



## **Reproductive Health - Who is Setting the Agenda in Australia**

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The Australian Reproductive Health Alliance was established in 1995/6 as a direct result of the UN Conference on Population and Development, held in Cairo in 1994. It is primarily an advocacy agency – bringing together a wide range of expertise in order to ensure that Australia keeps the faith, as it were, with the undertakings it gave at this conference.

Accordingly, we have been working hard to try and keep the key issues of the conference before the opinion leaders in this country since our establishment. One of the methods used to achieve this has been the establishment and support of an All Party Parliamentary Group on Population and Development. Eventually, this will develop into a ginger group based on the model already existing in UK. Most European countries, Canada and New Zealand now also have such groups and there is a very active Pan African Group, Caribbean Group, Asian Forum and now South American Group. Our Group has been working quite closely with the Asian Forum of Parliamentarians on Population and Development and we hope that this relationship will expand. We are also working hard to support a fledgling group in the Pacific.

What are we trying to do? Mainly advocacy – trying to get the Cairo Program of Action implemented – and as you are probably aware, the Cairo program attempted to shift the focus away from demography and targets towards reproductive health, and empowering women through education and access to choice.

## **WHAT IS 'REPRODUCTIVE HEALTH'?**

What do I mean by 'reproductive health'?

Reproductive health<sup>1</sup> is a state of complete physical, mental and social well being — **not** merely the absence of disease or infirmity — in everything related to one's reproductive system.

Reproductive health includes –

- the ability to have a satisfying and safe sex life, and
- the freedom to have children if, when, and how often one decides.

**It therefore involves the right to be informed of, and have access to –**

- safe, effective, affordable, acceptable family planning methods, and
- health-care which will ensure safe pregnancy and childbirth, and healthy infants.

## **WHAT HAPPENS IF THERE IS NO EFFECTIVE NGO ADVOCACY?**

Without effective and sustained advocacy by NGOs to influence government policy agendas, many governments let reproductive health outcomes slip down the priority tree.

Governments need to be continually reminded of the direct benefits that flow from investment in reproductive health, including not only the health and quality of life benefits but the economic benefits.

Unless strong advocacy is maintained, as ministers and officials change over time, there is a risk that the incoming crop of decision-makers will downsize the government's commitment to reproductive health in favour of other more 'obvious' priorities.

## **WHY ARE SOME NGOS NOT INTO ADVOCACY?**

Yet not all NGOs see advocacy as their natural role. Why not? There can be several reasons for this.

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<sup>1</sup> For a fuller definition, see the definition settled upon in the Program of Action agreed by the International Conference on Population and Development in Cairo in 1994, from which the above is extracted.

First, the NGO may have a well-founded concern that governments and funding bodies will see advocacy as an irritating and unwelcome intrusion by the NGO (especially when the NGO had previously confined itself to service delivery or general education) and that support for the NGO could diminish as a result of so-called 'inappropriate' political activity.

Second, the NGO may feel that it simply doesn't have the time, energy or expertise to extend itself into advocacy without over-stretching its resources, and that its other functions may suffer as a result.

Third, the NGO may have a limited vision of the potential role of NGOs generally, and may not have thought about what it could achieve through advocacy.

### **COMBINING SERVICE DELIVERY WITH ADVOCACY**

Let us look at some harsh facts of life.

First, the fact of the matter is that governments **do** see NGOs as intrusive when they become involved in advocacy.

Second, it's also a fact that, in practice, it's almost impossible for an NGO to combine advocacy with service delivery.

There are two main reasons for this —

- first, if you're an NGO running family planning clinics and your funding is confined to service delivery, it is hard for you to get funding for advocacy from any government source
- second, the demands of meeting your clients' day-to-day needs — especially in a region where unmet need for family planning and other reproductive health services is monumental and your funding miniscule — will so consume your mental and physical energies that you'll simply have no energy left for advocacy. To put it more bluntly, when you're up to your arse in alligators, it's very hard to concentrate on persuading governments to drain the swamp!

Only a few, mainly European, NGOs have succeeded in combining service delivery with advocacy — such agencies tend to have two clearly distinct and separate funding lines —

- with funding from US foundations they pursue advocacy — mainly in their own countries and in fora associated with the European Union
- in Africa and elsewhere, they provide service delivery — funded by entirely separate sources.

## IS NGO ADVOCACY WORKING? IF NOT, WHY NOT?

Currently, NGO advocacy is failing dismally all over the world, except in the Netherlands and some Scandinavian countries. Why?

In Australia we are failing for three reasons —

- Firstly, there is no political will to take seriously the commitments which Australia (and other countries) made at the 1994 Cairo United Nations International Conference on Population and Development.
- Secondly, because of **perceived** opposition by right-wing mainly religious groupings. I say 'perceived' because politicians and other leaders are taking the views of the church hierarchy as representing the views of the **members** of the church, when in fact there is a huge gulf between the official church position - what the church **tells** its members to do and think - and what the members **actually** do and think. For instance, in nearly all developed countries, the percentage of Catholics who use contraceptives is similar to non-Catholics, despite the church hierarchy's current position on contraception.
- Thirdly, Australia today is following the more restrictive and conservative US model for the funding of reproductive health, rather than the more progressive and enlightened European model – even though historically Australia has (on most broad policy issues) tended to be closer to Europe.

The preoccupation with the US approach is quite a recent development in Australia, and I'll be quite blunt about how it came about. It's come about because organisations such as Human Life International have managed to infiltrate our Parliament — with or without the knowledge of some members of the Parliament — and on a much broader base than is generally assumed.

We are all very eager to blame one Tasmanian Senator<sup>2</sup> for Australia's backward stance on family planning and reproductive health issues generally — both domestically, and in our overseas aid program. But in fact there are 30 or 40 members of parliament who actively support his stand on these issues.

**Why?** I believe they do so for several reasons —

- firstly, because of their own personal conservative vision;
- secondly, because of their lack of understanding of the global situation; and
- thirdly, because of their irrational belief in human ingenuity.

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<sup>2</sup> Senator Brian Harradine

Mankind (and I use the term MAN-kind advisedly!) has seemed to often achieve technical solutions to seemingly monumental challenges, and this has led to an almost irrational belief that this will continue indefinitely. Neither a naïve belief in human cleverness, nor looking to the supernatural to save us, constitutes application of the precautionary principle!

There is also a growing belief even amongst some respectable scientific groups that population is no longer an issue - it has been solved. We are far from achieving this even though I admit we have done a lot better than many feared in the seventies. The UN predictions are still looking at a population around 10 billion by 2050. This is even taking into account the current global HIV/AIDs pandemic. This is because of the young age structure of the current population. Even if we overcome the commodity shortages and opposition to good family planning practice and all goes well, we cannot plateau out at much below this figure. I will not go into the other reasons that some people oppose family planning programs domestically. These include both moral issues and also issues surrounding the ageing of Australia's population. Suffice it to say that by international standards, our ageing "crisis" is still minute and many European Countries have been coping with this issue far better than us for a much longer time – this is the subject for another paper!

We also have in Australia an overseas aid agency (AusAID) that does not have a particularly high status within the bureaucracy, and within which population issues (including family planning and reproductive health generally) do not have a particularly high profile. Because of the opposition, most officials within the agency would prefer NOT to deal with reproductive health and one has to play silly games of "hiding" family planning components in maternal and child health programs. However, it is quite understandable that such reluctance exists when one sees the viciousness of some of the questioning recorded in Hansard during the Senate Estimates hearings.

This means that we in Australia subject programs concerned with population-type issues to far more scrutiny than perhaps any other type of program, and we put narrow and restrictive limitations on such programs.

One example of this is our Government's decision not to provide abortion or emergency contraception services through our overseas aid program - even in countries where it's legal to do so.<sup>3</sup> This is despite the fact that both abortion and emergency contraception (although not purpose packed) – are available in Australia!

No one who works holistically in the family planning field believes that these two issues – abortion and emergency contraception – can be ignored, or can be seen outside a continuum of good family planning services.

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<sup>3</sup> The so-called 'morning after pill', which women can take up to 72 hours after unprotected sex to prevent pregnancy.

Despite the fact that Australia agreed to the Cairo Program of Action in 1994, along with 179 other nations, it is falling well behind in meeting its contribution to the target of universal access to reproductive health care by 2015.

## HOW SERIOUS IS THIS FAILURE?

This audience will not need me to remind them that —

- **every minute in the world** 380 women become pregnant, of which 190 did not plan to do so or do not wish for the pregnancy;
- **every minute in the world** 110 women experience a pregnancy-related complication, 40 women have an unsafe abortion, and 1 woman dies from a pregnancy-related cause (including unsafe abortion); and
- **every minute in the world** 10 people are infected with HIV/AIDS, more than 50 per cent of them women and girls.

In the face of these figures, I maintain that we — NGOs world-wide — are failing dismally in our advocacy role, and that governments are failing to respond to these needs.

We're currently failing to meet the most basic contraceptive needs, and there are serious shortages of contraceptive supplies (products) in Asia, Latin America, and Africa.

If we're not meeting **current** needs, we must remember that there will be —

- 28 per cent more potential users of contraception by 2005, and
- 89 per cent more potential users of contraception by 2015.

It is also sobering to realise that a massive 85.2 per cent of funds for the purchase of contraceptive commodities<sup>4</sup> are supplied by only 5 donors. All the other donors in the world — including the World Bank and the governments of all other countries — contribute only 14.8 per cent.

Many countries' overseas development assistance programs insist that only supplies and services from their own countries can be used, which of course limits access to contraceptive commodities considerably.

Many pharmaceutical companies have totally withdrawn from both research into, and supply of, contraceptive products because of pressure from minority groups. And this is a trend that has been evident since at least the 1980s.

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<sup>4</sup> Products (goods, as distinct from services)

Furthermore, many overseas development agencies are insisting on short-term financial sustainability for the programs they fund. This is a quite unrealistic expectation – especially for many of the poorest developing countries, which simply cannot afford contraceptives, particularly when they need foreign currency to buy them.

## WHAT THEN CAN NGO ADVOCACY REALLY ACHIEVE?

So, is there anything realistically that advocacy organisations can do to reverse these abysmal trends?

One thing NGOs can do is to seek funding for advocacy from sources that have committed themselves to advocacy as a legitimate and major focus of their funding activities — from the US foundations, for instance. Funding from the US foundations — a large percentage of which is for advocacy — has risen from US\$100 million in 1995 to over US\$500 million in 2000<sup>5</sup>, a five-fold increase in a mere 5 years.

But it's not just about *funding* for advocacy — it's also about *guts*.

Advocacy agencies must become much braver and more outspoken — both at national and international level — on these issues.

Not only do they have right on their side, but they must expose the opposing forces as being a *minority* — a minority which *need not make national governments fearful*.

## SHOULD WE BE LOOKING FOR FURTHER ALLIES IN OUR ADVOCACY?

While planning on speaking to you here today, I suddenly realised that we could perhaps all make stronger links for advocacy between ourselves. We have some of the top scientific minds in Australia attending this conference. Is there a way we can harness the energy and power of this group so that they can join us in advocating more strongly, particularly in the area of quality and quantity of overseas aid, especially in ensuring that appropriate cognisance is taken by Government of the vast pool of skilled workers, and new relevant technologies we have readily available in this country?

While AusAID handles most overseas aid on a bilateral basis, many large contracts for such programs (some with extensive health components) are tendered out to commercial firms, some of whom have little health expertise. They in turn, tender out those components to consultants. We need to ensure that such consultants come from the widest possible scientific background and have some knowledge of development issues. This is not currently always the case.

We also need people with good scientific backgrounds to counteract some of the amazingly misinformed statements put out by those people who oppose reproductive choice both in the international and domestic contexts.

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<sup>5</sup> US\$99.3 million in 1995, US\$537.9 million in 2000 (estimated)

This means that at the very minimum, we need a mechanism for ongoing dialogue and we also need to be able to act very quickly when required. The whole debacle regarding Mifepristone may not have occurred if the pro-choice advocates could have had more support from scientists who understood and could explain succinctly to politicians in particular that this was a worthwhile option to explore. The drug itself was and is being widely investigated internationally for other uses. As it was, we did get support from a range of excellent health practitioners and scientists, but the Government saw them as being too close to the issue (ie. obstetricians, gynecologists, and other people working directly in the reproductive health field, often themselves being service providers). The thought that ministerial approval must be sought before TGA even begins to evaluate a drug for its scientific efficacy and effectiveness must be as abhorrent to you as it is to me and other people working in my field.

## **CONCLUSION**

In addressing delegates here today, I'm keenly aware of their sincere commitment to our mutual goals. But I'm also aware of the constraints they can experience in speaking out as bravely and honestly as they would like.

The NGO and scientific community must join together – as it's currently doing in Europe and Asia, through emerging networks – to speak out loudly and courageously on these issues at every opportunity, so that the general population of every country becomes vividly aware of the importance of the issues we are facing.

Because until the broader community understands and supports these issues, governments will fail to act.

Thank you for your interest.

# Reproductive health is:

A state of complete physical, mental and social well-being, including –

- ability to have a satisfying and safe **sex life**
- freedom to **have children** if, when and how often one decides

**To that end, the right to be informed of, and have access to –**

- safe, effective, affordable, acceptable **family planning** methods;
- health-care to ensure safe **pregnancy** and childbirth, and healthy infants.

# Every minute in the world

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- **110** women experience a pregnancy-related complication
- **40** women have an unsafe abortion
- **1** woman dies from a pregnancy-related cause (including unsafe abortion)
- **10** people are infected with HIV/AIDS - more than **50%** of them women and girls

# Contraception – future needs

- **28%** more potential users of contraception by **2005**
- **89%** more potential users of contraception by **2015**

# US foundations funding

- **US\$100 million 1995**
- **US\$500 million 2000**
- a five-fold increase in 5 years