead agency and Chair); DFAT, AusAID, AQIS, DIAC, Customs and the TSRA. It has members of the Queensland government, including the Department of Health, and Premier and Cabinet, and also from a number of PNG government agencies.[31]

2.42 The key aim of HIC is to strengthen the health service capacity both in the Torres Strait and in Western Province in PNG, and to increase surveillance and communication between the two areas to minimise or control communicable diseases within the treaty zone.[32]

2.43 The Australian government is keen to increase health services on the PNG side to protect the Australian borders from communicable diseases

29 DFAT, Briefing, 2 September 2009, pp. 4-5.
30 Department of Health, Briefing, 19 August 2009, p. 4.
31 Department of Health, Briefing, 19 August 2009, p. 4.
32 Department of Health, Briefing, 19 August 2009, p. 4.

entering Australia and has a strong interest in improving communications and helping to improve PNG's capacity to manage disease.[33]

Status of health services in Western Province

2.44 The Committee enquired why PNG nationals would seek treatment at Australian health clinics on Saibai or Boigu rather than at their own. In addition to the fact that there are generally shorter travel distances involved for those living in the PNG treaty villages to travel to Australia than to travel to the Western Province capital, Daru, where there is a hospital, (for example, a 15-30 minute boat trip versus a 2 hour-plus journey), the Committee learnt that there are vast disparities between the health facilities and services in PNG compared to those available in Australia. A Thursday Island doctor told the Committee that there is little capacity for PNG patients to access acute care in Daru:

> For example, if you break your arm in Sigabadaru, your closest place to go to is Saibai…they tend to try to access care through our service.[34]

2.45 Service delivery outcomes for health and education are poor in the province. This is despite Western Province's considerable wealth (having three times the revenue to the next wealthiest province in PNG) owing to mineral resources.[35]

2.46 Work done by the PNG National Economic and Fiscal Commission shows that Western Province is one of the few provinces that actually has access to adequate funds for service delivery, including basic health services, but there are a host of reasons why those funds do not necessarily translate to improved services. There are logistical challenges: it is a large province, with difficult physical geography (there are few roads, people travel by banana boat) and low population density. Historically there have been governance and administration difficulties. There are also population pressures in the capital of Daru, which is an ever-growing, and an increasingly overcrowded island with some 20, 000 people reliant on government services.[36]

2.47 PNG treaty villagers in the South Fly of Western Province face pressing health concerns which are brought about mainly by the poor sanitation

33 Department of Health, Briefing, 19 August 2009 p. 7.

34 Thursday Island Hospital, Briefing, 2 September 2009, p. 29

35 Written briefing material provided by AusAID to committee delegation.

36 AusAID, Briefing, 19 August 2009, p. 7, and written briefing material provided by AusAID to committee delegation.

and water quality that they have and limited disease control activities. The local health services, including the Daru hospital, suffer from poor infrastructure and shortages of staff and clinical supplies. There are limited diagnostic capacities. All these factors lead to high levels of communicative disease occurring in the Western Province, which includes the mosquito borne diseases such as malaria, sexually transmitted infections, and TB, with multi-drug resistant TB of particular concern. There is also a degree of HIV/AIDS infection, although limited surveillance means that the prevalence is somewhat unknown.[37]

Australian assistance to Western Province

2.48 Western Province is of special interest to Australia because of its geographical proximity to Australia, its long history of Australian mining activity, and cross-border health issues making it of strategic importance. Australian assistance directed to the Province includes:

- $1.2 million to establish sexually transmissible infection clinics in Daru, Morehead and Kiunga;
- $0.5 million for the health radio network in the South Fly District to strengthen health surveillance and responsiveness on both sides of the border (especially critical in places where radio is the only form of communication);
- funding a TB officer to help roll out the national stop TB Program;
- funding a medical communications officer based in Daru who undertakes patrols and liaises with the Torres Strait health services;
- funding an adviser to the provincial government to improve the reliability and regularity of flows for health service operations, including health centres and aid posts.[38]

2.49 Western Province is also a priority province under AusAID's 4 year HIV/AIDS program, valued at $178 million.[39]

Package of measures

2.50 At the roundtable, the Department of Health informed the Committee that the HIC had been tasked with developing a 'package of measures' for addressing cross-border health concerns, at the 2008 Australia-Papua New

37 Department of Health, Briefing, 19 August 2009, p. 5, and JTA International Submission no. 7.

38 AusAID, Briefing, 19 August 2009, p. 7.

39 AusAID. Briefing, 19 August 2009, p. 7.

Guinea Ministerial Forum, to be presented at the ministerial forum the following year. The focus of the package is to strengthen health services in the Torres Strait and Western Province of PNG and reduce the incidence and transmission of communicable disease such as TB, which, even if numbers are not high, free movement increases the likelihood of.[40]

2.51 Under the 2009-2010 Budget, the Australian Government committed $13.8 million over 4 years to the Torres Strait Health Protection Strategy, which addresses the Australian elements of the package of measures. Core components include:

- $9.2 million for capital infrastructure spending to upgrade and extend the Saibai Island clinic, providing staff housing and delivering a sexual health program in the Torres Strait;
- $2.9 million for the ongoing joint Australian and Queensland government mosquito control program in the Torres Strait to eliminate exotic species like *Aedes albopictus* which is a vector for dengue fever; 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.[41]

2.52 As part of the package, the Australian government through AusAID has committed $561, 000 to a Tuberculosis Clinical Management and Laboratory Capacity Building Project which will focus on improving the capacity of PNG to detect and test for tuberculosis. Progress to-date includes capital works to upgrade the Central Public Health laboratory in Port Moresby and holding clinical workshops Daru Hospital. Scoping studies have also been undertaken to upgrade the laboratory in Daru to a lab able to test for TB.[42]

2.53 The Department of Health advised that the Western Province Communications Officer position, based in Daru, had commenced clinical outreach visits to the village aid posts and health centres along the South Fly coast to provide follow-up treatment and support of PNG nationals diagnosed with TB in Torres Strait Island clinics. Work had started on upgrading the Buzi village aid post to a two-person facility, including the

40 Department of Health, Official Transcript of Evidence, Friday 11 September 2009, p. 21.

41 Department of Health, Official Transcript, Friday 11 September 2009, p. 21.

42 Department of Health, Briefing, 19 August 2009, p. 5.

recent installation of a solar refrigerator to store vaccines (with funding provided by the Western Province Health Office).[43]

Solar fridge installed at Buzi

2.54 The Department of Health noted that funding challenges remained on the PNG side:

> 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 to 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.[44]

2.55 Following the roundtable, the Committee wrote to the Minister responsible for Torres Strait affairs, The Hon Warren Snowdon MP, requesting further information on the status of the package of measures.

43 Department of Health, Official Transcript, Friday 11 September 2009, p 22

44 Department of Health, Official Transcript, Friday 11 September 2009, p 22

2.56 In his response, Minister Snowdon provided details of the package of measures as at June 2009, including of the PNG Specific Treaty Area Strategy which PNG is responsible for funding. The following projects are ones that PNG has agreed to fund, with funding responsibilities divided between the National Department of Health, Daru General Hospital Board, Western Province Health Office, and Western Provincial Administration:

- the redevelopment of Daru Hospital;
- upgrading the Mabaduan Health Centre;
- supporting health workers from South Fly District, including the treaty villages, to be trained at the Rumginae Community Health Workers Training School in North Fly;
- strengthening public health programs (in malaria, HIV/AIDS and TB) and community awareness of them;
- establishing a system of outreach programs;
- strengthening human resource capacity;
- transportation for medical drug distribution to health facilities in the South Fly District and treaty villages, and for emergency medical referrals to Daru Hospital, outreach services and supervision from health centres to aid posts or community health posts;
- improving community water supply which is continuously affected by shortages, especially during the dry season – and sanitation; and
- improving laboratory capacity in Daru and health facilities along the border – and linking with the Australian funded tuberculosis project.[45]

Facilitated cross-border movements for health professionals

2.57 One of the 'Package of Measures' initiatives that the Committee heard will make an enormous difference once implemented is 'facilitated cross-border movements.' Presently, health workers and government officials cannot travel between Saibai and Boigu and the treaty villages directly (entry and exit must be via declared ports at Horn Island or Cairns in Australia and Daru Island or Port Moresby in PNG). This makes travel

45 Correspondence to HAA Committee from Minister Snowdon, dated 30 October 2009.

between both very expensive and time consuming (a boat trip across being a much cheaper and quicker alternative).[46]

2.58 The new initiative will allow identified health workers and government officials to travel directly between Saibai and Boigu and treaty villages in South Fly. People crossing the border under this arrangement will be required to have valid passports and visas, and otherwise comply with all customs and quarantine requirements.[47]

2.59 Queensland Health told the Committee that this measure was a 'fundamental enabler':

> Given that Queensland Health already has officers in attendance at Boigu and Saibai, the marginal cost of having them pop over the border [to say] look at water supply sanitation issues in Western Province would be very low – that is, if we could go directly across. We would be very receptive to that…investment.[48]

2.60 The Committee supports the proposal to facilitate cross-border movements for health and other government professionals between non-declared ports in the Torres Strait and South Fly region, and believes that it should be enacted as soon as practical. The Committee notes that the Ministers for Foreign Affairs in both Australia and PNG recently endorsed the proposal in principal. The Department of Foreign Affairs and Trade has carriage of the initiative. Discussions have commenced between key Australian agencies around the detailed operational planning required to implement the initiative. It is proposed that these discussions will be progressed more broadly and with PNG officials ahead of the Australia – PNG Ministerial Forum scheduled for later in 2010.

2.61 Minister Snowdon advised that a final form of the Package of Measures should be presented for bilateral endorsement at the 20th joint Australia - PNG Ministerial Forum in 2010.[49] Thus far, the PNG government has committed $5 million PNG kina to the PNG components of the Package.[50]

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46 Written briefing material provided to Committee delegation by AusAID and correspondence to HAA Committee from Minister Snowdon, dated 30 October 2009.

47 Written briefing material provided to Committee delegation by AusAID and correspondence to HAA Committee from Minister Snowdon, dated 30 October 2009.

48 Queensland Health, Official Transcript, 31 August 2009, p. 18.

49 Correspondence to HAA Committee from Minister Snowdon, dated 30 October 2009.

50 Personal communication to secretariat, Department of Health, 13 January 2010.

Regional health issues

Avoidable blindness: partnerships and institutional strengthening through cooperation

2.62 At its regular private meeting on 17 June 2009 the Committee received a joint briefing on the status of eye health in Australia and the Pacific from some of Australia's eycare experts:

- Ms Jennifer Gersbeck, CEO of Vision 2020 Australia (Australia's peak body for the eye health and vision care sector representing the views of some 50 member organisations);
- Professor Hugh Taylor AC, Deputy Co-Chair, Vision 2020;
- Professor Brien Holden OAM, Board Member Vision 2020;
- Dr Richard Le Mesurier, Chair, Pacific Region, International Agency for the Prevention of Blindness (IAPB); and
- Mr Brian Doolan, CEO, The Fred Hollows Foundation.

2.63 The Committee was advised that the prevalence of avoidable eye disease amongst Indigenous Australians was much higher than in the non-indigenous population.[51]

2.64 At the roundtable hearing in Canberra, Vision 2020 elaborated on the incidence of eye disease amongst Indigenous Australians:

> Eye problems are the most commonly reported long-term health condition among Indigenous people. Diabetic retinopathy[52] is a major problem for Indigenous Australians – four times that of the national average. The eye disease trachoma[53] is found almost exclusively within the Indigenous population and remains endemic in large parts of Central and Western Australia. The

51 Personal communication at the HAA Committee's private meeting on 17 June 2009.

52 Diabetic retinopathy refers to damage to the retina caused by complications of diabetes, which can eventually lead to blindness. Source: Wikipedia, http://en.wikipedia.org/wiki/Diabetic_retinopathy

53 Trachoma is an infectious disease caused by the bacterium *Chlamydia trachomatis*, spread by direct contact with eye, nose and throat secretions or flies and found in areas where there is poor personal and family hygiene and common in communities without access to adequate water and sanitation. Source: Wikipedia, http://en.wikipedia.org/wiki/Trachoma

prevalence of cataracts[54] 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.[55]

2.65 Professor Le Mesurier spoke to the equally high incidence of eye conditions in the Pacific. He referred to the approximately 800, 000 people in the Pacific who are blind and an additional 250, 000 people with severe vision impairment. According to the Professor, 70 per cent of this is due to two easily treated conditions. One is cataracts, which requires a 20 minute procedure and only costs about $ 20-30 to treat in most developing countries. The other, refractive error,[56] can be fixed by the provision of glasses. [57]

2.66 The main barriers to restoring sight, common to remote parts of Australia and the Pacific alike, include poverty and a lack of access to appropriate care.[58]

2.67 In recognition of this issue, in early 2009, the Australian government committed $ 58 million over 4 years to tackle chronic eye (and ear) disease.

2.68 As part of the initiative the Australian government announced at least 1000 additional surgical procedures and an increase of at least 10 regional teams to treat and prevent eye disease in Northern Territory, Western Australia, South Australia and other states.[59]

2.69 In the 2008-2009 Budget, the Australian government also provided an initial $ 45 million over 3 years to implement the *Fighting Avoidable Blindness Initiative* (ABI) Strategy which will address eye health and vision needs in Asia and the Pacific.[60]

2.70 Activities under the ABI initiative include:

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54 A cataract is a clouding in the crystalline lens of the eye, varying in degree from slight to complete opacity and obstructing the passage of light. Source: Wikipedia, http://en.wikipedia.org/wiki/Cataract

55 Vision 2020, Official Transcript, 11 September 2009, p. 15

56 Refractive error is an error in the focusing of light by the eye and a frequent reason for reduced visual acuity. Source: Wikipedia, http://en.wikipedia.org/wiki/Refractive_error

57 Professor Le Mesurier, Official Transcript, 11 September 2009, p. 15.

58 Professor Le Mesurier, Official Transcript, 11 September 2009, p. 16.

59 Vision 2020 website, media release, "Australian Government commits to Indigenous eye health", 27/05/09,

60 AusAID 2008-2009 Budget, http://www.ausaid.gov.au/budget/budget08/budget_avoidableblindness.pdf

- developing strategic partnerships with a range of non-government organisations and organisations working in eye health and vision care, building on and expanding existing work;
- strengthening existing eye care training institutions and the capacity of eye care workers;
- piloting the Vision Centre approach as part of the delivery of eye health and vision care needs;
- assessing eye health and vision care needs to inform future efforts to reduce avoidable blindness; and
- developing a disability-inclusive development strategy to guide Australia's aid program.[61]

2.71 At the roundtable hearing in Canberra, the Vision 2020 Australia CEO explained how Australia's Vision 2020 Global Consortium had been established through a strategic partnership agreement with AusAID to coordinate implementation of the ABI. Comprised of nine leading eye agencies, Ms Gersbeck said the consortium reflects a growing consensus in aid and innovative response to the changing nature of aid, namely that,

> Partnerships and collaboration are effective means through which to provide assistance to the world's poorest people.[62]

2.72 Vision 2020 stated that 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, sharing key lessons learnt and minimising inefficiencies.[63]

2.73 Professor Le Mesurier said that the consortium and ABI had proved 'a godsend' and allowed NGOs to look at much closer partnerships and better coordination in what they do. He gave examples of successes to-date in PNG and the SI.

2.74 In PNG, the International Centre for Eye Health has done a lot of work in training optical technicians and providing affordable glasses for people at the Port Moresby Vision Centre located at the Port Moresby General Hospital.[64]

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61 AusAID 2008-2009 Budget, http://www.ausaid.gov.au/budget/budget08/budget_avoidableblindness.pdf

62 Vision 2020, Official Transcript, 11 September 2009, p. 28.

63 Vision 2020, Official Transcript, 11 September 2009, p. 28.

64 Professor Le Mesurier, Official Transcript, 11 September 2009, pp. 28

2.75 The Vision 2020 submission summarised the achievements of the Port Moresby Vision Centre to-date:

> Since its opening in 2008, the number of spectacles dispensed and refractions conduction has steadily increased, showing an improved uptake of the services by the community. In the 2008-2009 financial year, 1200 patients were seen for refractions and eye examinations, and 1350 pairs of glasses were dispensed.[65]

2.76 There are also workshops being conducted to help PNG develop a national eye care plan.[66]

2.77 In the Solomon Islands, the Royal Australian College of Surgeons delivers services including ophthalmology, in conjunction with other members of the ABI consortium.[67]

Child and maternal health: Millennium Development Goals (MDGs)

2.78 Dr Stuckey described the types of obstetrics cases that he sees at Thursday Island Hospital from Western Province.

> There is very limited procedural obstetric care in the Western Province, outside Daru. ..We see patients who present in obstructed labour and who have been for many days, often with the baby passed away. We see a lot of cases of retained placenta, which requires a simple operation to remove, and these women present, having almost lost their entire blood volume. We see a lot of ectopic pregnancy, which requires a fairly simple operation to cure them, and save their lives…the PNG women have very limited access to contraception. This leads to high rates of birthing, and the more children you have the more complications you have.[68]

2.79 PNG government figures report that the Maternal Mortality Rate (MMR) in PNG has increased to 733 for every 100, 000 live births (2006 Demographic and Health Survey). The increase is likely due to an underestimate in the previous survey.[69] The increase makes it unlikely that MDGs 4 and 5 will be reached by 2020.

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65 Vision 2020, Submission no. 10, p. 2.

66 Professor Le Mesurier, Official Transcript, 11 September 2009, pp. 29.

67 Professor Le Mesurier, Official Transcript of Evidence, 11 September 2009, p. 29.

68 Dr Stuckey, TI Hospital, Briefing 2 September 2009, p. 30.

69 AusAID written briefing material provided to Committee delegation.

2.80 The MMR is the second highest in the Asia Pacific region after Afghanistan. Only about 53 per cent of women in PNG receive delivery assistance from health professionals.[70] There is a shortage of midwifes. Antenatal care of pregnant women in PNG is basic. It is based in the village and is a health worker level of care.[71]

2.81 Contributing factors to the high MMR in PNG include: lower availability of functioning health services; high transport and access costs; and poor referral pathways for women in need of emergency obstetric care.[72]

2.82 That said, there is some encouraging news. In recent years, child death rates have decreased in PNG. The under-five mortality rate has decreased from 94 per 1000 live births in 1990 to 75 in 2006. Similarly, the infant mortality rate has dropped from 69 per 1000 in 1990 to 54 in 2006.[73] Professor Toole qualified these statistics, saying that the decreases had been due to a reduction in the incidence of childhood illnesses rather than an improvement in the adequacy of clinical services. He also noted that the case fatality rate (the proportion of children with those diseases treated in health facilities who die) has not changed.[74]

2.83 Solomon Islands' under –five mortality rate has dropped more substantially than PNG's from 121 per 1000 live births in 1990 to 70 in 2007. The infant mortality rate has also dropped from 86 to 53. And, the reported maternal mortality ratio is 140 per 100, 000 births, down from 550 in 2000. By comparison with PNG, some 85 per cent of births are attended by a healthcare profession in the SI.[75]

2.84 The University of Melbourne and World Vision report, "Reducing maternal and child deaths: experiences from Papua New Guinea and the Solomon Islands", highlights some examples of progress in both countries, and strategies they assert are in need of continued and increased support from governments, donor countries and NGOs, in order to achieve further gains.

2.85 At the roundtable hearing, the World Vision representative elaborated on what more needs to done: increased access to family planning,

70 The University of Melbourne and World Vision, Reducing maternal and child deaths: experiences from Papua New Guinea and the Solomon Islands, p. 4.

71 Dr Stuckey, TI Hospital, Briefing 2 September 2009, p. 31.

72 AusAID written material provided to Committee delegation.

73 The University of Melbourne and World Vision, Reducing maternal and child deaths: experiences from Papua New Guinea and the Solomon Islands, p. 4.

74 Professor Toole, Official Transcript, 11 September 2009, p. 14.

75 The University of Melbourne and World Vision, Reducing maternal and child deaths: experiences from Papua New Guinea and the Solomon Islands, p. 4.

contraceptive services and ensuring all births are attended by skilled birth attendants. Specifically, World Vision advocates increased resources to expand the midwifery workforce in PNG, something that has been achieved to some extent already in the SI, and been seen to contribute to improved maternal and child health outcomes there.[76] The World Vision submission recommends that Australia consider supporting funding a midwifery curriculum and workforce to supplement health system support in PNG for the next 10 years.[77]

2.86 In building its case, World Vision referred to the success of the Solomon Islands Diploma in Midwifery which has trained 110 midwives since the program was established in 2001 (out of 122 midwives in the country). The program illustrates the potential for producing skilled midwives over a relatively short period of time. The course comprises 18 weeks in the capital, Honiara, learning theory in classrooms; and a further 23 weeks undertaking practical training at the National Referral Hospital in Honiara, and provincial hospitals, under the supervision of trained clinical educators. At the conclusion of their studies, the graduate midwives return to their own provinces to practice.[78]

2.87 According to World Vision, the course, with its strong clinical focus, is also seen as a model to increase the number of child health nurses in the Solomons.[79]

2.88 It should be noted that the midwifery and paediatrics nursing curriculum in PNG is presently under evaluation, after calls for review from the Nursing Council of PNG and WHO.[80]

2.89 Professor Toole of the Burnet Institute[81] underscored the importance of child health to the Committee and, in particular, the need to address malnutrition. He noted that significant numbers of children in PNG are underweight (18 per cent) and stunted (44 per cent). [82]

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76 World Vision Australia, Official Transcript, 11 September 2009, p. 13.

77 World Vision Submission no. 11, p. 1.

78 The University of Melbourne and World Vision, Reducing maternal and child deaths: experiences from Papua New Guinea and the Solomon Islands, p. 7.

79 The University of Melbourne and World Vision, Reducing maternal and child deaths: experiences from Papua New Guinea and the Solomon Islands, p. 7.

80 Sir Isi Kevau, Speech at launch of Health Education and Clinical Services (HECS) Program at School of Medical and Health Services, 24 July 2009, provided at PNG medical school site visit, 7 October 2009.

81 The Burnet Institute is Australia's largest virology and communicable disease research institute. For more details see the website, http://www.burnet.edu.au/home

82 Professor Toole, Burnet Institute, Official Transcript, 11 September 2009, p. 30.

2.90 CARE Australia agreed,

> While there is rarely starvation in PNG…the diets…tend to be quite poor; they are high in carbohydrates but can be low in protein and nutrition.[83]

2.91 Professor Toole suggested that child nutrition is something that could be focused on more in Australia's aid program to PNG. He noted that exclusive breastfeeding, recommended for the first six months of life, is quite rare in PNG. The main problem is a lack of knowledge:

> It is mostly not a competition between breastmilk and artificial formula. [Rather], a tradition passed on from grandmother to granddaughter than 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.[84]

2.92 People in the capitals of Port Moresby and Honiara are adopting an increasingly Western or fast food diet (full of too much salt, sugar, fat, and too much carbohydrate from replacing traditionally eaten root vegetables with rice which takes less time and fuel to prepare) and a sedentary lifestyle which contributes to an increasing incidence of diabetes and CVD. At the same time, many young children and women are not getting enough protein in their diet, or a diet sufficiently balanced to provide the necessary range of essential vitamins or minerals to sustain healthy pregnancies or young growing bodies.

Indigenous child and maternal health indicators

2.93 One of the HAA Committee's earlier inquiries into breastfeeding in Australia noted that low birth weight, growth failure and iron deficiency [in indigenous children, as a group] are indicators of poor nutritional status which have shown little improvement over the past decade.[85]

2.94 On the plus side, the Committee learnt that the majority of Indigenous women breastfed their children, with the rate as high as 92 % in remote areas.[86]

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83 CARE Australia, Official Transcript, 11 September 2009, p. 34.

84 Professor Toole, Burnet Institute, Official Transcript, 11 September 2009, pp. 30 -32.

85 HAA Committee, The Best Start breastfeeding report, 9 August 2007, p. 116, http://www.aph.gov.au/house/committee/haa/breastfeeding/report/chapter7.pdf

86 HAA Committee, The Best Start breastfeeding report, 9 August 2007 p. 116, http://www.aph.gov.au/house/committee/haa/breastfeeding/report/chapter7.pdf

Violence against women: gender equality

2.95 At its Canberra roundtable the Committee was pleased to have as one its roundtable participants, Ms Emele Duituturaga, a development specialist with considerable experience in government and non-government roles in the Pacific Islands development sector and currently Acting Director of the Pacific Association of Non- Government Associations. In addition to the ambassadors present at the hearing, Ms Duituturaga was able "to bring voice for the many Pacific voices that cannot be here, especially as a Pacific Island woman."[87]

2.96 Ms Duituturaga referred to a real need to address gender issues. She mentioned maternal health and the fact that women in the Pacific are dying of curable diseases, and complications in pregnancy and childbirth. She talked about the 'big man' Melanesian leadership systems. She spoke about the prevalence of violence against women. Two out of three women, she said, suffer from domestic violence in the Solomon Islands. She emphasised the fact that in PNG there is only one woman in Parliament. In the Solomon Islands there are no women in Parliament and there has only been one since independence 30 years ago. The under-representation of women in public office has all sorts of implications, not least of all for health,

> While it might not clearly be 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.[88]

2.97 These are all matters confirmed in the latest Asia Pacific Human Development Report which focuses on gender equality in the region.

2.98 The 2010 Asia Pacific Human Development Report: "Power, Voice and Rights: A Turning Point for Gender Equality in Asia and the Pacific" notes that progress in advancing gender equality and women's empowerment has been slow and uneven in the region.

2.99 The report states that, the Asia-Pacific region ranks near the worst in the world on basic issues such as protecting women from violence as well as on indicators in such key areas as nutrition, health, and political participation.[89]

2.100 When visiting the Torres Strait, the Committee asked medical staff to comment on the level of domestic violence injuries they observed in the

87 Ms Duituturaga, Official Transcript, 11 September 2009, pp. 10-11.

88 Ms Duituturaga, Official Transcript, 11 September 2009, p. 11.

89 United Nations, Asia-Pacific Human Development Report 2010, p. vii.

Torres Strait, be it amongst Torres Strait Islanders or PNG nationals using the health services there. Staff responded that they suspected levels were high in PNG and amongst Torres Strait Islanders there are high levels of domestic violence, as there are in a lot of places in our society, although [it is hard to say] whether the level is higher or lower than average.[90]

2.101 The Australian government committed $8.5 million in 2009-2010 to support Papua New Guinea's efforts to reduce the rate of violence against women. Specifically, AusAID funding supports:

- printing and dissemination of materials to raise awareness and advertise safe house locations;
- shelters for women affected by violence such as Haus Ruth in Port Moresby;
- work with UNICEF to establish 'Stop Violence Centres' in general hospitals to improve access to medical treatment and counselling services for victims;
- UNIFEM's Pacific Regional Funds, a grant that supports civil society work to eliminate Violence Against Women; and
- better access by women to the legal process through village courts, more female public lawyers and training in sexual assault law for public prosecutors and criminal investigators.[91]

2.102 AusAID also funds a "Famili SEIF Line." If a woman or child is in crisis they can call the 24-hour free of charge crisis helpline in Port Moreby, Mount Hagen, Goroka, Lae, Mandang and Rabaul. A security vehicle is able to be dispatched to evacuate them to a place of safety.[92]

2.103 Additional support is offered through the Australian National University's Centre for Democratic Institutions (CDI), which was established by the Australian government to support the efforts of new democracies in the Asia Pacific region to strengthen their political systems[93] . The CDI runs a "Women in Politics Course," designed to assist participants from the region promote more women for election to their national parliaments.

2.104 The delegation was profoundly affected by the level of violence it heard was being experienced by women in the Pacific and the impact that this

90 Dr Stuckey, TI Hospital, Briefing, 2 September 2009, p. 30.

91 Personal communication from AusAID, 12 March 2010.

92 AusAID Annual Report 2008-2009, p. 46.

93 See CDI website for more details, http://www.cdi.anu.edu.au/

has on the health and lives of women, through its discussions in country with the few women it met with in positions of public office and influence, and locals. Delegates met with a couple of female secretaries of departments and provincial ministers and PNG's only female parliamentarian and minister.

2.105 The Committee recognises the value of programs like the CDI's women in politics course which seeks to help women in the region get elected to parliament and other similar activities which aim to bring Pacific women into contact with female parliamentarians in the region, on an ad-hoc basis. The Committee wonders if it might not be time to instigate a more substantial or sustainable model whereby female parliamentarians in the Australian parliament are matched with a Pacific counterpart though a parliamentary mentoring program. Both parties could learn from each other and be a conduit for contacts and engagement in the respective countries, over a longer period of time.

Recommendation 1

The Committee recommends that the Speaker of the House of Representatives and the President of the Senate establish a parliamentary mentoring program between women in the Australian Parliament and women in Pacific Island Parliaments or aspiring female candidates.

Water supply and sanitation: basic infrastructure and preventative health measures

2.106 A significant number of countries in the region, including Papua New Guinea, appear unlikely to achieve Millennium Development Goal (MDG7, target 10) Target 10, which aims to halve the proportion of people without sustainable access to safe drinking water and basic sanitation by 2015, relative to 1990 levels.[94]

2.107 TI Hospital told the Committee that they see a lot of preventable illnesses (gastroenteritis and diarrhoea) presenting from PNG caused by contaminated water and lack of hygiene in villages, as well as a generally increased level of bacterial infections, including severe skin infections.[95]

94 AusAID website, Water and Sanitation, http://www.ausaid.gov.au/keyaid/water.cfm

95 Dr Stuckey, TI Hospital, Briefing 2 September 2009, p. 31.

2.108 The treaty villages do not have a reticulated water supply (instead, sourcing water from a combination of bores and rainwater tanks), and have pit latrines.

2.109 At best Daru, the capital of Western Province gets 4 hours of water a day and only 40 % of the population there is connected to a sewerage system, which is overwhelmed.[96]

2.110 In August 2009, there was a serious cholera outbreak in Morobe province in PNG (with some 300 reported cases, 20 dead), with cases also confirmed in the capital Lae and additional suspected cases in other province. None were reported in Western Province.[97]

2.111 Cholera is a diarrhoeal illness contracted by drinking water or eating food contaminated with the cholera bacterium, which can spread rapidly in areas with inadequate treatment of sewage and drinking water.[98]

2.112 Australian government support to stem the cholera outbreak included some 250, 000 water purification tablets, protective clothing, and 37,000 clean containers for storage and transport of water to support PNG's response. Australia also funded the WHO to provide 500, 000 oral rehydration salts. Australia provided an environmental health specialist to work with the WHO and PNG Department of Health, an Australian Defence Force Officer to provide logistical support, and administrative support and funding for coordination centres in Lae and Moresby. In addition, AusAID used networks established under its HIV/AIDS program to assist in coordination of public health messages.[99]

2.113 At the roundtable, CARE Australia and the Burnet Institute noted that the recent outbreak of cholera in PNG– the first in more than 60 years- underscores weaknesses in the health system,

> …including access to clean water and sanitation and less than adequate quality health facilities in order to treat this lethal condition.[100]

96 Personal communication from briefing by Mr Kerr, 7 October 2009.

97 Written briefing material provided to Committee by AusAID.

98 Australian Government website, Health insite, http://www.healthinsite.gov.au/topics/Cholera

99 Written briefing material provided to Committee by AusAID.

100 Ms Clement, CARE Australia, Official Transcript, 11 September 2009, p. 40, and Professor Toole, Burnet Institute, Official Transcript, 11 September 2009, p. 30.

2.114 At the roundtable hearing in Canberra the Committee asked witnesses if money directed more towards basic measures such as clean water might not pre-empt a lot of problems at the treatment end.[101] Witnesses agreed.

2.115 Written material from AusAID indicated that $ 4 million has been allocated from AusAID's Clean Water Initiative to provide water and sanitation to treaty villages in the Western Province, which is the major environmental health problem impacting on treaty villagers.[102]

2.116 AusAID is working with villagers and Western Province officials to provide a minimum level of drinking water to remote treaty villages, installing 9, 000 litre polypropylene water tanks to catch rain water. This relieves the burden on villages having to walk for hours to collect water or travel across to the Torres Strait to collect water.[103]

2.117 AusAID has also offered to provide technical support to support the PNG Government's undertaking under the Package of Measures to rehabilitate water supply and sanitation in some treaty villages. [104]

2.118 Dr Stuckey of Thursday Island Hospital emphasised the need to build up this sort of capacity, and that hygiene and running water will make a huge difference.[105]

2.119 Written briefing material provided to the Committee, indicated that PNG Sustainable Development Program Ltd (SDP)[106] is in discussions with Post and the Western Province Government to develop capacity in Western Province.[107] The company has offered to contribute some 50% of the costs.[108]

101 Official Transcript, 11 September 2009, p.33.

102 Written briefing material provided to Committee delegation by AusAID, p. 2.

103 AusAID website, http://www.ausaid.gov.au/closeup/water.cfm

104 Written briefing material provided to Committee delegation by AusAID, p. 1.

105 TI Hospital, Briefing, 2 September 2009, p. 34.

106 A unique organisation created by the PNG government and BHP Billiton who run the OK Tedi mine in Western Province, whose objective is to support selected sustainable development programs through projects and initiatives to benefit PNG. See website for details: http://www.pngsdp.com/index.php?option=com_content&view=article&id=2&Itemid=24

107 Written material provided by AusAID to Committee delegation, p.2.

108 Personal communication from Mr Kerr to Committee on 7 October 2009.

HIV/AIDS and Sexually Transmissible Infections: need for data collection and effective prevention strategies that mobilise the community

Prevalence of HIV

2.120 The National Centre in HIV Epidemiology and Clinical Research produces an annual surveillance report of HIV/AIDS[109], viral hepatitis and sexually transmissible infections (STIs) in Australia.[110]

2.121 The table overleaf from their most recent report shows the estimated HIV prevalence in selected countries, including Australia and Papua New Guinea.

109 HIV (human immunodeficiency virus) is the cause of AIDS (acquired immunodeficiency syndrome). HIV is a type of virus called a retrovirus, which infects humans when it comes in contact with tissues such as those that line the vagina, anal area, mouth, or eyes, or a break in the skin. Source: Medicine.Net.Com

110 University of New South Wales (UNSW), National Centre in HIV Epidemiology and Clinical Research, http://www.nchecr.unsw.edu.au/NCHECRweb.nsf/page/Annual+Surveillance+Reports

1.6 Global comparisons

Table 1.6.1 Estimated HIV prevalence in selected countries

	HIV prevalence	
Country	**2008[1]**	**Rate[2]**
Asia Pacific		
Australia	17 444	123
Cambodia[3]	75 000	800
China[3]	700 000	100
India[3]	2 400 000	300
Indonesia[3]	270 000	200
Japan[3]	9 600	<100
Malaysia[3]	80 000	500
Myanmar[3]	240 000	700
New Zealand[3]	1 400	100
Papua New Guinea[3]	54 000	1 500
Philippines[3]	8 300	<100
Republic of Korea[3]	13 000	<100
Thailand[3]	610 000	1 400
Vietnam[3]	290 000	500
Europe		
France[3]	140 000	400
Germany[3]	53 000	100
Italy[3]	150 000	400
Spain[3]	140 000	500
United Kingdom[3,4]	77 400	127
North America		
Canada[3]	73 000	400
United States[3]	1 200 000	600

1 Estimated number of people living with HIV/AIDS.

2 Rate per 100 000 population aged 15 – 49 years.

3 Estimated HIV prevalence in 2007.

4 Rate per 100 000 population in 2007.

3 Estimated HIV prevalence in 2007.

4 Rate per 100 000 population in 2007.

2.122 An estimated 17, 444 people including 123 per 100, 000 between 15-49 years were living with HIV infection in Australia at the end of 2008. This is an increase of 38% from 10 years ago.[111]

2.123 Trends in newly diagnosed HIV infection rates differ across different state and territory jurisdictions. Whilst the rate has stabilised in some jurisdictions, the rate in Queensland has steadily increased from 3. 4 in 1999 to 4.7 in 2008. HIV continued to be transmitted primarily through sexual contact between men.[112]

2.124 There is a similar per capita rate of HIV diagnosis in the Aboriginal and Torres Strait Islander and non-Indigenous populations. However, higher proportions of cases are attributed to heterosexual contact and injecting drug use in the Aboriginal and Torres Strait Islander population.[113]

2.125 By comparison, an estimated 54, 000 thousand people in PNG have HIV/AIDS, including 1500 per 100, 000 between 15-49 years.[114] This equates to about 1-2% of the population.[115] Clearly, HIV/AIDS presents an enormous challenge to PNG. That said, Professor Toole of the Burnet Institute commented that,

> While this is bad, we believe it is not alarming. [It is not on the same scale as an African or South –East Asian epidemic][116]

2.126 AIDS remains a leading cause of hospital admissions and death. At Port Moresby General Hospital, up to 70 % of beds are occupied by people with HIV-related illnesses. The main mode of transmission in PNG appears to be unsafe heterosexual intercourse. Unprotected paid sex is also a factor.[117]

2.127 By contrast, in 2008, the Solomon Islands reported only 12 new infections, although, as mentioned earlier, this may reflect underreporting.[118]

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111 Annual Surveillance Report 2009, http://www.nchecr.unsw.edu.au/nchecrweb.nsf/resources/SurvReports_3/$file/ASR2009-updated-2.pdf Summary, p. 7

112 Annual Surveillance Report 2009, Summary, p. 7

113 Annual Surveillance Report 2009, Summary, p. 7

114 Annual Surveillance Report 2009, p. 54.

115 Prof. Toole, Burnet Institute, Official Transcript, 11 September 2009, p. 14.

116 Prof. Toole, Burnet Institute, Official Transcript, 11 September 2009, p. 14.

117 Dr Darren Russell, Submission no. 3, p. 1.

118 Prof. Toole, Burnet Institute, Official Transcript, 11 September 2009, p. 14.

Prevalence of Sexually Transmitted Infections (STIs)

2.128 The submission from Dr Darren Russell, Director of Sexual Health at Cairns Base Hospital, on HIV and STI issues in the Torres Strait and Cairns, informed the Committee that rates of STIs in the Torres Strait are very high, with gonorrhoea, chlamydia and tricomoniasis diagnoses being several times higher than that in the general Australian population.[119] Dr Stuckey from TI hospital concurred that he sees very high rates of STIs in the Torres Strait.[120]

2.129 In a recent study of 270 Indigenous adults from Cape York (which included the Torres Strait) aged 16 and older, the prevalence rate of genital herpes infections was 58. 5 %. This compares with a rate of 12.5% in the general Australian population.[121]

2.130 In PNG recent community-based studies found some 40 % of people to be infected with at least one STI.[122]

Transference between PNG and Torres Strait and potential for HIV epidemic

2.131 At the Cairns hearing, Dr Russell summarised the HIV situation from his standpoint,

> In Cairns we have the highest incidence, that is the number of new cases per head of population, of HIV in Australia. We also have one of the largest populations of HIV-positive people in Australia, which is quite strange considering we are such a small city. Our closest capital city is Port Moresby…The Torres is not far away and there are a lot of movements between PNG and the Torres and between Torres and Cairns (for family reasons, employment, commerce, study and tourism).[123]

2.132 The Committee heard that, anecdotally, sexual relationships between PNG nationals and Torres Strait Islanders in the treaty zone take place, and sometimes in exchange for money or goods.[124] Moreover, several HIV diagnoses in Cairns relate to Australia males contracting HIV from women in PNG. And, the Cairns Sexual Health Service also sees a number

119 Dr Darren Russell, Submission no. 3, p. 1.

120 TI Hospital, Briefing, 2 September 2009, p. 28.

121 Dr Darren Russell, Submission no. 3, p. 2.

122 Dr Darren Russell, Submission no. 3. p. 1.

123 Dr Russell, Official Transcript, 31 August 2009, p. 5. And Dr Russell, Submission no. 3, p. 2.

124 Dr Darren Russell, Submission no. 3, p. 1 and Dr Stuckey, Briefing, 2 September 2009, p. 28, personal communications, Saibai community consultations, 1 September 2009.

of HIV-positive expatriates (and their sexual partners) who are living in PNG.[125]

2.133 Dr Russell told the Committee that all three conditions are there for HIV to take off in the region. These are a high rate of partner change; foreskins (if a man has a foreskin he is 9 times more likely to contract HIV); and high rates of sexually transmitted diseases. Yet, despite the many people movements across the border each year, there has not been a HIV outbreak so far.[126]

2.134 And, while there are people residing in the Torres Strait who are HIV positive, the numbers are currently very small.[127]

2.135 The Committee was curious as to why there had not been an HIV outbreak if the pre-conditions exist, and, if as Dr Russell asserts, 'transmission of HIV from PNG nationals to Australians in the Torres Strait is inevitable.[128]

2.136 Dr Russell submitted that not enough is known about 'sexual networks' in the Torres Strait, nor about the rates of STIs and HIV in people living in the PNG treaty zone, and that further data needs to be collated.[129]

2.137 There is some screening for STIs in the Torres Strait which involve urine tests and blood tests, but,

> It is often difficult to do those blood tests or they are not always carried out.[130]

2.138 Although some testing of PNG nationals for HIV takes place at outpatient clinics or if someone presents unwell or with TB in an Australian clinic, there is not yet a comprehensive screening program in place.[131] Dr Russell said that it is standard procedure that every pregnant woman coming down from the Torres Strait is tested for HIV.[132]

2.139 Dr Russell said that little is known about how much HIV exists in the capital of Western Province, Daru.[133] Professor Toole says it has reached

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125 Dr Russell, Submission no. 3, p. 2.

126 Dr Russell, Official Transcript, 31 August 2009, p. 5 and Dr Stuckey, Briefing, 2 September 2009, p. 28.

127 Dr Russell, Submission no. 3, p. 2.

128 Dr Russell, Submission no. 3, p. 2.

129 Dr Russell, Submission no. 3 p. 1, & 4.

130 Dr Russell, Official Transcript, 31 August 2009, p. 8.

131 Dr Russell, Submission no. 3, p. 1 and Dr Stuckey, Briefing, 2 September 2009, p. 28.

132 Dr Russell, Official Transcript, 31 August 2009, p. 8.

133 Dr Russell, Official Transcript, 31 August 2009, p. 13.

the administrative centre of Western Province (the latest figures indicate that 0. 6% of pregnant women are infected), with the figure in the south-laying villages likely to be closer to zero. He cautioned that large projects like the new liquid petroleum gas project may increase vulnerability with workers spending money on sex.[134]

2.140 Dr Fagan, a public health physician in sexual health with Queensland Health, supported the call for more research into sexual behaviours:

> There is a need for an ethnographic study to give us greater insight into what happens within the treaty zone itself.[135]

2.141 Dr Fagan echoed Dr Russell's sentiment that we do not know the extent of the local HIV/AIDS problem in rural Western Province.[136]

2.142 Dr Russell suggested that the Australian Research Centre in Sex, Health and Society (ARCSHS) based at La Trobe University in Melbourne may be well-placed to conduct such research.[137]

2.143 The Committee believes that it would be very useful to conduct research into sexual networks in the treaty area in order to better understand the dynamics of these networks, and to collect data on the levels of STIs, including HIV, on both sides of the border.

Recommendation 2

The Committee recommends that collaborative research be undertaken into the sexual networks that exist in the Torres Strait Treaty zone, that includes the collection of data on the levels of Sexually Transmitted Infections, including HIV, on both sides of the border.

Window of opportunity now

2.144 Queensland Health noted a number of strategies put in place and implemented through the primary health care system in recent years that

134 Prof. Toole, Burnet Institute, Official Transcript, 11 September 2009, p. 14.
135 Dr Fagan, Queensland Health, Official Transcript, 31 August 2009, p. 14.
136 Dr Fagan, Queensland Health, Official Transcript, 31 August 2009, p. 15.
137 Dr Russell, Submission no. 3, p. 4.

had resulted in significant reductions in some common STIs, in particular, syphilis and tricomonas. These include sexual health promotion and complementary population wide STI testing strategies. Dr Fagan believes that the success of these measures has paid off in terms of preventing local transmission of HIV in the Torres region. She suggests that there is a narrow window of opportunity to prevent an HIV epidemic in the region and we need to scale up efforts in the strategies that work.[138]

2.145 The PNG High Commissioner told the Committee that HIV/AIDS is a priority for the PNG Government, with health receiving the second highest allocation of funding of all priority areas in the Budget (after infrastructure).[139]

2.146 In briefings, AusAID outlined its support to help PNG strengthen and coordinate an effective response to the HIV/AIDS epidemic. Australia is providing $178 over five years (2007-2011):

- $100 million for the PNG-Australia HIV/AIDS Program, to expand prevention and treatment services including support to 17 national and international non-government organisations;
- $68 million to strengthen the health sector response, working with partners such as the Clinton Foundation ($10. 2 million), to increase access to HIV treatment services, and with churches and non-government organisations to provide infrastructure and training to treat STIs; and
- $10 million for activities in law and justice, education and infrastructure to ensure these sectors take account of HIV/AIDS in their area of responsibility.[140]

2.147 Mr Bowtell, Director of the HIV/AIDS project at the Lowy Institute for International Policy in Sydney and Executive Director of the recently formed Pacific Friends of the Global Fund to fight AIDS, TB and Malaria (funded by the Bill and Melinda Gates Foundation)[141] spoke about the importance of bipartisan parliamentary engagement on important issues like HIV:

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138 Dr Fagan, Queensland Health, Official Transcript, 31 August 2009, p. 15.

139 H.E. Mr Lepani, PNG High Commissioner to Australia, Official Transcript, 11 September 2009, p. 3.

140 AusAID, Briefing, 19 August 2009, p. 7 and AusAID written briefing material provided to Committee delegation.

141 See Global Fund to fight AIDS, TB and malaria website for details on how the fund works and its activities, http://www.theglobalfund.org/en/

> It is really vital that when we try to confront the serious health problems in the Pacific that parliamentarians have this interaction because they are the gatekeepers of the resources.[142]

Regional leadership

2.148 Mr Bowtell informed the Committee that the Pacific region Friends of the Global Fund group has been established to raise awareness of AIDS, TB and malaria, to talk to national leaders and to other eminent leaders in the region, increase knowledge of the Global Fund's existence and how applications can be made to it, and to closely monitor and evaluate it so that the most good is done for the money invested.[143] Friend Members include:

- Sir Peter Barter Kt, OBE, Chair of the National AIDS Council of PNG;
- Lady Ros Morauta from PNG, whose board and committee memberships include the Asia-Pacific Leadership Forum on HIV/AIDS;
- Mr Ian Clarke, Chair of the Australia Papua New Guinea Business Council;
- Mr Murray Proctor, Australian Ambassador for HIV/AIDS; and
- Senator Payne from the Australian Senate. [144]

Importance of prevention

2.149 As Queensland Health did, Mr Bowtell emphasised to the Committee the importance of investing in prevention. He acknowledged that treatment for HIV/AIDS sufferers is immensely important (as is funding for nurses, doctors and health care workers), but believes that significant resources also need to be put into affecting behaviour change of the young people most at risk of contracting the disease.[145] He highlighted how history shows that where a strategy of community mobilisation at grassroots level has been employed, including in Australia, there have been good outcomes.[146]

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142 Mr Bowtell, Lowy Institute, Official Transcript, 11 September 2009, p. 16.

143 Mr Bowtell, Lowy Institute, Official Transcript, 11 September 2009, p. 17.

144 See website for the other Friend Members and further details on the organisation, http://www.pacificfriendsglobalfund.org/

145 Mr Bowtell, Lowy Institute, Official Transcript, 11 September 2009, p. 26.

146 Mr Bowtell, Lowy Institute, Official Transcript, 11 September 2009, p. 27.

2.150 Further, leaders and others need to be able to talk openly about HIV/AIDS and try and lessen the social stigma because behaviour change will not occur if the subject remains taboo.

Recommendation 3

The Committee recommends that the Australian government facilitate forums for leaders in the region to come together at regular intervals to discuss HIV/AIDS prevention strategies, and, in particular, to seek ways to lessen the social stigma of talking about the disease.

Effective programs in Papua New Guinea and the Solomon Islands

Tingim Laip

2.151 The AusAID funded, Burnet Institute run[147], Tingim Laip Program (which means think about/consider life) was cited as a successful program, or at least one that is successful in its approach, if not yet proven in its impact. The largest community-based HIV prevention program in PNG, it operates in 35 sites in 14 provinces. The 35 sites (which include military barracks, mining sites, border posts and urban settlements) were chosen because they were identified as areas where there are people participating in high levels of sexual and other risk behaviours (namely, female sex workers, men who have sex with men, injecting drug users). [148] One of the important premises of the program is mentoring and facilitating youth leadership.

SIPPA youth program

2.152 The Solomon Islands Planned Parenthood Association (SIPPA) youth program similarly empowers youth, through the use of youth FM radio (popular with young people in SI), face-to-face provincial workshops, school focus groups and a youth friendly health centre and drop-in centre. SIPPA also works closely with the youth coordinators from various church groups.[149]

147 See Burnet Institute website for more details on the Tingam Laip program, http://www.burnet.edu.au/home/cih/programs/png/tingimlaip

148 Prof. Toole, Burnet Institute, Official Transcript, 1 September 2009, p. 29.

149 SHFPA, Submission no. 8, p. 9.

2.153 Recognising that music and sport can prove effective mediums for communicating with young people, SIPPA targets music concerts and also intends developing a partnership with a sports federation like the Solomon Islands Football Federation, in order to integrate reproductive and sexual health information within the football culture.[150]

2.154 Programs that reach out to and connect with youth are especially important in PNG and Solomons because their populations are such young ones. 40 % of the population in PNG is under 15 years of age.[151] And, some 45 % of the population in the Solomons is under 15.[152]

Men and Boys Behaviour Change Program (MBBC)

2.155 At the Canberra roundtable, Ms Knight, CEO, Sexual Health and Family Planning Australia (SHFPA), outlined a community-based program that is being rolled out across PNG and the Solomon Islands called the Men and Boys Behaviour Change Program (MBBC).

> 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.[153]

2.156 Building on its success in the Solomon Islands, SHFPA has also established the MBBC program in PNG.

2.157 SHPA told the Committee that a recent evaluation had highlighted pleasing results to-date in PNG such as, making pregnancies safer, reducing gender based violence and preventing STI-HIV infection.[154]

2.158 Moreover, Family Planning Australia New South Wales intends to use aspects of the MBBC program in its indigenous men and boys programs.[155]

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150 SHFPA, Submission no. 8, p. 9.

151 Oxfam Australia website, http://www.oxfam.org.au/about-us/countries-where-we-work/papua-new-guinea

152 SHFPA, Submission no. 8, p. 8.

153 Ms Knight, SHFPA, Official Transcript, 11 September 2009, p. 36. Also see their submission, Submission no. 8.

154 Ms Knight, SHFPA, Official Transcript, 11 September 2009, p. 36.

155 Ms Knight, SHFPA, Official Transcript, 11 September 2009, p. 36.

Cross-border collaboration

2.159 The SHFPA submission outlined a cross-border network that has been developed to unite family planning organisations in PNG, Solomon Islands and Indonesia. The collaborative network is a forum to discuss and develop strategies for jointly addressing the cross-border management of HIV/STIs, and other issues.[156]

2.160 At the roundtable SHFPA provided an update on its progress:

> We have had face-to-face meetings over the last 18 months and agreed on a work plan and advocacy strategy to garner the commitment and leadership of national governments…with a view to [obtaining] national government agreement to a meeting between the four nations and developing an effective national response.[157]

Tuberculosis : strengthening compliance, importance of outreach services, improving communication and coordination

Definition

2.161 TB is an infection, primarily in the lungs (a pneumonia), caused by bacteria called *Mycobacterium tuberculosis*. It is spread from person to person by breathing infected air during close contact. The most common symptoms of TB are fatigue, fever, weight loss, coughing, and night sweats. The diagnosis of TB involves skin tests, chest x-rays, and sputum analysis. TB can remain in an inactive (dormant) state for years without causing symptoms or spreading to other people. When the immune system of a patient with dormant TB is weakened, the TB can become active (reactivate) and cause infection in the lungs or other parts of the body. People with HIV/AIDS are at a higher risk of developing the disease due to their lower immunity. [158] At the Cairns hearing, the Committee learnt that TB is much more common in poor communities where overcrowding is common and there is a lack of adequate ventilation. Patients' are also less resistant to the disease if they have other diseases such as HIV, or are malnourished.[159]

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156 SHFPA Submission no. 8, p. 11.

157 SHFPA, Official Transcript, 11 September 2009, p. 37.

158 Definition from Medicine.Net.Com, http://www.medicinenet.com/tuberculosis/article.htm

159 Dr Konstantinos, Queensland Tuberculosis Control Centre, Official Transcript, 31 August 2009, p. 25.

Growing number of TB cases in Torres Strait and costs of treatment

2.162 Dr Konstantinos, Director of the Queensland Tuberculosis Centre informed the Committee that TB is a leading cause of death worldwide. Although we have very low rates in Australia, rates are very high in Papua New Guinea and the Solomon Islands.[160]

2.163 Professor Maguire, of the James Cook University's School of Medicine and Dentistry, noted that TB incidence is rising in PNG. The rate there is estimated to be 95. 30 per 100, 000 people compared with an Australian rate of 5.3 per 100,000 per year in 2005.[161]

2.164 Dr Konstantinos cited concerns he has about the growing number of TB cases in the Torres Strait region, an increase he attributes to cross-border movement from PNG.

> From 1990 to 1999 there were probably only 7 cases that came across the border…From 2000-2004, there were approximately 43 cases. There have been more than 20 a year since then.[162]

2.165 Since 2000, approximately 25 per cent of these cases have been multi-drug resistant forms[163], which add complexity and expense to treatment of the disease.[164]

2.166 Dr Stuckey described how the two beds available at TI Hospital for TB patients have almost always been filled, in the last 12 months. He outlined the extensive treatment patients with multi-drug resistant tuberculosis (MDR-TB) require; at least 6 months of intravenous treatment and long stays of up to 9 months.[165]

160 Dr Konstantinos, Queensland Tuberculosis Control Centre, Official Transcript, 31 August 2009, p. 20.

161 Submission no. 2, Professor Maguire, p. 6, http://www.aph.gov.au/house/committee/haa/pacifichealth/subs/sub002.pdf

162 Dr Konstantinos, Queensland Tuberculosis Control Centre, Official Transcript, 31 August 2009, p. 20.

163 Multidrug resistant TB is defined as a strain that does not respond to two or more standard anti-TB drugs. MDRT usually occurs when treatment is interrupted thus allowing mutations in the organism to occur that confer drug resistance. Source Medicine.Net.Com

164 Dr Konstantinos, Queensland Tuberculosis Control Centre, Official Transcript, 31 August 2009, p. 20.

165 Dr Stuckey, TI Hospital, Briefing, pp. 28 – 29.

MDR strains and treatment compliance

2.167 Multi-drug resistant TB occurs when there is incomplete treatment of the disease: namely poor patient compliance, poor diagnostic capability; and/or unavailable therapies.

2.168 Dr Konstantinos confirmed that there are difficulties on the PNG side with tracking patients on release from hospital into the provinces and erratic drug supplies, and that these have been key contributors to the development of MDR-TB strains there.[166]

2.169 In Western Province, specifically,

> Diagnostic facilities for identifying people with TB and for identifying people with multi-drug resistant TB are limited to non-existent in Western Province.[167]

2.170 So far, MDR –TB has not been transmitted from PNG to the Torres Strait, even though there is MDR-TB in the coastal villages and there has been a transmission of drug –sensitive TB. However, according to Professor Simpson of Cairns Base Hospital, 'it is only a matter of time.'[168]

Containment

2.171 The absolute population numbers in South Fly and the Torres Strait are small – about 10, 000 people each. Professor Simpson said that, while treating TB, and particularly MDR-TB, can be very expensive, dealing with the absolute numbers of MDR-TB will not overwhelm our systems in Australia. Much more needs to be done on the PNG side however to contain the epidemic there,

> [They have] got to get their standard DOTS program (broad TB control strategy outlined by the World Health Organisation')…& manage drug-sensitive TB…[169]

2.172 Dr Konstantinos noted they now have a provincial coordinator in the Western Province. PNG is also establishing a national TB program. If that becomes effective in delivering care to the coastal villagers, he said, we may see the numbers peak.[170]

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166 Dr Konstantinos, Queensland TB Control Centre, Official Transcript, 31 August 2009, p. 22.

167 Prof. Maguire, School of Medicine and Dentistry, JCU, Official Transcript, 31 August 2009, p. 10.

168 Professor Simpson, Cairns Base Hospital, Official Transcript, 31 August 2009, p. 23.

169 Prof. Simpson, Cairns Base Hospital, Official Transcript, 31 August 2009, p. 23.

170 Dr Konstantinos, Queensland TB Centre, Official Transcript, 31 August 2009, p. 21.

Developing PNG capacity and leadership

2.173 The Committee spoke with doctors working at TI hospital who endorsed Professor Simpson's remarks that the greatest improvements need to be made on the other side of the border, in terms of developing their capacity to deal with TB.[171]

2.174 In addition to the tuberculosis project under the new Package of Measures, the Committee wanted to know what more the Australian government can do to help PNG 'get [in Professor Simpson's words] the easy stuff – right.'

2.175 Professor Simpson would like to see more support for Daru Hospital and support for greater communication between Daru and Cairns.[172]

2.176 While the Commonwealth and PNG government have funded a communication officer on the PNG side and Australian sides, with communication protocol in place for them to talk to each other, the Committee heard that the working relationship could be developed further.

2.177 One proposal put forward to the Committee by Professor Maguire was the establishment of a Western Province – Northern Australian Clinician's Network whereby Australian doctors, nurses, and health workers would undertake a monthly outreach service to Daru Hospital and South Fly Province.[173]

2.178 Professor Simpson advised the committee that the clinicians at Daru Hospital are good and very keen to treat patients themselves. He said that,

> If they get the tools, they will do the job.

2.179 Queensland is currently finalising a funding agreement with the Commonwealth which would allow PNG clinicians to travel to the Torres Strait clinics to increase their knowledge and skills in TB management.[174]

2.180 Dr Konstantinos emphasised the need for strong leadership on the PNG side:

> The issue may be slightly higher up in the chain [than with the doctors]…I think it is important to ensure that whoever is in charge of TB has a commitment to TB so that they drive it. If they

171 Dr Stuckey and Dr Parish, TI Hospital, Briefing, 2 September 2009, p. 33.

172 Prof. Simpson, Official Transcript, 31 August 2009, p. 24.

173 Prof. Maguire, Submission no. 2, http://www.aph.gov.au/house/committee/haa/pacifichealth/subs/sub002.pdf

174 Submission no. 20, Senate Inquiry into matters relating to the Torres Strait region, p. 17.

> drive it, they need to drive the government plus the peripheral services.[175]

Outreach services

2.181 Cairns Base Hospital operates a range of outreach services, ranging from a general medical clinic to specialist clinics for chronic disease –including TB management; some surgery; obstetrics and gynaecological services and paediatric community health.[176]

2.182 The value of outreach services on the Australian side in the Torres Strait was impressed upon the Committee repeatedly at hearings. Cairns Base Hospital emphasised its cost-effectiveness.

> It was proven in the early nineties that, for every dollar we spend in the community, we will save $5 or $10 in the tertiary sector.[177]

2.183 Dr Beaton acknowledged that the services are costly to run and the budget for funding them is currently in deficit to the tune of between $ 7 and $ 9 million. He stressed the need for ongoing funding to maintain these vital services, not least to help contain disease.

> It is much better to travel to a patient and not bring the TB into Cairns.[178]

Continued funding

2.184 Several witnesses impressed upon the Committee the need for ongoing funding for TB programs. They said that TB programs, especially, take time to produce substantial results.

> Once you start funding for TB, it has got to be for 10-15 years. It is that long before people at the peripheries start to see the benefits, which allows a strengthening of local services…if you pull out too early….you might as well never have started…[179]

2.185 The Committee was advised that in Australia - and places like New York – maintaining, or in the case of the latter, reinvigorating, good public health systems for TB has kept the disease under control.[180]

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175 Dr Konstantinos, Queensland TB Centre, Official Transcript, 31 August 2009, p. 25.
176 Dr Beaton, Cairns Base Hospital, Official Transcript, 31 August 2009, p. 34.
177 Dr Beaton, Cairns Base Hospital, Official Transcript, 31 August 2009, p. 34.
178 Dr Beaton, Cairns Base Hospital, Official Transcript, 31 August 2009, p. 34.
179 Dr Konstantinos, Queensland TB Centre, Official Transcript, 31 August 2009, p. 25.
180 Dr Konstantinos, Queensland TB Centre, Official Transcript, 31 August 2009, p. 28.

Treatment guidelines and funding issues

2.186 Medical practitioners expressed concern that, treating PNG nationals with MDR-TB (something which might take 2 ½ years of management and people coming to and fro for care) contravenes the terms of the treaty. Or, rather, 'the treaty does not cover people coming across to access health care services unless they are acutely injured or are on the point of death.'[181]

2.187 This is also an issue for immigration officers. The Committee heard that MMOs can find it conflicting to refuse entry to people seeking ongoing medical treatment when they know that compliance with taking medication is so important.[182]

2.188 Professor Simpson said that if that issue could be clarified,

> …it would make life a lot more comfortable.[183]

2.189 Dr Beaton, Director of Medical Services at the Cairns Base Hospital, elaborated on the ethical and practical dilemmas that the hospital faces in managing some of the patients who come across the border from PNG. The Committee heard that administrators frequently have to decide how to fund ongoing treatment of diseases. The guidelines they adhere to suggest that funding can be provided where life is at risk. However, applying these guidelines can be challenging in situations when patients present for trauma but have a co-morbidity such as TB or HIV.[184]

2.190 Dr Beaton echoed Professor Simpson's call to clarify some of the arrangements concerning ongoing chronic treatment for TB and HIV. He stated that broad guidelines are not specific enough, which makes decision making difficult.[185]

2.191 However, he also acknowledged that the current arrangement does give clinicians a degree of flexibility.[186]

2.192 The cost of treatment for TB and HIV patients can be very high. For example, the pharmaceutical costs for a single admission for the treatment of TB at TI Hospital in 2008 were $24, 588.[187]

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181 Prof. Simpson, Cairns Base Hospital, Official Transcript, 31 August 2009, p. 27.

182 Department of Immigration, Briefing, 2 September, p. 16.

183 Prof. Simpson, Cairns Base Hospital, Official Transcript, 31 August 2009, p. 27.

184 Dr Beaton, Cairns Base Hospital, Official Transcript, 31 August 2000, p. 30.

185 Dr Beaton, Cairns Base Hospital, Official Transcript, 31 August 2000, p. 33.

186 Dr Beaton, Cairns Base Hospital, Official Transcript, 31 August 2000, p. 33.

187 Submission no. 20, Queensland Health, Senate Foreign Affairs Committee Inquiry into matters relating to the Torres Strait region, p. 16.

2.193 Queensland Health describes funding shortfalls for the treatment of PNG patients for which it currently receives about $3. 8 million per annum. In its submission to the Senate Foreign Affairs Committee inquiry into Torres Strait matters, Queensland Health states that in 2007-2008 the funding provided by the Commonwealth met only a half of actual costs for a range of services, including hospital services predominantly at TI Hospital and Cairns Base Hospital. Funding shortfall estimates for 2008-2009 indicate the shortfall may be less for that year.[188]

2.194 At the Cairns hearing, Dr Beaton explained the difficult position they are placed in: while the costs of treatment are high and the hospital 'is not going to be able to afford it', they feel morally obligated to treat sick patients and, moreover, duty-bound to manage the risk to the broader community. A further frustration for them is that, whereas in Australia if a patient presents with TB a contact-tracing process is undertaken to contain the disease's spread in the community, that is not possible with the PNG patients.[189]

2.195 The Committee learnt that the Health Issues Committee is presently considering a new framework for healthcare delivery which seeks to redress these issues, and allay any concerns Torres Strait Islanders may have that their access to treatment is disadvantaged by arrangements for PNG nationals.[190] The document, "Queensland Health Policy: Management of PNG Nationals presenting to Queensland Health facilities in the Torres Strait" is awaiting endorsement from the Director-General of Queensland Health.[191]

Vector borne diseases (dengue fever and malaria)

Themes: success through concerted collaboration and reducing vectors

Malaria

2.196 Malaria is an infectious disease caused by protozoan parasites from the Plasmodium family that can be transmitted by the sting of the Anopheles

188 Submission no. 20, Queensland Health, Senate Foreign Affairs Committee Inquiry into matters relating to the Torres Strait region, p. 17, http://www.aph.gov.au/Senate/committee/fadt_ctte/torresstrait/submissions.htm

189 Dr Beaton, Cairns Base Hospital, Official Transcript, 31 August 2009, p. 33.

190 Department of Immigration, Briefing, 2 September 2009, p. 15.

191 Personal communication to secretariat, Health Protection Policy Branch, Department of Health, 27 January 2009.

mosquito or by a contaminated needle or transfusion. Falciparum malaria is the most deadly type.[192]

2.197 The symptoms of malaria include cycles of chills, fever, sweats, muscle aches and headache that recur every few days. There can also be vomiting, diarrhoea, coughing, and yellowing (jaundice) of the skin and eyes. People with severe falciparum malaria can develop bleeding problems, shock, kidney and liver failure, central nervous system problems, coma, and die. Malaria is treated with oral or intravenous medications.[193]

2.198 Malaria transmission occurs primarily between dusk and dawn because of the nocturnal feeding habits of Anopheles mosquitoes. Protective measures should be taken to reduce contact with mosquitoes, especially during these hours. These measures include remaining in well-screened areas, using mosquito nets, and wearing clothes that cover most of the body. Additionally, insect repellent should be used on exposed skin.[194]

2.199 Although malaria is no longer endemic in Australia, approx. 700-800 cases occur here each year in travellers infected elsewhere, and the region of northern Australia above 19^{o}S latitude is a receptive zone for malaria transmission. Occasional cases of local transmission occur in the Torres Strait islands and rarely in northern Queensland, and vigilance is required to prevent re-establishment of the infection in some northern localities.[195]

2.200 Solomon Islands has the highest malaria rate in the Pacific[196] with a prevalence rate of some 15, 565 people per 100, 000 and death rate of 2 per 100, 000 (2006 figures).[197]

2.201 Malaria is also a leading cause of illness in PNG.[198] The prevalence rate is 1, 311 per 100, 000 with a death rate of 11 deaths per 100, 000 (2006 figures).[199]

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192 MedicineNet.com, http://www.medterms.com/script/main/art.asp?articlekey=4255

193 MedicineNet.com, http://www.medterms.com/script/main/art.asp?articlekey=4255

194 MedicineNet.com, http://www.medterms.com/script/main/art.asp?articlekey=4255

195 Associate Professor Richard Russell, Malaria factsheet, http://medent.usyd.edu.au/fact/malaria.htm#malaust

196 AusAID website, http://www.ausaid.gov.au/media/release.cfm?BC=Media&ID=9575_7334_2174_3905_9498

197 Asian Development Bank website, MDG tables, http://www.adb.org/Documents/Books/Key_Indicators/2008/pdf/Goal-06.pdf

198 AusAID website, http://www.ausaid.gov.au/media/release.cfm?BC=Media&ID=9575_7334_2174_3905_9498

199 Asian Development Bank website, MDG tables, http://www.adb.org/Documents/Books/Key_Indicators/2008/pdf/Goal-06.pdf

2.202 Although the prevalence of malaria in the Solomons remains very high, it has been substantially reduced in recent years. This is due to a concerted effort on the part of the Solomon Islands and international donors to control and progressively eliminate the disease by 2014.

2.203 AusAID's Pacific Malaria Initiative ($ 25 million, 2007-2011) is an important regional program for Solomon Islands. The initiative aims to reduce the burden of malaria through prevention, disease management, and health system strengthening. The $ 14 million allocated to Solomon Islands supports the Government to implement its National Malaria Action Plan and targets areas of highest malaria prevalence for those most at risk, such as pregnant women and children, working closely with the Global Fund, World Health Organisation and Secretariat of the Pacific Community. The initiative has strong links with Australian and international institutions engaged in malaria research. The initiative has contributed to a marked reduction in the malaria incidence rate from 199 cases per 1000 people in 2003 to 82 cases per thousand in 2008.[200]

2.204 There is a dedicated website for the Pacific Malaria Initiative Support Centre (PacMISC), based at the University of Queensland, whose role is to provide program management support and technical advice to the initiative.[201]

2.205 On the PacMISC website, Technical Director Dr Andrew Vallely states:

> We believe that malaria elimination in Solomon Islands is achievable: important new tools have recently become available that mean we now have strong technical and scientific foundation for this optimism. These include simple rapid diagnostic tests that can be used at community level, highly effective artemisinin-based drug therapy, and long-lasting insecticide treated bednets.[202]

2.206 At the Canberra roundtable, the Solomon Islands High Commissioner, H.E. Mr Ngele, paid tribute to the cooperation from Australia and other nations to achieve the notable success of the malaria program so far.[203]

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200 Written briefing material provided to Committee delegation by AusAID.

201 Pacific Malaria Initiative Support Centre website, http://www.pacmisc.net/pacmisc/index.asp

202 PacMISC website, http://www.pacmisc.net/pacmisc/about.asp

203 H.E. Mr Ngele, Solomon Islands High Commissioner, Official Transcript, 11 September 2009, p. 18.

Dengue fever

2.207 Dengue is prevalent throughout the tropics and subtropics. Dengue fever is a disease caused by a family of viruses that are transmitted by mosquitoes. It is an acute illness of sudden onset with symptoms including headache, fever, exhaustion, severe joint and muscle pain, swollen glands, and rash.[204]

2.208 Dengue strikes people with low levels of immunity. Because it is caused by one of four serotypes of virus, it is possible to get dengue fever multiple times. However, an attack of dengue produces immunity for a lifetime to that particular serotype to which the patient was exposed.[205]

2.209 Dengue hemorrhagic fever is a more severe form of the viral illness. Manifestations include headache, fever, rash, and evidence of hemorrhage in the body. This form of dengue fever can be life-threatening or even fatal.[206]

2.210 The virus is contracted from the bite of a striped *Aedes aegypti* mosquito that has previously bitten an infected person. The mosquito flourishes during rainy seasons but can breed in water-filled flower pots, plastic bags, and cans year-round. One mosquito bite can inflict the disease.[207]

2.211 After being bitten by a mosquito carrying the virus, the incubation period ranges from three to 15 (usually five to eight) days before the signs and symptoms of dengue appear.[208]

2.212 Because dengue is caused by a virus, there is no specific medicine or antibiotic to treat it. For typical dengue, the treatment is purely concerned with relief of the symptoms. Rest and fluid intake for adequate hydration is important.[209]

2.213 Dr Ritchie, a medical entomologist at James Cook University and Tropical Public Health Unit at Queensland Health, referred to a pandemic of dengue which has been going on for several years in the region.[210]

2.214 The Sanofi aventis submission to the inquiry stated that the most recent outbreak of dengue in Australia (which started in December 2008) is the largest recorded in at least 50 years. The epidemic involved Cairns, Port

204 MedicineNet.Com, http://www.medicinenet.com/dengue_fever/article.htm
205 MedicineNet.Com, http://www.medicinenet.com/dengue_fever/article.htm
206 MedicineNet.Com, http://www.medicinenet.com/dengue_fever/article.htm
207 MedicineNet.Com, http://www.medicinenet.com/dengue_fever/article.htm
208 MedicineNet.Com, http://www.medicinenet.com/dengue_fever/article.htm
209 MedicineNet.Com, http://www.medicinenet.com/dengue_fever/article.htm
210 Dr Ritchie, James Cook University, Official Transcript, 31 August 2009, p. 4.

Douglas Yarrabah, Injinoo, Innisfail and Mareeba with 931 cases presenting over 48 weeks.[211]

2.215 An ABC *Catalyst* program on the dengue epidemic reported that it was the first time that the Queensland Health authorities had activated an emergency plan of such magnitude. An unprecedented number of Dengue Action Response Teams had been deployed. In Cairns alone, teams sprayed up to 300 houses a day.[212]

2.216 There is a high level of dengue activity in PNG at any given time. Of the imported cases of dengue fever to Queensland (an average of 10 per year since 1999), some 60 per cent of these cases were from PNG and East Timor, with the remainder from Thailand, Bali and South Pacific nations. Given the proximity of the Torres Strait to PNG and the free movement between, there is an increased risk of importations into the Torres Strait.[213]

2.217 Dr Ritchie stated that North Queensland had over a thousand cases of dengue this year, with twice as many imported cases into Cairns this year as they had ever had before.[214]

2.218 In his evidence, Dr Ritchie talked about the need to reduce the numbers of mosquito vectors [in Cairns] to prevent them from spreading and getting re-established in Brisbane. He cited concerns about ad hoc rainwater storage:

> There was a telephone survey by Queensland health…Twenty per cent of the people were hoarding water in some other unregulated container [i.e. not a rainwater tank].[215]

2.219 He suggests that we need to examine our policy of storing water (including reinspecting water tanks), to make sure that it is safe and that includes legislating so water storage units fit a standard.[216]

2.220 The Committee was concerned to learn that there is no regulatory requirement for reinspections of installed water tanks and thinks that the federal and state governments should work together to establish an appropriate reinspection program, in dengue affected areas.

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211 Sanofi aventis, Submission no. 9, pp. 3-4.

212 ABC Catalyst program, "Dengue Mozzie", 3 September 2009, video and transcript available from website, http://www.abc.net.au/catalyst/stories/2675796.htm

213 Sanofi aventis, Submission no. 9, p. 4

214 Dr Ritchie, James Cook University, Official Transcript, 31 August 2009, p. 4.

215 Dr Ritchie, James Cook University, Official Transcript, 31 August 2009, p. 12.

216 Dr Ritchie, James Cook University, Official Transcript, 31 August 2009, p. 5.

Recommendation 4

The Committee recommends that the Australian government work together with the Australian state and territory governments to establish a reinspection program of installed water tanks, in dengue affected areas in Australia.

Vaccines

2.221 Alongside policy and legislative efforts, the Committee heard that vaccines have the potential to reduce the receptivity to mosquito borne diseases.

2.222 Sanofi Pasteur has been developing a dengue vaccine since the 1990s. Clinical studies with the most advanced vaccine have been ongoing since the 2000s. In Australia, Sanofi Pasteur has completed one Phase II dengue fever vaccine, is supporting a Melbourne-based epidemiological study in travellers and in October 2010 will commence tests to demonstrate consistency of manufacturing quality with their quadrivalent dengue fever vaccine.[217]

2.223 At the Cairns hearing, Dr Ritchie explained how in groundbreaking research at James Cook University they had created a dengue vaccine for dengue mosquitoes by transferring the fruit fly bacterium, Wolbachia, into the dengue mosquito. The bacteria is passed on to the offspring and triggers the immune system of the mosquito so that it will not get infected with dengue.[218] Some strains of the bacteria are able to shorten the lifespan of the mosquito, before it has a chance to breed, which also prevents transmission of the disease.[219]

2.224 Australian scientists (at the Walter and Eliza Hall Institute in Melbourne, Q-pharm Ltd and the Queensland Institute of Medical Research) are also working on developing a malaria vaccine.[220]

2.225 Researchers at the Walter and Eliza Hall Institute have isolated three proteins- MSP3, MSP1 and AMA1 - responsible for transferring the

217 Sanofi aventis, Submission no. 9 p. 5.

218 Dr Ritchie, James Cook University, Official Transcript, 31 August 2009, p. 5.

219 ABC Catalyst program, "Dengue Mozzie", 3 September 2009, video and transcript available from website, http://www.abc.net.au/catalyst/stories/2675796.htm

220 The Sydney Morning Herald, "Proteins hold the key as scientists close in on malaria vaccine", Wednesday, January 20, 2010, p. 6, http://www.smh.com.au/world/science/proteins-hold-the-key-as-scientists-close-in-on-malaria-vaccine-20100119-mj6y.html

malaria infection from mosquitos to humans. Their research suggests that a vaccine which targets these proteins could have the effect of blocking a malaria infection, even if the parasite was inside the body.[221]

Impact of climate change: threats to food and water security, more disease, and environmental refugees

2.226 During its private meeting on 18 March 2009, the Committee received a briefing from experts at the ANU National Centre for Epidemiology and Population Health on the health impacts of climate change in the region.

2.227 The Committee was advised by Professor Capon that "climate change endangers health in fundamental ways."

2.228 Impacts are wide-ranging and include increased heat stress, increased gastroenteritis illnesses, and increased dengue fever outbreaks such as those experienced in parts of Queensland in recent times.[222]

2.229 Higher temperatures, changing rainfall patterns and more frequent extreme events like droughts and flooding potentially impact crop production and food supply too.[223]

2.230 Mr See Kee, General Manager of the Torres Strait Regional Authority, told the Committee that,

> Climate change is going to be a huge issue [especially on Saibai Island, which is low lying]. Inundation is happening now.[224]

2.231 An ABC *Lateline* program about the Torres Strait islands at risk from climate change outlined the impacts already being experienced by the low lying mud islands of Saibai and Boigu, which sit below the high tide mark.[225]

2.232 On the program, the Torres Strait Regional Authority described erratic weather patterns on Saibai Island. Footage of flooding from a king tide combined with a tidal surge caused by a Category 1 cyclone hundreds of kilometres away was shown to illustrate the point. On that occasion, the

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221 The Sydney Morning Herald, "Proteins hold the key as scientists close in on malaria vaccine", Wednesday, January 20, 2010, p. 6.

222 Private briefing to Committee from ANU NCEPH, 18 March 2009.

223 Private briefing to Committee from ANU NCEPH, 18 March 2009.

224 TSRA, Briefing, 2 September 2009, p. 21.

225 ABC Lateline Program, Torres Strait islands risk from climate change, Broadcast 7/12/09, transcript available online, http://www.abc.net.au/lateline/content/2008/s2764521.htm

flooding came close to the community dam and threatened the water supply.[226]

2.233 On Boigu Island, erosion is already an issue, with sacred burial grounds being washed away.[227]

2.234 There is also concern amongst some locals that, if sea levels rise, people living in the equally low lying villages in PNG's Western Province may not flee to their undeveloped highlands, but to Australia instead, as 'climate change refugees'.[228]

2.235 The PNG High Commissioner, H.E. Mr Lepani advised the Committee that PNG recognised that some of its smaller islands are being gradually lost as the sea levels rise, and an office of climate change had been established in the Prime Minister's Office to address these very important issues.[229]

Non-communicable diseases (obesity, diabetes and CVD): rising incidence and need for community awareness and engagement

2.236 While increasing levels of overweight and obesity (with attendant co-morbidities including cardiovascular disease[230] and Type 2 diabetes[231]) is occurring in all population groups in Australia, it is well-documented that Indigenous persons and people from low socio-economic backgrounds are particularly susceptible to these chronic lifestyle diseases.[232] There is also growing evidence to suggest that there are intergenerational impacts, with

226 ABC Lateline Program, Torres Strait islands risk from climate change, Broadcast 7/12/09, transcript available online, http://www.abc.net.au/lateline/content/2008/s2764521.htm

227 ABC Lateline Program, Torres Strait islands risk from climate change, Broadcast 7/12/09, transcript available online, http://www.abc.net.au/lateline/content/2008/s2764521.htm

228 ABC Lateline Program, Torres Strait islands risk from climate change, Broadcast 7/12/09, transcript available online, http://www.abc.net.au/lateline/content/2008/s2764521.htm

229 H.E. Mr Lepani, PNG High Commissioner, Official Transcript, 11 September 2009, p. 18.

230 Cardiovascular disease is any disease of the heart (cardio) or blood vessels (vascular). The major preventable risk factors for cardiovascular disease are tobacco smoking, high blood pressure, high blood cholesterol, insufficient physical activity, overweight and obesity, poor nutrition and diabetes. Source: National Health and Medical Research Council website: http://www.nhmrc.gov.au/your_health/facts/cvd.htm

231 Diabetes is a chronic disease, which occurs when the pancreas does not produce enough insulin, or when the body cannot effectively use the insulin it produces. This leads to an increased concentration of glucose in the blood (hyperglycaemia). Type 2 diabetes (formerly called non-insulin-dependent or adult-onset diabetes) is caused by the body's ineffective use of insulin. It often results from excess body weight and physical inactivity. Source: WHO, http://www.who.int/topics/diabetes_mellitus/en/

232 Australian Indigenous HealthInfoNet, Overweight and obesity among Indigenous peoples, http://www.healthinfonet.ecu.edu.au/health-risks/overweight-obesity/reviews/our-review

mothers passing on a genetic imprint to their children that will predispose them to developing chronic diseases like coronary heart disease and diabetes.[233]

2.237 According to the Australian Institute of Health and Welfare, rates of Type 2 diabetes in some Aboriginal and Torres Strait Islander communities are among the highest in the world. In some Indigenous communities as many as one third of the population may have diabetes.[234]

2.238 Queensland Health confirmed to the Committee that,

> There are extraordinary levels of obesity and diabetes in the Torres.[235]

2.239 Overall, the Indigenous population experiences socio-economic disadvantage (including education, employment and income, and housing) and has lower levels of access to health services than the general population. As a group, the population also has higher health risk factors like poor nutrition (including, often, less access to affordable fresh foodstuffs), alcohol consumption and smoking.[236]

2.240 Queensland Health confirmed that Torres Strait Islanders have relatively low access to healthy food such as fruit and vegetables. They told the Committee that virtually everything they consume is imported.

> There has been a very strong change of lifestyle away from a traditional diet to a diet that is centred around the food that is available to people in stores….[including] massive quantities of sugar sweetened drinks.[237]

2.241 Professor Whittaker of the Australian Centre for International and Tropical Health advised the Committee that increasing urbanisation in both [PNG and SI] there too is starting to show the burden of non-communicable diseases as being a double burden to those countries too (with non-communicable diseases comprising about 25 per cent of the burden of disease in both 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 for

233 Queensland Health, Official Transcript, 31 August 2009, p.19.

234 Australian Institute of Health and Welfare (AIHW), http://www.aihw.gov.au/diabetes/index.cfm

235 Queensland Health, Official Transcript, 31 August 2009, p. 14.

236 AIHW website. http://www.aihw.gov.au/indigenous/health/index.cfm

237 Queensland Health, Official Transcript, 31 August 2009, p. 19.

> non-communicable diseases like obesity, diabetes and issues related to tobacco, alcohol and injury.[238]

2.242 Professor Whittaker spoke about the need for preventative health campaigns that take into account the social, cultural and environmental determinants of health in the Pacific context.

2.243 For instance, in some Pacific cultures people do not necessarily value the same body sizes that, from a health point of view, we think are healthy. Rather, big is deemed beautiful because it is associated with wealth and doing well.[239]

2.244 And, not dissimilar to the situation of some remote communities in Australia, healthy foods are not always affordable or available to people in the Pacific.[240]

2.245 The Committee was told that the choices people make surrounding nutrition – be it in the Torres Strait or elsewhere - are not readily amenable to change.[241]

2.246 Both Professor Whittaker and Queensland Health say that the solutions require community engagement,

> That means working and listening with the community…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.[242]

238 Professor Whittaker, Australian Centre for International and Tropical Health, Official Transcript, 11 September 2009, p. 8.

239 Professor Whittaker, Australian Centre for International and Tropical Health, Official Transcript, 11 September 2009, p. 42.

240 This was the subject of a recent inquiry by the House of Representatives Standing Committee on Aboriginal and Torres Strait Islander Affairs, into remote Aboriginal and Torres Strait community stores. See the website for the report's recommendations for improving the situation , http://www.aph.gov.au/house/committee/atsia/communitystores/report/Front%20pages.pdf

241 Queensland Health, Official Transcript, 31 August 2009, p. 19.

242 Queensland Health, Official Transcript, 31 August 2009, p. 19 and Professor Whittaker, Australian Centre for International and Tropical Health, Official Transcript, 11 September 2009, p. 42.

Recommendation 5

The Committee recommends that the Australian government partner with non-government organisations and communities to find nutritional solutions that promote healthy eating and redress malnutrition, in affected areas in the Torres Strait and Papua New Guinea.

Capacity development

2.247 All the evidence to the Committee pointed to the importance of empowering communities and local and national institutions in the two countries to identify their own priorities, and to develop community resilience. Australia's contribution should be to help the countries build their knowledge base, managerial and leadership structures; and to help individuals gain the necessary associated skills. As the Committee found, there are many dedicated health professionals and community leaders in PNG and the Solomon Islands who are working hard to improve local health outcomes. Australia can best help by listening to these people and supporting, rather than directing, their initiatives.