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Health, reproduction and amenities

5.1 The Department of Foreign Affairs Defence and Trade's (DFAT) submission stated that: 'Health and education are the foundation blocks for gender equality and women's empowerment'.[1]

5.2 The Burnet Institute asserted that 'health is one of the fundamental rights of every human being', and also noted the 'consequent impact of poor health status on economic and social development'.[2]

5.3 This chapter outlines the major health issues for women and girls, as presented in evidence to the inquiry. By necessity, it does not discuss all health issues relevant to women and girls but focusses on those that witnesses highlighted as major barriers to women's human rights.

5.4 The chapter examines:

- the importance of good health for women and girls;
- reproductive health, including birth care, family planning, safe abortion and sex education for young people;
- care and medical support for survivors of violence;
- health issues for refugees and those in conflict zones;
- child health, stunting and nutrition;
- disease and disability; and
- sanitation and infrastructure.

5.5 The chapter then considers achievements in promoting the health of women and girls, as well as examples of programs that appear to be making a difference.

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1 Department of Foreign Affairs Defence and Trade (DFAT), *Submission 27*, p. 25.

2 Burnet Institute, *Submission 47*, p. 2.

The importance of good health

5.6 Access to reliable health care is critical for all people, including women and girls. The Gavi Vaccine Alliance (Gavi) affirmed:

> Poor health is a key barrier to the enjoyment of human rights and social and economic advancement for women and girls in developing nations within the Indian Ocean - Asia Pacific region.[3]

Gavi also asserted that poor health can have:

> … a devastating impact not only on the physical wellbeing of women and girls but also, as they are often the care providers, on their capacity to generate income and participate in community life including education.[4]

5.7 DFAT explained that good health is critical to 'improving livelihoods, enabling poor people to participate in the economy, and lifting living standards'.[5]

5.8 The Department explained that it invests in health through the aid program 'so that women, men and children can achieve better health and live healthy and productive lives'.[6]

5.9 The Burnet Institute emphasised that, as a founding member of the World Health Assembly, 'Australia recognises health as a universal human right'. It further pointed out that:

> Every country in the world is now party to at least one human rights Treaty that addresses health-related rights. This includes the right to health as well as other rights that relate to conditions necessary for health.[7]

Health challenges for women and girls

5.10 Witnesses to the inquiry emphasised that women and girls' health care needs differ to those men and boys. This is especially true in regards to reproductive and sexual health.[8]

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3 Gavi Vaccine Alliance (Gavi), *Submission 80*, p. 1.

4 Gavi, *Submission 80*, p. 2.

5 DFAT, *Supplementary Submission 27.2*, pp. 18–19.

6 DFAT, *Supplementary Submission 27.2*, p. 18.

7 Burnet Institute, *Submission 47*, p. 5.

8 See, for instance, International Sexual and Reproductive Health and Rights (ISRHR) Consortium, *Submission 52*, p. 3.

5.11 The Secretariat of the Pacific Community (SPC) expressed frustration that healthcare planning in the Pacific tends to fail to account for the specific health needs of women. They said:

> Despite the tremendous health issues faced by women in the Pacific, regional health dialogues and frameworks for action on various aspects of health in the Pacific are largely gender-blind —that is, they do not consider gender—and there is limited technical expertise in gender and health at regional and national levels. Existing and new health initiatives designed at both national and regional level do not integrate a gender perspective nor do they deliver gender-specific outputs.[9]

5.12 Some of the most significant health issues faced by women and girls in the Indo–Pacific, including the various facets of reproductive and sexual health, are discussed below.

Reproductive health

5.13 A number of witnesses to the inquiry highlighted the critical role of reproductive health in promoting development around the world, as well as advancing women and girls' human rights. Marie Stopes International stated:

> It is widely agreed that advancing reproductive rights is a pre-requisite for poverty reduction, equitable economic development, and the success of other development initiatives.[10]

5.14 Marie Stopes pointed out:

> The United Nations has explicitly defined the right to sexual and reproductive health as a fundamental part of the right to health, and denial of reproductive rights as a form of torture.[11]

Birth care

5.15 Sadly, many women in the Indo–Pacific region die from complications associated with having children. DFAT stated that:

> Each year more than 280 000 women around the world die as a result of complications during pregnancy and childbirth. Satisfying the global unmet need for contraception could reduce maternal deaths by an estimated 30 per cent.[12]

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9 Secretariat of the Pacific Community (SPC), *Submission 24*, p. 13.

10 Marie Stopes International, *Submission 40*, p. 2.

11 Marie Stopes International, *Submission 40*, p. 2.

12 DFAT, *Submission 27*, p. 39.

5.16 The Burnet Institute noted that: 'Maternal causes are the second leading cause of death in women globally between the ages of 15 and 49.'[13] The Australian Council for International Development (ACFID) indicated that one third of these deaths occur in the Asia Pacific region.[14]

5.17 In many locations, maternal and infant mortality are high due to isolation and lack of medical facilities. Dr Sarah Dunn from Youth With a Mission (YWAM) Medical Ships explained to the Committee how this sometimes happens in Papua New Guinea (PNG):

> I would particularly like to paint a picture of the Gulf and Western provinces. There we might be seeing a woman who is giving birth to her baby in a bush and in a fabricated small hut there. She would be on a couple of planks of wood, sitting on top of some quite deep mud, often with a few banana palms over the top to shelter her from the rain. She has birthed her child and she has the baby in hand, but unfortunately the baby is inside the bag from inside the uterus and the placenta has not come out yet. Her placenta has been unable to contract and slowly but surely she is bleeding out her life onto that bush floor. This happens all around the world.[15]

5.18 The SPC listed the leading causes of maternal mortality in the Pacific, which are:

- post-partum haemorrhage;
- pre-eclampsia;
- obstructed labour;
- puerperal sepsis; and
- complications from unsafe abortions.[16]

5.19 The Churches Agency Network asserted that, in PNG 'the risk of death during childbirth is exceptionally high'. This is because the maternal mortality rate is 733 deaths per 100 000 women (the highest in the Pacific), with the second highest rate being in Kiribati, with 250 deaths per 100 000 women.[17] The SPC added that the Solomon Islands, Vanuatu, and Federated States of Micronesia also 'have high maternal mortality'.[18]

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13 Burnet Institute, *Submission 47*, p. 5.

14 Australian Council for International Development (ACFID), *Submission 25*, p. 12.

15 Dr Sarah Dunn, Partner Relations and Field Strategy, Youth With a Mission (YWAM) Medical Ships, *Committee Hansard*, Canberra, 18 June 2015, p. 2.

16 SPC, *Submission 24*, p. 12

17 Churches Agencies Network, *Submission 12*, p. 3.

18 SPC, *Submission 24*, p. 12.

5.20 The Churches Agency Network pointed out that only 53 per cent of births in PNG are attended by skilled birth attendants, noting there is a 'direct correlation between poor maternal mortality rates and a lower percentage of births attended by skilled health personnel'.[19]

5.21 Banteay Srei reported that maternal mortality rates 'remain unacceptably high at 206 deaths per 100 000 live births', in Cambodia. The submission attributed this figure to the 'lack of skilled, well-trained birth attendants and midwives, not enough functioning health facilities and financial barriers'.[20]

5.22 Maternal mortality is also a significant problem in the Democratic Republic of Timor-Leste. The Secretary of State for the Promotion of Equality from the Democratic Republic of Timor-Leste indicated that there were still 'significant challenges' in Timor-Leste for women in accessing quality healthcare services, as well as a high adolescent fertility rate. The Secretary of State for the Promotion of Equality was concerned that '[t]here are few doctors that specialize in reproductive health at the district level and services for women's health are weak throughout Timor-Leste'.[21]

5.23 The Secretary of State further advised that the maternal mortality rate in Timor-Leste is around '300 maternal deaths per 100 000 births', this rate is a '100 per cent higher than the regional average in Southeast Asia'. The Secretary also noted that, 'Timor-Leste also has the highest population growth in the region, with over 46 per cent of the population aged under 14 years'.[22]

5.24 The SPC reported that access to trained birth care specialists has increased in most countries in the Pacific region 'compared to the 1990s', with nine countries reporting rates over 90 per cent, and the Cook Islands, Nauru, Niue and Palau reporting 100 per cent 'skilled birth-attendant rates'. However, SPC also reported that access to skilled birth attendants has actually regressed in the Federated States of Micronesia, PNG and Vanuatu. SPC revealed that:

> According to the 2012 MDG Tracking Report, Kiribati, Solomon Islands and Vanuatu reported rates below 90 [per cent] and PNG less than 50 [per cent]; the latter three countries are regressing.[23]

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19 Churches Agencies Network, *Submission 12*, p. 3.

20 Banteay Srei, *Submission 51*, p. 7.

21 Secretary of State for the Promotion of Equality (SEPI), Democratic Republic of Timor-Leste, *Submission 45*, p. 2.

22 SEPI, Democratic Republic of Timor-Leste, *Submission 45*, p. 3.

23 SPC, *Submission 24*, p. 28.

5.25 The SPC reported on the development of the *Pacific Sexual Health and Wellbeing Shared Agenda 2014-2018*, which aims to 'address sexual and reproductive health needs in the region'. The Secretariat reported that:

> The Shared Agenda sets out the vision for addressing sexual health in the region, as identified by 22 Pacific Island governments, regional partners, civil society organisations and at-risk groups.[24]

5.26 DFAT reported that Australia runs a 'Maternal and Neonatal Health Program' in Indonesia, which 'aims to make pregnancy and childbirth safer for poor women by increasing the number of women giving birth with the help of skilled birth attendants and in health facilities'.[25] DFAT reported that, from 2009 to 2012, approximately 130 000 pregnant women and 99 000 babies have 'benefited from the program'. Also that, during 2012–13, 'an additional 27 530 births were attended by skilled birth attendants'.[26]

Contraception and family planning

5.27 Evidence suggested that access to safe, reliable contraception, and the freedom to plan the number and spacing of children a woman has, is critical for women's human rights. DFAT stated:

> Access to family planning services … has important flow-on effects for women's empowerment, enhancing their ability to participate in public life and the economy.[27]

5.28 The International Sexual and Reproductive Health and Rights (ISRHR) Consortium agreed, stating that: 'Sexual and reproductive health and rights saves lives, empowers women, and lifts women and their families out of poverty'.[28]

5.29 ACFID emphasised that: 'Family planning is recognised as one of the most cost-effective approaches to improving maternal health'.[29] ACFID suggested that: 'Each dollar invested in family planning can save up to four dollars in health expenditure', which is money that would otherwise have been spent on 'pregnancy services, delivery care and treating complications from unsafe abortion'.[30]

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24 SPC, *Submission 24*, p. 28.
25 DFAT, *Submission 27*, p. 42.
26 DFAT, *Submission 27*, p. 42.
27 DFAT, *Submission 27*, p. 27.
28 ISRHR Consortium, *Submission 52*, p. 1.
29 ACFID, *Submission 25*, p. 11.
30 ACFID, *Submission 25*, p. 11.

5.30 Further, ACFID argued that meeting the contraceptive needs of all women and men globally could save approximately AUD $12 billion 'in maternal and newborn health services alone'. The submission further suggested that 'family planning is widely regarded as a key driver of equitable economic development and poverty reduction'.[31]

5.31 The ISRHR Consortium advised that the return on investments in sexual and reproductive health is very significant, saying:

> Emerging evidence indicates an economic return of US $20 for every US $1 invested in sexual and reproductive health, in large part due to increased productivity, making it one of the most cost-effective investments in global health and development.[32]

5.32 Marie Stopes International argued that:

> … there is huge opportunity for Australia to play a greater role in expanding access to sexual and reproductive health services in the Indian Ocean–Asia Pacific region.[33]

5.33 World Vision explained that Pacific island states such as Kiribati and Tuvalu have an 'unmet need for family planning' that is 'on par with such volatile regions of the world as the Democratic Republic of Congo, Chad and Sudan'. It also highlighted the situation in Samoa, where '48 per cent of sexually active women—the highest percentage in the world—report an inability to access family planning'.[34]

5.34 World Vision also reported that adolescent pregnancies are increasing in the Pacific, 'as recent studies find that 50 births occur per 1 000 women aged 15–19 years in Nauru, Papua New Guinea, Solomon Islands and Vanuatu'.[35]

5.35 Family Planning NSW presented research from Tuvalu and Samoa Family Planning which found the following barriers to women and girls achieving their sexual and reproductive health rights:

- Men are the decision makers in all aspects of life and at all levels of society, and therefore women may not be given the option to use contraception to manage family size and birth spacing. They may not be able to attend medical appointments for serious reproductive health issues or negotiate or even consent to safe sex.
- Cultural and religious norms do not always support sexual and reproductive health and rights. For example, unmarried

31 ACFID, *Submission 25*, p. 11.

32 ISRHR Consortium, *Submission 52*, p. 8.

33 Marie Stopes International, *Submission 40*, p. 5.

34 World Vision, *Submission 37*, p. 10.

35 World Vision, *Submission 37*, p. 10.

> adolescents may not be provided with contraception by health workers who bring their own prejudices and practices to their decision making. Condoms may not be promoted as a way of preventing STIs [Sexually Transmissible Infections] including HIV [Human Immunodeficiency Virus].[36]

5.36 The SPC explained that contraceptive use in the Pacific region is below 50 per cent, 'and rates of sexually transmitted disease STI rates continue to be high—up to 30 per cent in some cases'.[37] Fertility rates in many Pacific Island countries also remain relatively high 'with nine countries, including Papua New Guinea, having rates of four or more births per woman'.[38]

5.37 Citing a study published by the journal *Reproductive Health*, the Secretariat suggested that 'preventing unintended pregnancies in Vanuatu and the Solomon Islands could save up to US $112 million in health and education expenditures between 2010 and 2025'.[39]

5.38 Banteay Srei highlighted the problem of limited access to sexual and reproductive health products and services in Cambodia, 'particularly for women in rural areas'. It reported that only 35 per cent of married women have access to modern contraception, with at least 17 per cent of married women unable to obtain these products.[40]

5.39 ACFID suggested:

> Financial constraints, social norms, restrictive legislation and policy, weak health systems and geographical and physical obstacles are all barriers to accessing sexual and reproductive health information, counselling and services. In crisis and disaster situations, these barriers are multiplied while vulnerability to sexual violence and other gender-based and reproductive health risks are increased.[41]

5.40 DFAT reported that:

> In our region there are still more than 132 million women with an unmet need for family planning. The impact of fully meeting the need for sexual and reproductive health services in South and South East Asia alone could reduce maternal deaths from 130 000 to 30 000; cut unintended pregnancies by almost 75 per cent; and halve newborn deaths.[42]

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36 Family Planning NSW, *Submission 56*, p. 4.
37 SPC, *Submission 24*, p. 13.
38 SPC, *Submission 24*, p. 12.
39 SPC, *Submission 24*, p. 11.
40 Banteay Srei, *Submission 51*, p. 6.
41 ACFID, *Submission 25*, p. 11.
42 DFAT, *Submission 27*, p. 39.

5.41 DFAT advised that Australia had 'provided over AUD $370 million to support maternal and child health in developing counties in 2012-13.'[43]

Abortion

5.42 Without the ability to prevent unwanted pregnancies, many women look to abortion. The Burnet Institute reported that:

> … there are more than 80 million unintended pregnancies every year (41 [per cent] of all pregnancies), half of which end in induced abortion. Almost half of these abortions are clandestine and performed under unsafe conditions and associated with high rates of injury and death.[44]

5.43 In fact, the Burnet Institute estimates that 'every year, an estimated 47,000 women die as the result of unsafe abortions'.[45] These deaths are generally due to 'severe infections, bleeding and organ damage caused by the procedure'.[46]

5.44 ISRHR Consortium stated that: '[r]estrictive abortion laws are in place in 85 per cent of countries in the Indian Ocean–Asia Pacific region'.[47]

5.45 According to Marie Stopes, 'political and social opposition' to reproductive health can hinder the 'delivery of life saving services'. The submission observed:

> In developing countries with restrictive family planning and abortion policy, women are more likely to suffer negative health consequences associated with multiple, unplanned pregnancies, including as a result of unsafe abortion. In these environments, abortion rates are higher and, as they are unregulated, are generally unsafe. In contrast, countries with more liberalised family planning and abortion policy, such as Western Europe and Australia, have much higher contraceptive use and lower abortion rates.[48]

5.46 Professor Michael Toole, Deputy Director of the Burnet Institute, asserted that Australia should play a significant role in enhancing access to family planning and safe abortion in the region. Professor Toole also raised a concern about the possibility that Australia's diplomats may be risk averse

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43 DFAT, *Submission 27*, p. 40.

44 Burnet Institute, *Submission 47*, p. 7.

45 Burnet Institute, *Submission 47*, p. 7.

46 Burnet Institute, *Submission 47*, p. 9.

47 ISRHR Consortium, *Submission 52*, p. 3.

48 Marie Stopes International, *Submission 40*, p. 6.

when it comes to promoting family planning, such as through safe abortions.[49]

Sex education

5.47 Witnesses highlighted the lack of appropriate sex education in many regions. The ISRHR Consortium pointed out that while over a quarter of the population in the Indian Ocean–Asia Pacific region are aged 10-24 years, 'many lack access to high quality, youth-friendly sexual and reproductive health information and services'.[50]

5.48 The Burnet Institute emphasised the need for reliable, quality information, observing that:

> The most basic needs of adolescents, regardless of culture, age and marital status, are for accurate and complete information about their body functions, sex, safer sex, reproduction and sexual negotiation and communication skills.[51]

5.49 The Institute argued that gender-aware 'comprehensive' sex education programs:

> … have been demonstrated to have a positive impact not only on knowledge and attitudes, but also contribute to safer sexual practices (such as delaying sexual debut, reducing the number of partners, and increasing condom and contraceptive use) and can also reduce the negative consequences of unsafe sex.[52]

5.50 The ISRHR Consortium emphasised the need for 'school-based comprehensive sexuality education', particularly for adolescent girls who 'experience high rates of forced and coerced sex and poor access to family planning and safe abortion services'.[53]

5.51 A lack of sex education or ill-informed sex education can lead to misconceptions and superstition regarding contraceptive use. Family Planning NSW reported that, in some parts of the Pacific, women avoid 'modern methods of contraception because they believe contraception can cause birth deformities'.[54]

5.52 The Burnet Institute cited evidence from Vanuatu, where:

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49 Professor Michael James Toole, Deputy Director, Burnet Institute, *Committee Hansard*, Melbourne, 3 November 2014, p. 44.

50 ISRHR Consortium, *Submission 52*, p. 4.

51 Burnet Institute, *Submission 47*, p. 12.

52 Burnet Institute, *Submission 47*, p. 4.

53 ISRHR Consortium, *Submission 52*, p. 4.

54 Family Planning NSW, *Submission 56*, p. 5.

> … adolescent boys and girls are less likely [than adults] to have heard family planning messages in the media, and less than 25 per cent of girls have discussed family planning with a health worker.[55]

5.53 The Institute also revealed that adolescents are less likely than adults to access condoms 'through lack of knowledge, shyness or social prohibitions'.[56]

5.54 Other research cited by the Burnet Institute highlighted the necessity of reaching out to boys as well as girls 'to promote shared responsibility for prevention of early and unintended pregnancy'.[57]

5.55 The SPC reported that there is a paucity of 'youth-friendly information, services and contraception' for young people in the Pacific region. It further cited research indicating that many young people 'lack control over their sexual and reproductive health'. For instance, studies conducted by UNICEF in the Solomon Islands, Vanuatu and Kiribati found:

> … between 38 [per cent] and 45 [per cent] of sexually active youth had experienced forced sex, with approximately 20 [per cent] reporting their first sexual encounter as forced.[58]

Violence and health

5.56 As discussed in chapter three, women and girls experience violence at unacceptably high rates in the Indo–Pacific region. A number of witnesses to the inquiry submitted that women who have experienced violence have specific health needs.

5.57 The ISRHR Consortium claimed that sexual and gender-based violence has 'significant, negative physical consequences' resulting in:

> … unintended pregnancy, infertility, poor health outcomes for children, sexually transmitted infections (including HIV) and implications for mental health.[59]

5.58 Médecins Sans Frontières (MSF) noted that survivors of sexual and gender-based violence 'can suffer both acute and long-lasting medical and psychological consequences', highlighting the need for 'adequate and

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55 Burnet Institute, *Submission 47*, p. 10.

56 Burnet Institute, *Submission 47*, p. 11. For example, see information on survey concerning adolescent use of condoms in the Philippines.

57 Burnet Institute, *Submission 47*, p. 10.

58 SPC, *Submission 24*, p. 13.

59 ISRHR Consortium, *Submission 52*, p. 4.

timely care' to avoid lasting impacts on the individual and people around them.[60]

5.59 MSF explained:

> Rape, due to its violent nature, is likely to involve a higher risk of HIV than consensual sex due to possible genital injuries. The risk of infection with other sexually transmitted diseases also exists. The risk is further increased in the case of gang rape.[61]

5.60 The ISRHR Consortium revealed that sexual and gender-based violence also 'acts as a barrier to accessing sexual and reproductive health services'.[62]

5.61 The UN Pacific Gender Group was particularly concerned about the lack of appropriate services for survivors of sexual and gender-based violence in the Pacific, especially PNG, noting:

> Despite the severity and extent of the violence, services for survivors are limited and virtually non-existent in remote areas. This is of particular concern as 80 [per cent] of Pacific Islanders live in rural areas or on outer islands.[63]

5.62 MSF cited data confirming that there is a 'high level of need' for medical care for sexual and gender-based violence in PNG:

> Close to 19 000 FSV [family and sexual violence] consultations have been provided in MSF-supported clinics since 2007. Between the three current projects in Tari, Maprik and Port Moresby, MSF treats an average of 130 cases of family and sexual violence per month, 57 of which are for rape.[64]

5.63 MSF added that 'an alarmingly large number of [sexual violence] survivors are children', advising that:

> The rate of children below 18 years seen by MSF in the Regional Treatment and Training (RTT) supported facilities in the National District Capital was 53 [per cent] of all rape survivors in February 2014 and 65 [per cent] of all rape survivors in March.[65]

5.64 According to the UN Pacific Gender Group, most health service agencies in the Pacific 'do not have units responsible for addressing special needs of [gender-based violence] victims'. This means that victims are often

60 Médecins Sans Frontières (MSF), *Submission 38*, p. 1.

61 MSF, *Submission 38*, p. 5.

62 ISRHR Consortium, *Submission 52*, p. 4.

63 UN Pacific Gender Group, *Submission 49*, p. 2.

64 MSF, *Submission 38*, p. 3.

65 MSF, *Submission 38*, p. 3.

treated in hospital emergency departments without 'counselling or follow-up'.[66]

5.65 The Group also expressed concerns about:

> [The] physical and social proximity of healthcare staff to the local communities means that healthcare professionals in small and medium size healthcare facilities often harbour some of the same views and stigmatize survivors as do local communities and family members.[67]

5.66 Witnesses asserted that prompt medical attention after an assault (within 120 hours) reduces the chances of contracting a disease, in particular HIV,[68] and can prevent unwanted pregnancy through the use of emergency contraception.[69]

5.67 MSF emphasised the need for a multi-pronged approach to caring for survivors of sexual and gender-based violence. MSF recommends that survivors should receive five essential services 'in one session as a minimum level of care'. These services should include, 'medical first aid; psychological first aid; prevention of HIV and other STIs; vaccination against hepatitis B8 and tetanus, and emergency contraception to prevent unwanted pregnancies that are the result of rape.'[70] MSF stated:

> While the national and provincial governments [of PNG] have made improvements in the medical care of FSV [family and sexual violence] survivors, there is still a very long way to go. Currently, due to the scarcity of Family Support Centres (FSCs) across the country, access of FSV survivors to all of the essential services in a timely manner is not assured. This can lead to unnecessary further suffering, illness and even death. All of which is preventable.[71]

5.68 The UN Pacific Gender Group explained that while there is capacity development taking place in some Pacific Island countries, 'very few have the full package of essential services associated with a robust health response'.[72]

5.69 The Group also voiced concerns that healthcare facilities 'do not conduct evidence collection in the cases of sexual/physical GVB [gender-based violence]'. According to the Group, most healthcare facilities 'lack policies,

66 UN Pacific Gender Group, *Submission 49*, p. 8.
67 UN Pacific Gender Group, *Submission 49*, p. 9.
68 MSF, *Submission 38*, p. 3.
69 MSF, *Submission 38*, p. 5.
70 MSF, *Submission 38*, p. 4.
71 MSF, *Submission 38*, p. 1.
72 UN Pacific Gender Group, *Submission 49*, p. 8.

equipment and trained professionals (including legal literacy) necessary for conducting forensic medical examination'. This can impede any investigations of the crime.[73]

5.70 The poor services for survivors of sexual and gender-based violence in PNG must be seen in context. The MSF pointed out:

> For a population nearing 7 million, PNG has less than 400 doctors of which only 51 work outside Port Moresby, despite 87 percent of people living in rural areas. That's one doctor per 17 068 people, compared to one per 302 in Australia … Within this overall context, there is a specific shortage of healthcare workers trained in working with FSV survivors.[74]

5.71 According to MSF, PNG faces a massive challenge in hiring and retaining health workers with knowledge in the family and sexual violence field:

> Despite the widespread nature of sexual violence across PNG, medical and counselling staff do not currently receive specific training on working with survivors of FSV.[75]

5.72 The Secretary of State for the Promotion of Equality in Timor-Leste also expressed concern about sexual and gender-based violence in Timor-Leste and reported a strong need for '[s]ervices to address the needs of victims that are easily accessible and confidential and supported by trained professionals'.[76]

Conflict zones and refugees

5.73 The inquiry heard evidence that women and girls who are displaced, and those in conflict or disaster zones, can be particularly vulnerable to violence and health issues. Marie Stopes International explained:

> In times of crisis, women are more vulnerable to sexual violence and face an increased spread of sexually transmissible infections, whilst struggling to access family planning and safe childbirth services.[77]

5.74 According to Marie Stopes, women in crisis situations often lack access to contraceptives, while the need for them increases, because:

73 UN Pacific Gender Group, *Submission 49*, p. 9.

74 MSF, *Submission 38*, p. 6.

75 MSF, *Submission 38*, p. 6.

76 SEPI, Democratic Republic of Timor-Leste, *Submission 45*, p. 1.

77 Marie Stopes International, *Submission 40*, p. 7.

> … many women would prefer not to have children under conditions of crisis, since their newborn would be exposed to stressful—and even harrowing—circumstances.[78]

5.75 Consequently, the number of unsafe abortions increases. According to Marie Stopes, unsafe abortions are 'responsible for up to 50 per cent of maternal deaths in refugee settings'.[79]

5.76 ACFID confirmed that, in crisis and disaster situations, barriers to reproductive services and contraception 'are multiplied while vulnerability to sexual violence and other gender-based and reproductive health risks are increased'.[80]

5.77 Marie Stopes noted that an estimated 80 million people needed humanitarian assistance in 2014, and three quarters of these were women and children. Among those of childbearing age in crisis or refugee settings 'one in five is likely to be pregnant'. Marie Stopes contended:

> The well-being and lives of these women and their babies are seriously jeopardised by loss of medical services, often within a context of suffering, ill-health and exposure to violence.[81]

5.78 DFAT informed the inquiry:

> Providing health services to women and children in fragile states and conflict-affected countries, or following disasters, can be especially challenging and needs carefully designed responses.[82]

5.79 Marie Stopes urged the Australian Government to:

> ... leverage its long history of humanitarian work to ensure targeted support that aims to improve access to sexual and reproductive health services in humanitarian and crisis situations.[83]

5.80 A number of NGOs reported that they are working to limit the exposure of women and children to violence in crisis situations. For example, Australian Volunteers International (AVI) explained:

> Along the Thai-Burma border, Australian volunteers are working with local organisations on child protection measures for the large

78 Marie Stopes International, *Submission 40*, p. 7.
79 Marie Stopes International, *Submission 40*, p. 7.
80 ACFID, *Submission 25*, p. 11.
81 Marie Stopes International, *Submission 40*, p. 7.
82 DFAT, *Submission 27*, p. 26.
83 Marie Stopes International, *Submission 40*, p. 7.

> groups of Burmese children who've fled their families or been sent away from their families for an education or to receive care.[84]

5.81 Amnesty International drew the Committee's attention to the treatment of asylum seekers in Malaysia, where, Amnesty argues, the Government detains:

> … vulnerable groups of non-citizens in immigration detention depots, such as children (including unaccompanied minors), pregnant and lactating women, the elderly, and individuals with mental illness and with disabilities.[85]

5.82 The submission maintained that conditions in immigration detention depots 'are poor, with overcrowding, insufficient access to water, poor sanitation, and inadequate medical care, as well as cases of deaths in detention'.[86]

5.83 Amnesty also reported that women asylum seekers often 'choose to give birth outside of the healthcare system' for fear of being reported by hospital authorities, so their children are at risk of becoming stateless. NGOs and health groups within Malaysia are lobbying to have the practice of reporting non-citizen mothers ended. Amnesty explained that asylum seeking women admitted to General Hospital Kuala Lumpur 'continue to be told that they will be detained after delivery, even those who have undergone a Caesarean section delivery'.[87]

Nutrition and child health

5.84 For women in many countries disadvantage starts at, or even before, birth with abortion of female foetuses common in some Asian countries.[88] Girl children who are born in poor countries often have to contend with poverty and poor healthcare. The UN's *Millennium Development Goals Report 2015* found that children from 'the poorest 20 per cent of households are more than twice as likely to be stunted as those from the wealthiest 20 per cent'.[89]

5.85 DFAT emphasised that 40 per cent of the world's child deaths occur in the Indo–Pacific region and over 40 per cent of children under five are stunted in countries such as Timor-Leste, Papua New Guinea and Laos.[90] DFAT

84 Australian Volunteers International (AVI), *Submission 43*, p. 5.

85 Amnesty International, *Submission 74*, p. 14.

86 Amnesty International, *Submission 74*, p. 14.

87 Amnesty International, *Submission 74*, p. 14; for a case study on women's rights to reproductive health in Nepal see p. 15.

88 DFAT, *Submission 27*, p. 44.

89 UN, *Millennium Development Goals Report 2015*, p. 8.

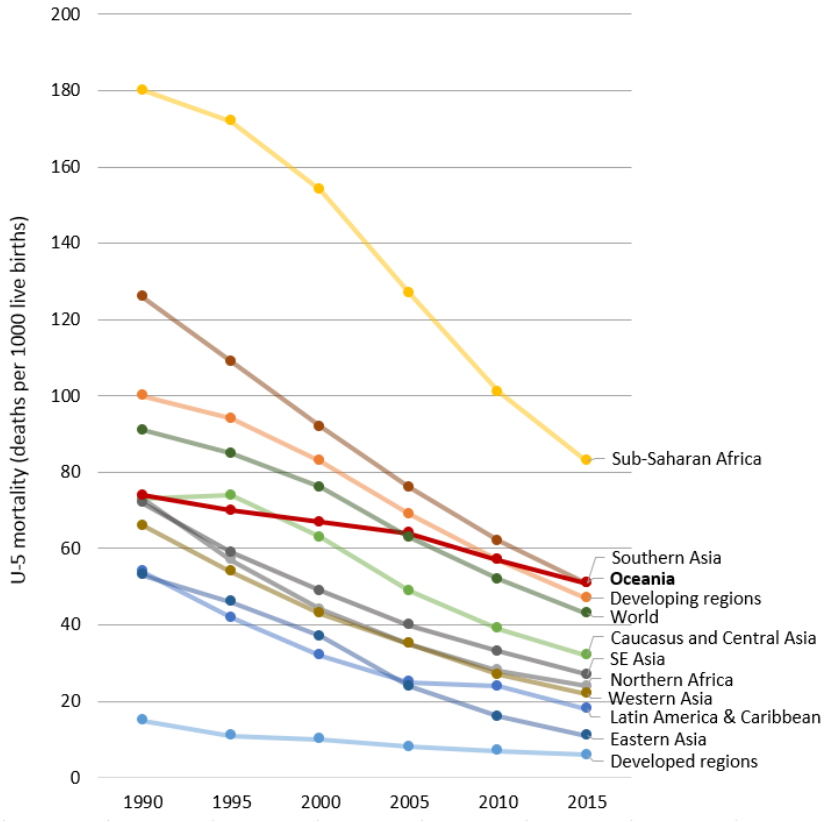
90 DFAT, *Supplementary Submission 27.2*, p. 19.

also stated that more than 1.5 million children die every year due to 'diarrhoeal disease', which is 'the second leading cause of deaths for children under five'.[91]

5.86 Recent work by UNICEF has found that the rates of death among children under five (measured in relation to Millennium Development Goal 4) have fallen more slowly in the countries of Oceania than in any other region. While the child mortality rate (deaths per 1 000 live births) is still higher in Sub-Saharan Africa, that region's rate fell much more sharply since 1990.[92]

5.87 The following table, with data from UNICEF's *Levels and Trends in Child Mortality Report 2015,* illustrates the comparison.

Figure 5.1 Under 5 Mortality by Region (deaths per 1000 live births)



Source: Devpolicy Blog, reporting figures from UNICEF's Levels and Trends in Child Mortality Report 2015.[93]

91 DFAT, *Supplementary Submission 27.2*, p. 19.

92 Camilla Burkot 'Child Mortality in the Pacific Region: Latest UNICEF Findings', *Devpolicy Blog*, 15 September 2015 <devpolicy.org/in-brief/child-mortality-in-the-pacific-region-latest-unicef-findings-20150915/> viewed 29 September 2015.

93 C Burkot, 'Child Mortality in the Pacific Region: Latest UNICEF Findings', *Devpolicy Blog*, 29 September 2015.

5.88 Banteay Srei pointed out that malnutrition is a problem before women give birth, with high rates of malnutrition, especially anaemia, affecting women's reproductive health and productivity.[94]

5.89 The ISRHR Consortium pointed out that children whose mothers have died are 'up to ten times more likely to die prematurely' than children who are cared for by their mother.[95]

5.90 World Vision asserted that the 'economic and social empowerment of women' is linked to good child nutrition and decreases in infant mortality. They argued:

> The impact of women's empowerment on the prospects and wellbeing of a generation is undeniable, and confirms the need for the promotion of the rights of mothers, and all women, to provide a foundation for sustainable economic and social development.[96]

5.91 World Vision further explained that giving women more say over the 'distribution of household resources' has results in improved wellbeing and health outcomes for girls, as 'women more typically favour children'. World Vision reported that:

> … this manifests as increased educational attainment for the children of more highly educated or working mothers, which in turn improves children's long-term prospects for economic participation.[97]

5.92 Witnesses argued that women health care workers are needed to assist in the prevention of child death and maternal mortality. ACFID reported that:

> Bangladesh has reduced its under-five mortality rate by 64 per cent since 1990 with the help of tens of thousands of female health workers who have promoted family planning, safe motherhood and essential care for newborn babies.[98]

5.93 The Australian Government is working on child health in a number of countries in the region. For instance, DFAT reported on the 'PNPM Generasi' pilot community grant program Indonesia, which is designed to improve health and education outcomes. The Department explained that the program was projected to have 'helped 5.4 million women and children attend health clinics and access school' by the end of 2014.[99]

94 Banteay Srei, *Submission 51*, p. 7.
95 ISRHR Consortium, *Submission 52*, p. 8.
96 World Vision, *Submission 37*, p. l4.
97 World Vision, *Submission 37*, p. l4.
98 ACFID, *Submission 25*, p. 12.
99 DFAT, *Submission 27*, p. 42.

5.94 DFAT also explained that robust evaluation had shown that the Generasi program 'reduced rates of childhood malnutrition by ten per cent compared with other communities that did not receive the program'. In light of this success, DFAT reported 'the Government of Indonesia has scaled up the program, matching donor funds dollar for dollar'.[100]

5.95 While malnutrition is a significant concern in many parts of the Indo-Pacific region 'lifestyle diseases' are also a problem in some areas. The SPC reported that:

> Non-communicable diseases, such as diabetes, cancer and heart disease, are a significant concern for the Pacific region, causing eight in every 10 deaths. When not fatal, they can cause disability and poor health. Unhealthy diets, smoking, drinking alcohol and physical inactivity are key causes of non-communicable diseases.[101]

5.96 DFAT shared this concern, pointing out that in the Pacific 'it is estimated that 75 per cent of premature deaths are caused by non-communicable diseases'.[102]

Immunisation

5.97 The Gavi Vaccine Alliance submitted that immunisation is 'one of the most successful and cost-effective public health interventions known, saving 2–3 million lives globally each year'. Gavi argued that the benefits of vaccinating children flow through to society as whole, as women are able to remain more productive if their children are not sick.[103]

5.98 Women whose children are vaccinated are able to be more economically productive, and more productive women are also more likely to vaccinate their children. Gavi explained that:

> … when women are empowered, immunisation coverage overall increases … and the children of mothers who are educated are more likely to be vaccinated and enjoy better overall health.[104]

5.99 Gavi praised 'Australia's commitment to immunisation', saying it has 'helped save millions of lives and contributed to substantial improvements in the human rights, health and development for women and girls within

100 DFAT, *Submission 27*, p. 42.

101 SPC, *Submission 24*, pp. 13–14

102 DFAT, *Supplementary Submission 27.2*, p. 18.

103 Gavi, *Submission 80*, p. 1.

104 Gavi, *Submission 80*, p. 2.

the Indian Ocean–Asia Pacific region'.[105] The Alliance proposed that more investment would see an even greater benefit, saying:

> Harvard University scientists have calculated that investment in Gavi's programmes to expand vaccine coverage in eligible countries will deliver a rate of return of 18 per cent by 2020 —higher than most other health interventions.[106]

5.100 Gavi explained that the Alliance also delivers vaccines that 'directly benefit and empower women and girls', such as the human papillomavirus (HPV) vaccines, which help to prevent cervical cancer. They also support the rubella vaccine to protect pregnant women.[107]

5.101 According to Gavi, an estimated 266 000 women died from cervical cancer in 2012, with more than 85 per cent of those deaths occurring in poor countries 'where women often lack access to cancer screening and treatment services'. The Alliance estimates that, without the HPV vaccines, the death toll could rise to over 400 000 deaths by 2035.[108]

5.102 The SPC explained that rates of cervical cancer among Pacific women caused by HPV are 'among the highest in the world'.[109]

5.103 In addition, 90 000 children are born with birth defects in countries Gavi supports each year because their mothers contracted rubella during pregnancy. Gavi expressed frustration that the vaccine to prevent these disabilities 'has been available since the 1970s but it remains underused in some regions, particularly South Asia'.[110]

5.104 Gavi supports HPV and rubella vaccines in a number of priority countries in the Indo–Pacific. The Alliance reported that:

> Over 20 countries including Laos have already been approved for support. By 2020 it is estimated that over 30 million girls in more than 40 countries will be vaccinated against HPV with Gavi support.[111]

5.105 Gavi also launched new measles/rubella vaccination campaigns in a number of countries in the Indo–Pacific region, including in Bangladesh, Cambodia and Vietnam.[112]

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105 Gavi, *Submission 80*, p. 1.
106 Gavi, *Submission 80*, p. 2.
107 Gavi, *Submission 80*, p. 1.
108 Gavi, *Submission 80*, p. 3.
109 SPC, *Submission 24*, p. 14.
110 Gavi, *Submission 80*, p. 5.
111 Gavi, *Submission 80*, p. 5.
112 Gavi, *Submission 80*, p. 6.

5.106 According to Gavi, its investment priorities align well with the Australian Government's, with countries in the region accounting for 'close to 50 per cent of the total projected demand'.[113]

Disease

5.107 Women and girls experience different risks in relation to some diseases than men. For instance, women are especially vulnerable to certain diseases during pregnancy, such as malaria,[114] and are vulnerable to contracting HIV due to sexual assault and unsafe sexual practices.[115]

HIV/AIDS

5.108 The ISRHR Consortium told the inquiry that HIV/AIDS [Acquired Immune Deficiency Syndrome] is one of the two 'leading causes of death for girls and women of reproductive age' in developing countries—the other being complications that arise from pregnancy and childbirth.[116]

5.109 Uncontrolled levels of HIV transmission have a devastating impact on societies. MSF explained that a high prevalence of HIV within a community, 'can, and does, destroy the social and productive fabric of a country and its workforce'.[117] DFAT asserted that 'the HIV/AIDS epidemic is contributing to excess female mortality in Africa, particularly in young women'.[118]

5.110 Violence perpetrated against women and girls, harmful gender norms promoting unsafe sex, and a lack of access to reproductive health services can all increase the exposure of women and girls to HIV. According to UN AIDS 'HIV-related stigma and punitive legal environments are holding back progress in the regional HIV response.'[119]

5.111 UNAIDS explained that women living with HIV are often denied their 'basic rights':

> In healthcare settings, violations of their sexual and reproductive health rights can include denial of obstetric and gynecologic care or the delivery of substandard care. Healthcare providers may also knowingly or unknowingly misinform them [of] standards of care and pressure patients to undergo unwanted procedures, such as

113 Gavi, *Submission 80*, p. 6.
114 Medicines for Malaria Venture (MFMV), *Submission 5*, p. 1.
115 UNAIDS, *Submission 1*, p. 1.
116 ISRHR Consortium, *Submission 52*, p. 3.
117 MSF, *Submission 38*, p. 3.
118 DFAT, *Submission 27*, p. 276
119 UNAIDS, *Submission 1*, p. 1.

> medically unnecessary abortions or sterilizations, without their full consent.[120]

5.112 Family Planning NSW reported that in the Pacific healthcare workers may discriminate against women living with HIV, refusing to treat them 'because of a perceived risk of infection, or preconceived view about how they acquired the virus'.[121]

5.113 GLASS Research Unit reported 'troubling patterns' of HIV infection in PNG, influenced by a range of 'intersecting factors', including:

> … poor knowledge/education of safe sex practices (whilst the literacy rate for young people is higher than that for older adults, it still remains at around 70 [per cent]; girls are still less likely to even start school); early sexual activity and marriage; polygamy and men having numerous partners; and 'development' - the 'hotspots' for HIV transmission are along the main transportation routes through the country associated with the mining and logging industry and the subsequently high levels of transactional sex.[122]

5.114 RESULTS International Australia Inc indicated that people with HIV are particularly vulnerable to tuberculosis (TB), which is 'currently the leading cause of HIV-related deaths'. RESULTS advised that TB is 'preventable and treatable', and yet it caused 320 000 deaths among HIV-positive people in 2012. RESULTS also reported that the World Health Organisation (WHO) has recently put forward guidelines outlining 'collaborative activities to fight TB and HIV together'.[123]

5.115 Dame Carol Kidu lamented that incidents of tuberculosis, including drug resistant tuberculosis, has increased in the Western Province capital of Daru and in the National Capital District of Port Moresby. She further advised:

> There has been a health department awareness campaign led by the Prime Minister and the governor of the city, about "TB can be cured", "Help to cure TB"[but] I do not know how effective it is.[124]

5.116 MSF reminded the Committee that Hepatitis B is also a health concern for women, and is 'more contagious than HIV'. MSF explained that the

120 UNAIDS, *Submission 1*, p. 2.

121 Family Planning NSW, *Submission 56*, p. 4.

122 GLASS Research Unit, *Submission 7*, p. 10.

123 Results International Australia Inc, *Supplementary Submission 72.3*, p. 3.

124 Dame Carol Kidu, Private capacity, *Committee Hansard*, Canberra, 3 February 2015, p. 12.

vaccination is 'very effective in preventing transmission' if given to victims within 24 hours of an assault.[125]

Malaria

5.117 The Medicines for Malaria Venture (MFMV) submitted that malaria is a significant health problem for women in the Indo–Pacific region. MSMV explained that:

> Malaria takes a child's life every minute. It is estimated that between 610 000–971 000 people die from malaria each year, mostly young children.[126]

5.118 MFMV stated that 'a pregnant woman's risk of infection increases due to changes in her hormone levels and immune system', with first-time mothers particularly vulnerable. MFMV added that there is a higher risk of 'anaemia and miscarriage' in pregnant women with malaria, and that 'their babies are at risk of stillbirth, prematurity, intrauterine growth retardation, and low birth weight'.[127]

5.119 MFMV advised that 67 per cent of the world's 'at risk' population resides in 22 countries in the Asia–Pacific (2.3 billion people). According to MFMV, Southeast Asia is 'the global epicentre for drug-resistant forms' of malaria. MFMV also cited WHO research that demonstrated that, in countries where the incidence of malaria is especially high:

> … the disease accounts for up to 40 [per cent] of public health expenditures, 30–50 [per cent] of inpatient hospital admissions, and up to 60 [per cent] of outpatient health clinic visits.[128]

5.120 MFMV emphasised that malaria limits 'regional economic growth', thus having 'implications for Australian economic diplomacy in the region'.[129]

5.121 In further evidence, Professor Bambrick explained that climate change also affects women disproportionately through the increased spread of mosquito-borne diseases, such as malaria. She said:

> Warmer temperatures intensify transmission of malaria and dengue, for example, and enable disease to spread to new, highly susceptible regions. Women's daily work, collecting water, wood and food, for example, means that they are more often exposed to infection.[130]

125 MSF, *Submission 38*, p. 5.
126 MFMV, *Submission 5*, p. 1.
127 MFMV, *Submission 5*, p. 1.
128 MFMV, *Submission 5*, p. 1.
129 MFMV, *Submission 5*, p. 1.
130 Professor Bambrick, *Committee Hansard*, Canberra, 7 May 2015, p. 17.

5.122 Witnesses highlighted the need for Australia to continue to support efforts to develop effective low cost treatments for use in the Indo–Pacific region and beyond. For instance, MMV recommended the Australian Government:

> Continue to support the Asia-Pacific Leaders Malaria Alliance and investment in the Asia Development Bank's Regional Malaria and Other Communicable Diseases Trust Fund, with a view to expanding support for the development of new malaria medicines as part of an integrated strategy towards malaria elimination.[131]

Disability

5.123 Witnesses submitted that women and girls with disabilities are doubly marginalised. Vision 2020 Australia, for instance, submitted that minority women, including 'ethnic minorities, particular castes, and with a disability, such as blindness or low vision', often have less legal rights, less opportunities for education, and can often be denied access to 'productive resources', like land. Further, that:

> A woman or a girl living with a disability is less likely to be employed than a man with disability, and less likely to be employed than a woman without a disability.[132]

5.124 Witnesses also highlighted the vulnerability of women with disabilities to violence. Banteay Srei cited research conducted in 2013 which 'found that women with disabilities in Cambodia are equally vulnerable to partner violence but much more vulnerable to family violence'.[133]

5.125 CBM Australia and Australian Disability Development Consortium (ADDC) told the Committee that the majority of people living with a disability live in developing countries—'70 per cent of all people and 85 per cent of children'. The joint submission stated:

> While the human rights of women and girls with disability are protected under the [UN Convention on the Rights of Persons with Disabilities] UNCRPD there are significant gaps in implementation. Developing countries in particular need support to assist meeting their treaty obligations. For example, legislation and policy may need to be reviewed as well as finding assistance to implement services and programs.[134]

131 MFMV, *Submission 5*, p. [3].

132 Vision 2020, *Submission 66*, p. 4.

133 Banteay Srei, *Submission 51*, p. 2.

134 CBM Australia and the Australian Disability Development Consortium (ADDC), *Submission 14*, p. 2.

5.126 The SPC highlighted 'consistent reports across the Pacific' that indicated women with disabilities are not receiving the 'same quality of health care as other women'. The Secretariat also referred to the UN Population Fund study *A Deeper Silence* which considered the health status of women with disabilities in Kiribati, Solomon Islands and Tonga. The study identified:

> … a lack of awareness about the needs of women with disabilities and their sexual and reproductive health needs. It was also found that women and girls with disabilities are two to three times more likely to be victims of physical and sexual abuse than those without a disability.[135]

5.127 Witnesses also submitted that girls with disabilities are often less able to access education and training 'than their non-disabled peers'. The SPC cited a survey by the Fiji National Committee on Disabled Persons which found:

> … 57 [per cent] of people with disabilities had received primary education (29 [per cent] of women with disabilities) and 17 [per cent] secondary education (7 [per cent] of women with disabilities). Overall, 13 [per cent] received special education (4 [per cent] women and girls).[136]

5.128 The UN Population Fund study also found that women with disabilities experienced 'additional forms of violence', such as:

> … withholding of medication, medical assistance and reproductive health options, denial of food or water, forced sterilisation and medical treatment, and are vulnerable to sexual assault in institutions.[137]

5.129 CBM Australia and ADDC emphasised the importance of reproductive rights for women with disabilities, stating that 'Article 23 of the UNCRPD reinforces the right of people with disabilities to establish and maintain a family and to retain their fertility on an equal basis with others'. They argued that, despite this protection, forced sterilisation, and other forms of reproductive discrimination, regularly occur, affecting 'the access, level and availability of sexual and reproductive health services'.[138]

5.130 Vision 2020 Australia submitted evidence about the effect of blindness and vision loss on women, stating that around 90 per cent of the world's blind

135 SPC, *Submission 24*, p. 14.

136 SPC, *Submission 24*, pp. 14–15.

137 SPC, *Submission 24*, p. 11.

138 CBM Australia and ADDC, *Submission 14*, p. 4.

and vision impaired people live in developing countries, and two thirds of these people are women.[139]

5.131 Vision 2020 also explained the correlation between blindness and poverty, lack of education, poor access to housing, and limited access to clean water and sanitation, arguing that addressing eye health 'has a significant impact on addressing inequity of opportunities and the potential to act as a catalyst in driving systemic change'.[140]

5.132 Vision 2020 Australia advised that it is working to 'reduce the gender gap' in eye health through the Vision 2020 Australia Global Consortium East Asia Vision Program. This program operates in Vietnam, Cambodia and Timor-Leste.[141]

5.133 CBM Australia and ADD referred to the *WHO Global Disability Action Plan 2014–2021: Better Health for all People with Disability*.[142] According to CBM and ADDC, the plan aims 'to contribute to achieving optimal health, functioning well-being and human rights for persons with disabilities' by working to:

- remove barriers of access to health for persons with disabilities;
- strengthen rehabilitation services; and
- improve collection of data on disability.

The plan also contains 'measures that will focus specifically on women and girls with disability'.[143]

5.134 The SPC explained that several countries in the Pacific are currently undertaking initiatives designed to assist women with disabilities. Some of these initiatives resulted from the 2013 UN Population Fund study.[144] The Secretariat also highlighted Kiribati's *National Development Plan 2012-2015* 'which aims to strengthen support services for women and inclusion for people with a disability in decision-making', and referred to a Draft Kiribati National Disability Policy 2011–2014, developed to 'meet the needs of people with a disability and dismantle barriers to equality'.[145]

5.135 DFAT provided a number of examples of Australian initiatives to address the needs of women with disabilities, including an Australian Development Research Award that supported a comparative study on 'the

139 Vision 2020 Australia, *Submission 66*, p. 3.

140 Vision 2020 Australia, *Submission 66*, p. 2.

141 Vision 2020 Australia, *Submission 66*, p. 4.

142 This Plan, which was not yet finalised when the submission was received, is now available. See <www.who.int/disabilities/actionplan/en/> viewed 25 August 2015.

143 CBM Australia and ADDC, *Submission 14*, p. 4.

144 SPC, *Submission 24*, p. 5, footnote 6.

145 SPC, *Submission 24*, p. 29.

lives of women with disability and those without' in Cambodia. DFAT explained that:

> The study found that women with disability experienced poorer physical and mental health outcomes as a consequence of the violence, and are at increased risk of experiencing high levels of stigma, discrimination and other rights violations. In addition women with disability were found to be 4.2 times more likely to have their activities and whereabouts restricted by partners.

DFAT further explained that the findings of this research were being used to inform new programs in the area of violence against women.[146]

Sanitation and infrastructure

5.136 Another key issue for the health of women and girls is access to safe water and sanitation facilities. Clean water and satisfactory sanitation are essential to prevent disease. DFAT estimated that 'poor sanitation leads to around 700 000 premature deaths globally each year'.[147]

5.137 As an example, Banteay Srei observed that in Cambodia:

> Poor sanitation and hygiene practices, limited access to safe and clean water sources as well as household latrines, further contributes to women's and families' poor health. According [to] the CDHS [Cambodia Demographic and Health Survey] 2010, in rural areas, more than 66 [per cent] of households have no toilet facilities while only 53 [per cent] of households have 'improved sources' of water during the dry season, rising to 76 [per cent] during the rainy season.[148]

5.138 Amnesty International highlighted the inadequate sanitation facilities across much of India, where around '600 million people—over half of India's population—defecate in the open'. Amnesty argued that this practice puts women and girls in harm's way, making them more vulnerable to violence.[149]

5.139 ACFID explained that, around the world, close to '748 million people live without safe water and 2.5 billion live without improved sanitation' and 695 million of these people are in East Asia and Pacific region, 'more than in Sub–Saharan Africa'.[150]

146 DFAT, *Submission 27*, p. 43.

147 DFAT, *Supplementary Submission 27.2*, p. 19.

148 Banteay Srei, *Submission 51*, p. 6.

149 Amnesty International, *Submission 74*, p. 7.

150 ACFID, *Submission 25*, p. 12.

5.140 According to ACFID, this 'is catastrophic, especially for women', because women and girls are twice as likely as boys to be collecting water for their families, an activity that 'consumes a significant amount of their time'.[151] Collecting water and going to the toilet in the open 'puts women at greater risk of disease, shame, harassment and sexual assault'. ACFID argued that '[l]ack of progress in the provision of water, sanitation and hygiene is to the detriment of all other development goals and targets'.[152]

5.141 Professor Bambrick suggested that:

> If you can provide adequate and appropriate sanitation for a community, then you have already cut disease dramatically and you have freed up women's time—you have freed up their caring time; you have freed up the time that they are not spending sick —so they can actually spend more time being economically productive for that community as well.[153]

5.142 A number of witnesses also talked about the need for safe and accessible toileting facilities, particularly for girls attending school. Professor Bambrick explained that girls who want to attend school can be 'put off by the lack of toilets' in many schools, which are ill equipped for the needs of girls, especially once they have started menstruating. The Professor also stressed that '[y]ou need functioning toilets. There is no point going into a place and putting a toilet in there if there is no system to then maintain the toilet'.[154]

5.143 ACFID also asserted that when 'safe sanitation facilities are available in schools, girl's attendance has been shown to increase by up to 11 per cent'.[155]

5.144 World Vision praised recent work by Australia and by international aid providers in establishing separate female toilet facilities in humanitarian and aid programs, which has:

> … reduced [the] threat of sexual assault for women and girls, and has driven declines in cases of girls either missing school during their menstrual cycles or leaving formal education altogether at the onset of puberty.[156]

5.145 GLASS Research Unit examined the impact of climate change on water security, where environmental disasters, erosion and salination limit

151 ACFID, *Submission 25*, p. 12.

152 ACFID, *Submission 25*, p. 13.

153 Professor Bambrick, *Committee Hansard*, Canberra, 7 May 2015, p. 18.

154 Professor Bambrick, *Committee Hansard*, Canberra, 7 May 2015, p. 19.

155 ACFID, *Submission 25*, p. 13.

156 World Vision, *Submission 37*, p. 11.

access for women and their families to fresh water. GLASS provided as an example the Satkhira region of Bangladesh where 'salt water inundation has had a significant impact on fresh water availability and resulted in women having to walk much further to source fresh water'. Examples are also said to be found in the coastal regions of the Pacific 'where storm surges, cyclone activity and salt water intrusion are causing major damage to fresh water stocks'. GLASS argued that these impacts are mostly felt by women and girls who are tasked with retrieving water.[157]

5.146 Professor Bambrick pointed out that 'key drivers of climate change' also directly affect the health of women and girls, saying:

> Burning wood and other biomass fuels for cooking creates dangerous indoor air pollution and kills nearly four million people annually, mostly women and girls. It contributes to poor lung function, tuberculosis and pneumonia.[158]

5.147 ACFID insisted that access to clean water, adequate sanitation and hygiene facilities for women and girls 'is critical to enabling women's full participation in families and communities, and should be a focus of Australian aid initiatives'.[159]

Achievements to date

5.148 Significant achievements have been made in areas relevant to women's health around the world in the last two and half decades, including in the Indo–Pacific region. DFAT submitted:

> In health, dramatic improvements have been made in life expectancy and decreases in child mortality for women and men, girls and boys, in most regions of the world in the last few decades. In most countries girls and boys have the same access to vaccinations and health care in infancy and childhood.[160]

5.149 The UN *Millennium Development Goals Report 2015* recorded significant progress, in that:

- Rates of children dying before their fifth birthday have declined by more than half since 1990—'dropping from 90 to 43 deaths per 1 000 live births'.

157 GLASS Research Unit, *Submission 7*, p. 3.

158 Professor Bambrick, *Committee Hansard*, Canberra, 7 May 2015, p. 17.

159 ACFID, *Submission 25*, p. 12.

160 DFAT, *Submission 27*, p. 26.

- Maternal mortality has declined by 45 per cent worldwide— most of this reduction has occurred since the year 2000.
- 'Over 6.2 million malaria deaths were averted between 2000 and 2015'.
- Tuberculosis prevention, diagnosis and treatment interventions saved 'an estimated 37 million lives between 2000 and 2013'.
- 2.1 billion more people around the world now have access to 'improved sanitation', and the proportion of people defecating in the open 'has fallen almost by half since 1990'.
- Official development assistance (ODA) from developed countries increased by '66 per cent in real terms from 2000 and 2014' to reach $135.2 billion.[161]

5.150 Marie Stopes surmised that the last few decades mark a period of 'strong progress towards improving sexual and reproductive health and rights':

> In the last 20 years for example, 17 countries have reduced restrictive legislation on reproductive health services, and global maternal mortality has declined by 47 [per cent].[162]

5.151 The ISRHR Consortium agreed that there had been improvements in women's health and reproductive rights, while asserting that there was much more to be done:

> Nonetheless, violation against women and girls' sexual and reproductive rights remains a significant issue, and health indicators reveal widespread inequities at both the inter- and intra-national level.[163]

5.152 The Consortium identified that increased political and financial commitments around the world have led to increased access to family planning services, citing countries like Nepal, Cambodia and South Africa, which have improved access to safe abortion services. The Consortium also highlighted South Africa, where the annual number of abortion-related deaths fell by 91 per cent after the abortion law was 'liberalised'.[164]

5.153 The Burnet Institute agreed that maternal deaths have reduced substantially in the last two decades, with the global maternal mortality ratio declining by 47 per cent between 1990 and 2010. The Institute noted, however, that 'this falls short of the reduction needed by 2015 to achieve

161 UN, *Millennium Development Goals Report 2015*: *Summary*, 2015, *passim* <www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20Summary%20web_english.pdf> viewed 30 October 2015.

162 Marie Stopes International, *Submission 40*, p. 7.

163 ISRHR Consortium, *Submission 52*, p. 5. For more detail see case studies, pp. 5–7.

164 ISRHR Consortium, *Submission 52*, p. 5.

the Millennium Development Goal to reduce maternal mortality by three quarters'. Further, according to the Institute, South Asia still accounts for one third of global maternal mortality.[165]

5.154 According to the Burnet Institute, rates of contraceptive use in Asia increased overall from 50 per cent in 1998 to 60 per cent in 2011, although rates varied by country—from 22 per cent in Afghanistan and Timor-Leste, and 38 per cent in Laos, to more than 80 per cent in Thailand and China. As a contrast, the rate of contraceptive use in Sub–Saharan Africa 'increased modestly from 15 to 25 per cent', with higher rates in some countries—45 per cent in Kenya and 34 percent in Tanzania.[166]

5.155 The Burnet Institute also noted that contraceptive use fell in the Oceania region, from 60 per cent in 1990 to 57 per cent in 2011, 'with significant variation between countries, being only 32 per cent in PNG, 34 per cent in Solomon Islands, and 38 per cent in Vanuatu'.[167] The SPC shared these concerns, citing research that shows 'maternal health remains a serious concern across the Pacific Islands region, despite gains made over the past few decades'.[168]

5.156 The SPC reported that '[s]killed birth-attendant rates are improving'. However, as previously noted:

> According to the 2012 MDG Tracking Report, Kiribati, Solomon Islands and Vanuatu reported rates below 90 [per cent] and PNG less than 50 [per cent]; the latter three countries are regressing.[169]

5.157 The Secretariat also asserted that:

- Teenage pregnancy rates are falling in most Pacific countries.
- Positive progress on HIV/AIDS and STIs continues.
- National health-service mechanisms are being improved.[170]

Programs that work

5.158 A number of witnesses to the inquiry provided evidence on the positive impacts of health programs for women and girls. Dame Carol Kidu praised recent work by Australia and New Zealand on:

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165 Burnet Institute, *Submission 47*, p. 5.
166 Burnet Institute, *Submission 47*, p. 7.
167 Burnet Institute, *Submission 47*, p. 7.
168 SPC, *Submission 24*, p. 12.
169 SPC, *Submission 24*, p. 27.
170 SPC, *Submission 24*, pp. 27–28.

> … addressing the ministerial report on maternal mortality, with a very systematic midwifery training program which, from every report I have heard and known about, is having an impact.[171]

5.159 The UN Pacific Gender Group described the Health Systems Strengthening Programme, which is run with the support of the UN Population Fund, UN Children's Fund, and the WHO. This program provides:

> Technical support … to strengthen policy and budget frameworks, commodity security, information systems, workplace training and to implement survivor centered health services. UNFPA has also integrated GBV response into programming for maternal health and adolescent sexual reproductive health programming.[172]

5.160 The UN Pacific Gender Group also described a joint Comprehensive Sexuality Education programme, as part of which the UN Population Fund has been providing support to Pacific Island countries to 'improve the quality and expand access to Comprehensive Sexuality Education' for youth. The program is aimed at:

> … enhancing knowledge, behaviours and attitudes towards sexuality and sexual reproductive health, including sexually transmitted infections and HIV, and include supplementary issues faced by young people such as drug and alcohol use, mental health, gender inequality, violence with emphasis on girls and women, respectful relationships, and personal and community health and safety.[173]

5.161 The Group revealed that the UN Educational, Scientific and Cultural Organisation (UNESCO), the UN Population Fund and UN Children's Fund presented a proposal for a program of work in sex education in the Pacific to Pacific Ministers of Health in April 2014. They reported that the 'Joint Programme was endorsed by the Ministers and efforts are underway to begin implementing it'.[174]

5.162 DFAT emphasised the funding it provides to Marie Stopes International to support sexual and reproductive health in Timor-Leste, where Marie Stopes works in eight out of 13 districts, serving 50 000 clients in 2013. DFAT stated that:

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171 Dame Carol Kidu, *Committee Hansard*, Canberra, 3 February 2015, p. 9.

172 UN Pacific Gender Group, *Submission 49*, p. 12.

173 UN Pacific Gender Group, *Submission 49*, p. 12. More information about the program in PNG is at <www.unfpa.org/news/youth-take-lead-papua-new-guinea> viewed 18 September 2015.

174 UN Pacific Gender Group, *Submission 49*, p. 12.

> Marie Stopes International is responsible for providing around one third of the total contraceptive protection to Timorese couples. This has allowed Timorese families to plan and space their families to avoid an estimated 12 000 unwanted pregnancies, and so prevent around 2000 unsafe abortions.[175]

5.163 Amnesty International University of Western Australia Group (UWA) pointed to promising results from programs in maternal health in the Philippines, including the National Safe Motherhood Programme, where it is estimated that 'seven women die every 24 hours from pregnancy-related causes'.[176]

5.164 The Committee heard from YWAM who reported success working closely with the Government in PNG:

> We are very pleased to report that the national health plan in Papua New Guinea has a strong emphasis on the health of women in particular. There is a key result area within the planning in Papua New Guinea which particularly focuses on women's health and supports not only the local health system but NGOs such as ourselves.[177]

5.165 YWAM explained that its medical ships are reaching into remote parts of PNG providing support, including to new mothers. Dr Dunn advised:

> The maternal child health outreach patrol is getting out into remote spots with contraceptive assistance, assistance with antenatal care and education around safe birthing alongside immunisations.[178]

5.166 AVI described a number of initiatives that are having an effect across Asia and in the Pacific region:

- Bougainville—AVI supports the Sisters of Nazareth to run the Nazareth Centre for Rehabilitation 'providing services to women and children who are the victims of violence', including 'counselling and life skills training and support for repatriation into their communities'. AVI provides Australian volunteers with skills in 'education, horticulture and food security' and 'leadership and human rights for women'.
- Thai–Burma border—AVI provides volunteer psychologists to work with local community-based organisations and international NGOs in five Burmese refugee camps along the Thai–Burma border, 'providing

175 DFAT, *Supplementary Submission 27.1*, p. 1.

176 Amnesty International University of Western Australia Group (UWA), *Submission 58*, p. 2. (data from 2010)

177 Dr Dunn, YWAM Medical Ships, *Committee Hansard*, Canberra, 18 June 2015, p. 2.

178 Dr Dunn, YWAM Medical Ships, *Committee Hansard*, Canberra, 18 June 2015, p. 2.

services to women experiencing violence, and on education programs to prevent violence against women'.[179]

5.167 World Vision described its work in 'Timed and Targeted Counselling (ttC)', which trains community health workers to provide 'comprehensive health and nutrition messages to every pregnant woman and her family in each village supported by World Vision'. This program ensures community health workers provide ten visits to relevant households over a 1 000 day period from pregnancy until the child is two. World Vision advised:

> During visits, CHWs [community health workers] deliver appropriate messages at the right time, which include specific messages about healthy timing and spacing of pregnancy and modern family planning at least once during the pregnancy and two more times in the postnatal period … This approach aims to increase access to post-partum family planning, which protects the mother and child as well as future pregnancies and children from the negative effects of multiple close pregnancies and births.[180]

5.168 Marie Stopes highlighted the recent passing of the *Philippines Responsible Parenthood and Reproductive Health Act*, which it argued represents a 'growing recognition in the region for both the right to and benefits of expanded access to reproductive health services'. Marie Stopes explained that this success followed after many years of 'advocacy and support from NGOs … and at the grassroots level'.[181]

5.169 The ISRHR Consortium offered the example of a program from Laos, which they argued is having some success. The Legal Awareness and Life Skills (LALS) project, run by CARE International, 'has been supporting the empowerment of marginalised urban women in Laos'. The project initially focussed on women in the 'entertainment industry' and later expanded to include garment factory workers. The project worked by 'establishing peer networks and self-help groups' where women could share knowledge and skills on 'laws, women's rights, preventing violence and self-defence, and sexual and reproductive health issues'.[182]

5.170 The Consortium praised this program saying:

> Evaluations revealed that since the start of the project five years ago, entertainment workers, who were typically considered 'bad and dirty' women with no position in society, now have better

179 AVI, *Submission 43*, p. 5.

180 World Vision, *Submission 37*, pp. 10–11.

181 Marie Stopes International, *Submission 40*, p. 6.

182 ISRHR Consortium, *Submission 52*, p. 9.

> self-esteem, no longer feel they deserve to be treated violently and feel they have more influence over what happens to them, such as preventing or escaping violence and negotiating safe sex. They have learnt new skills and knowledge and are using this to help their peers.[183]

5.171 Further, the Consortium argued that as a result of the program, social attitudes towards these women have improved, with the Lao Women's Union now accepting these women as part of their community to be protected.[184]

5.172 DFAT stated that the Australian Government is working hard to promote good health for women and girls in the region. DFAT submitted that the Australian Government had launched the *Health for Development Strategy 2015–2020* on 15 June 2015, which:

> … provides guidance for DFAT policy engagement and investment decisions in health for development to promote prosperity and economic growth. The focus is on strengthening country-level health systems tailored to people's needs, and regional health security to ensure effective regional solutions to trans-boundary health threats.[185]

5.173 According to DFAT, the strategy puts forward a range of ways to strengthen the impact of aid on the health of women and girls, including:

- influencing behaviour change around gender, nutrition, and hygiene and supporting women's leadership in health governance and accountability measures as a priority;
- strengthening civil society organisations that can be active partners and provide women's voice in holding authorities to account for quality, accessible services;
- ensuring that nutrition investments embed gender equality measures in order to respond to the disproportionate effects of poor nutrition on women and girls in many countries; and
- supporting access to sustainable clean water and sanitation, including through addressing affordability issues for women and girls, in order to support economic growth and gender equality in rural and urban areas, especially in small and medium-sized towns.[186]

5.174 Witnesses offered suggestions to the inquiry for how Australia's work can be strengthened and better focussed. Marie Stopes pointed to initiatives

183 ISRHR Consortium, *Submission 52*, p. 9.

184 ISRHR Consortium, *Submission 52*, p. 9.

185 DFAT, *Supplementary Submission 27.2*, p. 19.

186 DFAT, *Supplementary Submission 27.2*, p. 19.

run by United States Aid (USAID) and Norwegian and Danish policy programs, which it argued:

> … offer substantial opportunity to leverage best practice approaches to improving sexual and reproductive health and rights, particularly in terms of combining service delivery, organisational strengthening and policy support in a single program of work. Australia could build on the lessons and successes of existing programs that have proven impact and are cost-effective.[187]

5.175 Marie Stopes suggested the Australia Government should consider supporting:

> … a large scale, multi-country program of work dedicated to advancing the sexual and reproductive health and rights of women and girls in the Indian Ocean–Asia Pacific region.[188]

Working with faith based organisations

5.176 Faith based organisations have significant influence in some of the countries in the Indo–Pacific, and are involved in social welfare and health services provision in some areas. The Committee was interested to hear how faith based organisations are working to improve the health of women and girls in PNG. Representatives from YWAM told the Committee that:

> Church-based health services are a significant rural health provider. We are engaging a lot across that area. Also, the churches do have a significant leadership role in communities, particularly the women's fellowships. There is a strong network there.[189]

5.177 DFAT explained that sexual and reproductive health programs it funds also engage with faith based organisations, including the Marie Stopes program of work in Timor-Leste, which 'involves cooperation with the Catholic Church'.[190]

5.178 The Committee asked YWAM how they go about delivering messages around gender-based violence through faith based organisations. YWAM's representatives stated:

> We do regularly take up opportunities … to raise the dialogue around the value of women and girls and to encourage the men as

187 Marie Stopes International, *Submission 40*, p. 10.

188 Marie Stopes International, *Submission 40*, p. 10.

189 Dr Dunn, YWAM Medical Ships, *Committee Hansard*, Canberra, 18 June 2015, p. 6.

190 DFAT, *Supplementary Submission 27.1*, p. 1.

> champions of championing women and girls. Often we bring up challenges where it is necessary as well. We have seen things in the clinic that can be quite challenging at times—the realities of gender-based violence and other issues. Where appropriate, we do bring that conversation within whichever sector we are talking about, whether it is the church leadership or the local government we are speaking to or the school context. We engage in some significant dialogues across all of those groupings, including churches.[191]

5.179 The Churches Agencies Network described the advantages of working through faith-based agencies, maintaining that:

> CAN agencies recognise the importance of bottom-up approaches that respect social context, and work through community strengths to address barriers to women and girls' realising their human rights. CAN agencies seek to mainstream gender into all program areas and have the active participation of men and women in program planning and implementation.[192]

5.180 Caritas Australia also emphasised the potential for governments to leverage the networks and influence of faith based orgnisations, suggesting that:

> Church leaders and their capillary networks can facilitate sustainable and low cost avenues for development that are culturally appropriate and engaged with local governments, businesses and communities.[193]

5.181 The Church Agencies Network reported that faith based organisations are already working to increase the leadership capabilities of women in the Pacific, through programs such as the Uniting World's Women's Fellowship networks, noting:

> The Women's Fellowship networks tend to be well structured and organised, spanning the sphere of church leadership to the community level. These networks tend to be the main arena in which women have a voice within the church and community.[194]

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191 Dr Dunn, YWAM Medical Ships, *Committee Hansard*, Canberra, 18 June 2015, p. 6.

192 Churches Agencies Network, *Submission 12*, p. 4. For further information including a case study on a mother and child health program in Kenya, see *Submission 12*, p. 9.

193 Caritas Australia, *Submission 42*, p. 6.

194 Church Agencies Network, *Submission 12,* p. 7.

Committee comment

5.182 The Committee acknowledges the Australian Government's support for programs in the fields of maternal and child health, reproductive health, disease reduction and immunisation, and child nutrition in the Indo–Pacific region.

5.183 While evidence to the inquiry regarding the experience of women and girls with disabilities was limited, the Committee accepts that women and girls with disabilities are often 'doubly disadvantaged'—a fact that must be considered in planning and delivering aid in the region.

5.184 The Committee is concerned about the levels of violence perpetrated against women and girls with disabilities, the impact of disability on women's reproductive rights, and the unmet need for appropriate health care for these women and girls in many Indo–Pacific countries.

5.185 The Committee proposes that the Government review gender-based violence support services currently available in the Pacific region, particularly with regard to the resourcing and co-ordination of health services and whether there is a case to provide further services. Services need to be integrated, including case management, healthcare, counselling, emergency accommodation and long term sustainable housing. These services should operate as a partnership between with the Australian Government, governments in the region and non-government organisations.[195]

5.186 The Committee recognises that malaria, HIV/AIDS and tuberculosis are serious health concerns impacting many women and girls in the Indo–Pacific region. As such, the Committee urges the Australian government to prioritise supporting work being conducted by scientists, governments and NGOs working in the field, such as the Gavi Alliance, Medicines for Malaria Venture, James Cook University and others, in the development of effective, low cost, accessible medicines and distribution channels to treat malaria, and other diseases, especially for poor women and children.

5.187 The Committee notes that access to clean water, sanitation and hygiene are critical components of development and is encouraged to note that DFAT has a focus on measuring the involvement of women in water, sanitation and hygiene initiatives.[196]

5.188 The Committee further notes the importance of appropriate, hygienic and safe sanitation facilities for women and girls, including in school and work environments, and as part of humanitarian responses to crisis situations.

195 See for further discussion: UN Pacific Gender Group, *Submission 49*, p. 8.

196 DFAT, *Supplementary Submission 27.3*, p. 13.

5.189 In addition to providing adequate facilities, local communities need to be engaged and women and girls educated on how feminine hygiene products can help support school and work attendance. By working with local communities, and particularly women's groups, as well as NGOs and the private sector, the Australian Government could facilitate access to affordable and accessible products.

5.190 The Committee applauds the Australian Government's aim to 'embed gender equality measures' into DFAT's child nutrition programs, as stated in the *Health for Development Strategy 2015–2020*.[197]

197 DFAT, *Health for Development Strategy 2015–2020*, p. 12.

Recommendations

Recommendation 11

In light of the continuing high levels of maternal mortality, unsafe abortions, and infant and child ill health in many parts of the Pacific and Timor-Leste, the Committee recommends that the Australian Government maintain funding and support for reproductive health programs, including obstetric and gynaecological services, across the Indo–Pacific region with an increased focus on the Pacific and Timor-Leste. In particular, the Australian Government should:

- **work in partnership with non-government organisations and Pacific Island authorities to increase funding to maternal and reproductive health programs in the Pacific region;**
- **support improved provision of timely and high quality sex education in the Pacific region by providing support to Pacific leaders and health ministers in implementing the program of work in sex education these leaders endorsed in 2014; and**
- **maintain a strong strategic focus on maternal mortality in the design and delivery of aid programs in Timor-Leste and the Pacific.**

Recommendation 12

The Committee recommends that the Australian Government prioritise funding for services that address the immediate needs of survivors of sexual and physical violence in the Indo–Pacific region. These services should be holistic, incorporating:

- **accessible, timely and affordable treatment for physical injury;**
- **accessible, timely, affordable and culturally sensitive counselling and trauma relief;**
- **legal and justice services, including timely collection of evidence for prosecution;**
- **counselling and appropriate assistance for pregnancies and diseases arising from sexual assaults; and**
- **support to prevent further exposure to violence, such as through the provision of safe emergency accommodation.**

Recommendation 13

The Committee recommends that the Australian Government prioritise work with governments in the Indo–Pacific region, non-government organisations, and the scientific research community for the development of effective, low cost, accessible medicines to treat HIV/AIDS, tuberculosis and malaria, with a focus on disadvantaged women and children in the region.

Recommendation 14

To support women and girls with disabilities, who are 'doubly disadvantaged', the Committee recommends that:

- **all programs funded or supported by the Australian Government that seek to address violence against women and girls are designed with the specific needs of women and girls with disabilities taken into account in the design phase;**
- **all women's health and reproductive rights programs supported by the Australian Government take into consideration the needs of women and girls with disabilities and seek to ensure these women and girls are included—and not adversely affected—by the programs; and**
- **work to support women and girls with disabilities in the Indo-Pacific region remains a priority for the Australian Government, and is included in the Department of Foreign Affairs and Trade's Country Plans.**

Recommendation 15

The Committee recommends that the Australian aid program retain a focus on ensuring that clean water, and access to satisfactory sanitation and hygiene, especially in schools, underpins development initiatives.

Recommendation 16

The Committee recommends that the Australian Government prioritise providing culturally appropriate, hygienic and safe sanitation facilities for women and girls, and that:

- **all Australian Government funded humanitarian relief responses, including refugee settlements and disaster relief shelters, provide culturally appropriate, hygienic and safe sanitation facilities; and**
- **all education programs designed to keep girls in school address the issue of sanitation facilities; providing facilities that can be adequately maintained and serviced locally.**

Recommendation 17

The Committee recommends that the Australian Government support culturally appropriate, community-driven programs that provide sanitary products for girls and women to allow them to remain engaged in work and education during menstruation.

Recommendation 18

The Committee recommends that Australian Government agencies working in the Indo–Pacific region take advantage of opportunities to partner with faith based networks where they play a major role in delivery of health care services and care support.