Submission to the Joint Standing Committee on Foreign Affairs, Defence and Trade

Inquiry into the human rights issues confronting women and girls in the Indian Ocean – Asia Pacific region

Purpose and focus of this Submission

I was invited to make a submission to this Inquiry. I wish to confine my observations to the economic and development aspects of human rights issues confronting women and girls in the Indian Ocean-Asia Pacific region, with a particular focus on health.

Progress in reducing maternal mortality, but significant challenges in our region.

The right to health has been explicitly recognised in several international and regional human rights treaties including the International Covenant on Economic, Social and Cultural Rights (ICESCR), 1966; the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), 1979; and the Convention on the Rights of the Child (CRC), 1989. The link between health and human rights is also recognised in the international literature.[1, 2]

Despite these Conventions, reducing the maternal mortality ratio is the least likely of all of the eight Millennium Development Goals (MDGs) to be achieved globally. Latest estimates suggest only 16 countries out of more than 180 will achieve the target of reducing the maternal mortality ratio by 75% between 1990 and 2015.[3] An estimated 292,982 maternal deaths occurred globally in 2013, and an even larger number of disabilities.[3] While significantly less than the baseline of an estimated 376,034 maternal deaths in 1990, many of the current deaths were nevertheless preventable with proven, affordable, interventions.

The number of avoidable maternal deaths in the Asia Pacific region is high in absolute and relative terms. Over one third (an estimated 107,827 or 36% of the global total) of the absolute number of maternal deaths in 2013 occurred in South Asia, especially India and Pakistan. Papua New Guinea had the highest maternal mortality ratio (592 maternal deaths per 100,000 live births) of any country in South East Asia or the Pacific.

Maternal mortality and disability, and maternal under-nutrition, undermines social and economic progress at the national and household level.

Maternal under-nutrition is widespread in much of Asia (and over-nutrition in parts of the Pacific) undermining the health of the mother and her child.[4-6] Maternal under-nutrition and poor feeding practices is estimated to be a cause of 3.1 million child deaths or 45% of the global total in 2011.[7] Girls are too often taken out of school to look after sick and elderly adults. Conversely, healthy girls and mothers is a valuable goal in its own right, and facilitates healthy and more productive individuals and societies.

Government expenditure on maternal health is often insufficient to meet basic needs, and is inequitable

Government expenditure on health care is very low in much of Asia. The World Health Organization estimates that per capita government expenditure on health care in 2010 (latest year available) was, for example, $US 2 per person in Myanmar; $US 10 per person in Cambodia; and $US 30 in Indonesia compared to $US 3545 per person per year in Australia.[8] As a result of low public

expenditure, many poor women and their families either forego essential health care or pay directly out of pocket: an independent source of poverty and debt.[9] What little public money is spent is often skewed towards the richer, and urban, sectors of society. For example, 94% of women in the Philippines and Cambodia in the richest quintile had births attended by a skilled health person; this fell to 26% of women in the poorest quintile in the Philippines and 49% for the poorest quintile in Cambodia.[8]

Affordable, proven, and cost-effective interventions exist to improve the health and wellbeing of women. The technical interventions required to dramatically improve health outcomes for women and infants are well known, affordable, and scientifically based.[10-12] Culture, class and caste are obstacles to accessing basic adequate, affordable, acceptable care. What is missing is political commitment and adequate financing. Investing in maternal nutrition has high social, health and economic returns.[13-15] Funding family planning also has high social, health and economic returns. The total cost of investing simultaneously in modern family planning and maternal and newborn health services to meet existing needs has been estimated to be around $US 4.50 per capita. [16]

A recently launched Global Investment Framework has identified, and costed, six high impact investment packages addressing maternal and newborn health relevant to developing countries.[17] The investment packages focus on child health; immunization; family planning; HIV/AIDS; and malaria, with nutrition as a crosscutting theme. The estimated benefits are significant. Scaling up essential interventions from current levels would prevent more than 147 million child deaths, 32 million stillbirths and more than five million maternal lives between 2013 and 2035 globally. Expanded coverage of family planning, in particular, would yield significant benefits. Increasing the use of modern contraceptives to 50% coverage on average across 74 countries with high burdens of death and disability would reduce unintended pregnancies and thereby avert 54% of the maternal deaths and 47% of child deaths. The estimated additional costs are, ultimately, affordable. The additional investment required for high coverage of essential interventions reaches US$ 30 billion per year globally in year 2035, with a cumulative total of US$ 678 billion in 2013-2035 On average an extra US$ 4.48 per capita will be needed in 2035, with a range across the 74 countries from US$ 1.2-US$ 112.7. [17]

Strategic interventions

Several interventions are available that disproportionately benefit poor women in the region. Such interventions are affordable, evidence-based, developmentally effective, sustainable, and needed. Investing in girls' education is often seen as one of the most powerful investments that can be made.[18] Latest studies also confirm that micro-finance for women in Bangladesh is more effective in raising household expenditure and female labour supply than providing the same loan to men.[19] Raising taxes on tobacco in developing countries frees up household income that can be equivalent to the expenditure spent on health and education combined.[20]

Investing in health is also a strategic way of improving the lives of many poor and vulnerable women. Australia has taken a leading role in promoting an investment case for women and children in Asia and the Pacific in the past.[21] Australia has expertise in public health, international development, and policy and programming. Australia could and should take a leadership role in policy reform and investing in the health of poor and vulnerable women in the region.

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