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Chair

Mr. Dean Allison

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● (1125)

[*English*]

The Chair (Mr. Dean Allison (Niagara West—Glanbrook, CPC)): Order, please.

Pursuant to Standing Order 108(2), our study on the group of eight, G-8, summit, with a focus on the maternal and child health initiative will commence.

I just want to say once again to our witnesses, thank you very much for letting us take care of some of our own business.

We've got Ms. Scott-Parker from the Canadian Federation for Sexual Health here today.

I believe you've already been asked by the clerk to have statements kept to eight minutes, so we're going to do that. I also believe you're going to read a statement on behalf of International Planned Parenthood.

I'm going to start with you and we'll move all the way down the line, and then I'll come back so that we don't make you talk for 16 minutes straight. How does that sound?

Ms. Jolanta Scott-Parker (Executive Director, Canadian Federation for Sexual Health): I appreciate that.

The Chair: I know most of us could do that, but I don't want to have to put you through that.

We will start then with Ms. Scott-Parker from the Canadian Federation for Sexual Health.

You have eight minutes, and if you could try to keep to that, we'll move forward very quickly.

Thank you.

Ms. Jolanta Scott-Parker: Thank you.

I'd like to take the opportunity first to thank the committee for having us here today. I'm certainly very honoured to have been asked to appear alongside my other civil society colleagues here today.

I'll just take a moment and introduce the organization that I represent. The Canadian Federation for Sexual Health, formerly the Planned Parenthood Federation of Canada, is a national network dedicated to supporting access to comprehensive sexual health information, education, and services in every community in Canada and around the world.

We have member organizations in a variety of communities across Canada, and these members range from full-service primary health care providers to small information- and education-based organizations. Together, they work dedicatedly to provide quality sexual and reproductive health information and services to the members of their community.

In addition to being a network of Canadian organizations, the Canadian Federation for Sexual Health is very proud to be the Canadian member organization of the International Planned Parenthood Federation. And I'll thank you for the opportunity to read my colleague's statement. He apologizes. His flight got cancelled yesterday and he's not able to be here today. I'll do that after.

CFSH and our many colleagues working in sexual and reproductive health welcomed the Canadian government's announcement in the early part of 2010 that it will focus on maternal, newborn, and child health as its G-8 legacy initiative. We believe this plan must be an integrated approach to saving women's lives that includes comprehensive sexual and reproductive health services, including access to modern contraception and safe abortion, where abortion is legal.

For too long there has been little progress on maternal and child health, and yet we have a strong international consensus about the actions required to make change. We also have a strong international commitment, at least in principle. We have simply lacked the political will and the financial investment. With unprecedented attention on this issue in the last 12 months, we have a tremendous opportunity to move forward with a new momentum.

To review quickly some of the facts around maternal health, there are an estimated 215 million women worldwide who want to plan their families and cannot access family planning services. A dramatic improvement in access to contraception would dramatically reduce the number of unintended pregnancies, which would mean fewer pregnancy-related deaths and complications.

There is strong evidence to show that family planning saves lives. The World Bank estimates that 40% of maternal deaths could be prevented by the wider uptake of reliable contraceptive methods. Recent research published by the Guttmacher Institute suggests that if we meet both the unmet need for contraception and the unmet need for maternal and newborn care services, instead of the latter alone, pregnancy-related deaths could be reduced by 70%. In this case, it's also estimated that unsafe abortions would decrease from 20 million to 5.5 million.

The study suggests that meeting the combined need would actually be less expensive than simply meeting the need for maternal and newborn care. This cost savings would be as a result of the dramatic reduction in the need for pregnancy-related care due to a reduction in unplanned pregnancies. I don't think there is any stronger evidence for the need for comprehensive sexual and reproductive health services, including access to contraception, as part of a maternal health initiative.

Somewhere between 530,000 women and 330,000 women die every year of complications related to pregnancy and childbirth, and this range refers to recent research suggesting that some change may have occurred, which is very positive. It's estimated that 13% of these deaths are due to unsafe abortion, which represents as many as 70,000 women's deaths a year.

To mention a few of the other statistics, approximately 25% of those deaths are due to postpartum hemorrhage; 13%, infections; 12%, eclampsia; 8%, obstructed labour; and other direct and indirect causes.

Contraception and safe abortion services must go hand in hand. In some instances, access to contraception is not enough to ensure that women are exercising their right to control the timing and spacing of their children. This is true in cases of contraceptive failure or in cases of rape or sexual coercion. In cases where abortion is legal, women must be afforded access to this procedure safely.

At the 2009 G-8, Canada committed to “accelerating progress on maternal health, through sexual and reproductive health care and services and voluntary family planning”. All of the G-8 leaders signed onto the consensus for maternal and child health, which agreed that the actions needed to address maternal and child health include a quality package of evidence-based interventions delivered through effective health systems. These include comprehensive family planning advice, service, and supplies; skilled care for women and newborns during and after their pregnancy as well as during childbirth; safe abortion services where abortion is legal; and improved nutrition and prevention of major childhood diseases.

● (1130)

The upcoming G-8 meetings come at a critical time as world leaders also prepare to gather in September of this year to review the world's progress on the MDGs. MDG 5 and MDG 5(b) are the goals toward which the least progress has been made, and this G-8 meeting provides a tremendous opportunity to change that.

Strong and effective civil society organizations are critical to ensuring the effective implementation of the maternal and newborn health strategy. Civil society and governments must work together to ensure that we meet the MDGs and to ensure progress in sexual and reproductive health and rights. Civil society organizations are often in a unique position to deliver specialized sexual and reproductive health services, especially to the poorest and most marginalized populations. IPPF and its member organizations around the world are a critical component of the maternal health infrastructure, working in the world's least developed countries to build capacity to deliver effective, high-quality services from a rights-based perspective.

The approach that we've heard proposed for this G8 initiative is one where countries would choose elements of a menu approach of interventions required to improve maternal and child health, as opposed to investing comprehensively. I believe this approach is dangerous and risks leaving critical areas of women's health underfunded, undermining health systems and putting women's lives at risk. The evidence is overwhelming and the global consensus is clear with respect to what action is required.

In just under three weeks, hopefully not much sooner, I expect to give birth to my second child. I will do so within the Canadian health care system in the capable care of a midwife. If I am in the unfortunate position of experiencing a postpartum hemorrhage, as I did three years ago with the birth of my first child, I will seek emergency obstetrical care and be transferred to the care of an obstetrician/gynecologist. I have a guaranteed form of transportation to the hospital, and I can be assured that the roads will be passable when I need them. I can be assured that the tertiary care hospital that I will go to will have blood products available and a specialist on call 24 hours a day.

A pregnancy-related complication for me will be an unfortunate reality, but it will not likely threaten my life or the long-term well-being of my family. I'm choosing to have my second child almost exactly three years after my first, and I've had the privilege of a variety of forms of modern contraception to assist me in making this choice. I've also had very readily available access to abortion services had this not been a pregnancy that I could choose to continue.

All of the women of the world have the right to the same opportunities to control their fertility and to safe pregnancy and childbirth. Canada has an opportunity to demonstrate tremendous leadership on the world stage. We continue to wait with great anticipation for the details of this signature initiative, for the plan, and for the financial commitments. Let us lead by example by investing in an integrated maternal, newborn, and child health strategy that is built on evidence and that maximizes on its investment by providing comprehensive sexual and reproductive health services.

Thank you very much.

The Chair: Thank you.

Now I'm going to move over to Ms. McDonald, who is from Action Canada for Population and Development. Ms. McDonald, the floor is yours for eight minutes.

Ms. Katherine McDonald (Executive Director, Action Canada for Population and Development): Thank you.

ACPD is a human rights advocacy organization, which focuses primarily on women's rights and sexual and reproductive rights.

Around the world in the past year there has been unprecedented global attention on the issue of maternal mortality as both a health issue and a human rights issue. While a woman in Canada has a one in 11,000 chance of dying from complications of pregnancy and childbirth, in Niger, pregnancy-related causes will kill one in seven women. This injustice and inequity underscores the seriousness of these human rights violations. It is the underlying reason why industrialized states like Canada must do more.

So let's begin by talking about what these industrialized states have already agreed to do.

The millennium development goals, or MDGs, include a global promise to reduce maternal mortality by three-quarters by 2015 and to achieve universal access to reproductive health by the same date. In September, world leaders will gather to review progress on the achievement of the MDGs. In light of this meeting, UN Secretary-General Ban Ki-Moon announced a joint action plan in April to accelerate progress on maternal and newborn health.

The MDGs are not new. In 1994, at the International Conference on Population and Development, 179 governments, including Canada, committed to provide by 2015 universal access to a full range of safe and reliable family planning methods and to related reproductive health services that are not against the law, thereby referring to abortion services. These commitments have been further fleshed out by human rights experts within the UN system. In recent years, the right to survive pregnancy and childbirth has increasingly been recognized as a basic human right. According to human rights experts, avoidable maternal mortality violates women's right to life, health, equality, and non-discrimination. Several UN treaty-monitoring bodies have found violations of key human rights treaties where states have failed to take measures to prevent maternal mortality.

In 2006, African leaders, without exception, adopted the Maputo plan of action on sexual and reproductive health and rights, which, among other strategies, mandates their health systems to provide safe abortion services to the fullest extent of the law. All African states permit abortion under at least some circumstances. And in April of this year, the African Union convened a continental conference to accelerate progress on maternal and child health, showing their commitment to this very important issue.

As you well know, Canada also committed to deliver its foreign aid in accordance with the ODA accountability act. It requires all aspects of Canadian aid to focus on poverty reduction and it requires that the perspectives and concerns of those who receive ODA be taken into account, hence the Maputo plan of action. Canadian aid and all decision-making related to it, including the maternal and child health initiative, must be consistent with, among other factors, international human rights standards.

Let's talk about those standards developed by the experts that interpret international human rights treaties and develop the international standards or state obligations that states are required to follow. They include affordable and comprehensive reproductive health care services, including: family planning services; programs geared to increasing knowledge about and access to contraceptives as well as safe abortion services in accordance with local laws; measures to eliminate unintended pregnancy and unsafe abortion; dissemination of reproductive health and family planning information; guaranteed access to emergency obstetric care; ensuring that births are attended by trained personnel; and that quality emergency care for complications from unsafe abortion is available to all women.

Last June, the Human Rights Council at the UN adopted a landmark resolution recognizing maternal mortality and morbidity as a pressing human rights concern. With this resolution, which Canada co-sponsored, member states acknowledged that the issue of maternal health must be recognized as a human rights challenge and that efforts to curb the unacceptably high global rates of preventable maternal mortality and morbidity must be urgently intensified and broadened.

● (1135)

On June 2—one year ago tomorrow—Parliament passed an all-party resolution to reduce maternal and newborn morbidity and mortality, both at home and abroad, including through the G-8 and other global initiatives.

Then, last year, at the G-8 in Italy, the G-8 heads of government, including Canada, agreed that maternal and child health was one of the world's most pressing global health problems. They committed to accelerate progress on maternal health, including through sexual and reproductive health care and services, and voluntary family planning.

Last Thursday, Minister Oda appeared before the Standing Committee on the Status of Women. In her testimony she quoted parts of paragraph 8.25 of the Programme of Action adopted at the International Conference on Population and Development.

The two quotes she used were: “In no case should abortion be promoted as a method of family planning.” She went on to quote: “Prevention of unwanted pregnancies must always be given the highest priority.” She then said: “That is the action plan that we are following. That's the action plan that the UNFPA has based their definition [on], as have other world United Nations agencies.” However, Minister Oda neglected to quote from the rest of the paragraph. It talks about the need “to deal with the health impact of unsafe abortion...as a major public health concern”. Governments are urged “to reduce the recourse to abortion through expanded and improved family-planning services” and to ensure that women who have unintended pregnancies “have ready access to reliable information and compassionate counselling”.

It also says that any measures or changes related to abortion must be determined through legislative processes, thereby begging the question why they should be changed through Canadian foreign aid policy. It also requires that where abortion is not against the law, it should be safe, and that in all cases women should have access to quality services for complications arising from abortion.

If the government is relying on paragraph 8.25 of the Programme of Action, which seems to be the case, it should rely on the entire paragraph, not just the part of the sentence it likes. The government cannot cherry-pick.

Let's look at what we might want from this G-8. If this government is relying on UN definitions of reproductive health, it cannot choose which part of which paragraph it wants to rely on for its programming. This government must base its programming on the ODA accountability act and on international human rights standards. This government must base its programming on the evidence that family planning saves lives and that safe abortion must be provided where it is legal, and in all cases services must be provided for the estimated eight million women, every year, who suffer from the complications arising from unsafe abortion.

Thank you.

● (1140)

The Chair: Thank you, Ms. McDonald.

We're now going to move over to Ms. Lynch, who's coming to us today from the International Confederation of Midwives.

Ms. Lynch, the floor is yours. You have eight minutes.

Ms. Bridget Lynch (President, International Confederation of Midwives): Thank you. It's a pleasure for me to be able to speak before this committee this morning.

As president of the International Confederation of Midwives, I represent 250,000 midwives in 87 countries. I also represent the confederation on the board of the Partnership for Maternal, Newborn, and Child Health, an international partnership made up of UN agencies, the Gates Foundation, USAID, formerly Canadian CIDA, and other major NGOs organized to address the fundamental issues and the interventions required to achieve the targets in MDGs, millennium development goals, 4 and 5.

Much time has been spent during the last few weeks discussing the statistics and failures of governments to reduce maternal and infant morbidity and mortality and the lack of progress in achieving MDGs 4 and 5 here in Canada. Canada has made a tremendous commitment in its determination to address this issue at the upcoming G-8. This commitment has allowed the Canadian public to become educated and involved in the discussions of Canada's role in addressing maternal and newborn health in the world's poorest nations.

This week we learned that the government has committed $1 billion to this initiative. Although this falls short of the $2 billion that had been hoped for, we should nonetheless be proud of this commitment. But we must not be naive. Canada has made its commitment. It is time now to focus on implementation.

This morning I will be highlighting a significant area of Canada's plan, that of supporting the development of the health care workforce to achieve MDGs 4 and 5. As we discuss the imperative of improving health systems, we must bear in mind that the health care workforce is the critical axis through which health care is delivered. We need to make sure we have the right person in the right place at the right time. The education and training, deployment, and retention of health care workers is our next challenge. As we look at this need and distribution, it is important, first of all, to identify the challenges in order to achieve the health MDGs in sub-Saharan Africa, where most of the lowest-income countries are located. The investment case for health in Africa, compiled by African ministers of health, the WHO, and the World Bank, has found that the lowest levels of public spending on health per capita are, not surprisingly, in the poorest countries.

What is needed to save 3.9 million lives, of which 90% will be women and children, is an additional average annual investment per capita, over the next five years, of $21 to $32 U.S. This will provide 58,000 to 77,000 additional health facilities. This plan also calls for 2 million to 2.8 million additional health workers and administrators. This investment is estimated to provide at least $6 billion in economic and productivity gains in these countries. It's important to recognize that in saving lives, we're also providing countries with tremendous economic gains. These numbers can seem overwhelming, especially the numbers of the health care workforce at 2 million to 2.8 million. When we look at it in this fashion, the health care workforce can become a nameless, faceless, and overwhelming entity. In order to address the needs of developing this workforce, and particularly addressing MDGs 4 and 5, we must break it down into the specialties required and identify the services each area of the workforce will provide.

The World Health Organization, the World Bank, UNICEF, and UNFPA have identified midwives as the critical workforce to achieve millennium development goals 4 and 5. It is estimated that a midwifery workforce working within a functioning health care system would reduce maternal and infant deaths and disability by 99%. The WHO estimates that to achieve these targets there is a need for 350,000 more midwives globally. If we are going to develop a health care workforce—and most critically a sustainable midwifery workforce—we must address the following challenges.

Education for midwives in most of these countries is remarkably poor. Few are attracted to the profession, because midwifery is an invisible workforce in many of these sub-Saharan and South Asian countries.

● (1145)

A recent story was told to me by the CEO of the International Federation of Gynecology and Obstetrics. He was visiting a minister of health in one of the low-resource countries in sub-Saharan Africa, and the minister proudly took him to not one, not two, but three new medical universities where they're planning to educate more physicians. He turned to the minister of health and asked to be taken to see the new midwifery schools. The minister of health said there weren't any new midwifery schools.

They went to visit the existing midwifery schools, which were underserviced, falling apart, and had had no facility improvement in easily 20 years. The CEO of FIGO, the obstetrics association globally, looked at the minister of health and said, “Why are you wasting your resources on physicians? What we need now are midwives.”

The second area is regulation. In many of these low-resource countries, Canada has to insist that as we're growing the workforce, we have to have regulated health care providers. On my recent visit to Haiti, where there is no regulation for physicians, for midwives, or for nurses, I found that the government is recognizing that in order to have sustainable high standards of care, there need to be standards of regulation.

Retention is a huge issue, and one that we're facing square on as we're devoting our billion dollars to improving a workforce. The midwifery and health care workforce is largely a female workforce. This goes back to MDG 3, which is looking for equity for women globally. It applies directly to the female health care workforce, in which too many women are underpaid, working in terrible working conditions, and brutally overworked. About 250,000 health care providers go abroad globally from these low-resource countries, or else go into privatized health care and NGOs in their own countries, leaving the publicly funded health care system very underserviced. Women are dying in the underfunded public health care system, and, as we know, fewer and fewer government dollars are spent, while privatized health care continues to proliferate globally. At this point in time, 50% of health care in the world is privatized.

The health care worker exodus to western countries, where governments purposely undereducate their own health care workers, is also something we need to identify as Canadians. Countries such as Canada, where governments purposely undereducate health care workers and count on making up these shortages, are taking advantage of the situation in Africa by offering better working conditions to the African health care workers. This was identified at a meeting I attended last year in Addis Ababa in Ethiopia, where ministers of health from 23 sub-Saharan countries were gathered to look at this issue of health care workers. They were discussing charging the high-resource countries the costs that they have incurred in educating the health care workers who leave the country.

Most people do not want to leave their countries of origin, and decent pay and improved working conditions within properly functioning health systems will make the freedom-of-movement argument a non-issue for the majority of professionals. Canada currently recruits approximately 23% of its health care workers; as part of our global commitment to reduce this brain drain, we can commit to training 100% of our workers. This happens currently in both Japan and the Scandinavian countries.

Canada has committed to the development of the health care workforce to reduce maternal and infant mortality globally. Let us use our world-renowned midwifery schools and our own country to give guidance. Let us share our high standards of midwifery regulation. Let us share our successes in working with obstetricians and pediatricians and multi-disciplinary teams and commit this country to working with those low-resource nations to develop a high-quality and sustainable health care workforce.

We know what needs to be done. Let's work together to make sure our committed moneys are well spent.

Thank you.

● (1150)

The Chair: Thank you, Ms. Lynch.

I am going to move over to Ms. Morris, who is from the Micronutrient Initiative.

Welcome, Ms. Morris. You have eight minutes.

Ms. Aynsley Morris (Communications Manager, Micronutrient Initiative): Thank you very much to the members for having us today.

The Micronutrient Initiative is a Canadian-based development organization focusing on the delivery of micronutrients, which are vitamins and minerals needed in only small quantities, and the delivery of nutrition health programs to the world's most vulnerable populations, particularly women and children.

The Government of Canada has pledged to make maternal and child health central to this year's G-8 meeting, and it is asking G-8 members and other countries to make commitments to saving and improving lives. Canada's leadership in this matter is timely and much needed. We understand that the aim of the Government of Canada's initiative is to generate international commitment to action to address the tragic rates of maternal and child mortality and morbidity that prevail in developing countries. Success in this initiative is essential if the world community is to achieve the millennium development goal of reducing global child and maternal mortality rates by two-thirds and three-quarters respectively by 2015.

The Micronutrient Initiative believes that to achieve these goals, maternal and child health programs must place a strong emphasis on measures that tackle undernutrition. Nutrition has been called the forgotten MDG. Slow progress on the health MDGs is at least partially due to the neglect of nutrition.

The distinguished medical journal, *The Lancet*, provided recent indisputable evidence of this. Following a careful review of thousands of studies, it reported that maternal and child undernutrition is the direct or indirect cause of an estimated 3.5 million preventable maternal and child deaths annually. It showed that a child's growth trajectory is set for life in the first few years of life, and not having adequate nutrition during this critical time has lifelong consequences on health, productivity, and economic growth.

Finally, *The Lancet* confirmed that ready availability of nutrition and health interventions, when targeted during the critical window of opportunity in a child's life of minus 9 months to 24 months, reduces child mortality and improves maternal health. Additional evidence shows that improving nutrition during this window of opportunity provides cognitive development and school performance, reduces school dropouts, and promotes national economic productivity.

The 2008 Copenhagen consensus summarized the conclusions of a panel of leading economists, including five Nobel laureates, on the top ten investments that could be made in development. Five of these were nutrition-related. Micronutrients were at the very top of the list.

● (1155)

[*Translation*]

Undernutrition is one of the most serious health problems in the world, but rapidly applicable solutions can provide the highest returns on investments in development. However, this issue remains terribly neglected in international development efforts. Indeed, recent assessments of official development assistance provided by OECD countries showed that there was strong growth in investments in health in general, but weakness and stagnation of investment levels in nutrition. For the Canadian government, this initiative, in light of the approaching G8 summit, is an opportunity to remedy this shortcoming and to take advantage of our cutting-edge donor history in this area.

When UN member states made their commitment to children in 1990 at the World Summit for Children, a historic summit, Canada translated its leadership as co-chair of the event into pragmatic and concrete action, in particular in the area of nutrition, through the creation of the Micronutrient Initiative. For close to 20 years, our country has been supporting the Micronutrient Initiative's efforts to finance innovative work and encourage new international partners to participate in improving child health. This has meant that Canada has been recognized worldwide for its central role in the success of programs to supplement vitamin A, and for its role in the significant reductions in child mortality this supplementation has brought.

[*English*]

Yet Canada, characteristically, rarely takes the credit. Even in remote rural health posts in developing countries, one of the few things you can usually find on the shelf is a small Canadian flag. That flag is on a bottle containing life- and sight-saving vitamin A made in Canada. I would very much like you to pass on our thanks to all your constituents for making that possible.

To deliver its programs, the Micronutrient Initiative does not go it alone but relies on being able to coordinate and work effectively with other health programs. This ensures that essential drugs and other services, for children and for women, are delivered as a package. We rely on trained front-line community health workers to be able to take that essential package of health services so that they are all within reach of all the communities those front-line health service workers serve.

One good example is the treatment of diarrhea. Diarrheal disease remains one of the major killers of children. Nearly one in five children under the age of five dies needlessly as a result of dehydration, weakened immunity, or malnutrition associated with diarrhea. Treating diarrhea with zinc can help reduce that risk. The Micronutrient Initiative is calling for a major new investment in zinc, but also for all measures needed to help both treat and prevent diarrheal disease. This means providing not only a micronutrient, in this case 20¢ worth of simple zinc supplements to help children get better faster, but also oral rehydration to make sure the children don't get too dehydrated, and for adequate investment in areas such as the promotion of exclusive breastfeeding, access to clean water and sanitation, the use of soap in the household, and up-to-date measles vaccinations and vitamin A supplementation.

Another good example is antenatal care. A mother needs extra iron during pregnancy, as well as folate to help prevent some types of birth defects. Significant investment needs to be pledged not only to provide iron and folic acid supplements but also to make sure that each pregnant mother has access to trained front-line health workers who can provide those supplements, along with counselling, screening for complications, and other services. Those mothers also need access to skilled attendance at the birth from someone who knows what to do, such as delaying cord clamping so that the new baby gets the iron they need from the mother.

We are hopeful that the funding commitments made at the upcoming G-8 summit will represent a truly significant step towards realizing the MDGs for child survival and maternal health. The world can achieve them if it puts its mind to it, and Canada can show the way.

● (1200)

The Chair: Thank you very much, Ms. Morris.

We're now going to move over to Ms. Dendys from Results Canada.

Welcome. The floor is yours for eight minutes.

Ms. Christina Dendys (Executive Director, Results Canada): Thank you.

Results Canada is a national grassroots advocacy organization, and we're committed to creating the political will to end poverty and needless suffering. We champion cost-effective, proven, tangible, and impactful solutions that will benefit the world's poorest, and we believe, by extension, the world as a whole. I thank you for your invitation to be here today.

I know you're well versed in the statistics by this point, but I think they bear repeating. They speak to the immense need but also the immense opportunity that this G-8 initiative represents. As you've heard, at least 350,000 women die due to complications from pregnancy, labour, and delivery each year, and at least eight million mothers watch as their children die from mostly preventable causes before they reach their fifth birthday. In Canada, that would be the equivalent of 1,000 preschool classrooms full of kids being wiped out every single day. It's a tragedy, and it's unacceptable. The tragedy is compounded by the fact that we know what to do when it comes to saving lives. Many life-saving solutions are proven, simple, and inexpensive, and even if they cost a little bit more, they are well known to us.

To paint a picture, which I've actually shared before, I'm going to share this brief story. Last year Results Canada led a parliamentary delegation to Bangladesh. We were looking at the challenges associated with poverty, but we were also focused on hope and solutions. One day, we went to a hospital. It was called the ICDDR,B Hospital in Dhaka, and we were there in March. It was just before rainy season. At that point, waters are stagnant, and small children get sick primarily of diarrheal disease and other diseases as well. Every day, about 700 or 800 children with diarrheal disease stream into that hospital with their moms. There are moms and babies coming in for treatment. It's such a busy time of the year that they don't have enough wards or beds, so they construct these giant white tents outside the hospital, in the parking lots or in the ravine next door. I think there were two or three of them. When you walked into them, there was row upon row of kids getting oral rehydration therapies and intravenous therapies. While they're being treated for diarrheal disease, they're being looked at for other illnesses as well. Kids who are malnourished are getting therapeutic feeding and access to other treatments that are, again, very inexpensive, often costing dimes, not dollars, for treatment.

That scenario was very poignant for anyone, but especially for a mom like me. It is played out throughout the world. The good news is that most of the children who made it to that hospital will survive because they had access to health services. However, many more in the most impoverished pockets of the globe, unfortunately, will not. Diarrheal disease alone, as Aynsley was saying, kills about 1.5 million children every single year. Too many of the world's poorest children and their families have no access to basic health services, and it may take many hours or even days to walk to the nearest health centre or hospital. Their community may have only a handful of obstetricians or pediatricians, or they may simply be unable to afford what limited health care does exist.

For Canadians who see health care as core to our national identity and rights, this inequity is unacceptable. That's why Results Canada has joined with five of Canada's largest NGOs, including UNICEF, CARE, World Vision, Save the Children, and Plan Canada, to say that Canada's value-added contribution to the G-8 initiative can be to help bridge this health divide. We believe that part of the answer is to provide families with the health care they need in the communities where they live. The answer is a legion of front-line health workers prepared to tackle the leading causes of illness and disease in the developing world. Front-line health workers include doctors, nurses, and midwives, but they also include community health workers, promising young women who are supported and trained to provide life-saving medical interventions in their own community, be it in a rural area or urban slum.

Our joint call to action, which again is focused only on Canada's contribution to the G-8 initiative, has four core recommendations.

Number one, as I've said, Canada can commit to ramping up the number of front-line community health workers who are supported, trained, equipped, and motivated to deliver essential services to mothers and children at the community level. Community health workers are central to the continuum of care, the broad range of health services that connect homes and communities to health centres, clinics, and hospitals.

Number two is to provide these front-line health workers with the capacity to deliver an integrated package or a bundle of interventions to get at the leading causes of death among the poorest. Kids don't die of just one thing. They're susceptible to a whole gamut of illness and disease. Just four diseases—pneumonia, diarrhea, malaria, and measles—account for close to half of under-five deaths in the developing world. Underlying all of those is malnutrition. The majority of these lives, experts say, could be saved by increasing the use of low-cost, high-impact treatments and interventions, such as immunizations, bed nets, antibiotics to treat pneumonia, or, as we have seen, micronutrients.

● (1205)

I think what Aynsley didn't say was that two pills can save a life. Each pill is 2¢, and that's just 4¢ for vitamin A every year to save a life.

For pregnant women, front-line health workers have the capacity to monitor and support healthy pregnancies, and they need to be trained in safe birthing techniques and providing counselling on all-important contraception and birth spacing.

Third, we need to focus on the poorest families in their communities. Of those 8 million children, 80% get sick and die at home, far away from urban centres and hospitals. I think at least 50 million women give birth at home every year.

Fourth, we should commit to accountability and tracking results, in other words, ensure that we're getting it right and then that we have the capacity to improve practice as we go along, so we continue to get it right and get it better.

In sum, we need to have front-line health workers delivering an integrated bundle of interventions that have an impact on the poorest people where they live and measuring the results.

If I get an opportunity afterwards, I can tell you about a tangible story of how this is playing out in Ethiopia, where I was recently, where they have trained 30,000 young women to be health extension workers in 15,000 health posts across the country and who are creating transformative change in that country.

We estimate that Canada's fair share of the estimated $30 billion global financing gap to save 10 million women and children's lives by 2015 is $1.4 billion over five years. This must be new funding—not reassigned, not repackaged, not reallocated funding—to ensure tremendous and measurable impact in the lives saved.

In closing, we have a tremendous opportunity to make a difference in the lives of millions at this G-8 summit, so I want to thank you for your role in ensuring that we make the most of this opportunity.

The Chair: Thank you, Ms. Dendys.

I would also add the word “reprofile” to your list. It's another word that's used as well. You might want to add it to your list.

We're going to move back over here to Ms. Scott-Parker to read the comments from the International Planned Parenthood Federation, whose witness couldn't make it here, as his flight was cancelled.

You have eight minutes, and then we'll get right to questions by our members of Parliament.

Ms. Jolanta Scott-Parker: I'll just ask you to imagine that I'm Pierre La Ramée from the International Planned Parenthood Federation office in New York, which is the headquarters for our western hemisphere region.

Reading from his notes, I'd like to begin by telling you a little bit about my organization, the International Planned Parenthood Federation, or IPPF, which is a critical part of the global maternal and reproductive health architecture. IPPF provides an unparalleled network of health providers in 174 countries, delivering 67 million health services to 31 million women, men, and young people annually through over 8,400 clinics and 52,000 community-based health points and outreach services. IPPF has been delivering health services to communities for 60 years and is trusted by those communities. IPPF's comprehensive services complement those of governments and other primary health care providers by targeting the poor, marginalized, and most vulnerable who cannot otherwise access these life-saving services.

When it was announced initially, IPPF warmly welcomed the Government of Canada's initiative to champion maternal and child health as a host of the G-8 summit. And since the Government of Canada has supported IPPF's work for 50 years, we fully anticipated a comprehensive approach to saving women and children's lives that includes family planning and reproductive health, as well as safe abortion services. Indeed, there was no reason to think otherwise, since the G-8 had already agreed on what needs to be done to deliver comprehensive maternal and child health in an agreement that was endorsed by Canada at the 2009 G-8, an agreement including: comprehensive family planning advice, services, and supplies; skilled care for women and newborns during and after pregnancy and childbirth; safe abortion services, where abortion is legal; improved child nutrition, and prevention and treatment of major childhood diseases.

While full definition and clarity on the exact structure and content of the Canadian initiative are still to come, it does seem clear that it will be characterized by a so-called menu approach, with each government picking and choosing what aspects of maternal, newborn, and child health it will choose to fund. And while the status of family planning and contraception is vague, it has been made abundantly clear that the Canadian package will not include safe abortion services. It is therefore incumbent upon us to once again review the overwhelming evidence that including family planning as part of a comprehensive package of reproductive health services saves lives, and it is the rational choice in the context of the new international aid architecture and the MDGs.

What do we know about the impact of family planning and reproductive health? Maternal deaths in developing countries could be slashed by 70% and newborn deaths cut nearly in half if the world doubled investment in family planning and pregnancy-related care. The World Bank estimates that 40% of maternal deaths could be prevented by wider adoption of reliable, modern contraceptive methods. The UNFPA estimates that satisfying the unmet need for contraceptives would avert 52 million unintended pregnancies annually, saving over 1.5 million lives. Every $1 million invested in commodity support for contraceptives would save the lives of 670 women and 900 infants, prevent 12,000 additional deaths of children under five, while averting 500,000 unwanted pregnancies.

There is also global consensus on aid effectiveness, as agreed in the Paris Declaration, which strongly aligns development assistance to the specific needs of countries as outlined in their national development plans and with which Canada's proposed menu approach is distinctly at odds. The menu approach is at odds with principles of aid effectiveness because it cherry-picks issues that are apparently non-controversial but which do not address maternal or child health comprehensively and efficiently. The menu approach also risks leaving critical areas of women's health underfunded, undermining health systems in developing countries and putting women's lives at risk. And while the menu approach may produce some gains, do we really want to see a maternal health initiative that provides a woman with clean water or better nutrition only to fail to provide the help she needs to prevent an unwanted pregnancy or prevent a sexually transmitted infection, including HIV?

Looking more closely at the costs and benefits of a comprehensive versus a menu approach, services have to be comprehensive to ensure client choice and rights. IPPF's experience is that the menu approach does not work at the community level, in the clinic where real doctors and real nurses and real women, men, and young people are dealing with real problems. For example, suppose one donor country funds condoms, a second sterilizations, and a third safe abortion. The decision about what a client can access could depend on which donor still has funds remaining. While this may sound ludicrous, IPPF has before been in a position in which in the clinic we have had to ask clients whether they want the condom for pregnancy or for STI prevention. This was because the donor for the former was the European Community and the latter was the United States government. Not only is this invasive and confusing for clients, but it also precludes dual protection, if you run out of the family planning condoms.

● (1210)

What might this mean for a family planning clinic that is funded in whole or in part by CIDA dollars? Does it mean that they're simply not able to perform an abortion service, or does it mean they're also not able to treat a woman suffering from a post-abortion complication, or that they're not able to provide information and counselling, or that the clinicians in that clinic are not able to provide training to their peers on how to conduct safe abortion services?

The global gag rule during the Bush administration created precisely these types of circumstances and launched a wave of closed clinics, reduced programs, and falling levels of service in communities and countries across Africa and other parts of the world. Other restrictions, such as the anti-prostitution loyalty oath, have also had a chilling effect. In those cases, even if you could use other funds to carry out restricted, banned, or stigmatized activities, organizations simply declined to do so for fear of losing their funding.

Finally, I would like to close by saying a few words about the issue of IPPF's still pending application for renewal of its funding from CIDA, which has recently become the subject of political debate and media commentary in conjunction with the debate swirling around the G-8 maternal, newborn, and child health initiative. Currently, IPPF's funding agreement with Canada ended on December 31, 2009. IPPF has submitted a proposal to CIDA to renew its contract for $18 million over three years, $6 million per year. This was submitted in June 2009. To date, IPPF has yet to receive an indication of whether its funding agreement will be renewed.

It is worth noting that IPPF has been a partner of Canada continuously since the 1960s, regardless of the political party in power. This includes the current government, which renewed IPPF's funding three years ago. It is also worth noting that IPPF is politically neutral and non-party political. IPPF was not aware of and in no way solicited the call made by the Liberal Party of Canada for the current government to maintain its relationship with IPPF.

What exactly is at stake here? Very simply, by supporting IPPF, Canada invests in a unique network of reproductive health organizations with an unrivalled global reach and a strong voice able to advocate for commitment to achieving reproductive health for all, internationally, regionally, nationally, and at the community level. Funding IPPF has been and continues to be a wise investment for Canada, especially in the context of the G-8 maternal health initiative.

In 2008–09, IPPF's funding represented less than 0.1% of Canada's total international assistance expenditure and 1.35% of Canada's total ODA expenditure on population programs and reproductive health, a modest investment that has produced reliable results year after year.

Thank you again for the opportunity to read the statement from IPPF.

● (1215)

The Chair: Thank you, Ms. Scott-Parker, for doing double time there.

We're going to start, I believe, with Mr. Pearson, who is going to split his time with Mr. McKay. You will have seven minutes.

Go ahead, sir.

Mr. Glen Pearson (London North Centre, Lib.): Thank you, Chair.

You're all so eloquent. Thank you.

Ms. Scott-Parker, I offer all the best as you come to full term. I appreciated your story.

We had World Vision here at a breakfast last week. They said that when it came to issues around children, the MDG 4, we had roughly reached 40% of capacity. When it came to women, MDG 5, we were at 9%. Now, I don't know whether those figures are fully accurate; you can correct me. But it seems to me that as we're coming into a G-8 meeting that is dealing with child and maternal health, we have such a huge, long way to go that I'm not sure $1 billion will do it. That's from Canada alone; I realize they're looking for over $40 billion worldwide.

My question is as a person who has done development in the past. Usually what happens is that when funding is not as adequate as it perhaps needs to be, it becomes scattershot. People start funding a whole bunch of different initiatives to try to keep everybody happy. My question for you is, as this money is doled out, what are the delivery mechanisms that are so important?

I commend the government for choosing this as a subject for the G-8; I think that's great. But what I've been hearing over and over again is around micronutrients and also direct support at the place where it happens, front line service.

I guess my question for you would be, how then do you see this? If the government is going to make this commitment, it's one thing to announce the money; it's another thing to determine how it's delivered. Can I ask you what mechanisms you think are the best ways to do it? What do we do about partnering countries that have struggling health care systems that also need to have capacity built up during that time?

I know it's a bit of a loaded question. I don't mean it to be, but I just wondered whether you could take a kick at it.

Was it that bad?

Ms. Christina Dendys: I can start.

It's an excellent question, because the way we deliver this or where the money flows is absolutely crucial to the impact we're going to get out at the other end. I've heard the same sorts of comments that you've heard, Mr. Pearson.

I'm going to use the example of Ethiopia, because I think it is telling, in terms of how it was funded and is supported.

In Ethiopia they have a willing health ministry, a health minister who is very motivated, and a pro-poor health agenda. What they have done is train 30,000 young women, grade 10-educated at least, with a year's training in the leading causes of death. They have gotten a couple of extra months of training in support. It's not enough, but it's 14 months training in the leading causes of illness and death among the poorest people. They go back to 15,000 health posts in rural Ethiopia that they've built, no bigger than your living room, that are equipped in a comprehensive way with the interventions that can have impact. It's an amazing story and one that I encourage anybody to go and see.

It is funded from a number of different entry points. It is the Ministry of Health in Ethiopia that funds it, with bilateral support. Canada's contribution is the Catalytic Initiative to Save a Million Lives, because those are the core tenets of that UNICEF sort of initiative model. It is also funded through Global Fund support, because the Minister of Health there understands that the Global Fund, when used correctly, can be a health system strengthening sort of mechanism.

So there are those three core funding entry points; they'd be able to build up that end of the continuum of care so that it has impact.

Ms. Bridget Lynch: To follow along with that, Ethiopia was also the first country that signed an IHP, an integrated health plan. The Norwegians set it up, and their Prime Minister has been a leading advocate in reducing maternal and infant mortality over the last few years. They put aside a $10 billion amount of money, a fund, out of their oil moneys to commit to reducing maternal and infant mortality.

The way in which governments have access to that fund is they have to provide an agreed-upon health care plan for their country. This IHP process has been extremely helpful. Tedros is the Minister of Health in Ethiopia, and Ethiopia was the first government to sign this plan.

Canada has been in discussions with Norway, as we know, to continue to have the provisions for giving money. We know now, based on the Paris principles and Alma Ata as well, that countries need to be responsible for the delivery of their health care services; they need to be in charge, and those of us who are giving moneys need to be in agreement that the plans they've provided are adequate for the moneys as we give them.

● (1220)

Mr. Glen Pearson: Thank you.

Ms. Jolanta Scott-Parker: I have just a couple of little additions.

I referenced in my statement the existing architecture of maternal health initiatives and the civil society organizations engaged. I think that's a really important mechanism in looking at opportunities for investment in this strategy.

Of interest, and I regret that I forgot to bring the notes with me, is that Ethiopia has been mentioned on two occasions here. It's a very interesting country, in that it's an example of a country that has recently—in the last decade—liberalized its abortion laws. But while it now is legal, it continues to be the case that three-quarters, I think, of abortions in that country are unsafe and performed by unskilled practitioners in unsafe circumstances. That's an interesting example as well.

I just wanted to make those two notes.

The Chair: There is a minute and a half remaining.

Hon. John McKay (Scarborough—Guildwood, Lib.): I'll direct my question to Ms. Dendys.

It has to do with the last part of your comment on funding. What we know from the budget is that CIDA's funding has been flatlined. The increases over the next five years have been foregone in the name of cost savings of some kind or another, and to my knowledge there have not been any supplementary estimates to fund these announcements. So there's a bit of a food fight going on here, in which people are scrambling about how the money should be spent, with—to my knowledge, at least—no actual, real commitment in the form of a supplementary estimate, or a special provision, or a motion by the government to allocate the funding.

Do you have any information to the contrary?

Ms. Christina Dendys: I'll just start by saying that I think all of us would agree it's an extremely unfortunate decision to flatline aid, particularly at this time—or any time, frankly—because what happens over there matters over here. You know that H1N1 didn't start in Kanata; it started in a real village in Mexico. We're in a world without borders.

Having said that, I suspect what is happening is that there was a one-time aid increase of 8%. This is the last year, which means the envelope expands by roughly $400 million. Stretched over five years, that potentially is money that has not been allocated or assigned yet, and it provides an envelope for perhaps a billion-dollar or more commitment to this G-8 initiative as new funding. That's my suspicion.

Hon. John McKay: That would pretty well use up that entire envelope for the next five years, if in fact that's true.

Do you have any information from CIDA or other sources that that's actually true?

Ms. Christina Dendys: That's what I suspect and that's what I think has been rumoured. I don't know if my colleagues have any other information, but I don't have any information about extraneous funding from outside the aid envelope.

Ms. Katherine McDonald: I think it's just been a suggestion from the civil society that it would be one way to avoid a “rob Peter to pay Paul” scenario. But with the other, commitments around Haiti, you know....

Hon. John McKay: It essentially means that CIDA does nothing for the next five years, if in fact all the money gets used up for this particular initiative.

Ms. Katherine McDonald: Yes.

Hon. John McKay: Thank you.

The Chair: Okay.

Let's move down to the Bloc, to Madame Deschamps.

[*Translation*]

Ms. Johanne Deschamps (Laurentides—Labelle, BQ): I'm going to share my time with Ms. Lalonde.

Good afternoon, ladies. I had the opportunity of meeting with you and discussing things with several of you at the Standing Committee on the Status of Women. At the Standing Committee on Foreign Affairs and International Development, women are in the minority. And so we are very sensitive to the cause, and also very concerned.

I have two brief questions for you, Ms. Scott-Parker. Are you funded by CIDA? Please answer briefly.

● (1225)

[*English*]

Ms. Jolanta Scott-Parker: Thank you for the question.

No, we're not funded by CIDA. The Canadian Federation for Sexual Health national organization doesn't receive any Canadian government funding. Although we're an accredited member of the International Planned Parenthood Federation, we don't receive funding from them, because of course the dollars they receive from donor governments, such as the Canadian government, are directed internationally to the global south. They would use their internal processes for determining that.

[*Translation*]

Ms. Johanne Deschamps: I'm going to try and summarize what I heard today. You say, Ms. Scott-Parker, that in order to attain objectives effectively, and reduce maternal and infant mortality, we should offer a range of services that would provide access to all means, including contraception and abortion. That is the vision you are defending, in Canada and elsewhere.

Ms. McDonald, you said something that touched me deeply. You spoke about a fundamental right. You said that last year in Italy, industrialized countries had committed to reducing maternal and infant deaths. This assistance must also be in compliance with international treaties.

In light of what we have been hearing for some time, and given that this debate is being reopened—you even referred to two recent quotes from Ms. Oda, who omitted a few passages from paragraph 8.25—given this approach—is the government not politicizing this whole issue? This is a basic human right. Is the government not trampling human rights by not meeting the commitments that the Conservative government made internationally? That is my perception. Is my understanding correct? This is a basic right, and by attempting to get around it, the government is politicizing the whole issue.

[*English*]

Ms. Katherine McDonald: Thank you for the question.

Certainly, the international community has agreed for decades that individuals and couples have the right to decide the number, timing, and spacing of their children. In 1994—and that was 15 years ago—reproductive rights were recognized for the first time by the international community.

Reproductive rights are very expansive. They include reproductive health. They include sexual health. We are talking about a broad framework of human rights that are based on our international treaties, that are based on the interpretations of human rights experts, that form the standards, and that are fleshed out in these consensus agreements at international conferences.

In fact, the title of paragraph 8.25 is "Addressing Unsafe Abortion". That's what the paragraph is meant to address. That paragraph took over one year to negotiate. As you can imagine, in early 1994 it was extraordinarily controversial.

So every government in the world in the United Nations system has agreed on this carefully formulated language, which says where abortion is legal, it must be safe and accessible, and where it is not legal, we have to deal with the millions of women every year who suffer from complications from unsafe abortions. When states do not do that, they are violating women's rights to life, to health, to equality, and to non-discrimination. That's the agreed-upon consensus.

So for this government to ignore those extraordinary internationally agreed-upon human rights standards is inappropriate, especially given that we have signed an all-party ODA accountability act that requires us to give our foreign aid consistent with international human rights standards.

That's exactly what I said and it's what I believe. I'm a human rights lawyer. That's what I do for a living. I work on sexual and reproductive health, so it was very concerning to me to hear the minister's testimony, to take even a part of a sentence and say that this is what we're going to base our action plan on, when, if you read the entire paragraph—which I have as a footnote in my speaking notes—it's far broader.

I have some of the international agreed-upon definitions here around sexual and reproductive rights. They're very comprehensive. We have agreed to them and reaffirmed them over and over and over again.

● (1230)

[*Translation*]

Ms. Francine Lalonde (La Pointe-de-l'Île, BQ): Thank you very much for being here and for sharing all of your expertise and objectives with us.

My question is simple. Do you think you will be able to reach the country representatives who are going to come here, and get across to them the points you feel are crucial? Will it be possible?

[*English*]

Ms. Katherine McDonald: We have been in touch with the other governments and civil society in different countries. In fact, in a couple of weeks we'll be releasing.... We've had a series of letters from parliamentarians around the world.

We had a letter from the Ugandan all-party group on population and development, which was written to this government, setting out their position that safe abortion should be included in this maternal health initiative. We had a letter from the European Parliamentary Forum, which is an all-party group as well and spans Europe. We had a letter from the U.K. all-party parliamentary group saying the same thing. We had letters from many civil society organizations. So they're very well aware.

I just came back from Kampala, where I was at a meeting of the Reproductive Health Supplies Coalition, comprising 120 members. Within one hour I got 62 signatures on a letter to the Canadian government.

There is a great deal of interest in civil society and among parliamentarians on this issue. They know very well what the issues are.

The Chair: Thank you very much.

We're going to move over to Mr. Donnelly.

Welcome to the committee, sir. You have seven minutes.

Mr. Fin Donnelly (New Westminster—Coquitlam, NDP): Thank you very much, Mr. Chair.

The Chair: Oh, my mistake. I sit on two committees and I got a little confused with the order.

We'll come back to you in a second, Mr. Donnelly.

Mr. Van Kesteren.

Mr. Dave Van Kesteren (Chatham-Kent—Essex, CPC): Thank you, Mr. Chair. I will be splitting my time with Mr. Goldring.

I want to thank you all for coming here as well.

Ms. Lynch, you'll be interested to know that I'm a big advocate of midwifery. As a matter of fact—get ready for this—20 out of my 21 grandchildren were delivered with the help of midwives, and I can tell you that I know my wife would have been very pleased to have had that opportunity as well. I know the good work that you do.

You stated, as did Ms. Morris, that Canada needs to use the expertise we have. That is the case. We're trying to pursue that in the low-cost, highly effective solutions that we are experts on.

Going now to my question, I want just a quick answer from each one of you, if I could. I'm going to start with Ms. Scott-Parker from the Canadian Federation for Sexual Health.

Who funds you? Are you publicly funded? Are you privately funded? Are you funded through donations?

Ms. Jolanta Scott-Parker: The Canadian Federation for Sexual Health is a charitable organization in Canada, and we're funded exclusively through private donations.

Mr. Dave Van Kesteren: Through private donations. Okay.

What about Action Canada for Population and Development?

Ms. Katherine McDonald: We are a human rights advocacy organization. We do not have charitable status. We are funded by the United Nations Population Fund, we have two grants from the Ford Foundation, and we are funded through the European Parliamentary Forum.

Mr. Dave Van Kesteren: So you're publicly funded?

Ms. Katherine McDonald: We're funded by private foundations and the United Nations.

Mr. Dave Van Kesteren: Is that the case with the Canadian Federation for Sexual Health too, or is it strictly private funding? When I say private, I mean the Gates Foundation or something like that.

● (1235)

Ms. Jolanta Scott-Parker: Our only source of funding is individual donations. We don't have any government funding of any kind as an organization.

Mr. Dave Van Kesteren: And midwifery, I suppose, would be....

Ms. Bridget Lynch: We're funded through fees paid by our member associations.

Mr. Dave Van Kesteren: Okay.

And what is the case for the Micronutrient Initiative?

Ms. Aynsley Morris: We're primarily funded by CIDA. We've enjoyed strong CIDA support for almost 20 years. We also have smaller grants from our partners in the UN system and also from some private foundations. Because the Micronutrient Initiative also works to fortify food with micronutrients, at times we'll receive funding from food companies in countries to help us with our work.

Mr. Dave Van Kesteren: And Results Canada...?

Ms. Christina Dendys: We have no government funding. It's all grassroots network fundraising and a few private foundation grants.

Mr. Dave Van Kesteren: That's my question. I might come back in just a second.

I'll pass it over to Mr. Goldring.

Mr. Peter Goldring (Edmonton East, CPC): Thank you, Mr. Chair.

Thank you, ladies, for your appearance here today.

Ms. Morris, you made a comment that I found rather interesting, along with the nutrition requirements of children from “minus nine months to 24 months”. I'm assuming that's from conception straight through to birth and then to 24 months after birth. It's an interesting way of looking at it.

The comments have been made here, and I believe that it's so, but perhaps you could help me by giving me some kind of idea of what the overall benefit of this action would be, for providing nutrition, for providing maternal health care, for providing all the services that we're envisioning could come forward from this. If we were able to impact and reach everybody who would be concerned with this, what would the raw numbers be of the expectations? It has been mentioned before that one child in five dies of diarrhea. What would the impact of this intervention be, in lives saved globally, if all of this were to have an impact upon the direction the government is proceeding in?

Ms. Aynsley Morris: Micronutrients aren't one single intervention. In the case of diarrheal disease, there is the provision of zinc supplements, about a 10-day course of them. Every child who has diarrheal disease won't be saved, but there's about a 20% mortality reduction when a child receives zinc supplements along with oral rehydration therapy. We could significantly reduce the number of child deaths from diarrhea by using zinc in association with oral rehydration therapy. So your 1.5 million children, that's going to reduce by about 20%. There are many children who are currently being treated with oral rehydration therapy. Some live, some don't. Providing that additional zinc supplement would reduce deaths in children.

In the case of vitamin A, we have fairly good coverage. Vitamin A strengthens a child's immune system and helps a child survive illnesses such as measles. It boosts their immune systems. Most studies have shown that two doses of vitamin A per year for the first five years of life reduces the overall child mortality rate by about 20% to 25%. We have pretty good coverage of vitamin A supplementation around the world, and probably 75% of those children who are deficient in vitamin A are getting the vitamin A supplements. Actually, it's probably a bit higher than that. The children we're currently missing are those who are the hardest to reach with health services, so it's geographic. This is why the Micronutrient Initiative is putting an emphasis on the front-line trained health care workers who can actually go out. If we can reach those children with vitamin A supplementation, we can also reach them with an integrated package of services, including bed nets and things that Canada funds.

● (1240)

Mr. Peter Goldring: This is a significant initiative. It sounds as though it could affect the lives of millions of children and mothers. It sounds as if it's a significant initiative on behalf of the Government of Canada. How does this compare with past initiatives? What makes this substantially different ?

Ms. Aynsley Morris: The Micronutrient Initiative has been in operation for about 20 years. UNICEF, when it announced its reduced child mortality rates in September 2009, stated that child mortality rates dropped from 12.5 million in 1990 to about 8.8 million now. The *Lancet* put out a further review saying that it was perhaps 7.2 million child deaths. UNICEF has credited vitamin A as one of the major reasons that child mortality has been reduced during the past 20 years.

Mr. Peter Goldring: The millennium development goals are not limited to this initiative. There are initiatives for democracy development, women's rights, respect, and education. If we were able to approach all of the millennium development goals, there would be a considerable impact. Certainly, this initiative by the Government of Canada must be affecting several million people.

Ms. Aynsley Morris: We believe that Canada's strong support, through the Canadian taxpayers, has made a significant difference in reducing child mortality and improving maternal health. There is also a millennium development goal for universal primary education. If a child has access to proper nutrition micronutrients such as iodine and iron during its formative development, the child's cognitive development is enhanced and IQs can be increased. That's the iodized salt that you eat. Rarely do people understand why the iodine is there. It's actually for brain development in a child.

Mr. Peter Goldring: Thank you.

Ms. Aynsley Morris: It goes beyond these two millennium development goals.

The Chair: Mr. Donnelly.

Mr. Fin Donnelly: Thank you, Mr. Chair.

It's good to be here, and thank you very much to all our witnesses for your passionate and very informed presentations. I very much appreciated hearing what you had to say.

I wanted to change tack a bit here and focus a little more on HIV/AIDS. By the end of 2008, women comprised half the adults living with HIV/AIDS. In sub-Saharan Africa, women and girls account for six out of every ten people living with HIV. I'm wondering if any of you or each of you could tell us what impact HIV has on maternal mortality or its implications generally for the G-8 initiative and beyond, and what role Canada has and can play in addressing this crisis.

In the last budget, the government announced it would not be increasing our overall aid budget past the 2011 fiscal year, which goes against previous commitments. I'm wondering if anyone would like to comment on that.

Ms. Christina Dendys: Thank you for that question, because I think it speaks to the notion of the need for new money in terms of addressing this. We can't forget that HIV is the leading killer on the planet, and we can't start shifting priorities to the point where millions are left stranded.

I think some of the studies I've seen about HIV and its impact—and I'm sure my colleagues are much more informed. The maternal mortality ratio appears to be more than six times higher in HIV-positive women than in HIV-negative women. Also, in terms of HIV having an impact on this initiative, I think there is a real area and focus of prevention of mother to child transmission of HIV which half.... I think 500,000 children die every year because of it. It's very easy to treat. It's ARV, isn't it? And it's treatment right after birth.

Not losing sight of the fact that HIV is crucial to this initiative, and way beyond it in terms of global health, but also in terms of getting at it, I think this year is important because of the G-8 initiative that's happening in June in Canada. There's also a Global Fund replenishment happening in the fall. The Global Fund is one of the biggest legacies of the G-8, born out of the G-8.

Half the people who have HIV in Africa are on ARVs. That would never have been thought possible before. Half of those are because of funding to the Global Fund to Fight AIDS, Tuberculosis and Malaria. I think we need to recognize that along with a significant G-8 initiative, we need to ensure a robust replenishment of the Global Fund.

● (1245)

Ms. Jolanta Scott-Parker: I think the question around HIV/AIDS speaks very strongly to the need for comprehensive sexual reproductive health services as part of the initiative, and comprehensive would obviously include prevention both in the form of contraception, in terms of birth spacing, but also in terms of STI prevention, including HIV/AIDS, and then along the continuum of care, including, as my colleagues mentioned, ARVs for all those who are HIV positive. In particular, women who are pregnant, who are treated, have a much greater chance of success in terms of their childbirth, as well as access to the prevention of maternal to child transmission. It's all part of an important comprehensive and integrated approach.

Ms. Katherine McDonald: One of the five issues International Planned Parenthood Federation addresses is HIV/AIDS. The others are safe abortion, advocacy, access to sexual and reproductive health services, and adolescents, all of which would address in an integrated and comprehensive manner the issues you are talking about.

Ms. Bridget Lynch: I wanted to address some of the statistics on that. The leading cause of death, globally, among women of reproductive age is HIV. At this point, only 45% of women who are pregnant receive antiretroviral drugs to prevent mother to child transmission.

The other thing to throw into this, and it's not exactly apropos of HIV, but the leading cause of death for 15- to 19-year-olds globally is pregnancy and childbirth.

Mr. Fin Donnelly: Did anyone want to comment on the aid budget question in my remaining two minutes?

Ms. Bridget Lynch: You know, Canada has taken the lead in putting maternal and newborn health, including issues of nutrition, including issues of workforce, on the table. This is our point in time to continue to be leaders.

It's one thing to pick up a ball and hold it and start a game and play the game. It's another thing to pick up a ball and start a game and then walk away from the game. This is really important. This is Canada's opportunity to shine.

The amount of feedback from the Canadian public in terms of taking up this global initiative has been profoundly, resonatingly powerful. It has rallied this nation together. It has said that we can lead the countries of the world. We're not the biggest superpower; we never will be. We need to take a lead ideologically. We need to take a lead that was handed to us in the 1960s by Pearson. Where is our 0.07%? Scandinavian countries are doing this. This is simply a matter of choice. It's not that we can't do it; it's that we're choosing not to lead. What is that all about? The stop/start leaves us.... We're not gaining a global profile here; we're gaining a global “Oh, there's Canada putting up its hand and then taking it down again and running off, and putting its hand only halfway up.”

Ms. Katherine McDonald: The economic numbers came out this morning: first quarter, 6.1% productivity in Canada. We can do it. The eurozone is in big trouble. We have the money. We should change that flatlining. We should change that in the next budget and we should increase aid, not decrease aid, and we should have a significant amount of money for this maternal and child health initiative.

The Guttmacher Institute says that doubling the investment is what we need, doubling the investment is what we should be doing.

Ms. Bridget Lynch: If I could add just one further point, I beg just a moment.

The other piece is the innovative financing piece of this. It isn't up to Canada, necessarily, to be funding it, but we can continue in terms of pressing innovative financing. There's a fantastic proposal on the table of 0.05% on money transactions that can be picked up by the stock exchanges. The British government and the other governments are far ahead of us on this. Where is Canada in supporting this plan?

● (1250)

The Chair: Thank you very much.

We're going to start our second round for five minutes each.

I'm going to start with Mr. Lake, and then we're going to finish with Mr. Pearson.

Mr. Mike Lake (Edmonton—Mill Woods—Beaumont, CPC): Thank you, Mr. Chair, and thank you to the guests for coming today.

I'll start with a comment. Madame Lalonde brought up the fact that there are very few women at the committee table. I just want to stress that you don't have to be a woman to understand the issues we're talking about.

In my personal experience, I have two kids...well, my wife had two kids and I was along for the ride, and it was a bumpy ride. Both of my kids were born by emergency C-section in very difficult circumstances, more or less at the last second. Three weeks after my daughter was born, my wife wound up going into the hospital with very serious complications. She had twice her body's blood volume transfused in a 24-hour period. You can get a little bit of a grasp of how serious that was. Eventually she had to have an emergency hysterectomy, with all of the issues that followed. Thankfully, she made it through okay, but I'm always reminded that if we lived in a different country in the developing world, I wouldn't have a wife and I wouldn't have the two kids.

So when I'm looking at these numbers...I try to get beyond the numbers. I think of every one of these kids as though I'm thinking about my own and about every one of these mothers as though I'm thinking about my wife. It helps to put some perspective on it.

I ask why we, as a global community, haven't made the progress that we ought to have made on these millennium development goals. I think Mr. Pearson touched on a part of it when he talked about scattershot initiatives to try to keep everyone happy. That seems to have been an approach. There's a lot of talk, but nothing actually seems to be coming of it.

Even in this discussion that we've been having in Canada over the past few months, it seems as though many groups are focused on ideas and rights and equality. It's an important discussion for sure, but I think what the government tried to do when we came forward with this initiative was to focus on actually saving lives, bringing down those horrendous numbers, and having the most efficient and effective impact possible while, importantly, having the most support among Canadian taxpayers. I think that's an important part of the process here.

Ms. Dendys talked about funding as we move forward. If we're going to ensure long-term public support for funding moving forward, I think it's important to focus on measures that obviously have tremendous impact and are efficient, but that also have the broad support of the Canadian public. With regard to the measures we put forward as a government, the measures we've discussed, if you did a poll, probably 98% of Canadians would say, “Yes, we want to do that; that's a good idea. We need to move forward. We can't live with these numbers anymore.” As we get into the broader debate, I think we get closer to a 60-40 or 50-50 split, and I don't think that's productive. I don't think that's going to help us bring those numbers down.

Because it's important, I want to come to Ms. Dendys and talk about one of the things that impressed me about your presentation today. You actually put forward core recommendations. It looks like a game plan that seems fairly well thought out in terms of actually making an impact. Maybe you could speak to the research done by the organizations that make up your organization, in terms of the type of impact that approach will make in terms of bringing those numbers down.

Ms. Christina Dendys: As I said, Results Canada developed this brief with five leading development organizations in Canada. To repeat, they are Save the Children, UNICEF, CARE, World Vision, and Plan Canada. They are in the field and doing this incredible work day in and day out.

In terms of developing this proposal and this brief with our core recommendations, it's about an acknowledgement that, first of all, broadly and globally there's a belief in supporting the continuum of care, meaning the connection between home and community to health centre and hospital. We wanted to put an emphasis on that and support our colleagues globally in terms of what they've been calling for.

The emphasis on front-line community health care was really about the capacity to reach the poorest people where they live. It recognizes that the bulk of the world's poorest children and poorest mothers are far away from hospitals; they live in rural and remote communities, so we need to bring health services and dependable health care close to home.

The approach of using an integrated bundle and package of interventions, which would include micronutrients, contraception, and other interventions, was taken because there's absolutely no debate. It didn't take a lot of research. We know what works when it comes to saving children's lives and mothers' lives.

It didn't take very much, actually, on the part of our six organizations to come together on this, because for the most part these approaches are widely endorsed in terms of being a core part of the solution. That's what we came to in our analysis.

● (1255)

Mr. Mike Lake: Okay. Thanks.

The Chair: We're going to finish off with Mr. Pearson.

We'll get back to you, sir.

Mr. Glen Pearson: If we lose a child, we lose a generation. If we lose a mother, we lose whole communities. I have three children from Sudan who lost their mother. I was there when she died. Her whole worry as she was dying was what was going to happen to them and their community.

I'd like to throw it open to you to see what you have to say about that. The cost of losing a mother is so phenomenal. I would like you to speak to that.

Ms. Katherine McDonald: There are the social and the economic costs. It's the community cost. It's the cost at every level. There's research out of the USAID that says that the economic cost is somewhere around $15 billion a year around maternal deaths. I don't know the source of that, but I've read that in the materials.

Also, I think especially when we're talking about conflict zones, we have rape used as a weapon of war; we have women who are dying from a myriad of diseases. If we don't provide those women with the services they need to stay alive, then we're doing a huge disservice for those three children. Also, we have to understand that Canadians actually would support this initiative, if it was a comprehensive initiative. I don't think this is an issue that Canadians are divided upon. Only 30% of Canadians, according to the latest poll, support this government's initiative to exclude safe abortion services from the maternal and child health initiative. Canadians historically are pro-choice 70% of the time; the numbers haven't changed in 20 years. Are we agreed on any other issue at those numbers? I don't think so. I think those numbers are needed to save children like those three children from Sudan. We have to put our money where our mouth is and where our beliefs are.

Mr. Glen Pearson: Thank you, everyone.

The Chair: Thank you.

Once again to all our witnesses this morning, thank you very much for being here. We started this morning; it's now this afternoon. So thank you.

With that, the meeting is adjourned.

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